Federally Qualified Health Center

Reimbursement Policy ID: RPC.0015.1200

Recent review date: 02/2025

Next review date: 01/2026

AmeriHealth Caritas North Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas North Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses covered services provided by Federally Qualified Health Centers (FQHC's) and how these services are reimbursed. Federally Qualified Health Centers are paid based on the applicable NC Medicaid FQHC fee schedule. Per visit payment amounts (PVPAs) are effective October 1 through September 30 and are inflated by the Medicare economic index (MEI) in effect on October 1 of each year.

Exceptions

N/A

Reimbursement Guidelines

Federally Qualified Health Centers (FQHCs) are reimbursed based on encounters billed. An "encounter" is defined as face-to-face contact between a patient and provider of core or noncore services except for transportation services. Encounters and any services provided are billed on separate claim lines with appropriate modifiers. A visit is one face- to-face encounter between a patient and a provider. For Medicaid reimbursement purposes, a covered service rendered through telehealth by an FQHC practitioner is a face-to-face encounter.

Multiple encounters with one health professional or encounters with multiple health professionals constitute a single visit if all of the following conditions are satisfied: all encounters take place on the same day; all contact involves a single FQHC service; and the service rendered is for a single purpose, illness, injury, condition, or complaint. Multiple encounters constitute separate visits if one of the following conditions is satisfied: the encounters involve different FQHC services; or the services rendered are for different purposes, illnesses, injuries, conditions, or complaints or for additional diagnosis and treatment.

FQHC's have a limit of 3 encounter visits per day based on Section 5.6 of North Carolina Department of Health and Human Services (DHHS) No: 1D-4. FQHC's are eligible to bill for additional services outside of the encounter visit as defined by Clinical Coverage Policy (CCP) No: 1D-4 and the FQHC fee schedule.

Services may be provided by a physician, physician assistant or advanced practice registered nurse. The services provided also include dental services, physical and occupational therapy, speech therapy, audiology services, vision, behavioral health/substance abuse disorder and podiatry.

Per CMS Medicaid FQHC core services guidelines, for accurate reimbursement, the encounter is billed using CPT code, T1015, with the appropriate rate on the first detail line. Providers are required to list all the CPT/HCPCS services provided during the encounter priced at zero dollars on subsequent lines. CPT codes included with the T1015 encounter code must accurately indicate the service(s) provided during the encounter and conform to National Correct Coding Initiative (NCCI) standards. Claims submitted without the corresponding CPT/HCPCS codes will be denied.

Definitions

Federally Qualified Health Center
FQHCs are public health centers focused on serving at-risk and underserved populations.
Minimum services required including, but not limited to, maternity and prenatal care, preventive health and dental services, emergency care, and pharmaceutical services. Other services may include vision services, auditory services, behavioral health services, physical therapy, and speech therapy.

Prospective Payment System
A bundled payment that drives efficiency, not cost-based reimbursement. Rather than being paid fee-for-service, FQHCs receive a single, bundled rate for each qualifying patient visit. This single rate pays for all covered services and supplies provided during the visit.

Edit Sources

I. Current Procedural Terminology (CPT)
II. Healthcare Common Procedure Coding System (HCPCS)

III. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and associated publications.
IV. Centers for Medicare and Medicaid Services (CMS).
V. NC Division of Medical Assistance Medicaid and Health Choice Core Services Provided in Federally Qualified Health Centers - Clinical Coverage Policy No: 1D-4

Attachments

N/A

Associated Policies

N/A

Policy History

02/2025	Reimbursement Policy Committee Approval
01/2025	Annual review • No major changes
04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
02/2024	NC Medicaid Clinical Coverage Policy No: 1D-4
08/2023	Policy Implemented by AmeriHealth Caritas North Carolina
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section