INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Federally Qualified Health Centers and Rural Health Clinics

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Dec. 15, 2016	Scheduled update	FSSA and HPE
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2.0	Policies and procedures as of May 1, 2017 Published: Sept. 12, 2017	Scheduled update	FSSA and DXC
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6.0	Policies and procedures as of Jan. 1, 2022 Published: May 19, 2022	Scheduled update: • Edited text as needed for clarity • Updated web links • Changed ISDH references to IDOH • Updated the *Rendering Providers* section • Updated the *FQHC and RHC Encounters* section and subsections to include new dental information and new POS codes • Updated the *Services Provided Outside a Valid Encounter* section • Added the *COVID-19 Vaccination* section • Removed the *Dental Services* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated the *Crossover Claims for Dually Eligible Members* section to add dental information and POS codes • Updated the *Third-Party Liability* section • Updated the *Managed Care Considerations – Wraparound Payment for Medical and Dental Encounters* section	

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Federally Qualified Health Centers and Rural Health Clinics

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

Introduction

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are facilities designated to provide healthcare services to medically underserved urban and rural communities. FQHCs receive government grants, which help them provide primary care services to all patients, regardless of their ability to pay. FQHCs and RHCs have increased the use of nonphysician practitioners, such as physician assistants and nurse practitioners, in rural areas.

The Indiana Health Coverage Programs (IHCP) provides reimbursement for medical care provided to its members in FQHCs and RHCs.

Provider Enrollment Considerations

IHCP requirements for FQHC and RHC enrollment are described in the following sections. See the *Provider Enrollment* module for more information about enrolling as an IHCP provider and updating provider information on file.

Federally Qualified Health Centers

FQHCs receive funds through the *Public Health Service (PHS) Act* and receive FQHC status from the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. For IHCP reimbursement purposes, FQHCs and FQHC look-alikes are treated the same. For information regarding this process, contact the Indiana Primary Health Care Association at 317-630-0845 or info@indianapca.org.

To enroll as an FQHC with the IHCP, providers must submit a copy of the Centers for Medicare & Medicaid Services (CMS) approval letter verifying FQHC status, along with their completed application, to the IHCP Provider Enrollment Unit.

The provider must also submit the proper financial documents to Myers and Stauffer LC, the IHCP rate-setting contractor, to have a reimbursement rate determined for the FQHC. Myers and Stauffer forwards the rate document to the Provider Enrollment Unit so the encounter rate can be loaded into the Core Medicaid Management Information System (*Core*MMIS).

Rural Health Clinics

RHC services are defined in *Code of Federal Regulations 42 CFR 405.2411* and *42 CFR 440.20*. RHCs receive Medicare designation through the CMS. Clinics must contact the Indiana Department of Health (IDOH) to request RHC status for the IHCP.

The IHCP requires all RHCs to submit finalized (reviewed or audited) cost reports and copies of their Medicare rate letters to Myers and Stauffer. For more information about becoming an RHC under the IHCP, contact the IDOH at 317-233-1325 or 800-382-9480 , the Indiana Primary Health Care Association at 317-630-0845, or other practice consultants.

Rendering Providers

The IHCP reimburses FQHCs and RHCs for valid encounters with the following qualifying practitioners:

- Physician
- Physician assistant
- Advanced practice registered nurse (APRN)
- Licensed clinical psychologist
- Licensed clinical social worker (LCSW)
- Licensed clinical addiction counselor (LCAC)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Dentist
- Dental hygienist
- Podiatrist
- Optometrist
- Chiropractor

All FQHC and RHC qualifying practitioner specialties that are eligible for IHCP enrollment must be enrolled in the IHCP as rendering providers, and their Provider IDs and National Provider Identifiers (NPIs) must be linked to the FQHC or RHC group enrollment.

> *Note: When billing for services performed by a qualifying FQHC or RHC practitioner with a specialty that is **not eligible for IHCP enrollment**, the NPI of an IHCP-enrolled supervising practitioner must be entered as the rendering provider on the claim.*

When a rendering provider is no longer associated with the FQHC or RHC, the clinic must notify the IHCP Provider Enrollment Unit in writing or via the *Provider Maintenance* page of the Provider Healthcare Portal (Portal) so that the information on file for the clinic provider is current.

Change in Scope of Services

The IHCP understands that changes may occur in the scope of FQHC and RHC services. The IHCP considers changes in scope of services on a case-by-case basis, when providers meet filing requirements with Myers and Stauffer prior to the occurrence of a planned change in scope of services. The FQHC or RHC must, on their own behalf, correspond with Myers and Stauffer to complete the change in scope of services. For more information, see the *Indiana FQHC/RHC Change in the Scope of Service Guidelines*, accessible from the Myers and Stauffer website at mslc.com.

Each time an FQHC or RHC facility expands or decreases its scope of service and receives an adjustment to its encounter rate, Myers and Stauffer must forward the new rate letter to the IHCP Provider Enrollment Unit to ensure that reimbursement remains accurate.

Termination of FQHC or RHC Status

When a clinic's FQHC or RHC status is terminated, notifications are typically made as follows:

- Termination of FQHC status:
  - The CMS notifies the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP).
  - The FSSA OMPP then notifies the IHCP Provider Enrollment Unit.
- Termination of RHC status:
  - The CMS notifies the clinic.
  - The provider must send a copy of the termination to the IDOH.
  - The IDOH then forwards the termination notice to the IHCP Provider Enrollment Unit.

Until FQHC or RHC status is reinstated, the provider must enroll in the IHCP as a medical clinic. Failure to do so will result in disenrollment as a provider and loss of any managed care members assigned to primary medical providers (PMPs) linked to that location.

Covered FQHC and RHC Services

The IHCP reimburses FQHCs and RHCs for services – and supplies incidental to such services – that the IHCP would otherwise cover if furnished by a physician or incidental to a physician's services. The IHCP considers any ambulatory service included in the Medicaid State Plan to be a covered FQHC or RHC service, if the FQHC or RHC offers such a service. FQHCs and RHCs are subject to the same prior authorization requirements as other IHCP providers.

The IHCP reimburses FQHCs and RHCs for services to homebound individuals only in the case of FQHCs and RHCs located in areas with shortages of home health agencies, as determined by the FSSA.

FQHCs and RHCs can provide preventive services and encounters, care coordination, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/HealthWatch services (see the *Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/HealthWatch Services* module).

FQHC and RHC Billing and Reimbursement

In accordance with Section 702 of the *Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000* (BIPA), the IHCP implemented a prospective payment system (PPS) for reimbursing FQHCs and RHCs for IHCP-covered services. FQHCs and RHCs receive a facility-specific PPS rate determined by Myers and Stauffer. Myers and Stauffer forwards the specific PPS rate information to the IHCP fiscal agent, and the Provider Enrollment Unit loads the applicable PPS rate for reimbursement of the Healthcare Common Procedure Coding System (HCPCS) dental or medical encounter procedure code to the specific provider enrollment file for reimbursement of fee-for-service (FFS) FQHC and RHC claims.

> *Note: IHCP-enrolled FQHCs must submit an Indiana Medicaid Cost Report annually, which is used in establishing their PPS rate, as well as when reviewing any requests for a change in scope of service. Instructions for completing the FQHC cost report and filing it with the state of Indiana are available in the FQHC Cost Report Instructions and Manual on the Myers and Stauffer website at mslc.com.*

The following subsections provide **FFS** billing and reimbursement information for FQHC and RHC providers. For *general* FFS billing instructions, see the *Claim Submission and Processing* module. For FQHC and RHC claims submitted under the **managed care** delivery system, see the *Managed Care Considerations – Wraparound Payment for Medical and Dental Encounters* section.

FQHC and RHC Encounters

A valid FQHC or RHC encounter is defined as a face-to-face visit (either in person or via telehealth) between an IHCP member and a qualifying practitioner (see the *Rendering Providers* section) at an FQHC, RHC or other qualifying, nonhospital setting.

FQHC and RHC facilities are required to submit fee-for-service claims for valid encounters as follows:

- Report valid **medical** encounters on the professional claim (*CMS-1500* claim form, Portal professional claim or 837P transaction) using HCPCS encounter code **T1015 –** *Clinic, visit/ encounter, all-inclusive*.
- Report valid **dental** encounters on the dental claim (*American Dental Association 2012 Dental Claim Form* [*ADA 2012*], Portal dental claim or 837D transaction) using HCPCS encounter code **D9999** – *Unspecified adjunctive procedure, by report*. This guidance applies for dates of service on or after July 1, 2021.

Additionally, all claims for valid FQHC and RHC encounters must include one of the following place-of-service (POS) codes:

- 02 – *Telehealth**
- 03 – *School**
- 04 – *Homeless Shelter**
- 11 – *Office*
- 12 – *Home*
- 31 – *Skilled nursing facility*
- 32 – *Nursing facility*
- 50 – *Federally qualified health center*
- 72 – *Rural health clinic*

> *Note: POS codes 02, 03 and 04 were added as allowable for valid FQHC and RHC encounter claims effective July 1, 2021.*

FQHC and RHC claims submitted with a POS code of 02, 03, 04, 11, 12, 31, 32, 50 or 72 that do not include the T1015 or D9999 encounter code are denied for EOB 4121 – *D9999 & T1015 must be billed with a valid CPT/HCPCS code.* Providers can resubmit these claims with the appropriate encounter code properly included on the claim.

In addition to the T1015 or D9999 encounter code, FQHC and RHC providers must also include all Current Procedural Terminology (CPT®[1]), Current Dental Terminology (CDT®[2]) codes, and other HCPCS procedure codes appropriate to the services provided during the visit. For claims containing the T1015 or D9999 encounter code, the claim logic compares the other procedure codes used to a list of valid procedure

[1] *CPT copyright 2022 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

[2] *CDT copyright 2022 American Dental Association. All rights reserved. CDT is a registered trademark of the American Dental Association.*

codes approved by the Family and Social Services Administration (FSSA) as meeting criteria for the encounter code, and adjudicates the claim as follows:

- If the claim contains one of the allowable procedure codes from the encounter criteria, all procedure codes other than the T1015 or D9999 encounter code are denied for explanation of benefits (EOB) 4173 – *The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology*, and the encounter rate (T1015 or D9999) is reimbursed according to the usual and customary charge (UCC) established by Myers and Stauffer from the provider-specific rate on the provider file. The provider should not resubmit procedure codes separately that were denied for EOB 4173.
- If the claim does not contain any of the allowable procedure codes from the encounter criteria, the entire claim is denied for EOB 4124 – *The CPT/HCPCS code billed is not a valid encounter*. Providers should not resubmit claims denied for EOB 4124 for payment.

See the Myers and Stauffer website at myersandstauffer.com for a complete list of medical and dental procedure codes that meet the criteria for a valid FQHC or RHC encounter. The list is reviewed periodically to account for new or end-dated procedure codes.

> *Note: When billing valid encounters provided by **telehealth**, FQHC and RHC providers must use POS code 02 with both the encounter code (T1015 or D9999) as well as the procedure codes for the specific allowable services provided during the telemedicine encounter. Modifier 95 is also required for all services provided via telehealth, with the exception of dental services.*

Encounters on Consecutive Dates of Service

Providers can bill only one unit of T1015 or D9999 on a single detail line of the claim. Providers should break down consecutive service dates so that they bill each day on a separate line.

Multiple Encounters on the Same Date of Service

The IHCP allows reimbursement for only one medical encounter code (T1015) per IHCP member, per billing provider, per day – unless the primary diagnosis code differs for each additional encounter. Multiple T1015 encounter claims from an FQHC or RHC for a member on the same date of service that do not include a different primary diagnosis code are denied for EOB 5000 or 5001 – *This is a duplicate of another claim*.

If a member visits an office twice on the same day with two different diagnoses, a second claim can be submitted for the second visit, using a separate professional claim form or electronic claim submission. However, this policy does not allow a provider to bill multiple claims for a *single* visit with multiple diagnoses by separating the diagnoses on different claims.

When two valid practitioners, such as a physician and a psychologist, see the same patient in the same day, the principal diagnoses should not be the same.

> *Note: FQHCs and RHCs must strictly follow proper billing guidelines when submitting multiple diagnosis codes on a single claim. Diagnosis codes must be listed according to their importance, with the first code being the primary diagnosis – that is, the one that most strongly supports the medical necessity of the service:*
>
> - *The diagnosis code submitted in field 21A on the CMS-1500 claim form is considered the primary diagnosis for determining duplicate claims.*
> - *In the Portal, the first code entered in the Diagnosis Codes field is the primary diagnosis.*
> - *For 837P electronic transactions, the first diagnosis code entered in the Loop 2300 HI segment (H101) is the primary diagnosis.*

The IHCP allows reimbursement for only one dental encounter code (D9999) per IHCP member, per billing provider, per day. If a claim is submitted with more than one unit, the claim detail will be cut back to one unit and post EOB 9916 – *Pricing Adjustment – Usual and customary charge (UCC) rate pricing applied*.

Services Provided Outside a Valid Encounter

Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling and dispensing prescriptions, giving injections, or providing optician services do not, *in and of themselves*, constitute encounters. Providers can include these services in the encounter reimbursement when they are performed *in conjunction with* an office visit with a qualifying practitioner. The IHCP does not reimburse for these services through claim submission if performed *without* a face-to-face visit with a qualifying practitioner. (See the *COVID-19 Vaccination* section for an exception to this rule.)

For services provided by FQHCs or RHCs that are not valid encounters with a qualifying practitioner (such as injections performed by a nurse without a corresponding visit to satisfy the valid encounter definition), reimbursement is included in the PPS rate because the cost of the service is included in the facility's cost report. FQHCs and RHCs should contact Myers and Stauffer for information about cost reports.

COVID-19 Vaccination

Beginning April 1, 2021, the IHCP separately reimburses FQHCs and RHCs for the administration of the coronavirus disease 2019 (COVID-19) vaccine provided to IHCP members. Claims for this service should be submitted directly to Medicaid (the IHCP) on a professional or dental claim (*CMS-1500* or *ADA 2012*, or electronic equivalent) using POS code 71 – *Public Health Clinic* along with the applicable COVID-19 vaccination procedure code. The T1015 or D9999 encounter code must **not** be included on the claim, or the claim will deny with EOB 4173. The vaccine administration is carved out of managed care; therefore, the claim must be submitted as FFS for all IHCP members, including those enrolled under a managed care program.

> *Note: For all **other** vaccinations, FQHC and RHC rates include payment for the vaccine and its administration, and these services cannot be billed separately. These services can be included in the encounter reimbursement when performed in conjunction with an office visit to a valid provider, but they are not reimbursable through claim submission if performed without a face-to-face visit with a qualifying practitioner.*

Hospital Services

FQHCs and RHCs use the professional claim (*CMS-1500* or electronic equivalent) to bill the IHCP for medical services provided in **all** settings, including hospitals and other facilities that do not qualify as FQHC or RHC encounter settings. The claim must include the appropriate POS code for the setting in which the service was delivered.

It is not necessary for FQHCs or RHCs to include the T1015 encounter code on claims with POS codes 19 through 26 (urgent care facilities, on- and off-campus outpatient hospitals, inpatient hospitals, emergency rooms, ambulatory surgical centers, birthing centers, and military treatment facilities). The IHCP reimburses FQHCs and RHCs for claims with POS codes 19 through 26 at the current reimbursement rate for each specific CPT or HCPCS code. The IHCP considers these services to be non-FQHC or -RHC services provided by a valid practitioner, but in a setting other than an FQHC- or RHC-qualifying place of service.

Medicaid Rehabilitation Option Services

IHCP reimbursement for Medicaid Rehabilitation Option (MRO) services is available only when the services are billed by an IHCP-enrolled community mental health center (CMHC). MRO services are not reimbursed when billed under the FQHC or RHC provider specialties.

Because a number of FQHC facilities are operated by CMHCs, the IHCP allows such facilities to enroll separately as both a FQHC and a CMHC for the purposes of MRO billing. Any MRO services provided at the facility must be billed under the CMHC Provider ID, and following the normal MRO billing procedures, as described in the *Medicaid Rehabilitation Option Services* module.

The *Non Reimbursable Costs* section of the FQHC cost report (page 3: *Expenses, Reclassifications, and Adjustments*) has been updated to include a line for MRO services. FQHC providers must include nonreimbursable costs associated with MRO services provided at their facility in all cost reports. This information is used for calculating prospective payment reimbursement rates.

> *Note: In a clinic where both FQHC and CMHC providers render services, the FQHC provider must include their separate POS code when billing.*

Crossover Claims for Dually Eligible Members

The IHCP excludes all FQHC and RHC Medicare crossover claims from the PPS logic, as well as the crossover reimbursement methodology, and continues to pay coinsurance or copayment and deductible amounts for dually eligible (Medicare and Medicaid) members.

When submitting claims to Medicare, FQHCs and independent RHCs use the institutional claim (*UB-04* claim form or electronic equivalent). The IHCP accepts the institutional claim type for FQHC and RHC claims that cross over ***automatically*** from the Medicare payer to the IHCP. However, FQHCs and RHCs **must** use the professional claim (*CMS-1500* claim form or electronic equivalent) to submit Medicare-processed claims that did ***not*** automatically cross over to the IHCP, including claims allowed by Medicare that failed to cross over as well as Medicare-denied claims.

FQHC and RHC crossover claims with POS code 02, 03, 04, 11, 12, 31, 32, 50 or 72 must contain the T1015 encounter code (or D9999 for Medicare Advantage Plan dental claims) and the procedure codes for the specific services rendered.

> *Note: All professional crossover claims submitted to the IHCP must show Medicare as the previous payer and must include the Medicare-paid amount (actual dollars received from Medicare) as well as Medicare deductible and coinsurance or copayment information at both the header (claim) and detail (service) level. If submitting the claim on a paper form, billers must include a completed IHCP TPL/Medicare Special Attachment Form, available on the Forms page at in.gov/medicaid/providers. If Medicare denied the claim, providers must attach the Explanation of Medicare Benefits (EOMB). For additional information about Medicare crossover billing, see the Claim Submission and Processing module.*

Third-Party Liability

All third-party liability (TPL), patient or waiver liability, and copayments apply, as appropriate, to FQHC and RHC services. Designated preventive pediatric care services provided during an encounter and appropriately billed bypass TPL. See *Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance* on the *Code Sets* page at in.gov/medicaid/providers.

The IHCP applies previous TPL payments at the detail level. See the *Third-Party Liability* module for general information about TPL.

Managed Care Considerations – Wraparound Payment for Medical and Dental Encounters

FQHCs and RHCs can participate with a managed care entity (MCE). The MCE provider contract must specify the contractual arrangements to ensure that the FQHC or RHC is reimbursed for services. FQHC and RHC claims for IHCP members enrolled in a managed care plan such as Hoosier Care Connect, Hoosier Healthwise or the Healthy Indiana Plan (HIP) must be submitted to the applicable MCE for processing.

Effective for dates of service on or after July 1, 2021, the IHCP requires encounter code T1015 on professional (medical) claims and D9999 on dental claims for all FQHC and RHC encounters, including for managed care members. FQHC and RHC wraparound (supplemental) payments for medical and dental encounters with IHCP managed care members are systematically processed on a claim-by-claim basis by Gainwell Technologies. This process replaces the monthly and year-end settlement process for medical services reported on professional claims and dental services reported on dental claims. FQHC and RHC providers will no longer submit manual supplemental payment requests to Myers and Stauffer to receive the difference between the MCE payment and the FQHC/RHC encounter rate for claims with dates of service on or after July 1, 2021 (manual requests will no longer be accepted after Feb. 28, 2022).

Effective with this change, *Core*MMIS will systematically process the wraparound payment and display the wraparound amounts on the weekly provider Remittance Advice (RA). The IHCP RA for FQHCs and RHCs includes the following fields:

- Sum of All Payors – This field displays the total amount paid by the MCE and other insurance carriers, on a claim-by-claim basis. Claims with a sum of all payors amount of zero will be returned with EOB 3370 – *Sum of all payors amount is zero for the COB field for the encounter claim. Please verify and resubmit.*
- Wrap Amount – This field displays the difference between the provider-specific FQHC/RHC rate and the sum of all payors' amount for each claim. Claims where the difference between the provider-specific rate and the sum of all payor's amount is zero will post with EOB 3372 – *Calculated Wrap Around payment amount is zero*.

Wraparound payments and adjustments are grouped separately on the RA, and listed for each claim with a wraparound payment or adjustment processed for the week. Claims are sorted by type (medical or dental).

> *Note: To improve the identification of health-risk factors of expectant mothers, the IHCP provides an additional $60 for Notification of Pregnancy (NOP) when submitted for managed care members as described in the Obstetrics and Gynecological Services module and billed to the MCE as 99354 TH. The NOP service itself does not constitute a valid encounter. Wraparound FQHC/RHC payments will not be made if the NOP (99354 TH) is the only service reported with encounter code T1015.*