Federally Qualified Health Center

Reimbursement Policy ID: RPC.0015.2100

Recent review date: 01/2025

Next review date: 01/2026

AmeriHealth Caritas Louisiana 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 Louisiana 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 but not limited to Current Procedural Terminology (CPT®), the Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM). Other factors that may affect payment include but are not limited to 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 policies. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all healthcare services billed on CMS-1500 forms or its electronic equivalent and, when specified, billed on UB-04 forms or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses covered services provided by Federally Qualified Health Centers (FQHCs) and how these services are reimbursed. PPS rates for primary care services are adjusted effective July 1 of the state fiscal year (SFY) by the published Medicare Economic Index (MEI).

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. Encounters and any services provided are billed on separate claim lines with appropriate modifiers. For Prospective Payment Services (PPS) other than transportation, 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 PPS 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 PPS services; or the services rendered are for different purposes, illnesses, injuries, conditions, or complaints or for additional diagnosis and treatment.

Services may be provided by a physician, physician assistant or advanced practice registered nurse. Services and supplies that are furnished by FQHC staff and incidental to an FQHC professional service as commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications and supplies used in a patient service visit are considered part of the FQHC service. The services also provided include dental services, physical and occupational therapy, speech therapy, audiology services, vision, behavioral health/substance abuse disorder, community health services, and podiatry.

Medical health services provided in FQHCs are reimbursed as encounters. These encounter visits must be billed on a CMS-1500 using procedure code T1015, Clinic visit, encounter, all-inclusive. The encounter reimbursement includes all services provided to the beneficiary on that date of service and any services on a subsequent day incidental to the original encounter visit. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines. For obstetrical services, providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service.

Behavioral health services provided by a licensed mental health provider are billed with CPT code H2020, therapeutic behavioral services, per diem. The claim must also include an accepted E/M detail line (procedure codes between 99202 thru 99215) or accepted specialized behavioral health (SBH) service detail line. SBH services are identified in the SBH Fee Schedule.

Reimbursement will be made for adjunct services in addition to the encounter rate paid for professional services when these services are rendered during the evening, weekend or holiday hours as outlined in the Current Procedural Terminology (CPT) manual under "Special Services, Procedures and Reports".
These adjunct codes are reimbursed in addition to the reimbursement for outpatient evaluation and management services when the services are rendered in settings other than hospital emergency departments:

- Between the hours of 5 p.m. and 8 a.m. Monday through Friday;
- On weekends between 12 a.m. Saturday through midnight on Sunday; and
- State proclaimed legal holidays,12 a.m. through midnight.

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, chiropractic service 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. AmeriHealth Caritas Louisiana Provider Manual
V. Claim Filing Instructions - Providers - AmeriHealth Caritas Louisiana (amerihealthcaritasla.com)
VI. Applicable Louisiana Medicaid Fee Schedule

Attachments

N/A

Associated Policies

N/A

Policy History

04/2025	Revised preamble
01/2025	Reimbursement Policy Committee Approval
01/2025	Annual review • No major changes
04/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section
	Precedes Act 319