Federally Qualified Health Center

Reimbursement Policy ID: RPC.0015.72KF

Recent review date: 02/2025

Next review date: 01/2026

Keystone First Community HealthChoices 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. Keystone First Community HealthChoices 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 on a prospective payment system (PPS). 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 (FQHC's) are reimbursed based on encounters billed. An encounter is a face to-face in-person, telehealth, telemedicine, or tele dentistry visit between a beneficiary and the physician, dentist or licensed non-physician practitioner. Encounters and any services provided are billed on separate claim lines with appropriate modifiers. For transportation services, a visit is a one-way trip provided to or from a site where a covered service is rendered on the same date.

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, advanced practice registered nurse or dentist. 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 guidelines, for accurate reimbursement, the encounter is billed using CPT code, T1015, with the appropriate rate on the first detail line. Providers must bill all CPT codes related to services provided for payment.

Definitions

Federally Qualified Health Center (FQHC)
Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. An FQHC is a community-based organization that provides comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse.

Prospective payment system (PPS)
FQHC PPS consisted of bundled payments that drives efficiency, not cost-based reimbursement. The PPS base rate is calculated for each FQHC, derived from the historical costs of providing comprehensive care to Medicaid patients to ensure each rate is appropriate and accurate. There is a single, bundled rate for each qualifying patient 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. PROMISE Provider Handbooks and Billing Guides
VI. Pennsylvania Outpatient Fee Schedule

Attachments

N/A

Associated Policies

N/A

Policy History

02/2025	Reimbursement Policy Committee Approval
01/2025	Annual Review • No major changes
04/2024	Revise preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First Community HealthChoices from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section