SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) PROVIDER MANUAL

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South Carolina Department of Health and Human Services

CONTENTS

1 PROGRAM OVERVIEW

PROGRAM DESCRIPTION

The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of Federally Qualified Health Center (FQHC) services delivered to Healthy Connections Medicaid members via the following programs:

- Fee-for-Service (FFS)
- Managed Care Organization (MCO)

The FQHC Services Provider Manual supplements SCDHHS's general policies and procedures detailed in the Provider Administrative and Billing Manual and it provides policies and requirements specific for FQHC providers for the FFS program and South Carolina's (State) wrap-around payment policies and supplemental payments for services in managed care. For services delivered to MCO members, providers must follow the member's MCO's policies and requirements.

For the purpose of this manual, FQHC services are defined as services furnished by FQHC providers meeting all applicable Medicaid provider qualifications, Health Resources and Services Administration (HRSA) Health Center Program Statutes and Regulations as defined in the HRSA Health Center Program Compliance Manual, and any applicable state licensure regulations for rendering providers affiliated with FQHCs as specified by the South Carolina Department of Labor, Licensing, and Regulation (LLR).

Providers must review, reference, and comply with both the FQHC Services Provider Manual and the Provider Administrative and Billing Manual.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- Provider Administrative and Billing Manual
- Provider Manual List | SCDHHS

2 COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Beneficiary Requirements

Healthy Connections Medicaid Beneficiaries with full benefits and those enrolled in the Family Planning limited benefit program are eligible to receive services in a FQHC.

- Children (beneficiaries under the age of 21 years)
- Adults (beneficiaries ages 21 years and older)
- Beneficiaries in the Family Planning Limited Benefit Program (Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level income percentage and are ineligible for full Medicaid benefits under another eligibility category. The program provides coverage for preventive health care, family planning services, and family planning-related services.)

Verifying Beneficiary's Eligibility

Participating Healthy Connections providers must access beneficiary eligibility information through the SCDHHS' Web Portal or Customer Service Center. Beneficiaries must be eligible on the date of service for payment to be made.

3 ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

An eligible FQHC provider is a HRSA approved FQHC or FQHC look-a-like [under the authority of *Sections 330(a)(1), (b)(1)-(2) of the Public Health Service (PHS) Act; and 42 CFR 51c.303(a), 42 CFR 51c.303(p), 42 CFR 56.303(a), 42 CFR 56.303(p) and 1861(aa)(4) of SSA*]; entity with a written participation agreement in effect with SCDHHS to provide medical, remedial, dental, pharmacy and behavioral health services to beneficiaries enrolled in the Healthy Connections program pursuant to the South Carolina State Plan for Medical Assistance and in accordance with Title XIX of the Social Security Act, as amended.

For general information regarding provider qualifications and enrollment in the South Carolina Healthy Connections Medicaid program please refer to the Provider Administrative and Billing Manual .

FQHC General Requirements:

- The health center must provide the required primary and approved additional FQHC health services through staff and supporting resources of the center or through contracts or cooperative arrangements.
- The health center must provide FQHC health services so that such services are available and accessible promptly, as appropriate, and in a manner that will assure continuity of service to the residents of the center's catchment area.
- The health center must utilize staff that are qualified by training and experience and practicing within the scope of practice to carry out the activities of the center.
- FQHC services must be performed by or under the supervision of a physician or other qualified healthcare practitioner licensed by the appropriate state licensing agency. The medical supervision and physician involvement of midlevel practitioners and related medical services performed in the clinic must be in accordance with the governing laws of the appropriate state agency and standard medical practice. Nurse practitioners and midwife services must comply with the scope of services permitted by the applicable nursing laws of the appropriate state agency. Physician assistants must comply with the scope of services permitted by the South Carolina Board of Medical Examiners or appropriate state medical agency.
- FQHC services must conform to federal and state laws, rules and regulations.

- Each permanent site at which a FQHC offers services must be enrolled separately. In addition to permanent sites, service sites may also be seasonal, mobile van, or intermittent as defined by HSRA, and they must provide comprehensive primary health care services and/or single service such as oral or mental health services, on a regularly scheduled basis, to a defined service area or target population. Sites that are not equipped to provide the array of services described above or that are not utilized for direct patient care, are not considered service sites. Separate Medicaid enrollment **is required** for the seasonal, mobile vans, or intermittent **service sites.**

- To become a Healthy Connection Medicaid provider the FQHC organization must enroll each of its service sites (permanent, seasonal, mobile vans or intermittent sites). Each service site of the same FQHC organization must have the same Tax Identification Number (TIN). The FQHC organization must submit the following information to the Provider Enrollment Department at SCDHHS:
    1. Enrollment application(s), and
    2. The HRSA Notice of Grant Award for each service site, and
    3. Documentation identifying the type of site being enrolled.

Note: Information for adding a new site is in the Terms and Conditions section on the HRSA Notice of Grant Award. For general requirements on Provider enrollment refer to SCDHHS's website at: https://www.scdhhs.gov/providers/become-provider

The following practitioners are qualified providers to perform services in an FQHC:

- Physician
- Physician Assistant (PA)
- Advanced Practice Registered Nurse (APRN)
- Certified Nurse Midwife (CNM)
- Licensed Psychologist
- Licensed Independent Social Worker — Clinical Practice
- Licensed Master Social Worker
- Licensed Professional Counselor (LPC)
- Licensed Clinical Addiction Counselor (LAC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Registered Dietician
- Pharmacist (Consultation and Education)

- Chiropractor
- Dentist
- Podiatrist
- Optometrist

All practitioners qualified to perform services in a FQHC, who are eligible for enrollment in Healthy Connections Medicaid, must be enrolled in Medicaid and their individual National Provider Identifiers (NPIs) must be linked to the FQHC provider. Individual dentists must be linked to the dental clinic of the FQHC which has an enrollment status of a dental group provider. Individual pharmacists must be linked to the pharmacy of the FQHC which has an enrollment status of pharmacy provider.

Enrolled providers are prohibited from using their NPI to bill Medicaid for services rendered by a non-enrolled, terminated, or excluded provider.

4 COVERED SERVICES AND DEFINITIONS

DEFINITIONS

1. **Covered Services** means a medical service, including those services coverable through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program meeting the following criteria:
   a. Is medically necessary.
   b. Is provided to an eligible beneficiary by a participating provider.
   c. Is the most appropriate supply or level of care consistent with professionally recognized standards of medical practice within the service area and applicable policies and procedures.
   d. Is not rendered for convenience, cosmetic or experimental purposes.

2. **Provider** means an individual, firm, corporation, association or institution providing, or has been approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act, as amended.

3. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** program is for persons under age 21 [pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a)(4)(B) and 1396d(r), and 42 C.F.R. Part 441, Subpart B] to ascertain a child's individual physical and mental illness and conditions discovered by screening services, whether or not such services are covered.

4. **Medically Reasonable and Necessary** means procedures, treatments, medications or supplies (the provision of which may be limited by specific provisions, bulletins and other directives [42 CFR 440.230 (d) and SC Code of Regulations 126-300 (D)]), ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury which per [S.C. Code of Regulations 126-425(9)]:
   a. Must be provided at appropriate facilities, at the appropriate levels of care and in the least costly setting required by the beneficiary's condition.
   b. Must be administered in accordance with recognized and acceptable standards of medical and/or surgical discipline at the time the beneficiary receives the service.
   c. Must comply with standards of care and not for the beneficiary's convenience, experimental or cosmetic purposes.
   d. Medical necessity or any referral information must be documented in the beneficiary's health record and must include a detailed description of services rendered. The fact that a provider prescribed a service or supply does not deem it medically necessary.

5. **Health Resources and Service Administration (HRSA)-**HRSA is the primary federal agency responsible for ensuring access to health care services for people who are uninsured, isolated, or medically vulnerable, including those living with HIV/AIDS, mothers and children, and those living in rural areas.

COVERED SERVICES

In compliance with Authority: *Section 330(a)-(b), Section 330(h)(2), and Section 330(k)(3)(K) of the PHS Act; and 42 CFR 51c.102(h) and (j), 42 CFR 56.102(l) and (o), and 42 CFR 51c.303(l)* the Health Center must provide:

- Required primary health services.
- Substance use disorder services.
- Additional (supplemental) health services as approved by HRSA.

All FQHC services are subject to a medical necessity determination by SCDHHS through established utilization management policies based on the application of industry standards of medical practice, and through applications of reasonable limitations and criteria, as defined in their respective SCDHHS provider manual (such as the Physicians, Rehabilitative Behavioral Health Services, Dental Services, and Pharmacy Services Manuals).

Medically necessary FQHC services are covered as follows:

State Plan Services

Federally Qualified Health Centers (FQHC) services are:

- Procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, clinical social worker, incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services.
- Procedures performed by a visiting nurse in areas with shortages of home health agencies. In certain cases, services to a homebound Medicaid patient may be provided.
- Any other ambulatory service included in the State Plan is considered a covered FQHC service, if the FQHC offers such a service.
- FQHC providers are eligible to serve as referring site or consulting site providers for telehealth services.

EPSDT Benefit

- Children under the age of twenty-one (21) are eligible for medically necessary services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Federal law at [42 U.S.C.§1396d(r), §1905(r) of the Social Security Act (SSA)] requires state Medicaid programs to provide EPSDT services for recipients under 21 years of age. The scope of EPSDT benefits under the federal law covers services that are medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by

screening," whether or not the service is covered under the State Plan. EPSDT benefit includes services provided at intervals that meet reasonable standards of medical practice and at intervals necessary to determine the existence of a suspected illness or condition. EPSDT benefit is detailed on the SCDHHS EPSDT website at EPSDT | SCDHHS.

- SCDHHS has adopted the **Bright Futures/American Academy of Pediatrics (AAP) Medical Periodicity Schedule** for medical, hearing and vision screenings as well as age-appropriate assessment, procedures and immunization.
- SCDHHS has also developed an **Oral Health Section of the Medical Periodicity Schedule** for oral screenings and oral health services performed by medical providers.
- Additionally, SCDHHS has developed the **Dental Periodicity Schedule** following the recommendations of the American Academy of Pediatric Dentistry (AAPD) on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Infants, Children and Adolescents.
- Refer to the EPSDT services section of the Physician Services Provider Manual for coverage details.

Family Planning Services

Family planning services are defined as preconception services that prevent or delay pregnancies and do not include abortion or abortion-related services. Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage in order to be eligible and who are ineligible for full Medicaid benefits under another eligibility category. This program provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventive health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a limited set of services. Family Planning provides coverage for a limited set of services, including biennial physicals, family planning services, and family planning related services. Any services provided to a beneficiary enrolled in Family Planning that is not specifically outlined as a covered service are the sole responsibility of the beneficiary. Refer to the Family Planning section of the Physician Services Provider Manual for coverage details.

NON-COVERED SERVICES

The South Carolina Medicaid program does not cover health education, social work, or other related ancillary services unless noted in this section. Services provided in an inpatient or outpatient hospital department, including critical access hospital, or a facility with specific requirements excluding FQHC visits are not considered FQHC services. Services provided to members with Emergency Only Limited benefit are not considered FQHC services.

5 UTILIZATION MANAGEMENT

For general policies regarding Program Integrity, Utilization Management, Fraud, Waste and Abuse providers must refer to the Provider Administrative and Billing Manual.

AUTHORIZATION

Authorizations are a utilization tool that require participating providers to submit "documentation" associated with certain services for a beneficiary either before the service is rendered (prior authorizations) or after service is rendered but prior to payment. Participating providers will not be paid if this "documentation" is not furnished to SCDHHS or its designee. Participating providers must hold the beneficiary and SCDHHS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization.

For beneficiaries enrolled in a MCO, refer to the individual MCO plan regarding its services and authorization policies. Failure to comply with these requirements may result in denial or recoupment of payment.

- Providers must file a prior authorization request for FQHC services that require an approval prior to rendering the service. The prior authorization request must be submitted with appropriate documentation that supports medical necessity for the service(s).

- Payment for services that exceed frequency limitations must be justified through an EPSDT examination and pre-approved by SCDHHS or its designee.

- Providers must submit proper documentation with the claim for FQHC services that require review by SCDHHS or its designee for determination of medical necessity prior to reimbursement for the procedures. These claims are subject to pre-payment edits. If a pre-payment edit is received, providers must file a new claim and submit documentation to support medical necessity.

- Beneficiaries with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier denied the service, or the service is considered not covered. This is applicable only for services that require prior authorization by Medicaid.

- For pharmacy or dental services, all prior authorizations requests must be submitted to the SCDHHS pharmacy or dental vendor respectively. Information about the authorization process for pharmacy or dental services can be found in the Pharmacy Services Provider Manual and Dental Services Provider Manual.

- For physician administered drugs that require prior authorization, providers must file the authorization request to Magellan Specialty at:

  Magellan Rx Management
  Telephone: 1-800-424- 8219
  Website: https://MRxGateway.com

- For medical and behavioral health services, all prior authorization requests must be submitted to the Quality Improvement Organization (QIO). All applicable forms for requests for prior authorizations are posted to QIO website https://scdhhs.kepro.com.

  QIO Customer Service Phone: +1 855 326 5219
  QIO Fax #: +1 855 300 0082
  Provider Issues Email: atrezzoissues@Kepro.com

6 REPORTING/DOCUMENTATION

General policies for Medicaid beneficiaries' health records documentation, reporting and signature requirements are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, FQHC providers must comply with specific policies for health records requirements and documentation detailed below.

HEALTH RECORDS

In addition to providers' compliance with state and federal laws and regulations regarding health record retention requirements [e.g., Social Security Act 1902(a)(27), 42 CFR 431.107]. SCDHHS requires FQHC providers to retain health records on site. For Medicaid purposes all health and fiscal records must be retained for a minimum period of four (4) years after the last payment was made for services rendered, to facilitate audits and reviews of the beneficiary's health record. No other documentation (except for hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, ledger cards, claim forms, and computer records.

Health Record Compliance requirements

Providers must:

- Document the rationale and justification of medical necessity for services, including all findings, diagnosis and supporting information.
- Detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the Current Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) nomenclatures and descriptors, or as indicated in the SCDHHS policy.
- Ensure that health records are signed and dated at the time of service, or the rendering provider must attest to the date and time as appropriate to the media (e.g., paper or electronic signature); and information, including rendering provider, date, and time of the service, must be verifiable.

Medicaid services that are not properly documented in clinical notes are subject to denial or recoupment. All required documentation must be present in the health record before the provider files claims for reimbursement. All services performed must be recorded in the beneficiary's health record, which must be available as required by the Participating Provider Agreement.

MEDICAL SERVICE DOCUMENTATION

Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Documentation of services must comply with

guidelines set forth under each service within the respective Service Provider Manuals. Adequate documentation reflects:

- Services performed
- Medical necessity
- Performing provider and supervising provider (when required)
- Time period the services were performed
- Treatment plan if applicable

For Documentation requirements for specific services please refer to respective policy within the Behavioral Health or Physician Services Provider manuals.

Referrals

When the FQHC refers a patient to another provider who is responsible for the treatment plan and billing for the services provided, information from the referral visit should be provided back to the FQHC for appropriate follow-up care and included in the patient's medical records. In addition, the process for how patients are referred for services outside of the FQHC and tracking and referring patients back to the FQHC for appropriate follow-up care (for example, exchange of patient record information, receipt of lab results) should be specified when referrals are made. See the Provider Administrative and Billing Manual for specific information on referral requirements.

Procedure Codes

FQHC providers are required to submit the applicable Current Procedural Terminology (CPT) codes as defined in the CPT reference guide, Healthcare Common Procedure Coding System (HCPCS) or International Classification od Diseases, 10th Revision (ICD-10) or as otherwise specified by SCDHHS in this manual.

7 Billing Guidance

General Billing Guidance, such as Usual and Customary Rates; Timely Filing; Third Party Liability and Coordination of Benefits (COB); Adjustments and Refunds; Remittance Advices; and Electronic Fund Transfer, is detailed in the Provider Administrative and Billing Manual. Additional Billing Guidance specific to FQHC services is detailed in this manual.

Providers must follow the National Correct Coding Initiative (NCCI) edits and its related coding policy, unless otherwise indicated in this manual. For detailed information about the NCCI refer to the Administrative and Billing Provider manual.

FQHC ENCOUNTERS

Encounters

The FQHCs are reimbursed for medically necessary, primary health services, and qualified preventive health services performed by an FQHC practitioner. Core services are reimbursed using encounter codes. A valid FQHC encounter is defined as a face-to-face, one-on-one visit (either in person or via telehealth) between a Healthy Connections Medicaid member and a qualifying practitioner (see the Qualified Providers section) at an FQHC facility or other qualifying, nonhospital setting (please refer to Place of Service allowed below). For billing purposes, SCDHHS has deemed a “visit” as an “encounter”.

Only one encounter code is allowed per day, except for the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day. The most appropriate encounter code must be billed based on the service(s) provided. All supplies, lab work, injections, surgical procedures (unless noted in the Special Clinic Services section of this manual), etc., are included in the encounter code reimbursement. The only fragmented services billable on an FFS basis is listed under Special Clinic Services.

FQHC services are covered when furnished to patients at the service site (which includes permanent, seasonal, mobile van or intermittent site), in a skilled nursing facility, or at the client’s place of residence.

FQHC 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.
- Additionally, all claims for valid FQHC encounters must include a valid Place of Service (POS) code from the CMS POS Code Set. FQHC services are allowed to be performed in the following setting:
    - School
    - Homeless Shelter
    - Telehealth or Telehealth at Home

- Home
- Mobile Unit
- Assisted Living Facility
- Skilled Nursing Facility
- Nursing Facility
- Federally Qualified Health Center

Note: When billing valid encounters provided by telehealth, FQHC providers must use POS code 02 with the encounter code T1015 as well as the procedure codes for the specific allowable services provided during the telemedicine encounter. Modifier GT is also required for all services provided via telehealth.

FQHC claims submitted without the T1015 encounter code and/or the allowed POS will be denied.

In addition to the T1015 encounter code, FQHC providers must also include all Current Procedural Terminology (CPT) codes, and other HCPCS procedure codes appropriate to the services provided during the visit. Providers must bill for FQHC services utilizing the procedure codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT). Procedure codes that deviate in description from the HCPCS/CPT assigned description, are indicated in the respective provider manuals for that service. For additional information on procedural coding, refer to the Administrative and Billing Provider Manual.

Supplies and Ancillary Services

Supplies and ancillary services such as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, giving injections (except vaccinations), applying fluoride varnish or providing optician services do not, in and of themselves, constitute encounters. These services and supply costs are included in the encounter rate when provided during an encounter.

Providers can include these services in the encounter reimbursement when they are performed in conjunction with an office visit with a qualifying practitioner. The SCDHHS does not reimburse for these services through claim submission if performed without a face-to-face visit with a qualifying practitioner. Reimbursement for services provided by FQHCs 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), is included in the encounter rate because the cost of the service is included in the facility's cost report.

Encounters on Consecutive Dates of Service

Providers can bill only one unit of T1015 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 SCDHHS allows reimbursement for only one medical encounter code (T1015) per Medicaid member, per billing provider, per day – unless the primary diagnosis code differs for each additional

encounter. Multiple T1015 encounter claims from an FQHC for a member on the same date of service that do not include a different primary diagnosis code are denied.

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 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.

Claim Form

SCDHHS requires FQHC providers to submit all claims on a professional CMS-1500 claim form.

Billing by units

When billing for services with units of fifteen (15) minutes, at least eight (8) minutes of direct contact with the patient must be provided for a single unit of service to be appropriately reported and billed.

FQHC Provider Number

All encounter services and ancillary services described in this section of the manual must be billed under the FQHC provider number

National Correct Coding Initiative

Providers must follow the National Correct Coding Initiative (NCCI) edits and its related coding policy, unless otherwise indicated in this manual. For detailed information about the NCCI, please see the Administrative and Billing Provider Manual.

Types of Encounters

Medical Encounter

All medical encounters must be billed using the appropriate encounter code unless otherwise specified. A medical “visit” (encounter) is defined as a face-to-face, one-on-one encounter between a patient and an eligible rendering provider during which an FQHC core service is provided. FQHC providers will be reimbursed their contracted encounter rate, and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day.

Maternal Encounter

All maternal care encounters must be billed with the appropriate encounter code with a TH modifier. FQHC providers will be reimbursed their contracted rate for all maternal services rendered. The use of this procedure code and a TH modifier will not affect the beneficiary's number of allowable ambulatory visits. Intrauterine devices (IUDs), the technical component of ultrasounds, and fetal non-stress tests may be billed separately. Please refer to Family Planning and Special Clinic Services coding guidelines below.

Behavioral Health Encounter

A mental health visit is defined as a face-to-face, one-on-one encounter between the FQHC beneficiary and the eligible rendering provider (including an Allied Professional under the direct supervision of a physician or APRN for mental health services). Only one behavioral health encounter code is allowed per day. All behavioral health encounters must be billed using procedure code T1015 with the HE modifier, mental health program. This code is not intended for billing case management services.

Cancer Treatment and HIV/AIDS Encounter

SCDHHS allows FQHCs to bill for HIV/AIDS and cancer-related services using the appropriate encounter code, with the P4 modifier.

Charges for such services will be reimbursed at the contract rate.

EPSDT Screening Encounter

All EPSDT screenings (periodic and inter-periodic screenings) must be billed as an encounter at the FQHC contract rate, however, the appropriate CPT screening codes must be billed for reimbursement. A screening and an encounter code may not be billed on the same DOS. FQHCs must bill under their FQHC provider number.

Prior authorizations are NOT required for Periodic or Inter-periodic screening services.

Family Planning Encounter

Family Planning Program refers to services allowed to Family Planning eligibility group, which are a limited set of family planning services. See the E&M services for Family Planning benefit in the Physician Services Provider Manual for more details on this coverage.

There are four types of encounters covered for beneficiaries enrolled in the Family Planning Program. These encounters include biennial (once every two years) physical examinations, annual family planning encounter, periodic family planning, and contraceptive counseling.

- Biennial Physical Encounter: The Family Planning program allows adult physical examinations under the following guidelines:
    - An FQHC would bill T1015 with a FP modifier appended. Only one encounter code can be billed in a day

  - The biennial encounter is allowed once every two years per beneficiary.
  - It is a preventative encounter.
  - Diagnosis code Z00.00 or Z00.01 must be used when billing for the Family Planning biennial physical.
  - The encounter must be performed by a Nurse Practitioner, Physician Assistant or a Physician.
  - Family Planning counseling must be offered to Family Planning beneficiaries during the physical encounter. Portions of the physical may be omitted if the beneficiary is not cooperative and resists specific system examinations (despite encouragement by the physician, nurse practitioner or office staff). A well-documented note must be written in the patient's record explaining why that part of the exam was omitted.
  - All laboratory procedures are included in the reimbursement for the encounter.
- Annual Family Planning Encounters: The annual visit is the re-evaluation of an established patient requiring an update to the medical record, interim history, physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated.
  - This visit should be billed using T1015 with the FP modifier.
- Periodic Revisit: is a follow up of an established patient with a new or existing family planning treatment. These encounters are available for multiple reasons such as change in contraceptive method due to problems with the particular method or issuance of birth control supplies.
  - This visit should be billed using the T1015 with FP modifier. Only one encounter code can be billed in a day.
- Family Planning Counseling Encounters: Family Planning Counseling/Education is a face-to-face, one-on-one interaction to enhance a beneficiary's comprehension or compliance with his or her family planning method of choice. These services are for the expressed purpose of providing education/counseling above and beyond the routine contraceptive counseling that are included in the clinic visits.
  - The Family Planning Counseling/Education visit is a separate and distinct service, using the T1015 with FP modifier. Only one encounter code can be billed in a day.
  - FQHC Reporting Positive Screens

Family Planning beneficiaries have Medicaid coverage for a limited set of services. This coverage does not include treatment, medication, or office visits for many of the conditions that a FQHC provider may identify during the physical examination or annual family planning visit. If a problem or condition is identified during the physical examination or annual family planning visit, the FQHC should schedule a follow-up visit with the patient in order to address the problem. Family Planning patients will be responsible for any fees associated with follow-up visits. All follow-up visits for uninsured Family Planning beneficiaries should follow the FQHC provider's established policies and procedures for treating uninsured patients. For data collection and monitoring purposes, SCDHHS requests that FQHCs report positive screening results when a problem or condition is identified

during the physical examination or annual family planning visit. The instructions that follow describe the process for reporting these positive screenings.

When a problem or condition requiring follow-up care is identified, FQHCs should include the Positive Screening Code along with one or more of the modifiers listed below as a separate line on the Encounter Claim Form.

FQHCs must use the appropriate modifier from the list below. Up to four modifiers can be used for the Positive Screening Code (e.g., if a patient is scheduled to receive a follow-up visit for more than one positive screening, include modifiers for all positive screenings):

- If scheduling a follow-up visit for a patient for a positive diabetes screen, use modifier P1.
- If scheduling a follow-up for a patient for a positive cardiovascular screen, use modifier P2.
- If scheduling a follow-up visit for a patient for any positive cancer screen, use modifier P3.
- If scheduling a follow-up visit for a patient for any mental or behavioral health screens, use modifier P4.
- If scheduling a follow-up visit for a patient for any other condition or problem, use modifier P5.

Telehealth Encounters

Telehealth substitutes for an in-person visit, and generally involves two-way, interactive technology that permits communication between the practitioner and patient. FQHCs can provide telehealth to extend care when a patient is in a different place.

Referring Site

FQHCs are eligible to receive reimbursement for a facility fee for the telehealth services when operating as the referring site. Claims must be submitted with the HCPCS code for telehealth referring site facility fee. When serving as the referring site, the FQHC cannot bill the encounter code if these are the only services being rendered.

Consulting Site

FQHCs would bill an encounter code when operating as the consulting site. Only one encounter code can be billed for a DOS. Both provider types will use the appropriate encounter code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

SPECIAL CLINIC SERVICES

Special clinic services include services that are excluded from the FQHC encounter rate and may be billed and reimbursed separately from the encounters. Providers must use the appropriate CPT/HCPCS code when billing for the special clinic services.

The special clinic services include the following:

Service Category	Procedure Code(s)	Criteria and limitations
Fetal non-stress test (NST)	59025	Only the technical component is billed outside of the encounter. Services must be billed with TC modifier. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist or other provider for interpretation, the specialist's services are reimbursed under the FFS program following Medicaid policy for their specialty.
Radiology /Imaging	70000-79999*; 92250; 93880; 93970	Only the technical component is billed outside of the encounter. Services must be billed with TC modifier. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist or other provider, for interpretation, the specialist's services are reimbursed under the FFS program following Medicaid policy for their specialty. *Only services within the range that are in scope for FQHC setting are allowed.
Electrocardiography (EKG)	93005; 93017; 93041; 93225	Only the technical component is billed outside of the encounter. Services must be billed with TC modifier. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist or other provider, for interpretation, the specialist's services are reimbursed under the FFS program following Medicaid policy for their specialty.
Covid testing	0202U; 86328; 86769; 87426; 87428; 87635; 87636; 87637; 87811; U0001; U0002	
Immunization and Vaccine Administration	90375-90756 Q2035-Q2039; 90480 91318-91322	Adult reimbursement only, VFC reimburses for vaccines for children. Child reimbursement is limited to vaccine administration only.
Vision	92340	
Drug Testing	80305; 80307; G0480	
Substance Abuse services	Q9991; Q9992; J2315	
Long- Acting Reversible Contraceptive (LARC)	A4261; A4264; A4266-A4269; J1050; J1950; J7296; J7297, J7298; J7300; J7301; J7307	
Telehealth originating site	Q3014	
After Hours	99050; 99051	
PHE Limited Telehealth	G2010; G2012; 99441-99443; 98966-98968; 92507; 97110; 97530; 99381-99385; 99391-99395	Time limited/temporary telehealth coverage benefits per Medicaid Bulletins (MB) dated March 19, 2020 (MB# 20-004), March 23, 2020 (MB# 20-005), and March 25, 2020 (MB# 20-007), as additional Bill Above services.

FQHC CROSSOVERS

Crossover claims must be filed initially to the assigned FQHC Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare.

CLINIC-BASED PHYSICIAN PROGRAM (CBP) POLICY

The CBP program covers the billing for physician, CNM, and NP services rendered by FQHC providers at a hospital or other facilities that do not qualify as FQHC encounter settings. Providers must bill for these services on a professional claim (CMS-1500 or electronic equivalent) using the CBP provider number (Section 33) and rendering physician, CNM or NP's Medicaid provider number (Section 24K) on the CMS-1500 claim form.

All services provided to hospital patients (including ER services) or other settings such as: urgent care facilities, ambulatory surgical centers, birthing centers, and military treatment facilities, by a FQHC provider must be billed under the CBP program.

The claim must include the appropriate POS code for the setting in which the service was delivered. It is not necessary for FQHCs 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 SCDHHS reimburses FQHCs for claims with POS codes 19 through 26 at the current reimbursement rate for each specific CPT or HCPCS code. The SCDHHS considers these services to be non-FQHC services provided by a valid practitioner, but in a setting other than a FQHC-qualifying place of service. These services will not be cost-settled.

REIMBURSEMENT AND CHARGE LIMITS

For general policies regarding charge limits and reimbursements, providers must refer to the Provider Administrative and Billing Manual. Reimbursement and charge limits specific to FQHC providers are addressed in this section of the manual.

- Payment for all approved services must be accepted as payment in full.
- Providers must check the beneficiary's eligibility and service history.
- Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition, providers may not charge the beneficiary for the primary insurance carrier's co-payment.
- Billing covered procedures prior to the date of service is prohibited.

- Providers are prohibited from billing the beneficiary for any service that the beneficiary is eligible to receive under the Healthy Connections Medicaid program, Medicaid payments may be made only to a provider, a provider's employer or an authorized billing entity. Payments will not be reimbursed to a beneficiary. Therefore, seeking payment from a beneficiary is prohibited.
- Providers are prohibited from billing a beneficiary for coverable services denied due to the following:
    - untimely filing (refer to the Administrative and Billing Provider Manual)
    - insufficient/lack of medical necessity documentation
    - claims filed with clinical and/or administrative errors
    - failure to obtain prior authorization (when applicable)
- Providers are prohibited from billing a beneficiary while the prior authorization process is ongoing.
- Providers are prohibited from billing a beneficiary during an appeals process. Beneficiaries have the right to appeal any decision that delays, denies, or reduces a covered benefit.
- Provider must inform the beneficiary if services requested through prior authorization were deemed by SCDHHS as not medically necessary, therefore:
    - no claim will be filed with Medicaid and no reimbursement is expected from Medicaid for the service(s), and
    - provider and beneficiary may agree to forego with the service delivery, or
    - provider and beneficiary agree to proceed with the service delivery without Medicaid reimbursement.

Reimbursement

FQHCs will be reimbursed based on the South Carolina Medicaid State Plan reimbursement methodology.

Wrap - Around Payment Methodology

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection ACT of 2000 (BIPA) requires the determination of supplemental payments for FQHCs contracting with Medicaid MCOs. These supplemental payments are calculated and paid to ensure that these providers receive reimbursement for their services to Medicaid MCO beneficiaries at least equal to the payment that would have been received under the traditional FFS methodology. These determinations, generally referred to as wrap-around payments, are mandated by BIPA 2000 to be completed at least every four months. SCDHHS performs these determinations quarterly and prepares a final reconciliation annually for providers. Submission of quarterly and annual MCO encounter data and payment information that is required for these wrap-around payment determinations is the responsibility of each MCO contracting with FQHCs. The quarterly and annual reconciliation processes are incorporated into the agency's State Plan for Medical Assistance, Attachment 4.19-B.

Questions relating to the FQHC reimbursement methodology or wrap-around payments should be directed to the SCDHHS Division of Ancillary Reimbursements at +1 803 898 1040.

Annual Medicaid Cost Report

SCDHHS-enrolled FQHCs must submit a Medicaid Cost Report annually, which is used to establish their encounter 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 are available in the FQHC Cost Report Instructions.

8 BENEFIT CRITERIA AND LIMITATIONS

The criteria outlined in SCDHHS' FQHC Services Provider Manual are based around procedure codes as defined in the Code of Procedural Terminology (CPT), unless otherwise indicated in the respective provider manual.

Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the "Patient Record" and "Documentation Required" sections listed in the respective provider manuals for additional detail.

The ***Healthy Connections*** Covered FQHC services are defined as follows:

1. State Plan Covered Services
2. EPSDT Services (Non-State Plan Covered Services)
3. Family Planning benefit services

STATE PLAN COVERED SERVICES

The subsections below outline a list of services referred to as FQHC core services. Core services are reimbursed using encounter codes.

The specific health care encounters that constitute a core service are documented in 42 CFR 405.2411, 42 CFR 405.2463, and 42 CFR 440.20 (b) and (c) and include the following face to face, one-on-one encounters:

- physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self administered;
- services provided by physician assistants and incident to services supplied;
- nurse practitioners and incident to services supplied;
- nurse midwives and incident to services supplied;
- clinical psychologists and incident to services supplied; and
- clinical social workers and incident to services supplied

Encounter Services

Currently the definition of a visit is a face-to-face, one-on-one encounter between a FQHC patient and a FQHC qualified provider, during which a Medicaid-covered FQHC core service is furnished. The South Carolina Medicaid program does not cover health education, social work, or other related ancillary services unless noted in this section. For billing purposes, SCDHHS has deemed a "visit" as an "encounter". Physicians and practitioners providing services under the FQHC program must meet the regular Medicaid enrollment requirements to provide services to Medicaid patients.

Only one encounter code is allowed per day, except for the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day. FQHC services are covered when furnished to patients at the FQHC's service site (permanent, seasonal, mobile vans or intermittent sites), in a SNF, or at the client's place of residence. Services provided to hospital patients, including ER services, are not considered FQHC services.

Services and Supplies

Supplies, lab work, injections (excluding vaccines), etc., are not reimbursable services. These services and supply costs are included in the encounter rate when provided during a physician, PA, NP, CNM, chiropractor, clinical psychologist and/or clinical social worker visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office.
- Commonly provided either without charge or included in the FQHC bill (i.e., lab tests).
- Provided as incidental, although an integral part of the above provider's services.
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies.
- Provided by a clinic employee.
- Not self-administered (drug, biological).

Physician Services

Physician services refer to the professional services (diagnosis, treatment, therapy, surgery and consultation) performed by or under the supervision of a physician for the FQHC. For detailed policies, criteria and limitations of physician services, refer to the Physician Services Provider Manual.

Medical or Other Remedial Care Provided by Licensed Practitioners

Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)
PA, NP and CNM services refer to the medical or remedial care or services, other than physicians' services, provided by the licensed practitioner who:

- Is employed by or receives payment from the FQHC.
- Is under a physician's general or direct medical supervision within the scope of practice as defined under State law.
- Provides services according to clinic policies or any physician's medical orders for the care and treatment of the patient.
- Provides the type of services that a CNM, NP or PA is legally permitted by the State to perform.
- Provides the type of services that Medicaid would cover if provided by a physician or incidental to physician services.

For detailed policies, criteria and limitations of PA, NP or CNM services, refer to the Physician Services Provider Manual.

Clinical Psychologist and Clinical Social Worker Services
Clinical psychologist and clinical social worker services refer to professional services performed by a provider who:

- Is employed by or receives compensation from the FQHC.
- Provides services of any type that the professional is legally permitted to perform by the State in which the services are furnished.
- Provides the type of services that Medicaid would cover if furnished by a physician.

Chiropractor Services
Chiropractic services are those which are limited to manual manipulation of the spine for the purpose of correcting subluxation demonstrated on x-ray. For the purpose of this program, subluxation means an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray). Chiropractic services must conform to policies, guidelines and limitations as specified in the Chiropractic Services Manual. Chiropractic providers are licensed practitioners and provide services within the scope of practice as defined under State law and in accordance with the requirements of CFR 440.60(a).
For detailed policies, criteria and limitations of chiropractor services, refer to the Physician Services Provider Manual.

Podiatry Services
Podiatry services must be medically necessary and conform to the guidelines and limitations as specified under the Physician Services Provider Manual. Podiatry providers are licensed practitioners and provide services within the scope of practice as defined under State law and in accordance with the requirements of 42 CFR 440.60(a). Podiatry services are those services that are necessary for the diagnosis and treatment of foot conditions. These services are limited to the specialized care of the foot as outlined under the laws of the State of South Carolina.
For detailed policies, criteria and limitations of podiatry services, refer to the Physician Services Provider Manual.

Dietitian Services
For detailed policies, criteria and limitations of dietitian services, refer to the Physician Services Provider Manual. Group nutritional counseling therapy is not reimbursable.

Diagnostic, Screening and Preventive Services
"*Diagnostic services,*" includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.

"Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

"Preventive services" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to:

- Prevent disease, disability, and other health conditions or their progression;
- Prolong life; and
- Promote physical and mental health and efficiency.

For detailed policies, criteria and limitations of diagnostic, screening and preventive services, refer to the Physician Services Provider Manual.

Immunization
Providers must follow the Advisory Committee on Immunization Practices (ACIP) recommendations on vaccines for both children and adults available at ACIP Vaccine Recommendations | CDC, when administering vaccines to full benefit Healthy Connections Medicaid Members

For immunizations for Family Planning Limited benefit members, please refer to the Family Planning section of the Physician Services Provider Manual.

Vision Services
Vision Care services are those which are reasonable and necessary for the diagnosis and treatment of conditions of the visual system and the provision of lenses and/or frames as applicable. Optometry providers are licensed practitioners and provide services within the scope of practice as defined under State law and in accordance with the requirements of CFR 440.60(a)
For detailed policies, criteria and limitations of vision services, refer to the Physician Services Provider Manual.

Behavioral Health Services
"Rehabilitative services," includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Policy criteria and limitations for behavioral health services are detailed in the Rehabilitative Behavioral Health Services Provider Manual.

Other Laboratory and Radiology Services
These are professional and technical laboratory and radiological services which are provided at the FQHC center, ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his/her practice as defined by State law.

Policy criteria and limitations for laboratory and radiology services are detailed in the Physician Services Provider Manual.

EPSDT Services
Refer to EPSDT services policies within the Physician Services Provider Manual.
https://www.ecfr.gov/current/title-42/part-441/subpart-B

Family Planning Services

Family Planning services are available to all Medicaid recipients and include all medical and counseling services related to alternatives of birth control and pregnancy prevention services prescribed and rendered by physicians, hospitals, clinics, pharmacies and other practitioners and other Medicaid providers recognized by state and federal laws and enrolled as Medicaid Providers.

Pharmacist Services

For detailed policies, criteria and limitations of pharmacist services, refer to the Physician Services Provider Manual. Pharmacist services are not FQHC services and are not included in the encounter rate or the wrap payment.

Dental Services

"Dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of:

- The teeth and associated structures of the oral cavity; and
- Disease, injury, or impairment that may affect the oral or general health of the beneficiary.

For covered dental services, criteria and limitations refer to the Dental Services Provider Manual.

Pharmacy Services

For details on pharmacy services policies refer to the Pharmacy Services Provider Manual.