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1.0 Description of Procedure, Product, or Service

This policy describes the policies and procedures that are defined as core services provided in a federally qualified health center (FQHC) or a rural health clinic (RHC). The N.C. Medicaid program covers these services as a core service but also allows for “other health” visits, such as behavioral health services, to occur on the same day without the submission of additional documentation with the claim.

Note: Prior to the implementation of mental health reforms, the N.C. Medicaid program allowed one core service visit per day. If an additional visit on the same day occurred, providers were asked to submit documentation supporting the necessity for the visit. In effect, this practice led RHCs and FQHCs to schedule appointments for their recipients with behavioral health issues on subsequent days, which created a barrier to care and treatment. The implementation of mental health reforms in North Carolina has resulted in the recognition of needed changes to this practice and promotes the delivery of services to improve mental health.

1.1 Federally Qualified Health Centers

Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add Federally Qualified Health Center (FQHC) services to the Medicaid program. Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services to which Medicaid recipients are entitled. Medicaid shall cover these services on a reasonable cost basis when provided by an FQHC. Medicaid FQHC services are defined as either *core* or *other ambulatory* services.

1.2 Rural Health Clinics

Congress passed Public Law 95-210, the Rural Health Clinic (RHC) Services Act, in December 1977. The Act authorized Medicare and Medicaid payments to certified rural health clinics for “physician services” and “physician-directed services” whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services to which Medicaid recipients are entitled. Medicaid shall cover these services on a reasonable cost basis when provided by an RHC. Medicaid RHC services are defined as either *core* or *other ambulatory* services.

1.3 Definition of a Core Service

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:

- a. 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;
- b. services provided by physician assistants and incident services supplied;
- c. certified nurse practitioners and incident services supplied;
- d. certified nurse midwives and incident services supplied

- e. clinical psychologists and incident services supplied; and
- f. licensed clinical social workers and incident services supplied.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental or investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

- a. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

FQHC and RHC core services are covered when Medicaid-covered services are furnished to Medicaid-enrolled recipients at the clinic, skilled nursing facility, adult care home, other medical facility, or the recipient's place of residence by a staff member employed by an FQHC or RHC. Medicaid coverage includes the FQHC and RHC core services defined in 42 CFR 405.2412 through .2415 and 42 CFR 405.2446, .2450, and .2452.

FQHC and RHC core services include the following:

- a. physician services;
- b. services and supplies incident to physician services (including drugs and biologicals that cannot be self administered);
- c. physician assistant services and services and supplies incident to such services;
- d. nurse practitioner services and services and supplies incident to such services;
- e. certified nurse midwifery services and services and supplies incident to such services;

- f. licensed psychologist services and services and supplies incident to such services; and
- g. clinical social worker services and services and supplies incident to such services.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

As defined by the Centers for Medicare and Medicaid Services (CMS), the following services are not covered as core services, but may be separately reimbursable physicians' services. For coverage criteria for these services, refer to DMA's policy index page, <http://www.ncdhhs.gov/dma/mp/>.

- a. Health Check services including clinic visit for immunizations or injections only (refer to the most recent version of the Health Check Billing Guide, linked from <http://www.ncdhhs.gov/dma/healthcheck/>)
- b. Delivery
- c. Depo-Provera when used for family planning
- d. Diagnostic laboratory services
- e. Services provided to hospital patients (including emergency room services)
- f. Durable medical equipment
- g. Dental services
- h. Other ambulatory physician services
- i. On-site radiology services (the technical component only)
- j. Physician Fluoride Varnish Program

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

5.1 Prior Approval

Prior approval is not required.

5.2 Regulatory Requirements

FQHC and RHC providers shall comply with the federal regulations cited in 42 CFR 405, 42 CFR 440.20(b) and (c), 42 CFR 491, and any other applicable state and federal laws and regulations.

5.3 Definition of a Core Visit

As defined by 42 CFR 405.2463, a core visit shall be a professional service that is rendered during a face-to-face encounter by a physician or other health professional listed in this policy. If the only services rendered during a visit are "incident to" services ordinarily performed by a nurse, technician, or office assistant (such as taking blood pressure and temperature, giving injections, or changing dressings), the visit does not constitute a core visit. This rule applies even when "incident to" services are performed by a physician, nurse practitioner, physician assistant, or other health professional.

The following services are also defined as core visit services and are not separately reimbursable.

- a. Home health services provided in accordance with 42 CFR 405.2416. Refer to **Subsection 6.2, Specific Requirements**, for additional information. Home health services are subject to the requirements and limitations in Clinical Coverage Policy 3A, *Home Health Services* (<http://www.ncdhhs.gov/dma/mp/>).
- b. Adult health assessments
An adult health assessment is a package of components, defined in 42 CFR 405.2448, that shall be provided at every annual screening. The only components that can be billed separately by FQHC and RHC providers are screening mammograms and diagnostic laboratory components. Refer to Clinical Coverage Policy 1A-2, *Preventive Medicine Annual Health Assessment*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>. An immunization cannot be billed in conjunction with a core visit. The immunization given during the core visit is reported without billing the administration fee.
- c. Family planning services, except any one of those listed below:
 1. Depo-Provera injections for contraception;

2. Norplant removal, including the clinic visit;
 3. Diaphragm fitting, including the cost of the device and the clinic visit;
 4. IUD insertion, including the cost of the device and the clinic visit;
 5. IUD removal, including the clinic visit; or
 6. Implanon (implant and supplies only, not procedures of insertion, removal, or removal with re-insertion).
- d. Antepartum (prenatal) care and postpartum care
 - e. Immunizations and injectable medications for recipients aged 21 years and older
 - f. Outpatient diabetes self management training for recipients with diabetes

5.4 Components of a Core Visit

Core visits, as defined by CMS, include any of the following components and are not separately reimbursable:

- a. drugs and biologicals that cannot be self-administered;
- b. all injectable medications, including Depo-Provera if prescribed for purposes other than family planning (Depo-Provera injections used for family planning are not covered as a core service);
- c. immunizations provided as part of a Health Check (ESPDT) screening are not covered as core services. Refer to the *Health Check Billing Guidelines* on DMA's Web site at <http://www.ncdhhs.gov/dma/healthcheck/>;
- d. nebulizer treatments; or
- e. electrocardiograms (EKGs).

5.5 Service Limits

Medicaid service limits are subject to prior approval requirements, service requirements, and limitations stated in applicable policies. Additionally, FQHCs and RHCs shall comply with the following:

- a. Core visits for "other health" visit, such as behavioral health services by the licensed clinical social worker or the licensed psychologist, are subject to the requirements and limitations specified in 42 CFR 405.2450 and 405.2452.
- b. The adult health assessment service is subject to the requirements and limitations specified in 42 CFR 405.2448 and in Clinical Coverage Policy 1A-2, *Preventive Medicine Annual Health Assessment* (<http://www.ncdhhs.gov/dma/mp/>).

5.6 Encounter Limits

As documented in 42 CFR 405.2463(b)(1)(2), core service encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same date of service and at a single location, constitute a single visit and are limited to one encounter per day, except when one of the following conditions exists:

- a. After the first encounter, the recipient appears or presents with or suffers illness or injury requiring additional diagnosis or treatment; or
- b. The recipient has a medical visit and an "other health" visit, such as a behavioral health visit. Core service visits for behavioral health are subject to the requirements and limitations specified in 42 CFR 405.2450 and 405.2452.

Note: Service is limited to a maximum of three encounters per day when the conditions of the above paragraphs are met. Written documentation shall be provided to justify more than three core visits billed on the same date of service.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 General Requirements

As indicated in 42 CFR 491.3, FQHCs and RHCs shall be certified for participation with Medicare to qualify for participation with Medicaid and shall be licensed pursuant to state and local laws as required by 42 CFR 491.4(a). FQHCs and RHCs that meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for FQHC and RHC core services when the service is within the scope of their practice.

FQHCs and RHCs shall ensure that, as required by 42 CFR 491.4(b), staff are licensed, certified, or registered in accordance with state law.

6.2 Specific Requirements

Home health services may be provided if all of the following conditions, as documented in 42 CFR 405.2416, are met:

- a. The FQHC or RHC shall be located in an area that has a shortage of home health agencies as determined by CMS.
- b. The FQHC or RHC may provide, as a core service, part-time or intermittent nursing care, rendered by professional licensed nursing personnel, and related medical supplies, except for drugs and biologicals, to homebound recipients.
- c. These services shall be provided under a written plan of treatment established and periodically reviewed by a physician or nurse practitioner.

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Records Retention

As mandated by 42 CFR 491.10, each FQHC and RHC shall maintain a clinical record system in accordance with written policies and procedures. The records shall be retained for at least six years from the date of the last entry.

Copies of records shall be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

8.0 Policy Implementation/Revision Information

Original Effective Date: August 1, 1998

Revision Information:

Date	Section Revised	Change
91/2009	Throughout	Initial promulgation of current coverage, with the following specific revisions.
91/2009	Section 1.0	Updated the definition of the service to reflect the allowance of a mental health visit on the same day as a core service without the submission of additional medical documentation with the claim.
91/2009	Section 5.3	Added information about billing for Implanon and its insertion, removal, or removal with re-insertion.
91/2009	Section 5.4	Deleted the reference to Clinical Coverage Policy 8A.
91/2009	Section 5.5	Deleted the reference to Clinical Coverage Policy 8A; changed the maximum allowable encounters per date of service from two to three.
91/2009	Attachment A	Added the modifiers HI (other health visits) and SC (visits which occur after the first encounter) which are required when billing for a core service visit; added information about billing for Implanon and its insertion, removal, or removal with re-insertion.
2/15/2011	Throughout	Updated standard DMA template language
2/15/2011	Subsection 1.3	Definition converted to a list format
2/15/2011	Attachment B.11	Clarification of reimbursement for current existing coverage for behavioral change intervention
08/1/2011	Subsection 3.4.d	Deleted postpartum care
08/1/2011	Subsection 3.4.1	Deleted obstetrics services
08/1/2011	Subsection 5.3.c	Added the words "any one of"
08/1/2011	Subsection 5.3.d	Added postpartum care
08/1/2011	Subsection 5.4	Added the words "any of"
08/1/2011	Subsection 5.4.d	Deleted "and" Added "or"
08/1/2011	Subsection 5.6	Corrected citation to read, "As documented in 42 CFR 405.2463(b)(1)(2)"
08/1/2011	Attachment B	Moved "Billing Guidelines" from Attachment A to Attachment B
08/1/2011	Attachment B.10	Added information about antepartum and postpartum care as a core service and billing delivery or C-section only codes when billing for a delivery

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

For a medical visit, FQHC and RHC core services are billed under the FQHC and RHC provider number using the HCPCS code T1015 (clinic visit/encounter, all-inclusive).

D. Modifiers

Providers are required to follow applicable modifier guidelines.

“Other health” visits, such as behavioral health visits, shall be billed with modifier HI.

Use modifier SC to bill non-behavioral health visits that occur after the first encounter in which the recipient appears with, presents with, or suffers illness or injury requiring additional diagnosis or treatment.

E. Billing Units

One visit = one encounter.

F. Place of Service

Clinic, Skilled nursing facility, Adult care home, Home, School, Other medical facilities

G. Co-payments

Co-payments are not required for core services provided in FQHCs and RHCs.

H. Reimbursement

Providers shall bill their usual and customary charges.

Attachment B: Billing Guidelines

1. Claims for core services are billed with the FQHC's or the RHC's NPI number.
2. For an "other health" visit, such as a behavioral health visit, the medical director's NPI number is placed in block 33 of the CMS-1500 claim form.
3. The NPI number of the medical provider rendering the service, or of the supervisory physician, shall be entered in block 33 of the CMS-1500 claim form. If an "other health" visit, such as a behavioral health visit, and a medical visit occur on the same day, the medical director's NPI number is placed in block 33 of the CMS 1500 claim form.
4. An FQHC or RHC that does not employ permanent physicians and uses temporary physicians is required to use the medical director's NPI number when filing claims.
5. When an on-site radiology service and a core service are performed on the same date of service, the FQHC or RHC bills on two separate claims: the clinic encounter under the FQHC or RHC NPI number and the radiology service using the FQHC or RHC physician NPI number.
6. Laboratory services furnished by the FQHC or RHC are not core services and are reimbursed based on the fee schedule allowable for the FQHC or RHC.
7. The insertion, removal, or removal with re-insertion of Implanon is included in the core service and is not separately reimbursed to the FQHC or RHC. The drug itself is a separately reimbursable physician service.
8. An FQHC or RHC that is not enrolled in the pharmacy program bills Depo-Provera injections on the CMS-1500 claim form under the FQHC or RHC physician provider NPI number.
9. A clinic visit for immunizations or injections only is not a core visit. The FQHC or RHC shall maintain a record of the number of injections and shall not bill for a core visit.
10. Antepartum care and postpartum care are core services. They are not reported using the all-inclusive CPT obstetrics procedure codes that include antepartum and/or postpartum care. The number of antepartum (core service) visits is unlimited and is determined by the physician's assessment and documentation for medical necessity. The FQHC or RHC bills the delivery only or C-Section only codes when billing for a delivery.
11. Behavior Change Interventions, Individual service(s) that include smoking and tobacco use cessation counseling visit and alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services) are covered Medicaid services but are not separately billable as a core service or an ancillary service. The services must be rendered as a component of a primary core service visit.