Federally Qualified Health Center

Reimbursement Policy ID: RPC.0015.DEDS

Recent review date: 02/2025

Next review date: 01/2026

AmeriHealth Caritas VIP Care 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 VIP Care 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 based on the FQHC prospective payment system (PPS) for medically necessary primary health services and qualified preventive health services provided by a FQHC health provider.

Exceptions

N/A

Reimbursement Guidelines

Reimbursement is allowed for:

- Professional services only
- Laboratory tests (excluding venipuncture) and technical component of billable visits are paid separately.
- Procedures are included in payments of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, charges for the procedure must be included on the claim for the qualified visit.

An FQHC payment code must be included on the claim.

- G0466 – Federally qualified health center (FQHC) visit; new patient
- G0467 - Federally qualified health center (FQHC) visit; established patient
- G0468 - Federally qualified health center (FQHC) visit; includes an initial preventative physical exam or annual wellness exam
- G0469 - Federally qualified health center (FQHC) visit; mental health, new patient
- G0470 - Federally qualified health center (FQHC) visit; mental health, established patient

Paid services including, but not limited to are:

- Screening mammography
- Screening pap smear and screening pelvic exam
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetic self-management training services
- Diabetes screening tests
- Medical nutritional training services
- Bone mass measurement
- Screening for glaucoma
- Cardiovascular screening blood tests
- Ultrasound screening for abdominal aortic aneurysm

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, certified nurse midwife, clinical social worker, a certified diabetes self-management training/medical nutrition therapy provider. The services provided also include dental services, physical and occupational therapy, speech therapy, audiology services, vision, behavioral health/substance abuse disorder, chiropractic and podiatry.

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. Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Attachments

N/A

Associated Policies

N/A

Policy History

02/2025	Reimbursement Policy Committee Approval
01/2025	Annual review • No major changes
04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care 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