COVERED SERVICES

A Federally Qualified Health Center (FQHC) agrees to provide those primary care services typically included as part of a physician's medical practice. Services and supplies that are furnished by FQHC staff and are incident to the FQHC professional service are considered part of the FQHC service. An FQHC can also provide services related to the diagnosis and treatment of mental illness, and, in certain instances, visiting nurse services.

The following FQHC reimbursable services are referred to as core services:

- Physician services;
- Services and supplies incident to physician's services;
- Physician assistant services;
- Nurse practitioners and certified nurse mid-wife services;
- Services and supplies incident to the services of nurse practitioners, physician assistants, and certified nurse mid-wives;
- Visiting nurse services to the homebound;
- Clinical psychologist services;
- Clinical social worker services; and
- Services and supplies incident to the services of clinical psychologists and clinical social workers.

NOTE: For reimbursement purposes, a service visit must be provided in order for a provider to be paid a Prospective Payment System (PPS) rate. (See Section 22.4 for more information about reimbursement).

Physician Services

Physician services are the professional services performed by a licensed physician for a beneficiary including diagnosis, therapy, surgery, and consultation.

Physician services are covered if they are professional services performed by a licensed physician at the center, or performed away from the center if the physician has an agreement with the center to be paid for the services. The services must be within the scope of his/her profession under Louisiana law.

Services and Supplies Incident to a Physician's Services

Services and supplies incident to a licensed physician's professional service are covered if the service or supply is furnished:

- In a physician's office;
- Either without charge or included in the center's bill;
- As an incidental, although integral, part of a physician's professional services;
- Under the direct, personal supervision of a physician; and
- By a member of the center's health care staff who is an employee of the center.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

Physician Assistant Services

A physician assistant (PA) is eligible to enroll in Medicaid and must obtain a provider number and use it on the billing form when performing services or prescribing drugs. PA services are covered if:

- Furnished by a licensed PA who is employed by or receives compensation from the center and is enrolled in the Louisiana Medicaid Program;
- Identified by placing his/her provider number in the attending licensed physician space on the CMS 1500;
- Furnished under the medical supervision of a licensed physician. The licensed physician supervision requirements are met if the conditions specified and any pertinent requirements of state law are satisfied;
- Furnished in accordance with medical orders for the care and treatment of a beneficiary prepared by a licensed physician;

- Consistent with the type of service the PA is legally permitted to perform; and
- Services are covered by Medicaid.

Nurse Practitioner and Certified Nurse Mid-wife Services

Services are covered if:

- Furnished by a licensed nurse practitioner or certified nurse mid-wife who is employed by or receiving compensation from the center;
- Enrolled in Louisiana Medicaid;
- Identified by placing his/her provider number in the attending physician space on the CMS 1500;
- Furnished in collaborative practice with a physician. The physician supervision requirement is met if the conditions specified and any pertinent requirements of State law are satisfied;
- Furnished in accordance with any medical orders for the care and treatment of a beneficiary prepared by a licensed physician;
- Performed by a licensed nurse practitioner or certified nurse mid-wife, who is legally permitted to provide this type of service; and
- Services are covered by Medicaid.

Nurse practitioners and certified nurse mid-wives are eligible to enroll in Medicaid and must obtain a provider number and use it on the billing form when performing services or prescribing medications.

Services and Supplies Incident to Physician Assistant, Nurse Practitioner and Nurse Mid-wife Services

Services and supplies incident to a nurse practitioner, nurse mid-wife or physician assistant services are covered if:

- Furnished in a licensed medical provider's office;
- Rendered either without charge or included in the center's bill;

- Furnished as an incidental, although integral part of professional services furnished by nurse practitioner, PA or certified nurse mid-wife;

- Furnished under his/her direct, personal supervision. The direct personal supervision requirement is met only if the person is permitted to supervise these services under the written policies governing the center; and

- Furnished by a member of the center's health care staff who is an employee of the center.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

Visiting Nurse Services to the Homebound

Part time or intermittent visiting nurse care and related supplies are covered if:

- The center is located in an area designated by CMS as a home health agency shortage area;

- The services are rendered to a homebound individual. For purposes of visiting nurse services, "homebound" means a Medicaid beneficiary who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or skilled nursing facility;

- The services are furnished by a licensed registered nurse or licensed practical nurse or a licensed vocational nurse, who is employed by or received compensation for the services from the center; and

- The services are furnished under a written plan of treatment.

Plan of Treatment

The plan of treatment must be established and reviewed at least every 60 days by a supervising physician of the center or established by a physician, nurse practitioner, physician assistant or certified nurse mid-wife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician. The plan must be signed by the nurse practitioner, physician assistant, certified nurse mid-wife or the supervising physician of the center.

The plan of treatment must relate visiting nurse services to the beneficiary's condition. The plan must specify the following:

- Types of services required and prognosis for changes in the beneficiary's condition;
- Diagnosis and a description of the beneficiary's functional limitations resulting from the illness or injury;
- Type and frequency of nursing services needed;
- Special diets;
- Activities permitted;
- Rehabilitation and therapy services;
- Medical social services;
- Home health aide services; and
- Necessary medical supplies.

All changes in orders for controlled substance drugs must be signed by the physician.

Clinical Psychologist

Clinical psychologist services refer to services performed by a licensed clinical psychologist for diagnosis and treatment of mental illness which the clinical psychologist is legally authorized to perform under State licensure as would otherwise be covered if furnished by a licensed physician or as an incident to a physician's services.

Clinical Social Worker Services

Clinical social worker services refer to services performed by a licensed clinical social worker for diagnosis and treatment of mental illness which the clinical social worker is legally authorized to perform under state licensure and such services as would otherwise be covered if furnished by a physician or as an incident to a physician 's professional service.

Services and Supplies Incident to the Services of Clinical Psychologists and Clinical Social Workers

Services are covered if furnished:

- In a physician's office;
- Either without charge or included in the center's bill;
- As an incidental, although integral part of professional services furnished by a Clinical Psychologist or Clinical Social Worker;
- Under his/her direct, personal supervision. The direct personal supervision requirement is met only if the person is permitted to supervise these services under the written policies governing the center; and
- By a member of the center's health care staff who is an employee of the center.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

Other Ambulatory Services

FQHCs may provide other non-primary care ambulatory services covered by the Louisiana Medicaid State plan that are not included in the listing of FQHC services. These other ambulatory services may be provided by the FQHC if the FQHC meets the same standards as other enrolled providers of those services. Examples include:

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for beneficiary's under the age of 21;
- Vision care services (for beneficiaries under the age of 21);
- Speech and language services (for beneficiaries under the age of 21);
- Hearing services (for beneficiaries under the age of 21);
- Dental services;
- Podiatry services;

- Pregnancy-related services;
- Perinatal case management;
- Chiropractic services;
- Nutrition counseling as part of an encounter;
- Family planning services;
- Physical and occupational therapy services; and
- Behavioral health services provided by licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs).

The above services are governed by Medicaid policies and procedures specific to each program. The policies and procedures for the FQHC services program do not apply to these "other" ambulatory services. Billing must be submitted according to the policies and procedures for each program. Service visits will be reimbursed at the all-inclusive PPS rate per visit. (See Section 22.4 for more information about reimbursement).

Diabetes Self-Management Training

Diabetes self-management training (DSMT) is provided to beneficiaries diagnosed with diabetes. These services are comprised of one hour of individual instruction and nine hours of group instruction on diabetes self-management. Beneficiaries shall receive up to ten hours of services during the first 12-month period beginning with the initial training date. After the first 12-month period has ended, beneficiaries shall only be eligible for two hours of individual instruction on diabetes self-management per calendar year.

Fluoride Varnish Applications

Coverage shall be provided for fluoride varnish applications performed in the FQHC to beneficiaries under 21 years of age based on medical necessity. Fluoride varnish applications will be reimbursed when performed in the FQHC by:

- The appropriate dental providers;
- Physicians;
- Physician assistants;

- Nurse practitioners;
- Registered nurses;
- Licensed practical nurses; or
- Certified medical assistants.

All participating staff must review the Smiles for Life training module for fluoride varnish and successfully pass the post assessment. All staff involved in the varnish application must be deemed as competent to perform the service by the FQHC and be practicing within the licensed practitioner's scope of practice.

Fluoride varnish applications shall only be reimbursed to the FQHC when performed on the same date of service as an office visit or preventative screening. Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit

Services Not Covered

- Injections ordered incident to a previous face-to-face encounter (these injections would be incident to the initial encounter and part of the PPS reimbursement of the initial encounter which warranted the injection);
- Medications provided by a pharmacy that is not part of the FQHC;
- Weight or blood pressure check only;
- Services for which medical necessity is not clearly established;
- Information provided to a patient over the telephone;
- Cosmetic surgery;
- A visit for the sole purpose of a patient obtaining a prescription when the need for the prescription has already been determined;
- Canceled visits or for appointments not kept;
- Foot care such as routine soaking and application of topical medication;

- Transsexual surgery or a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis; and

- Tattoo removal.

Encounter

Medical (inclusive of DSMT services) encounters are defined as face-to-face visits with a physician, physician assistant, nurse practitioner, certified nurse mid-wife, or visiting nurse during which a FQHC service is rendered. Behavioral health encounters are defined as face-to-face visits with a physician with a psychiatric specialty, nurse practitioner with a psychiatric specialty, clinical nurse specialist with a psychiatric specialty, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, respectively, during which behavioral health service is rendered. A behavioral health specific service must be rendered in order to bill a behavioral health encounter. The submission of an evaluation and management code only will not suffice, with the exception of certain provider/specialty combinations identified in Section 22.1 of this manual under "Service Limits." A medical and a behavioral health encounter are allowed on the same day of service.

Multiple medical and/or behavioral health encounters, however, with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. When the beneficiary suffers illness or injury requiring additional diagnosis or treatment unrelated to the initial encounter visit an additional medical and/or behavioral health encounter may be billed.

A dental encounter is defined as a face-to-face visit with a dentist where dental services are rendered. Multiple dental encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Multiple Same-day Visits

Only one medical encounter (inclusive DSMT encounters) per day per beneficiary, one behavioral health encounter per day per beneficiary, and one dental encounter per day per beneficiary may be billed except in cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

Service Limits

There is no annual limit placed on the number of federally qualified health center visits (encounters) payable by the Medicaid Program for eligible beneficiaries.

Services not defined as an FQHC service or other ambulatory service rendered to Louisiana Medicaid beneficiaries are not permitted to be billed to the Louisiana Medicaid program.

Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

Exclusions

Medicaid policy does not provide for payment of follow-up visits occurring on the same date as a previously billed visit, consultation, emergency room care or hospital admission date.

Any services "incident to" an encounter code ARE NOT billable. These include, but are not limited to the following:

- Injections (allergy, antibiotic, steroids, etc.);
- Laboratory tests performed on site, Peak Flow and Spirometry, Respiratory Flow Volume Loop, EKG testing and interpretation, and x-rays;
- Immunizations;
- Hearing/Vision screenings; and
- Filling and/or obtaining prescriptions.

Service Delivery

Upon presentation at the clinic, a full mental, physical and dental assessment shall be performed and include a written plan for each identified problem noted in the history and physical exam. Any health problems identified must be addressed to the highest degree possible. Encounters for beneficiaries under the age of 21 shall include all the aspects of a well-child screening visit unless:

- The provider determines that the child's medical condition at the time of the visit contraindicates the well-child screening as inadvisable; or
- The child's medical record reflects that he or she is up to date on the well-child screenings in accordance with the Medicaid periodicity schedule.

NOTE: Service delivery for beneficiaries under the age of 21 includes the administration of required immunizations.

The medical encounter level of service must include **at a minimum**:

- An expanded, problem-focused history (chief complaint, brief history of present illness, problem pertinent system review); or
- An expanded, problem-focused exam (limited exam of the affected body area or organ system and other symptomatic or related organ systems).

This would be low-level complexity of medical decision making (limited number of diagnoses, limited complexity of data to review, the risk of complications and management options- low).

A new patient medical encounter level of service is to include the following:

- A detailed history (chief complaint, history of present illness, problem pertinent system review, pertinent past, family, social history); and
- A detailed exam with low-to moderate complexity decision making.

The dental encounter level of service must include **at a minimum**:

- Comprehensive oral healthcare. Comprehensive oral healthcare is defined as all of the covered restorative and therapeutic services described in the Medicaid Dental Services Manual.

NOTE: Dental health preventive services should be rendered on the same day unless otherwise indicated due to identified medical issues preventing completion of all preventive services.

The behavioral health encounter level of service shall include **at a minimum**:

- Face-to-face visits with a physician with a psychiatric specialty, nurse practitioner with a psychiatric specialty, clinical nurse specialist with a psychiatric specialty, licensed clinical psychologist, or licensed clinical social worker; (exclusive of medication management only;

- Face–to-face visit with a licensed professional counselor (LPC) or licensed marriage and family therapist (exclusive of medication management only); and

- A qualified service for the assessment, diagnosis and/or treatment of a behavioral health disorder to include services such as psychotherapy, mental health assessment, psychiatric evaluation, psychological testing and medication management. These services may be provided in combination with medication management as well.

Behavioral Health Specific Service Delivery Limits

The below provider type/specialty combinations are the only behavioral health providers allowed to be reimbursed for claims including an evaluation and management HCPCS code as the only detailed line:

Provider Type	Provider Specialty	Description
20	26	Psychiatrist
20	2W	Psychiatrist – Addictionologist
19	26	Psychiatrist
19	27	Psychiatrist –Psychiatry, Neurology, Addiction, Medicine
19	2W	Psychiatrist – Addictionologist
78	26	Nurse Practitioner (NP) - APRN
93	26	Clinical Nurse Specialist (CNS) - APRN
94	26	Physician's Assistant (PA)
31	6G	Medical Psychologist

- All other behavioral health provider type/specialty combinations require at least one qualified psychiatric service included as a detailed line on the claim.