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 nurse midwife services,
- Services and supplies incident to the services of nurse practitioners, physician assistants, and certified nurse midwives,
- 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 physician for a recipient including diagnosis, therapy, surgery, and consultation.

Physician services are covered if they are professional services performed by a 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 in the scope of his/her profession under Louisiana law.

Services and Supplies Incident to a Physician's Services

Services and supplies incident to a 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 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 physician space on the CMS 1500,
- Furnished under the medical supervision of a physician. The 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 recipient prepared by a physician,
- Consistent with the type of service the PA is legally permitted to perform, and
- Furnished by a physician and covered by Medicaid.

Nurse Practitioner and Nurse Midwife Services

Services are covered if:

- Furnished by a nurse practitioner or nurse midwife 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 under the medical supervision of 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 recipient prepared by a physician,
- Performed by a nurse practitioner or mid-wife, who is legally permitted to provide this type of service, and
- Furnished by a physician and the service is covered by Medicaid.

Nurse practitioners and 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 Midwife Services

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

- Furnished in a physician'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 nurse midwife,

- 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 recipient 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 registered nurse or licensed practical nurse or a licensed vocational nurse, which 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 nurse midwife, 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, nurse midwife or the supervising physician of the center.

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

- Types of services required and a long-range forecast of likely changes in the recipient's condition,
- Diagnosis and a description of the recipient'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-like services, and
- Necessary medical supplies.

All changes in orders for dangerous drugs and narcotics must be signed by the physician.

Clinical Psychologist

Clinical psychologist services refers to services performed by a 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 physician or as an incident to a physician's services.

Clinical Social Worker Services

Clinical social worker services refers to services performed by a 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 nurse practitioner, PA or nurse midwife,
- 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 recipients under the age of 21,
- Vision care services (for recipients under the age of 21),
- Speech and language services (for recipients under the age of 21),
- Hearing services (for recipients 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, and
- Physical and occupational therapy services.

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)

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.

Diabetes Self-Management Training

Diabetes self-management training (DSMT) is provided to recipients diagnosed with diabetes. These services are comprised of one hour of individual instruction and nine hours of group instruction on diabetes self-management. Recipients 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, recipients shall only be eligible for two hours of individual instruction on diabetes self-management per calendar year.

Encounter

A medical encounter (inclusive of mental health and DSMT services) is defined as a face-to-face visit with a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Multiple medical 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 recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

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 recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Service Limits

Only one medical encounter (inclusive of mental health and DSMT encounters) per day per recipient and one dental encounter per day may be billed per recipient except in cases in which the recipient, 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.

Each FQHC medical encounter (inclusive of mental health and DSMT encounters) is counted as 1 of the 12 allowable physician outpatient visits per calendar year for recipients who are 21 years of age or older. Visits for recipients who are under 21 years of age and for prenatal and postpartum care are excluded from this service limitation.

For Louisiana Medicaid to reimburse outpatient visits beyond the maximum allowed visits per calendar year, the physician must request an extension from the fiscal intermediary's Prior

Authorization (PA) Unit. Extensions will be granted only for emergencies, e.g., trauma, life threatening conditions and life-sustaining treatments, e.g., chemotherapy for malignant diseases or radiation therapy.

Services not defined as an FQHC service or other ambulatory service rendered to Louisiana Medicaid recipients 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.

Request for Emergent or Life Threatening Conditions

To request an extension for a visit for emergent or a life threatening condition, providers must obtain prior approval from the PA Unit. Providers must complete and submit the 158-A form with medical documentation substantiating the need for additional visits using encounter code T1015. (See Appendix A for contact information and Appendix B for a copy of form 158-A)

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 recipients under the age of 21 must include all the aspects of a well-child screening visit.

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).
- An expanded, problem-focused exam (limited exam of the affected body area or organ system and other symptomatic or related organ systems).
- 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).
- A detailed exam with low-to moderate complexity decision making.