Revision Dates: 7/8/2024; 10/1/2018; 5/23/2018; 3/2/2018

General Information

This billing manual chapter provides information about the 638 FQHC provider type, which facilities are eligible to make the change to become a 638 FQHC, and billing and claims information.

For any additional questions not answered in the contents of this chapter please email the Fee-for-Service Provider Training email inbox at ProviderTrainingFFS@azahcccs.gov.

Providers Eligible to Elect to Become a 638 FQHC

Tribal 638 Clinics that are provider type 05 or 77 are eligible to elect to become a 638 FQHC. IHS Clinics are not eligible to become a 638 FQHC.

> Note: To elect to become a 638 FQHC, a Tribal 638 Clinic does **not** need to meet the requirements for receipt of grant funds under section 330 of the Public Health Service Act and does **not** need to meet the requirements for designation as a "look alike" FQHC by the Health Resources and Services Administration (HRSA).
>
> The **only** requirement the Tribal 638 Clinic must meet, in order to be recognized as an FQHC by Medicaid, is to be operated by a Tribe or Tribal organization under P.L. 93-638.
>
> The facility does **not** need to enroll in Medicare as an FQHC in order to change its designation to a 638 FQHC. A facility will be recognized as an FQHC by Medicaid if it is operated by a Tribe or Tribal organization in accordance with P.L 93-638.

4 Walls

4 Walls Definition

The "4 Walls" of a 638 Clinic refer to the physical building the clinic operates within. The CMS interpretation of section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that "clinic services" do not include any services delivered outside of the "four walls" of the clinic, except if services are provided to a homeless individual.

Due to this interpretation, even if a Tribal 638 Clinic has a written care coordination agreement in place with a non-Tribal provider, if the service takes place outside of the clinic's physical building then the clinic is unable to be reimbursed at the facility rate for clinic services. The reimbursement is instead based on the non-Tribal provider and service(s) rendered.

638 FQHC Exemption

FQHC facilities are exempt from the "4 Walls" requirement. An FQHC may bill the facility rate for services rendered to its patients outside of its "4 Walls" by a non-Tribal provider.

If an FQHC has a care coordination agreement with a non-Tribal provider, such as a neurologist, and the service is provided offsite (outside of the FQHC's building), the FQHC may still bill the facility rate for the service. However, the FQHC would need to bill for the service, **not** the offsite provider.

A Tribal 638 Clinic that elects to become a 638 FQHC will have the same exemption from the limitations of the "4 Walls" requirement that current FQHCs receive. A 638 FQHC will be able to bill for reimbursement at **the facility rate, also called the Alternative Payment Methodology (APM)**. Services provided in the member's home or at a facility acting as the member's home, such as an assisted living or skilled nursing facility, would also be eligible for reimbursement at the APM facility rate.

Documentation Requirements for Electing 638 FQHC Status

For information pertaining on how a Tribal 638 Clinic can elect to become a Tribal 638 FQHC, including all applicable provider registration requirements, please refer to Chapter 3, Provider Records and Registration, in the IHS/Tribal Provider Billing Manual.

Reimbursement and Visit Limits

638 FQHCs will receive reimbursement for authorized categories of service at an **Alternative Payment Methodology (APM)** rate, which is equivalent to the AIR (the OMB outpatient rate for all FQHC services). Authorized services are currently reimbursed at the AIR. For additional information on the APM please refer to the State Plan Amendment (SPA) surrounding 638 FQHCs, which is available on the AHCCCS website.

The published APM rate may be paid for up to five (5) encounters/visits per member, per day, per distinct visit.

Note: The system is set up to automatically deny any claims submitted for reimbursement at the APM rate in excess of 5 per member, per day.

The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

Note: Pharmacy and Non-Emergency Medical Transportation (NEMT) Services are **not** FQHC services. These services should continue to be billed as a part of the provider's **clinic** ID. These services should not be billed under the 638 FQHC provider type.

Pharmacy Services

Pharmacy services will **not** be billed under the new 638 FQHC provider type and will continue to be billed under the provider's previous designation (05). The reimbursement methodology for pharmacy services will *not change* and shall continue to be reimbursed at the **All-Inclusive Rate (AIR).**

- Note: Only 1 AIR per member, per day, per pharmacy may be reimbursed. The AIR limits for pharmacy will not change.

Non-Emergency Medical Transportation (NEMT) Services

Claims for Non-Emergency Medical Transportation (NEMT) services shall be submitted on the **CMS 1500 claim form**. These services will be billed under the provider's previous provider type (05 or 77). These services will be reimbursed at the capped FFS fee schedule.

NEMT services will **not** be billed under the new 638 FQHC provider type and will continue to be billed for under the provider's previous designation (05 or 77). The reimbursement methodology for NEMT services will *not change* and shall continue to be reimbursed at the **capped FFS fee schedule.** NEMT will not be reimbursed at the APM rate.

Case Management Services for Behavioral Health Claims for case management behavioral health to be billed with T1016, will be reimbursed at the capped FFS fee schedule. Case management claims should be submitted on a CMS 1500 claim form.

- Note: A 638 FQHC that is also an American Indian Medical Home (AIMH) will not be eligible for reimbursement of T1016.

Medical and behavioral health case management services, to be billed with T1016, will be billed under the C5 provider type. The reimbursement methodology for case management will be at the **capped FFS fee schedule.** Case management will not be reimbursed at the APM rate as it is not an FQHC service.

A 638 FQHC that is also an American Indian Medical Home (AIMH) will not be eligible for reimbursement of T1016. AIMHs receive a **Per Member Per Month (PMPM) rate** for case management services.

Delivery of more than 1 hour of behavioral health case management services in a single day for a member may require submission of clinical documentation for review prior to payment. Clinical documents should include a signed consent to treat, a comprehensive assessment, a service plan, and a progress note.

Group Therapy

A Tribal 638 Clinic that elects to become a 638 FQHC can bill for group therapy services under their clinic provider type (05 or 77). The claim should be submitted on the CMS-1500 claim form and it will be reimbursed at the capped FFS fee schedule.

Group therapy and/or any other services provided to a group do not qualify as an FQHC service, since it is not a face-to-face encounter. For a visit to qualify as a face-to-face encounter the visit must be one-on-one, disqualifying group therapy and/or any other service provided to a group from being a PPS-eligible service. Group Therapy shall be reimbursed according to the Capped FFS Fee Schedule.

Group therapy lasting more than 1 hour in a single day for a member may require submission of clinical documentation for review prior to payment. Clinical documents should include a signed consent to treat, a comprehensive assessment, a service plan, and a progress note.

Behavioral Health Technician (BHT)

Behavioral Health Technician (BHT) services, excluding case management, may qualify as an FQHC/RHC visit when those services qualify as services incident to the services of an FQHC/RHC practitioner consistent with 42 CFR 405.2462.

Telehealth and Telemedicine

Telehealth and telemedicine may qualify as an FQHC/RHC visit if it meets the requirements specified in AMPM 320-I, Telehealth and Telemedicine.

Claim Submission Requirements

The preferred method of claims submission is via the 837 electronic claims process.

Claims may also be submitted via the AHCCCS Online provider portal, available on the AHCCCS website at:

https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

The final method of claims submission is via a paper claim form.

For information on submitting claims on the CMS 1500, UB-04, and ADA 2012 claim forms, please refer to Chapter 10 Addendum, FQHC/RHC; Chapter 5, Billing on the CMS 1500 Claim Form; Chapter 6, Billing on the UB-04 Claim Form; and Chapter 7, Billing on the ADA 2012 Claim Form of the Fee-For-Service Provider Billing Manual.

638 FQHC Clinic Visits

Claims for 638 FQHC services reimbursed at the APM rate shall be submitted on the **CMS 1500 claim form**. These services will be billed under the provider's new provider type (C5).

- Clinic Visit/Encounter - The APM should be entered on the first service line of the claim and HCPC code T1015 (FQHC visit/encounter, all inclusive) should be used.
- HCPC Codes & Charges - Claims must include all HCPC codes (including E&M codes) describing the services rendered as a part of the visit. These individual services will be billed with a $0.00 charge in the $ Charges column (Column F) of the CMS 1500 claim form.
- Modifiers - Multiple visits on the same day that are distinct and separate visits must be identified by billing the T1015 HCPC code with **modifier 25**. Modifier 25 indicates a same day, subsequent visit that is a distinct and separate visit. The modifier will be entered under the Modifier column in section D, Procedures, Services, or Supplies on the CMS 1500 claim form.
- APM - Include the APM in the Total Charges field (Field 28).

Pharmacy

Claims for pharmacy services shall be reimbursed at the AIR and submitted on the **UB-04 claim form**. These services will be billed under the provider's previous provider type (05). The UB-04 claim form must include the NDC codes for **all prescriptions filled that day**. However, only one (1) AIR shall be reimbursed.

- The outpatient AIR should be entered on the first service line of the claim and revenue code 0519 (Other Clinic) should be used.
- Include the AIR in the Total Charges field (Field 47), on the 0001 line.

Claims should be submitted with the facility's NPI as the attending provider, since AHCCCS does not register pharmacists.

Dental Services

Claims submitted for dental services shall be submitted on the **ADA 2012 form**. These services will be billed under the 638 FQHC provider type (C5) and reimbursed at the APM.

References

For additional guidance on the CMS interpretation of the "4 walls" please refer to the State Health Official letter from February 26, 2016 titled *Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives,* which can be found at https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

For additional information on the 638 FQHC provider type please refer to the FAQ released in January of 2017 at https://www.medicaid.gov/federal-policy-guidance/downloads/faq11817.pdf.

For information on submitting claims on the CMS 1500, UB-04, and ADA 2102 claim forms, please refer to Chapter 5, Billing on the CMS 1500 Claim Form; Chapter 6, Billing on the UB-04 Claim Form; and Chapter 7, Billing on the ADA 2012 Claim Form of the Fee-For-Service Provider Billing Manual.

For information on submitting FQHC claims on the CMS 1500 Claim Form, please refer to Chapter 10 Addendum, FQHC/RHC, in the Fee-For-Service Provider Billing Manual.

For general billing requirements, please refer to Chapter 4, General Billing Rules, and Chapter 5, Claim Form Requirements, of the IHS/Tribal Provider Billing Manual.

For information on initial provider registration requirements and documentation requirements for electing to become a 638 FQHC, please refer to Chapter 3, Provider Records and Registration, of the IHS/Tribal Provider Billing Manual.

For the definition of what qualifies as an FQHC visit please refer to the Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.

Revision History

Date	Description of changes	Page(s)
07/08/24	Clarifying services required to be submitted on CMS 1500 claim form Case Management and Group Therapy section updated to include prepayment review of clinical documentation for services Group Therapy section updated to include Capped FFS Fee Schedule reimbursement	3-4 4 4
10/1/18	A section on billing for group therapy was added	6
5/23/18	Group therapy section added BHT services section added Telehealth/telemedicine services sections added Reference added to direct the reader to the definition of a FQHC visit.	4 4 4 6
3/2/18	Initial Chapter Creation What Providers are Eligible to Elect to Become a 638 FQHC 4 Walls Documentation Requirements for Electing to Become a 638 FQHC Reimbursement & Visit Limits Pharmacy Reimbursement and limits NEMT Reimbursement Case Management Services for Medical and Behavioral Health Reimbursement General Claim Submission Requirements section added 638 FQHC Clinic Billing section added Pharmacy Billing section added Case Management Services for Medical and Behavioral Health Billing section added Professional Services Billing section added NEMT Billing section added Dental Billing section added References added Revision History	All 1 1-2 2 2-3 3 3 3 4 4 4-5 5 5 5 5 6 7