



# **FEDERALLY QUALIFIED HEALTH CENTERS PROVIDER MANUAL**

*Chapter Twenty-two of the Medicaid Services Manual*

**Issued December 1, 2010**

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana  
Bureau of Health Services Financing**

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION: TABLE OF CONTENTS** **PAGE(S) 3**

---

**FEDERALLY QUALIFIED HEALTH CENTERS**

**TABLE OF CONTENTS**

---

**SUBJECT** **SECTION**

---

**OVERVIEW** **SECTION 22.0**

**COVERED SERVICES** **SECTION 22.1**

- Physician Services
- Services and Supplies Incident to a Physician’s Professional Services
- Physician Assistant Services
- Nurse Practitioner and Nurse Midwife Services
- Services and Supplies Incident to Physician Assistant, Nurse Practitioner and Nurse Midwife Services
- Visiting Nurse Services to the Homebound
  
- Plan of Treatment
- Clinical Psychologist
- Clinical Social Worker Services
- Services and Supplies Incident to the Services of Clinical Psychologists and Clinical Social Workers
- Other Ambulatory Services
- Diabetes Self-Management Training
- Fluoride Varnish Applications
- Services Not Covered
- Encounter
- Multiple Same Day Visits
- Service Limits
- Exclusions
- Service Delivery

**PROVIDER REQUIREMENTS** **SECTION 22.2**

- Location
- Shortage Area Designation
- Staffing
- Medicaid Enrollment Criteria

---

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION: TABLE OF CONTENTS** **PAGE(S) 3**

---

- Services
- Billing
- Diabetes Self-Management Training
- Satellite Clinics
- Mobile Clinics
- Out of State FQHCs in Trade Areas
- Changes
  - Change in Ownership
- Cost Reports

**RECORD KEEPING** **SECTION 22.3**

- Record Maintenance and Availability
- Protection of Record Information
- Adequacy of Records
- Retention of Records

**REIMBURSEMENT** **SECTION 22.4**

- Rates
  - Determination of Rate
  - Adjustment of Rate
  - Out of State/Trade Area FQHC
  - Notice of Rate Setting
  - Appeals
- Cost Report Submission
  - Audits
- Encounter Visits
  - Payment for Adjunct Services
  - Services with Alternative Payment Methodology
  - Long Acting Reversible Contraceptives
- Encounter Billing Guidelines
  - Medical Encounters
  - Behavioral Health Encounters/Psychiatric Services
    - Physicians with a Psychiatric Specialty
    - Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty
    - Licensed Clinical Social Workers
    - Clinical Psychologist

---

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION: TABLE OF CONTENTS** **PAGE(S) 3**

---

Dental Encounters  
Adjunct Services  
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Services  
Medicare/Medicaid Dual Eligible Billing  
Outpatient Services  
Inpatient Services

<b>CONTACT INFORMATION</b>	<b>APPENDIX A</b>
<b>FORMS AND LINKS</b>	<b>APPENDIX B</b>
<b>GLOSSARY</b>	<b>APPENDIX C</b>
<b>CLAIMS RELATED INFORMATION</b>	<b>APPENDIX D</b>
<b>FQHC SERVICES FACILITY SURVEY</b>	<b>APPENDIX E</b>
<b>FQHC Behavioral Health Services Examples</b>	<b>APPENDIX F</b>

## **OVERVIEW**

The Social Security Act §1905(1)(2)(B) defines a Federally Qualified Health Centers (FQHC) for Medicaid purposes as an entity which:

- Is receiving a grant under Section 330 of the Public Health Service (PHS) Act; and
- Is receiving funding from such grant under a contract with the recipient of such a grant; and
- Meets the requirements to receive a grant under 330 of such Act;
- Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled or operated by another entity; or
- Was treated by the Secretary, for the purposes of Part B of Title XVIII, as a comprehensive Federally funded health center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

FQHCs must be located to make services accessible to residents of a designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). Location in a Health Professional Shortage Area or government designated shortage area does not meet the shortage area requirements for the FQHC program. FQHC look-alikes may serve a whole or partial MUA/MUP so long as it demonstrates that it serves the neediest population in the service area or addresses gaps in services and or health disparities.

An FQHC provider must be a non-profit organization. All FQHC services provided by qualified individuals employed by or under contract with an FQHC are billed using the organization's provider number (e.g., FQHC's National Provider Identifier (NPI), FQHC's Medicaid ID number for each location) and Tax Identification Number (TIN).

The purpose of this chapter is to set forth the conditions and requirements that FQHCs must meet in order to qualify for reimbursement under the Louisiana Medicaid program. The manual chapter is intended to make available to Medicaid providers of FQHC services a ready reference for

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**SECTION 22.0: OVERVIEW**

information and procedural material needed for the prompt and accurate filing of claims for services furnished to Medicaid recipients. The Louisiana Department of Health, Bureau of Health Services Financing (BHSF) is responsible for assuring provider compliance with these regulations.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

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### **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.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

---

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;



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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

---

- 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;

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

---

- 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.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

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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 refers 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 refers 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.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

---

**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;

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

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- 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;

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

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- 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;

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

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- 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, clinical psychologist, or clinical social worker, respectively, during which an FQHC 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. 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.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

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**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



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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.1: COVERED SERVICES****PAGE(S) 12**

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- 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).
- 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).
- 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, clinical psychologist, or clinical social worker; and
- A qualified service for the assessment, diagnosis and/or treatment of a behavioral health disorder to include services such as psychotherapy, mental health

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**SECTION 22.1: COVERED SERVICES**

assessment, psychiatric evaluation, psychological testing and medication management.

## **PROVIDER REQUIREMENTS**

### **Location**

Each Federally Qualified Health Center (FQHC) that receives Public Health Service (PHS) 330 grant funding must be located, as appropriate, to make services accessible to the residents of a designated medically underserved area or medically underserved population.

### **Shortage Area Designation**

In order for FQHCs to be eligible for a Health Professional Shortage Area (HPSA) facility designation, the center shall:

- Not deny requested health care services, and shall not discriminate in the provision of services to an individual who is unable to pay for services or whose services are paid by Medicare, Medicaid, or the Children’s Health Insurance Program;
- Prepare a schedule of fees consistent with locally prevailing rates or charges;
- Prepare a corresponding schedule of discounts (including waivers) to be applied to such fees or payments, with adjustments made on the basis of the patient’s ability to pay;
- Make every reasonable effort to secure from patients the fees and payments for services, and fees should be sufficiently discounted in accordance with the established schedule of discounts;
- Enter into agreements with the State Medicaid agency to ensure coverage of beneficiaries; and
- Take reasonable and appropriate steps to collect all payments due for services.

**NOTE:** Location in an HPSA alone or government designated shortage area does not meet the shortage area requirement for the FQHC program.

### **Staffing**

FQHC primary care services are to be provided by licensed physicians, licensed physician assistants, nurse practitioners, or nurse-midwives operating under the direct supervision of the FQHC physician and within the scope of the physician extender’s licensure or certification.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****SECTION 22.2: PROVIDER REQUIREMENTS****PAGE(S) 7**

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Direct supervision does not mean that the physician must be in the same room when services are rendered; however, the physician must be immediately available (at least by telephone) to provide direction or assistance when necessary.

Services of licensed clinical psychologists and clinical social workers are not required, but can be considered an FQHC service when these personnel provide diagnosis and treatment of mental illness. These services must be included in the HRSA scope of service in order to receive reimbursement.

**Commingling**

Commingling refers to the sharing of FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis); or
- Selectively choosing a higher or lower reimbursement rate for the services.

FQHC practitioners may not furnish FQHC-covered professional services as a Part B provider while in the FQHC or in an area outside of the certified FQHC space, such as a treatment room adjacent to the FQHC, during FQHC hours of operation.

If an FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the FQHC space must be clearly defined. If the FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between FQHC and non-FQHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based FQHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit an FQHC physician from providing on-call services for an emergency room, as long as the FQHC would continue to meet the FQHC conditions for coverage even if the practitioner were absent from the facility. The FQHC must be able to allocate appropriately the practitioner's salary between FQHC

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.2: PROVIDER REQUIREMENTS****PAGE(S) 7**

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and non-FQHC time. It is expected that the sharing of the physician with the hospital emergency department would not be a common occurrence.

The fiscal intermediary has the authority to determine acceptable accounting methods for allocation of costs between the FQHC and another entity. In some situations, the practitioner's employment agreement will provide a useful tool to help determine appropriate accounting.

**Medicaid Enrollment Criteria**

To be eligible for enrollment in the Louisiana Medicaid Program, the FQHC must be an entity receiving a Public Health Service grant under the following:

- The Consolidated Health Center Programs (Community Health Center (CHC), Migrant Health Center (MHC), Health Care for the Homeless (HCH), Public Housing Primary Care (PHPC) and Healthy Schools, Healthy Communities (HSHC) Programs authorized under Section 330 of the Public Health Service (PHS) Act as amended.

OR

- Be designated by the U.S. Department of Health and Human Services (DHHS) to meet the requirements to be receiving such a grant as a "look-a-like" entity.

The entity must provide a copy of the Health Resources and Services Administration (HRSA) Notice Grant Award designating the center as a grantee under the applicable section of the Public Health Services Act or the CMS notification letter designating the FQHC look-a-like with its enrollment packet. Only the entity designated as the grantee on the Notice of Grant Award/CMS notification letter may enroll in Louisiana Medicaid as a FQHC. The fiscal intermediary (FI) will verify CMS enrollment via the Provider Enrollment, Chain, and Ownership System (PECOS).

The FQHC must provide to the fiscal intermediary's (FI's) provider enrollment unit a list of the names of all physicians and other practitioners who will be providing medical services at the center and include the practitioners':

- National Provider Identifier (NPI); and
- Assigned Medicaid provider number, if they are enrolled in Medicaid.

All enrollments of any practitioner in any Medicaid category of service, other than the FQHC program, must be submitted to the FI's provider enrollment unit.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.2: PROVIDER REQUIREMENTS****PAGE(S) 7**

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**NOTE:** The FI's provider enrollment unit must be notified immediately of any change in the above. Failure to maintain current information with the provider enrollment unit may result in a loss of reimbursement for services provided by those practitioners not identified as FQHC staff.

All practitioners providing patient services must be enrolled with the fiscal intermediary's (FI) provider enrollment unit and be linked to the FQHC at the time of enrollment in order for the facility to receive reimbursement.

Since the grant awards are time-limited by budget years, the Medicaid provider agreement is time-limited, depending on the approval periods.

After enrollment, the FQHC must provide a copy of the current Notice of Grant Award each year to the Bureau of Health Services Financing. Failure to supply the notice within 30 calendar days from the effective date of the renewal of the grant will result in termination of the center's enrollment as a provider of Medicaid services. (See Appendix A for contact information)

**NOTE: The effective date of enrollment shall not be prior to the date of receipt of the completed enrollment packet and the PECOS enrollment effective date.**

### Services

The FQHC agrees to provide those primary care services typically included as part of a physician's medical practice. The FQHC must provide, either directly or by referral, a full range of primary diagnostic and therapeutic services and supplies which include:

- Medical history
- Physical examination;
- Assessment of health status and treatment of a variety of conditions amenable to medical management on an ambulatory basis by a physician or a physician extender;
- Evaluation and diagnostic services to include:
  - Radiological services; and
  - Laboratory and pathology services,
- Services and supplies incident to a physician's or a physician extender's services such as:
  - Pharmaceuticals; and

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

---

**SECTION 22.2: PROVIDER REQUIREMENTS****PAGE(S) 7**

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- Supplies.

In addition, an FQHC can provide services related to the diagnosis and treatment of mental illness, and in certain instances, visiting nurse services.

**Billing**

The FQHC agrees to bill its usual and customary charge for each FQHC-related service using applicable diagnoses and procedure codes. FQHC services must be billed using the FQHC's NPI and Medicaid provider number assigned to the specific FQHC location and Tax Identification Number (TIN) of the specific FQHC location where the services were provided and/or the rendering provider is based, as required by each health plan and/or the fiscal intermediary.

"Usual and customary" is defined as the fee charged to private paying patients for the same procedure during the same period of time. Records on both Medicaid eligible and private paying patients must be maintained for a minimum of five years in order to verify compliance with this policy. The FQHC shall also furnish its authorized representative or contractual agents, with all information that may be requested regarding "usual and customary" fees.

The FQHC must ensure that no staff or contract provider will seek separate reimbursement from Medicaid for specific services that are ordered and/or performed in the FQHC and are billable under the FQHC program. Laboratory, pathology, radiological and other services ordered by the FQHC staff, but provided by an organization independent of the FQHC, must be billed by the provider of the service and not the FQHC.

**Diabetes Self-Management Training**

In order to receive Medicaid reimbursement for diabetes self-management training (DSMT) services, a FQHC must have a DSMT program that meets the quality standards of one of the following accreditation organizations:

- The American Diabetes Association;
- The American Association of Diabetes Educators; or
- The Indian Health Service.

All DSMT programs must adhere to the national standards for diabetes self-management education. Each member of the instructional team must:

- Be a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educator; or

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.2: PROVIDER REQUIREMENTS****PAGE(S) 7**

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- Have recent didactic and experiential preparation in education and diabetes management.

At a minimum, the instructional team must consist of one of the following professionals who is a CDE:

- A registered dietician;
- A registered nurse; or
- A pharmacist.

All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

**Satellite Clinics**

A satellite clinic must enter into a separate provider agreement from the parent center and obtain its own provider number for billing and reimbursement purposes.

**Mobile Clinics**

An FQHC is prohibited from enrolling a mobile clinic in the Louisiana Medicaid program. Services rendered at the mobile clinic must be billed using the main center's provider number.

**Out of State FQHCs in Trade Areas**

An FQHC located in the trade areas designated by the Department that wishes to enroll in the Louisiana Medicaid program, must meet all the provider enrollment requirements of an FQHC located in Louisiana and include a letter from the FQHCs home state verifying its reimbursement rate.

**Changes**

FQHCs are required to notify Medicaid in writing within seven working days of any of the following changes:

- Loss of FQHC status;
- Changes in dates of the FQHC grant budget period;



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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.2: PROVIDER REQUIREMENTS****PAGE(S) 7**

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- Opening(s) and/or closing(s) of any satellite center(s); or
- Addition or termination of providers.

**Change in Ownership**

When there is a change in ownership, Medicaid must be notified within 30 calendar days of the date of the FQHC ownership change. The new owner is required to enter into a new provider agreement with the Louisiana Medicaid program. Failure to enter into a new provider agreement following a change in ownership will result the center's termination as a Louisiana Medicaid provider.

**Change of Address**

FQHCs are required to report address changes. Providers must complete a file update form to submit to Provider Enrollment along with documentation from HRSA of the address change.

**Cost Reports**

FQHCs are required to submit cost reports with all requests for change in scope. Cost reports will not be accepted for rate changes without a change in scope of service. For more information on adjustment of rate for a change in scope, refer to Section 22.4.

**Medicare Certification**

FQHCs are required to submit proof on an annual basis of Medicare certification as an FQHC. Failure to submit the annual certification may result in disenrollment or payments being suspended.

## **RECORD KEEPING**

The center must maintain all clinical and fiscal records in accordance with written policies and procedures. The records must readily distinguish one type of service from another that is provided.

A designated member of the professional staff must be responsible for maintaining the records to ensure that they are complete, accurately documented, readily accessible, and systematically organized.

For each recipient receiving health care services, the center must maintain a record that includes the following as applicable:

- Identification and social data, consent forms, pertinent medical history, assessment of the health status and health care needs of the recipient, and a brief summary of the episode, disposition, and instructions to the recipient.
- Reports of physical examinations, diagnostic and laboratory test results, consultative findings, physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the recipient's progress, as well, as the physician's or health care professional's signature.

### **Record Maintenance and Availability**

The center is responsible for:

- Maintaining adequate financial and statistical records in the form that contains the data required by the BHSF and fiscal intermediary that supports the payment and distinguishes the type of service provided to the recipient.
- Making the records available for verification and audit by BHSF or its contracted auditing agent, and
- Maintaining financial data on an accrual basis, unless it is part of a governmental institution that uses a cash basis of accounting. In the latter case, depreciation on capital assets in accordance with the Health Insurance Manual 15 (HIM-15) is required. (See Appendix A for information about the HIM-15)

### **Protection of Record Information**

The center must maintain the confidentiality of records, provide safeguards against loss, destruction or unauthorized use, govern removal of records from the center and the conditions

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.3: RECORD KEEPING****PAGE(S) 2**

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for release of information. The recipient's written consent must be obtained before the release of information not authorized by law.

**Adequacy of Records**

Reimbursement may be suspended if the center does not maintain records that provide an adequate basis to support payments. The suspension will continue until the center demonstrates to the satisfaction of the BHSF it does, and will continue to, maintain adequate records.

**Retention of Records**

Records must be retained for at least five years from the date of service or longer as required by state statute.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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**REIMBURSEMENT**

Reimbursement for Federally Qualified Health Center (FQHC) services is made for those primary care services provided to Medicaid beneficiaries by enrolled FQHC providers. These services are described in Section 22.1 – Covered Services of this manual chapter. FQHCs are reimbursed for Medicaid covered services under an all-inclusive Prospective Payment System (PPS) as specified under Section 1902(bb) of the Social Security Act.

Payments specified as the PPS rates are all inclusive of professional, technical and facility charges, including evaluation and management, routine surgical and therapeutic procedures and diagnostic testing (including laboratory/pathology and radiology) capable of being performed on site at the FQHC and must be billed by utilizing the facilities' provider identification number (ID) and Tax Identification Number (TIN).

- Laboratory/pathology, radiology and medications administered are not separately reimbursable. To the extent that the provider has the capabilities to provide these services and has historically provided these services, the FQHC shall continue to provide such services; and
- The bundling of therapeutic and diagnostic testing services in the PPS rate is not meant to imply that the FQHC shall vend or refer out such ancillary services to other providers merely for the purpose of maximizing reimbursement.

Services and supplies incidental to a service visit include those services commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications, supplies used in a patient service visit. Section 22.1 of this manual has a list of "incident to" services. Services provided incidental to a service visit must be furnished by an employee and must be furnished under the direct supervision of an FQHC health care practitioner, meaning the health care practitioner must be immediately available when necessary, even if by telephone.

**NOTE:** Professional services performed in the FQHC will be subject to recoupment if billed under a physician/practitioner's individual Medicaid ID number.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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**Rates****Determination of Rate**

Payments for Medicaid covered services will be made under a PPS and paid on a per visit basis.

For an FQHC which enrolls and receives approval to operate, the facility's initial PPS per visit rate will be the weighted average cost payment rate per encounter for all FQHCs.

**Adjustment of Rate**

PPS rates for primary care services are adjusted effective July 1 of the state fiscal year by the published Medicare Economic Index (MEI) as prescribed in Section 1902(bb)(3)(A) of the Social Security Act.

PPS rates are adjusted to take into account any change (increase or decrease) in the scope of services furnished by the FQHC. A change in scope is an addition, removal or relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the base line rate calculation. The relocation of a site that does not impact the budget, the services provided and the number of patients served, or the number and type of providers available does not require a change in scope request for such relocation.

**The FQHC is responsible for notifying the Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), in writing, of any increases or decreases in the scope.** If the change is for the inclusion of an additional service or deletion of an existing service/site, the FQHC shall include the following in the notification:

- The current approved organization budget and a budget for the addition or deletion of services/sites;
- A detailed request for change in scope;
- A cost report for the years preceding the change in scope; and
- An assessment of the impact on total visits and Medicaid visits.

A new interim rate will be established based upon the reasonable allowed cost contained in the budget information. The final PPS rate will be calculated using the first two years of audited Medicaid cost reports which include the change in scope.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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**Out of State/Trade Area FQHC**

An out of state FQHC in the trade area will be reimbursed the lesser of the Louisiana state-wide average or the PPS rate assigned to that FQHC in its state's location.

**Notice of Rate Setting**

BHSF will send written notice to the center notifying the center of the reimbursement rate per encounter and the methodology used to establish the rate.

BHSF, or its contracted auditing agency, will reconcile the initial PPS rates to the final audited PPS rates and inform the center of the rate determination and any reconciling amounts owed to the center or due from the center.

**Appeals**

FQHCs requesting to appeal the established PPS rate must submit their request in writing. (See Appendix A for contact information).

**Cost Report Submission**

To receive a PPS rate adjustment, FQHCs must submit cost reports for Health Resources and Services Administration (HRSA) approved changes in scope of service. **A cost report must be submitted prior to the consideration for PPS rate adjustments.** A HRSA approved change in scope can include: addition, removal or relocation of services sites, or the addition or deletion of specialty and non-primary services that were not included in the baseline rate calculation.

An interim rate will be set based on the initial cost report and effective the next state fiscal year. The final PPS rate will be determined using the first two years of audited Medicaid cost reports, which must include documentation of the change in scope. **Cost reports will not be accepted for rate changes without a HRSA approved change in scope of service.**

**NOTE:** All HRSA approved changes in scope of service must be reported to the Department using the completed Services Facility Survey. (See Appendix E of this manual chapter).

**Audits**

All cost reports are subject to audit, including desk audits and field audits.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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**Encounter Visits**

An FQHC provider can be reimbursed for only one medical, one behavioral health, and one dental encounter per day. Core service encounters with more than one health professional, and multiple encounters with the same health profession, that take place on the same date of service, at a single location, constitute a single visit, and are limited to one encounter per day except when one of the following conditions exists:

- After the first encounter, the beneficiary suffers illness or injury requiring additional diagnosis or treatment.
- The beneficiary has a medical visit or dental visit on the same day. Behavioral health benefits are subject to the requirements outlined Section 22:1 Covered Services of this provider manual.

Services and supplies that are furnished by FQHC staff and incidental to an FQHC professional service as commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications and supplies used in a patient service visit are considered part of the FQHC service.

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.

Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician.

**Payment for Adjunct Services**

Reimbursement will be made for adjunct services in addition to the encounter rate paid for professional services when these services are rendered during the evening, weekend or holiday hours as outlined in the *Current Procedural Terminology* (CPT) manual under "Special Services, Procedures and Reports".

To facilitate beneficiary access to services during non-typical hours and to reduce the inappropriate use of the hospital emergency department, the reimbursement provided by use of the adjunct codes is intended to assist with covering the additional administrative costs associated with staffing

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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during these times. Providers are not to alter their existing business hours for the purpose of maximizing reimbursement.

The reimbursement is a flat fee in addition to the reimbursement for the associated encounter. Reimbursement for adjunct services are only billable for services rendered on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m., Monday through Friday. Documentation must include the time the services were rendered.

**NOTE:** Payment is not allowed when the encounter is for dental services only.

**Services with Alternative Payment Methodology****Long Acting Reversible Contraceptives**

FQHCs will receive reimbursement outside of their prospective payment system rate for long acting reversible contraceptives (LARCs). Reimbursement for LARCs will be the lesser of the Medicaid fee for service rate on file or the actual acquisition cost (AAC), for entities participating in the 340B program. The rates for LARCs are located on the Durable Medical Equipment fee schedule on [www.lamedicaid.com](http://www.lamedicaid.com).

FQHC providers must submit the medical encounter and required detail line(s) for services provided to the beneficiary on the date of service according to current policy. The procedure code for the appropriate LARC and LARC insertion must be included in the detail lines of the claim. Detail lines for the LARC and LARC insertion cannot be the only detail lines on the claim or the claim will deny. The procedure code for the services listed will pay accordingly. All other detail lines on the claim will pay at zero.

**Encounter Billing Guidelines**

Reimbursement for medical, behavioral health and dental encounters include all services provided to the beneficiary on a specific date of service and any services on a subsequent day incidental to the original encounter visit. In addition to the appropriate encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines of the claim.

A visit to pick up a prescription or a referral is not considered a billable encounter. Lab or x-ray services with no “face-to-face” encounter with a covered FQHC provider do not constitute an FQHC visit and will not be reimbursed separately as they are part of the original encounter which warranted these additional services.



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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), providers must refer to Chapter Five (5) of the Professional Services Provider Manual on [www.lamedicaid.com](http://www.lamedicaid.com) for specific billing instructions.

**Medical Encounters**

Medical health services provided in FQHCs are reimbursed as encounters. These encounter visits must be billed on a CMS-1500 using procedure code T1015. The encounter reimbursement includes all services provided to the beneficiary on that date of service and any services on a subsequent day incidental to the original encounter visit. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines.

For obstetrical services, providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service.

**NOTE:** Professional services not covered through the Professional Services Program are not covered through the FQHC Program.

**Behavioral Health Encounters/Psychiatric Services**

For behavioral health services provided during an encounter, and administered by a physician with a psychiatric specialty, a nurse practitioner or clinical nurse specialist with a psychiatric specialty, a licensed clinical social worker or a clinical psychologist, the FQHC provider identification number must be placed as the billing provider. The practitioner's provider identification number must be placed as the attending provider with the appropriate modifiers and detail line procedure codes on the claim. These services should be billed on the CMS-1500 using procedure code H2020 as the first line of the claim. 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. (*See examples of behavioral health billing in Appendix F*)

Louisiana Medicaid reimburses professional service providers for select procedure codes specific to psychiatric services delivered in the office or other outpatient facility setting. This policy is applicable to physician services in the Professional Services program and mental health services provided in FQHCs. FQHC providers should enter the appropriate psychiatric procedure codes as encounter detail lines when submitting claims for the following services:

- Psychiatric diagnostic or evaluative interview procedures;

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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**NOTE:** Procedure codes are reimbursable once per 365 days per attending provider.

- Psychiatric therapeutic procedures; and
- Psychological testing.

Psychological testing is reimbursable once per 365 days per attending provider. All applicable units of services related to this procedure code should be billed on one date of service and the units should not be divided among multiple dates of services or claim lines.

**NOTE:** Should nationally approved changes occur to CPT codes at a future date that relate to psychiatric services, providers are to follow the most accurate coding available for covered services for that particular date of service, unless otherwise directed.

In order to receive reimbursement from Louisiana Medicaid for behavioral health services, the FQHC's HRSA approval must include behavioral health services as a part of the clinic's scope of service. In addition, the FQHC must notify LDH by completing a new Services Facility Survey (see Appendix E) and submitting it to the Department. The FQHC is not required to obtain a Behavioral Health Service provider (BHSP) license from LDH Health Standards. A FQHC will be reimbursed the all-inclusive PPS rate for these services and must follow FQHC rules, policies, and manuals when billing. Practitioners who meet the above criteria can provide behavioral health services in the FQHC if they are one of the below:

- Physicians with a Psychiatric Specialty;
- Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty;
- Licensed Clinical Social Workers; or
- Clinical Psychologists.

**Physicians with a Psychiatric Specialty**

The FQHC Medicaid ID number must be listed as the billing provider and the physician's individual Medicaid ID number must be listed as the attending provider on the claim for mental health services rendered by a physician with a psychiatric specialty.

**Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty**

The FQHC Medicaid ID number must be listed as the billing provider and the nurse practitioner or clinical nurse specialist's individual Medicaid ID number must be listed as the attending

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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provider on the claim for mental health services rendered by a nurse practitioner or clinical nurse specialist.

**Licensed Clinical Social Workers**

The FQHC Medicaid ID number is listed as the billing and attending provider on the claim for mental health services provided in an FQHC by a licensed clinical social worker. If the service provided is one of the procedure codes listed above, the AJ modifier is appended to the procedure code in the detail line of the claim.

**Clinical Psychologist**

The FQHC Medicaid ID number must be listed as the billing and attending provider on the claim for mental health services provided in an FQHC by a clinical psychologist. If the service provided is one of the procedure codes listed above, the AH modifier is appended to the procedure code in the detail line of the claim.

**NOTE:** Reimbursement for services for the above providers will be at the prospective payment system (PPS) rate on file on the date of service. Behavioral health services provided by a licensed professional counselor (LPC) or licensed marriage and family therapist (LMFT) are considered other ambulatory services in the clinic and are reimbursed at the PPS rate on file.

**Other Mental Health Providers Rendering Services in an FQHC**

If the FQHC provides specialized mental health rehabilitation services, i.e. community psychiatric support and treatment (CPST), crisis intervention, (CI), and/or psychosocial rehabilitation (PSR) without the service being included in their HRSA scope of service approval or if services are delivered by an individual who is not a psychiatrist, an advanced practice registered nurse (APRN) with psychiatric specialty, a licensed clinical social worker or a licensed clinical psychologist, the entity is required to obtain a BHSP license issued by LDH Health Standards. The entity must enroll as an appropriate Specialized Behavioral Health Service (SBHS) provider, obtain a unique National Provider Identifier (NPI), have an active BHSP license issued by LDH Health Standards and meet qualifications and requirements established in the Medicaid Behavioral Health Services Provider Manual, rules, laws and regulations. The entity must bill using its unique BHSP NPI in accordance with the SBHS Medicaid rules, policies and manuals.

**Dental Encounters**

All dental services must be billed on the 2006 ADA claim form using the encounter code D0999. In addition to the encounter code, providers must list the specific dental services provided by

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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entering the procedure code for each service rendered on subsequent lines. The provider should also include zero or usual/customary charges for each service provided.

**Adjunct Services**

FQHC adjunct services should be billed with the T1015 encounter code, the appropriate detail procedure, along with the adjunct service procedure code. The adjunct service procedure code may not be submitted as the only “detail line” for the encounter.

These adjunct codes are reimbursed in addition to the reimbursement for outpatient evaluation and management services when the services are rendered in settings other than hospital emergency departments:

- Between the hours of 5 p.m. and 8 a.m. Monday through Friday;
- On weekends between 12 a.m. Saturday through midnight on Sunday; and
- State proclaimed legal holidays, 12 a.m. through midnight.

Providers are instructed to bill usual and customary charges. (See Appendix A for information on accessing the fee schedule).

Only one of the adjunct codes may be submitted by a billing provider per day. Providers are to select the code that most accurately reflects their situation. Adjunct codes are reported with another code or codes describing the service related to the beneficiary’s visit or encounter. For example:

- If the existing office hours are Monday-Friday 8 a.m. – 5 p.m. and the physician treats the beneficiary in the office at 7 p.m., then the provider may report the appropriate basic service (Evaluation/Management (E/M) visit code or encounter) and adjunct code.
- If a beneficiary is seen in the office on Saturday during existing office hours, the provider may report the appropriate basic service (E/M visit code or encounter) and adjunct code.

Documentation in the medical record relative to this reimbursement must include the time that the services were rendered. Should there be a post payment review of claims, providers may be asked to submit documentation regarding the existing office hours during the timeframe being reviewed.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**SECTION 22.4: REIMBURSEMENT****PAGE(S) 11**

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FQHC providers will receive fee-for-service reimbursement for the adjunct service codes separate from, but in addition to, the PPS reimbursement for the associated encounter (T1015).

- For FQHC providers whose services meet the guidelines outlined in this policy:
  - The encounter and required detail line(s) for services provided to the beneficiary on a date of service should be reported as directed in current FQHC policy.
  - If appropriate, the adjunct services code may also be reported as a detail line, but it may not be submitted as the only “detail line” for an encounter.
  - The adjunct code will be reimbursed fee-for-service in addition to the payment for the encounter.
- The adjunct codes are not reimbursable for dental encounters.

Payments to all providers are subject to post payment review and recover of overpayments.

**Early and Periodic Screening, Diagnosis and Treatment Screening Services**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services must be billed using the 837P Professional format using encounter code T1015 with modifier EP.

It will be necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on the appropriate line. If a registered nurse performs the screening, the appropriate procedure code must be entered followed by the modifier TD.

If immunizations are given at the time of the screening, those codes continue to be billed on the CMS-1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and modifier EP must include supporting detail procedures. Only a physician doing a screening should bill with no modifier.

The Beneficiary Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain beneficiary eligibility information. Providers should keep hardcopy proof of eligibility from MEVS on file. Medicaid eligibility verification is also available on the web. (See Appendix A for web information).

**NOTE:** The dental encounter, D0999, may be billed on the same date of services as the encounter codes T1015, T1015 TH (OB encounter), T1015 EP (EPSDT screening) and/or H2020 (Behavioral Health encounter).

**Medicare/Medicaid Dual Eligible Billing**

Medicaid pays the Medicare co-insurance, up to the Medicaid established encounter rate, for beneficiaries who are eligible for Medicare and Medicaid. Providers should first file claims with the regional Medicare fiscal intermediary/carrier, ensuring the beneficiary's Medicaid ID number is included on the Medicare claim form, before filing with Medicaid.

After the Medicare claim has been processed, then Medicaid should be billed. Providers must bill these claims on the UB92/UB04 and include the Medicare Explanation of Benefits, a copy of the Medicare claims and put the Medicaid provider number and Medicaid ID number in the appropriate form locators. (See Appendix A for information on where to send the claim).

**NOTE:** This is the only instance where Louisiana Medicaid may be billed using the UB92/UB04 for FQHC services. Straight Medicaid claims must be processed on the CMS-1500 claim form.

**Outpatient Services**

For all services rendered at the FQHC, in a nursing home or during home visits, the FQHC provider identification number must be used as the billing provider number in the appropriate place on the CMS 1500 claim form.

**Inpatient Services**

Physician inpatient services are billed through the physician's individual provider number as the billing provider. Physicians are not allowed to bill through their FQHC group number for inpatient services.

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****APPENDIX A: CONTACT INFORMATION****PAGE(S) 1****CONTACT INFORMATION**

<b>OFFICE NAME</b>	<b>TYPE OF ASSISTANCE</b>	<b>CONTACT INFORMATION</b>
Louisiana Department of Health	Receives annual notice of grant award from FQHC	Louisiana Department of Health Bureau of Health Services Financing Medicaid Policy and Compliance P.O. Box 91030 Baton Rouge, LA 70821-9030
DXC Technology – PA Unit	Receives prior authorization requests	DXC Technology Medicaid Solutions Prior Authorization Unit P.O. Box 14919 Baton Rouge, LA 70898-4919
DXC Technology – Provider Relations Unit	Provides assistance with questions regarding billing information	DXC Technology Medicaid Solutions Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821
DXC Technology – Claims Processing Unit	Processes Medicare crossover claims	DXC Technology Medicaid Solutions P. O. Box 91023 Baton Rouge, LA 70821
MEVS/REVS	Verifies recipient eligibility	<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>
Division of Administrative Law	Receives appeal requests	Division of Administrative Law Health and Hospitals Section PO Box 4189 Baton Rouge, LA 70821-4189
LeBlanc, Robertson, Chisholm & Associates, LLC (LRCA, LLC)	Receives cost reports	<a href="http://lrcaudit.com">http://lrcaudit.com</a>
Professional Services Fee Schedule	Reimbursement information relative to adjunct codes	<a href="http://www.lamedicaid.com">www.lamedicaid.com</a> following “Fee Schedules” then “Professional Services” links

See <http://www.cms.hhs.gov/Manuals/PBM/list.asp> for information concerning the Health Insurance Manual 15 (HIM-15)

## **FORMS AND LINKS**

### **158-A Form and Instructions**

The 158-A is to be completed by the Physician to request an extension of the 12 allowable office visits when the reason for the additional visit(s) is medically necessary. The form is available at the below link:

<https://www.lamedicaid.com/provweb1/Forms/158%20A%20Instructions.pdf>



## GLOSSARY

**Adjunct Services** – Services provided by the FQHC on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m. Monday through Friday.

**Bureau of Health Services Financing (BHSF)** – The Bureau within the Louisiana Department of Health responsible for the administration of the Louisiana Medicaid Program.

**Change in Scope** – an addition, removal and relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the baseline rate calculation.

**CMS** – The Center for Medicare and Medicaid Services (Formerly known as Health Care Financing Administration-HCFA) is the federal agency in DHHS responsible for administering the Medicaid Program and overseeing and monitoring of the State’s Medicaid Program.

**Louisiana Department of Health (LDH)** – The state agency responsible for administering the Medicaid Program and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services. In this manual the use of the word “department” will mean LDH.

**Department of Health and Human Services (DHHS)** – The federal agency responsible for administering the Medicaid Program and public health programs.

**Encounter** – A face-to-face visit with a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, clinical social worker, or any other State plan approved ambulatory provider during which an FQHC core or other ambulatory 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.

**Enrollment** – A determination made by LDH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other LDH-funded services. This is also referred to as provider enrollment.

**Federally Qualified Health Center** – An entity receiving a grant under Section 330 of the Public Health Service Act; is receiving funding from such grant under a contract with the recipients of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; is not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of DHHS to meet the requirements for receiving a grant based on the recommendation of the HRSA; is operating as an outpatient health program or facility of a tribe or tribal organization under the

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**APPENDIX C: GLOSSARY****PAGE(S) 3**

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Indian Self Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

**Fiscal Intermediary** – Is the private fiscal agent with which LDH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

**Health Professional Shortage Area** – An urban or rural area, population group, or public or nonprofit private medical facility which the Secretary of DHHS determines has a shortage of health professionals.

**Health Resources Services Administration (HRSA)** – An office within the Department of Health and Human Services whose mission is to improve access to healthcare services for the uninsured, isolated, or medically vulnerable through leadership and financial support.

**Medicaid** – A federal-state financed entitlement program which provides medical services primarily to low-income individuals under a State Plan approved under Title XIX of the Social Security Act.

**Medically Underserved Area** – Areas designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population.

**Medically Underserved Population** – Areas designated by HRSA as having high infant mortality, high poverty, and/or high elderly population.

**Medicare** – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

**Medicaid Management Information System (MMIS)** – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

**Prospective Payment System (PPS)** – Method of reimbursement in which payment is made on a predetermined, fixed amount. Section 1902(bb) of the Social Security Act describes the methodology used to determine the PPS for FQHCs.

**Provider Enrollment** – Another term for enrollment.

**Secretary** – The Secretary of the Louisiana Department of Health or any official to whom (s)he has delegated the pertinent authority.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**APPENDIX C: GLOSSARY**

**Satellite Clinics** – Separate clinics of the primary FQHC.

**Service site** – Any center which provides primary health care services to a geographic service area or population.

**Trade Areas** – Counties in the states of Texas, Arkansas, and Mississippi that physically share a border with Louisiana.

## **CLAIMS FILING**

This appendix contains the following information:

- Instructions for billing using the CMS-1500 Claim Form
- Samples of the CMS-1500 Claim Form
- Instructions for adjusting or voiding a CMS-1500 claim
- Samples of a CMS-1500 Claim Form Adjustment
- Instructions for billing using the ADA Dental Claim Form
- Sample of the ADA Dental Claim Form
- Instructions for adjusting or voiding an ADA claim using the 209 Adjustment/Void Form
- Sample of the 209 Adjustment/Void Form
- Instructions for adjusting or voiding an ADA claim using the 210 Adjustment/Void Form
- Sample of the 210 Adjustment/Void Form

### **CMS 1500 (02/12) Billing Instructions for FQHC Services**

Hard copy billing of Federally Qualified Health Centers (FQHC) services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

**Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

**Situational** information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

DXC Technology  
P.O. Box 91020  
Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com), directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

**CMS 1500 (02/12) Billing Instructions for FQHC Services**

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's ID Number	<b>Required</b> – Enter the recipient's 13 digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS or REVS.  <b>NOTE:</b> The recipients' 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date  Sex	<b>Situational</b> – Enter the recipient's date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example 01 02 07).  Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	<b>Situational</b> – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the recipient's permanent address.	
6	Patient Relationship to Insured	<b>Situational</b> – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	Reserved for NUCC Use	<b>Leave Blank.</b>	
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	<p><b>Situational</b> – If recipient has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block. This carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	<p><b>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</b></p>
9b	Reserved for NUCC Use	Leave Blank.	
9c	Reserved for NUCC Use	Leave Blank.	
9d	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	<b>Situational</b> – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	<b>Situational</b> – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	<b>Situational</b> – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	<b>Situational</b> – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	<b>Situational</b> – Obtain signature if appropriate or leave blank.	



**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	<p><b>Situational</b> – Complete if applicable.</p> <p>In the following circumstances, entering the name of the appropriate physician block is <b>required</b>:</p> <p>If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.</p>	
17a	Unlabeled	Leave Blank.	
17b	NPI#	Leave Blank.	
18	Hospitalization Dates Related to Current Services	Leave Blank.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	



CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
23	Prior Authorization (PA) Number	<p><b>Situational</b> – Complete if appropriate or leave blank.</p> <p>If the services being billed must be prior authorized, the 9 digit numeric PA number is <b>required</b> to be entered.</p>	
24	Supplemental Information	<p><b>Situational</b> – Applies to the detail lines for drugs and biologicals only.</p> <p><u><b>CURRENTLY, THIS IS NOT A REQUIREMENT FOR FQHC PROVIDERS.</b></u></p> <p>In addition to the procedure code, the <b>National Drug Code (NDC)</b> is <b>required</b> by the Deficit Reduction Act of 2005 for <b>physician-administered drugs</b> and <b>shall be entered</b> in the <b>shaded</b> section of 24A through 24G. <b><u>Claims for these drugs shall include the NDC from the label of the product administered.</u></b></p> <p>To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the <b>Qualifier N4</b> followed by the <b>11-digit NDC</b>. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.</p> <p>Providers should then leave one space then enter the appropriate <b>Unit Qualifier</b> (see below) and the <b>actual units administered</b>. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.</p> <p>The following qualifiers are to be used when reporting NDC units:</p> <p>F2 International Unit                      ML Milliliter                      GR Gram                      UN Unit</p>	<p><b>FQHCs who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s)</b></p>
24A	Date(s) of Service	<p><b>Required</b> -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	<p><b>Required</b> -- Enter the appropriate place of service code for the services rendered.</p>	

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
24C	EMG	<b>Situational</b> – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	<p><b>Required</b> -- Enter the procedure code(s) for services rendered.</p> <p>Enter the appropriate encounter procedure code on the first line.</p> <p><b>Encounter Codes:</b></p> <ul style="list-style-type: none"> <li>• FQHC medical encounter visit: T1015</li> <li>• FQHC obstetrical service: T1015 w/TH modifier.</li> <li>• FQHC EPSDT service : T1015 w/EP modifier.</li> <li>• FQHC Behavioral Health encounter visit : H2020</li> </ul> <p>In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered.</p>	<p>If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required.</p> <p>For claims involving TPL, a claim line with the encounter code and the encounter rate must be added to the claim.</p>
24E	Diagnosis Pointer	<p><b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A” “B”, etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
24F	Amount Charged	<b>Required</b> -- Enter usual and customary charges, or zero when appropriate, for the service rendered.	
24G	Days or Units	<b>Required</b> -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	<b>Situational</b> – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	ID Qualifier	<b>Optional.</b>	
24J	Rendering Provider ID	<p><b>Situational</b> – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is <b>required</b>.</p> <p>Entering the Rendering Provider’s NPI in the non-shaded portion of the block is <b>optional</b>.</p>	
25	Federal Tax ID Number	<b>Optional.</b>	

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
26	Patient's Account No.	<b>Situational</b> – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	
29	Amount Paid	<b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor.  Enter '0' if the third party did not pay.  If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	<b>Leave Blank.</b>	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Optional.</b> – The practitioner or the practitioner's authorized representative's original signature is no longer required.  <b>Required</b> -- Enter the date of the signature.	
32	Service Facility Location Information	<b>Situational</b> – Complete as appropriate or leave blank.	
32a	NPI#	<b>Optional.</b>	
32b	Unlabeled	<b>Optional.</b>	
33	Billing Provider Info & Phone #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	
33a	NPI#	<b>Optional</b>	
33b	Unlabeled	<b>Required</b> – Enter the billing provider's 7-digit Medicaid ID number.  <b>ID Qualifier - Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	<b>The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.</b>

**Sample forms are on the following pages**

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Sample of FQHC CMS-1500 Claim Form with ICD-10 Diagnosis Code



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA	PICA
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE	3. PATIENT'S BIRTH DATE (MM DD YY) 06 19 85 M F X
5. PATIENT'S ADDRESS (No., Street) CITY STATE	6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other)
7. INSURED'S ADDRESS (No., Street) CITY STATE	8. RESERVED FOR NUCC USE
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) TPL Code if applicable	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO d. INSURANCE PLAN NAME OR PROGRAM NAME
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical coverage information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED DATE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL	15. OTHER DATE (MM DD YY) QUAL
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES NO \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Rate A-L to service line below (24E)) ICD Ind. 0 A. Z30011 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DTS OR UNITS H. ICD-10 Code I. ID. QUAL. J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
1 10 10 15 10 10 15 11 T1015 A 160.00 NPI 1236548	
2 10 10 15 10 10 15 11 99213 A 0.00 NPI 1236548	
3 N400703680101 UN150.00 DEPO-ROVERA INJ 10 10 15 10 10 15 11 J1050 A 0.00 NPI 1236548	
4	
5	
6	
25. FEDERAL TAX I.D. NUMBER SSN EIN 1234	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claim, see back) X YES NO
28. TOTAL CHARGE \$ 160.00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 160.00	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ima Biller DATE 10/15/15
32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (800) 222-3333 ALWAYS OPEN RHC/FQHC CLINIC 123 MAIN ST ANY TOWN, LA 70000 a. 1326547895 b. 1234567

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

### Sample of a Claim Form

[https://www.lamedicaid.com/provweb1/billing\\_information/CMS\\_1500\\_RHC\\_FQHC.pdf](https://www.lamedicaid.com/provweb1/billing_information/CMS_1500_RHC_FQHC.pdf)

### Adjustments and Voids

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.**

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment, with the exception of the Provider Identification Number and the Recipient/Patient Identification Number.

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****APPENDIX D: CLAIMS RELATED INFORMATION****PAGE(S) 32**

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**Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.**

**Adjustments/Voids Appearing on the Remittance Advice**

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.


**Sample forms are on the following pages**



CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Sample of FQHC CMS-1500 Claim Form Adjustment with ICD-10 Diagnosis Code

 **HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE (Medicare #)  MEDICAID (Medicaid #)  TRICARE (ID#)  CHAMPVA (Member ID#)  GROUP HEALTH PLAN (ID#)  FECA BLK LUNG (ID#)  OTHER (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
**LOU, JANNIE**

3. PATIENT'S BIRTH DATE (MM DD YY) **06 19 85** SEX **M**  **F**

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)  
CITY STATE ZIP CODE TELEPHONE (include Area Code)

6. PATIENT RELATIONSHIP TO INSURED  
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)  
CITY STATE ZIP CODE TELEPHONE (include Area Code)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:  
a. EMPLOYMENT? (Current or Previous) YES NO  
b. AUTO ACCIDENT? YES NO PLACE (State)  
c. AUTO ACCIDENT? YES NO PLACE (State)

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. IS THERE ANOTHER HEALTH BENEFIT PLAN?  
If yes, complete items 9, 9a and 9d.

13. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  
SIGNED DATE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL

15. OTHER DATE (MM DD YY) QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  
FROM (MM DD YY) TO (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
71a. NAME 71b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  
FROM (MM DD YY) TO (MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10 **Z30011**

22. RESUBMISSION CODE **A 02** ORIGINAL REF. NO. **5299198798700**

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-10 PROC. CODE	I. ID QUAL	J. RENDERING PROVIDER ID #
10   10   15   10   10   15   11	T1015			A	160   00			NPI	123654875
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. **1234**

27. ACCEPT ASSIGNMENT? (For prev. date, see back)  YES  NO

28. TOTAL CHARGE \$ **160 | 00**

29. AMOUNT PAID \$ **160 | 00**

30. BALANCE DUE \$ **160 | 00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  
SIGNED **Ima Biller** DATE **10/15/15**

32. SERVICE FACILITY LOCATION INFORMATION  
**ALWAYS OPEN RHC/FQHC CLINIC  
123 MAIN ST  
ANY TOWN, LA 70000**

33. BILLING PROVIDER INFO & PH# **(800) 222-3333**  
a. **1326547895** b. **1234567**

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

## **ADA Claim Form Billing Instructions for FQHC Services**

### **Medicaid EPSDT Dental and Adult Denture Program Services**

The 2006 American Dental Association Claim Form is the only hardcopy dental claim form accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program or Adult Denture Program. These claim forms may be obtained by contacting the American Dental Association or your dental supply company.

The following billing instructions correspond to the 2006 ADA Claim Form.

**Required** information must be entered to ensure claims processing.

**Situational** information may be required only in certain situations as detailed in each instruction item.

Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form.

EPSDT Dental Program and Adult Denture Program claims should be submitted to:

DXC Technology  
P. O. Box 91022  
Baton Rouge, LA 70821

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

**ADA Claim Form Billing Instructions for FQHC Services**

Locator #	Description	Instructions	Alerts
1	Type of Transaction	<p><b>Required</b> -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.</p> <p><b>Situational</b> – Check box marked “EPSDT Title XIX” if patient is Medicaid eligible and under 21 years of age.</p> <p>If block is not checked, the claim will be processed as an adult claim.</p>	<p>If a claim is being submitted for payment, you must mark “Statement of Actual Services” in Block 1 of the claim form.</p> <p>Claims for payment that are sent to DXC Technology should never include radiographs.</p>
2	Predetermination / Preauthorization Number	<b>Situational</b> – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.	
3	Company / Plan Name, Address, City, State, Zip Code	<b>Situational</b> – Enter the primary payer information if applicable.	
4	Other Dental or Medical Coverage?	<b>Situational</b> – If yes, complete Block 9.	
5	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	<b>Situational.</b>	
6	Date of Birth (MM/DD/CCYY)	<b>Situational.</b>	
7	Gender	<b>Situational.</b>	
8	Policyholder/Subscriber ID	<b>Situational.</b>	
9	Plan/Group Number	<p><b>Situational</b> – Enter the third party’s carrier code if a third party is involved.</p> <p>If there is other coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block. This code is returned through MEVS recipient eligibility inquiries as the Network Plan Identifier. The MEVS application is located on the secure portal of the web site, <a href="http://www.lamedicaid.com">www.lamedicaid.com</a>. (The carrier code list can be found at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> under the <b>Forms/Files</b> link)</p> <p>If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid.</p>	

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
10	Patient's Relationship to Person Named in #5	<b>Situational.</b>	
11	Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code	<b>Situational.</b>	
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	<b>Required</b> -- Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS.  Recipient's address is <b>optional</b> .	
13	Date of Birth (MM/DD/CCYY)	<b>Required</b> -- Enter the recipient's 8-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.	
14	Gender	<b>Optional</b> – Check appropriate block.	
15	Policyholder/Subscriber ID	<b>Required</b> -- Enter the 13-digit Medicaid ID number as obtained from REVS or MEVS.  Do not use the 16-digit Card Control Number (CCN) from the recipient's Medicaid card.	
16	Plan / Group Number	<b>Situational.</b>	
17	Employer Name	<b>Situational.</b>	
18	Relationship to Policyholder/Subscriber in #12 above.	<b>Situational.</b>	
19	Student Status	<b>Situational.</b>	
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	<b>Situational.</b> This field should be used only when other private insurance is primary.  <b>Note:</b> The Medicaid recipient's name is required to be entered in Block 12.	
21	Date of Birth (MM/DD/CCYY)	<b>Situational.</b>	
22	Gender	<b>Situational.</b>	
23	Patient ID / Account # (Assigned by Dentist)	<b>Optional</b> – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice.  The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.	
24	Procedure Date (MM/DD/CCYY)	<b>Required</b> -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.  A service must have been performed/delivered before billing Medicaid for payment.	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
25	Area of Oral Cavity	<p><b>Situational</b> – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific <b>requirements</b> regarding oral cavity designator.</p> <p>If an oral cavity designator is <b>required</b> by Medicaid, do not enter a tooth number or letter in Block 27.</p>	<p>Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.</p>
26	Tooth System	Leave Blank	
27	Tooth Number(s) or Letter(s)	<p><b>Situational</b> – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific <b>requirements</b> regarding tooth number or letter.</p> <p><u>If a tooth number or letter is <b>required</b> by Medicaid, do not enter an oral cavity designator in Block 25.</u></p>	<p>Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.</p>
28	Tooth Surface	<p><b>Situational</b> – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes:</p> <ul style="list-style-type: none"> <li>B = Buccal</li> <li>D = Distal</li> <li>F = Facial</li> <li>I = Incisal</li> <li>L = Lingual</li> <li>M = Mesial, and</li> <li>O = Occlusal</li> </ul> <p>Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.</p>	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
29	Procedure Code	<p><b>Required</b> – Enter the all-inclusive encounter code (D0999) on the first line then enter the appropriate dental procedure codes from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.</p>	<p>REMINDER: The all-inclusive encounter code (D0999) must be entered on the first line of the claim form. Tooth number/letter, surface or oral cavity designator is not required for this line. In addition to the encounter information, it is necessary to indicate on subsequent lines of the claim form, the specific dental services provided by entering the individual procedures, including all appropriate line item information for each service rendered.</p>
30	Description	<p><b>Required</b> – Enter the description of the service performed.</p>	
31	Fee	<p><b>Required</b> -- Enter the dentist's full (usual and customary) fee for the dental procedure reported.</p>	
32	Other Fee(s)	<p><b>Leave Blank</b></p>	
33	Total Fee	<p><b>Required</b> – Total of all fees listed on the claim form.</p>	
34	(Place an 'X' on each missing tooth)	<p><b>Situational</b> – Complete if applicable.                      Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/".</p> <p>In the following circumstances, this information is <b>required</b>:</p> <p>If the claim is for the Adult Denture Program.</p> <p>If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy.</p>	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
35	Remarks	<p><b>Situational</b> – Enter the amount paid by the primary payor if block 9 is completed.</p> <p>Write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [\$0] payment) in this block.</p> <p>Enter any additional information <b>required</b> by Medicaid regarding requested services (including description of the patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include).</p> <p>For prior authorization requests, if the information <b>required</b> in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the recipient's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record.</p>	
36	Authorizations	<b>Optional.</b>	
37	Authorizations	<b>Optional.</b>	
38	Place of Treatment	<p><b>Situational</b> – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48.</p> <p>If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is <b>required</b>.</p>	
39	Number of Enclosures	<p><b>Situational</b> – Enter 00 to 99 in applicable boxes.</p> <p>Claims submitted for prior authorization are <b>required</b> to contain the identified attachments.</p> <p>Claims submitted for payment should not contain any of the attachments listed in Block 39.</p>	



**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
40	Is Treatment for Orthodontics?	<b>Situational</b> – Complete if applicable.  Claims requesting comprehensive orthodontic services are <b>required</b> to enter information in this block.  Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.	
41	Date Appliance Placed	<b>Situational.</b>	
42	Months of Treatment Remaining.	<b>Situational.</b>	
43	Replacement of Prosthesis	<b>Situational</b> – Check appropriate box if applicable; if checked, complete Block 44 if known.	
44	Date Prior Placement	<b>Situational</b> – If Block 43 is checked and if known, enter the appropriate 8-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	<b>Situational</b> – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is <b>required</b> . Check the appropriate box.	
46	Date of Accident (MM/DD/CCYY).	<b>Situational.</b> If Block 45 is completed, then this block is <b>required</b> . Enter the eight-digit date in month, day and year (MM/DD/CCYY).	
47	Auto Accident State	<b>Situational.</b> If Auto Accident is checked in Block 45, this block is <b>required</b> . Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	<b>Required.</b> Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group.  Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	<b>Optional</b> – Enter the billing provider's 10-digit NPI number.	
50	License Number	<b>Optional.</b>	
51	SSN or TIN	<b>Optional.</b>	
52	Phone Number	<b>Required</b> -- Enter the phone number for the billing dental provider.	
52A	Additional Provider ID	<b>Required</b> – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	
53	Signature	<b>Optional.</b>	



**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
54	NPI	<b>Optional</b> – Enter the 10-digit NPI of the treating (attending) dental provider	
55	License Number	<b>Required</b> – Enter the license number of the treating (attending) dental provider.	
56	Address, City, State, Zip Code	<b>Situational</b> – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48.	
56A	Provider Specialty Code	<b>Optional.</b>	
57	Signature	<b>Optional.</b>	
58	NPI	<b>Optional</b> – Enter the 10-digit NPI of the treating (attending) dental provider	

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Sample of ADA Claim Form

**ADA Dental Claim Form** MSA 07-02  
Attachment 1

<b>HEADER INFORMATION</b> 1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Presubscription <input checked="" type="checkbox"/> EPSDT Title XIX		<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b> (For Insurance Company Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <b>Brown, Wade</b> <b>8269 Chilly Rd</b> <b>Winter, LA 70000</b>															
2. Predetermination/Presubscription Number <b>123456789</b>		13. Date of Birth (MM/DD/YYYY)    14. Gender    15. Policyholder/Subscriber ID (SSN or ID#) <b>08/14/2004</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>1234567890123</b>															
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b> 3. Company/Plan Name, Address, City, State, Zip Code		16. Plan/Group Number    17. Employer Name															
<b>OTHER COVERAGE</b> 4. Other Dental or Medical Coverage? <input checked="" type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		<b>PATIENT INFORMATION</b> 18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other    19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PFS															
5. Name of Policyholder/Subscriber in #1 (Last, First, Middle Initial, Suffix)		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
6. Date of Birth (MM/DD/YYYY)    7. Gender    8. Policyholder/Subscriber ID (SSN or ID#) <input type="checkbox"/> M <input type="checkbox"/> F		21. Date of Birth (MM/DD/YYYY)    22. Gender    23. Patient ID/Account # (Assigned by Dentist) <input type="checkbox"/> M <input type="checkbox"/> F															
9. Plan/Group Number <b>TPL Carrier Code</b>		10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other															
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																	
<b>RECORD OF SERVICES PROVIDED</b>																	
	24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Teeth System	27. Tooth Number(s) or ICDM(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee									
1	2/4/12					D0999	Encounter - All Inclusive	100.00									
2	2/4/12	10				D4341	Periodontal Scaling and Root Planing	110.00									
3	2/4/12			13		D2954	Post & Core	94.00									
4	2/4/12			15		D2931	Stainless Steel Crown	140.00									
5																	
6																	
7																	
8																	
9																	
10																	
<b>MISSING TEETH INFORMATION</b>																	
34. (Place an 'X' on each missing tooth)																32. Other Fees	
35. Remarks <b>If TPL involved: write the words "Carrier Paid" and enter the amount paid by the TPL here.</b>																33. Total Fee	
<b>444.00</b>																	
<b>AUTHORIZATIONS</b> 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.  X Patient/Guardian signature _____ Date _____  37. I hereby authorize and direct payment of the dental benefits (otherwise payable to me, directly to the below named dentist or dental entity).  X Subscriber signature _____ Date _____									<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b> 38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other 39. Number of Enclosures (00 to 99): Radiographs: <input type="checkbox"/> Gut Images: <input type="checkbox"/> Models: <input type="checkbox"/> 40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/YYYY) 42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44. Date Prior Placement (MM/DD/YYYY) 45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident 46. Date of Accident (MM/DD/YYYY)    47. Auto Accident Date								
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber) 48. Name, Address, City, State, Zip Code <b>XYZ Dental Group</b> <b>8956 No Cavity Ave.</b> <b>Smiley, LA 70000</b>									<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b> 49. NPI <b>1987654321</b>								
49. NPI <b>1987654321</b>									50. License Number    51. SSN or TIN 52. Phone Number    53. Additional Provider ID <b>(222) 999-4444</b> <b>1234567</b>								
54. NPI <b>1234567890</b>									55. License Number    56. Address, City, State, Zip Code <b>99999</b>								
57. Phone Number ( ) -    58. Additional Provider ID <b>1987654</b>																	

© 2005 American Dental Association  
J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)

To Provider call 1-800-547-4748 or go online at www.adacatalog.org

**EPSDT Dental Services Adjustment/Void (209) and  
Adult Dental Services Adjustment/Void (210) Form**

The EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04) must be used when submitting adjustments/voids for EPSDT Dental Program services for all dates of service.

Additionally, when submitting adjustments/voids for the Adult Denture Program for all dates of service, dental providers must use the Adult Dental Services 210 Adjustment/Void form (revision date 10/04).

For both adjustment/void forms, the Form Locator 15 has been renamed as “Patient I.D./Account# Assigned by Dentist”. If the patient’s account (medical record) number is entered here, it will appear on the Medicaid Remittance Advice. It may consist of letters and/or numbers, and it may be a maximum of 20 positions.

Providers can obtain these forms from DXC Technology or through the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com). Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****APPENDIX D: CLAIMS RELATED INFORMATION****PAGE(S) 32****Instructions for Completing 209 Adjustment/Void Form (EPSDT)**

Locator #	Description	Instructions	Alerts
1	Adj/Void	Check the appropriate box.	
2 3 4	Patient's Last Name First Name MI	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
7	Date of Birth	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
8	Sex	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider No.	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required	
19	Treatment Necessitated By	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

Locator #	Description	Instructions	Alerts
20	Payment Source Other Than Title XIX	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
21, 22		Leave these spaces blank.	
23	Diagram	Not required.	
24	Examination and Treatment Plan	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
25	Paid or Payable by Other Carrier	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero (\$0). <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved.	
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied claim.	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for Prior Authorization	Enter the 9-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.	
32	Attending Dentist's Signature - Provider Number	The attending provider number must be entered in this field.	

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to DXC Technology for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Sample of 209 Adjustment/Void Form (EPSDT)

FOR PREAUTHORIZATION MAIL TO: Louisiana Department of Health MEDICAID DENTAL PROGRAM P.O. BOX 9188 BATON ROUGE, LA 70821-4080

FOR PAYMENT REMIT TO: DXC TECHNOLOGY P.O. BOX 91822 BATON ROUGE, LA 70821 (800) 473-2783 (225) 924-5040

LOUISIANA DEPARTMENT OF HEALTH BUREAU OF HEALTH SERVICES FINANCING MEDICAL ASSISTANCE PROGRAM PROVIDER BILLING FOR EPSDT DENTAL SERVICES

Patient ID/Account Number  
**SAMPLE**

FOR OFFICE USE ONLY

1  PD  VOID

2 PATIENT'S LAST NAME (PRINT) **Smith** 3 FIRST NAME **Sally** 4 SEX **L** 5 MEDICAL ASSISTANCE ID NUMBER  
1 2 3 4 5 6 7 8 9 0 1 2 3

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.) 7 DATE OF BIRTH **02 15 2002** 8 SEX  M  F

9 REFERRING AGENCY NO. 10 DATE OF REFERRAL 11 REFERRED FOR:  EMERGENCY  DIAGN. SCREENING 12 DENTIST OR GROUP REFERRED TO: NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ TEL. NO. \_\_\_\_\_

13 REFERRED BY (SIGNATURE) 14 TELEPHONE NO. 15 REFERRING ACCOUNT# ASSIGNED BY DENTIST

16 PAY TO: DENTIST OR GROUP NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_ 17 PAY TO: DENTIST OR GROUP PROVIDER NO. **1800000** 18 ARE X-RAYS ENCLOSED?  YES  NO

19 TREATMENT NECESSITATED BY: A. EMPLOYMENT  YES  NO B. ACCIDENT/INJURY  YES  NO 20 PAYMENT SOURCE, OTHER THAN TITLE XXX 1% CARRIER CODE: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

21 PROGRESS, IS THIS THE INITIAL PLACEMENT?  YES  NO 22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM

23 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	E. DATE SERVICE PERFORMED MO. DAY YE.	F. ADJUSTED FEE FOR STATE USE ONLY	G. USUAL AND CUSTOMARY FEE
16		D2931	Stainless Steel Crown	02 16 12	135	00

24 CONTROL NUMBER \_\_\_\_\_ 25 THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REFERENCE ADVICE IS ALWAYS REQUIRED.) 26 DATE OF REFERENCE ADVICE THAT LISTED CLAIM WAS PAID.

27 REASONS FOR ADJUSTMENT  
**Billed wrong tooth #; should be tooth #16, not 15.**

01 THIRD PARTY LIABILITY RECOVERY  
 02 PROVIDER CORRECTIONS  
 03 FISCAL AGENT ERROR  
 90 STATE OFFICE USE ONLY - RECOVERY  
 99 OTHER - PLEASE EXPLAIN

28 REASONS FOR VOID  
 10 CLAIM PAID FOR WRONG RECIENT  
 11 CLAIM PAID TO WRONG PROVIDER  
 99 OTHER - PLEASE EXPLAIN

29 I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH

30 REQUEST FOR AUTHORIZATION - SEND TO LDH DENTAL PROGRAM ATTENDING DENTIST'S SIGNATURE \_\_\_\_\_ PROVIDER NUMBER \_\_\_\_\_ DATE \_\_\_\_\_

31 APPROVED - YES  NO  W/EXCEPTIONS  AUTHORIZED SIGNATURE **PA 123456780** DATE \_\_\_\_\_

32 DR. DDS ATTENDING DENTIST'S SIGNATURE \_\_\_\_\_ PROVIDER NUMBER **188888** DATE \_\_\_\_\_

REMARKS FOR UNUSUAL SERVICE: \_\_\_\_\_

33

**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS****APPENDIX D: CLAIMS RELATED INFORMATION****PAGE(S) 32****Instructions for Completing 210 Adjustment/Void Form (Adult)**

Locator #	Description	Instructions	Alerts
1	Adj/Void	Check the appropriate box.	
2 3 4	Patient's Last Name First Name MI	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
7	Date of Birth	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
8	Sex	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider No.	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required.	



**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

19	Treatment Necessitated By	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
<b>Locator #</b>	<b>Description</b>	<b>Instructions</b>	<b>Alerts</b>
20	Payment Source Other Than Title XIX	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
21		Not required.	
22		Leave blank.	
23	A-G	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
24	Paid of Payable by Other Carrier	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero (\$0). <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
25	Other Information	Leave blank.	
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the claim as paid/approved.	
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied claim.	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for Prior Authorization	Enter the 9- digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires prior authorization.	
32	Attending Dentist's Signature - Provider Number	The attending provider number must be entered in this field.	

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to DXC Technology for adjustment. If the code



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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

**APPENDIX D: CLAIMS RELATED INFORMATION**

was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS

APPENDIX D: CLAIMS RELATED INFORMATION

Sample of 210 Adjustment/Void Form (Adult)

FOR PREAUTHORIZATION MAIL TO: Louisiana Department of Health MEDICAID DENTAL PROGRAM P.O. BOX 1788 BATON ROUGE, LA 70821-8080

FOR PAYMENT REMIT TO: DXC TECHNOLOGY P.O. BOX 91022 BATON ROUGE, LA 70821 (800) 473-2783 (225) 924-5040

LOUISIANA DEPARTMENT OF HEALTH BUREAU OF HEALTH SERVICES FINANCING MEDICAL ASSISTANCE PROGRAM PROVIDER BILLING FOR EPSDT DENTAL SERVICES

Patient ID/Account Number  
**SAMPLE**

FOR OFFICE USE ONLY

1 ADJ. VOID

2 PATIENT'S LAST NAME (PRINT) **Smith** 3 FIRST NAME **Sally** 4 SEX **L** 5 MEDICAL ASSISTANCE I.D. NUMBER  
1 2 3 4 5 6 7 8 9 0 1 2 3

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.) 7 DATE OF BIRTH 02 15 2002 8 SEX  M  F

9 REFERRING AGENCY NO. 10 DATE OF REFERRAL 11 REFERRED FOR  EMERGENCY  BASIC SCREENING 12 DENTIST OR GROUP REFERRED TO: NAME ADDRESS TEL. NO.

13 REFERRED BY (SIGNATURE) 14 TELEPHONE NO. 15 PATIENT'S ACCOUNT # ASSIGNED BY DENTIST

16 PAY TO: DENTIST OR GROUP NAME ADDRESS CITY ST. ZIP 17 PAY TO: DENTIST OR GROUP PROVIDER NO. **1800000** 18 ARE X-RAYS ENCLOSED  YES  NO NUMBER OF X-RAYS

19 TREATMENT NECESSITATED BY: A. EMPLOYMENT  YES  NO B. ACCIDENT/INJURY  YES  NO 20 PAYMENT SOURCE OTHER THAN TITLE XIX IXL CARRIER CODE 1. 2. 3.

21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT?  YES  NO 22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM

24 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	E. UNITS	F. DATE SERVICE PERFORMED (MO. DAY YR.)	G. ADJUSTED FEE (FOR STATE USE ONLY)	H. USUAL AND CUSTOMARY FEE
16		D2931	Stainless Steel Crown		02 16 12		135 00
H. ORAL CAVITY					25 PAID OR PAYABLE BY OTHER CARRIER		\$

26 CONTROL NUMBER THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.) 27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.

28 REASONS FOR ADJUSTMENT **Billed wrong tooth #; should be tooth #16, not 15.**

01 THIRD PARTY LIABILITY RECOVERY  
 02 PROVIDER CORRECTIONS  
 03 FISCAL AGENT ERROR  
 90 STATE OFFICE USE ONLY - RECOVERY  
 99 OTHER - PLEASE EXPLAIN

29 REASONS FOR VOID

10 CLAIM PAID FOR WRONG RECIENT  
 11 CLAIM PAID TO WRONG PROVIDER  
 99 OTHER - PLEASE EXPLAIN

REMARKS FOR UNUSUAL SERVICE:

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

30 REQUEST FOR AUTHORIZATION - SEND TO LHM DENTAL PROGRAM ATTENDING DENTIST'S SIGNATURE PROVIDER NUMBER DATE

31 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY) APPROVED - YES  NO  W/EXCEPTIONS  AUTHORIZED SIGNATURE **PA 123456780** DATE

32 DR DDS ATTENDING DENTIST'S SIGNATURE PROVIDER NUMBER **1888888** DATE

DXC 02/2020



**FQHC SERVICES FACILITY SURVEY**

To access Appendix E – Federally Qualified Health Centers (FQHC) Services Facility Survey, visit:

[https://www.lamedicaid.com/provweb1/Forms/FQHC\\_Services\\_Facility\\_Survey.pdf](https://www.lamedicaid.com/provweb1/Forms/FQHC_Services_Facility_Survey.pdf)

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**CHAPTER 22: FEDERALLY QUALIFIED HEALTH CENTERS**

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**APPENDIX F: FQHC BEHAVIORAL HEALTH SERVICES EXAMPLES**

**FQHC BEHAVIORAL HEALTH SERVICES EXAMPLES**

A Medicaid beneficiary has a visit with a Federally Qualified Health Center (FQHC) provider with cold symptoms and requires testing and antibiotic injections. Upon presentation at the clinic, a full mental, physical and dental assessment is performed and a written plan is developed for each identified problem noted in the history and physical exam. The member has a diagnosis of major depression. Prior to leaving the clinic, an appointment is scheduled with the psychiatrist who is only available to see patients in the afternoon.

Example 1: Reimbursement of multiple encounters on the same day when a billable behavioral health service is performed.

Medical Claim		
T1015 Medical Encounter		(Paid at PPS rate on file)
99213 Established Patient Office Outpatient		(Approved and paid at zero)
J0558 Injection Penicillin G Benzathine		(Approved and paid at zero)
BH Claim Scenario #1		
H2020 Behavioral Health Encounter		(Paid at PPS rate on file)
99213 Established Patient Office Outpatient	(Denied-Duplicate service)	90791
Psychiatric Diagnostic Evaluation		(Approved and paid at zero)

Example 2: Reimbursement of multiple encounters on the same day when a billable behavioral health service is not performed.

Medical Claim		
T1015 Medical Encounter		(Paid at PPS rate on file)
99213 Established Patient Office Outpatient		(Approved and paid at zero)
J0558 Injection Penicillin G Benzathine		(Approved and paid at zero)
BH Claim Scenario#2		
H2020 BH Encounter		(Denied as no approved service provided)
99213 Established Patient Office Outpatient		(Denied as duplicate service)

NOTE: If the only code billed on the detailed lines for under the H2020 code is an E/M visit, the claim will deny as no approved psychiatric services was provided.