Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

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This section includes information for billing services rendered by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). RHCs and FQHCs provide ambulatory health care services to recipients in rural and non-rural areas.

Rural Health Clinics

‹‹RHCs›› extend Medicare and Medi-Cal benefits to cover health care services provided by clinics operating in rural areas. Specifically trained primary care practitioners administer the health care services needed by the community when access to traditional physician care is difficult.

Federally Qualified Health Centers

‹‹FQHCs›› were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989.

RHC and FQHC: Enrollment

Providers should enroll in the RHC and FQHC programs through the Department of Health Care Services (DHCS) Audits and Investigations ‹‹(A&I) Division››. As facilities enroll in the RHC and FQHC programs, they will receive a new National Provider Identifier (NPI) and their current provider numbers will be inactivated.

Physician Defined

The inclusion of a professional category within the term "physician" is for the purpose of defining the professionals and not for the purpose of defining the types of services that these professionals may render during a visit for RHC and FQHC services.

The following providers are defined as "physicians."

- A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license

- A medical resident in a federally or state sponsored Teaching Health Center Graduate Medical Education (THCGME) Program, under the supervision of a designated teaching physician, who is acting within his/her ‹‹Postgraduate›› Training License (PTL) ‹‹issued by the Medical Board of California››. The THCGME Program is required to be accredited by the Accreditation Council for Graduate Medical Education.

   Note: Subject to limitations as described in the Teaching Health Center Graduate Medical Education (THCGME) subheading on a following page.

- A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license

- A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

- A doctor of chiropractic authorized to practice chiropractic by the State and who is acting within the scope of his/her license

- A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license

CPSP Practitioner Defined

A Comprehensive Perinatal Services Program (CPSP) practitioner is defined in *Welfare and Institutions Code*, Section 14134.5, and *California Code of Regulations* (CCR), Title 22, Section 51179.7.

RHC/FQHC Covered Services

RHCs and FQHCs may bill for the following:

- Physician services

- Physician assistant services

- Nurse practitioner services

- Certified nurse midwife services

- Visiting nurse services (as defined in *Code of Federal Regulations* [CFR], Title 42, Section 405.2416)

- Comprehensive Perinatal Services Program (CPSP) practitioner services, if the clinic has an approved application on file with the California Department of Public Health, Maternal, Child and Adolescent Health Division

- Licensed clinical social worker services

- Marriage and family therapist services

- Clinical psychologist services

- Optometry services

- Acupuncture services

- Registered dental hygienist services

Dental Services Defined

‹‹FQHCs and RHCs may render any dental service in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice, complies with the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances (*https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Provider_Handbook/*), and determined to be medically necessary pursuant to *California Welfare and Institutions Code* (W&I code), Section 14059.5.›› Each provider shall develop a treatment plan that optimizes preventative and therapeutic care and that is in the patient's best interest, taking into consideration their overall health status. All phases of the treatment plan shall be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner.

For dental services, documentation should be consistent with the standards set forth in the *Manual of Criteria for Medi-Cal Authorization* of the *Medi-Cal Dental Provider Handbook* and all state laws.

Authorization and Documentation Requirements

RHCs and FQHCs services do not require a *Treatment Authorization Request* (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that ‹‹would be›› needed for authorization approval.

‹‹Documentation for all RHC and FQHC encounters must be sufficiently detailed as to clearly indicate the medical reason for the visit››.

Required documentation includes:

- ‹‹A complete description of the medical services provided››

- The full name professional title of the person providing the service

- The pertinent diagnosis(es) at the conclusion of the visit

- Any recommendations for diagnostic studies, follow up or treatments, including prescriptions

Note: ‹‹The documentation must be kept in writing for a minimum of three years from the date of service››.

DHCS ‹‹A&I Division›› may recover payments that do not meet the requirements under CCR, Title 22, Section 51458.1 "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."

CPSP Services: TAR and Reporting Requirements

Claims for Comprehensive Perinatal Service Program (CPSP) services in excess of the basic allowances will not be denied for the absence of a TAR. RHCs and FQHCs, however, must maintain in the patient's medical record the same level of documentation that ‹‹would be›› needed for authorization approval. DHCS ‹‹A&I Division›› may recover payments that do not meet the requirements under CCR, Title 22, Section 51458.1 "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."

Required documentation includes:

- Expected date of delivery

- Clinical findings of the high-risk factors involved in the pregnancy

- Explanation of why basic CPSP services are not sufficient

- Description of the services being requested

- Length of visits and frequency with which the requested services are provided, and

- Anticipated benefit of outcome of additional services

RHC and FQHC: Medi-Services

Medi-Service limitations (two services per month) apply when rendered in an RHC or FQHC.

"Visit" Defined

A visit is a face-to-face encounter between an RHC or FQHC recipient and a physician (refer to "Physician Defined" on a previous page in this section), physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, ‹‹marriage and family therapist››, licensed acupuncturist, ‹‹registered dental hygienist›› or visiting nurse (as defined in *Code of Federal Regulations*, Title 42, Section 405.2416), hereafter referred to as a "health professional," to the extent the services are reimbursable under the State Plan.

A face-to-face encounter with a Comprehensive Perinatal Services Program (CPSP) practitioner also qualifies as a visit. Refer to "CPSP Practitioner Defined" on a previous page in this section.

Qualifying Visits

Encounters with more than one health ‹‹care›› professional and multiple encounters with the same health ‹‹care›› professional that take place on the same day and at a single location constitute a single visit. ‹‹More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:››

- When a patient, after the first visit, suffers illness or injury that requires another health diagnosis or treatment

- When a patient is seen by a health ‹‹care›› professional or CPSP practitioner and also receives dental services on the same day

Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits.

Community-Based Adult Services (CBAS)

Community-Based Adult Services (CBAS) are not FQHC and/or RHC services; however, CBAS is a Medi-Cal waiver benefit which may be provided by an FQHC and/or an RHC and compensated at the appropriate CBAS rate. CBAS offers a package of health, therapeutic and social services in a community-based day health care program. The CBAS benefit is described in the *Community-Based Adult Services* section of this manual. The CBAS reimbursement rate is described in the *Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates* section of this manual.

For a reimbursable CBAS visit, FQHCs and RHCs must render CBAS pursuant to the requirements in the *Community Based Adult Services* (CBAS) section of this manual for a minimum of four hours per billable day.

- For billing codes to be used by FQHCs and RHCs providing CBAS, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* section in this manual.

- Beneficiary eligibility for CBAS provided by an FQHC or RHC shall be determined in the same manner as in the *Community-Based Adult Services* (CBAS) section of this manual except that the FQHC or RHC providing CBAS need not submit a TAR for approval. FQHCs and RHCs providing CBAS must meet the same record-keeping requirements as all other CBAS providers as described in the *Community-Based Adult Services* section of this manual, in addition to record keeping requirements for FQHCs and RHCs as described in *Community-Based Adult Services (CBAS): IPC and TAR Form Completion* section of this manual.

- FQHCs and RHCs providing CBAS must submit an Individual Plan of Care as described in *Community-Based Adult Services (CBAS): IPC and TAR Form Completion* section of this manual for each participant upon initial intake for approval of CBAS eligibility and CBAS service level by DHCS or a managed care plan that contracts with the FQHC or RHC for the provision of CBAS. FQHCs and RHCs shall accompany the IPC with a request that DHCS or contracting managed care plan schedule a face-to-face assessment of new CBAS participants for a determination of CBAS eligibility and CBAS service level need by DHCS or the contracting managed care plan. Additionally, the FQHCs and RHCs shall submit an updated IPC every six months for CBAS enrollees to DHCS or the contracting managed care plan.

- FQHCs and RHCs shall insert the Client Identification Number (CIN) in place of the TAR Control Number (TCN) in the top line of the IPC to be submitted to DHCS or contracting managed care plan.

Note: For more information on the new requirements, refer to the requirements in the settlement agreement in the Darling, et al. v. Douglas, et al. litigation, C09-03798 SBA, on the Community-Based Adult Services page of the DHCS website (*www.dhcs.ca.gov*) under the "ADHC Transition Information" heading.

Billing Services for Health Care Plan Recipients

RHCs and FQHCs must bill the appropriate Health Care Plan (HCP) when rendering services to HCP recipients. The California MMIS Fiscal Intermediary does not accept these claims unless the billed services are contractually excluded from the plan. Providers should contact the plan for plan-specific prior authorization and billing information.

‹‹If a Medi-Cal patient presents themselves to the clinic for treatment and the clinic finds the patient is enrolled in a Medi-Cal Managed Care Plan, or if located in Los Angeles County or Sacramento County, and the patient is enrolled in a Medi-Cal Dental managed care plan[*], the clinic can render services and submit a claim to Medi-Cal.›› However, the RHC and FQHC facility is required to redirect the patient to their "in-network" managed care provider and document this referral in the patient's medical/dental records. ‹‹While Medi-Cal beneficiaries enrolled in both Medi-Cal and Medi-Cal Dental managed care plans are required to be treated by in-network providers, except in emergencies or other isolated instances, RHC and FQHC facilities that provide services in these circumstances must maintain proof of payment or denial from the managed care plan.

Refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* section in this manual for codes to use when billing for services rendered to recipients of Medi-Cal and Medi-Cal Dental managed care plans.››

Riverbend Government Benefits Administrator

The Riverbend Government Benefits Administrator (RGBA) is the Part A Medicare Intermediary for free-standing RHCs. Questions may be directed to RGBA at (423) 763-3400 or (423) 752-6518 (fax). Correspondence may be sent to:

> Riverbend Government Benefits Administrator
> Medicare
> 730 Chestnut Street
> Chattanooga, TN 37402-1790

Reimbursement

Effective January 1, 2001, Federal legislation repealed the reasonable cost-based reimbursement requirements for services to Medicaid RHC and FQHC patients and is now requiring a payment for these services under a Prospective Payment System (PPS).

Los Angeles Demonstration Waiver Project

Cost-based reimbursement clinics that are participating in the Section 1115 Medicaid Waiver Demonstration Extension project are not affected by PPS rate determinations.

IHS-MOA 638 Clinics

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* section in this manual for billing details.

Crossover Claims

In the past, RHC and FQHC crossover claims were reimbursed at a rate of 20 percent of the provider's interim rate. Reimbursement adjustments, due either to the provider or DHCS, were determined through cost reports submitted by providers to the ‹‹A&I Division›› staff at the end of the provider's fiscal year.

Under PPS, RHCs and FQHCs are not required to file cost reports. Therefore, to ensure full reimbursement for crossover claims, ‹‹A&I Division›› will set the reimbursement rate for crossover claim codes at an amount that equals the difference between the Federal Medicare payments and the provider's PPS rate. This can only be accomplished if the provider is an RHC or FQHC for Federal Medicare as well as for DHCS Medi-Cal. Providers electing to remain fee-for-service for Federal Medicare will not receive their PPS rate for crossover claims.

EPSDT/CHDP Reporting Requirements and Billing

FQHC and RHC providers bill Early and Periodic Screening, Diagnostic and Treatment/Child Health and Disability Prevention (EPSDT/CHDP) services using the *UB-04* claim ‹‹form››. Effective September 1, 2019, FQHCs and RHCs no longer submit the *Confidential Screening/Billing Report* Information Only (PM 160 Information Only) with claims to fulfill reporting purposes. Instead, providers fulfill reporting requirements by including informational lines on their ‹‹claim form››. Required reporting data will be extrapolated from the informational lines.

Providers submitting paper ‹‹claim forms›› can refer to a sample *UB-04* claim ‹‹form›› populated with an informational line in the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Examples* provider manual section. Instructions for submitting informational lines on electronic claims is available in the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*, "Special Billing Instructions: Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services-Memorandum of Agreement" section.

Teaching Health Center Graduate Medical Education (THCGME)

FQHC and RHC THCGME programs sponsored by Health Resources and Services Administration (HRSA) or state sponsored THCGME programs (Primary Care Residency Programs) may seek reimbursement for primary care services furnished by a ‹‹medical›› resident when billed by a teaching physician, if all of the following conditions are met:

- THCGME programs must have an existing GME accreditation from the Accreditation Council for Graduate Medical Education (ACGME).

- Types of services furnished by residents include:

  - Primary care services

  - Acute care for undifferentiated problems or chronic care for ongoing conditions, including chronic mental illness

  - Coordination of care furnished by other physicians and providers

  - Comprehensive care not limited by organ system or diagnosis

- The teaching physician must have the primary medical responsibility for patients cared for by residents, and ensure the care provided is reasonable and necessary.

- The teaching physician must not supervise more than four residents at any given time.

- Residents with less than six months experience in a THCGME program must have the teaching physician physically present for critical or key portions of services.

- Teaching physicians must review the patient health record and document the teaching physician's participation in direction of services.

End of Life Services

Refer to the *End of Life Option Act Services* section of the appropriate Part 2 manual for additional information.

Telehealth

Overview

Policy related to telehealth is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. Providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual for additional information.

Definitions

For purposes of this policy, the following definitions shall apply:

Telehealth and Other Terms

For definitions of "telehealth," "asynchronous store and forward," "synchronous interaction," "distant site" and "originating site," providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.

Visit

Providers may refer to "'Visit' Defined" in this manual section.

Billable Provider

Providers may refer to "RHC/FQHC Covered Services" in this manual section.

Established Patient

A Medi-Cal eligible recipient who meets one or more of the following conditions:

- The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years.

- The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the originating site clinic, but within the FQCH's or RHC's service area. All consent for telehealth services for these patients must be documented.

- The patient is assigned to the FQHC or RHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC or RHC.

Documentation Requirements

Providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.

Covered Services

Services rendered via telehealth must be FQHC or RHC covered services.

Non-Covered Services

An e-consult is not a reimbursable telehealth service for FQHCs or RHCs.

Synchronous Telehealth Reimbursement Requirements

Services provided through synchronous telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person.

- FQHCs and RHCs may bill for a telehealth visit if it is medically necessary for a billable provider to be present with a patient during the telehealth visit.

- FQHCs and RHCs must submit claims for telehealth services using the appropriate all-inclusive billing code sets and related claims submission requirements. For more information, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* section in the appropriate Part 2 manual.

- FQHCs and RHCs are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the PPS rate.

Asynchronous Store and Forward Requirements

A patient may not be "established" on an asynchronous store and forward service, with the exception of HHMS.

Reimbursement is permitted for an established patient for teleophthalmology, teledermatology and teledentistry, and furnished by a billable provider at the distant site.

Note: Providers should note "Non-Covered Services" in this manual section.

Synchronous Telehealth

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corporation (Corp) A – Site 1 *Established patient with non-billable provider*	FQHC/RHC Corp A – Site 2 *Billable provider*	FQHC/RHC Corp A – Site 2 can bill one visit at the PPS rate.
FQHC/RHC Corp A – Site 1 *Established patient with billable provider*	FQHC/RHC Corp A – Site 2 *Billable provider*	Only one site can bill one visit at the PPS rate.
FQHC/RHC Corp A *Established patient with non-billable provider*	FQHC/RHC Corp B *Billable provider*	FQHC/RHC Corp B can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.
FQHC/RHC Corp A *Established patient with billable provider*	FQHC/RHC Corp B *Billable provider*	FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present. FQHC/RHC Corp B can bill one visit at the PPS rate.
FQHC/RHC Corp A *Established patient with non-billable provider*	Non-FQHC/RHC Medi-Cal Provider *Billable provider (no service payment contract)*	The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.

Synchronous Telehealth (continued)

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corp A *Established patient with billable provider*	Non-FQHC/RHC Medi-Cal Provider *Billable provider (no service payment contract)*	FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present. The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.
Non-FQHC/RHC Medi-Cal Provider *Established patient with non-billable provider*	FQHC/RHC Corp A *Billable provider*	FQHC/RHC Corp A can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for the non-FQHC/RHC.
Non-FQHC/RHC Medi-Cal Provider *Established patient with billable provider (no service payment contract)*	FQHC/RHC Corp A *Billable provider*	The non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider. FQHC/RHC Corp A can bill one visit at the PPS rate.
FQHC/RHC Corp A *HHMS established patient*	FQHC/RHC Corp A *Billable provider*	FQHC/RHC Corp A can bill one visit at the PPS rate.
FQHC/RHC Corp A *HHMS established patient with billable provider*	FQHC/RHC Corp A *Billable provider*	Only one site can bill one visit at the PPS rate.

Synchronous Telehealth (continued)

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corp A *HHMS established patient with billable provider*	FQHC/RHC Corp B *Billable provider*	FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present. FQHC/RHC Corp B can bill one visit at the PPS rate.

Asynchronous Store and Forward Telehealth

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corp A – Site 1 *Established patient with non-billable provider*	FQHC/RHC Corp A – Site 2 *Billable provider*	FQHC/RHC Corp A – Site 2 can bill one visit at PPS rate.
FQHC/RHC Corp A – Site 1 *Established patient with billable provider*	FQHC/RHC Corp A – Site 2 *Billable provider*	Only one site can bill one visit at the PPS rate.
FQHC/RHC Corp A – Site 1 *Established patient with non-billable provider*	FQHC/RHC Corp B *Billable provider*	FQHC/RHC Corp B can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.
FQHC/RHC Corp A *Established patient with billable provider*	FQHC/RHC Corp B *Billable provider*	Only one site can bill one visit at the PPS rate.
FQHC/RHC Corp A *Established patient with non-billable provider*	Non-FQHC/RHC Medi-Cal Provider *Billable provider (no service payment contract)*	The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.

Asynchronous Store and Forward Telehealth (continued)

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corp A *Established patient with billable provider*	Non-FQHC/RHC Medi-Cal Provider *Billable provider* *(no service payment contract)*	FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present. The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.
Non-FQHC/RHC Medi-Cal Provider *Established patient with non-billable provider*	FQHC/RHC Corp A *Billable provider*	FQHC/RHC Corp A can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for the non-FQHC/RHC.
Non-FQHC/RHC Medi-Cal Provider *Established patient with billable provider* *(no service payment contract)*	FQHC/RHC Corp A *Billable provider*	The non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider. FQHC/RHC Corp A can bill one visit at the PPS rate.
FQHC/RHC Corp A *HHMS established patient*	FQHC/RHC Corp A *Billable provider*	FQHC/RHC Corp A can bill one visit at the PPS rate.
FQHC/RHC Corp A *HHMS established patient with billable provider*	FQHC/RHC Corp A *Billable provider*	Only one site can bill one visit at the PPS rate.
FQHC/RHC Corp A *HHMS established patient with billable provider*	FQHC/RHC Corp B *Billable provider*	Only one site can bill one visit at the PPS rate.

<u>Legend</u>

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	‹‹If the patient is not enrolled in a Medi-Cal Dental managed care plan, a straight Medi-Cal dental visit may be billed, per visit code 03.››