
Tribal Federally Qualified Health Centers (Tribal FQHCs)

Page updated: May 2021

This section includes information for billing services rendered by Tribal Federally Qualified Health Centers (Tribal FQHCs).

Background

The Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) to establish Tribal FQHCs as a provider type, per State Plan Amendment (SPA) 20-0044. The SPA outlines Tribal FQHC eligibility, payment methodology and allowable visit combinations.

Under Section 1905(l)(2)(B) of the Social Security Act, outpatient health care programs operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (P.L.) 93-638, are eligible to enroll as a Tribal FQHC in Medi-Cal. Tribal FQHCs provide covered primary care clinic services to Medi-Cal patients. Tribal FQHC services may be provided in a clinic or off site by tribal providers and non-tribal providers that are contractors of the Tribal FQHC. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate (AIR).

Enrollment

Existing Medi-Cal Providers

Tribal health clinics operating under the authority of the ISDEAA may request designation as a Tribal FQHC by completing an [*“Elect to Participate” Indian Health Services Memorandum of Agreement \(IHS/MOA\) and Tribal Federally Qualified Health Center \(FQHC\)*](#) (form DHCS 7108). Form DHCS 7108 is available on the Medi-Cal website, www.medi-cal.ca.gov, as follows:

1. From the Home tab, select Resources.
2. Select References.
3. From the Billing section, select Forms.
4. From the Provider Enrollment section, select the “Elect to Participate” DHCS 7108 form.

New Medi-Cal Providers

Eligible tribal health programs requesting initial enrollment in the Medi-Cal program as a Tribal FQHC must apply through the DHCS Provider Application and Validation (PAVE) system and complete form DHCS 7108. To be eligible to enroll as a Tribal FQHC provider, the health programs must be operated by a tribe or a tribal organization under P.L. 93-638. Providers may contact the DHCS Provider Enrollment Division (PED) at (916) 323-1945 or visit the DHCS PAVE website at <https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx> for all applicable enrollment forms.

Visit Defined

A Tribal FQHC clinic encounter (visit) is defined as a face-to-face encounter between a tribal clinic patient and the health professional of the clinic. Refer to “Tribal FQHC Services Available” in this section for allowable services.

Reimbursement

Tribal FQHCs may be reimbursed for up to three visits per day, per recipient, in any combination of three different medical, mental health, dental and ambulatory services listed in the “Tribal FQHC Services Available” section in this manual. Reimbursement for services provided outside the clinic facility by clinic providers and contracted providers is allowable.

Tribal FQHC reimbursement is based on Alternative Payment Methodology (APM).

Note: The APM is set at the federal AIR. For Managed Care Plan reimbursement requirements, please see All Plan Letter (APL) 21-008.

Tribal FQHC Services Available

Tribal FQHCs may bill for the following services.

Medical Services

- Physician/specialist 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) services as described in the [Pregnancy: Comprehensive Perinatal Services Program \(CPSP\)](#) section in the appropriate Part 2 manual, if the clinic has an approved application on file with the [California Department of Public Health \(CDPH\), Maternal, Child and Adolescent Health \(MCAH\) Division](#).

Mental Health Services

- Licensed clinical social worker services
- Marriage and family therapist services
- Clinical psychologist services

Ambulatory Services

- Acupuncture services (subject to CCR, Title 22, Section 51309)
- Physical therapy
- Occupational therapy (subject to CCR, Title 22, Section 51309)
- Speech pathology (subject to CCR, Title 22, Section 51309)
- Audiology (subject to CCR, Title 22, Section 51309)
- Chiropractor services (a doctor of chiropractic authorized to practice chiropractics by the state and who is acting within the scope of his/her license. Subject to CCR, Title 22, Section 51309)
- Optometry (a doctor of optometry authorized to practice optometry by the state and who is acting within the scope of his/her license)
- Podiatry (a doctor of podiatry authorized to practice podiatric medicine by the state and who is acting within the scope of his/her license)

Dental Services

- Dental services (when performed by a doctor of dental surgery authorized to practice dentistry by the state and who is acting within the scope of his/her license)
- Dental hygienist services

Tribal FQHC Physician Defined

The inclusion of a professional category within the term “physician” is for the purpose of defining the professionals whose services are reimbursable on a per-visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit. The allowable service types and applicable designations are listed under the “Tribal FQHC Services Available” heading in this section.

The following providers are defined as “physicians”:

- A physician or osteopath authorized to practice medicine and surgery by the state and who is acting within the scope of his/her license
- 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
- A medical resident in the Tribal FQHC that operates a federal or state sponsored Teaching Health Center Graduate Medical Education (THCGME) grant 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 requirements and limitations as described in the “THCGME Grant Recipients” heading in this section.

Specialist Services Defined

Includes medical specialty services provided by a licensed physician who is certified by the appropriate board in the specialty of medical care provided.

Visiting Nurse Services Defined

Visiting nurse services include nursing services provided in the home by a nurse licensed by an appropriate state board of nursing. The services provided must be within the scope of practice as outlined in the appropriate nurse practice act. The nurse must furnish independent and complete face-to-face nursing assessments, interventions, evaluations and document services provided in the Patient Health Record.

Home visit encounters must be based on a licensed physician or other licensed practitioner generated referral/consult. The services must be furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician, or established by a nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner and reviewed and signed at least every 60 days by a supervising physician.

The licensed physician or other licensed practitioner who supervises those who provide the service(s) to the recipient must assume professional responsibility for the care of the recipient. Repeated or multiple visits to complete what is considered a reasonable and typical office visit are not covered services, unless it's medically necessary.

CPSP Services Defined

For Medi-Cal billable services and billing guidance please refer to the [Pregnancy: Comprehensive Perinatal Services Program \(CPSP\)](#) section in the appropriate Part 2 manual.

Dental Services Defined

Tribal FQHCs 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 *Manual of Criteria and Schedule of Maximum Allowances*, which can be found in the [Medi-Cal Dental 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.

THCGME Grant Recipients

Tribal FQHC 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.

Authorization and Documentation Requirements

Tribal FQHC 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 Tribal 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 service(s) 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 Audits and Investigations 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 CPSP services in excess of the basic allowances will not be denied for the absence of a TAR. Tribal FQHCs that are CPSP providers must maintain in the patient's medical record the same level of documentation that would be needed for authorization approval. DHCS Audits and Investigations 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

Medi-Service Limitations

The following Medi-Services are services that are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based upon medical necessity. All of the following services are subject to CCR, Title 22, Section 51309.

- Acupuncture
- Occupational therapy
- Speech pathology
- Audiology
- Chiropractor services

Prescriptions

Tribal FQHC clinics may be reimbursed at pharmacy fee-for-service rates for prescriptions or refills if they are a licensed pharmacy and approved by Medi-Cal to render pharmacy services. If the pharmacy is not enrolled in Medi-Cal, prescriptions or refills are not separately reimbursable services.

Non-Medical Transportation

Non-Medical Transportation is not included in the Tribal FQHC visit rate and is reimbursed separately. Refer to “Billing NMT” in the [Medical Transportation – Ground](#) section of the appropriate Part 2 provider manual.

Providers requesting enrollment in the Medi-Cal Program as a Non-Medical Transportation provider must apply through the DHCS Provider Application and Validation (PAVE) system. Providers may contact the DHCS Provider Enrollment Division at (916) 323-1945 or visit the DHCS PAVE website at <https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx> for all applicable enrollment forms.

Radiology and Laboratory Services

Radiology and laboratory services are included in the Tribal FQHC visit rate and are not reimbursed separately.

Annual Reconciliations

An annual reconciliation request is filed with DHCS Audits and Investigations (A&I) Division within 150 days of the Tribal FQHCs fiscal year end. The purpose of the reconciliation is to ensure a clinic receives the full reimbursement rate for all qualifying Medicare crossover visits and for services provided to recipients enrolled in a Medicare Advantage Plan. A&I reviews the filed reconciliation request to ensure Tribal FQHCs are receiving reimbursement at the APM rate.

A&I forms are available on the “Audits and Investigations – Financial Audits Branch Cost Reports Forms and Documents” page of the DHCS website at:

<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>.

Services for Recipients in MCPs

Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Tribal FQHCs can contract with MCPs to be a network provider.

Tribal FQHCs that contract with an MCP must bill the MCP when rendering services to MCP recipients. Providers contact the MCP for plan-specific authorization and billing information.

Tribal FQHC services are paid by the MCP at the APM, which is set at the AIR.

Refer to the *Tribal Federally Qualified Health Centers (FQHCs): Billing Codes* section in the appropriate Part 2 manual for codes to use when billing for services rendered to recipients in MCPs.

Crossover Claims

Billing Managed Care/Medicare Crossover Claims

Tribal FQHCs follow the same process as described the previous heading “Services for Recipients in MCPs” when rendering services to a recipient enrolled in both Medi-Cal Managed Care and Medicare.

Medicare crossover claims reimburse providers for the difference between the APM rate and the Medicare reimbursement rate for recipients with both Medicare and Medi-Cal coverage.

To ensure full reimbursement for crossover claims, the APM reimbursement rate for crossover claim codes is set at an amount that approximates the difference between the Federal Medicare payments and the Tribal FQHC APM rate. The APM crossover rate is listed in Attachment 1 of APL 21-008.

Billing and Rate Determination for Fee-For-Service Medi-Cal with Medicare Advantage Health Maintenance Organization (HMO) Plans

This section provides billing guidance for recipients enrolled in both a Medicare Advantage HMO plan (Medicare Part C) and fee-for-service Medi-Cal. Medicare Advantage HMO plans offer expanded Medicare services through private insurance companies approved by Medicare.

Tribal FQHCs submitting claims for fee-for-service Medi-Cal recipients in a Medicare Advantage Plan should first bill the plan and then submit claims for unpaid amounts to Medi-Cal using the crossover claims billing code sets listed in the *Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes* section of this manual. Additionally, the phrase “for a fee-for-service Medi-Cal recipient in a fee-for-service Medicare Advantage Plan” must be included in the *Remarks* (Box 80) field of the claim or in an attachment to the claim.

The reimbursement rate for crossover claim codes for recipients not enrolled in an MCP is set at an amount that approximates the difference between the Federal Medicare payments and the Tribal FQHC APM rate. The crossover rate for services provided to fee-for-service recipients can be adjusted upon request by the Tribal FQHC. DHCS A&I has posted forms on the “Audits and Investigations – Financial Audits Branch Cost Reports Forms and Documents” page of the DHCS website (www.dhcs.ca.gov). Tribal FQHCs can request to change crossover rates any time their Medicare Advantage Plan contract changes. Alternatively, the Tribal FQHC can include the crossover rate change form with their annually filed reconciliation request. Forms are available on the “Forms” page of the DHCS website (www.dhcs.ca.gov).

Billing and Rate Determination for Services Provided to Capitated Medicare Advantage Plan Recipients

This section provides billing guidance for recipients enrolled in both a Capitated Medicare Advantage HMO plan (Medicare Part C) and fee-for-service Medi-Cal. The Capitated Medicare Advantage Plan rate reimburses a provider the difference between the Tribal FQHC APM rate and the Medicare Advantage Plan (capitated) average reimbursement.

Tribal FQHCs submitting claims for recipients enrolled in a Capitated Medicare Advantage Plan should first bill the plan and then bill Medi-Cal using the Capitated Medicare advantage plans billing code sets listed in the *Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes* section in the appropriate Part 2 manual.

Additionally, the phrase “for a fee-for-service Medi-Cal recipient in a Medicare Advantage Plan” must be included in the *Remarks* (Box 80) field of the claim or in an attachment to the claim.

Rates for Capitated Medicare Advantage Plans are adjusted upon request by the Tribal FQHC In the same way as indicated in this section under “Billing and Rate Determination for Fee-For-Service Medi-Cal with Medicare Advantage Health Maintenance Organization (HMO) Plans.”

Documentation Requirements for Medicare Denials

Generally, claims submitted to Medi-Cal for crossover claims reimbursement and Capitated Medicare Advantage Plan billing code sets must include documentation of Medicare denial in one of the following ways:

- Enter three key facts in the *Remarks* field (Box 80) of the claim:
 - Whether the facility is Tribal FQHC
 - That the recipient is a managed care patient
 - One of the following: No Explanation of Medicare Benefits (EOMB), No Medicare Remittance Notice (MRN), or No Remittance Advice (RA)

Or

- On an 8 1/2" x 11" attachment to the claim, specify the following: Tribal FQHC Medi-Cal patient enrolled in a Capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the Capitated Medicare Advantage HMO.

EPSDT/CHDP Reporting Requirements and Billing

Consistent with federal law and regulations for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illness conditions for infants, children, and youth up to age 21 with full-scope Medi-Cal. Tribal FQHC providers billing for EPSDT electronically will fulfill reporting requirements by including informational lines on their claim form. Required reporting data will be extrapolated from the informational lines.

End of Life Services

Instructions for billing for end of life services are included in the [End of Life Act Services](#) section of the appropriate Part 2 manual.

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 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 the “Visit Defined” heading in this manual section.

Billable Provider

Providers may refer to the “Tribal FQHC Services Available” heading 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 Tribal FQHC 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 within or outside of the Tribal FQHC. All consent for telehealth services for these patients must be documented.
- The patient is assigned to the Tribal FQHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the Tribal FQHC.

Documentation Requirements

For telehealth documentation requirements, providers may refer to the [Medicine: Telehealth](#) section in the appropriate Part 2 manual.

Available Services

Services rendered via telehealth must be Tribal FQHC covered services as identified in this manual section.

Non-Available Services

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

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.

- Tribal FQHCs 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.
- Tribal FQHCs 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 *Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes* section in the appropriate Part 2 manual.
- Tribal FQHCs are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the APM.

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: E-consults are not available services in Tribal FQHCs.

Synchronous Telehealth

Synchronous Telehealth Table

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

Synchronous Telehealth Table (continued)

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

Synchronous Telehealth Table (continued)

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

Asynchronous Store and Forward Telehealth**Asynchronous Store and Forward Telehealth Table**

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
Tribal FQHC Corp A – Site 1 <i>Established patient with non-billable provider</i>	Tribal FQHC Corp A – Site 2 <i>Billable provider</i>	Tribal FQHC Corp A – Site 2 can bill one visit at APM rate.
Tribal FQHC Corp A – Site 1 <i>Established patient with billable provider</i>	Tribal FQHC Corp A – Site 2 <i>Billable provider</i>	Only one site can bill one visit at the APM rate.
Tribal FQHC Corp A – Site 1 <i>Established patient with non-billable provider</i>	Tribal FQHC Corp B <i>Billable provider</i>	Tribal FQHC Corp B can bill one visit at the APM rate. No APM rate reimbursement is permitted for Tribal FQHC Corp A.
Tribal FQHC Corp A <i>Established patient with billable provider</i>	Tribal FQHC Corp B <i>Billable provider</i>	Only one site can bill one visit at the APM rate.

Asynchronous Store and Forward Telehealth Table (continued)

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

Asynchronous Store and Forward Telehealth Table (continued)

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
Non-tribal FQHC Medi-Cal Provider <i>Established patient with billable provider (no service payment contract)</i>	Tribal FQHC Corp A <i>Billable provider</i>	The non-tribal FQHC can bill the MCP or fee-for-service directly if no service payment contract exists between tribal FQHC Corp A and the non-tribal FQHC billable provider. Tribal FQHC Corp A can bill one visit at the APM rate.
Tribal FQHC Corp A <i>HHMS established patient</i>	Tribal FQHC Corp A <i>Billable provider</i>	Tribal FQHC Corp A can bill one visit at the APM rate.
Tribal FQHC Corp A <i>HHMS established patient with billable provider</i>	Tribal FQHC Corp A <i>Billable provider</i>	Only one site can bill one visit at the APM rate.
Tribal FQHC Corp A <i>HHMS established patient with billable provider</i>	Tribal FQHC Corp B <i>Billable provider</i>	Only one site can bill one visit at the APM rate.

Legend

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.