



Federally Qualified Healthcare Center
Module 1: Designation as a Federally Qualified Health Center,
Benefits and Services

I. Federally Qualified Health Center (FQHC) Defined

- A. Federally Qualified Health Centers (FQHCs) were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and were effective beginning on October 1, 1991. < See *Medicare Benefit Policy Manual*, Chapter 13, § 10.2>
- B. An entity that entered into an agreement with Centers for Medicare and Medicaid Services (CMS) to meet Medicare program requirements. They include Health Center Program award recipients and look-alikes, and certain outpatient clinics associated with tribal organizations.
 - 1. Health Center Program Award Recipients <Health Resources and Services Administration>
 - a. Community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas.
 - b. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.
 - 2. FQHC Look-alikes <Health Resources and Services Administration>
 - a. Provide comprehensive primary health care services that are responsive to identified health care needs,
 - b. Provide services to all persons regardless of ability to pay, and
 - c. Must meet all Health Center Program requirements.

3. Certain Outpatient Clinics with Tribal Organizations

- a. Healthcare programs and facilities that specialize in caring for American Indians and Alaska Natives.
- b. Operated under the Indian Self-Determination Act <Health Resources and Services Administration>

C. To qualify for an FQHC, you must meet one of the following:

- 1. Is receiving grant funding under the Public Health Service (PHS) Act or funding from a grant under a contract with the receipt of such grant and meets the requirements to receive a grant under section 330 of the PHS Act;
- 2. Determined by the Health Resources and Services Administration (HRSA) to meet the requirements for receiving a grant;
- 3. Treated by CMS, for the purposes of Medicare Part B, as a comprehensive federally funded health center as of January 1, 1990; or
- 4. Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act. <MLN Matters 006397>
- 5. An FQHC can be certified by CMS if they attest that the facility follows all applicable Medicare regulations. <Medicare State Operations Manual Chapter 2, §2825A>
- 6. Must meet all of the following <MLN006397>:
 - a. Meet all health and safety requirements.
 - b. Not approved as a Rural Health Clinic (RHC)
 - c. Provide comprehensive services, including an ongoing quality assurance program and annual review.
 - d. Meet all the Public Health Service requirements, including:
 - i. Serve a designated medically underserved area (MUA) or medically underserved population (MUP),
 - ii. Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale, and

- iii. Be governed by a board of directors, where most members get care at the FQHC.

II. Location Requirements

- A. To be certified by CMS as an FQHC, the health center must be located in a rural urban area that is designated as either a shortage area or an area that is medically underserved. <See 42 C.F.R. 491.5(a)>

1. Rural or Urban Areas Defined

a. Rural

- i. Rural areas are those areas not delineated as urbanized areas by the Census Bureau in the last census conducted.
- ii. Portions of extended cities that the Census Bureau has determined to be rural are also included in the rural classification.
 - a) Extended cities are defined as an incorporated place that contains large expanses of sparsely populated territory for which the Census Bureau provides separate urban and rural population counts and land area figures.
- iii. Excluded from the rural area classification are:
 - a) Central cities of 50,000 residents or more;
 - b) Cities with at least 25,000 residents which, together with contiguous areas having stipulate population density, have combined populations of 50,000 and constitute, for general economic and social purposes, single communities; and
 - c) Closely settled territories surrounding cities and specifically designated by the Census Bureau as urban. <See 42 C.F.R. 491.5(c)>

- b. Urban – add Census Bureau definition as either: Urbanized areas, which contain 50,000 or more people. Urban clusters, which have at least 2,500 people but fewer than 50,000 residents.

FQHC's MUST meet one of the following criteria: furnish services to a medically underserved population or be located in a medically underserved area, as demonstrated by an application approved by the Public Health Service

2. Shortage Area Defined

- a. The clinic must be located in a federally designated area where a shortage of personal health services exists
- b. Determination that a shortage of personal health services exists is based on many factors:
 - i. The ratio of primary care physicians practicing in the area to the population;
 - ii. Infant mortality;
 - iii. Percentage of the population 65 years of age or older; and
 - iv. Percentage of the population with a family income below 200% of the federal poverty guidelines a sliding fee scale <See 42 C.F.R. 491.5(d)>
- c. Criteria for determining the shortage of primary medical care manpower (under section 332(a)(1)(A) of the Public Health Services Act) are:
 - i. The area served is a rational area for the delivery of primary medical care services;
 - ii. The ratio of primary care physicians practicing within the area to the resident population; and
 - iii. Primary medical care manpower in contiguous area is over-utilized, excessively distant, or inaccessible to the population in the area.

3. Medically-Underserved Population Defined

- a. A population of an urban or rural area that is designated by PHS as having a shortage of personal health services.
- b. A population group that is designated by PHS as having a shortage of personal health services.

4. Medically-Underserved Area (MUA)

- a. The ratio of primary care physicians practicing in the area to the resident population which has been determined to be an MUA.

B. When location requirements are met FQHCs may be located in:

- 1. Community centers;
- 2. Migrant health centers;

3. Homeless health centers;
 4. Public housing primary care centers;
 5. Health center program “look-alikes”; or
 6. Outpatient health programs or facilities a tribe or tribal organization operates.
- C. An FQHC may be physically located in one of the above permanent structures or in a mobile unit. <42 C.F.R. 491.5; *Medicare Benefit Policy Manual*, Chapter 13 § 20>
1. If an FQHC is located in several permanent locations, each location is independently certified by CMS.
 2. If an FQHC is located in a mobile unit, it must have a fixed schedule that specifies the date(s) and applicable location(s) for providing services.
- D. Exception during the COVID-19 Public Health Emergency (PHE)
1. CMS is temporarily waiving the requirement that more than one permanent location must be independently considered for Medicare approval. This allows flexibility for existing FQHCs to expand service locations to meet the needs of Medicare beneficiaries which may be outside of the usual location requirements. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 08/20/20>

III. Staffing Requirements and Related Services

A. Staffing

1. No specific requirements for staffing mix at health centers.
 - a. Must maintain a core staff that can carry out the required and additional health services at the health center.
 - b. Staffing may vary based on the needs of the community. <Rural Health Information>
2. Clinical staffing can include but limited to:
 - a. Licensed Independent practitioners: Physician, Dentist, Physician Assistant, Nurse Practitioner

- b. Other licensed personnel: Registered Nurse, Licensed Practical Nurse, Registered Dietitian, Certified Medical Assistant <HRSA.gov chapter 5>
- 3. The FQHC must include one or more physicians.
- 4. The physician assistant, nurse practitioner, nurse-midwife, clinical social worker or clinical psychologist member of the staff may be the owner or an employee of the FQHC or may furnish services under contract to the FQHC. <42 CFR 491.8>
- 5. The staff may also include ancillary personnel supervised by the professional staff.
- 6. The staff is sufficient to provide the services essential to the operation of the clinic or center.
- 7. A physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist is available to furnish patient care services at all times the clinic or center operates. <42 CFR 491.8>

B. Physician Staffing

- 1. An FQHC must include one or more physicians (i.e., MD or DO) who oversees the operations of the clinic and provides medical supervision of the healthcare staff. <42 C.F.R. 491.8>
 - a. CMS has determined that many of the physician's required oversight functions may be performed remotely via electronic means. Where state law allows, the FQHC physician is no longer required to provide a supervisory visit for non-physician practitioners at least once every two weeks. <79 Fed. Reg. 27107>
 - b. The physician, in collaboration with at least one NP and/or PA:
 - i. Develops and reviews the center's policies and procedures to determine if they are appropriate and followed; and,
 - ii. Conducts reviews of the patients' records, including review of the types and volume of services provided based on its patient population. <42 C.F.R. 491.8; 42 C.F.R. 491.11>
- 2. Exception during the COVID-19 PHE

- a. The physician, either in person or through telehealth or other remote communications, remains responsible for providing medical direction, consultation, and supervision for the FQHC's health care staff. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 10/13/2022>
 - b. This allows FQHC's to use NPPs to the fullest extent possible and allows physicians to direct their time to more critical tasks during the PHE. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 10/13/2022>
- C. Non-Physician Practitioner (NP, PA, or CNM) Services
- 1. Services furnished by an NP, PA, or CNM are those that are also considered covered physician services under the Medicare benefit, such as the examination and diagnosis of the patient, preventive services, therapy services, consultations, and minor surgical procedures. <Medicare Benefit Policy Manual, Chapter 13 § 130>
 - a. Services provided by an NP, PA, or CNM must meet additional requirements, including:
 - i. Must be provided under the general supervision of a physician (or direct supervision, if required by state law);
 - ii. Must be furnished according to the FQHC's internal policies that specify what services non-physician practitioners may order and furnish to its patients; and,
 - iii. Must be within the practitioner's scope of practice and permitted under state law. <Medicare Benefit Policy Manual, Chapter 13 § 130.1>
 - b. An FQHC that is not physician-directed must have an arrangement with a physician that provides supervision for the NP, PA, and CNM in accordance with state law. <Medicare Benefit Policy Manual, Chapter 13 § 130.2>

IV. Services Provided by Other Healthcare Professionals

A. Clinical Psychologist (CP)

- 1. A CP must hold a doctoral degree in psychology and be licensed or certified to practice independently in the state in which he or she practices. <Medicare Benefit Policy Manual, Chapter 13 § 150>

B. Clinical Social Worker (CSW)

1. A CSW must hold a master's or doctor's degree in social work, have performed two years of supervised clinical social work, and be licensed or certified as a CSW by the state in which he or she practices. <Medicare Benefit Policy Manual, Chapter 13 § 150>
 - a. Where a state does not provide licensure, a CSW must have completed at least two years or 3,000 hours of post master's degree clinical social work practice and was supervised by a master's level social worker in an appropriate setting, such as a hospital, SNF, or clinic. <42 C.F.R. 410.73(a)(3)>
2. Services furnished by a CP or CSW are those that would also be covered physician services under the Medicare benefit, including the examination and diagnosis of patients and providing consultations. <Medicare Benefit Policy Manual, Chapter 13 § 150>
3. Services furnished by a CP or CSW must also meet the following requirements:
 - a. Must be performed under the general supervision of a physician (or direct supervision, if required by state law);
 - b. Must be furnished according to the FQHC's policies that specify what services a CP or CSW may order and furnish to patients; and,
 - c. Must be within the practitioner's scope of practice and permitted under state law.

Caution: A CSW is only authorized to furnish services for the diagnosis and treatment of mental illnesses.

V. Hours of Operation

- A. A physician, NP, PA, CNM, CP, or CSW must be available to furnish patient care services within their scope of practice when the FQHC is open to provide patient care. <Medicare Benefit Policy Manual, Chapter 13 §, 40.2>
 1. The days of the week and the hours of operation must be posted at or near the clinic's entrance.
 2. The notice must be easily readable and accessible for all patients (e.g., patients with vision problems or patients in wheelchairs).

3. A clinic that is open solely to address administrative matters or to provide shelter from inclement weather is not considered to be in operation during that time and is not subject to the staffing requirements.
- B. Services that are provided after the posted hours of operation can be billed by the clinic only when provided by a practitioner that is compensated by the FQHC and only when those services are reported on the cost report. <Medicare Benefit Policy Manual, Chapter 13 § 40.2>
1. If the services are provided after the posted hours of operation in accordance with the FQHC's policies, procedures and employment contracts, and are not reported on the cost report, the practitioner may separately bill those services to Medicare Part B.
 - a. The appropriate Medicare coverage policies and payment methodology will apply.
 - b. All costs associated with non-FQHC services billed separately to Part B must be removed from the cost report, including costs associated with space, equipment, supplies, facility overhead, and personnel. <Medicare Benefit Policy Manual, Chapter 13 § 60>

VI. FQHC Services Defined

- A. FQHC services are those services generally provided in a physician's office and must include at a minimum: <42 C.F.R. 405.2400 – 405.2417; Medicare Benefit Policy Manual, Chapter 13 § 50.2>
1. Physician services and supplies incident to a physician's service; and
 2. NP and/or PA services and supplies incident to their services.
- B. An FQHC is also required to be able to furnish the following services:
1. Screening mammography
 2. Screening pap smear and screening pelvic exam;
 3. Prostate cancer screening tests;
 4. Colorectal cancer screening tests;
 5. DSMT services;
 6. Diabetes screening tests;

7. MNT services;
8. Bone mass measurement;
9. Screening for glaucoma;
10. Cardiovascular screening blood tests; and
11. Ultrasound screening for abdominal aortic aneurysm.

C. In general, an FQHC ***may*** provide certain additional services under its certification, including but not limited to: < See *Medicare Benefit Policy Manual*, Chapter 13 §§ 10.2, 50.2>

1. Services of a clinical nurse midwife (CNM) or clinical psychologist (CP) and services incident to a qualifying visit;
2. Services of a clinical social worker (CSW);
3. Visiting nurse services for patients confined to home, in certain circumstances;
4. Services of registered dietitians or nutrition professionals for diabetes self-management training services and medical nutrition therapy, when incident to a qualifying visit with an FQHC practitioner;
5. Covered drugs, biologicals, and other services when provided incident to a qualifying visit with an FQHC practitioner;
6. Routine diagnostic services;

Caution: When performed by an FQHC practitioner or furnished incident to a qualifying visit, only the professional component of a diagnostic service is within the scope of the FQHC benefit. The technical component cannot be billed on the FQHC claim. Billing for diagnostic services will be discussed in detail in a later module.

7. Certain care management and virtual communication services;
8. Certain preventive services when specified by statute or National Coverage Determination (NCD) policy, which may include:
 - a. Influenza, pneumonia, and Hepatitis B vaccines;
 - b. Initial Preventive Physical Examination (IPPE);
 - c. Annual Wellness Visit (AWV); and,

- d. Other covered preventive services as recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B.
- i. An FQHC practitioner may refer patients to other facilities for preventive services which are not usually provided in a physician's office.

D. Non-FQHC Services

1. An FQHC may provide other services beyond the scope of its certification and the FQHC benefit. <Medicare Benefit Policy Manual, Chapter 13 § 60>
 - a. If the service is covered under another Medicare benefit category, the service must be billed separately (not by the FQHC) under the payment rules that apply to that service (i.e., Medicare Physician Fee Schedule (MPFS) or Clinical Laboratory Fee Schedule (CLFS)).

Caution: All costs associated with non-FQHC services (e.g., overhead, staff, supplies, etc.) are not considered to be allowable costs and may not be reported on the FQHC's cost report. Billing for certain non-FQHC services will be discussed in detail in a later module.

2. Non-FQHC services include, but are not limited to:
 - a. Services excluded from coverage under the Medicare program (e.g., routine physical exams, hearing tests, eye exams, and self-administered drugs (SADs));
 - b. The technical component of a diagnostic service performed in an FQHC (e.g., x-ray or EKG);
 - c. Laboratory services;
 - d. Durable medical equipment, prosthetic devices, body braces;
 - e. Medically necessary ambulance transport services to the nearest appropriate facility;
 - f. Practitioner services furnished to inpatients or outpatients in a hospital or CAH, ambulatory surgery center, or comprehensive outpatient rehabilitation facility;

- g. Telehealth distant-site services;
- h. Hospice services; and,
- i. Group services including education activities or classes. <Medicare Benefit Policy Manual, Chapter 13 § 60.1>

VII. Services and Supplies Provided "Incident to" an FQHC Practitioner's Services

A. Definition of "Incident to"

1. In general, "incident to" refers to those covered services and supplies that are integral, though incidental, to an FQHC practitioner's service and are:
 - a. Usually provided in an outpatient clinic setting;
 - b. Usually included in the FQHC Medicare PPS payment;
 - c. Performed by a staff member of the FQHC in a medically appropriate timeframe; and,
 - d. Generally, furnished under the appropriate FQHC practitioner's direct supervision. <Medicare Benefit Policy Manual, Chapter 13 §§ 120, 140, 160>

B. Exceptions to "Incident to"

1. Transitional Care Management (TCM) and General Care Management may be furnished under general supervision rather than direct supervision (discussed in detail in a later module). <Medicare Benefit Policy Manual, Chapter 13 §§ 120, 140, 160>

Caution: The Part B benefit does not authorize a CSW to have services furnished incident to their professional services and must personally perform their own services.

C. Services Provided by FQHC Staff "Incident to" a Qualifying Visit

1. Services provided by auxiliary staff, either employed by or under an employment contract with the FQHC, are covered as incident to when provided as a result of a qualifying visit and performed under the FQHC practitioner's direct supervision, excluding care management services. <Medicare Benefit Policy Manual, Chapter 13 §§ 120.1, 140, 160>
 - a. Services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the FQHC for inclusion on the claim, services provided by an independent laboratory

or a hospital outpatient department, services furnished by a nurse, medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the FQHC, including services provided by a third party under contract. <Medicare Benefit Policy Manual Transmittal 263>

- b. Direct supervision does not require that the practitioner be present in the same room; however, the supervising practitioner must be in the FQHC and immediately available to provide assistance and direction during the time when the services are being provided. <Medicare Benefit Policy Manual, Chapter 13 § 120.1>
- c. Direct supervision is met for an NP, PA, CNM, or CP who supervises the performance of services by FQHC staff only if the non-physician practitioner can provide supervision under the FQHC's written policies, their scope of practice, and as allowed under state law. <Medicare Benefit Policy Manual, Chapter 13 §§ 140, 160>
- d. Services furnished by an FQHC employee incident to a physician's visit in a patient's home or location other than in the FQHC must be provided under the direct supervision of a physician. <Medicare Benefit Policy Manual, Chapter 13 § 120.2>
 - (i) The availability of the physician by telephone or in a different location in the same building does not meet the definition of direct supervision.

Note: The direct supervision requirement does not apply to visiting nurse services appropriately provided in the home or to certain care management services provided by FQHC staff (discussed in detail in a later module).

- 2. Incident to services or supplies are either provided without charge (e.g., routine supplies) or are included in the FQHC's total charge for the qualifying visit (e.g., venipuncture performed by a nurse or medical assistant). <Medicare Benefit Policy Manual, Chapter 13 §§ 120, 140, 160>
 - a. More than one incident to service can be provided during a qualifying visit with an FQHC practitioner.
 - b. Supplies that must be billed to the DME MAC or to Part D are not included as part of the qualifying visit.
- 3. Most drugs and biologicals are covered when they are provided as part of a qualifying visit and **are not** "usually self-administered". Payment for Medicare-covered Part B drugs is included in the PPS payment. <Medicare Benefit Policy Manual, Chapter 13 § 120.3>

- a. Drugs that are usually self-administered (e.g., oral pain medication or oral antibiotic) are not included in the FQHC's total charge for the qualifying visit. <Medicare Benefit Policy Manual, Chapter 13 § 120>

Coverage and billing for drugs and self-administered drugs will be discussed in detail in a later module.

- b. Certain drugs that are specifically covered by a Medicare statute (i.e., influenza or pneumococcal vaccine) are not paid as part of the qualifying visit and are not reported on the FQHC claim. <Medicare Benefit Policy Manual, Chapter 13 § 220.1>

Reporting vaccines and their administration will be discussed in detail in a later module.

VIII. Other FQHC Requirements

A. Emergency Care

1. Generally, an FQHC must provide limited emergency care as a first response to common life-threatening injuries and acute illnesses during regular hours of operation. The FQHC must maintain a supply of commonly used drugs and biologicals adequate to handle the volume and type of medical emergencies it typically encounters. <42 C.F.R. § 491.9; Medicare Benefit Policy Manual, Chapter 13 § 50.3; Medicare State Operations Manual Transmittal 194>
 - a. An FQHC, either independent or provider-based, is not subject to the Emergency Medical Treatment and Active Labor Act (EMTALA).
 - b. When a physician, NP, PA, CNM, CP, or CSW is not present, any care provided in an emergency must be within the staff's ability, training, and scope of practice, and in accordance with state laws.
 - c. Emergency Care – After Hours
 - (i) After their operating hours, FQHCs must provide telephone access to an individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open. <Medicare Benefit Policy Manual, Chapter 13 § 50.3>

2. The final rule for *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* went into effect on November 16, 2016. All healthcare providers and suppliers were required to comply and implement all applicable regulations by November 16, 2017. <81 Fed. Reg. 63860-64044>

- a. In general, an FQHC must comply with all federal, state, and local emergency preparedness requirements, including but not limited to the following elements:

- (i) Emergency plan;

- (ii) Policies and procedures;

- (iii) Communication plan;

- (iv) Training and testing; and,

- (v) Integration with the healthcare system, where applicable. < See 42 C.F.R. 491.12; *Medicare State Operations Manual*, Appendix Z>

B. Arrangements with Other Providers

1. An FQHC must have an agreement or arrangement with other providers participating under Medicare and/or Medicaid to furnish additional services to its patients, including:

- a. Inpatient hospital care;

- b. Physicians' services; and

- c. Specialized diagnostic and laboratory services not available at the clinic. <See 42 C.F.R. § 491.9 (d)>

- (i) If the agreement is not in writing, there must be evidence that patients being referred by the FQHC practitioner are being accepted and treated by other providers (i.e., consultation reports, procedure reports, etc.).

C. Commingling in an FQHC

1. Definition of commingling

- a. Commingling refers to when an FQHC shares space, employed or contracted staff, supplies, equipment, and/or other resources with another onsite Medicare Part B or Medicaid fee-for-service practice operated by the same FQHC practitioner. <Medicare Benefit Policy Manual, Chapter 13 § 100>
2. Prohibition on commingling
- a. During the FQHC's posted hours of operation, the clinic practitioner may not provide services as an independent Part B provider in the FQHC or in an area outside of the designated FQHC space (i.e., adjacent treatment room). <Medicare Benefit Policy Manual, Chapter 13 § 100>
 - (i) Covered services provided by a clinic practitioner during the FQHC's hours of operation cannot be carved out of the cost report and billed separately to Part B.
 - (ii) This prohibition is intended to prevent duplicate payments to the FQHC and the practitioner and to prevent selectively choosing a higher or lower reimbursement rate for the same service.

Case Study 1

Facts: An FQHC is staffed by one physician Monday-Friday, 8:00 a.m. to 4:00 p.m. During the clinic's posted hours of operation, the physician goes across the hall into a separate procedure room (not part of the FQHC) to perform a simple biopsy on a non-FQHC patient.

- Can the physician bill for the services on a separate Part B claim (1500 claim form)?

D. Further Defining Shared Space

1. When an FQHC is in the same building with another entity (e.g., an unaffiliated medical practice, x-ray facility, or emergency room), the FQHC's space must be clearly defined to prevent duplicate reimbursement.
<Medicare Benefit Policy Manual, Chapter 13 § 100>
 - a. An FQHC that shares resources (e.g., a waiting room, receptionist, or telephones) with another entity must appropriately allocate shared staff, space, and resources on the cost report.
 - b. An FQHC that leases space to another entity must appropriately report the leased space on the cost report.

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Case Study 1

Facts: An FQHC is staffed by one physician Monday-Friday, 8:00 a.m. to 4:00 p.m. During the clinic's posted hours of operation, the physician goes across the hall into a separate procedure room (not part of the FQHC) to perform a simple biopsy on a non-FHQC patient.

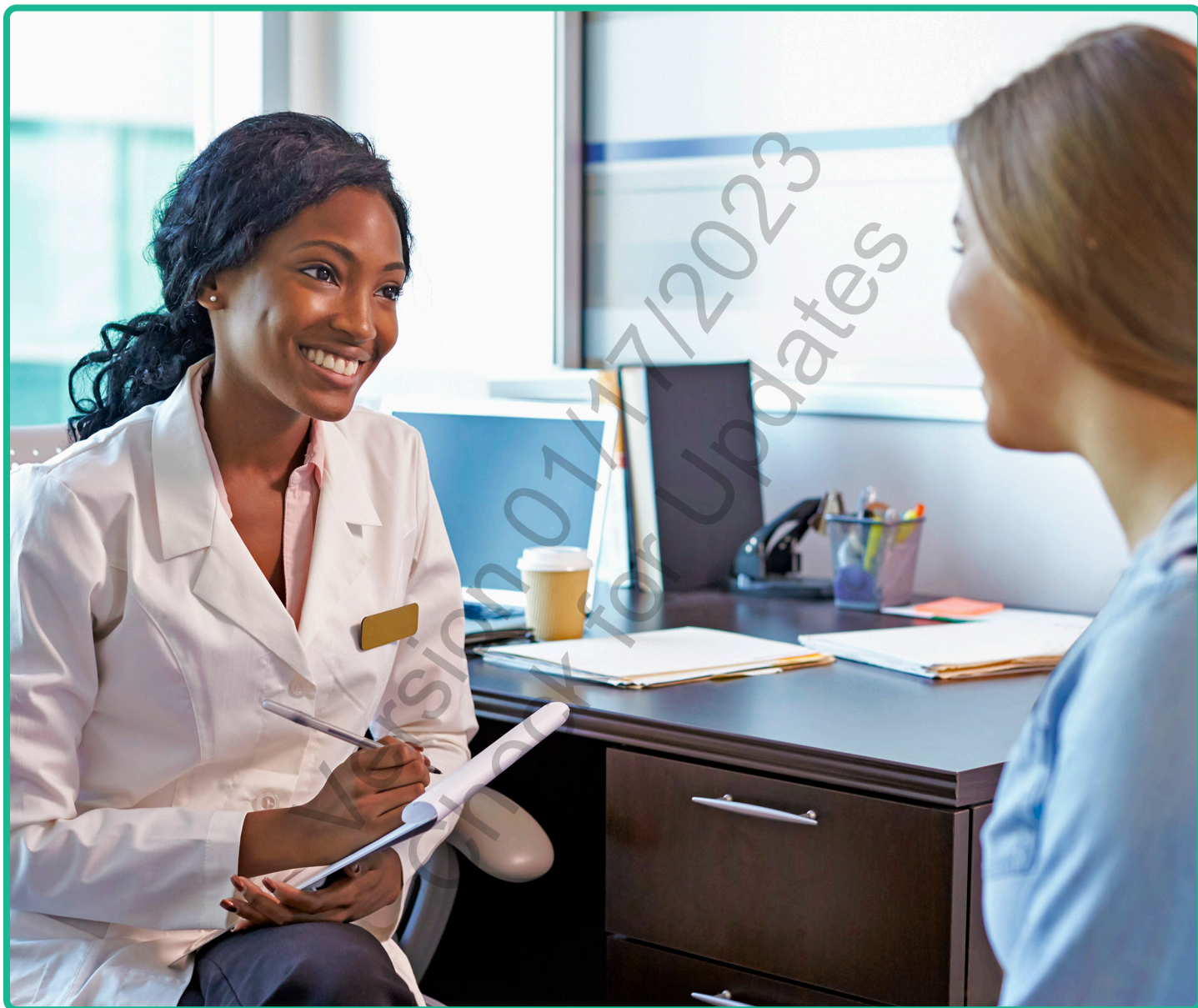
- Can the physician bill for the services on a separate Part B claim (1500 claim form)?

Analysis: No – covered services that are provided during the FQHC's posted hours of operation by an FQHC practitioner cannot be carved out of the cost report and billed separately to Part B. The practice that CMS refers to as "commingling" is prohibited to prevent duplicate payments to the FQHC. It also prevents selectively choosing a higher or lower reimbursement for the same service that may be billed on different claim types/forms. In this case, the staffing requirements would not be met during the FQHC's posted hours (i.e., at least one physician, NP, PA, or CNM must be in the clinic to provide services).

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Federally Qualified Health Center



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What's Changed?

- Starting January 1, 2022:
 - Federally Qualified Health Centers (FQHCs) get payment for hospice attending physician services when provided by specific providers (pages 5 & 6)
 - We allow mental health services using telecommunications (pages 5 & 12)
 - We allow concurrent billing for chronic care management (CCM) and transitional care management (TCM) services (page 5)
 - We changed G2064 and G0265 to 99424 and 99426, respectively (page 8)
- We added COVID-19 shot and monoclonal antibody therapy administration information (page 9)

You'll find substantive content updates in dark red.

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Federally Qualified Health Centers (FQHCs) are safety net providers that give services in an outpatient clinic setting. Section 1861(aa) of the [Social Security Act](#) allows additional FQHC Medicare payments.

FQHCs may be located in rural or urban areas and include:

- Community health centers
- Migrant health centers
- Homeless health centers
- Public housing primary care centers
- Health center program “look-alikes”
- Outpatient health programs or facilities a tribe or tribal organization or an urban Indian organization operates

Together we can advance health equity and help eliminate health disparities in rural populations. Find these resources and more from the [CMS Office of Minority Health](#):

- [Rural Health](#)
- [Data Stratified by Geography \(Rural/Urban\)](#)
- [Health Equity Technical Assistance Program](#)

Note: The information in this publication may not apply to [Grandfathered Tribal FQHCs](#).

Practitioners

You and your staff must comply with all licensure and certification laws and regulations. We pay FQHCs based on the [FQHC Prospective Payment System](#) (PPS) for medically necessary primary health services and qualified preventive health services from an FQHC practitioner, including:

- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)

Patient Services

FQHCs provide:

- Physician services.
- Services and supplies incident to physician services like taking blood pressure or administering shots.
- Services and supplies incident to NP, PA, CNM, CP, or CSW services.
- Medicare Part B-covered drugs supplied incident to FQHC practitioner services.
- Medicare patient homebound visiting nurse services when a registered nurse (RN) or licensed practical nurse (LPN) provides them in an area we certify as having a shortage of home health agencies.*

- Outpatient [diabetes self-management training](#) (DSMT) and [medical nutrition therapy](#) (MNT) from qualified DSMT and MNT practitioners in a 1-on-1, face-to-face visit for patients with diabetes or renal disease.
- Certain care management services like [transitional care management](#) (TCM), [chronic care management](#) (CCM), general [behavioral health integration](#) (BHI), principal care management (PCM), and psychiatric collaborative care model (CoCM) services. **You can bill TCM services with other care management services (starting January 1, 2022).**
- [Virtual communication services](#) like communication-based technology and remote evaluation services.
- **Mental health services using telecommunications (starting January 1, 2022).**
- **Hospice attending physician services from an FQHC physician, NP, or PA employed or working under contract for an FQHC, instead of employed by a hospice program (starting January 1, 2022).**
- **During a hospice election, attending physician services can take place at the patient's home, a Medicare-certified hospice freestanding facility, skilled nursing facility (SNF), or hospital.**

*You should [check eligibility](#) before providing visiting nurse services to ensure the patient isn't already under a home health plan of care.

Certification

To qualify as an FQHC, you must meet **1** of these requirements:

- Get a grant under Section 330 of the [Public Health Service \(PHS\)](#) Act or be funded by the same grant contracted to the recipient
- Get a grant as an FQHC "look-alike" based on a [Health Resources and Services Administration](#) (HRSA) recommendation
- Be treated by the HHS Secretary as a comprehensive federally funded health center since January 1, 1990, for Part B purposes
- Operate as an outpatient health program or tribe or tribal organization facility under the Indian Self-Determination Act or as an urban Indian organization getting funds under [Title V of the Indian Health Care Improvement Act](#)

FQHC certification requires you meet **all** these requirements:

- Provide comprehensive services, including an ongoing quality assurance program and annual review
- Meet all health and safety requirements
- Not be approved as a [rural health clinic](#) (RHC)
- Meet **all** Section 330 of the [PHS](#) requirements, including:
 - Serve a designated medically underserved area (MUA) or medically underserved population (MUP)
 - Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale
 - Be governed by a board of directors, where most members get care at the FQHC

Visits

FQHC visits **must**:

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC where the practitioner provides 1 or more qualified FQHC services
- Include an RN or LPN homebound patient visit (in certain limited situations)
- Meet certain conditions when a qualified practitioner offers outpatient DSMT or MNT services and the FQHC meets the requirements to provide these services

FQHC visits **can** take place at:

- An FQHC
- A patient's home, including an assisted living facility
- A Medicare-covered Part A SNF
- The scene of an accident
- A hospice facility (when an FQHC physician, NP, or PA who's employed or working under contract for an FQHC but isn't employed by a hospice program provides them)

FQHC visits **can't** take place at:

- An inpatient or outpatient hospital department, including a [critical access hospital](#) (CAH)
- A facility with specific requirements excluding FQHC visits



Multiple Visits on the Same Day

Visits with more than 1 FQHC practitioner on the same day, or multiple visits with the same FQHC practitioner on the same day, count as a single visit, **except** when a patient:

- Returns to the FQHC to diagnose or treat an injury or illness that happened after the initial visit (for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the FQHC)
- Has a qualified medical and mental health visit on the same day

Payments

- FQHC claims must include an FQHC payment code.
- We pay claims at 80% of the lesser of the FQHC charges or the FQHC PPS rate for the specific payment code (national encounter-based rate with geographic and other adjustments).
- We annually update the FQHC PPS base payment rate using the FQHC market basket.
- Coinsurance is 20% of the lesser of the FQHC charges or the PPS rate for the specific payment code, except for certain preventive services. We waive Part B coinsurance and deductible for certain preventive services, including specific [Medicare Wellness Visits](#).
- Telehealth services are the only services billed on FQHC claims that are subject to the [Part B deductible](#).

Visit the [FQHC Center](#) webpage for more information on PPS rates.

Payment Adjustments

These adjustments apply to the FQHC PPS base payment rate:

- FQHC geographic adjustment factor
- New patient adjustment
- Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) adjustment

Charges & Payment

FQHCs set their own service charges and determine which services to include with each FQHC G code. Patient charges must be uniform.

The [FQHC Center](#) webpage has more information about submitting claims with FQHC PPS payment codes and lists of billable visits.

We pay for professional services only. We pay lab tests (excluding venipuncture) and the technical component of billable visits separately. We include not separately billable procedures in the payment of an otherwise qualified visit. If a procedure is associated with a qualified visit, include procedure charges on the visit's claim.

Cost Reports

FQHCs must file an annual cost report. Include graduate medical education adjustments, bad debt, flu and pneumococcal shots, and your administration payments. Use [FQHC Cost Report Form \(CMS-224-14\)](#) to determine your payment rate and reconcile interim payments.

The [Provider Reimbursement Manual – Part 2](#) has more cost reports and forms.

Care Management Services

Chronic Care Management or General Behavioral Health Integration Services

- We pay CCM or general BHI services at the **national non-facility Physician Fee Schedule (PFS) average payment rate** for CPT codes **99424, 99426**, 99484, 99487, 99490, and 99491 using general care management HCPCS code G0511, which is updated annually based on these codes' PFS amounts
- We update G0511's payment rate annually based on the PFS amounts for these codes
- **We adopted (in 2022), CPT codes 99424 and 99426 to replace HCPCS codes G2064 and G2065 in calculating G0511's rate**
- You can bill 20% [coinsurance](#) of the lesser of submitted charges or G0511's payment rate for care management services
- You can report care management costs in the cost report's non-reimbursable section, and not determine the FQHC PPS rate
- You can bill G0511 once per month per patient when you deliver at least 20 minutes of CCM services, at least 20 minutes of general BHI services, or at least 30 minutes of PCM services, and your services meet all other requirements
 - You can count only FQHC practitioner or auxiliary personnel services within the scope of service elements toward the 20-minute general care management services billing minimum or the 30-minute PCM services minimum
 - **Don't** include administrative activities like transcription or translation services

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Psychiatric Collaborative Care Model

- We pay at the **national non-facility PFS payment rate** for CPT code 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services), when HCPCS code G0512 is on an FQHC claim either alone or with other payable services
- You must provide at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services to bill for this service
- You can bill 20% coinsurance of the lesser of submitted charges or G0512's payment rate for care management services coinsurance
- You can report care management costs in the cost report's non-reimbursable section, and not determine the FQHC PPS rate
- You can bill G0512 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services and your services meet all other requirements
 - You can count only FQHC practitioner or auxiliary personnel services within the scope of service elements toward the 60-minute psychiatric CoCM billing minimum
 - **Don't** include administrative activities like transcription or translation services

Flu Shots, Pneumococcal Shots, COVID-19 Shots, & COVID-19 Monoclonal Antibody Therapies

We pay for flu, pneumococcal, and COVID-19 shots, **and COVID-19 monoclonal antibody products** and their administration at 100% of reasonable cost. We include the cost in the cost report so you don't bill a visit. You must include these charges on the claim if they're part of a visit. If you only provide the shot administration on that day, waive the patient coinsurance, and don't file a claim.

Note: We updated the FQHC cost report to reflect costs related to COVID-19 shots, COVID-19 monoclonal antibody products, and their administration.

For Medicare Advantage (MA) patients, submit COVID-19 shot administration claims to the patient's MA plan for dates of service on or after January 1, 2022. Original Medicare stopped paying these claims December 31, 2021.

Hepatitis B Shot Administration & Payment

We include the hepatitis B shot and its administration in the FQHC visit. They aren't separately billable. If you provide a qualifying FQHC visit on the same day as the hepatitis B shot, report the charges for the shot and related administration as a separate line item to ensure we don't apply coinsurance. You can't bill a visit if shot administration is the only service provided.

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Telehealth

Telehealth generally involves 2-way, interactive, audio-video technology that permits communication between the practitioner and patient. FQHCs can provide telehealth to extend care when a patient is in a different place.



The originating site refers to the patient's location. FQHCs can be originating sites for telehealth if they're in a qualifying area. FQHCs serving as telehealth originating sites get an originating site facility fee. You may include the originating site facility fee charges on the claim. Although FQHC services aren't subject to a deductible, the facility fee isn't considered an FQHC service. You must apply the [deductible](#) when billing the telehealth originating site facility fee.

During the COVID-19 Public Health Emergency (PHE)

FQHCs can provide and get payment for distant site telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE. The distant site refers to the provider's location. FQHCs are only authorized to be a distant site during the COVID-19 PHE.

Practitioners can furnish telehealth services from any distant site location, including their home, during the time they're working for the FQHC, and they can provide any distant site-approved telehealth service under the PFS. You can't bill the visit's cost or include it on the cost report. During the PHE, practitioners can furnish some telehealth services using audio-only technology.

For information on new and expanded FQHC flexibilities during the COVID-19 PHE, refer to [MLN Matters® Article SE20016](#).

Virtual Communication Services

You can also provide virtual communication services. Practitioners bill virtual communication services differently than telehealth services.

Virtual communication services are services where a practitioner meets with a patient for at least 5 minutes to determine if the patient needs a visit. There are 2 ways to provide virtual communication services:

- Through communication-based technology
- With remote evaluation services

During the COVID-19 PHE

During the COVID-19 PHE, payment for virtual communication services includes online digital evaluation and management services. Digital assessment services are non-face-to-face, patient-initiated, digital visits using a secure patient portal.

For information on new and expanded FQHC flexibilities during the COVID-19 PHE, refer to [MLN Matters® Article SE20016](#).

We pay for virtual communication services when an FQHC practitioner meets certain requirements, including:

- Practitioner provides at least 5 minutes of billable FQHC virtual communications, either through communication-based technology or remote evaluation services
- Patient had at least 1 face-to-face billable visit within previous year
- Virtual visit isn't related to services provided within last 7 days
- Virtual visit doesn't lead to in-person FQHC service within the next 24 hours or at next appointment

When the virtual communication HCPCS code G0071 is on an FQHC claim alone or with other payable services, we require FQHCs to submit HCPCS code G2012 (communication technology-based services) or HCPCS code G2010 (remote evaluation services).

When an FQHC practitioner provides virtual communication services, they don't need to meet face-to-face, so the coinsurance doesn't apply.

See [Virtual Communication Services FAQs](#) for more information.

Mental Health Visits

In 2022, we revised current regulatory language to allow FQHC and RHC mental health visits using telecommunications. We're allowing payment in the same way as face-to-face services. The changes also allow you to use audio-only technology in cases where patients can't, or don't consent to, using audio-video technology. [MLN Matters® Article SE22001](#) has more information.

Resources

- [Care Management Services in RHCs and FQHCs FAQs](#)
- [Medicare Benefit Policy Manual, Chapter 13](#)
- [Medicare Claims Processing Manual, Chapter 9](#)

Other Helpful Websites

- [American Hospital Association Rural Health Services](#)
- [National Association of Rural Health Clinics](#)
- [National Rural Health Association](#)
- [Rural Health Clinics Center](#)
- [Rural Health Information Hub](#)

Regional Office Rural Health Coordinators

Get contact information for [CMS Regional Office Rural Health Coordinators](#) who offer technical, policy, and operational help on rural health issues.

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