

Federally Qualified Health Center

Reimbursement Policy ID: RPC.0015.5420

Recent review date: 04/2026

Next review date: 01/2027

Healthy DC reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Healthy DC may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses covered services provided by Federally Qualified Health Centers (FQHCs) and how these services are reimbursed. Federally Qualified Health Centers are paid based on:

- the FQHC prospective payment system (PPS) or Alternative Payment Method (APM) for medically necessary primary health services and qualified preventive health services provided by a FQHC health provider under the Medicaid product.
 - Medical, dental and behavior health APM reimbursement of services are allowed for the same date of service by a different provider specialty.

Federally Qualified Health Center (FQHC) are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations.

FQHCs provide health care services such as:

- Traditional PCP services
- Disease Management services
- EPSDT
- Dental
- Family planning
- Behavioral Health

NOTE: Qualified APM services and per visits reimbursement, do not follow **lesser of logic** guidelines. Any services that do not qualify for the APM reimbursement, lesser of logic would apply.

Exceptions

**Routine Dental and Vision care are not covered for the Healthy DC Plan

Reimbursement Guidelines

Reimbursement is allowed for:

- Professional services only
- If a procedure is associated with a qualified visit, charges for the procedure must be included on the claim for the qualified visit.
- Providers should bill POS 2, 11 or 50 for FQHC services.
- FQHC claims may be submitted with more than one POS on the same claim.
- Telehealth services must be billed with POS 02

APM (Alternative Payment Methodology) services/benefits are payable for Behavioral Health and Medical services for the same date of service by a different provider specialty. If the same provider specialty bills these secondary services, the second claim could be denied as a duplicate.

Medicaid:

- FQHC claims must be billed with CPT code T1015 in conjunction with a qualifying encounter rate code.

APM Reimbursement and Trigger Codes

- Each FQHC has a specific APM rate determined by the DHCF on a Calendar Year Basis
 - The reimburse if for PCP, Behavioral Health, and **Dental Services (3 separate rates that can be reimbursed on the same day)
 - Medical/PCP and Behavioral Health services are reimbursed using code T1015 (for Medicaid) processed in house by Healthy DC.
 - Dental claims use codes D0999 and D2999 are processed by our Dental contractor.
 - Facets is configured to reimburse the APM rate on the **T1015** code.
- The FQHC is required to only bill the T1015 code when the services rendered meets the APM criteria.
 - The criteria are based on the approved "Trigger Codes" outlined for each category of service.

Services may be provided by a physician, physician assistant or advanced practice registered nurse, certified nurse midwife, clinical social worker and a certified diabetes self-management training/medical nutrition therapy provider. The services provided also include dental services, physical and occupational therapy,

speech therapy, audiology services, vision, behavioral health/substance abuse disorder, chiropractic and podiatry.

Definitions

Federally Qualified Health Center

FQHCs are public health centers focused on serving at-risk and underserved populations.

Minimum services required including, but not limited to, maternity and prenatal care, preventive health and dental services, emergency care, and pharmaceutical services. Other services may include vision services, auditory services, behavioral health services, physical therapy, and speech therapy.

Prospective Payment System

A bundled payment that drives efficiency, not cost-based reimbursement. Rather than being paid fee-for-service, FQHCs receive a single, bundled rate for each qualifying patient visit. This single rate pays for all covered services and supplies provided during the visit.

APM (Alternative Payment Methodology) services/benefits are payable for Behavioral Health and Medical services for the same date of service by a different provider specialty. If the same provider specialty bills these secondary services, the second claim could be denied as a duplicate.

Edit Sources

- I. Current Procedural Terminology (CPT)
- II. Healthcare Common Procedure Coding System (HCPCS)
- III. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and associated publications.
- IV. Centers for Medicare and Medicaid Services (CMS).
- V. District of Columbia Medicaid Reimbursement FQHC Notice – Final Rulemaking
- VI. Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Attachments

N/A

Associated Policies

N/A

Policy History

04/2026	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section