

FQHC AND RHC SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenen provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirement.

FQHC/RHC PPS Services

Facilities must meet the definition of a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as defined in [42 CFR § 405.2401](#) as either. FQHC and RHC billing NPIs must be enrolled with Medicare and recognized as an FQHC or RHC to enroll in South Dakota Medicaid. This requirement does not apply to stand-alone FQHC dental clinics.

The following individual provider types are eligible to generate a FQHC/RHC Prospective Payment System (PPS) encounter:

- Dentist;
- Nurse practitioner;
- Physician;
- Physician assistant.
- Psychologist;
- CSW-PIP;
- CSW-PIP Candidate;
- LPC-MH;
- LPC working toward MH designation;
- Clinical Nurse Specialist – Mental Health;
- Licensed marriage and family therapists;
- Substance Use Disorder Agencies accredited by the Division of Behavioral Health; and
- Visiting nursing services may be provided by a registered nurse or a licensed practical nurse.

Registered nurses and licensed practical nurses are not eligible to enroll with South Dakota Medicaid. Dietitians, nutritionists, applied behavior analyst, speech language pathologists, occupational therapists, and physical therapists are not eligible to enroll as a servicing provider of an FQHC/RHC.

FQHC/RHC Non-PPS Services

FQHC/RHCs billing for non-Prospective Payment System (PPS) services must acquire a separate billing NPI. Services outside the FQHC/RHC definition must utilize a separate billing NPI under a group enrollment with associated servicing NPIs and bill accordingly. The Covered Services and Limits section of this manual addresses which services are Prospective Payment System (PPS) services. Non-PPS services are based on the servicing provider. The servicing provider must be enrolled with South Dakota Medicaid.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitation described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Postpartum Care Only (47)	Coverage restricted to postpartum care only.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to co-payments and deductibles on Medicare A and B covered services.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including issues that can harm the life of the mother or baby.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to \$5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

FQHC/RHC Overview

Most FQHC/RHC services are covered on a per visit basis. A “visit” is a face-to-face encounter between a FQHC or RHC patient and a provider listed in the Eligible Provider section of this manual that can generate a PPS encounter. Services must be provided under the medical direction of a physician.

FQHC/RHC PPS Services

The following services are considered FQHC/RHC PPS services. These services are paid via a single per diem payment and are not separately billable to South Dakota Medicaid. The services are only considered a PPS encounter when provided by a provider listed in the Eligible Provider section of this manual or when incidental to a billable encounter.

Service	Description
Physician services	Provided in accordance with the limitations in ARSD Ch. 67:16:02 , ARSD Ch. 67:16:11 , and the Physician Services Manual or other applicable professional services manual.
Services and supplies furnished incidental to a physician’s service	<p>“Incident to” refers to services and supplies that are integral, though incidental, part of the physician’s professional services and are:</p> <ul style="list-style-type: none"> • Commonly rendered without charge and included in the FQHC/RHC payment; • Commonly furnished in an outpatient clinic setting; • Furnished under the physician’s direct supervision; except for authorized care management services which may be furnished under general supervision; and • Furnished by FQHC/RHC auxiliary personnel. <p>Incident to services and supplies include:</p> <ul style="list-style-type: none"> • Drugs and biological that are not usually self-administered, and Medicaid covered preventative injectable drugs such as the flu vaccine; • Venipuncture; • Bandages, gauze, oxygen, and other supplies; or • Services furnished by auxiliary personnel such as a nurse, medical assistant, or other clinical personnel acting under the supervision of the physician. <p>An encounter that includes only an incident to service is not a stand-alone billable visit for an FQHC/RHC.</p>
Nurse practitioner, physician assistant, and nurse midwife services	Provided in accordance with the limitations of ARSD Ch. 67:16:02 , ARSD Ch. 67:16:11 , and the Physician Services Manual or other applicable professional services manual.

<p>Services and supplies furnished incident to a nurse practitioner, physician assistant, nurse midwife, services</p>	<p>Services and supplies that are integral, through incident to a nurse practitioner, physician assistant, or nurse midwife service:</p> <ul style="list-style-type: none"> • Commonly rendered without charge and included in the FQHC/RHC payment; • Commonly furnished in an outpatient clinic setting; • Furnished under the direct supervision of a nurse practitioner, physician assistant, or nurse midwife except for authorized care management services which may be furnished under general supervision; and • Furnished by FQHC/RHC auxiliary personnel. <p>Incident to services and supplies include:</p> <ul style="list-style-type: none"> • Drugs and biological that are not usually self-administered, and Medicaid covered preventative injectable drugs such as the flu vaccine; • Venipuncture; • Bandages, gauze, oxygen, and other supplies; or • Services furnished by auxiliary personnel such as a nurse, medical assistant, or other clinical personnel acting under the supervision of the physician. <p>An encounter that includes only an incident to service is not a stand-alone billable visit for an FQHC/RHC.</p>
<p>Services of a Psychologist, CSW-PIP, CSW-PIP Candidate, LPC-MH, LPC working toward MH designation, Clinical Nurse Specialist – MH, and licensed marriage and family therapists.</p>	<p>Provided in accordance with ARSD Ch. 67:16:41 and the Independent Mental Health Practitioner manual. Group psychotherapy and multiple family group psychotherapy are not covered.</p>
<p>Services and supplies furnished incident to a Psychologist, CSW-PIP, CSW-PIP Candidate, LPC-MH, LPC working toward MH designation, Clinical Nurse Specialist – Mental Health and licensed marriage and family therapist services as described in 42 CFR 405.2415.</p>	<p>Services and supplies that are integral, though incident to a mental health service are:</p> <ul style="list-style-type: none"> • Commonly rendered without charge or included in the RHC or FQHC payment; • Commonly furnished in an outpatient clinic setting; • Furnished under the direct supervision of an allowable provider, except for authorized care management services which may be furnished under general supervision; and • Furnished by a member of the RHC or FQHC staff.
<p>Dental services</p>	<p>Dental services provided in accordance with the limitations in ARSD Ch. 67:16:06 and the Dental Services Provider Manual.</p>

Substance use disorder services	Substance use disorder services provided in accordance with the limitations in ARSD Ch. 67:16:48 and the Substance Use Disorder Agency Services Manual . Substance use disorder providers must be accredited by the Division of Behavioral Health and enrolled with Medicaid as a substance use disorder agency.
Visiting nurse services	Visiting nurse services provided by a registered nurse or licensed practical nurse are covered when provided in accordance with the requirements in 42 CFR 405.2416 and 42 CFR 405.2417 . The FQHC/RHC must be located in an area that has a shortage of home health agencies. The services must be provided in accordance with the Home Health Services administrative rules in ARSD Ch. 67:16:05 .

Incidental Services

The following services can be provided incident to a physician, nurse practitioner, physician assistant, or nurse midwife service, but do not constitute a separately billable visit:

- Blood pressure checks;
- Allergy injections;
- Prescriptions;
- Nursing services;
- Diabetes education provided in accordance with [ARSD Ch. 67:16:46](#);
- Medical nutrition therapy provided in accordance with the [Dietician and Nutritionist Services](#) manual;
- Speech language pathology services provided by a therapist in accordance with [ARSD Ch. 67:16:02](#) and the [Therapy Services Manual](#).
- Physical therapy services provided by a therapist in accordance with [ARSD Ch. 67:16:02](#) and the [Therapy Services Manual](#).
- Occupational therapy services provided by a therapist in accordance with [ARSD Ch. 67:16:02](#) and the [Therapy Services Manual](#).
- Vaccines provided in accordance with the [Physician Administered Drugs, Vaccines, and Immunizations Manual](#).

Incidental services are included in the PPS payment and cannot be billed separately to South Dakota Medicaid unless otherwise noted in the FQHC/RHC Non-PPS Services section.

Unbundling Services

Services that are normally rendered during a single visit may not be unbundled for the purpose of generating multiple encounters. FQHC/RHCs must not develop procedures or otherwise ask recipients to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary.

FQHC/RHC Non-PPS Services

FQHCs and RHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit, such as laboratory services or the technical component of an RHC or FQHC service. If these services are authorized to be furnished by the RHC or FQHC and are covered under a separate Medicaid benefit category, the services must be billed separately (not under the RHC or FQHC billing NPI for services paid at the PPS rate).

The normal Medicaid coverage and reimbursement rules that apply to these services. Covered non-PPS services include:

- Technical component of an RHC or FQHC service - Includes diagnostic tests such as x-rays, electrocardiograms (EKGs), and other tests. These services may be billed separately to South Dakota Medicaid by the facility. The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner or furnished incident to an RHC or FQHC visit. An RHC/FQHC practitioner is an individual listed in the Eligible Provider section of this manual that is able to generate and RHC/FQHC encounter.
- Laboratory services. Venipuncture is included in the PPS payment and is not separately billable.
- Durable Medical equipment;
- Prosthetic devices;
- Practitioner services at another facility provided to a Medicaid recipient including inpatient and outpatient hospitals and ambulatory surgical centers.
- Transportation services; and
- Hospice services.

Standalone Vaccines/Immunizations

Vaccines/immunizations and their administration are factored into each provider's encounter rate and are reimbursed as part of the encounter rate when furnished incidental to a reimbursable medical encounter. It is recommended that providers screen a recipient's immunization status and administer appropriate vaccines/immunizations when seeing a recipient for their well-child or well-adult visit. For purposes of data collection, it is required that immunizations provided during an encounter be included on the encounter claim.

FQHCs/RHCs are allowed to bill for vaccines/immunizations and the associated administration provided on a date of service when a billable medical encounter did not occur. Standalone vaccines/immunizations and the associated administration code will be reimbursed on a fee for service basis.

Vaccines/immunizations may not be administered on a separate day than an FQHC/RHC encounter for the purpose of increasing the provider's reimbursement.

Telemedicine

FQHC/RHCs are eligible to serve as an originating site for telemedicine services and may also provide distant site telemedicine services. An originating site is the physical location of the Medicaid recipient at the time the service is provided. A distant site is the physical location of the practitioner providing the service via telemedicine. Please refer to the [Telemedicine](#) manual for additional information.

FQHC/RHC Services Locations

FQHC/RHC services must be provided at one of the following locations:

- The FQHC or RHC;
- The recipient's residence (including an assisted living facility);
- A skilled nursing facility; or
- The scene of an accident.

A visit may not take place in the following locations:

- An inpatient or outpatient department of a hospital, including a critical access hospital; or
- A facility which has specific requirements that preclude FQHC or RHC visits.

Multiple Visits

Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day constitute a single visit. Payment is limited to two visits a day. A second visit is payable only under the following conditions:

- After the first visit, the patient suffers illness or injury which requires additional diagnosis or treatment.
- One of the services is a complete comprehensive EPSDT screening with the components required in [67:16:11:04](#).
- One of the visits is for behavioral health services covered under the provisions of [67:16:41](#) or [67:16:48](#).
- One of the visits is for dental services provided under the provisions of [67:16:06](#).

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

REIMBURSEMENT AND BILLING

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

PPS Reimbursement

FQHC/RHC PPS services will be reimbursed at the established per diem rate for all reimbursable services associated with the visit. Payment is limited to two visits a day and a second visit is only payable if the conditions in the Covered Services and Limits section of this manual are satisfied.

Telemedicine Originating Site Fee

Reimbursement for the telemedicine facility fee is limited to the amount listed on the Physician Services [fee schedule](#).

Long Acting Reversible Contraceptives (LARC) / Intrauterine Devices (IUDs) Reimbursement

South Dakota Medicaid reimburses providers for procedure codes J7298, J7300, and J7307 in addition to the PPS rate. The maximum reimbursement rate for these codes is listed on the Physician Services [fee schedule](#). Facilities must bill the appropriate HCPCS code with the associated NDC.

Fluoride Varnish

South Dakota Medicaid reimburses providers for a fluoride varnish on a fee for service basis. The service is reimbursable in addition to the PPS rate if provided on the same day as a reimbursable encounter. Effective January 1, 2020, providers must bill for the service using CPT code 99188. CDT code D1206 will not be billable on a CMS 1500 or 837P. The maximum reimbursement rate for CPT code 99188 is listed on the Physician Services [fee schedule](#). Fluoride varnishes are limited to recipients age 20 or younger and to 3 applications in a 12-month period.

Substance Use Disorder Treatment Reimbursement

Substance use disorder treatment is reimbursed at the PPS rate for services listed below and at 28 percent of the PPS rate for group services. Services must be billed with the HF modifier. Reimbursable services are listed below:

- H0001 HF - Assessments
- H0004 HF - Individual counseling
- H0005 HF - Group counseling
- T1006 HF - Family counseling (recipient must be present)
- H0050 HF - Early intervention services

Services that do not list the HF modifier will be denied. For providers contracted with the Division of Behavioral Health, non-Medicaid claims should continue to be billed through STARS and will be reimbursed according to the Division of Behavioral Health's [fee schedule](#).

If group counseling is provided on the same date of service as another SUD encounter service, both services are reimbursable. The services must be billed on separate CMS 1500 or 837P claims. Other SUD services provided on the same date of service are considered part of the same encounter and are only eligible for a single encounter payment.

Non-PPS Reimbursement

Non-PPS services, including vaccines/immunizations and the associated administration that did not occur the same day as a medical encounter, must be billed at the provider's usual and customary rate and will be reimbursed at the lower of this rate or the amount listed on the South Dakota Medicaid [fee schedule website](#).

Cost Report

Per [ARSD 67:16:44:05](#) providers must annually submit a cost report to DSS's Office of Provider Reimbursements and Audits that shows the actual costs and total number of visits for the services furnished during the reporting period. A provider must submit the required cost report to the department within five months after the provider's fiscal year ends.

Change in Scope of Services

FQHCs/RHCs are responsible for notifying DSS's Office of Provider Reimbursements and Audits at the time there is a change in their scope of services. The provider must supply the needed documentation to the department for any adjustments in the rate resulting from any increases or decreases in the scope of services. The documentation must consist of two full years of Medicaid cost reports and must be provided to the department within 150 days from the RHC's fiscal year end to be considered in the calculation of the adjusted rate. Upon the department's determination of a change in the scope of services, the effective date for the new rate will be 30 days after receipt of the Medicaid cost reports.

Claim Instructions

PPS Services

PPS services must be billed on a CMS 1500 claim form or via an 837P electronic transaction. Detailed claim instructions are provided on our [website](#). Claims must be at the provider's usual and customary charge. Claims submitted for mental health services may contain only procedure codes listed in the Independent Mental Health Practitioners [fee schedule](#). Claims submitted for dental services may contain only procedure codes listed in the dental [fee schedules](#).

If a physician or other licensed practitioner is employed or under contract with a FQHC/RHC and provides services within the walls of the clinic, the clinic must bill for those services under their FQHC/RHC NPI number.

Telemedicine Originating Site Fee

A claim for a telemedicine originating site fee should be billed under the FQHC/RHC's NPI. As indicated above, payment is limited to the fee schedule amount.

Long Acting Reversible Contraceptives (LARC) / Intrauterine Devices (IUDs)

If billing for procedure codes J7298, J7300, and J7307, the codes should be included on the PPS claim under the FQHC/RHC's NPI.

Multiple Same Day Visits for PPS Services

Two separately payable visits that occur on the same day must be submitted on two separate claim forms.

Non-PPS Special Instructions

Non-PPS services must be billed separately from PPS services. Non-PPS services should be billed on a CMS 1500 or via an 837P electronic transaction. The services must be billed under a separately enrolled billing NPI and taxonomy code not recognized as an FQHC/RHC. The servicing provider and their taxonomy code are also required to be listed on the claim form.

DEFINITIONS

1. "Federally Qualified Health Center" or "FQHC," an entity that meets the requirements set forth in [42 C.F.R. § 405.2401](#), as amended to July 1, 2017;
2. "Rural Health Clinic" or "RHC," a facility that meets the requirements set forth in [42 C.F.R. § 405.2401](#), as amended to July 1, 2019; and
3. "Visit," a face-to-face encounter between a federally qualified health center or rural health clinic patient and a physician, physician assistant, nurse practitioner, or visiting nurse, mental health provider listed in [ARSD 67:16:41:03](#), dentist, or an accredited substance use disorder provider.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

1. Are any services separately reimbursable in addition to the PPS rate?

Yes, South Dakota Medicaid will reimburse a fee according to the Physician fee schedule for long acting reversible contraception HCPCS codes J7297, J7298, J7300, and J7307 in addition to the PPS rate. Facilities will need to bill the appropriate HCPCS code with the associated NDC.

2. Can an FQHC/RHC be paid two per diems for two separate visits in a day?

An FQHC/RHC is limited to reimbursement for two visits a day. A second visit is payable only under the following conditions:

- After the first visit, the patient suffers illness or injury which requires additional diagnosis or treatment;
- One of the services is a complete comprehensive EPSDT screening with the components required in [67:16:11:04](#);
- One of the visits is for behavioral health services covered under the provisions of [67:16:41](#) or [67:16:48](#); or
One of the visits is for dental services provided under the provisions of [67:16:06](#).

3. Can a registered nurse or licensed practical nurse generate a PPS encounter?

No, PPS encounters can only be generated by practitioners listed in the eligible providers section of this manual. Services provided by a registered nurse or licensed practical nurse are not separately billable.

4. How are vaccines/immunizations and administration reimbursed?

Vaccines/immunizations and administration are factored into each provider's PPS rate and are reimbursed as part of the PPS per diem when furnished incidental to a reimbursable medical PPS encounter. It is recommended that providers screen a recipient's immunization status and administer appropriate vaccines when seeing a recipient for their Well-Child or Well-Adult visit. For purposes of data collection, it is required that immunizations provided during a PPS encounter be included on the claim for PPS reimbursement.

FQHCs/RHCs are allowed to bill for vaccines/immunizations and the associated administration provided on a date of service when a billable medical encounter did not occur. Standalone vaccines/immunizations may not be billed under the FQHCs/RHCs billing NPI. FQHC/RHCs billing for standalone vaccines/immunizations must utilize/acquire a separate billing NPI under a group enrollment with associated servicing NPIs and bill accordingly. The servicing provider must be enrolled with South Dakota Medicaid. Standalone vaccines/immunizations and the associated administration code will be reimbursed on a fee for service basis. Vaccines/immunizations may not be administered on a separate day than an FQHC/RHC encounter for the purpose of increasing the provider's reimbursement.

5. Can an FQHC/RHC be reimbursed for diabetes education and dietician and nutritionist services?

These services may be incidental to an FQHC/RHC's PPS encounter with a provider listed in the Eligible Provider section of this manual. These services are not reimbursable visits when they are the only services provided.

6. Can an FQHC/RHC be reimbursed for Speech Language Pathology, Occupational Therapy, or Physical Therapy services.

These services may be incidental to an FQHC/RHC's PPS encounter with a provider listed in the Eligible Provider section of this manual. These services are not reimbursable visits when they are the only services provided.

7. Can an FQHC/RHC be reimbursed for substance use disorder services?

Yes, FQHC/RHCs that are accredited substance use disorder providers with the Division of Behavioral Health can be reimbursed for substance use disorder services. Services are reimbursed in accordance with the methodology in the Reimbursement section of this manual.

8. Is Medication Assisted Treatment (MAT) considered a behavioral health encounter or a medical encounter?

MAT is considered a medical health encounter.