Federally Qualified Health Center Payment Process

Frequently Asked Questions

What type of claim form do I use to submit my claims?

For claims with a date of service on or after September 1, 2017, all Federally Qualified Health Center (FQHC) claims must be submitted on a CMS-1500 or 837P claim form.

Do I need to follow a different process for CHIP claims since those changes are not being implemented until March 2018?

In an effort to ease the administrative burden for FQHC's, providers should bill all of Superior's claims the same, regardless of the member's coverage type. Please submit CHIP and CHIP Perinate claims exactly the same as STAR, STAR Health, STAR Kids, or STAR+PLUS claims.

What location/place of service code do I use?

All services provided in the FQHC should be billed with a location code 50. If a service is provided outside of the FQHC, use the location code appropriate to where the service was provided. (Ex. A delivery performed during an inpatient confinement would be billed with location 21.)

Am I required to use modifiers on my claim?

Yes, all E&M services and T1015 must be billed with the modifier indicator that describes the type of provider rendering the service. (Ex. A service performed by a physician would be billed with modifier AM.)

Please note:

- Modifier 25 is not required for multiple encounters on the same day for the same patient, however it is required with the appropriate vaccine administration codes.
- Modifier TH must be submitted for all pre and postnatal services, and must be in the first modifier position.
- Modifier EP must be submitted on the T1015 and the E&M service line for Texas Health Step services and any additional required modifier.

Do I have to bill procedure code T1015 on every claim?

All face-to-face visits billed for services provided in an FQHC (location code 50) must be billed with a T1015 service line. Claims billed with location code 50 without a T1015 service line, will not receive the Prospective Payment System (PPS) payment and may result in denial.

Do I have to enter something in the "charge" field of the T1015 service line, even though I am submitting my actual billed charges on the other service lines?

Yes, you should enter your PPS rate in the charge field on the T1015 service line.

Does every claim have to contain itemized services?

Yes, every claim must contain at least one face-to-face procedure code, in addition to the T1015 service line.

What do I use for billed charges on my itemized service lines?

You should bill your facilities usual and customary charge for the service.

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Am I required to enter rendering provider information on my claim form?

You are not required to enter a rendering provider for services provided at the FQHC, as long as the billing provider information contains the facility's National Provider Identifier (NPI) and taxonomy code.

Services provided outside of the FQHC, but billed by the FQHC must contain the rendering provider NPI and appropriate taxonomy code.

Rendering provider information is submitted in field 24j or equivalent 837P loop. If you bill the rendering provider NPI in field 24j, that provider must have an active Texas Provider Identifier (TPI) attested to with your facilities tax ID number.

Am I required to submit National Drug Codes (NDC) with my clinician administered drugs?

All pertinent NDC information is required to be billed on claims containing clinician administered drugs.

Is box 32 a required field?

Yes, all claims must contain the service location in box 32.

What information do I enter in box 33?

Box 33 must contain the billing provider name and address.

- Box 33A is required to be completed with the facility's NPI.
- Box 33B is required to be completed with the facility's taxonomy codes.

Please note: Failure to accurately complete box 33 may result in incorrect payment or claim denial.

How do I bill for sports physicals and will I be paid my PPS rate for them?

Sports physicals are a value-added service and are not reimbursable at the PPS rate, however these are reimbursable as "fee for service" at the flat rate of $35.00.

Sports physicals must be billed with the appropriate E&M and diagnosis code in the primary position. Sports physical claims should not be billed with T1015. This is an incorrectly billed claim and will result in denial.

Can I bill multiple encounters on same claim?

Claims submitted with multiple encounters/face-to-face visits on the same claim will be denied. Please submit one encounter per claim.

Can LARC services be billed?

Long-Acting Reversible Contraception (LARC) devices may be paid in addition to the family planning encounter. The encounter should be submitted with the appropriate family planning visit E&M and diagnosis, T1015, and the procedure code for the LARC device. Procedure code 58300 is considered informational.