

Federally Qualified Health Center and Rural Health Clinics

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- [Overview](#)
- [Establishing Payment Rates](#)
- [Eligible Providers](#)
- [Covered Services](#)
- [Noncovered Services](#)
- [Billing](#)
 - [FQHC and RHC Medicare Crossover Claims for Non-MCO Enrollees](#)
 - [Electronic Claim Attachments](#)
 - [FQHC Major Program Billing](#)
 - [RHC Major Program Billing](#)
 - [RHC Claim Submission for MCO-Enrolled Members on MA](#)
 - [FQHC Claim Submission for MCO-Enrolled Members on MA](#)
 - [FQHC and RHC MCO Carve-Out Exclusions](#)
 - [Pharmacy Billing and Copays](#)
 - [Maternity and Surgical Services: FFS and MCO Enrollees Services](#)
 - [Low-Level Services Provided by Mid to High-Level Practitioner](#)
- [Definitions](#)
- [Legal References](#)

Overview

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) provide covered services to Minnesota Health Care Programs (MHCP) members in a manner similar to other physician clinics. However, federal mandates and guidelines apply specifically to FQHCs and RHCs.

Establishing Payment Rates

Existing Clinics

The Benefits Improvement and Protection Act (BIPA) of 2000, section 702, deleted federal cost-based reimbursement provisions and created a prospective payment system (PPS) for FQHCs and RHCs. BIPA allows states to offer alternative payment methods (APMs) that must pay at least what the center or clinic would receive under PPS. Minnesota has three different APMs through Dec. 31, 2020. Complete an annual election form, [Alternative Payment Methodology Election for FQHCs and RHCs \(DHS-3903\) \(PDF\)](#), to indicate the chosen payment level for the year. It is only necessary to complete the form again when changing the APM selection.

As of Jan. 1, 2021, Minnesota offers only PPS or APM IV

Per Legislative changes effective July 1, 2019, [Minnesota Statutes, 256B.0625, subdivision 30 \(g\)](#), each FQHC or RHC organization must elect the Prospective Payment System (PPS) or the new Alternative Payment Method IV (APM IV) that will go into effect Jan. 1, 2021. (See [APM IV](#) in the Methodology and payment information table.)

All other APMs end Dec. 31, 2020. The Department of Human Services (DHS) will not implement the APM IV until an organization has submitted all required documentation for rate setting. The APM IV rate is an organizational rate and includes all clinics on a given Medicare Cost Report. If the APM IV rate does not exceed the PPS rate, the PPS rate will still apply. Failure to make an election, by sending in the required documentation, will result in assignment of the PPS rate effective Jan. 1, 2021. DHS will implement the APM IV rate elections occurring after Jan. 1, 2021, only when all required documentation is received.

DHS will calculate the APM IV using the average of two years of an FQHC or RHC organization's Medicare cost report. The initial 2021 calculation will use 2017 and 2018 fiscal year end cost reports. 2017 and 2018 cost reports will be inflated to the base year using the [Centers for Medicare and Medicaid Services \(CMS\) Market Basket inflator](#) established under United States Code, title 42, section 1395m (o), less productivity. DHS will rebase the APM IV every two years. DHS will inflate the interim rates using the CMS Market Basket inflator.

Submit the required documentation electronically to the Department of Human Services (DHS) within six months following the date the applicable Medicare cost reports are due to CMS. Submit the [required documents](#) electronically to DHS.FQRHCrates@state.mn.us

Methodology and payment information

Payment Rate Methodology	Methodology Explanation
Prospective Payment System (PPS)	<ul style="list-style-type: none"> Rate developed using 100 percent of the average costs of the FQHC or RHC during fiscal years 1999 and 2000, trended forward Adjustments made for change in scope of services
Alternative Payment Method (APM I) Expired Dec. 31, 2020	Historical cost-based methodology
Alternative Payment Method (APM II) Expired Dec. 31, 2020	PPS rate plus MinnesotaCare provider tax
Alternative Payment Method (APM III) Expired Dec. 31, 2020	200 percent when medical and mental health are provided to member on the same date of service
Alternative Payment Method (APM IV) Effective Jan. 1, 2021	<ul style="list-style-type: none"> Rate is developed using 100 percent of the average costs of the FQHC and RHC during fiscal year end 2017 and 2018, inflated by the market basket to 2021 Adjustments made for change in scope of services between rebasing years resulting in a medical, dental or both medical and dental rate change greater than plus or minus 2.5 percent Rate will be rebased every two years Rate will be inflated by market basket every other year
Alternative Payment Method (APM V) Effective July 1, 2023	<ul style="list-style-type: none"> An enrolled Indian health service facility or Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC Rate will be equivalent to the IHS All Inclusive Rate (AIR)
Alternative Payment Method (APM VI) Effective Jan. 1, 2026	Enrolled FQHCs that are also urban Indian organizations may elect to be paid PPS, APM IV, or APM VI

For fiscal year 2002 and succeeding fiscal years, DHS increases the PPS rate by the percentage increase in the Medicare Economic Index (MEI) and any increases or decreases in the scope of services.

PPS and APM rates for FQHCs and RHCs include a rate for dental services, if provided, and a medical rate for all other FQHC or RHC services. The all-inclusive medical payment rate (PPS or

APM) is the same whether a physician, nurse midwife, nurse practitioner, or physician assistant performs the service.

APM I – Expired Dec. 31, 2020

For the specific reporting period, an FQHC or RHC that elects payment under APM I and participates in the Medicare program is required to submit the following:

- A cost report prepared for the intermediary
- A chart of services provided that shows actual visits

The reporting period must coincide with Medicare's reporting requirements.

After the end of the fiscal year, an FQHC or RHC choosing payment under APM I must provide a copy of the finalized Medicare cost report, Medicare's rate determination letter and the facility's audited financial statements to the DHS Payment Policy Section. If an FQHC does not have Medicare FQHC status, or if Medicare does not desk-audit the RHC facility, and the FQHC or RHC chooses payment under APM I, the clinic should provide the following to MHCP:

- A cost report using Medicare cost-reporting principles
- Additional documentation showing specific Medical Assistance (MA) covered service costs, including pharmacy and dental services
- Audited financial statements

MHCP will desk-audit the financial information submitted and establish the finalized APM I encounter rate(s) for the cost reporting period. Desk-audit rates may be subject to adjustments for Medicare appeal settlements, amendments and on-site audit adjustments by Medicare or MHCP.

MHCP will continue to pay a FQHC or RHC already receiving an APM I rate in a previous period at the APM I rate until new rates are established using the updated historical cost information from the most recent finalized reporting period. If the PPS rate for the period exceeds the APM I rate, DHS will pay for FQHC and RHC services at the PPS rate. If the facility's current cost per visit differs significantly from the established APM I interim rate, MHCP will consider adjusting the APM I interim rate. To establish a new APM I interim rate, the FQHC or RHC must present to MHCP the cost estimate and updated statistical information for the non-historical items that affect the cost per visit calculation.

For both PPS and the APMs, legislative increases provided for fee-for-service (FFS) items such as obstetric, pediatric, physician and dental services are not applicable to the FQHC or RHC for MA services.

APM IV – Effective Jan. 1, 2021

For the specific reporting period, an FQHC or RHC that elects payment under APM IV and participates in the Medicare program is required to submit the following:

- Cost reports for 2017 and 2018 fiscal year end, as submitted to the intermediary
- Spreadsheet of face-to-face visits for all eligible providers broken down by practitioner. Also, include visits by physicians providing services at hospitals and emergency rooms
- Electronic trial balance and corresponding detail for expenses
- Electronic mapping of expenses:
 - FQHC - Worksheet A summary and detail tabs
 - RHC - Worksheet A-6 and A-8
- Identify Medical Education Research Cost (MERC) grant received each fiscal year
- Identify MinnesotaCare provider tax expense in each cost report

The reporting period must coincide with Medicare's reporting requirements.

If an FQHC does not have Medicare FQHC status and the FQHC or RHC chooses payment under APM IV, the clinic should provide the following to MHCP:

- A cost report using Medicare cost-reporting principles
- Additional documentation showing specific Medical Assistance (MA) covered service costs, including pharmacy and dental services
- Audited financial statements

For both PPS and the APMs, legislative increases provided for fee-for-service items such as obstetric, pediatric, physician and dental services are not applicable to the FQHC or RHC for MA services.

New Center or Clinic

Under BIPA, DHS payment policy staff will assign the payment rate of an existing center or clinic in the area, or adjacent area with similar caseload, to a new FQHC or RHC. MHCP uses provider service and utilization information to identify those providers who MHCP considers to have a similar caseload to that of the new center or clinic.

Clinic Merger or Acquisition

For FQHC and RHC organizations resulting from a merger or acquisition of two existing clinics or clinic organizations, the encounter rates must use the combined costs and caseloads from both clinics or clinic organizations to set the encounter rate for the new merged FQHC or RHC. The scope of services for the newly formed FQHC or RHC must be inclusive of the scope of services of the clinic organizations participating in the merger or acquisition.

Change in Scope of Services

If a FQHC or RHC has a change in the scope of services provided, resulting in a medical or dental rate change greater than plus or minus 2.5 percent, the DHS Payment Policy staff will adjust the PPS or APM IV rates. The FQHC or RHC must do the following:

- Complete [Rate Adjustment for Scope of Service Change \(DHS-4561\) \(PDF\)](#)
- Provide historical and budgeted cost information showing the facility's expenses before and after the change in scope of services
- Provide the last two audited financial statements
- Provide the projected increase or decrease in the number of encounters due to the change
- Scan and email the completed DHS-4561 along with any necessary documents to the DHS Payment Policy Unit at: DHS.FQRHCrates@state.mn.us

If you have questions about this process, email DHS Rates Unit at DHS.FQRHCrates@state.mn.us

Some services do not require a face-to-face visit with a FQHC or RHC provider (for example, laboratory, x-ray, pharmacy) and may not affect the number of encounters.

Examples of changes in scope of services include adding or discontinuing one of the following:

- [Pharmacy services \(PDF\)](#)
- [Radiology services \(PDF\)](#)
- [Dental services \(PDF\)](#)

Examples of items that MHCP does not consider a change in scope of services include:

- Increase or decrease in expenses for salaries, benefits and supplies not directly related to a change in the scope of services
- Increase or decrease in facility overhead or administration expenses not directly related to a change in the scope of services

- Increase or decrease in assets not directly related to a change in the scope of services
- Expenditures for items covered by insurance not directly related to a change in the scope of services

Calculating Rate Adjustment for Change in Scope of Services

MHCP uses the same Medicare formula employed on the Form CMS-222 (in the [Medicare Provider Reimbursement Manual](#)) as modified for MA covered services, and used to establish PPS rates for Jan. 1, 2001, or APM IV rates for Jan. 1, 2021. It is necessary to identify the 1999 and 2000 costs used to calculate the PPS rate. For each year prior to the year of the change, the Medicare Economic Index (MEI) inflates these costs. DHS then adjusts the inflated costs for budgeted costs using the Medicare formula. The resulting increase or decrease in encounters, related to the change in scope of services determines the rate impact of the change. Since the costs are distributed among all of the encounters, in some instances the PPS/APM IV rate decreases. Detailed worksheets are available to enable FQHCs and RHCs to calculate the impact of a change in the scope of services. If a provider does not have a record of the costs used to establish their PPS or APM IV rate, DHS Payment Policy can provide a copy for them to establish a rate.

Adjustments to the clinic's PPS or APM IV rate for changes in the scope of services will be effective on the first day of the month following the change in scope of services. MHCP will conduct a "look back" after the new services have been in place for a year and will revise the rate according to the actual costs and encounters directly related to the change in scope of services. When determination of the revised rate is completed, MHCP will settle-up to the new rate by making retroactive adjustments for paid claims back to the effective date of the revised rate.

Rate Change Claim Adjustments

In the event of a PPS or APM rate change, MHCP will make retroactive adjustments for paid claims back to the effective date of the revised rate. MHCP adjusts FQHC or RHC paid claims through an individual claim adjustment process.

Appeal Final Rates

DHS notifies FQHCs and RHCs of final rates by submitting the rate notice to the organization's MN-ITS mailbox. Review the final rates within 60 days.

To dispute the final rates:

- File a written appeal within 60 days from the date MHCP sent the notice in the MN-ITS mailbox.
- List the disputed items, reasons for the disputes and the name and address of the contact person for the appeal.

Send the appeal to:

Department of Human Services
 FQHC/RHC Rates Specialist
 MN Department of Human Services
 P. O. Box 64984
 St. Paul, MN 55164-0984

- When an appeal is resolved, MHCP will reprocess claims with the correct adjusted rate.
- DHS cannot accept appeals filed after 60 days.
- If you do not file an appeal within 60 days, we reprocess the claims with the final rates.

Eligible Providers

Providers that meet the definition of a FQHC or RHC must enroll as a FQHC or RHC with MHCP to receive payment at the PPS or APM rate level. Providers who qualify may elect to enroll as another type of fee-for-service clinic provider, instead of electing FQHC or RHC status. See the [Enrollment](#) section of this manual for more information about enrolling.

Individual providers within the enrolled FQHC or RHC may include the following:

- Chiropractor
- Clinical psychologist
- Clinical social worker
- Dentist
- Nurse practitioner
- Nurse midwife
- Physician
- Advanced dental therapist
- Dental therapists
- Physician assistant
- Qualified [mental health professionals](#)

FQHC and RHC providers who provide substance use disorder (SUD) services must first enroll following the [SUD Services Enrollment Criteria and Forms](#).

Covered Services

MHCP covers one medical and one dental encounter per day for federally funded MA members. A medical encounter and a dental encounter can occur on the same day. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

MHCP covered services descriptions

Services	Description
Dental services	Provide in compliance with dental service guidelines
Drugs and biologicals	Incidental to a FQHC or RHC professional service only if they cannot be self-administered
FQHC or RHC professional services inpatient visits	Services provided to FQHC or RHC patients if covering inpatient hospital visits
FQHC or RHC surgical services	Provided to FQHC or RHC patients if surgical services are directly provided by the center or clinic
RN or LPN part-time or intermittent nursing care	In an area in which a shortage of home health agencies exists, part-time or intermittent nursing care by a registered nurse or licensed practical nurse to a homebound person under a written plan of treatment, either established and reviewed by a physician every 60 days or established by a nurse practitioner or physician assistant and reviewed at least every 60 days by a supervising physician.
Mental health	Provided in compliance with mental health guidelines
Obstetrical or perinatal	Provided by a FQHC or RHC professional in compliance with medical service guidelines
Pharmaceuticals	Provided by a FQHC or RHC in compliance with pharmacy guidelines

Services and supplies	Incidental to FQHC or RHC professional services; covered by the encounter rate if they are: <ul style="list-style-type: none"> • Of a type commonly furnished in physicians' offices • Of a type commonly rendered either without charge or included in the bill • Furnished as an incidental, although integral, part of a physician's professional services Furnished under the direct, personal supervision of a physician • Provided by a member of the clinic's health care staff who is an employee of the clinic
SUD Services	FQHC and RHC's must have a 245G Substance Use Disorder treatment license in order to provide non-residential treatment services including individual and group therapy, comprehensive assessments, treatment coordination and peer recovery support. Obtain licensure and then refer to Substance Use Disorder (SUD) services Enrollment Criteria and Forms for MHCP enrollment and substance use disorder services guidelines for additional information on coverage.
Vaccines	Incidental to FQHC or RHC professional services. Please review the Immunizations and Vaccinations manual

In addition, MA coverage of services furnished by a FQHC or RHC includes all other ambulatory services covered under the Minnesota State Plan that are furnished by the FQHC or RHC. Non-dental ambulatory services are part of the medical encounters and are included in developing the medical encounter payment rate for both PPS and Minnesota's APMs.

RHC must directly provide routine diagnostic and lab services. RHC must provide these lab tests on site in accordance with [Code of Federal Regulations](#); stick or tablet chemical urine or both, hemoglobin or hematocrit, blood sugar, occult blood stool specimens exam, pregnancy tests and primary culturing to send to a certified lab. The cost of the routine diagnostic and lab services are included in the RHC encounter rate.

Noncovered Services

If MHCP does not cover a service for other service areas, it will also not cover it as a FQHC or RHC service.

Billing

Current billing procedure: To comply with [electronic transaction requirements](#) to create uniform electronic health care billing standards, MHCP requires FQHC and RHCs to use the following guidelines when billing:

- Bill medical claims using the [837P \(Professional\)](#) claim format
- Bill dental claims using the [837D \(Dental\)](#) claim format and include tooth number, quadrant or surface as appropriate
- Use the corresponding enumerated NPI assigned to the FQHC or RHC location and service to bill all MHCP services
- Use the NPI of the rendering provider

- For billing MHCP: Follow all frequency guidelines and request for [authorization](#) requirements
- For billing MCO's: Refer to [MCO](#) frequency guidelines and request for authorization requirements
- Enter time units according to the requirements for the services provided
- Report applicable modifiers

Note: the above claim format instructions do not apply to Medicare crossover claims.

FQHC and RHC Medicare crossover claims for non-MCO enrollees

MHCP will deny FQHC and RHC Medicare-denied (for non-coverage) 837I crossover claims with remark code N34. FQHCs and RHCs must resubmit 837I Medicare-denied crossover claims using the [837P](#) format.

Electronic Claim Attachments

Review the [FQHC Major Program Billing](#) and [RHC Major Program Billing](#) tables to determine where to submit claims.

- For submitting claims to MHCP that require a claim attachment, follow the MHCP [electronic claim attachment process](#).
- For submitting claims to an MCO that require a claim attachment, contact the appropriate [MCO](#) to determine their process for submitting claim attachments.
- For submitting claims to an MCO following the [Managed Care Organization \(MCO\) Contracts - FQHC/RHC Carve-Out Process](#), MHCP may require a claim attachment for some services that the MCO does not. In these instances follow:
 - Step 1: Submit the claim directly to the MCO.
 - Step 2: Fax a copy of the claim attachment to MHCP following the MHCP [electronic claim attachment](#) process, but skipping step 5.

FQHC Major Program Billing

Major Program	Billing Submission	Payment Received
Medical Assistance: FP, MA, NM, RM, EH	Bill to MHCP, even if there is an MCO	MHCP Encounter if face-to-face*
MinnesotaCare: BB, FF, LL, XX	Bill to MCO, when there is an MCO	MCO FFS
MinnesotaCare: BB, FF, LL, XX	Bill to MHCP, when there is no MCO	MHCP FFS
Institution for Mental Disease: IM	Bill to MHCP	MHCP FFS
Substance Use Disorder: OO	Bill to MHCP	Behavioral Health Fund. State funded for Substance Use Disorder (SUD) service only. See SUD Rate grid .

RHC Major Program Billing

Major Program	Billing Submission	Payment Received
Medical Assistance: FP, MA, NM, RM, EH	Bill to MCO, then MCO will cross-over claim to MHCP	MHCP Encounter if face-to-face*
Medical Assistance: FP, MA, NM, RM, EH	Bill to MHCP, when there is no MCO	MHCP Encounter if face-to-face*
MinnesotaCare: BB, FF, LL, XX	Bill to MCO	MCO Fee-for-Service (FFS)

MinnesotaCare: BB, FF, LL, XX	Bill to MHCP, when there is no MCO	MHCP FFS
Institution for Mental Disease: IM	Bill to MHCP	MHCP FFS
Substance Use Disorder: OO	Bill to MHCP	Behavioral Health Fund. State funded for Substance Use Disorder (SUD) service only. See SUD Rate grid .

*face-to-face service includes [Telehealth Services](#) provided by an [eligible provider](#)

Effective Jan. 1, 2025, audio-only communication will end as part of a face-to-face encounter [payment methodology](#).

Managed Care Organization (MCO) Contracts – FQHC/RHC Carve-Out Process

RHC claim submission for MCO-enrolled members on MA

RHCs submit claims for MCO enrollees to the MCO and the MCO submits payable claim lines to MHCP for payment:

- The RHC submits 837P or 837D to the MCO using MCO member identification number
- The MCO will adjudicate the claim and determine payable and denied claim lines (each service on a claim)
- The MCO will issue a Remittance Advice (RA) to the provider for the following:
 - Payable claim lines the MCO pays at \$0
 - Denied claims or claim lines
 - Copay obligation information
- The MCO will submit payable lines to MHCP within seven days of the initial adjudication
- MHCP will process the payable lines the MCO submits using the MHCP claims adjudication process
- MHCP will pay the full encounter rate for qualifying services, without regard to the person's copay obligation as determined by the MCO.
- MHCP will zero pay claim lines for services that do not generate the RHC encounter rate.
- MHCP will deny claims or claim lines that do not pass applicable MHCP processing edits.
- MHCP will issue an RA to the provider, billing intermediaries and MCOs.
- Quarterly copay reconciliation includes the following:
 - MCO's must track copay obligations and report them to MHCP quarterly.
 - MHCP will create gross adjustments quarterly.
 - MHCP gross adjustments are set up to recoup the MCO reported copay obligation and will appear on the provider's remittance advice.

Contact the appropriate MCO with questions about a claim submitted to DHS by the MCO.

RHC void or replacement claim

When submitting void or replacement claims to the MCO, include the MHCP TCN (LOOP 2300/REF, F8 qualifier) if MHCP processed an original carve-out claim for the person and date of service.

Include the MCO internal control number (ICN) in the 837 header claim note L2300/NTE02, under the "situational claim information" section.

FQHC claim submission for MCO-enrolled members on MA

FQHCs submit their claims for MCO enrolled members on Medical Assistance (MA) directly to MHCP for payment. Carve out exclusions apply. All MHCP claim submission rules apply to the FQHC MCO carve-out process including prior authorization, benefit limits, copays and interpreter services.

FQHC and RHC MCO carve-out exclusions

Providers must bill claims for MCO-enrolled patients meeting these exclusions directly to the MCO. Medicare claims follow standard Medicare billing practice. The MCO handles final resolution and will not forward claims to DHS. This includes pharmacy claims. The only exception is that FQHC providers must submit dental claims for Medicare enrollees directly to MHCP.

- Claims in which a third-party liability (TPL) insurer paid the claim in full. MCOs will not forward claims to MHCP.
- Behavioral and Medical Health Care Home claim procedure codes S0280 and S0281. MCOs will continue to pay these claims directly to the provider.
- All MinnesotaCare member claims: major program BB, FF and LL claims. MCOs will pay these claims directly to the provider.

Fee-for-Service (FFS) Members and MCO Enrollees Dental Services

Dentures, partials and root canals

Refer to the following guidelines for denture, partial or root canal services:

- For appointments prior to the delivery of the denture or partial, use code D5899 and enter "Encounter in preparation for denture/partial" as the description.
- Bill the appropriate code for the denture or partial when the appliance is delivered to the patient.
- For all adjustment appointments after delivery of the appliance, use code D5899 and enter "Encounter for denture adjustment," as the description.
- When a root canal cannot be completed in one visit, use code D5899 and enter "Additional visit requiring professional" as the description for the first visit. Bill the appropriate code for the root canal procedure on the second visit when the root canal is completed.

Pharmacy Billing and Copays

RHC Pharmacy billing for MCO enrollees services

Submit claims to the MCO pharmacy. DHS includes pharmacy costs in the RHC rates, so MCO pharmacy claims will pay at \$0. The MCO point-of-sale transaction provides the FQHC or RHC copay information in real time. The MCO will track copays and process through quarterly reporting to MHCP. MHCP creates gross adjustments quarterly to recoup copays from the provider.

FQHC pharmacy billing for MCO enrollee services

Submit pharmacy claims to MHCP, unless patient meets a carve-out exclusion. DHS includes pharmacy costs in the FQHC rates, so pharmacy claims will pay at \$0. The MHCP point-of-sale transaction provides copay information in real time.

FFS pharmacy billing MHCP directly

Submit pharmacy services through point-of-sale (POS) to correctly identify and report pharmacy copays. DHS will provide pharmacy copay information to the pharmacist and will track the monthly copay obligation. Because pharmacy services are part of the medical encounter, MHCP does not make a separate pharmacy payment. MHCP will post reason code 89 with a cutback and adjust the claim amount to \$0. For MA payments to reflect the applicable pharmacy copays, recognition of copay amounts that apply to FQHC and RHC services will occur during the payment cycle in which the pharmacy service occurred. Collect copays at the time of the visit or bill the recipient according to office policy.

Maternity and Surgical Services: FFS and MCO Enrollees Services

Bill the MHCP encounter rate preoperative and postoperative care on the 837P using each pre- and postoperative date of service.

When providing the surgical procedure only, modify the surgical procedure code based on the procedure code description.

Examples:

- Procedure code 59409 states "vaginal delivery only"; therefore, the "54" modifier is not required
- Procedure code 38300 assumes the surgery and pre- or postoperative management; therefore, the "54" modifier is required

When providing the pre-operative or postoperative care only, submit E&M procedure codes that best describe the level of care. The preoperative and postoperative management modifiers are not required on E&M procedure codes.

Provider based RHC and freestanding RHC billing MHCP hospital services

RHC Professional fee on the 837P claim format:

- Pay-to-Provider = RHC NPI
- Place of service = 21, 22, 23

Hospital Facility fee on the 837I claim format:

- Pay-to-Provider = Hospital NPI

Hospital Ancillary Services

- Hospital Lab = Hospital NPI
- Hospital X-Ray = Hospital NPI

Hospital Pharmacy = Pharmacy NPI

Low-Level Services Provided by Mid to High-Level Practitioner

If a mid to high-level practitioner provides a low-level, non-encounter generating procedure, such as a dentist providing hygiene services or a physician providing an ultrasound, and the covered service requirements for MA or MinnesotaCare are met, the provider must indicate this as follows in order to receive payment at the PPS or APM rate level:

Claims submission procedure – dental

On the 837D, include the word "PROFESSIONAL" in upper case letters in the claim note field when the dentist has provided a lower-level service, like hygiene.

(For batch claims submission, claim note description is located in loop 2300, NTE02)

837D example: A dentist provides adult prophylaxis, D1110. Claim line 1 contains the CPT D1110. Claim notes: PROFESSIONAL

Claims submission procedure – medical

On the 837P, include the word "PROFESSIONAL" in upper case letters in the line note field for the service provided by the doctor.

(For batch claims submission, line note description is located in loop 2400, NTE02)

837P example: Doctor performs ultrasound, 76801. Claim line 3 contains the CPT 76801. Venipuncture, 36416, and Hemoglobin, 85014 CPTs are also included on this claim on line 1 and 2. Line level notes: PROFESSIONAL

Definitions

FQHC: A Federally Qualified Health Center (FQHC) is a facility that meets one of the following:

- Is receiving a grant under section 329, 330, or 340 of the Public Health Service (PHS) Act, or is receiving funding from such a grant under a contract with the member of such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the PHS Act
- Is based on the recommendation of the PHS, determined by the Centers for Medicare & Medicaid Services (CMS) to meet the requirements for receiving such a grant
- Was treated by CMS, for purposes of Medicare Part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990
- Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act

Rural Health Clinic: A Rural Health Clinic is a freestanding or provider-based facility certified under Code of Federal Regulations, title 42, part 491.

Dental encounter: Services provided during a dental visit by a dentist. Certain services provided by a dental therapist or advanced dental therapist also qualify.

Medical encounter: Services provided during a medical visit, including but not limited to the following:

- Professional services
- Obstetrical and perinatal care
- Clinic visits
- FQHC or RHC professional services provided to FQHC or RHC patients if covering inpatient hospital visits
- FQHC or RHC professional services provided to FQHC or RHC patients if surgical services are directly provided by the center or clinic
- Mental health visits provided in compliance with mental health guidelines

Provider-based facility: A clinic that is an integral part of a hospital, skilled nursing facility, or home health agency that is participating in Medicare and is used, governed, and supervised with other departments of the facility.

Legal References

[Minnesota Rules, 9505.0250 \(Clinic Services\)](#)

[Code of Federal Regulations, title 42, section 491 \(RHC\)](#)

[United States Code, title 42, section 1396d \(RHC\)](#)

[Code of Federal Regulations, title 42, section 491 \(FQHC\)](#)

[Social Security Act, title XIX, section 1905\(l\) \(FQHC & RHC\)](#)

[CMS Manual System, Change Request \(CR\) 4210 \(PDF\) \(FQHC & RHC\)](#)

[Minnesota Statutes, 256B.0625, subdivision 30 \(Other clinic services – FQHC & RHC Covered Services\)](#)