Federally Qualified Health Centers (FQHC)

PURPOSE

North Dakota Medicaid covers services provided by Federally Qualified Health Centers (FQHC) that are enrolled with Medicare and ND Medicaid.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Servicing providers acting as a locum tenens provider must enroll with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

The following FQHC services can be provided by the providers listed below.

Medical Encounter:

- Physician
- Physician Assistant
- Nurse Practitioner
- Certified Nurse-Midwife
- Visiting Nurse[1]
- Licensed Registered Dietitian
- Podiatrist
- Optometrist

Behavioral Health Encounter:

- Licensed Clinical Social Worker
- Licensed Master Social Worker
- Licensed Professional Counselor
- Licensed Professional Clinical Counselor
- Licensed Marriage and Family Therapist

[1] Visiting nurse services are skilled nursing services both reasonable and necessary to diagnose and treat a patient's medical condition per the determination of the primary care provider. The patient must be considered homebound, and services must be provided under a written treatment plan. Nursing care must be furnished by a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

- Licensed Psychologist
- Nurse Practitioner
- Licensed Addiction Counselor

Dental Encounter
- Dentist

Dental hygienist services rendered by hygienists working within their scope as allowed under North Dakota law, regulations, and practice guidelines, and under the appropriate level of dental supervision must be billed under the supervising dentist.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System by dialing 1.877.328.7098.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled with ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The Procedure Code Look-up Tool can be used to identify if a procedure code qualifies as an encounter.

Payment to FQHCs for covered services furnished to members is made by means of an all-inclusive rate for each encounter. FQHCs may furnish services that qualify as a medical, dental, or behavior health encounter. Each encounter includes services and supplies incident to the service.

Incident-to Services

If the only services rendered during a visit are "incident to" services, the visit does not qualify for claiming of an encounter. Services provided "incident to" are included in the encounter and cannot be billed separately (e.g. laboratory services, x-rays, and procedures performed during the visit).

Lab or x-ray services with no face-to-face visit with a qualifying provider are not reimbursed separately from the original encounter from which these tests or services were ordered.

Service Location

FQHC services can be rendered at one of the following locations:

- The FQHC,
- The member's residence, including skilled nursing facilities and assisted living facilities,
- Community-based locations including:
    - Homeless shelters;
    - Low-income housing units;
    - Schools; and
    - The scene of an accident.

FQHC services cannot be rendered at:

- An inpatient or outpatient hospital department, including a critical access hospital; or
- A facility with specific requirements precluding FQHC visits.

Limits

Face-to-face services with more than one health professional and/or multiple services with the same health professionals on the same day and at a single location constitute a single encounter.

Payment is limited to one medical visit, one dental visit, and one mental health visit a day except when a member suffers an illness or injury requiring additional diagnosis or treatment after the member's first encounter.

Medical nutritional therapy or a diabetes self-management training provided on the same day as a medical encounter is not eligible for a separate encounter. If medical nutritional therapy or diabetes self-management training is the only medical service provided, a medical encounter may be claimed. Diabetes self-management training may be provided by a registered nurse with a diabetic educator certification under supervision of a licensed practitioner. Bill diabetes self-management training rendered by a registered nurse under the supervising licensed practitioner's NPI.

Encounter rates may be generated by a hygienist for the following services:

- Dental prophylaxis (full mouth);

- Periodontal maintenance services (full mouth);
- Scaling and root planning (minimum of one quadrant);
- Dental screening and assessment if provided in addition to another qualifying service; and
- Sealants, if provided with another qualifying service, as part of the school-based sealant program.

Encounter rates cannot be generated when the only service rendered by a hygienist is:

- Impressions;
- Application of fluoride varnish;
- Denture cleanings;
- Suture removal;
- Dental case management; and/or
- Any type of oral hygiene instruction or education, including nutritional counseling and smoking cessation.

Immunizations

Immunizations administered in conjunction with a medical encounter are considered incident to the medical encounter and neither the immunization nor the immunization administration will be reimbursed in addition to a medical encounter.

When the only service provided is immunization:

- The immunization administration can be billed, but an encounter cannot be billed. The immunization administration must be billed using Revenue Code 0771 (immunization administration) along with the appropriate CPT® code. The claim must include Revenue Code 0636 (drugs requiring detailed coding) and the appropriate CPT® code for the immunization.
- If the immunization is supplied by the Vaccine for Children (VFC) program, ND Medicaid will not make payment for the immunization. ND Medicaid will only make payment for the immunization administration; however, the claim must include Revenue Code 0636 (drugs requiring detailed coding) and the appropriate CPT® code for the immunization. If the immunization is not supplied by the VFC program and is currently covered by ND Medicaid, the immunization will be reimbursed according to the Medicaid fee schedule using the appropriate CPT® code.

SERVICE AUTHORIZATION REQUIREMENTS

No service authorization required.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North 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 ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

Effective July 1, 2024, all FQHCs must report all services provided during the encounter visit on the claim. Services that do not generate an encounter payment must be submitted for quality reporting and informational purposes.

CLAIM FORM

FQHC services must be billed using the UB 04 claim form or 837i. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

CLAIM REQUIREMENTS

For each service, submit a separate claim line with the appropriate revenue code and procedure code along with the date of service. The provider must submit each claim line with their usual charges for the services.

Make sure to use the appropriate revenue code. For example, do not submit an immunization administration code with revenue code 0521. Immunization administration must be submitted with revenue code 0771.

When multiple encounters of the same encounter type – i.e. two medical or two behavioral health encounters are rendered on the same calendar day for separate diagnoses, report the second encounter with modifier 59.

Do not submit modifier 59 when the member has multiple encounters of differing encounter types.

Dental Claims (Prior to date of service 01/01/2026)

All dental encounter services must be submitted with revenue code 0512. Dental Case Management must be billed in addition to another qualifying dental service to receive reimbursement for the encounter.

Dental Claims (Date of service 01/01/2026 after)

All dental encounter claims billed with date of service 01/01/2026 or after must be submitted on an ADA (837d) claim form. Providers can use the Procedure Code Look up tool to verify covered dental services.

If the dental service requires an authorization, the authorization number is required on the claim.

When billing for more than one encounter type for a member on the same day, the facility must bill each encounter separately using the correct revenue code and the appropriate diagnosis codes on each claim.

Claims must be submitted using the following Revenue Codes when billing for:

Revenue Code **0512**	Dental Clinic
Revenue Code **0521**	Clinic Visit by Member to RHC/FQHC
Revenue Code **0522**	Home Visit by RHC/FQHC Practitioner
Revenue Code **0524**	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a skilled nursing facility (SNF)
Revenue Code **0525**	Visit by FQHC practitioner to a member in a SNF (not in a covered Part A stay) of NF or ICF/MR or other residential facility
Revenue Code **0529**	Behavioral Health

DEFINITIONS

Encounter - a face-to-face visit or synchronous telehealth visit during which a qualifying encounter service is rendered.

CONTACT

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POLICY UPDATES

October 2025

Section	Summary
	Format updates and clarifications added throughout.

January 2026

Section	Summary
Eligible Providers	Added LMSWs to eligible providers list.
Claim Requirements	Updates added