PROVIDER REIMBURSEMENT GUIDANCE			
Federally Qualified Health Centers & Community Health Center Billing (T1015)			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
02/10/2022	04/01/2022	04/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance © (CCA) reimburses for medically necessary all-inclusive clinic visits rendered in a Federally Qualified Health Center (FQHC) or Community Health Center (CHC).

HCPC Code T1015 identifies an all-inclusive clinic visit rendered in a FQHC or CHC.

BILLING AND CODING GUIDELINES:

Providers should bill using code T1015 along with the applicable CPT/HCPS codes to identify the service provided. HCPCS code T1015 will be reimbursed once per day, per member.

Providers must use the appropriate CPT and HCPCS codes with modifier 25 to bill for significant, separately identifiable evaluation and management services rendered by the provider on the day of the procedure. Providers may need to submit medical documentation with the claim. Refer to the Evaluation and Management Services Payment Policy for more information.

REIMBURSEMENT REQUIREMENTS:

Providers will be compensated based upon their contracted rate. The following services may be separately reimbursed when medically indicated and appropriately billed in addition to HCPC T1015:

- Radiology Services
- Laboratory Services
- Behavioral Health Services
- Pharmacy

CCA does not routinely provide separate reimbursement for the following services:

- Dental Services
- Preventative Visits (including well child)
- Women, infant and children services (WIC)
- Vaccine Administration
- Family Planning
- Wellness Services (tobacco cessation, nutritional counseling)
- School based services

PRIOR AUTHORIZATION/REFERRAL REQUIREMENTS:

Prior authorization is not required for FQHC and/or CHC clinic visits.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

Reimbursement is provided for all medically necessary covered services when the medical criteria and the guidelines for medical necessity are met. CCA reserves the right to request preauthorization or to complete a retrospective review of services provided. In some instances, medical records may be requested for determination of medical necessity. When medical records or clinical information is requested, all supporting documentation to support medical necessity should be included for clinical review.

REFERENCES:

CMS Website
CCA Website

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

POLICY TIMELINE DETAILS

1. Drafted November 2021 for CCA MAPD