

ForwardHealth **UPDATE**

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REVISED BILLING FOR TRIBAL FEDERALLY QUALIFIED HEALTH CENTERS

On January 1, 2024, ForwardHealth changed how it reimburses for services provided by Tribal federally qualified health centers (FQHCs). A Tribal FQHC is an outpatient health program or facility operated by a Tribe or Tribal organization receiving funds under the Indian Self-Determination Act (Public Law 93-638).

This ForwardHealth Update provides information about:

- [Prospective payment system \(PPS\) and all-inclusive rate \(AIR\) FQHC encounters.](#)
- [Reimbursement for encounters.](#)
- [Changes to provider enrollment.](#)
- [Submitting claims for Tribal FQHC encounters \(including information on the procedure code representing the encounter\).](#)
- [Coordination of benefits.](#)
- [Impact for managed care organizations \(MCOs\).](#)
- [Terms of reimbursement.](#)

AFFECTED PROGRAMS

BadgerCare Plus, Medicaid

TO

Tribal Federally Qualified Health Centers, Pharmacies, HMOs and Other Managed Care Programs

The information provided in this ForwardHealth Update is published in accordance with Wisconsin State Plan Amendment 24-0008.

ForwardHealth is not changing coverage of services or prior authorization (PA) requirements.

Prospective Payment System and All-Inclusive Rates for Tribal Federally Qualified Health Center Encounters

Beginning January 1, 2024, Wisconsin Tribal FQHCs could receive reimbursement for Medicaid-covered services through one of two options:

- PPS—ForwardHealth establishes a prospective encounter rate for each Tribal FQHC that reflects their estimated reasonable costs of providing care in accordance with the Benefits Improvement and Protection Act of 2000.
- AIR—Indian Health Services (IHS) calculates and publishes all-inclusive reimbursement rates each year in the [Federal Register](#). The rates are based on annual cost reports prepared by IHS's contractor.

ForwardHealth uses these reimbursement rates through the authority of the approved [Wisconsin State Plan Amendment 24-0008](#). The [Medicaid State Plan Attachment 4.19-B](#) has:

- Pharmacy information on page 5a.
- AIR information on pages 10.d.–10.h.

Each year, the Tribal FQHC may choose between the PPS or AIR as a reimbursement method.

ForwardHealth previously reimbursed Tribal FQHCs under either a cost-settlement process or a PPS rate. Under the cost-settlement process, ForwardHealth calculated a cost-based encounter rate for each Tribal FQHC that reflected the actual reasonable costs of providing services that they reported on an annual cost report. **ForwardHealth will no longer reimburse Tribal FQHCs under the cost-settlement process for services rendered on and after January 1, 2024.**

Reimbursement Based on Date of Service

ForwardHealth uses dates of service (DOS) to determine how to reimburse Tribal FQHCs for billed services.

- For services provided before January 1, 2024, Tribal FQHCs are reimbursed under the cost settlement process in effect before the AIR implementation. Tribal FQHCs should continue to submit their cost reports for services rendered before January 1, 2024.

THE KEY MESSAGE

On January 1, 2024, ForwardHealth changed how it reimburses for services provided by Tribal FQHCs. Each year, Tribal FQHCs may choose between the PPS or AIR as a reimbursement method.

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- For services provided on and after January 1, 2024, and the Tribal FQHC's payment model implementation date, Tribal FQHCs are reimbursed using either PPS rate or AIR. ForwardHealth will reconcile with each Tribal FQHC for services provided during this period.
- For DOS on or after the Tribal FQHC AIR or PPS implementation date, the Tribal FQHC must submit claims for services per the guidelines described in this ForwardHealth Update and will automatically be reimbursed at PPS rate or AIR through the claims processing system for each allowable encounter.

Billing Procedure Code

The Tribal FQHC PPS or AIR implementation date is the date when a Tribal FQHC became eligible for billing Healthcare Common Procedure Coding System (HCPCS) procedure code T1015 (Clinic visit/encounter, all inclusive) for eligible claims. **Billing providers must include HCPCS code T1015 on the claim along with a dental, mental health, or medical covered service code to receive their PPS rate or AIR for eligible encounters.**

Tribal FQHCs may email the Wisconsin Department of Health Services (DHS) Tribal FQHC inbox at DHSTRIBALFQHC@dhs.wisconsin.gov to find out when they can start submitting claims with HCPCS code T1015.

Refer to the [Dental Care](#) section of this Update for dental billing details.

Tribal Federally Qualified Health Center Encounter Reimbursement

Under PPS and AIR, ForwardHealth reimburses Tribal FQHCs for an encounter rate that includes all direct and indirect services provided to a member during an encounter.

ForwardHealth will apply PPS or AIR for the encounter type to a claim detail with HCPCS code T1015. All other payable claim details for direct and indirect services on the claim associated with the encounter will process in a paid status with a \$0 allowed amount.

ForwardHealth only reimburses Tribal FQHCs for covered services and does not reimburse providers for the cost of any Tribal FQHC activities and services that:

- Are not required by ForwardHealth.
- Are part of Tribal FQHC-related services included in state statute or administrative code.

CONTACT INFORMATION

DHS Tribal FQHC inbox:
DHSTRIBALFQHC@dhs.wisconsin.gov

All Tribal FQHC services reimbursed under PPS or AIR are exempt from member cost share and copay requirements.

Calculation of the Prospective Payment System Rate and All-Inclusive Rate

ForwardHealth calculates a separate PPS rate for each Tribal FQHC per the Benefits Improvement and Protection Act of 2000. At the end of each FQHC fiscal year, ForwardHealth adjusts the PPS rate using the FQHC market basket in effect at that time, which replaced the Medicare Economic Index in 2017. In addition, ForwardHealth may adjust a Tribal FQHC's PPS rate to account for changes in the FQHC's scope of service.

AIR will be reimbursed per the rate published annually in the Federal Register.

Choosing a Reimbursement Rate

A Tribal FQHC can choose between the PPS and AIR as their preferred reimbursement rate at the start of each calendar year using this information:

1. The Centers for Medicare & Medicaid Services will publish the market basket data and update the Federal Register for the upcoming year.
2. DHS will send a letter to the Tribal FQHC detailing the new rates for both PPS and AIR. DHS intends for Tribal FQHCs to receive these letters in December each year.
3. Tribal FQHCs must inform DHS of their chosen rate for the upcoming year within the timeline specified in the letter.

If a Tribal FQHC chooses their rate after January 1, non-pharmacy claims dating back to January 1 will be automatically adjusted to their chosen rate.

If the Tribal FQHC does not send a decision to DHS within the timeline detailed in the letter, DHS will apply the method the Tribal FQHC chose the previous year with the updated rates.

Reimbursement Guidelines

ForwardHealth reimburses a Tribal FQHC a maximum of one PPS rate or AIR per encounter type, per member, per DOS unless the member suffers an illness or injury after the first encounter that requires additional diagnosis or treatment on the same day.

When a Tribal FQHC member receives services of the same encounter type in a single day at more than one Tribal FQHC location (for example, the main clinic, an off-site clinic, or a contracted facility), ForwardHealth will reimburse

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a Tribal FQHC for only one encounter type per DOS—unless the additional encounter qualifies as a subsequent encounter.

Reimbursement for Dental Care

ForwardHealth will reimburse Tribal FQHCs an encounter rate for each allowed dental visit. A dental visit qualifies for PPS or AIR by meeting all defined program requirements:

- The rendering provider must be enrolled with Wisconsin Medicaid.
- The services provided must qualify as [direct services](#).
- The services provided must be [covered procedure codes](#).

ForwardHealth reimburses Tribal FQHCs for dental services requiring multiple visits when:

- The provider bills the procedure code, or base code, that represents the final prosthesis or dental service.
- Each additional visit that occurs before completing the final procedure is represented on the claim by an associated code.

Note: Not every base code requires an associated procedure code. Refer to the [Multiple Dental Visits](#) section of this Update for more information.

DHS requires a compliance review of each associated procedure code service when a base procedure code is not rendered or is denied (such as when the base procedure code does not meet program requirements for reimbursement). Provider reimbursement for the associated codes depends on DHS review.

Refer to the [Subsequent Encounters](#) section of this Update for instructions on submitting additional documentation for review.

Reimbursement for Services Provided by a Pharmacist

If the billing provider is a Tribal FQHC and the rendering provider is a pharmacist, then the Tribal FQHC may bill for covered medical services provided by the Tribal FQHC's pharmacist. However, because the pharmacist is providing medical services, the one payer per service per day rule still applies. Encounter counting logic for PPS rates or AIRs apply when all conditions are met for eligible encounters.

Services Not Included in the Prospective Payment System Rate and All-Inclusive Rate

Physician-administered drugs, telehealth distant site services, and certain pharmacy services are “carved out of” (not included in) PPS and AIR and are reimbursed separately.

Pharmacy Services

Some Tribal FQHCs provide pharmacy services and bill for them on a ForwardHealth compound or noncompound drug claim. An FQHC pharmacy provider must enroll as a separate Medicaid provider under the applicable pharmacy provider type and specialty. The pharmacy must have the same tax ID as the main service location of the associated Tribal FQHC. Compound drug claims are not eligible for AIRs.

If a Tribal FQHC adds pharmacy services to their practice, they may qualify for a change in scope that may increase their PPS rate.

The [Pharmacy Resources](#) page of the ForwardHealth Portal (the Portal) contains reference guides and quick links to other pharmacy resources.

Physician-Administered Drugs

Physician-administered drugs are drugs administered by a provider in an office setting. The [Physician-Administered Drugs Resources](#) page of the Portal contains a list of procedure codes classified as physician-administered drugs that may be reimbursed in addition to the PPS rate for a Tribal FQHC encounter. These services are subject to change and must meet all applicable ForwardHealth program requirements, including medical necessity, PA, claims submission, prescription requirements, and documentation requirements.

Refer to the ForwardHealth Online Handbook Physician-Administered Drug Claim Requirements topic [#4382](#) for more information.

Telehealth Services

ForwardHealth may reimburse for both synchronous services (two-way, real-time, interactive communications) and asynchronous services (information stored and forwarded to a provider for later review) identified under permanent policy when provided via telehealth (also known as telemedicine).

Telehealth services include “originating site” and/or “distant site” services.

- Originating site services are not eligible for PPS rates or AIRs.

QUICK LINKS

- [Physician-Administered Drugs Resources](#) page
- [Telehealth Policy #510](#)

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- Distant site services are counted as encounters and must meet PPS rate guidelines.

Refer to the [Telehealth Services](#) section of this Update for the definitions of originating and distant sites.

Tribal FQHC costs associated with telehealth or teledentistry services may be reported for change in scope adjustment consideration; therefore, telehealth and teledentistry service costs may be used for future rate-setting purposes.

Refer to the [Telehealth](#) chapter of the Tribal Federally Qualified Health Center service area of the Online Handbook, specifically the Telehealth Policy topic [#510](#), for more information.

Provider Enrollment for Tribal Federally Qualified Health Centers

To make sure an FQHC can submit dental or professional claims for any rendering provider, each rendering provider can be included in the Group Panel in the demographic maintenance tool. The provider may include the Tribal FQHC in the Group Member panel in the demographic maintenance tool if a rendering provider is associated with multiple clinics.

Tribal FQHCs may refer to the [ForwardHealth Portal Demographic Maintenance Tool User Guide \(PDF\)](#) or reach out to their [professional field representative](#) for guidance on making changes in the demographic maintenance tool.

Tribal Federally Qualified Health Center Main Service Location

ForwardHealth will automatically enroll new Tribal FQHC providers as the main Tribal FQHC service location.

Tribal Federally Qualified Health Center Off-Site Clinics

An “off-site clinic” is a Tribal FQHC’s delivery site that is:

- Not the Tribal FQHC’s main service location.
- Approved by the IHS for the provision of Tribal FQHC services.

Refer to the [IHS](#) website for more information.

A Tribal FQHC must separately enroll each of its off-site clinics as a Tribal FQHC provider type for billing and reimbursement purposes. Refer to the Federally Qualified Health Center section of the [Information for Specific Provider Types](#) enrollment page of the Portal for enrollment criteria.

QUICK LINKS

- [Assigned Professional Field Representatives by County \(PDF\) map](#)
- [Information for Specific Provider Types](#) enrollment page

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Non-Medicaid-enrolled Tribal FQHC off-site clinics are encouraged to begin the Tribal FQHC provider enrollment process as soon as possible. ForwardHealth will associate each new Tribal FQHC off-site clinic with the Tribal FQHC's main service location during the provider enrollment process.

Note: All Tribal FQHC off-site clinics must have the same tax ID as the associated Tribal FQHC main service location.

Tribal Federally Qualified Health Center Pharmacies

Providers should refer to Update [2026-02](#), "Tribal Federally Qualified Health Centers Can Bill Pharmacy Visits as Encounters," for information about reimbursement of Tribal FQHC pharmacy services.

Outstationed Enrollment Survey for Tribal Federally Qualified Health Centers

Following the end of the Tribal FQHC's fiscal year, the FQHC must complete a Federally Qualified Health Center Outstationed Enrollment Survey form, F-02758 (01/2021), and submit it to the Tribal FQHC inbox at DHSTRIBALFQHC@dhs.wisconsin.gov. A Tribal FQHC has 120 days to fill out this form after the end of their fiscal year.

This form can be found on the [Forms](#) page of the Portal.

Tribal Federally Qualified Health Center Outpatient Encounters

Per Wisconsin State Plan Amendment 24-0008, an encounter is a qualifying visit between a client and a qualified Medicaid Tribal FQHC provider who delivers a Medicaid-covered medical, dental, and/or behavioral ambulatory service on a single day at an approved Tribal FQHC location (including main and off-site locations) for a diagnosis, treatment, or preventative service. Only one medical, one dental, and one mental health encounter will be paid per member per day.

ForwardHealth considers a service as an encounter when it is:

- Performed in a Tribal FQHC location.
- Performed by a Tribal FQHC provider in a location such as:
 - Ambulatory surgery centers
 - Extended care facilities
 - Hospitals

QUICK LINKS

[Forms](#) page

RESOURCES

[Indian Health Services](#) website

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- Members' homes
- Mobile units
- Primary sites of rendering providers (dentists contracted to provide services at FQHCs)
- School visits

Refer to the [interactive maximum allowable fee schedule](#) for all allowable place of service (POS) codes.

All services provided as part of the Tribal FQHC encounter must meet all applicable ForwardHealth program requirements, including medical necessity, PA, claims submission, prescription requirements, and documentation requirements.

Each Tribal FQHC encounter is classified as either a medical, dental, or mental health encounter based on the provider type of the rendering provider.

Encounters include:

- Direct services—These are core services provided during the encounter. For example, preventive or routine office visits are direct services.
- Indirect services—These are supplies and/or diagnostic or therapeutic ancillary services that are delivered as part of the core service(s) provided during the encounter. Indirect services include radiology, laboratory tests, medical supplies, durable medical equipment, ancillary provider services, and professional dispensing fees.

When a Tribal FQHC member is referred to a provider, that provider may only submit a claim for a Tribal FQHC service or encounter if they are under contract with a Tribal FQHC **and** the Tribal FQHC pays for the service.

Indirect Services

Indirect services are Medicaid-covered services that support core services provided during the encounter, but they do not count as individual encounters on their own.

Costs of allowable indirect services are included as a portion of the total cost in the PPS and AIR-setting method. Refer to the Encounters topic #21958 for more information.

Indirect costs not allowed under cost-based reimbursement will also not be included in PPS or AIR.

QUICK LINKS

[Interactive maximum fee schedule](#)

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Note: An indirect service is always considered part of the encounter and is not reimbursed separately, even if it's provided on a different DOS or at a different location than the associated encounter.

Tribal Federally Qualified Health Center Pharmacy Encounters

Drugs dispensed by IHS and Tribal facilities will be reimbursed under one of two options. Tribal providers may choose how to receive payment for in-scope Tribal FQHC services under the Wisconsin Medicaid State Plan:

- Option 1 (PPS)—The PPS rate excludes the cost of drugs associated with Tribal FQHC pharmacy claiming and is reimbursed per the DHS [drug fee schedule](#). Tribal FQHCs will be reimbursed for actual acquisition costs (AACs) for drugs, and professional dispensing fees will be included in the Tribal FQHC encounter rates except for SeniorCare members.
- Option 2 (AIR)—Tribal FQHCs will be reimbursed at the IHS outpatient rate per the annual [Federal Register](#) notice. All Tribal FQHC facility pharmacies are paid the encounter rate by Wisconsin Medicaid regardless of their method of purchasing. Prescriptions dispensed by a Tribal 638 FQHC Pharmacy are reimbursed as a separate encounter for each prescription.

With either option, Tribal FQHCs will receive ingredient costs based on AACs plus the FQHC-specific professional dispensing fee of \$24.92 for SeniorCare members.

Claims Submission for Non-Pharmacy Services Provided by Tribal Federally Qualified Health Centers

Tribal FQHCs identify encounters on claims by using HCPCS procedure code T1015 for services rendered. ForwardHealth assigns the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider.

When Tribal FQHCs submit claims to ForwardHealth for Tribal FQHC encounters, they must:

- Submit claims on either a dental or professional claim form or the electronic equivalent (for example, American Dental Association [ADA] 2012 Claim Form, 1500 Health Insurance Claim Form, 837 Health Care Claim: Dental or Professional transaction), as applicable.
- Submit each encounter using HCPCS code T1015 in the first detail line. If a single claim is used to bill multiple encounter types (for example, a medical

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encounter and a dental encounter), the claim should include a separate detail with procedure code T1015 for each encounter per DOS.

- Enter procedure code T1015 on only one DOS for the detail(s) associated with one encounter type. **Note: Submitting one claim detail for services given over multiple consecutive days is not allowed and will result in a denied claim. The exception is for dentures when the upper and lower dentures are delivered to the member on the same DOS.**
- Understand that the billed amount for HCPCS code T1015 is not required to be the assigned PPS or AIR for each Tribal FQHC. Tribal FQHC providers may bill procedure code T1015 for any amount that they deem appropriate, including zero. The reimbursed amount for procedure code T1015 will be the Tribal FQHC's assigned PPS rate or AIR.
- List the diagnosis most applicable to the encounter type associated with procedure code T1015.
- Include separate details for all direct and indirect services rendered as part of the encounter in addition to billing procedure code T1015 for each encounter type. Tribal FQHCs should use the most appropriate procedure codes to represent direct and indirect services. Each detail should identify the provider who delivered the direct or indirect service as the rendering provider. These services should be billed with the applicable charges.
- Include at least one allowable direct service associated with the encounter with the same rendering provider as procedure code T1015. Claims not meeting these requirements will not have a PPS rate or AIR applied. Note: Indirect services alone, without an accompanying allowable direct service, are not encounters. Claims for such instances may not include procedure code T1015. The claim will be denied if procedure code T1015 is present with indirect services only, and all payable indirect services will process in a paid status with a \$0 allowed amount.
- List the provider who delivered the services during the encounter as the rendering provider for procedure code T1015. If multiple providers rendered services during a single encounter, the Tribal FQHC should use its judgment based on its reporting capabilities to identify which provider is the most appropriate to list as the rendering provider for procedure code T1015.

- Submit claims for Tribal FQHC services under the National Provider Identifier (NPI) of the Tribal FQHC based on the physical Tribal FQHC site where the service was provided. The appropriate billing provider will be determined by the location of the service.
 - Use the NPI of the Tribal FQHC main site as the billing provider for services provided at the Tribal FQHC's main service location.
 - Use the NPI of the Tribal FQHC off-site clinic as the billing provider for services provided at a Tribal FQHC off-site clinic.
 - Use the NPI of the Tribal FQHC main site as the billing provider for services provided at a location other than the Tribal FQHC's main service location or a Tribal FQHC off-site clinic (for example, at a primary site of an identified contracted clinician).
 - Use the NPI of the separate pharmacy as the billing provider if the service was provided at a Tribal FQHC pharmacy.

Direct and Indirect Dental Services

Services related to direct dental services are typically considered indirect services. For example, a radiograph (X-ray) may or may not be an indirect service depending on the procedure being performed. An X-ray taken as part of a comprehensive exam is considered a direct service, but an X-ray taken during a root canal procedure is considered an indirect service. An X-ray is not a billable procedure as an indirect service.

If an indirect service is the only service provided during a visit and the Tribal FQHC bills for that service as an encounter with HCPCS code T1015, the claim will deny. Instead, the Tribal FQHC should bill for the ancillary (indirect) service without HCPCS code T1015. Refer to the Ancillary Providers topic [#647](#) for more information. The claim detail for the ancillary service will process in a paid status with a \$0 allowed amount.

Tribal Federally Qualified Health Center Responsibilities

Tribal FQHCs are responsible for ensuring that an encounter is only counted once across all providers involved in that encounter. ForwardHealth pays up to one procedure code T1015 encounter for **each** encounter type (dental, medical, or mental health) per member per day. For a single DOS, a Tribal FQHC could bill up to three instances of HCPCS code T1015—one for each encounter type. Encounters are assigned an encounter type based on the rendering provider.

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Providers may not delay or split services across multiple DOS to bill additional encounters. These actions could result in a DHS Office of the Inspector General audit and/or investigation, which could lead to Department of Safety and Professional Services and Department of Justice referrals.

Providers must follow national coding standards and rules for their claim submissions. Billing providers are responsible for the accuracy and completeness of all claims submitted either by the provider or outside billing service or clearinghouse. Additionally, Wis. Admin. Code § [DHS 106.02\(9\)](#) indicates that a provider shall prepare and maintain truthful, accurate, complete, legible, and concise documentation and medical and financial records.

Contracted Provider or Facility

When a member receives services from a provider contracted with the Tribal FQHC, the contracted provider should be listed as the rendering provider on the claim. The billing provider (the Tribal FQHC) will submit the claim.

Subsequent Encounters

A subsequent encounter is a unique situation that is unplanned or not anticipated. For example, a member sees their provider in the morning for a medical condition and later that same day has a fall and returns to the Tribal FQHC. Subsequent encounters can be medical, dental, or mental health when the encounter satisfies the subsequent encounter requirements.

Typically, claims are denied if they indicate more than one encounter for a given encounter type for the same member, same Tribal FQHC organization, and same DOS. However, when an additional encounter represents a subsequent encounter, providers may resubmit the claim with these documents to ForwardHealth for review:

- The applicable clinical documentation supporting the subsequent encounter
- The Written Correspondence Inquiry form, F-01170 (07/2012), by mail

This form can be found on the [Forms](#) page of the Portal. On the Written Correspondence Inquiry form, providers should check the “Other” box in the Reason for Inquiry field in Section II (Claim/Adjustment in Question) and indicate “Request for review of medical necessity for subsequent encounter” in the space provided. Providers should follow the instructions on the form for submitting the claim, clinical documentation, and form to ForwardHealth.



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Providers should keep a copy of the claim, clinical documentation, and form for their records.

Telehealth Services

Tribal FQHCs may be both the originating site and distant site providers for telehealth services.

- An originating site is the member's location at the time the telehealth service is being delivered.
- The distant site is the location of the provider delivering the telehealth service.

Tribal FQHCs may only submit claims for qualified telehealth services.

Procedure codes for services allowed under permanent telehealth policy have POS codes 02 (Telehealth Provided Other than in Patient's Home) and 10 (Telehealth Provided in Patient's Home) listed as an allowable POS in the [fee schedules](#).

ForwardHealth assigns a PPS rate for an allowable encounter when Tribal FQHCs bill HCPCS code T1015 with a telehealth procedure code.

ForwardHealth includes services billed with these modifiers in PPS reimbursement:

- FQ (The service was furnished using audio-only communication technology)
- GT (Via interactive audio and video telecommunication systems)
- 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System)

Tribal FQHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) and a POS code that indicates where the member received the service.

Providers will not be reimbursed for originating site services under PPS or AIR methods if they use modifier GT with procedure code Q3014.

ForwardHealth does not separately reimburse Tribal FQHCs for originating site services because costs of providing originating site services are incorporated into Tribal FQHCs' PPS rates and AIRs. However, Tribal FQHC claims for originating site services may be used for future PPS rate-setting purposes, and

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Tribal FQHC costs associated with telehealth services may be reported for changes in scope adjustment consideration.

Teledentistry

On a claim form, dental providers must:

- Identify if the teledentistry encounter was either:
 - Synchronous with procedure code D9995 (Teledentistry synchronous; real-time encounter)
 - Asynchronous with procedure code D9996 (Teledentistry asynchronous; information stored and forwarded to dentist for subsequent review)
- Include the applicable evaluation procedure codes.

Refer to the Teledentistry Policy topic [#22637](#) for billing guidance.

Dental Care

PA Requirements

PA requirements for dental services have not changed. Tribal FQHC providers must submit PA requests as described in the Prior Authorization section of the [Dental](#) service area of the Online Handbook.

Providers must submit claims for multiple visits when an existing PA request's effective date spans dates before and after a Tribal FQHC is removed from T1015 exemption. Refer to the [Multiple Dental Visits](#) section of this Update to determine the appropriate associated procedure codes for DOS on and after a Tribal FQHC is removed from T1015 exemption.

Codes designated as associated codes do not require PA. ForwardHealth will deny a PA request submitted for associated codes.

Tribal FQHCs must indicate area of oral cavity codes on PA requests and claims for encounters on the same DOS for complete maxillary and mandibular dentures. As a reminder, the area of oral cavity codes are "01" for maxillary and "02" for mandibular. The claim will deny if the area of oral cavity code isn't indicated on both the PA request and the claim. HCPCS code T1015 is associated with this requirement, even though this code isn't required on the PA. Refer to the [Codes](#) chapter of the Dental service area for dentures procedure codes.

QUICK LINKS

Teledentistry Policy topic
[#22637](#)

QUICK LINKS

Claims Denial Adjustment/
Review Request topic [#22277](#)

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Base Codes and Associated Codes for Dental Services

Tribal FQHCs may be [reimbursed](#) for dental services requiring [multiple visits](#).

ForwardHealth considers base codes (dental procedure codes) and associated codes as direct services for PPS or AIR reimbursement purposes.

Providers should use these procedure codes as associated codes:

- D1999 (Unspecified preventive procedure, by report)—This procedure code is for preventive services that require additional visits. Coverage is limited to a maximum of 1 unit per member per preventive procedure.
- D2999 (Unspecified restorative procedure, by report)—This procedure code is for restorative services that require additional visits. Coverage is limited to a maximum of 1 allowable unit per member per restorative procedure.
- D3999 (Unspecified endodontic procedure, by report)—This procedure code is for endodontic services that require additional visits. Coverage is limited to a maximum of 1 allowable unit per member per endodontic procedure.
- D5899 (Unspecified removable prosthodontic procedure, by report)—This procedure code is for complete and partial denture services that require additional visits. Coverage is limited to a maximum of 4 allowable units per member per denture procedure.

Refer to [Attachment A](#) to this Update for examples of base codes and associated codes and allowable units for dental services requiring multiple visits.

Note: Providers are required to document the specific service(s) performed for each dental visit in the member's dental record.

Multiple Dental Visits

There may be situations where certain dental services require more than one face-to-face visit for completion of the service.

When billing for dental services that require additional visits, Tribal FQHCs must use the dental procedure codes listed in Attachment A. Tribal FQHCs must submit all face-to-face visits related to the dental service on a single claim on or after the date of completion or delivery.

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Tribal FQHCs must submit a single claim for the dental services requiring additional visits as follows:

- Include the base code and associated code(s) with their respective DOS as separate details.
- Include HCPCS code T1015, when applicable, for the base code and each associated code per the PPS and AIR claims submission guidelines.

If a provider would like consideration when a base code is not rendered or a claim is denied (such as when the base code does not meet program requirements for reimbursement), DHS will review each associated code service for compliance.

For example, if a patient stops coming to a dental office before the final denture is delivered, the dental provider can request to be reimbursed for the accrued lab services. Providers can submit a lab bill to ForwardHealth explaining why the final denture(s) wasn't delivered. If the provider has not submitted a claim for any dental steps yet, they may attach the lab bill to the claim when submitting it.

If the provider has submitted a claim with the dental steps, they may complete an Adjustment/Reconsideration Request form, F-13046 (02/2025), by checking the "Consultant review requested" box in Element 16, attaching the lab bill, and submitting it to:

BadgerCare Plus
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This form can be found on the [Forms](#) page of the Portal. Refer to the Claims Denial Adjustment/Review Request topic [#22277](#) for more information.

ForwardHealth will consider reimbursing providers for the lab fees on a case-by-case basis.

Refer to [Attachment B](#) for sample claims submission details for multiple visits.

Dental Services That Only Need Base Codes

The following types of codes do not need associated codes and can be used to represent the service once per DOS per member per provider:

- Denture repair codes



- Reline codes (excluding the six-month post-care period)
- Tooth re-implantation base codes

Dental Services and Face-to-Face Visits

A face-to-face visit is a direct, in-person interaction between a member and a provider that:

- Requires a condition and/or reason for payment.
- Results in the provider documenting why the encounter was necessary and what occurred during the encounter.

When billing for dental services that require additional visits, Tribal FQHCs must submit all face-to-face visits related to the dental service on a single claim on or after the date of completion or delivery using associated procedure codes.

Tribal FQHCs must submit a single claim for dental services requiring additional visits and include:

- The base code and associated code(s) with their respective DOS as separate details.
- HCPCS code T1015, when applicable, for the base code and each associated procedure code per PPS or AIR claims submission guidelines.
- Area of oral cavity codes for encounters (indicated by HCPCS code T1015) on the same DOS to provide complete maxillary and complete mandibular dentures. Note: Procedures that require an area of oral cavity code must be submitted on either the ADA 2006 Claim Form, the ADA 2012 Claim Form, or the ADA 2024 Claim Form.

ForwardHealth does not allow global billing under PPS reimbursement for dental services.

Note: ForwardHealth will deny a claim submitted with one claim detail for services given over multiple consecutive days.

Orthodontic and Prosthodontic Services

Tribal FQHCs providing orthodontic and prosthodontic dental services must submit claims for dental procedure codes per visit. ForwardHealth will reimburse Tribal FQHCs an encounter rate for each allowable face-to-face visit for dental services requiring more than one visit under PPS or AIR.

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Billing Timelines for Dental Services

For DOS between January 1, 2024, and the date a Tribal FQHC implemented the PPS or AIR reimbursement model, providers should not indicate the associated procedure code for additional dental visits. These visits will be accounted for under the cost-settlement process.

For DOS on and after the date in which a Tribal FQHC implemented the PPS or AIR reimbursement model, providers must indicate the associated procedure code for each additional dental visit as appropriate on a single claim with the base code and associated codes listed as separate details.

Obstetric Care

ForwardHealth offers providers two options for how and when to file claims for obstetric care:

- Tribal FQHCs will be reimbursed an encounter for each component for separate obstetric components that are billed as they are performed.
- Tribal FQHCs will be reimbursed for only one encounter for an appropriate global obstetric procedure code with the date of delivery as the DOS.

Carved-Out Services

Carved-out services (physician-administered drugs and telehealth distant site services) may be submitted on the same claim as the encounter. Carved-out services procedure codes will be reimbursed using fee-for-service reimbursement.

For example, if a member receives mental health and substance abuse services and also receives an injectable medication with a procedure code found on the [physician-administered drugs crosswalk](#), then the FQHC may submit the encounter with the mental health and substance abuse service procedure code to receive the PPS rate and the physician-administered drug code to receive the fee-for-service rate.

Information about carved-out services will be available in the Submission chapter of the Tribal Federally Qualified Health Centers service area on January 23, 2026.

Medicare Crossover Claims

A Medicare-crossover claim is a Medicare-allowed claim for a dual eligible or Qualified Medicare Beneficiary-Only member sent to ForwardHealth for

QUICK LINKS

[Physician-Administered Drugs
Crosswalk](#)

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payment of coinsurance, copay, and deductible corresponding with the fee schedule.

PPS and AIR reimbursement are carved out of (not included in) Medicare Crossover coverage. For Medicare Crossover claims, the total reimbursement for a Medicare Part B-covered service may not exceed the Medicare-allowed amount. This includes any amount paid by other health insurance sources, any copay or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid.

Therefore, Medicaid reimbursement for coinsurance or copay of a Medicare Part B-covered service is the lesser of:

- The **Medicare**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.
- The **Medicaid**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.

If a service is not allowable by Medicare or a claim is denied by Medicare, then PPS or AIR could be used. When submitting these claims, the billing provider must include the appropriate Medicare disclaimer code. Refer to the Medicare Disclaimer Codes topic [#688](#) for descriptions of the codes.

If the service is covered by Medicare, then the Tribal FQHC cannot use procedure code T1015.

Claim Submission for Pharmacy Encounters Provided by Tribal Federally Qualified Health Centers—All-Inclusive Rate Only

Refer to Update [2026-02](#) for pharmacy and Tribal FQHC information. Providers don't need to include HCPCS code T1015 on pharmacy encounters related to dispensed drugs. ForwardHealth only reimburses Tribal FQHCs for eligible drug encounters. Refer to the [Pharmacy](#) service area of the Online Handbook for billing information.

Coordination of Benefits for Tribal Federally Qualified Health Centers

Coordination of benefits is when a Medicaid-enrolled member also has other health and/or prescription coverage. The programs must determine their



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respective payment responsibilities (determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program. Refer to the Retroactive Enrollment topic [#280](#) for more information.

For services rendered between January 1, 2024, and the date when the Tribal FQHC implemented PPS or AIR reimbursement, all payments from commercial health insurance, per encounter type, will be deducted from PPS or AIR, per encounter type, through a reconciliation. For services rendered after a Tribal FQHC implemented the PPS or AIR model, payments from commercial insurance, per encounter type, will be deducted from PPS or AIR per encounter type authorized by ForwardHealth under HCPCS code T1015 up to the PPS rate or AIR.

Note: G0466–G0470 are Medicare codes for FQHC bundled services, similar to the T1015 code with Wisconsin Medicaid. ForwardHealth does not recognize the G-series for fee-for-service claims. However, when G-series codes are on Medicare crossover claims, ForwardHealth policy provides reimbursement for deductible copay and co-insurance. These codes should not be used in combination with HCPCS code T1015.

For Non-Tribal Members

If applicable, Tribal FQHCs must bill a non-Tribal member's commercial health insurance first with all appropriate procedure codes, including HCPCS procedure code T1015. After commercial health insurance has processed a claim, the Tribal FQHC may submit the claim to ForwardHealth using the same Current Dental Terminology, Current Procedural Terminology, or HCPCS procedure codes used on the commercial health insurance claim. Tribal FQHCs must indicate the appropriate other insurance information on the claim or include a completed [Explanation of Medical Benefits form](#), F-01234 (04/2018), if the claim was submitted on paper. Tribal FQHCs must submit the commercial health insurance information at the level it was processed by the commercial health insurance (header or detail level).

QUICK LINKS

[Forms](#) page

QUICK LINKS

Explanation of Medical Benefits Form Requirement topic [#18497](#)

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ForwardHealth will deduct all payments from commercial health insurance from the PPS or AIR per encounter type authorized under HCPCS code T1015.

For Tribal Members

For Tribal members who receive coverage from IHS, Wisconsin Medicaid and BadgerCare Plus are not the payer of last resort. Providers should ask members if they have coverage from these other governmental programs.

If a member has Tribal coverage and there is concern about billing Wisconsin Medicaid as the primary due to rejected claims, the provider should contact their field representative.

Managed Care Impact

Tribal FQHCs that contract with an MCO should continue to bill the MCO and will be reimbursed according to the MCO's current contract with ForwardHealth and the Tribal FQHC.

When services are provided to MCO members, Tribal FQHCs are not required to follow the PPS or AIR claim submission process outlined in this Update, including for services that are carved out of the MCO rate (such as most provider-administered drugs).

Tribal FQHCs should not include separate details with procedure code T1015 when submitting claims for MCO members to ForwardHealth.

ForwardHealth will make supplemental interim report payments (wraparound payments) according to a payment schedule agreed to by ForwardHealth and the Tribal FQHC. These payments will be made no more often than every four months for the difference between the amounts paid by the MCO and the Tribal FQHC's assigned PPS rate or AIR.

Terms of Reimbursement

ForwardHealth has revised the Tribal Federally Qualified Health Center Terms of Reimbursement, P-01655 (01/2026), to reflect the revised billing policy for Tribal FQHCs effective January 1, 2024.

Refer to [Attachment C](#) for the revised terms of reimbursement, which will be available on the Terms of Reimbursement and Information for Specific Provider

REVISED TERMS OF REIMBURSEMENT

Tribal Federally Qualified
Health Center Terms of
Reimbursement, P-01655
(01/2026)

The information provided in this ForwardHealth Update is published in accordance with Wisconsin State Plan Amendment 24-0008.

Types pages of the Provider Enrollment Information area of the Portal on January 23, 2026.

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § [DHS 106.02\(9\)](#). Providers are required to produce or submit documentation, or both, to DHS upon request. Per Wis. Stat. § [49.45\(3\)\(f\)](#), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

Information Regarding Managed Care Organizations

This Update applies to Tribal FQHC services that members receive on a fee-for-service basis and through BadgerCare Plus, Medicaid SSI, and other managed care programs. For information about managed care implementation of the updated policy, contact the appropriate MCO. MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The information provided in this ForwardHealth Update is published in accordance with Wisconsin State Plan Amendment 24-0008.

The ForwardHealth Update is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services within the Wisconsin Department of Health Services (DHS). The Wisconsin HIV Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health within DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

ATTACHMENT A

Examples of Base Dental and Associated Procedure Codes and Allowable Units

Examples of base dental and associated codes that qualify for additional reimbursement are listed in the following table.

BASE CODE	DESCRIPTION	ASSOCIATED CODE	DESCRIPTION	NOTES
D1510*	Space maintainer—fixed—unilateral—per quadrant	D1999	Unspecified preventive procedure, by report	<ul style="list-style-type: none"> • Maximum of two allowed visits/encounters • One base code, one associated code
D2791	Crown—full cast predominantly base metal	D2999	Unspecified restorative procedure, by report	<ul style="list-style-type: none"> • Maximum of two allowed visits/encounters • One base code, one associated code
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	D3999	Unspecified endodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of two allowed visits/encounters • One base code, one associated code
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	D3999	Unspecified endodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of two allowed visits/encounters • One base code, one associated code
D3330	Endodontic therapy, molar (excluding final restoration)	D3999	Unspecified endodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of two allowed visits/encounters • One base code, one associated code

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BASE CODE	DESCRIPTION	ASSOCIATED CODE	DESCRIPTION	NOTES
D5110	Complete denture—maxillary	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/encounters • One base code, four associated codes
D5120	Complete denture—mandibular	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/encounters • One base code, four associated codes
D5211	Maxillary partial denture—resin base (including retentive/clasping materials, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/encounters • One base code, four associated codes
D5212	Mandibular partial denture—resin base (including, retentive/clasping materials, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/encounters • One base code, four associated codes
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/encounters • One base code, four associated codes

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BASE CODE	DESCRIPTION	ASSOCIATED CODE	DESCRIPTION	NOTES
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/ encounters • One base code, four associated codes
D5225	Maxillary partial denture—flexible base (including retentive/ clasping materials, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/ encounters • One base code, four associated codes
D5226	Mandibular partial denture—flexible base (including retentive/ clasping materials, rests and teeth)	D5899	Unspecified removable prosthodontic procedure, by report	<ul style="list-style-type: none"> • Maximum of five allowed visits/ encounters • One base code, four associated codes

*When submitting claims for a member receiving maxillary complete denture services with procedure code D5110, claims should include the procedure codes listed in this table.

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ATTACHMENT B

Sample Claims Submission Details for Multiple Visits

APPOINTMENT	SERVICE DATE	CLAIM DETAIL	REIMBURSEMENT STRUCTURE (SUBJECT TO PROGRAM REQUIREMENTS)
First Appointment	05/01/2025	Detail 1: T1015	Prospective payment system (PPS) rate
	05/01/2025	Detail 2: D5899	\$0.00
Second Appointment	05/05/2025	Detail 3: T1015	PPS rate
	05/05/2025	Detail 4: D5899	\$0.00
Third Appointment	05/10/2025	Detail 5: T1015	PPS rate
	05/10/2025	Detail 6: D5899	\$0.00
Fourth Appointment	05/20/2025	Detail 7: T1015	PPS rate
	05/20/2025	Detail 8: D5899	\$0.00
Fifth Appointment	05/21/2025	Detail 9: T1015	No payable direct service
	05/21/2025	Detail 10: D5899	Exceeds unit limit for D5899 (0–4 units per member/per base code)
Sixth Appointment	06/05/2025	Detail 11: T1015	PPS rate
	06/05/2025	Detail 12: D5110	\$0.00

When submitting claims for a member receiving a crown with procedure code D2791 (Crown—full cast predominantly base metal), claims should include the procedure codes in this table.

APPOINTMENT	SERVICE DATE	CLAIM DETAIL	REIMBURSEMENT STRUCTURE (SUBJECT TO PROGRAM REQUIREMENTS)
First Appointment	05/01/2025	Detail 1: T1015	PPS rate
	05/01/2025	Detail 2: D2999	\$0.00
Second Appointment	05/05/2025	Detail 3: T1015	PPS rate
	05/05/2025	Detail 4: D2791	\$0.00

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ATTACHMENT C

Tribal Federally Qualified Health Center Terms of Reimbursement

(A copy of the Tribal Federally Qualified Health Center Terms of Reimbursement can be found on the following page.)

The information provided in this ForwardHealth Update is published in accordance with Wisconsin State Plan Amendment 24-0008.

TRIBAL FEDERALLY QUALIFIED HEALTH CENTER

TERMS OF REIMBURSEMENT

The Wisconsin Department of Health Services (DHS) will establish an encounter-specific reimbursement rate for all Tribal federally qualified health center (FQHC) covered services provided to Wisconsin Medicaid members eligible on the date of service (DOS). The encounter rate will reimburse eligible costs that are reasonable and related to the cost of furnishing Tribal FQHC services. Wisconsin Tribal FQHCs may choose to participate in the Medicaid program and receive reimbursement for Medicaid covered services under one of two options:

- Prospective Payment System (PPS)
- Alternative Payment Methodology—Indian Health Services (IHS) Office of Budget Management All-Inclusive Rate (AIR)

Tribal FQHC services are defined as the services described in the Rural Health Clinic Act and any other ambulatory service included in a state's Medicaid plan that are provided to Medicaid members. Such costs cannot exceed the reasonable costs as determined by applicable Medicare cost reimbursement principles set forth in 42 C.F.R. Part 413 and Health Insurance Manual 15 and any additional mandated regulations when published as final rule in the Federal Register. PPS or AIR reimbursement to Tribal FQHCs will be made per the terms of reimbursement for the certified performing provider. Initial fee-for-service reimbursement to Tribal FQHCs will be made per the terms of reimbursement for HMO and crossover claims. In the case of any Tribal FQHC that contracts with a managed care organization, supplemental wrap-around payments will be made pursuant to a payment schedule agreed to by the State and the Tribal FQHC, but in no case less frequently than every four months, for the difference between the payment amounts paid by the managed care organization, not including financial or quality incentive payments and the amount to which the center is entitled under the PPS rate or AIR.

Under both PPS and AIR, an encounter is defined as a face-to-face contact for the provision of medical services between a clinic patient and any Medicaid-enrolled professional whose services are covered under this benefit. Contacts with more than one health professional and multiple contacts with the same health professional that take place on the same day at a single location constitute a single encounter unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. The Medicare-allowable costs of administration, laboratory, X-ray, and pharmacy services and services provided by the health professionals not eligible for Medicaid enrollment but covered under this benefit are included in the encounter rate. Upon final annual reconciliation, DHS will reimburse the provider 100% of the provider's allowed maximum encounter rate based on DHS's Tribal FQHC reimbursement policy.

DHS will reimburse the following drugs with the reimbursement methodology described, as the drugs are not required to meet the average acquisition cost (AAC) definition at 42 C.F.R. § 447.512.

Drugs dispensed by IHS/Tribal facilities will be reimbursed under one of two options, determined by how the Tribal provider elects to pay for in-scope FQHC services under the Tribal Federally Qualified Health Centers Reimbursement Methodology described beginning on page 10.d of Attachment 4.19B of the State Plan:

- Option 1 (PPS)—Tribal FQHCs will be reimbursed for AAC for drug costs, and professional dispensing fees will be included in the Tribal FQHC encounter rates except for SeniorCare members. For SeniorCare members, Tribal FQHCs will receive ingredient cost based on AAC plus the FQHC-specific professional dispensing fee of \$24.92.

- Option 2 (AIR)—Tribal FQHCs will be reimbursed at the IHS outpatient rate in accordance with the annual Federal Register Notice. All Tribal FQHC facility pharmacies are paid the encounter rate by Wisconsin Medicaid regardless of their method of purchasing.

Tribal FQHC providers who chose AIR reimbursement must continue to submit pharmacy claims using existing billing submission requirements.

Covered non-drug items submitted on noncompound drug claims, such as diabetic supplies and over-the-counter COVID-19 test kits, are not included in AIR reimbursement.

Only Tribal FQHC services are eligible for PPS or AIR reimbursement. Medicaid-covered services that are not considered Tribal FQHC services, including Medicaid services in which the cost and the liability for the services is not assumed by the Tribal FQHC and other services defined in the Tribal Federally Qualified Health Center service area of the Online Handbook, may be eligible for fee-for-service Medicaid or HMO reimbursement.

ForwardHealth reimburses a Tribal FQHC a maximum of one PPS rate or AIR per encounter type, per member, per DOS unless the member, subsequent to the first encounter, is in a unique situation that cannot be planned or anticipated. Drug encounters qualify only when the Tribal FQHC selects the AIR methodology.

ForwardHealth will reconcile outstationed enrollment expenditures incurred during the fiscal year such that Medicaid payments associated with outstationed enrollment will equal 100% of Tribal FQHC allowable outstationed enrollment expenditures.

Tribal FQHC reimbursement for services shall not be made in the absence of a signed Medicaid provider agreement for the Tribal FQHC and shall be determined by DHS pursuant to the State Plan for Title XIX Reimbursement effective April 1, 1990, for Tribal FQHCs identified by the federal Department of Health and Human Services as eligible on that date or as may be amended. Medicaid reimbursement, less appropriate copay and payments by other insurers, will be considered to be payment in full.

DHS will adjust payments made to providers to reflect the amounts of any allowable copays that the providers are required to collect pursuant to Wis. Stat. ch. [49](#). Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Wis. Stat. § [49.46\(2\)\(c\)](#).

In accordance with federal regulations contained in 42 C.F.R. § 447.205, DHS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting encounter rates for services.

P-01655 (01/2026)



Wisconsin
Department of Health Services