



Connecticut interChange MMIS

Provider Manual

Chapter 7 - Federally Qualified Health Centers

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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Federally Qualified Health Centers Regulation/Policy
Chapter 7

This section of the Provider Manual contains the Medical Services Policy and Regulations of Connecticut State Agencies pertaining to federally qualified health centers.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Federally Qualified
Health Centers

Requirements for Payment of Federally Qualified Health Centers

Requirements for the Payment of Federally Qualified Health Centers. Sec.17b-262-994 through Sec. 17b-262-1005 of the Regulations of Connecticut State Agencies

Requirements for Payment of Federally Qualified Health Centers

Sec. 17b-262-994. Scope

Sections 17b-262-994 to 17b-262-1004, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment to federally qualified health centers for services provided to clients who are eligible to receive such services under Medicaid pursuant to section 17b-261 of the Connecticut General Statutes. Federally qualified health centers shall be reimbursed in accordance with the Medicaid prospective payment system under 42 USC 1396a (bb).

Sec. 17b-262-995. Definitions

As used in section 17b-262-994 to section 17b-262-1004, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Advanced practice registered nurse" or "APRN" means a person licensed under section 20-94a of the Connecticut General Statutes;
- (2) "Allied health professional" or "AHP" means:
 - (A) A licensed or certified practitioner performing within his or her scope of practice in any of the professional and occupational license or certification categories in Chapters 376b, 378, 379a, 383a, 383c, and 384b of the Connecticut General Statutes and shall include alcohol and drug counselors, certified dietitians, certified nutritionists, dental hygienists, marital and family therapists, professional counselors, and registered nurses;
 - (B) A licensed master social worker working under the professional supervision of a physician, APRN, psychologist, licensed marital and family therapist, LCSW or a licensed professional counselor in accordance with section 20-195m of the Connecticut General Statutes; and
 - (C) A license-eligible individual as defined in subdivision (30) of this section;
- (3) "Baseline encounter rate" means the encounter rate calculated for the initial or first year under the prospective payment system;
- (4) "Behavioral health encounter" means an encounter between a client and a practitioner listed in subdivision (5) of this section for the provision of covered behavioral health services;
- (5) "Behavioral health service" means a preventive, diagnostic, therapeutic, rehabilitative or palliative item or service provided by:

- (A) A physician, psychiatric APRN, psychologist or LCSW acting within the practitioner’s scope of practice as defined in chapters 370, 378, 383 and 383b of the Connecticut General Statutes;
- (B) An alcohol and drug counselor, licensed master social worker, marital and family therapist or professional counselor acting within the practitioner's scope of practice, as defined in title 20 of the Connecticut General Statutes; or
- (C) An unlicensed or non-certified individual, who is otherwise qualified to perform services under the applicable licensure category sections of the Regulations of Connecticut State Agencies, working under the direct supervision of a licensed AHP. Supervision of unlicensed or non-certified individuals shall be provided in accordance with sections 20-74s, 20-195c, 20-195m, 20-195n and 20-195dd of the Connecticut General Statutes;
- (6) “Certified dietitian” or “certified nutritionist” means a person certified as a dietitian or nutritionist pursuant to section 20-206n or 20-206o of the Connecticut General Statutes;
- (7) “Change in the scope of service” means a change in the type, intensity, duration or amount of services provided by a FQHC. A change in the cost of the service alone is not considered a change in the scope of service;
- (8) “Chiropractor” means a person licensed pursuant to section 20-27 of the Connecticut General Statutes;
- (9) “Chiropractic services” means the services described in 42 CFR 440.60 and subdivision (1) of section 20-24 of the Connecticut General Statutes;
- (10) “Client” means a person eligible for goods or services under Medicaid;
- (11) “Clinical psychologist” means a person licensed pursuant to sections 20-188 and 20-190 of the Connecticut General Statutes;
- (12) “CMS-1500” means the official standard Medicare and Medicaid health insurance claim form required by the Center for Medicare and Medicaid services of the United States Department of Health and Human Services;
- (13) “Commissioner” means the commissioner of Social Services or the commissioner’s designee;
- (14) “Dental encounter” means an encounter between a client and a dentist or dental hygienist for the provision of covered dental services;
- (15) “Dental hygienist” means a person licensed pursuant to section 20-126j of the Connecticut General Statutes;

- (16) “Dental service” means any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a dentist;
- (17) “Dentist” means a person licensed pursuant to Chapter 379 of the Connecticut General Statutes;
- (18) “Department” or “DSS” means the Department of Social Services or its agent;
- (19) “Dietetic services” means services provided by a certified dietitian or certified nutritionist for the management of a person’s nutritional needs, including the evaluation and monitoring of nutritional status, nutrition counseling, dietetic therapy, dietetic education, and dietetic research necessary for the management of a recipient’s nutritional needs;
- (20) “Early and Periodic Screening, Diagnostic and Treatment Services” or “EPSDT services” means the services provided in accordance with the requirements of 42 USC 1396a (a) (43), 42 USC 1396d (r) and 42 USC 1396d (a) (4) (B) and implementing federal regulations found in 42 CFR 441, Subpart B and section 17b-261 (j) of the Connecticut General Statutes;
- (21) “Early and Periodic Screening, Diagnostic and Treatment Special Services” or “EPSDT Special Services” means services provided in accordance with 42 USC 1396d (r) (5), as amended from time to time;
- (22) “Encounter” means a face-to-face visit between a client and health professional or an allied health professional for medically necessary services and includes the client’s visit to the FQHC and all services and supplies incidental to the health professional’s services. Visits with more than one health professional or allied health professional or multiple visits with the same health professional or allied health professional that take place on the same day shall be considered one encounter, except under either of the following circumstances:
- (A) A client, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment; or
- (B) A client has different types of encounters (medical, behavioral health and dental) for different diagnoses on the same day;
- (23) “Encounter rate” means the all-inclusive PPS rate that the Department reimburses a FQHC for an encounter pursuant to 42 USC 1396a (bb);
- (24) “Federally qualified health center” or “FQHC” has the same meaning as provided in 42 USC 1396d (l) (2) (B);

- (25) “Healthcare common procedure coding system” or “HCPCS” means the set of health care procedure codes based on the American Medical Association’s current procedural terminology;
- (26) “Health professional” means a physician, physician assistant, advanced practice registered nurse, nurse midwife, chiropractor, ophthalmologist, optometrist, podiatrist, dentist, clinical psychologist, licensed clinical social worker or psychiatrist;
- (27) “Health Resources and Services Administration” or “HRSA” means the division of the U.S. Department of Health and Human Services that approves grant awards to and scope of projects for FQHCs;
- (28) “Licensed clinical social worker” or “LCSW” means a person licensed pursuant to section 20-195n of the Connecticut General Statutes;
- (29) “Licensed master social worker” or “LMSW” means a person licensed pursuant to 20-195n of the Connecticut General Statutes;
- (30) “License-eligible” means a person whose education, training, skills and experience satisfy the criteria, including accumulation of all supervised service hours, for any of the professional and occupational license or certification categories in Chapters 370, 376b, 379a, 383, 383a, 383b and 383c of the Connecticut General Statutes, and has applied for but not yet passed the licensure exam;
- (31) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;
- (32) “Medical encounter” means an encounter between a client and a health professional or an allied health professional for the provision of covered medical services;
- (33) “Medical service” means a preventive or diagnostic service provided by a physician, physician assistant, advanced practice registered nurse or nurse midwife for the treatment of an illness or injury;
- (34) “Medically necessary” and “medical necessity” have the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- (35) “Nurse midwife” means a person licensed under section 20-86c of the Connecticut General Statutes;
- (36) "Ophthalmologist" means a physician licensed pursuant to chapter 370 of the Connecticut General Statutes, who within his or her scope of practice as defined by state law, specializes in the branch of medicine dealing with the structure, functions, pathology, and treatment of the eyes;

- (37) "Optometrist" means a person licensed pursuant to Chapter 380 of the Connecticut General Statutes to practice optometry as delineated in subdivisions (1), (2) and (3) of subsection (a) of section 20-127 of the Connecticut General Statutes;
- (38) "Physician" means a person licensed pursuant to section 20-13 of the Connecticut General Statutes;
- (39) "Physician assistant" or "PA" means a person licensed pursuant to section 20-12b of the Connecticut General Statutes;
- (40) "Podiatric services" means services provided by a podiatrist within the scope of practice under Chapter 375 of the Connecticut General Statutes;
- (41) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to section 20-54 of the Connecticut General Statutes;
- (42) "Point-of-care testing" means medical testing at or near the site of patient care and includes, but is not limited to, blood glucose testing, blood gas and electrolyte analysis, rapid coagulation testing, rapid cardiac markers diagnostics, drugs-of-abuse screening, urine strips testing, pregnancy testing, fecal occult blood analysis, food pathogens screening, hemoglobin diagnostics, infectious disease testing and cholesterol screening;
- (43) "Prior authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;
- (44) "PPS" means the prospective payment system under 42 U.S.C. 1396a (bb);
- (45) "Registered Nurse" means a person licensed pursuant to section 20-93 of the Connecticut General Statutes;
- (46) "Registration" means the process of notifying the department of the initiation of a service, which includes providing information regarding the evaluation findings and plan of care;
- (47) "Routine foot care" means clipping or trimming of normal or mycotic toenails; debridement of the toenails that do not have onychogryposis or onychiauxis; shaving, paring, cutting or removal of keratoma, tyloma or heloma; and nondefinitive shaving or paring of plantar warts except for the cauterization of plantar warts;
- (48) "Scope of project" means the document that delineates the FQHC's approved service sites, services, providers, service area and target population for which grant funds have been approved by HRSA under section 330 of the Public Health Service Act;

(49) "Simple foot hygiene" means self-care including, but not limited to: observation and cleansing of the feet; use of skin creams to maintain skin tone of both ambulatory and bedridden patients; nail care not involving professional attention; and prevention and reduction of corns, calluses and warts by means other than cutting, surgery or instrumentation;

(50) "Systemic condition" means the presence of a metabolic, neurologic, or peripheral vascular disease, including, but not limited to, diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis and peripheral neuropathies involving the feet, which would justify coverage of routine foot care;

(51) "Under the direct supervision" means that a health professional or a licensed AHP:

(A) Provides weekly supervision of the work performed by unlicensed clinical staff or non-certified staff or individuals in training;

(B) Provides a minimum of monthly supervision for the work performed by certified staff; and

(C) Accepts primary responsibility for the health services performed by the unlicensed, certified or non-certified staff or individuals in training.

(52) "Under the professional supervision" has the same meaning as provided in section 20-195m of the Connecticut General Statutes.

Sec. 17b-262-996. Provider Participation

In order to participate in the Connecticut Medicaid program and provide FQHC services eligible for reimbursement from the department, each FQHC shall:

(1) Comply with all applicable state licensing requirements;

(2) Comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(3) Ensure that all health professionals and allied health professionals employed by or under contract arrangements with the FQHC to provide services meet all applicable federal and state licensing and certification requirements;

(4) Submit a copy of the FQHC's scope of project and any amendments to the scope of project in accordance with subsection (c) of section 17b-245d of the Connecticut General Statutes; and

(5) Submit a copy of the HRSA Notification of Grant Award Authorization of Public Health Service Funds.

Sec. 17b-262-997. Services Covered

(a) Covered core services for FQHCs include the following:

- (1) Medical services furnished by a physician, PA, APRN or nurse midwife. The services shall be within the scope of practice of his or her profession under state law. There shall be a written agreement between the FQHC and the physician, PA, APRN or nurse midwife, stating that he or she will be paid by the FQHC for such services; and
- (2) Services and supplies furnished as incident to professional services furnished by a physician, physician assistant, or advanced practice registered nurse.

(b) Covered noncore services for FQHCs are those services, other than core services, that include the following:

- (1) Behavioral health services;
- (2) Chiropractic services;
- (3) Dental services provided by a dentist or dental hygienist;

- (4) Dietetic or nutrition services when prescribed by a physician, PA, or APRN. Dietetic services are limited to clients whose disease or medical condition is caused or complicated by diet or nutritional status;
- (5) Podiatric services provided by a podiatrist, except for routine foot care, which is covered only when the client has a systemic condition and is limited to one treatment every 60 days;
- (6) Tobacco cessation counseling services; and
- (7) Vision care services provided by an ophthalmologist or optometrist.

Sec. 17b-262-998. Services Not Covered

The following services are not covered:

- (1) Services that are not covered in the Medicaid state plan;
- (2) Services that are not medically necessary;
- (3) Canceled services or appointments that are not kept;
- (4) Inpatient services, except as provided in section 17b-262-999 (d) (1);
- (5) Simple foot hygiene;
- (6) Any service requiring authorization or registration for which the provider did not obtain such authorization or registration;
- (7) Any procedures or services that are solely educational, social, research, recreational, experimental or generally not accepted by medical practice; or

(8) Visits for the sole purpose of obtaining or refilling a prescription, the need for which was previously determined.

Sec. 17b-262-999. Billable Services

(a) Billable services for FQHCs shall include core and noncore services identified in section 17b-262-997 of the Regulations of Connecticut State Agencies.

(b) Covered core and noncore services shall be billed on an encounter basis in accordance with section 17b-262-1002 and are subject to the following limitations:

(1) Billable encounters shall include encounters that:

(A) Take place at a service site approved by HRSA as part of a FQHC; or

(B) Take place in a patient's home for the purpose of providing services to FQHC patients; and

(C) Are documented in the patient health records.

(2) The services of a registered nurse may be billed as a medical encounter unless provided incident to a medical encounter as described in subsection (b)(3) of this section.

(3) Encounters with more than one health professional for the same type of service (e.g., a nurse and a physician provide a medical encounter) and multiple interactions with the same health professional that take place on the same day constitute a single encounter except when the patient, after the first interaction, suffers illness or injury requiring additional diagnosis and treatment.

(4) Tobacco cessation counseling shall be prescribed by a physician, physician's assistant, dentist or APRN and may be billed as a medical encounter, behavioral health encounter or dental encounter depending upon the type of health professional or allied health professional providing the service. The following health professionals may provide tobacco cessation counseling:

(A) Physicians;

(B) Physician assistants;

(C) APRNs;

(D) Dentists;

(E) Clinical Psychologists;

(F) LCSWs; and

(G) Allied health professionals.

(5) Group sessions prescribed by a health professional shall be billed as an encounter subject to the following limitations:

(A) All group sessions shall be limited to a maximum of twelve participants, shall be facilitated by a health professional or allied health professional practicing within his or her scope of practice and shall last at least 45 minutes; and

(B) The services provided in the session shall be documented in each client's health record if the FQHC bills the session as an individual encounter for each participant.

(6) Consultations with anyone other than the patient are not considered encounters, and are therefore not billable.

(c) The following services shall be included in the encounter rate and the FQHC shall not bill separately for these services:

(1) Services and supplies incidental to the services of a health professional or allied health professional when the services and supplies are:

(A) Of the type commonly furnished in a physician's office;

(B) Of a type commonly rendered either without charge or included in the FQHC's bill;

(C) Furnished as an incidental, although integral, part of the professional service; and

(D) Provided by FQHC employees under the direct supervision of a physician, clinical psychologist or licensed clinical social worker;

(2) Laboratory, point-of-care testing or radiology services provided in conjunction with a FQHC encounter and furnished by FQHC staff; and

(3) Transportation provided by the FQHC.

(d) The following services are not billable as a FQHC encounter. These services may be billed by the FQHC in accordance with the applicable Medicaid fee schedule:

(1) Inpatient hospital services;

(2) Delivery of a baby; and

(3) Outpatient surgery.

(e) The following services may be billed for by the provider of the services in accordance with the Medicaid fee schedule:

(1) Laboratory services beyond point of care testing that are referred to and performed by an independent laboratory; and

(2) The technical component of radiology tests that are referred to and performed by an independent radiologist.

(f) A FQHC shall not seek reimbursement for services provided under subsections (c) (d) and (e) of this section as a FQHC encounter. The non-FQHC services shall not be included in the overall costs of providing services at the FQHC.

Sec. 17b-262-1000. Prior Authorization Requirements

(a) In order to receive payment from the department, each FQHC shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met.

(b) The department shall designate services that require prior authorization or registration on the department's fee schedule, on the department's website or by other means accessible to providers with advance written notice to providers before establishing or amending such requirements. Registration may serve in lieu of prior authorization only if the department designates a service as requiring registration but not prior authorization. Prior authorization is also required for the following:

(1) Dental procedures or services that require prior authorization as set forth on the dental fee schedule;

(2) Chiropractic services in excess of 5 encounters per month;

(3) EPSDT Special Services; and

(4) Any procedure or service that is not listed on the department's medical clinic, behavioral health clinic or dental fee schedule as applicable.

(c) The provider shall attach a prescription from a physician, APRN or PA to all prior authorization requests for EPSDT Special Services. The provider may attach a physical or electronic copy of the prescription from the licensed practitioner to the prior authorization request in lieu of the actual signature of the licensed practitioner on the prior authorization request form. The provider shall keep the original prescription on file and subject to the department's review.

(d) The length of the initial prior authorization or registration period shall be for no longer than three months except as follows:

(1) For longer periods as determined by the department on a case-by-case basis; and

(2) For up to one year for routine psychotherapy.

(e) If the client needs a service beyond the initial authorization period, the provider may request authorization to continue services for up to six additional months of continued treatment per request.

(f) If the department denies a request for prior authorization for continuation of services, the recipient may request an administrative hearing in accordance with section 17b-60 of the Connecticut General Statutes.

Sec. 17b-262-1001. Change in Scope of Services

(a) Each FQHC shall notify the department of any increase or decrease in the scope of services provided by the FQHC in accordance with section 17b-245d of the Connecticut General Statutes. If the FQHC seeks an adjustment to its encounter rate based on the change in scope of services, the FQHC shall submit a written request to the department in accordance with subsection (c) of this section.

(b) Examples of changes in scope of services by a FQHC for which the department may adjust the encounter rate include, but are not limited to, the following:

(1) A change in the volume or amount of services as a result of a significant expansion or reduction of an existing clinic, or the addition or discontinuance of a satellite or new site;

(2) A change in operational costs that is attributable to capital expenditures, including new service facilities or regulatory compliance, provided that the additional costs result in a change in the volume, amount, or intensity of services. The cost of a new or expanded building alone would not necessarily qualify;

(3) The addition or deletion of any Medicaid covered service eligible under the FQHC reimbursement program;

(4) A change in the operational costs attributable to changes in technology or medical practices at the FQHC;

(5) A change of costs due to recurring taxes, malpractice insurance premiums, or workers' compensation premiums that were not recognized and included in the PPS baseline calculation;

(6) A change in federal or state regulatory requirements that would impact FQHC costs; or

(7) A HRSA-approved change in the scope of project, provided that the change is consistent with federal and state Medicaid regulations.

(c) In the event of a change in scope of service for which a FQHC seeks a rate adjustment, a FQHC shall submit a written request to the Commissioner that includes the following:

(1) A description of the change in scope of services and the reason for the change;

- (2) The impact on capital and operating costs;
- (3) The requested change in rate; and
- (4) All documentation submitted to HRSA regarding a change in scope of project, if applicable.

(d) A FQHC shall file a preliminary cost report to support its request for a rate adjustment not later than 90 days after the date on which the FQHC submitted its request for a rate adjustment.

(e) If a FQHC has received approval for a change in scope of project from HRSA for which it seeks a rate adjustment for a change in scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the FQHC has received approval from HRSA for the change in scope of project. The FQHC shall submit all documentation submitted to HRSA regarding the change in scope of project.

(f) If a FQHC is not required to file a change in scope of project with HRSA but plans an increase or decrease in services or sites to be offered by the FQHC that result in a change to the FQHC's scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the end of the FQHC's fiscal year. A FQHC shall submit all documentation required or requested by the department with respect to the change in scope of service.

(g) The department may initiate a change in scope of service and resulting encounter rates following a review of the FQHC's scope of project, subsequent amendments to the scope of project, cost reports and audited financial statements by notifying the FQHC in writing and requesting documentation with respect to the proposed change in scope of service. A FQHC shall submit all requested documentation not later than ninety days after receipt of the notice of the proposed change in scope of services.

(h) In making its determination with respect to whether a FQHC's encounter rate may be adjusted based upon a change in scope of services, the department shall review the following:

- (1) The FQHC's Medicaid cost report;
- (2) The FQHC's audited financial statements; and
- (3) Any other documentation relevant to the change in scope of services.

(i) The department shall issue a decision on a request for an adjustment to the FQHC's encounter rate not later than 120 days after the date on which the FQHC submits the request to the department.

(j) If the department approves the request, the new encounter rate shall take effect on the date specified in the department's decision. The FQHC shall submit a final cost report by January 1 of the year following the request for an adjustment to its encounter rate.

Sec. 17b-262-1002. Billing Requirements

(a) Each FQHC shall bill for FQHC services per encounter. Claims are limited to one all-inclusive encounter per day to include all services received by a client on the same day unless the client suffers an illness or injury subsequent to the first encounter that requires additional diagnosis or treatment or if the client has different types of visits on the same day such as medical and dental or medical and behavioral health. Medicaid pays for one medical, one dental, and one behavioral health encounter per day.

(b) Each FQHC shall submit medical and behavioral health claims on the CMS-1500 utilizing both the encounter code and all applicable HCPCS code(s) on the FQHC fee schedule that identify the services provided.

(c) Each FQHC shall submit dental health claims on the original designated American Dental Association Dental Claim form.

(d) Each FQHC shall submit claims electronically or on the department's designated form and shall include all information required by the department to process the claim for payment.

Sec. 17b-262-1003. Reimbursement

(a) The department shall reimburse a FQHC an all-inclusive encounter rate per client encounter in accordance with a PPS as required by 42 USC 1396a (bb).

(b) The department shall establish the baseline encounter rate for each FQHC in existence during fiscal years 1999 and 2000 as follows:

(1) Total encounters and costs shall be obtained from the annual reports submitted by the FQHC for fiscal years 1999 and 2000;

(2) Each year's total costs shall be divided by the total encounters. The FQHC shall include the costs of all Medicaid covered services provided by the FQHC;

(3) A two-year average of the calculated cost per encounter rates for fiscal years 1999 and 2000 will be used for each facility. The department shall determine the two-year

average for each FQHC by calculating the average cost per encounter rate separately for each year, then adding the averages together and dividing by two.

- (c) For a FQHC that did not file a 1999 annual report, the baseline encounter rate shall be based upon the annual report submitted for fiscal year 2000.
- (d) For a center that first qualified as a FQHC after fiscal year 2000, the department shall determine the baseline encounter rate based upon the encounter rate established under this section for FQHCs located in the same area with similar services.
- (e) The department shall adjust annual encounter rates by applying the percentage increase in the Medicare economic index (MEI) as defined in 42 USC 1395u (i)(3) to the previous fiscal year's encounter rate in accordance with 42 USC 1396a (bb) (3) (A).
- (f) The department may adjust the encounter rate for a change in the scope of services provided by a FQHC in accordance with section 17b-262-1001 of the Regulations of Connecticut State Agencies.

Sec. 17b-262-1004. Documentation and Audit Requirements

- (a) Each FQHC shall maintain a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid Identification Number, pertinent diagnostic information, treatment notes signed by the provider, documentation of services provided and the dates on which the services were provided.
- (b) For services performed by an LMSW, an unlicensed individual, a non-certified individual or an individual in training, progress notes shall be co-signed by the supervisor at least weekly for each client in care and shall contain the name, credentials and the date of such signature. For services provided by a certified individual, evidence of clinical supervision for each client in care shall be documented in the client's chart and shall contain the name, credentials and the date of such signature. The supervisor's signature means that the supervisor attests to having reviewed the documentation.
- (c) Each FQHC shall maintain all required documentation in its original form for at least five years or longer in accordance with statute or regulation, subject to review by authorized departmental personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation until the dispute is resolved.
- (d) The department may disallow and recover any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.
- (e) The department may audit all relevant records and documentation and may take any other appropriate quality assurance measures it deems necessary to assure compliance with all regulatory and statutory requirements.

(f) Notwithstanding the provisions of subsections (a) through (d) of this section, FQHCs may maintain an electronic medical record system such that medical records for all patients treated within the FQHC shall be available to, and shared by, all health professionals.