United Healthcare Community Plan

Billing requirements and claim submission guidance for Federally Qualified Health Centers

All Federally Qualified Health Centers (FQHCs) are required to bill services in accordance with their executed contract, applicable payment terms and regulatory billing guidance. Accurate claim submission, including use of the correct claim form type and adherence to encounter-based billing methodology, is critical to ensure proper claim adjudication and timely reimbursement.

Impact of non-compliance

Claims submitted outside of contractual and billing requirements will be denied or incorrectly processed. Denied claims will require corrected claim resubmission, resulting in payment delays, increased administrative burden and potential pricing inaccuracies.

What providers need to do

- Review contract-specific billing requirements and payment terms
- Validate internal billing workflows for compliance with PPS or contractual requirements

Key billing requirements

- Use the correct claim form type (UB-04 or CMS-1500) based on contractual and program requirements
- Bill services in alignment with the Prospective Payment System (PPS), including one encounter per visit unless otherwise permitted
- Submit claims using the appropriate FQHC billing National Provider Identifier (NPI) and include required modifiers, valid place of service and CPT/HCPCS codes
- Do not unbundle services that are part of the FQHC encounter
- Ensure alignment between **Medicare and Medicaid billing practices** to avoid payment discrepancies

Key compliance reminders

- Bill **1 encounter per visit** unless multiple encounters are explicitly allowed (i.e. medical and behavioral health in the same day)
- Follow **state-specific billing rules**, which may override general CMS guidance
- Ensure all practitioners are credentialed and have a Medicaid ID number
    - Verify your providers are loaded correctly using My Practice Profile on **UHCProvider.com**

Common billing errors impacting claims

- Incorrect claim form submission (UB-04 versus CMS-1500)
- Billing under an individual provider NPI instead of the FQHC billing NPI
- Missing required modifiers or incomplete claim elements
- Unbundling services that should be billed as a single encounter
- Supporting CPT/HCPCS coding, where required
- Misalignment with Medicare PPS billing requirements or contract terms
- Ensure correct claim form and billing identifiers are used
- Implement front-end billing controls to prevent avoidable denials

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When to use CMS-1500 versus UB-04

A. CMS-1500– professional billing

Use CMS-1500 for:

- Non-encounter services when allowed by state/plan rules
- Professional services reimbursed outside the PPS bundle (i.e. certain labs, radiology or immunizations depending on configuration)
- Services billed under physician/individual practitioner setup in some lines of business

B. UB-04– facility/encounter billing

Use UB-04 for:

- **FQHC encounter services under Medicare PPS methodology**
- Medicare FQHC billing (typically institutional format)
- Services billed as part of the all-inclusive encounter

Key requirements:

- Bill using FQHC facility NPI (not individual rendering provider)
- Include appropriate revenue codes (i.e. 52X series)
- Submit correct Type of Bill (ei.e. 73X) based on service type

Questions? We're here to help.
For additional support, please contact the UnitedHealthcare Provider Call Center or refer to contract-specific billing guidance.