



Federally Qualified Health Center Version

KEY CONCEPTS OUTLINE
Module 2: General Billing Requirements for
Federally Qualified Health Centers

I. General Billing Guidelines

A. Qualifying Visit in an FQHC

A qualifying visit is a medically necessary face-to-face medical visit, or a preventive service between a patient and a qualified FQHC practitioner, such as a physician, nurse practitioner (NP), physician assistant (PA), clinical nurse midwife (CNM). < See *Medicare Benefit Policy Manual, Chapter 13 §40*; >

- a. In certain circumstances, other "incident to" services may be provided that do not require a face-to-face visit with a practitioner (discussed later in this module).
- b. In certain circumstances, multiple medically necessary visits with an FQHC practitioner one the same day may be billed separately (discussed later in this module).
- c. Certain preventive services may be provided in an FQHC; however, if the preventive service has a technical component, it must be separately billed (discussed later in the module).
- d. In most cases, telephone, or electronic communication between the FQHC practitioner and the patient or someone acting on behalf of the patient are covered services that are considered to be part of the face-to-face qualifying visit and therefore, not separately billable. <See *Medicare Benefit Policy Manual, Chapter 13 §130*,>
- e. Treatment plans and home care oversight are considered to be part of a face-to-face qualifying visit and not separately billable. < See *Medicare Benefit Policy Manual, Chapter 13, §110.2*>
 - i. Exception: Comprehensive care plans that are a component of authorized care management services.

2. A qualifying visit may also be a medically necessary face-to-face mental health visit between the patient and a clinic practitioner, such as a clinical psychologist (CP) or a clinical social worker (CSW) and are provided within the scope of practice <See Medicare Benefit Policy Manual, Chapter 13 § 170; see *Medicare Claims Processing Manual, Chapter 9 §§10.2, 30.1*>
 - a. A mental health qualifying visit is typically a psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis.
 - i. Medication management or a psychotherapy add-on service is not a separately billable service in an FQHC when provided during a qualifying visit. The payment for these services is included in the qualifying visit.
 - ii. When a medical visit with an FQHC practitioner is furnished on the same day that medication management or a psychotherapy add-on service is furnished by the same or a different practitioner, only one payment is made for the qualifying visit reported with revenue code 052X.
3. Exceptions for Billable Non-face-to-face Services
 - a. Care management services encompass structured ongoing coordination of care between an FQHC practitioner, staff, the patient, and their caregivers. These services are discussed in detail later in this module.
 - a) Transitional Care Management (TCM) services include direct contact, telephone communication, or electronic communication with the patient or caregiver. <See *Medicare Benefit Policy Manual, Chapter 13 § 230.1*>
 - b) General Care Management (GCM) (e.g., Chronic Care Management (CCM), Principal Care Management (PCM) and General Behavioral Health Integration (BHI)) services include care coordination for patients with multiple chronic conditions, a long-term single high-risk condition, or a mental/behavioral health condition using certified EHR or other electronic technology. <See *Medicare Benefit Policy Manual, Chapter 13 § 230.2*>
 - c) Psychiatric Collaborative Care Model (CoCM) services include primary healthcare services with care management team support for patients receiving behavioral health treatment. <See *Medicare Benefit Policy Manual, Chapter 13 § 230.3*>

- d) Virtual communication services include certain FQHC communications-based technology and remote evaluation services. Face-to-face requirements are waived when these services are furnished in an FQHC. <See *Medicare Benefit Policy Manual*, Chapter 13 § 240>

B. Qualifying Visit in a Non-FQHC Location

1. A qualifying visit with a practitioner may take place in locations other than in the FQHC, including:
 - a. A Medicare-covered SNF;
 - b. The scene of an accident; or,
 - c. The patient's residence, including an assisted living facility. <See Medicare Benefit Policy Manual, Chapter 13 § 40.1>

Under certain circumstances, a qualifying visit may include a visit by a registered nurse (RN) or licensed practical nurse (LPN) to a patient confined to home (discussed later in this module).

Services provided in locations other than the clinic may be subject to review by the MAC.

2. Services provided to a patient in a location other than in the FQHC are covered services, if the practitioner is compensated by the FQHC for the services and the cost is included on the clinic's cost report. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.1>
3. A qualifying visit may not take place in the following locations:
 - a. Any type of hospital setting (inpatient, outpatient, or emergency department); or
 - b. A facility with requirements that preclude FQHC visits (e.g., Medicare comprehensive outpatient rehabilitation or hospice facilities) <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.1>

II. Overview of the UB-04 Claim Form

- A. An FQHC submits a claim for its professional services on the UB-04 Form/837 I Electronic Format. <See *Medicare Claims Processing Manual*, Chapter 9 § 50; *Medicare Billing: 837I and Form CMS-1450 Fact Sheet*>

The NUBC manual, which contains the official code descriptions for fields on the UB-04, can be obtained by subscribing to the current version of the manual on the NUBC website: www.nubc.org.

CMS has also instructed providers to obtain the field code descriptions from the local Medicare Administrative Contractor (MAC).

General billing and claims processing information can be found in the Medicare Claims Processing Manual, Chapter 1. General admission and registration requirements for all claims can be found in the Medicare Claims Processing Manual, Chapter 2.

1. In certain circumstances, non-FQHC services provided by an independent practitioner are submitted to the Part B MAC on Form CMS-1500/837P (discussed later)

III. Completion of Key Fields on the UB-04 (CMS-1450)

- A. The following information addresses key fields that are required on the FQHC claim. See the *Medicare Claims Processing Manual*, Chapter 9 § 50 for details about other fields that are not discussed in this section.

Handout 2 provides an example of the UB-04 claim form and the 1500 claim form.

B. Type of Bill (TOB) FL 04

1. An FQHC reports their services on TOB 077X. <*Medicare Claims Processing Manual*, Chapter 25, §75.1 (FL 4)>

2. The TOB is a four-digit alphanumeric code that gives three specific pieces of information.
 - a. The first digit is always a leading zero and is ignored by CMS.
 - b. The second digit identifies the type of facility
 - i. 7 – Special facility (clinic)
 - c. The third digit identifies the type of care.
 - i. 7 – Federally Qualified Health Centers
 - d. The fourth digit identifies the bill sequence or frequency.

The most commonly used TOBs in an FQHC:

- 0770 = non-payment/zero claim that contains only non-covered charges (when no payment from Medicare is anticipated)
- 0771 = admit through discharge (original claim)
- 0777 = replacement of a prior claim (used to correct a previously submitted claim – Adjustment claim)
- 0778 - void prior claim (used to cancel a previously processed claim)
- 071Q - Reopening

C. From/Through Dates FL 06

- a. FQHC claims cannot overlap calendar years. Services must be billed in the same calendar year for the application of the annual Part B deductible and coinsurance.
 - i. Claim statement or from/through dates must be in the same calendar year. <See *Medicare Claims Processing Manual, Chapter 9 § 100*>

D. Revenue Codes FL 42

1. Revenue codes indicate the appropriate revenue center for each charge included on the bill for cost/charge-based payment purposes and for cost report reconciliation.

2. Revenue codes indicate the appropriate revenue center for each charge included on the bill for cost/charge-based payment purposes and for cost report reconciliation.

A qualifying visit is reported under one of the following revenue codes:

- 0521 = Clinic visit by member to an FQHC
- 0522 = Home visit by an FQHC practitioner
- 0524 = Visit by an FQHC practitioner to a member in a SNF or skilled swing bed in a covered Part A SNF stay <Official UB-04 Data Specifications Manual>
- 0525 = Visit by an FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF or other residential facility
- 0527 = FQHC visiting nurse service to a member's home when in a home health shortage area
- 0528 = Visit by an FQHC practitioner to other non-FQHC site (i.e., scene of accident)
- 0900 = Mental health treatment/services

The following revenue codes are excluded from reporting on an FQHC claim:

- 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x

E. HCPCS Codes, FL 44

1. An FQHC must report all services furnished during the encounter with appropriate HCPCS codes and associated charges. <Medicare Claims Processing Manual, Chapter 9, §60.1>
 - a. In addition to the appropriate HCPCS codes, FQHCs must report an FQHC payment code
 - b. CMS established five FQHC payment specific codes to be used by FQHCs submitting claims under the PPS. < see *Medicare Claims Processing Manual*, Chapter 9 §60.2>
 - i. G0466 – FQHC visit, new patient,
 - a) A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
 - ii. G0467 – FQHC visit, established patient
 - a) A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
 - iii. G0468 – FQHC visit, IPPE or AWW
 - a) A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.
 - iv. G0469– FQHC visit, mental health, new patient
 - a) A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

- v. G0470 – FQHC visit, mental health, established patient
 - a) A medically-necessary, face-to-face mental health encounter (one-on-one) between an
 - 1) established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
- c. The specific payment code reported must correspond to the type of visit that qualifies the encounter for Medicare payment.
- d. FQHC payment codes must be reported under the correct revenue code.
 - i. HCPCS G0466, G0467, and G0468
 - a) Reported under revenue code 052X
 - 1) For Medicare Advantage (MA) supplemental claims - revenue code 0519
 - ii. HCPCS G0469 and G0470
 - a) Reported under revenue code 0900
 - 1) For Medicare Advantage (MA) supplemental claims – revenue code 0519.
- 2. The FQHC claim must include the specific payment code (G04666-G0470) and a corresponding service with a HCPCS code that describes the qualifying visit. CMS publishes a list of qualifying visits for each payment specific code < See Handout 4>
- 3. The additional revenue lines with detailed HCPCS code(s) and charges are informational only and will not be paid.
 - a. Payment for these services is included in the payment under the FQHC payment code. <See *Medicare Claims Processing Manual*, Chapter 9 § 60.2>

F. Modifiers, FL 44

1. Reporting modifier -59

- a. When appropriate, modifier -59 may be reported with a subsequent qualifying visit HCPCS code when multiple medical visits occur on the same date of service (discussed in detail later in this module).
- b. Medicare allows for an additional payment when an illness or injury occurs subsequent to the initial visit, and the FQHC bills these visits with the specific payment codes and modifier 59.
 - i. Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day.
 - ii. For FQHCs modifier 59 is only valid with FQHC Payment Code G0467.

G. Reporting modifier -CS for COVID-19 testing-related services

- a. CMS had previously designated modifier -CS for the gulf oil spill in 2010. CMS has since repurposed the modifier for the COVID-19 PHE. <MLN Matters Article SE20011, revised September 8, 2021>
- b. For services furnished on March 18, 2020 and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use modifier -CS on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services. <MLN Matters Article SE20011, revised September 8, 2021>
 - i. Modifier -CS should be reported on applicable claim lines whether the testing-related services are performed face-to-face or via telehealth, which will be discussed later in this module. <MLN Matters Article SE20016, revised January 13, 2022>
- c. Medicare deductible and/or coinsurance for COVID-19 testing related services are waived for medical visits that result in the ordering of a test for COVID-19. < See MLN Matters Article SE20011, revised September 8, 2021; Families First Coronavirus Response Act, Section 6002>

- d. When the following four requirements for waiver of deductible and/or coinsurance are met, the COVID-19 testing related visit service is billed with modifier -CS and facilities should not charge the patient for any deductible and/or coinsurance amount. <MLN Matters Article SE20011, revised September 8, 2021; IOCE Specifications (v21.2), Section 5.1.3>
 - i. A specified visit service:
 - a) Visit (E/M service);
 - b) Critical care (99291); or
 - c) Hospital COVID-19 specimen collection (C9803¹). <IOCE Specifications v21.2; Section 5.1.3>
 - ii. The visit is provided on March 18, 2020 through the end of the COVID-19 PHE. <MLN Matters Article SE20011, revised September 8, 2021 >
 - iii. The visit results in an order for or administration of a COVID-19 test. <MLN Matters Article SE20011; Families First Coronavirus Response Act, Section 6002>
 - iv. The visit relates to the furnishing or administration of the COVID-19 test or to the evaluation of an individual for determining the need for the COVID 19- test. <MLN Matters Article SE20011, revised September 8, 2021; Families First Coronavirus Response Act, Section 6002>

Note: The MLN Matters Special Edition explaining this provision only mentions the laboratory tests U0001, U0002, and 87635. Subsequent to its original publishing, additional COVID-19 laboratory testing codes were adopted, including U0003 and U0004 for high throughput tests; and 86769 and 86328 for antibody testing. Presumably, the deductible and/or coinsurance waiver also applies when the visit results in the ordering of one of these additional test codes as well. Providers should confirm application of the waiver to these additional codes with their MAC.

¹ Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2)(coronavirus disease [COVID-19], any specimen source

2. Reporting modifier -CS for certain preventive services
 - a. For covered preventive services provided via telehealth on or after July 1, 2020, that have cost sharing waived, FQHCs must report the FQHC telehealth code (G2025) with the –CS modifier. The rules for billing and payment of FQHC telehealth services will be discussed in detail later in this module. <MLN Matters Article SE20016, revised November 22, 2022.>

Note: Providers, including FQHCs, should refer to SE20011, revised September 8, 2021, for applicable links to a listing of current HCPCS codes that support the reporting of modifier –CS, resulting in the waiver of otherwise applicable cost sharing amounts. Attaching modifier—CS to ineligible codes will trigger IOCE edit 114, resulting in a disposition of RTP.

H. Service Units, FL 46

1. The service unit represents a single visit for which one PPS payment is made regardless of whether other services are provided during the same visit or on the same date of service (e.g., a qualifying visit and an injection incident to the visit). <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.3; see *Medicare Claims Processing Manual*, Chapter 9, §§ 30.1, 50.>
 - a. In general, multiple visits with more than one FQHC practitioner on the same day, or multiple encounters with the same practitioner on the same day, constitute a single visit and are only payable as one qualifying visit.
 - b. Unless one of the following exceptions is met:
 - i. The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the FQHC), or
 - ii. The patient has a medical visit and a mental health visit on the same day.

I. Total Charges, FL 47

1. FQHCs must report all services occurring on the same day on one claim.
2. A single claim may span multiple days of service.
3. The total charges include the specific payment code charges as well as the associated charges with the HCPCS codes reported for informational purposes only. <See *Medicare Claims Processing Manual, Chapter 9, §60.2*>

The “total line (0001 revenue code)” is the sum of all charges reported on the claim which includes the charges for the specific payment code and the additional service lines, reported with appropriate HCPCS code. The FQHC payment is made by comparing the adjusted FQHC PPS rate to the specific payment codes.

IV. Integrated Outpatient Code Editor (IOCE)

A. Purpose of the IOCE

1. The IOCE is software used by the Fiscal Intermediary Shared System (FISS) to edit outpatient claims and return a series of edit flags. <See Handout 4 *Integrated OCE (IOCE) CMS Specifications: 3 Introduction to the IOCE*>
 - a. CMS publishes an *IOCE Specifications* document containing descriptions of the edits and logic included in the IOCE.
 - b. Handout 5 includes applicable excerpts for the FQHCs from the current version of the IOCE.

B. Applicability to FQHC Claims

1. All institutional outpatient Part B claims are processed through the IOCE, including certain non-OPPS providers, such as RHCs and FQHCs. <See Handout 5 *Integrated OCE (IOCE) CMS Specifications: 4 Processing that Applies to Both OPPS and Non-OPPS Claims*>
2. In general, the edits are driven by the ICD-10-CM diagnosis codes, the HCPCS codes, and any modifiers reported on the claim. <See Handout 5 *Integrated OCE (IOCE) CMS Specifications: 3 Introduction to the IOCE*>

- a. The *IOCE Specifications* sometimes answer billing/coding questions that are not clearly answered anywhere else.

3. IOCE Edits specific to FQHCs

- a. Edit 88 – FQHC payment code must be reported on the FQHC claim, TOB 077X.
 - i. FQHC claims that do not contain a required FQHC payment HCPCS code will be returned to the provider.
- b. Edit 90 – FQHC payment codes must be reported with revenue code 0519, 052X, or 0900.
 - i. FQHC payment HCPCS codes reporting revenue codes other than those listed will be returned to the provider.
- c. Edit 89 FQHC claims must contain both an FQHC payment and HCPCS code and a qualifying visit code.
 - i. FQHC claims that do not contain both FQHC payment and a HCPCS code and a qualifying visit code will be returned to the provider.

V. General Billing Requirements for Qualifying Visits, Preventive Services, and Other Special Services

A. Qualifying Visit

1. FQHCs must use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates <See *Medicare Claims Processing Manual*, Chapter 9 § 60.2>
2. The Specific Payment Codes for Federally Qualified Health Center Prospective Payment System (FQHC PPS) document provides a list of the FQHC payment codes and contains a list of Qualifying Visit HCPCS codes. To qualify as a FQHC visit, the encounter must include one of the services listed under Qualifying Visits. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40>

3. As noted earlier, a qualifying visit is typically a medically necessary one-on-one face-to-face medical or mental health visit, or a covered preventive health visit between the patient and a qualified FQHC practitioner, such as a physician, NP, PA, CNM, CP, CSW, or visiting registered professional or licensed practical nurse during which one or more FQHC services are rendered. <42 C.F.R. 405.2463; see *Medicare Benefit Policy Manual*, Chapter 13 § 40; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.2, 30.1>
 - a. A qualifying medical visit includes medically necessary evaluation and management (E/M) services or certain covered preventive services and is reported with revenue code 052X. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40; 42 C.F.R. § 405.2463>
 - b. A qualifying mental health visit is typically a psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis between the patient and a clinic practitioner such as a CP or CSW and is reported with revenue code 0900. <See *Medicare Benefit Policy Manual*, Chapter 13 § 170; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.2, 30.1>
 - c. In general, multiple visits with more than one FQHC practitioner on the same day, or multiple encounters with the same practitioner on the same day, constitute a single visit and are only payable as one qualifying visit, subject to certain exceptions discussed in more detail below.
4. Multiple Qualifying Visits on the Same Date of Service
 - a. Multiple qualifying visits on the same day of service within the FQHC are only payable:
 - i. After the first qualifying visit, the patient suffers an illness or injury that requires additional diagnosis or treatment on the same day.
 - ii. The patient has a medical and mental health visit on the same day. <See *Medicare Claims Processing Manual*, Chapter 9 §30.1>
 - b. Separate payment is not made for Initial Preventive Physical Exam (IPPS) or Diabetes Self-Management Training (DSMT) or Medical Nutrition Therapy (MNT) (DSMT/MNT) when furnished on the same day as another FQHC medical visit. < See *Medicare Claims Processing Manual*, Chapter 9 §30.1>
5. Billing FQHC Visits
 - a. A specific FQHC payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment.

- b. The FQHC visit corresponds to the appropriate prospective payment system rate <See *Medicare Claims Processing Manual*, Chapter 9 §60.2>
- c. The charges billed for the FQHC visit code must reflect the sum of regular rates charged to both beneficiaries and other patients for the bundle of services that would be furnished to a Medicare beneficiary.
- d. Medical Visits
- i. FQHC payment specific codes for medical visits and preventive services, G0466, G0467, and G0468 respectively must be reported under revenue code 052X (free-standing clinic) or 0519 (clinic).
Note: Revenue code 0519 is only used for Medicare Advantage (MA) supplemental claims to be discussed in a later module.
 - ii. Each FQHC payment code must have a corresponding service line with a HCPCS code that describes the qualifying visit.
 - iii. HCPCS codes that describe all services furnished during the FQHC encounter must be reported on the claim.

(a) All service lines must be reported with the associated charge

Qualifying Medical Visit Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0466 <i>FQHC Payment Code</i>		01/25/2022
0521	99204 <i>Qualifying Visit</i>		01/25/2022

e. Mental Health Visits

- i. FQHC payment specific codes mental health visits, G0469, and G0470 must be reported under revenue code 052X (behavioral health treatments/services) or 0519 (clinic).
- ii. Each FQHC payment code must have a corresponding service line with a HCPCS code that describes the qualifying visit.
- iii. HCPCS codes that describe all services furnished during the FQHC encounter must be reported on the claim.

(a) All service lines must be reported with the associated charge

Qualifying Mental Health Visit Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
<i>0900</i>	<i>G0470</i> <i>FQHC Payment Code</i>		<i>01/25/2022</i>
<i>0900</i>	<i>90792</i> <i>Qualifying Visit</i>		<i>01/25/2022</i>

f. Medical and Mental Health Visit Furnished on the Same Day

- i. An FQHC specific payment code for the medical visit (G0466, G0467, and G0468) and a specific payment code for the mental health visit (G0740) must be reported.
- ii. A service line, with a qualified visit, reported by HCPCS codes must be billed for each FQHC specific payment code.

Medical and Mental Health Visit Furnished on the Same Day Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0467 FQHC Payment Code		01/25/2022
0521	99213 Qualifying Visit		01/25/2022
0900	G0470 FQHC Payment Code		01/25/2022
0900	90832 Qualifying Visit		01/25/2022

Medical Visit with Subsequent Visit for Illness or Injury on the Same Date Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0467 FQHC Payment Code		01/25/2022
0521	99213 Qualifying Visit		01/25/2022
0900	G0467 FQHC Payment Code	-59	01/25/2022
0900	99212 Qualifying Visit		01/25/2022

A. Preventive Services

1. FQHCs must provide preventive health services on site or by arrangement with another provider. <Medicare Benefit Policy Manual, Chapter 13 §220.3>
 - a. Preventive Services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW.
 - b. Required preventive health services include:
 - i. Prenatal and perinatal services;
 - ii. Appropriate cancer screening;
 - iii. Well-child services;
 - iv. Immunizations against vaccine-preventable diseases;
 - v. Screenings for elevated blood lead levels, communicable diseases, and cholesterol;
 - vi. Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
 - vii. Voluntary family planning services; and
 - viii. Preventive dental services.
 - (a) The list of preventive health services can be found at:
<http://bphc.hrsa.gov/policiesregulations/legislation/index.html>,
2. An FQHC is paid for the professional component of a preventive service, when all the conditions of coverage are met, and frequency limits have not been exceeded. <See Medicare Benefit Policy Manual, Chapter 13 § 220; see Medicare Claims Processing Manual, Chapter 9 § 70>
3. Under the Affordable Care Act and where applicable, the patient's deductible and/or coinsurance are waived for the IPPE and AWW, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B. <Medicare Claims Processing Manual, Chapter 18 § 1.2>
 - a. Handout 6 CMS Federally Qualified Health Center (FQHC) Preventive Services Chart, revised August 10, 2016, provides a table of preventive services indicating if the deductible and/or coinsurance are waived. The table also identifies if the preventive service is paid under FQHC PPS methodology when billed without another covered visit, and the preventive services that have the coinsurance waived.

- b. A complete list of covered preventive services, including coding and billing requirements, and statutorily waived deductible and coinsurance amounts, can be found in the *Medicare Claims Processing Manual*, Chapter 18.
 - i. Other helpful resources for the coverage and billing of preventive services can be found in the MLN catalog found on the CMS MLN

*Link: MLN Publications under the Medicare Related Sites – General
Select the MLN Catalog button in the center of the page*

4. Billing Preventive Services

a. Initial Preventive Physical Exam (IPPE) - HCPCS G0402

- i. The IPPE, also known as the “Welcome to Medicare Preventive Visit” is a preventive visit offered to newly enrolled Medicare beneficiaries. The service is focused on health promotion and disease prevention and detection.
- ii. The IPPE includes the following services:
 - (a) Review of the individual’s medical and social history, risk factors for depression and mood disorders, and the individual’s ability and level of safety;
 - (b) Examination which includes measurement of the individual’s height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary’s medical and social history;
 - (c) End-of-life planning, if the beneficiary agrees;
 - (d) Education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B. <*Medicare Claims Processing Manual*, Chapter 18 § 80>
- iii. The IPPE does not include other preventive services covered separately covered and paid under Medicare Part B:

- iv. Medicare will cover one IPPE for a new beneficiary within the first 12 months of eligibility. The IPPE is payable once per beneficiary lifetime. <Medicare Claims Processing Manual, Chapter 18 §80>
- (a) Face-to-face one-time exam,
- (b) IPPE may be billed as a stand-alone visit, when it is the only medical service provided by the FQHC practitioner on that calendar date.
- v. The IPPE is a qualifying visit when billed under the FQHC specific payment code, G0468.
- (a) HCPCS G0468 - A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWV, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467. <See: Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS), 12-06-17>
- (b) Both the FQHC specific payment code (G0468) and the qualifying visit HCPCS code (G0402) are reported under revenue code 0521.

IPPE Visit Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
<i>0521</i>	<i>G0468</i> <i>FQHC Payment Code</i>		<i>01/25/2022</i>
<i>0521</i>	<i>G0402</i> <i>Qualifying Visit</i>		<i>01/25/2022</i>

- b. EKG – HCPCS G0403, G0404, and G0405
 - i. When an EKG is performed in conjunction with the IPPE, the professional component of the diagnostic test is part of the qualifying visit. <See *Medicare Claims Processing Manual*, Chapter 9, § 70.6; see *Medicare Claims Processing Manual*, Chapter 18, § 80>
 - 1. However, the technical component of the EKG is a non-FQHC service and cannot be billed on TOB 077X.
 - 2. The technical component or tracing of the EKG performed as part of the IPPE is reported with HCPCS G0404.
 - a. If an EKG is performed in conjunction with the IPPE at an independent FQHC, the practitioner who performs the service may bill the A/B MAC for the technical component on the 1500 claim form.
 - b. If an EKG is performed in conjunction with the IPPE at a provider-based FQHC, the technical component may be billed to the A/B MAC by the main provider on their usual outpatient bill type (i.e., TOB 0851 CAH or 0131 OPPS).
- c. Annual Wellness Visit – HCPCS G0438 and G0439
 - i. The AWV is a personalized prevention plan for beneficiaries who are not within the first 12 months of Medicare eligibility and have not received an IPPE or AWV within the past 12 months. <*Medicare Claims Processing Manual*, Chapter 18, § 140.4>
 - ii. The AWV can be billed as a stand-alone visit, if it is the only medical service provided on that day. When furnished on the same day as another medical visit, it is not a separately billable visit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 220.3>
 - iii. The AWV is a qualifying visit when billed under the FQHC specific payment code, G0468

1. HCPCS G0468 - A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWV, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467. <See: Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS), 12-06-17>

(b) Both the FQHC specific payment code (G0468) and the qualifying visit HCPCS codes (G0438/G0439) are reported under revenue code 0521

(c) The patient's coinsurance will be waived for the AWV. <See *Medicare Benefit Policy Manual*, Chapter 13 §220.3>

AWV Visit Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0468 <i>FQHC Payment Code</i>		01/25/2022
0521	G0438/G0439 <i>Qualifying Visit</i>		01/25/2022

5. Preventive Service and Qualifying Medical Visit During the Same Encounter

a. If an IPPE or AWV (initial or subsequent) is furnished on the same day as another medical visit, it is not a separately billable visit. <<See *Medicare Benefit Policy Manual*, Chapter 13 § 220.2>

6. Advanced Care Planning (ACP) – CPT 99497 and 99498

a. Voluntary advance care planning is a face-to-face visit between the patient and a physician or other qualified healthcare professional to discuss advance directives, with or without completing relevant legal forms. <*Medicare Benefit Policy Manual*, Chapter §280.5.1>

b. ACP can be offered as either:

- i. An optional element of a Medical Wellness Visit:
Per the Annual Wellness Visit (AWV) or the Initial Preventive Physical Examination (IPPE); or
 - ii. A separate Medicare Part B medically necessary service.
 - c. ACP may be furnished alone or as a stand-alone service. When performed on the same date as another FQHC services, the ACP will not be separately reimbursed.
 - d. When ACP is furnished with a Medicare wellness visit (MWV), only the MWV will be paid under FQHC PPS.
 - i. When ACP is furnished as part of a MWV (G0402, G0438 or G0439), the coinsurance is waived for both the ACP and the MWV.
 - 1. The ACP HCPCS code must be billed with modifier -33 (preventive services) to waive the coinsurance.
 - a. Do not append modifier -33 to the MWV codes.
 - ii. When ACP furnished outside of a MWV (G0402, G0438, or G0439), the Part B cost sharing (coinsurance) applies.
 - 1. Modifier -33 should not be appended to the ACP HCPCS code.
7. Vaccines and Injections
- a. Influenza and Pneumococcal Vaccines
 - i. FQHCs are reimbursed for influenza and pneumonia vaccines and their administration at 100 percent of reasonable cost through the cost report. <See *Medicare Benefit Policy Manual*, Chapter 13, § 220.3>
 - (a) Coinsurance and deductible do not apply.
 - ii. HCPCS Coding
 - (a) Coding vaccine administration requires both the administration and the vaccine (product) to be reported.
 - 1. Administration Codes
 - a. Pneumococcal – G0008
 - b. Influenza – G0009

2. Vaccine

- a. The CPT/HCPCS code reported is dependent upon specific product.
 1. Example: CPT 90686 - Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
- iii. Vaccine and Administration furnished as part of an encounter
 - (a) If there was another reason for the visit, the FQHC should bill for the visit without adding the cost of the influenza virus and pneumococcal vaccines to the charge for the visit on the bill.
 1. FQHCs must include the charges on the claim.
 - a. The information is submitted for informational and data
 - iv. When an FQHC practitioner sees the patient for the sole purpose of administering the influenza or pneumonia vaccine, a qualifying visit cannot be separately billed.

Pneumococcal Vaccine and Annual Wellness Visit Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
<i>0521</i>	<i>G0468</i>		<i>01/22/2023</i>
<i>0521</i>	<i>G0438</i>		<i>01/22/2023</i>
<i>0636</i>	<i>90686</i>		<i>01/22/2023</i>
<i>0771</i>	<i>G0008</i>		<i>01/22/2023</i>

b. Hepatitis B Vaccine and Administration

- i. Hepatitis B vaccine and its administration is included in the FQHC visit and is not separately billable. <See *Medicare Benefit Policy Manual*, Chapter 13, § 220.3>

- (a) Coinsurance and deductible do not apply.
- ii. HCPCS Coding
 - (a) Coding vaccine administration requires both the administration and the vaccine (product) to be reported.
 - 1. Hepatitis vaccine administration – G0010
 - 2. Vaccine
 - a. The CPT/HCPCS code reported is dependent upon specific product.
 - iii. Example: CPT 90746 - Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use.
 - iv. Hepatitis B vaccine and its administration is included in the FQHC visit and is not separately billable.
 - v. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit.
 - 1. FQHCs must include the charges on the claim.
 - a. The information is submitted for informational and data
 - vi. When an FQHC practitioner sees the patient for the sole purpose of administering the influenza or pneumonia vaccine, a qualifying visit cannot be separately billed.

Hepatitis Vaccine and a Medical Visit Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0467 FQHC Payment Code		01/22/2023
0521	99213 Qualifying Visit		01/22/2023
0636	90746		01/22/2023
0771	G0010		01/22/2023

c. Other Injections

- i. The charge for an injection that is provided incident to a qualifying visit performed on a different day may be included in the charge for the qualifying visit. The conditions of coverage must be met, and the service must be furnished in a “medically appropriate” timeframe. <See *Medicare Benefit Policy Manual*, Chapter 13 § 120.3>
 - (a) CMS does not define what it considers to be a medically appropriate time frame. An FQHC should develop a policy for consistent billing practices.
- ii. If a qualifying visit was previously billed and the injection occurred within a medically appropriate timeframe, the FQHC may correct the original claim using TOB 0777 (replacement claim).
 - a) The charges for the injection can be added to the qualifying visit charge and the claim rebilled using the date of service for the qualifying visit.
 - b) The coinsurance will be based on the total amount for the rebilled qualifying visit. The FQHC will not receive an additional PPS for the replacement claim.

- c) If an injection is the only service that was provided on a specific date of service and a qualifying visit does not occur within the FQHC's medically appropriate timeframe policy, the charge for the injection is not eligible to be separately billed as a qualifying visit.
 - a. The cost of the injection can be reported on the cost report.
 - d. COVID -19 Vaccine and Administration
 - i. Any vaccine that receives FDA authorization (through EUA or licensed under BLA) will be covered under Medicare at no cost to beneficiaries (Original Medicare and MA). <CMS.gov "Medicare Billing for COVID-19 Vaccine Shot Administration">
 - ii. For FQHCs, costs should generally be reported on the cost report and will be paid at 100% of reasonable costs through the cost report settlement process.
 - iii. Alternatively, FQHCs may request lump-sum payments in advance of cost report settlement, which will be paid at 100% of reasonable costs.
 - e. Monoclonal Antibodies to treat COVID-19 and Administration
 - i. Although treated as preventive vaccines, and, therefore, not subject to cost-sharing, a physician order is required for the administration, unlike other COVID-19 vaccines.
 - ii. Costs should be reported on the cost report and will be paid at 100% through the cost report settlement process.
8. Billing for Other "Incident to" Services without a Qualifying Visit
- a. All services and supplies provided incident to an FQHC practitioner's visit must meet the following requirements:
 - i. Be a result of the patient's encounter with an FQHC practitioner;
 - ii. Be performed under the appropriate level of supervision;

- iii. Be performed by a nurse, a medical assistant, or other qualified auxiliary personnel who is an employee of or working under contract to the FQHC;
 - (a) Services that are not considered incident to include services furnished by a nurse, a medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the FQHC, including services provided by a third party under contract.
 - b. The service must be provided in a medically appropriate timeframe. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120.1, 120.3>
 - i. Examples of incident to services furnished by FQHC staff include blood pressure checks, wound care, and other routine nursing services. These types of services do not generate a separately billable qualifying visit alone; however, the costs can be reported on the cost report.
 - ii. Incident to services provided on a different day as a separately billable qualifying visit may be included in the charge for the qualifying visit if they are furnished in a medically appropriate timeframe like injections (see above).
9. Drugs Provided During a Qualifying Visit or Incident to a Qualifying Visit
- a. HCPCS codes
 - i. Drugs and biologicals are billed with a HCPCS code, if one exists, and units of service consistent with the HCPCS code description. <*Medicare Claims Processing Manual*, Chapter 17 § 10, 90.2>
 - ii. If the provider furnishes a dose of a drug that does not equal a multiple of the units specified in the HCPCS code for the drug, the provider should round to the next highest unit when reporting the drug. <*Medicare Claims Processing Manual*, Chapter 17 § 10, 40>

Example: A patient is administered 7 mgs of a drug. The HCPCS code long descriptor indicates “per 5 mgs”. The FQHC should charge for 2 units of the drug. Drug units are rounded up for charging the drug itself; however, a MAC may require an FQHC to report only one unit of service for the drug HCPCS code on the claim.

b. Revenue codes

- i. Drugs with HCPCS codes should be reported with revenue code 0636 "Drugs Requiring Detailed Coding". <National Uniform Billing Committee UB-04 Data Specifications Manual, Program Memorandum A-02-129>
- ii. Drugs that do not have a HCPCS code should be billed with the appropriate revenue code in the "General Pharmacy" revenue code series 025X, which does not require a HCPCS code for reporting. <National Uniform Billing Committee UB-04 Data Specifications Manual>
- iii. When a self-administered drug (SAD) is integral to a procedure and is considered to be a "supply", the SAD should be reported under revenue code 0250. <Medicare Benefit Policy Manual, Chapter 15 § 50.2 M>

c. Drug administration

- i. When appropriate, drug administration HCPCS codes should be billed in addition to the HCPCS code for the drug administered, if one exists. <Medicare Claims Processing Manual, Chapter 4 § 230.2; Medicare Claims Processing Manual, Chapter 17 § 10>

d. Billing for non-covered drugs

- i. Non-covered self-administered drugs may be billed to Medicare under revenue code 0637 ("Self-administrable Drugs"), with or without a HCPCS code. <NUBC Official UB-04 Specifications Manual; IOCE Specification, Appendix F(a)>
 - (a) If no drug HCPCS code is available for the self-administered drug, and the provider wishes to bill with a modifier (e.g., -GY indicating an item or service is statutorily excluded from the Medicare benefit), the provider may use HCPCS code A9270 ("Non-covered Item or Service"). <Medicare Claims Processing Manual, Chapter 1 § 60.4.2>
- ii. The DHHS Office of Inspector General has stated that hospitals will not be subject to administrative sanctions if they discount or waive amounts owed for non-covered self-administered drugs, subject to the following conditions:
 1. The discounts or waivers are for drugs received for ingestion or administration in outpatient settings;

2. The policy is uniformly applied without regard to diagnosis or type of treatment;
 3. The policy is not marketed or advertised; and
 4. The hospital does not claim the discounted or waived amounts as bad debt or otherwise shift the burden of these costs to the Medicare or Medicaid program, other payers, or individuals. <OIG Policy Statement Regarding Hospitals That Discount or Waive Amounts Owed by Medicare Beneficiaries for Self-Administered Drugs Dispensed in Outpatient Settings, dated October 29, 2015>
- F. Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)
1. DSMT and MNT services that are provided by a certified DSMT and MNT providers are billable visits in the FQHC <42 C.F.R. 405.2463; see *Medicare Benefit Policy Manual*, Chapter 13 § 220.1; see *Medicare Claims Processing Manual*, Chapter 9, § 70.5>
 2. DSMT and MNT services are qualifying visits when billed under FQHC payment codes G0466 or G0467.
 3. DSMT and MNT do not qualify for separate payment when billed on the same day with another qualifying visit.
 - a. DSMT must be provided by a certified DSMT practitioner.
 - b. MNT service must be provided by a registered dietician or nutrition professional.
 - c. The service must be provided as a one-to-one face-to-face encounter; and all other program requirements must be met.
 - e. Other diabetic counseling or medical nutrition services provided by a registered dietician at the FQCH may be considered incident to a visit with the FQHC practitioner.
 - f. Coinsurance and Deductible
 - i. MNT services - coinsurance is waived
 - ii. DSMT services – coinsurance is applied

- g. HCPCS coding
 - i. DSMT – G0108
 - ii. MNT – 97802, 97803, G0207
- h. Revenue code – 052X

Medial Nutrition Therapy Example

<i>Revenue Code</i>	<i>HCPCS Code</i>	<i>Modifier</i>	<i>Service Date</i>
<i>0521</i>	<i>G0467 FQHC Payment Code</i>		<i>01/22/2023</i>
<i>0521</i>	<i>97802 Qualifying Visit</i>		<i>01/22/2023</i>

G. Transitional Care Management (TCM)

1. TCM may be provided in and when all the coverage requirements are met.
<See *Medicare Benefit Policy Manual*, Chapter 13 § 230.1>
 - a. TCM must be furnished within 30 days of the date of the patient's discharge from:
 - i. A hospital, including outpatient observation or partial hospitalization;
 - ii. A SNF; or
 - iii. A community mental health center (CMHC).
 - b. Discharge from the appropriate setting must be to the patient's home (i.e., actual residence, assisted living facility, rest home or domiciliary care).

- c. Communication with the patient or caregiver by direct contact, telephone, or electronic media must start within 2 business days of discharge.

If a practitioner makes two or more separate attempts to contact the patient in a timely manner but is unsuccessful, TCM can be still be reported if:

- *The attempts are documented in the medical record;*
- *All other TCM coverage criteria are met;*
- *Attempts are made until successful.*

- d. The required face-to-face visit with an FQHC practitioner must occur within specific timeframes.
- i. A face-to-face visit must occur within 14 calendar days of discharge with moderate complexity decision making (99495); or,
 - ii. A face-to-face visit must occur within 7 calendar days of discharge with high complexity decision making (99496).
 - iii. Medication reconciliation and management must be completed no later than the date of the face-to-face visit.

Services furnished by FQHC staff incident to a TCM visit may be furnished under general supervision.

- e. Only one TCM visit may be paid per beneficiary for services furnished during a 30-day post-discharge period, regardless of which practitioner provides the service (e.g., FQHC or non-FQHC provider).
- i. The period begins on the day of discharge from a qualifying setting.
 - ii. The period ends 30 calendar days after discharge.
- f. If the TCM visit is the only service provided on that day, the FQHC can bill the service as a qualifying visit using revenue code 052X, the appropriate HCPCS code and the date of the face-to-face visit. TCM will be paid a PPS rate and coinsurance applies.
- g. If the TCM visit occurs on the same day as another qualifying medical visit, preventive visit, or mental health visit, only one is paid.

- h. For dates of service on and after January 1, 2022, FQHCs may bill for both TCM and other care management services (i.e., GCM CoCM) provided during the same month for the same beneficiary. In this case, the use of modifier -59 would apply. <See *CY 2023 Medicare Physician Fee Schedule Fact Sheet*>

Link: Care Management Physician Center under Medicare Related Sites – Physician/Practitioner

K. General Care Management (GCM)

1. General care management (GCM) includes Chronic Care Management (CCM), Principal Care Management (PCM), and General Behavioral Health Integration (BHI) services. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2; see *Medicare Benefit Policy Transmittal 10729*;
 - a. Effective for dates of service on or after January 1, 2018, Medicare will pay FQHCs for certain general care management services (chronic care management [CCM], pain care management [PCM], and behavioral health integrated [BHI] services) when there are 20 or more minutes of such services provided during that month by clinical staff.
 - b. Effective for dates of service on or after January 1, 2021, Medicare will also pay FQHCs for principal care management (PCM) services when there are 30 or more minutes of such services provided during that month by clinical staff.
 - c. Incident to GCM services are generally performed by auxiliary staff and are subject to the general supervision of an FQHC practitioner. General supervision does not require the FQHC practitioner to be in the same building or immediately available.
2. All three types of GCM services are covered when applicable criteria are met.
 - a. An FQHC may bill for CCM services for non-face-to-face care coordination when a minimum of 20 minutes of CCM services are provided during the calendar month and these coverage requirements are met:
 - i. The patient must have multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, which place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline;

- ii. The patient must consent (verbally or in writing) to receive CCM from the FQHC; and
 - iii. A separately billable initiating visit (no more than one year before start of care) with an FQHC practitioner (physician, NP, PA, or CNM) is required, but CCM does not need to be discussed during the visit.
- b. An FQHC may bill for PCM services when a minimum of 30 minutes of PCM services are provided during the calendar month and these coverage requirements are met:
- i. The patient has a single complex chronic condition lasting at least three months, which is the focus of the care plan;
 - ii. The condition is of sufficient severity to place the patient at risk of hospitalization or have been the cause of a recent hospitalization;
 - iii. The condition requires development or revision of a disease-specific care plan;
 - iv. The condition requires frequent adjustments in the medication regimen;
 - v. The condition is unusually complex due to comorbidities;
 - vi. The patient must consent (verbally or in writing) to receive PCM from the FQHC; and
 - vii. A separately billable initiating visit (no more than one year before start of care) with an FQHC practitioner (physician, NP, PA, or CNM) is required, but PCM does not need to be discussed during the visit.
- c. An FQHC may bill for BHI services when a minimum of 20 minutes of BHI services are provided during the calendar month and these coverage requirements are met:
- i. A patient must have one or more new or pre-existing behavioral health or psychiatric conditions, including substance use disorders;
 - ii. BHI requires an initial assessment, ongoing monitoring, continuity of care and coordination of treatment (psychotherapy, pharmacotherapy, counseling and/or psychiatric consultations);

- iii. The patient must consent (verbally or in writing) to receive BHI from the FQHC; and
- iv. A separately billable initiating visit (no more than one year before start of care) with an FQHC practitioner (physician, NP, PA, or CNM) is required, but BHI does not need to be discussed during the visit.

Link: Care Management Physician Center under Medicare Related Sites – Physician/Practitioner

- 3. For dates of service on or after January 1, 2021, GCM (CCM, PCM or BHI) can be billed alone or with another qualifying visit on the same date of service, based on the following guidelines:
 - a. GCM is reported by the FQHC with HCPCS code G0511
 - b. An FQHC cannot bill GCM for the same beneficiary for the same time frame if another practitioner/facility has billed for that month;
 - c. For dates of service prior to January 1, 2022, an FQHC cannot bill for GCM and TCM for the same beneficiary for the same time frame;
 - i. For dates of service on or after January 1, 2022, however, FQHCs may bill for both TCM and other care management services (e.g., GCM, CoCM) provided during the same month. <See *CY 2023 Medicare Physician Fee Schedule Fact Sheet*>
 - d. Although GCM is an FQHC service, it is paid under the MPFS,
 - e. For CY 2023, the national payment rate for G0511 is \$77.94;
 - i. G0511's payment rate is updated annually based on the PFS amounts for the following CPT codes: 99424, 99426, 99484, 99487, 99490, and 99491.
 - f. MPFS coinsurance applies to GCM; and
 - g. GCM costs are reported in the non-reimbursable section of the cost report

Example for Chronic Care Management (CCM)

Revenue Code	HCPCS code	Modifier	Service Date
052X	G0511 Qualifying Visit		01/25/2023

Chronic Care Management - Outside of FQHC and RHC is reported with CPT 99487, 99489, 99490, and 99491

Example General Behavioral Health Integration (BHI)

Revenue Code	HCPCS Code	Modifier	Service Date
052X	G0511 Qualifying Visit		01/25/2023

Behavioral Health Integration - Outside of FQHC and RHC is reported with CPT 99484

Example Principal Care Management:

Revenue Code	HCPCS Code	Modifier	Service Date
052X	G0511 Qualifying Visit		01/25/2022

Principal Care Management - Outside of FQHC and RHC is reported with HCPCS G0264 and G0265

Psychiatric Collaborative Care Model (CoCM)

1. Psychiatric CoCM is a specific model of care provided by a primary care team which must consist of a primary care practitioner, a behavioral healthcare manager, and a psychiatric consultant. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - a. CoCM includes regular psychiatric inter-specialty consultation with the primary care team and a patient with mental health, behavioral health, or psychiatric conditions, including substance use disorders, whose conditions are not improving.
 - i. The FQHC practitioner is a primary care physician, NP, PA, or CNM who directs the care management team.
 - ii. The behavioral healthcare manager is a designated individual with formal education or specialized training in behavioral health and has a minimum of a bachelor's degree in a behavioral health field.

The behavioral manager furnishes both face-to-face and non-face-to-face services under general supervision. Other FQHC staff may provide related services under general supervision.
 - iii. The psychiatric consultant is a medical professional trained in psychiatry and is qualified to prescribe the full range of medications. The consultant is not required to be on-site or have face-to-face contact with the patient.
 - b. CoCM is reported with HCPCS code G0512 – FQHC psychiatric collaborative care model, 60 minutes or more of clinical staff time for psychiatric CoCM services directed by an FQHC or FQHC practitioner (physician, NP, PA, or CNM), including services furnished by a behavioral healthcare manager, and consultation with a psychiatric consultant, per calendar month.
 - i. A separately billable initiating visit with an FQHC primary care practitioner (physician, NP, PA, or CNM) is required before CoCM services can be provided. The initiating visit can be an E/M, AWW, or IPPE and must occur no more than one year prior to starting CoCM.
 - a) Psychiatric CoCM services do not need to be discussed during the initiating visit. The same initiating visit can be used for psychiatric CoCM and GCM services, if it occurs with an FQHC primary care practitioner within one year of the start of psychiatric CoCM services.

- ii. Although CoCM is an FQHC service, it is paid under the MPFS
 - a) For CY 2023, the national payment rate is \$147.07.
 - b) MPFS coinsurance applies.
- iii. CoCM can be billed alone or with another qualifying visit on the same date of service.
- iv. For dates of service on or after January 1, 2022, FQHCs may bill for both TCM and other care management services (e.g., GCM, CoCM) provided during the same month. <See *CY 2022 Medicare Physician Fee Schedule Fact Sheet*>
- v. CoCM costs are reported in the non-reimbursable section of the cost report.

Example Psychiatric Collaborative Care Model (CoCM)

Revenue Code	HCPCS Code	Modifier	Service Date
052X	G0512 Qualifying Visit		01/25/2022

Psychiatric Collaborative Care - Outside of FQHC and RHC is reported with HCPCS 99493 and 99494

M. Virtual Communication Services (VCS)

- 1. Effective for dates of service on or after January 1, 2019, an FQHC may receive an additional payment for the costs of certain communication technology-based services or remote evaluation services that are not already captured in the FQHC PPS payment when the following conditions are met. <See *Medicare Benefit Policy Manual*, Chapter 13 § 240; see *Virtual Communication Services in Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions December 2018*; >
 - a. An FQHC practitioner must provide at least 5 minutes of certain communications-based technology or remote evaluation services to a patient who has been seen in the FQHC within the previous year.

- i. Face-to-face requirements are waived.
 - ii. The medical discussion or remote evaluation must be for a condition that is not related to an FQHC service provided within the previous seven days and does not lead to an FQHC service within the next 24 hours or at the soonest available appointment.
 - iii. If the discussion between the patient and the FQHC practitioner is related to a prior billable visit furnished by the FQHC within the previous seven days or within the next 24 hours or at the soonest available appointment, the cost of the FQHC practitioner's time would be included in the FQHC PPS payment for the visit and is not separately billable as VCS.
 - iv. VCS services performed by FQHCs are reported with HCPCS code G0071
- b. Initially VCS services billable by FQHCs and reported with G0071 included only those services described by HCPCS codes G2010 or G2012. For dates of service on or after January 1, 2021, CMS has replaced the original codes with HCPCS codes G2250, G2251 and G2252 to describe the services reportable by FQHCs with VCS HCPCS code G0071:
- i. HCPCS G2250 - Remote assessment of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; replaces HCPCS code G2010;
 - ii. HCPCS G2251 - Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available, 5-10 minutes; replaces HCPCS code G2012;
 - iii. HCPCS G2252 – Same definition as G2251, except 11-20 minutes
2. For dates of service on or after March 1, 2020 and throughout the duration of the COVID-19 PHE, CMS is also expanding VCS (reportable by FQHCs with HCPCS G0071) to include certain additional online digital evaluation and management services using patient portals.

- a. Online digital evaluation and management services are non-face-to face, patient-initiated, digital communications using a patient portal, that require a clinical decision that otherwise typically would have been provided in the clinic by an FQHC practitioner.
 - b. A patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an Internet connection by using a secure username and password
 - c. The following codes describe the expanded VCS services which are reportable with HCPCS code G0071 during the PHE:
 - i. 99421 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 5-10 minutes);
 - ii. 99422 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 11-20 minutes); and,
 - iii. 99423 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 21 or more minutes).
 - d. An FQHC practitioner can respond from any location during time scheduled to work in the FQHC.
3. Services described by the expanded online digital assessment codes, as well as those described by HCPCS codes G2010 and G2012 (or their replacement codes), should be billed by FQHCs using HCPCS code G0071.
 - a. Although VCS is an FQHC service, it is paid under the MPFS, not the FQHC PPS.
 - i. For CY 2023, the payment rate for G0071 is \$23.72.
 - ii. MPFS coinsurance applies.
 - b. Because these codes are for a minimum 7-day period of time, FQHCs cannot bill G0071 more frequently than once every seven days.

- c. VCS may be provided to new and established patients, as long as patient consent has been obtained.

Link: Rural Health Clinics Center under Medicare Related Sites – Rural Health

Select COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) under the Frequently Asked Questions section.

N. Telehealth Services

1. Originating site telehealth services

- a. Although telehealth is not an FQHC benefit, the clinic may serve as an originating site for telehealth services. Originating site refers to the location of the patient at the time the service is being furnished via telecommunications systems. <See *Medicare Benefit Policy Manual*, Chapter 13 § 200>
- b. The originating site facility fee is reported with revenue code 0780 and HCPCS code Q3014.
 - i. The payment rate for originating site telehealth services is made under the MPFS and is updated annually.
 - ii. For CY 2022, the payment rate for HCPCS code Q3014 is the lesser of \$27.59 or billed charges. <*Medicare Claims Processing Manual* Transmittal 10505>
 - iii. MPFS deductible applies
 - a) Given that the telehealth originating site facility fee is not an FQHC service, the MPFS deductible applies.
 - iv. MPFS coinsurance applies
- c. Exception for telehealth services during the COVID-19 PHE
 - i. Effective for dates of service on or after March 6, 2020, an eligible originating site location includes the patient's home. <*MLN Matters SE20016*, revised January 13, 2022>
- d. An originating site facility service may be billed as the only billable service provided or in addition to a qualifying visit billed with revenue code 052X and/or 0900. <*Medicare One Time Notification Transmittal 1540*>

- e. Although the charges for originating site services are reported on the claim, they are reported in a special section in the cost report and are not taken into consideration in the calculation of the PPS payment.

2. Distant site telehealth services

- a. Usually, an FQHC may not serve as a distant site for telehealth services. Distant site refers to the location of the practitioner at the time of the service. <See *Medicare Benefit Policy Manual*, Chapter 13, § 200>
- b. Exception during the COVID-19 PHE
 - i. Prior to January 27, 2020, distant site services could not be billed by an FQHC. This includes telehealth services that are furnished by an FQHC practitioner who is employed by or under contract with the FQHC or a non-FQHC practitioner furnishing services through a direct or indirect contract. <*MLN Matters SE20016*, revised November 22, 2022 >
 - ii. Section 3704 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) authorizes FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. <*CARES January Act*>
 - a) Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. <*MLN Matters SE20016*, revised November 22, 2022 >
 - b) Distant site telehealth services can be furnished by any health care practitioner working for the FQHC within their scope of practice from any location, including their home, during the time that they are working for the FQHC and can furnish any telehealth service that is approved as a distant site telehealth service under the Medicare Physician Fee Schedule (MPFS). <*MLN Matters SE20016*, revised November 22, 2022; see *CMS Rural Health Clinic Center* website at [Rural Health Clinics Center | CMS](#)>

Link: Telehealth under Medicare Related Sites – Physician/Practitioner

See left navigation for a list of telehealth services

- iii. For distant site telehealth services beginning January 27, 2020, FQHCs must report HCPCS code G2025 for any covered service on the CMS telehealth list.

- a) Initially, CMS provided the following additional billing guidance for FQHC telehealth services. For dates of service from January 27 - June 30, 2020, that describe qualifying visits.
- 1) The FQHC Prospective Payment System (PPS) specific payment code (G0466, G0467, G0468, G0469, or G0470)
 - 2) The HCPCS/CPT code that describes the services provided via telehealth with modifier -95
 - 3) G2025 with modifier -95
 - 4) For COVID-19 testing-related services and preventive services not subject to cost sharing, FQHCs must waive collection of coinsurance from beneficiaries and attach modifier -CS to receive full payment from Medicare.
- b) Effective March 1, 2020, CMS included CPT codes 99441, 99442, and 99443 (which are audio-only telephone evaluation and management (E/M) services) in the list of covered telehealth services. FQHCs can also furnish and bill for these services using HCPCS code G2025, as long as the following requirements are met.
- 1) At least 5 minutes of medical discussion for a telephone E/M service by a physician or other qualified health care professional who may report E/M services are provided to a new or established patient, parent, or guardian.
 - 2) These services do not originate from a related E/M service provided within the previous 7 days or lead to another E/M service or a procedure within the next 24 hours or the soonest available appointment, including a service furnished via telehealth. <COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, updated 09/11/20>
 - 3) All otherwise applicable billing requirements for distant site telehealth services are met, including the reporting of modifiers (-95) when appropriate. <See *MLN Matters SE20016*, revised November 22, 2022>

Telehealth Visit Example

Revenue Code	HCPCS Code	Modifier	Service Date
052X	G2025	-95	01/25/2022

Note: Initially, payment was based on the actual FQHC rate, not the lesser of the FQHC rate or billed charges. Initially, coinsurance for distant site services was 20% of billed charges and payment was 80% of the FQHC rate (\$92.03) minus coinsurance. The intent, however, was for coinsurance and payment to be based on the lesser of the FQHC rate or billed charges.

- f) For dates of service during CY 2023, FQHC payment for HCPCS code G2025 is based upon the updated national rate of \$95.88, utilizing the "lesser of" methodology. <See *MLN Matters SE20016*, revised November 22, 2022>
- g) Cost reporting for telehealth services during the COVID-19 PHE
 - a. Costs for furnishing distant site telehealth services will not be used to determine the FQHC PPS rate; however, the costs must be reported on the appropriate cost report form. <*MLN Matters SE20016*, revised November 22, 2022>
 - i. FQHCs must report both originating site and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than FQHC Services."

Telehealth Services – Cost Sharing Waived Example

July 1, 2020

Revenue Code	HCPCS Code	Modifier	Service Date
052X	G2025	CS, -95 (optional)	01/25/2022

4. Virtual Mental Health Services

- b. Beginning January 1, 2022, CMS allows FQHCs to report and receive payment for virtual mental health visits in the same manner as if the visit was provided in-person. <See *MLN Matters* SE22001; 86 Fed. Reg. 39229;>
- c. Generally, these visits are furnished using two-way (audio/video) interactive real-time telecommunications technology. There is an exception that permits audio-only visits when the beneficiary is not capable of, or does not consent to, use of video technology.
 - i. When furnished using two-way technology, FQHCs should attach modifier --95.
 - ii. When furnished with audio only, FQHCs should report modifier –FQ.
- d. An initial in-person, non-telehealth visit is required within six months prior to initiation of virtual mental health services. At least one additional in-person, non-telehealth visit is required every 12 months thereafter.
 - i. An exception to the 12-month in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient’s medical record).
 - ii. More frequent visits are allowed, as driven by clinical needs on a case-by-case basis.

Virtual Mental Health Service Example

Revenue Code	HCPCS Code	Modifier	Service Date
0900	G0470 (or other appropriate FQHC specific Mental Health Visit Payment Code)	-95 (audio-video) or -FQ (audio-only)	01/25/2022
0900	90834 (or other FQHC PPS Qualifying Mental Health Visit Payment Code)	N/A	01/25/2022

O. Services Provided to a Hospice Patient

1. An FQHC may provide care to a hospice patient for any medical condition that is not related to their terminal illness. <See Medicare Benefit Policy Manual, Chapter 13 § 210.2>
 - a. In most cases, if the patient receives care from an FQHC practitioner during clinic hours for a condition that is related to the terminal illness, the FQHC cannot separately bill for or be reimbursed for the face-to-face visit, even if it is medically necessary.
 - b. Two exceptions
 - i. The FQHC has a contract with the hospice provider to furnish core hospice services when extraordinary circumstances exist within the hospice such as temporary staffing shortages, unanticipated high census, or temporary travel by the patient outside of their hospice's service area. <42 C.F.R. 418.64; see Medicare Benefit Policy Manual, Chapter 13 § 210.2>

- ii. The FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are not usually provided by the hospice and for the hospice to employ a nurse with that skill would be impractical and expensive. <42 C.F.R. 418.64; see *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
 - a) Costs associated with these hospice exceptions should not be reported on the clinic's cost report since the FQHC is reimbursed by the hospice under its contract.
- 2. Unless prohibited by their employment contract or scope of practice, a practitioner who is employed by the FQHC can provide hospice services when he or she is not working at the FQHC. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.1>

Any service provided to a hospice patient by an FQHC practitioner must comply with the prohibition on commingling and the practitioner would bill the hospice service to Part B under his or her own provider number.

- 3. Effective January 1, 2022, FQHCs can bill and receive payment under the FQHC PPS payment, when a designated attending physician, NP, or PA who is employed by or working under contract with the FQHC furnishes hospice attending services during the patient's hospice election. <See *Medicare Claims Processing Manual*, Chapter 9 § 60.6; see *Claims Processing Transmittal 11029 and MLN Matters 12357*>
 - a. Modifier --GV must be reported on the claim line each day a hospice attending physician services are furnished.

Hospice Service Example

Revenue Code	HCPCS Code	Modifier	Service Date
0521	G0466/G0470 FQHC Payment	-GV	01/25/2023
0521	Hospice Qualifying Visit		01/25/2023

- i. When the FQHC furnishes a hospice attending physician service that has a technical component, the technical component must be billed separately to the hospice for payment.

b. Coinsurance applies.

P. Visiting Nurse Services

1. The following requirements must be met for a visiting nurse service to be considered a covered FQHC visit. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 190.2, 190.3, 190.4>
 - a. There is a shortage of home health agencies in the area where the FQHC is located, as determined by CMS.
 - i. An FQHC located in an area that does not have a current home health shortage may make a written request to the CMS Regional Office for authorization to provide visiting nurse services.
 - b. The patient is confined to the home. <*Social Security Act* § 1835(a)>
 - c. The services are furnished under a written plan of treatment and under the supervision of a physician, NP, PA, CNM, or CP. <See *Medicare Benefit Policy Manual*, Chapter 13 § 190.5>
 - i. The plan of treatment must be reviewed by the supervising practitioner at least once every 60 days.
 - ii. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated unless:
 - a) The supervising practitioner has made a recertification within the 60-day period and the lapse of visits is part of the treatment plan; or,
 - b) The documentation supports that visiting nurse services are required at predictable intervals that occur less than once every 60 days (i.e., once every 90 days).
 - d. The nursing services are furnished on a part-time or intermittent basis only.
 - e. Drugs and biological products are not provided during the visit.

2. A visiting nurse may provide skilled nursing services in a patient's home as determined by an FQHC practitioner to be medically necessary for the diagnosis and treatment of an illness or injury based on the patient's unique medical condition. <See *Medicare Benefit Policy Manual*, Chapter 13 § 190.1>
 - a. The determination of whether visiting nurse services are reasonable and necessary is made by the FQHC practitioner, based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

3. For the duration of the COVID-19 PHE, CMS is revising certain requirements for coverage of visiting nurse services. <COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs)>
 - a. CMS will assume that the area typically served by the FQHC has a shortage of home health agencies, and no explicit shortage determination is required.
 - b. However, an FQHC must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.
 - c. Visiting nurse services are only billable as an FQHC visit when they require skilled nursing services.
 - i. For example, a nurse's collection of specimen to test for Covid-19 would not be a billable visit since no skilled services were provided.

Link: Rural Health Clinics Center under Medicare Related Sites – Rural Health

Select COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) under the Frequently Asked Questions section.

Q. Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) Services

1. PT, OT, and SLP services may be performed by a physician, NP, or PA when the services provided are within their scope of practice and state law. <See *Medicare Benefit Policy Manual*, Chapter 13 § 180>
 - a. A physician, NP, or PA may also supervise a therapist who provides services incident to a qualifying visit in the FQHC.

- i. A therapist providing incident to services may be employed or contracted by the FQHC.
- b. The charges for the therapy services are included in the qualifying visit if:
 - i. The therapy services are furnished by a qualified therapist as part of an otherwise billable visit, and the service is within the scope of practice of the therapist.
 - ii. If the services are provided by a therapist on a day when a qualifying visit was not provided, the therapy service would only be reported on the cost report.

If a therapist in private practice furnishes services in the RHC, the charges may not be reported on the FQHC claim. All associated costs must also be carved out of the FQHC's cost report.

V. General Billing Requirements for Diagnostic Tests and Laboratory Services

A. Diagnostic Tests

1. Generally, only the professional component of a diagnostic test is a benefit in an FQHC. The technical component of a diagnostic test is not a benefit of an FQHC and cannot be billed on TOB 077X. <See *Medicare Claims Processing Manual*, Chapter 9, §§ 60, 90>
 - a. Technical services/components of diagnostic tests performed by an independent FQHC are billed to the Part B MAC on the CMS-1500 claim form. <*Medicare Claims Processing Manual*, Chapter 12, § 80.2>
 - b. Technical services/components of diagnostic tests performed by a provider-based FQHC are billed to the Part A MAC on the UB-04 claim form with an appropriate base-provider bill type (i.e., TOB 085X CAH or TOB 0131 OPSS). <*Medicare Claims Processing Manual*, Chapter 4, § 280>

2. Laboratory Services

- a. Although FQHCs are required to furnish certain diagnostic laboratory services as defined in the Public Health Services Act, laboratory services are not within the scope of the FQHC benefit. < See *Medicare Benefit Policy Manual*, Chapter 13, § 60.1>

- b. Excluding venipuncture, all laboratory services must be billed separately on the appropriate claim form (i.e., 1500 or UB04),
 - i. Application of the deductible and/or coinsurance will not apply to laboratory services paid under the Clinical Laboratory Fee Schedule (CLFS).
 - ii. The costs of the space, equipment, supplies, facility overhead and staff associated with the laboratory services may not be reported on the FQHC cost report. <See *Medicare Claims Processing Manual*, Chapter 9 § 90; see *Medicare Benefit Policy Manual*, Chapter 13 § 60.1>
- c. When performed by the physician, non-physician practitioner, or other qualified staff incident to a qualifying visit, the cost associated with the venipuncture is included in the FQHC PPS payment. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60.1; see *Medicare Claims Processing Manual*, Chapter 9 § 90>
- d. The venipuncture charge is included with the charge for the qualifying visit.
- e. The venipuncture is also reported on a separate line with the appropriate revenue code, HCPCS code, and charge.
- f. If the venipuncture is the only service provided without a qualifying visit, the service cannot be billed separately on the FQHC claim.
 - i. If a qualifying visit was previously billed and the venipuncture occurred within a medically appropriate timeframe, the FQHC may correct the original claim using TOB 0777 (replacement claim).
 - (a) The charge for the venipuncture can be added to the qualifying visit charge and the claim rebilled using the date of service for the qualifying visit.
 - (b) The coinsurance will be based on the total amount for the rebilled qualifying visit. The FQHC will not receive an additional PPS for the replacement claim.
- g. If the venipuncture is the only service that was provided on a specific date and a qualifying visit does not exist within the FQHC's medically appropriate timeframe policy, the charge for the venipuncture is not eligible to be separately billed as a qualifying visit.
 - i. The cost of the venipuncture can be reported on the cost report

VI. Special Billing Considerations

A. Exclusion from the Three-Day Payment Window

1. Even though an FQHC is an “entity” under the three-day payment window, CMS does not apply this policy to the FQHC setting. <76 *Fed. Reg.* 73281-82; see *Medicare Benefit Policy Manual*, Chapter 13 § 40.5>

B. FQHC Practitioner Visits to Swing Bed Patients

1. To address the shortage of skilled nursing facility beds, rural hospitals with fewer than 100 beds may be reimbursed for furnishing post-hospital extended care services to Medicare beneficiaries. <*Medicare Benefit Policy Manual*, Chapter 8 § 10.3>
 - a. This type of hospital may “swing” its beds between acute hospital care and a SNF level of care, on an as needed basis, if it has obtained swing bed approval from CMS.
2. As discussed earlier in this module, revenue code 0524 (Visit by an FQHC practitioner to a member in a SNF or skilled swing bed in a covered Part A SNF stay) may be reported for a qualifying visit to a patient in a SNF or skilled swing bed in a covered Part A SNF stay.
 - a. When a hospital or CAH is providing extended care services, it will be treated as a SNF for purposes of applying coverage rules. This means that services provided in the swing bed are subject to the same Part A coverage, deductible, coinsurance, and physician certification and recertification provisions that are applicable to SNF extended care services. <*Medicare Benefit Policy Manual*, Chapter 8 § 10.3>
3. Although a CAH’s swing bed patient is receiving a SNF level of care and the CAH is reimbursed for providing skilled care, a CAH swing bed patient is not a SNF patient and instead, is a patient of the CAH.

An FQHC should seek further clarification from their MAC and/or CMS Regional Office Rural Health Coordinators as to whether it is appropriate to report revenue code 0524 for a qualifying visit to a swing bed patient in a CAH.

C. Application of Global Surgery Concept

1. Surgical procedures furnished in the FQHC during a qualifying visit are included in the FQHC PPS payment. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.4>
2. If an FQHC provides services to a patient who had a surgical procedure elsewhere and the patient is still in the global billing period, the FQHC must determine if the services it provides are already included in another facility's or clinic's surgical global billing period and payment. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.4>
 - a. The FQHC may bill for a qualifying visit during the global surgical period if the visit is for a service that is not part of the usual surgical service, including: <See *Medicare Claims Processing Manual*, Chapter 12 § 40.4>
 - i. An initial consultation to determine the need for a major surgery;
 - ii. A medical visit unrelated to the diagnosis for which the surgical procedure was performed; or,
 - iii. A medical visit due to complications from the surgery, treatment for the underlying condition, or an added course of treatment which is not part of the normal recovery period.

VII. Appropriate Use Criteria (AUC) for Advanced Imaging Services

A. General Overview

1. An ordering physician must consult a qualified Clinical Decision Support Mechanism (CDSM) before ordering certain advanced imaging services for a Medicare patient. <See *Medicare One Time Notification Transmittal 2404*>
 - a. Advanced imaging services include MRI, CT scans, nuclear medicine, and PET scans.
 - b. Information about the CDSM, or an exception, must be reported on the claim for the advanced imaging service that is performed in an applicable setting, in order for the claim to be paid under an applicable payment system.

B. Applicable Settings and Payment Systems

1. A CDSM consultation must take place for any applicable imaging service ordered by a practitioner that would be furnished in an applicable setting *and* would be paid under an applicable payment system. <See *Medicare One Time Notification Transmittal 2404*>

The applicable setting is where the imaging service is performed, not the setting where the imaging service is ordered.

- a. Settings that must report CDSM information on their claim include physician offices, independent diagnostic testing facilities (IDTF), ambulatory surgery centers (ASC), and hospital outpatient departments, including emergency departments. <See *Medicare One Time Notification Transmittal 2404*; 42 C.F.R. § 414.94(a)>
- b. Payment systems that require reporting CDSM information on their claims include the Medicare Physician Fee Schedule (MPFS), the Outpatient Prospective Payment System (OPPS), and the Ambulatory Surgery Center (ASC) payment system. <See *Medicare One Time Notification Transmittal 2404*; 42 C.F.R. § 414.94(a)>
 - i. A FQHC is paid under the PPS system and is required to report the informational HCPCS G-codes or related modifiers -MA through -MH obtained through the CDSM. <*MLN Matters SE20002*>
 - ii. In general, an FQHC is paid under the PPS system for its visits and incident to services.
 - (a) An FQHC is also paid under the MPFS for certain services, such as Care Management Services, Virtual Communication Services, and telehealth.
 - (b) However, if an FQHC practitioner orders an advanced imaging service for a Medicare patient that will be furnished in an applicable setting *and* paid under an applicable payment system, the CDSM must be consulted, and the information must be provided to the furnishing practitioner to include on their claim.

C. Ordering Practitioner Requirements

1. When ordering an advanced imaging service that will be furnished in an applicable setting *and* paid under an applicable payment system, the ordering practitioner must consult a CDSM, unless an exception applies. <See *Medicare One Time Notification Transmittal 2404*; 42 *C.F.R.* § 414.94(j) and (k)>
2. Exceptions to consulting CDSM for AUC:
 - a. Emergency services provided to patients with emergency medical conditions, as defined under EMTALA (modifier -MA);
 - b. Tests ordered for inpatients or paid under Part A;
 - c. Significant hardship for the ordering practitioner due to insufficient internet access (modifier -MB), EHR or CDSM vendor issues (modifier -MC), or extreme and uncontrollable circumstances (modifier -MD). <42 *C.F.R.* § 414.94(j) and (k); 83 *Fed. Reg.* 59697-700>
 - i. If a significant hardship applies, the ordering practitioner self-attests at the time of ordering the advanced imaging service and communicates this to the furnishing provider who will include the appropriate modifier on the CPT code for the applicable advanced imaging service. <83 *Fed. Reg.* 59697-700; see *Medicare One Time Notification Transmittal 2404*>
 - ii. For more details on circumstances representing a significant hardship, see the CY 2019 Medicare Physician Fee Schedule Final Rule, 83 *Fed. Reg.* 59699-700.
3. The requirement to consult a CDSM may be met by delegating to clinical staff acting under the direction of the ordering practitioner. <42 *C.F.R.* § 414.94(j)(2)>

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Version 01/17/2023
Check for Updates

Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)

(Rev. 12-06-17)

In accordance with Section 1834(o)(1)(A) and 1834(o)(2)(C) of the Social Security Act, we established specific payment codes that FQHCs must use when submitting a claim for FQHC services for payment under the FQHC PPS. Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other FQHC services furnished during the encounter are also required.

FQHC Visits

A FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between a FQHC patient and a FQHC practitioner during which time one or more FQHC services are furnished. A FQHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW), or a certified diabetes self-management training/medical nutrition therapy (DSMT/MNT) provider.

A FQHC visit can also be a visit between a home-bound patient and a RN or LPN under certain conditions. Outpatient DSMT/MNT, and transitional care management (TCM) services also may qualify as a FQHC visit when furnished by qualified practitioners and the FQHC meets the relevant program requirements for provision of these services. If these services are furnished on the same day as an otherwise billable visit, only one visit is payable.

The PPS is designed to reflect the cost for all the services associated with a comprehensive primary care visit, even if not all the services occur on the same day. Stand-alone billable visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. The professional component of a procedure is usually a covered service, but is not a stand-alone billable visit, even when furnished by a FQHC practitioner.

To qualify for Medicare payment, all the coverage requirements for a FQHC visit must be met. A FQHC visit must be furnished in accordance with the applicable regulations at 42 CFR Part 405 Subpart X, including 42 CFR 405.2463 that describes what constitutes a visit. For additional information on FQHC policies and requirements, see CMS Pub 100-02, Chapter 13, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>.

Effective January 1, 2016 *through December 31, 2017* CPT code 99490 (chronic care management *CCM*) is paid based on the PFS non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a FQHC claim. When reporting this service as a stand-alone billable visit a FQHC payment code is not required. *Service lines reported with CPT code 99490 will be denied for dates of service on or after January 1, 2018.*

Effective January 1, 2018 HCPCS code G0511 is reported for CCM or general Behavioral Health Integration (BHI). Payment is set annually at the average of the national non-facility PFS payment

rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services). When reporting HCPCS code G0511 as a stand-alone billable visit a FQHC payment code is not required.

Effective January 1, 2018 HCPCS code G0512 is reported for psychiatric Collaborative Care Model (CoCM) services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services). When reporting HCPCS code G0512 as a stand-alone billable visit a FQHC payment code is not required.

Specific Payment Codes



Following are the specific payment codes and the appropriate descriptions of services that correspond to these payment codes. FQHCs must use these codes when submitting claims to Medicare under the FQHC PPS:

G0466 – FQHC visit, new patient

A medically-necessary, face-to-face (one-on-one) encounter between a new patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services. A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.

To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”

If a new patient is also receiving a mental health visit on the same day, the patient is considered “new” for only one of these visits, and FQHCs should use G0466 to bill for the medical visit and G0470 to bill for the mental health visit.

Additional information on new patient determinations is available on the CMS FQHC PPS website (<http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.htm>) under “Frequently Asked Questions” (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf>).

G0467 – FQHC visit, established patient

A medically-necessary, face-to-face (one-on-one) encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services. An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.

To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”

If an established patient is also receiving a mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit.

G0468 – FQHC visit, IPPE or AWW

A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWW, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467.

G0469 – FQHC visit, mental health, new patient

A medically-necessary, face-to-face (one-on-one) mental health encounter between a new patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving a mental health visit.

A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.

To qualify as a FQHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy. If a new patient is receiving both a medical and mental health visit on the same day, the patient is considered “new” for only one of these visits, and FQHCs should not use G0469 to bill for the mental health visit; instead, FQHCs should use G0466 to bill for the medical visit and G0470 to bill for the mental health visit.

G0470 – FQHC visit, mental health, established patient

A medically-necessary, face-to-face (one-on-one) mental health encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving a mental health visit. An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.

If an established patient is receiving both a medical and mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit.

To qualify as a FQHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy.

Adjustments Applicable to Specific Payment Codes¹

¹ This section does not apply to grandfathered tribal FQHCs

New Patient Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC. For medical visits, use G0466 only if the beneficiary is new to the FQHC or any of its sites for any professional services. For mental health visits, use G0469 only if the beneficiary is new to the FQHC or any of its sites for any professional services.

IPPE and AWW Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary. A FQHC that furnishes an IPPE or AWW would include all medical services in G0468. FQHCs would not bill G0466 or G0467 on the same day, unless there was a subsequent illness or injury that would qualify for additional payment, which the FQHC would attest to by submitting the claim with modifier 59.

Qualifying Visits

The qualifying visits that correspond to the specific payment codes are as follows:

G0466 - FQHC visit, new patient

HCPCS	Qualifying Visits for G0466
92002	Eye exam new patient
92004	Eye exam new patient
97802	Medical nutrition indiv in
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min
99497	Advncd care plan 30 min
G0101	Ca screen; pelvic/breast exam
G0102	Prostate ca screening; dre
G0108	Diab manage trn per indiv

HCPCS Qualifying Visits for G0466

G0117	Glaucoma scrn hgh risk direc
G0118	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
G0490	Home visit RN, LPN by RHC/FQ
Q0091	Obtaining screen pap smear

G0467 – FQHC visit, established patient:**HCPCS Qualifying Visits for G0467**

92012	Eye exam establish patient
92014	Eye exam & tx estab pt 1/>vst
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessmnt
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est pat
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min

HCPCS Qualifying Visits for G0467

99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min
G0101	Ca screen; pelvic/breast exam
G0102	Prostate ca screening; dre
G0108	Diab manage trn per indiv
G0117	Glaucoma scrn hgh risk direc
G0118	Glaucoma scrn hgh risk direc
G0270	Mnt subs tx for change dx
G0296	Visit to determ LDCT elig
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
G0490	Home visit RN, LPN by RHC/FQ
Q0091	Obtaining screen pap smear

G0468 – FQHC visit, IPPE or AWW:**HCPCS Qualifying Visits for G0468**

G0402	Initial preventive exam
G0438	Ppps, initial visit
G0439	Ppps, subseq visit

G0469 – FQHC visit, mental health, new patient:**HCPCS Qualifying Visits for G0469**

90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvc
90832	Psytx pt &/family 30 minutes
90834	Psytx pt &/family 45 minutes
90837	Psytx pt &/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

G0470 – FQHC visit, mental health, established patient:**HCPCS Qualifying Visits for G0470**

90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvc
90832	Psytx pt &/family 30 minutes

HCPCS Qualifying Visits for G0470

90834	Psytx pt &/family 45 minutes
90837	Psytx pt &/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

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Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Frequently Asked Questions

December 2019

Topics:

- I. Care Management Services – General
- II. Care Management Services – Billing, Claims Processing, and Payment
- III. Care Management Services – Program Requirements
 - a. Initiating Visit
 - b. Consent and Opting Out
 - c. Care Plan
- IV. Care Management Service - Care Team
 - a. Behavioral Health Care Manager
 - b. Psychiatric Consultant
 - c. Auxiliary Staff

I. Care Management Services – General

Q1. What are care management services?

A1. Care management services in RHCs and FQHCs include the following 4 services:

- Transitional care management (TCM)
- Chronic care management (CCM)
- General behavioral health integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)

Q2. Are care management services considered RHC and FQHC services?

A2. Yes, care management services are RHC and FQHC services.

Q3. Are RHCs and FQHCs required to provide TCM, CCM, general BHI, or psychiatric CoCM services?

A3. No. These structured care management services are in addition to any routine care coordination services already furnished as part of an RHC or FQHC visit.

Q4. Where can I find information on the requirements for each of the care management services?

A4. Please see Addendum I of this FAQ document for information on RHC and FQHC requirements and payment for CCM, General BHI, and Psychiatric CoCM. Information is also available on the RHCs and FQHCs webpages:

<https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

II. Care Management Services – Billing, Claims Processing, and Payment

Q5. How do RHCs and FQHCs bill for care management services and how are they paid?

A5. Care Management services are billed and paid as follows:

TCM: For TCM services furnished on or after January 1, 2013, TCM services can be billed by adding CPT code 99495 or CPT code 99496 to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit is paid.

CCM: For CCM services furnished between January 1, 2016 and December 31, 2017, CCM services can be billed by adding CPT code 99490 to an RHC or FQHC claim, either alone or with other payable services. Payment is based on the Physician Fee Schedule (PFS) national average non-facility payment rate for CPT code 99490.

For CCM services furnished on or after January 1, 2018, CCM services can be billed by adding the general care management G code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

For CCM services furnished on or after January 1, 2019, CCM services can be billed by adding the general care management G code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), CPT code 99491 (30 minutes or more of CCM services furnished by an RHC or FQHC practitioner) and 99484 (20 minutes or more of general behavioral health integration services).

General BHI: For general BHI services furnished on or after January 1, 2018, general BHI services can be billed by adding the general care management G code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

Psychiatric CoCM: For psychiatric CoCM services furnished on or after January 1, 2018, psychiatric CoCM services can be billed by adding the psychiatric CoCM G code, G0512, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services).

Q6. What are the 2019 payment rates for care management services in RHCs and FQHCs?

A6. The 2019 care management payment rates are:

TCM (CPT code 99495 or 99496) – Same as payment for an RHC or FQHC visit

CCM or General BHI (HCPCS code G0511) – The 2019 rate is \$67.03.

Psychiatric CoCM (HCPCS code G0512) - The 2019 rate is \$145.96.

Q6a. What are the 2020 payment rates for care management services in RHCs and FQHCs?

A6a. The 2020 care management payment rates are:

TCM (CPT code 99495 or 99496) – Same as payment for an RHC or FQHC visit

CCM or General BHI (HCPCS code G0511) – The 2020 rate is \$66.77.

Psychiatric CoCM (HCPCS code G0512) - The 2020 rate is \$141.83.

Q7. Will the payment rate change?

A7. All payment rates are adjusted annually. The RHC TCM rate is the same as the RHC All-Inclusive Rate (AIR), which is adjusted annually based on the Medicare Economic Index. The FQHC TCM rate is the lesser of the FQHC's charges or the FQHC PPS rate, which is adjusted annually based on the FQHC Market Basket. The payment rates for general care management and psychiatric CoCM services are updated annually based on updates to the CCM, general BHI, and psychiatric CoCM codes in the PFS.

Q8. Will the payment methodology for care management services change?

A8. We will be reviewing available data over the next several years as more RHCs and FQHCs furnish these services. If the data indicates that a weighted average may be more appropriate in determining the payment rates, we would consider proposing a revision to the methodology. Any changes to the payment methodology would be undertaken through future notice and rulemaking.

Q9. Could new care management services be added in the future?

A9. If new care management services become available, we will evaluate them to determine their applicability to RHCs and FQHCs. The addition of any new codes or services would be undertaken through future notice and rulemaking.

Q10. Will claims submitted with CPT 99490 be paid?

A10. Claims with CPT code 99490 for CCM services furnished on or before December 31, 2017, will be processed and paid. Service lines reported with CPT code 99490 will be denied for dates of service on or after January 1, 2018.

Q11. Will claims with CPT codes 99487, 99484, or 99493 be paid?

A11. No. RHCs and FQHCs are required to bill for care management services using G0511 or G0512.

Q12. Do coinsurance and deductibles apply to care management services?

A12. Coinsurance and deductibles apply to all care management services in RHCs, and coinsurance applies to all care management services in FQHCs.

Q13. If a patient cannot afford the copayment but would benefit from this service, can the copayment be waived?

A13. The coinsurance for care management services cannot be waived, however, many RHCs and FQHCs offer financial assistance for patients who qualify.

Q14. How is coinsurance determined for care management services?

A14. Coinsurance is the lesser of the submitted charges or the payment rate.

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Q15. What are the care management CPT codes and rates for practitioners billing under the PFS?

A15. The CPT codes for practitioners billing under the PFS are:

TCM - CPT code 99490 (Moderate Complexity), CPT code 99496 (High Complexity)

CCM - CPT code 99490 (≥ 20 minutes), CPT code 99487 (≥ 60 minutes complex), CPT 99491 (≥ 30 minutes_practitioner furnished)

General BHI - -CPT code 99484 (≥ 20 minutes)

Psychiatric CoCM - CPT code 99492 (Init. ≥ 70 min.), CPT code 99493 (Subseq. ≥ 60 min.)

The care management rates paid under the PFS can be found at

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html?redirect=/pfslookup/02_pfssearch.asp

Q16. Are care management services required to be billed on a claim with an RHC or FQHC visit?

A16. No. Care management services can be billed either alone or on a claim with an RHC or FQHC billable visit.

Q17. Will care management services be paid in addition to an RHC or FQHC visit?

A17. Yes. If care management services are billed on the same claim as an RHC or FQHC visit, both will be paid.

Q18. If an RHC submits a claim for a billable visit and a care management service, is the total payment subject to the RHC payment limit?

A18. Except for TCM, which is paid as an RHC visit, payments for G0511 and G0512 are not factored in to the RHC AIR. The RHC would be paid 80% of their rate for the billable visit, subject to the RHC payment limit, plus 80% of the charges for care management.

Q19. If an FQHC submits a claim for a billable visit and a care management service, would these be added together to determine the payment?

A19. No. The FQHC would be paid 80% of the lesser of its charges or the fully adjusted PPS rate for the billable visit, plus 80% of the charges for care management.

Q20. What revenue code should be used for care management services?

A20. Care management services should be reported with revenue code 052x.

Q21. What date of service should be used on the claim?

A21. The service period for care management services is a calendar month. The date of service can be the date that the requirements to bill for the service have been met for that month, or any date after that but on or before the last day of the month.

Q22. When should the claim be submitted?

A22. The claim can be submitted when the requirements to bill for the services have been met, or any time after that within the timely filing requirement period, which is one year from the date of service (Pub 100-04, chapter 1, section 70).

Q23. What diagnosis code should be used when billing for care management services? Are there specific conditions that qualify?

A23. All claims must include a diagnosis code and practitioners should use the most appropriate diagnosis code for the patient.

Q24. Can care management costs such as software or management oversight be included on the cost report?

A24. Yes. Any cost incurred as a result of the provision of RHC and FQHC services, including care management, is a reportable cost and must be included in the Medicare cost report. Direct costs for care management services are reported in the "*Other than RHC/FQHC Services*" section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

Q25. Can RHCs and FQHCs bill for more than one care management service in the same month for an individual? For example, could an RHC or FQHC furnish 20 minutes of CCM services at the beginning of the month, and 70 minutes of psychiatric services later in the month, and bill for both?

A25. No. RHCs and FQHCs can only bill one care management service for an individual per month.

Q26. Can an RHC or FQHC bill HCPCS codes G0511 or G0512 twice in the same month if more than twice the required amount of time is used?

A26. No. The specified amounts of time are minimum requirements and there is no additional payment if more time is spent.

Q27. Can RHCs and FQHCs bill for care management during the same month as another facility that bills for care management?

A27. RHCs and FQHCs can bill for care management services if all the requirements for billing are met and there is no overlap of dates of services with another entity billing for care management services.

Q28. Can RHCs and FQHCs bill for care management services furnished to a patient in a skilled nursing facility (SNF)?

A28. RHCs and FQHCs cannot bill for care management services provided to SNF inpatients in Medicare Part A covered stays because the facility is being paid under Part A for extensive care planning and care coordination services. However, if the patient is not in the Part A SNF for the entire month, the RHC or FQHC could bill for care management services furnished to the patient while the patient is not in the Part A SNF if the care management requirements are met.

Q29. Can RHCs and FQHCs bill for care management services provided to beneficiaries in nursing facilities or assisted living facilities?

A29. If the nursing facility or assisted living facility is not furnishing care management services and the RHC or FQHC has met the billing requirements, then the RHC or FQHC can bill for care management services furnished to beneficiaries in nursing or assisted living facilities.

Q30. Are there other restrictions on when care management services can be billed?

A30. RHCs and FQHCs cannot bill for care management services during the same service period that care management is being provided by another facility or practitioner. This includes home health care supervision, hospice care supervision, certain ESRD services, or any other services that would result in duplicative payment for care management services.

Q31. Can RHCs and FQHCs bill HCPCS code G0511 if 10 minutes of general care management (CCM or general BHI services) are furnished at the end of one month and another 10 minutes are furnished at the beginning of the next month?

A32. No. A minimum of 20 minutes of CCM or general BHI services are required to be furnished within the calendar month, not during a 30 day period.

Q33. Can RHCs and FQHCs bill HCPCS code G0512 if 30 minutes of psychiatric CoCM services are furnished at the end of one month and another 30 minutes are furnished at the beginning of the next month?

A33. No. A minimum of 60 minutes of psychiatric CoCM services are required to be furnished within the calendar month, not during a 30 day period.

Q34. If 2 or more RHC or FQHC practitioners or auxiliary staff discuss a patient's care, would time for each of them be counted towards the minimum requirements?

A34. No. If 2 or more RHC or FQHC practitioners or auxiliary staff people are discussing the patient's care coordination, only one person's time would be counted. For example, if 2 people are discussing care for 5 minutes, then 5 minutes would be counted, not 10 minutes.

Q35. Can care management services be conducted by auxiliary personnel in a location other than the RHC or FQHC?

A35. The direct supervision requirements for auxiliary personnel have been waived for TCM, CCM, general BHI, and psychiatric CoCM services furnished by RHCs and FQHCs. These services can be furnished by auxiliary personnel under general supervision of the RHC or FQHC practitioner. General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the RHC or FQHC practitioner's overall supervision and control.

Q36. Is contact with the patient every month necessary to bill for care management services if the billing requirements are met?

A36. No, although we expect that RHCs and FQHCs will want to keep the patient informed about their care management, especially since this is a service that the patient is paying for but is not typically visible to them.

Q37. Can the time spent performing secure messaging or other asynchronous non face-to face consultation methods such as email count toward the minutes required to bill for care management services?

A37. Activities that are within the scope of service elements may be counted toward the time required for billing if they are measurable and can be documented.

Q38. Can smartphone medication adherence reporting from individual patient or caregiver back to their care manager count towards the minutes required to bill for care management services?

A38. No. Patient or caregiver time is not counted towards the time required to bill for care management services.

Q39. Are psychiatric consultant services for psychiatric CoCM separately billable?

A39. No. All services furnished as part of psychiatric CoCM are included in the psychiatric CoCM payment (HCPCS code G0512) and cannot be separately billed to Medicare wither by the RHC or FQHC or by the psychiatric consultant.

Q40. Can RHCs and FQHCs bill care management services for Medicare Advantage patients?

A40. RHCs and FQHCs should consult the MA plan for billing information.

III. Care Management Services – Program Requirements

a. Initiating Visit

Q41. Is an initiating visit required for all patients before care management services can begin?

A41. Yes. An initiating visit with an RHC or FQHC practitioner (primary care physician, NP, PA, or CNM) is required before CCM, general BHI, or psychiatric CoCM services can be furnished. The initiating visit must be an evaluation and management (E/M) visit, annual wellness visit (AWV), or an initial preventive physical exam (IPPE), and must occur no more than one-year prior to commencing care coordination services.

Q42. Does care management need to be discussed during the initiating visit before care management services can begin?

A42. Care management services do not need to have been discussed during the E/M, AWV, or IPPE visit in order to begin care management services. However, prior to the commencement of care management services, consent must be obtained. Consent may be verbal (written consent is not required) but must be documented in the medical record.

Q43. Who can determine if a patient is eligible for care management services?

A43. The RHC or FQHC practitioner (primary care physician, NP, PA, or CNM) determines if the patient meets the criteria for care management services and if they are likely to benefit from care management services.

Q44. Can a clinical social worker, clinical psychologist, or psychiatrist determine that a patient meets the criteria for general BHI or psychiatric CoCM services and furnish the initiating visit?

A44. General BHI and psychiatric CoCM are both defined models of care that focus on integrative treatment of patients with primary care and mental or behavioral health conditions. A social worker, clinical psychologist, or psychiatrist can recommend to the primary care practitioner that a patient would benefit from general BHI or psychiatric CoCM services, but only a member of the primary care team can make the eligibility determination and furnish the initiating visit.

Q45. Does the patient need to have a mental health encounter before general BHI or psychiatric CoCM services can be furnished?

A45. No. Only an initiating visit (E/M, AWV, or IPPE) with the primary care team (primary care physician, NP, PA, or CNM) within 1 year prior to commencement of care management services is required. The primary care practitioner determines if the patient is eligible for general BHI or psychiatric CoCM. An initial assessment by the behavioral health manager is part of the care management payment and is not separately billable.

Q46. Can the initiating visit be furnished via telehealth?

A46. No. RHCs and FQHCs are not authorized to serve as distant sites for telehealth services.

Q47. Does the time spent during the E/M, AWV, or IPPE discussing care management services count towards the time required to bill for these services?

A47. No. The E/M, AWV, or IPPE is separately paid and the time cannot be counted towards the required time for billing HCPCS codes G0511 or G0512.

b. Consent and Opting Out

Q48. When is patient consent for care management services required?

A48. Patient consent is required before time is counted toward care management services.

Q49. How often is consent required for care management services?

A49. If a patient continues to receive care management services from the same RHC or FQHC, consent is only required when the care management service is initiated.

Q50. Does the patient have to sign a consent form for care management services?

A50. Consent can be verbal (written consent is not required), but must be documented in the medical record.

Q51. If a patient has consented to receive CCM services and later is switched to general BHI or psychiatric CoCM services, does the patient have to provide additional consent?

A51. Yes. A patient that has consented to receive CCM services would need to separately consent to receiving general BHI or psychiatric CoCM services to ensure that they are aware of the change in services and any differences in copayment amounts.

Q52. How does a patient opt out of care management services?

A52. A patient can opt out of care management services by notifying the RHC or FQHC that he/she does not want to continue this service. The date of revocation must be recorded in the patient's medical record.

Q53. If a patient opts out of care management services and later wants to resume receiving care management services, is consent required?

A53. Yes.

Q54. Once a patient has consented to receive care management services, do the services have to be provided every month?

A54. Care management services should only be furnished on an as-needed basis. The consent for receiving care management services remains in effect until revoked, even if no CCM services are furnished.

c. Care Plan

Q55. How often does the care plan need to be reviewed and updated?

A55. There are no specific requirements for updating the care plan. It should be reviewed and updated as appropriate for the patient's care.

Q56. Should the general BHI and psychiatric CoCM care plans also include physical health issues?

A56. Although physical health care planning is not a required element of the general BHI or psychiatric CoCM care plan, physical health and extended care team members should be included as appropriate to assure that all aspects of care are coordinated.

Q57. Is certified EHR technology required for billing HCPCS code G0511 when BHI services are furnished?

A57. Certified EHR technology is a requirement for CCM, but it is not a requirement for general BHI or psychiatric CoCM services. To bill the new HCPCS code G0511, an RHC or FQHC must meet the requirements for either CCM (CPT code 99490 or CPT code 99487) or general BHI (CPT code 99484). If the requirements for CPT code 99484 are met, the code can be billed and certified EHR technology is not required.

IV. Care Management Services - Care Team

a. Behavioral Health Care Manager

Q58. What credentials are required for the CoCM behavioral health care manager?

A58. The behavioral health care manager must have formal education or specialized training in behavioral health such as social work, nursing, or psychology, and must have a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or be a clinician with behavioral health training, including RNs and LPNs.

Q59. Can a certified addiction counselor serve as the behavioral health care manager?

A59. A certified addiction counselor can serve as the behavioral health care manager if they meet the behavioral health care manager requirements listed in the previous response.

Q60. Can the RHC or FQHC contract with another company for the services of the behavioral health care manager?

A60. The behavioral health care manager furnishes both face-to-face and non-face-to-face services. This person works under the general supervision of the RHC or FQHC practitioner and may be employed by or working under contract to the RHC or FQHC, not to another company.

Q61. Can someone other than the health care manager administer screenings and enter data for the registry?

A61. RHCs and FQHCs can delegate duties as appropriate. It is the responsibility of the RHC or FQHC to assure that personnel meet any requirements and to manage any delegation of duties and supervision as appropriate.

b. Psychiatric Consultant

Q62. What credentials are required for the psychiatric CoCM psychiatric consultant?

A62. The psychiatric consultant must be a medical professional trained in psychiatry and qualified to prescribe the full range of medications.

Q63. Does the psychiatric consultant have any face-to-face contact with the patient receiving psychiatric CoCM services?

A63. No. The psychiatric consultant is a consultant to the RHC or FQHC. They are not required to be on site or have direct contact with the patient, and they do not prescribe medications or furnish treatment to the beneficiary directly.

Q64. Can a psychiatric mental health nurse practitioner (PMH-NP) serve as the psychiatric consultant to RHCs and FQHCs that are furnishing psychiatric CoCM?

A64. Any medical professional, including a PMH-NP, who is trained in psychiatry and qualified to prescribe the full range of medications serves would meet the requirements to serve as a psychiatric CoCM psychiatric consultant.

c. Auxiliary Staff

Q65. Can a pharmacist furnish CCM services?

A65. Yes. Pharmacists are considered auxiliary staff and can provide CCM services under general supervision once the service is initiated by an RHC or FQHC practitioner.

Addendum I
CCM, General BHI, and Psychiatric CoCM Requirements and Payment
For RHCs and FQHCs

Requirements	CCM	General BHI	Psychiatric CoCM
Initiating Visit	An E/M, AWV, or IPPE visit occurring no more than one-year prior to commencing care coordination services.	Same	Same
	Furnished by a primary care physician, NP, PA, or CNM.	Same	Same
	Separately billable RHC/FQHC visit.	Same	Same
Beneficiary Consent	Obtained during or after initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff.	Same	Same
	Written or verbal, documented in the medical record.	Same	Same
	Includes information: <ul style="list-style-type: none"> • On the availability of care coordination services and applicable cost-sharing; • That only one practitioner can furnish and be paid for care coordination services during a calendar month; • That the patient has right to stop care coordination services at any time (effective at the end of the calendar month); and • That the patient has given permission to consult with relevant specialists. 	Same	Same
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: <ul style="list-style-type: none"> • Furnished under the direction of the RHC or FQHC primary care physician, NP, PA, or CNM; and • Furnished by an RHC or FQHC practitioner, or by clinical personnel under general supervision. 	Same	At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services that is: <ul style="list-style-type: none"> • Furnished under the direction of the RHC or FQHC primary care practitioner; and • Furnished by an RHC or FQHC practitioner or behavioral health care manager under general supervision.
Patient Eligibility	Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline	Any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC	Same As General BHI

Requirements	CCM	General BHI	Psychiatric CoCM
		practitioner, warrants BHI services	
Requirement Service Elements	<p>Includes:</p> <ul style="list-style-type: none"> ● Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care; ● 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; ● Comprehensive care management including systematic assessment of the patient’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications; ● Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed; ● Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan 	<p>Includes:</p> <ul style="list-style-type: none"> ● Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; ● Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; ● Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation); and ● Continuity of care with a designated member of the care team. 	<p>Includes:</p> <p><u>RHC or FQHC primary care practitioner:</u></p> <ul style="list-style-type: none"> ● Direct the behavioral health care manager or clinical staff; ● Oversee the beneficiary’s care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and ● Remain involved through ongoing oversight, management, collaboration and reassessment <p><u>Behavioral Health Care Manager:</u></p> <ul style="list-style-type: none"> ● Provide assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the RHC or FQHC practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant; ● Be available to provide services face-to-face with the beneficiary; having a continuous relationship with the patient and a collaborative, integrated

Requirements	CCM	General BHI	Psychiatric CoCM
	<p>of care given to the patient and/or caregiver;</p> <ul style="list-style-type: none"> • Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers; • Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record; and • Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods. 		<p>relationship with the rest of the care team; and</p> <p><u>Psychiatric Consultant:</u></p> <ul style="list-style-type: none"> • Participate in regular reviews of the clinical status of patients receiving CoCM services; • Advise the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments; and • Facilitate referral for direct provision of psychiatric care when clinically indicated
Billing Code	G0511	G0511	G0512
Payment	TBD (Average of CPT codes 99490, 99487 and 99484)	TBD (Average of CPT codes 99490, 99487 and 99484)	TBD (Average of CPT 99492 and 99493)

March 17, 2016

Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services

Effective January 1, 2013, under the Physician Fee Schedule (PFS) Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization. This policy is discussed in the CY 2013, CY 2015 and CY 2016 PFS regulations. The following are some frequently asked questions that we have received about billing the PFS for transitional care management (TCM) services.

- **What should practitioners do if claims for appropriately furnished TCM services have been rejected or denied by Medicare?**

We understand that many practitioners have had difficulty being paid for TCM services, which are new services beginning January 1, 2013. In many cases, claims submitted for TCM services have not been paid due to several common errors in claim submission. We encourage practitioners to verify that all requirements for furnishing the service have been met, and if so, to re-submit any unpaid claims. In particular, the practitioner should ensure that the entire 30-day TCM service was furnished on or after January 1, 2013 (i.e. discharge occurred on or after January 1, 2013), that the service began with a qualified discharge from a facility, and that the appropriate date of service is reported on the claim. We also have made some adjustments to our claims processing systems to better accommodate the unique billing requirements of this new, 30-day service. We believe that with the adjustments that we have made and extra care with billing on behalf of practitioners, that the problems that have been encountered will be alleviated.

- **What date of service should be used on the claim?**

The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The date of service you report should be the date of the required face-to-face visit. You may submit the claim once the face-to-face visit is furnished and need not hold the claim until the end of the service period.

- **What place of service should be used on the claim?**

The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

- **If the codes became effective on Jan. 1 and, in general, cannot be billed until 29 days past discharge, will claims submitted before Jan. 29 with the TCM codes be denied?**

Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013 are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

- **The CPT book describes services by the physician's staff as "and/or licensed clinical staff under his or her direction." Does this mean only RNs and LPNs or may medical assistants also provide some parts of the TCM services?**

Medicare encourages practitioners to follow CPT guidance in reporting TCM services (see the CPT definition of the term "clinical staff"). Medicare requires that applicable state law, scope of practice and incident to rules must be met in order for a practitioner to bill the MPFS for TCM services. The practitioner must meet the "incident to" requirements described in Chapter 15 Section 60 of the Benefit Policy Manual 100-02.

- **Can the services be provided in an FQHC or RHC?**

While FQHCs and RHCs are not paid separately by Medicare under the PFS, the face-to-face visit component of TCM services could qualify as a billable visit in an FQHC or RHC. Additionally, physicians or other qualified providers who have a separate fee-for-service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the MPFS.

- **If the patient is readmitted in the 30-day period, can TCM still be reported?**

Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.

- **Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?**

Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate evaluation and management (E/M) code.

- **Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30 day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay?**

Medicare will only pay the first eligible claim submitted during the 30 day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

- **Can TCM services be reported under the primary care exception? Can the services be reported with the –GC modifier?**

TCM services are not on the primary care exception list, so the general teaching physician policy applies as it would for E/M services not on the list. When a physician (or other appropriate billing provider) places the -GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in the Medicare Claims Processing Manual, Chapter 12, sections 100.1 through 100.1.6.

- **Can practitioners under contract to the physician billing for the TCM service furnish the non-face to face component of the TCM?**

Physician offices should follow “incident to” requirements for Medicare billing. “Incident to” recognizes numerous employment arrangements, including contractual arrangements. Also there must be appropriate supervision, and state law and scope of practice apply. Note that for payment of TCM services under the PFS, CMS requires direct supervision for the face-to-face visit but all other TCM services may be furnished under general supervision.

- **During the 30 day period of TCM, can other medically necessary billable services be reported? What about chronic care management services?**

Other reasonable and necessary Medicare services may be reported during the 30 day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182. CCM could be billed to the MPFS during the same calendar month as TCM only if the TCM service period ends before the end of a given calendar month, at least 20 minutes of qualifying CCM services are subsequently provided during that month, and all other CCM billing requirements are met. However we expect that the majority of the time, CCM and TCM will not be billed during the same calendar month.

- **If a patient is discharged on Monday at 4:30, does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?**

In the scenario described, the practitioner must communicate with the patient by the end of the day on Wednesday, the second business day following the day of discharge. If two or more separate attempts are made in a timely manner and documented in the medical record, but are unsuccessful, and if all other TCM criteria are met, the service may be reported. We emphasize, however, that we expect attempts to communicate to continue until they are successful, and TCM cannot be billed if the face-to-face visit is not furnished within the required timeframe.

- **Can TCM services be reported when furnished in the outpatient setting?**

Yes. CMS has established both a facility and non-facility MPFS payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.

Version 01/17/2023
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