



Federally Qualified Health Center Version

KEY CONCEPTS OUTLINE

Module 4: 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 on 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 will be 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. 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. <see *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
- c. A medically-necessary, face-to-face mental health 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 mental health visit. 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.

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.
- b. Terminated at the end of PHE For services furnished on March 18, 2020 through May 11, 2023 (PHE end) 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 May 12, 2023>
 - 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 May 12, 2023>
- 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 May 12, 2023; 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 May 12, 2023>
- 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.

2. Reporting modifier -CS for certain preventive services

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

- 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 May 12, 2023>

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

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 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 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.
- c. 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.
- d. Edit 91 FQHC claim contains an item or service considered to be non-covered under FQHC PPS or for RHC.
 - i. Items or services not covered under the FQHC will be line item rejected PPS
 - (a) Non-covered items include:
 - 1. Durable medical equipment (029X);
 - 2. Ambulance services (054X);
 - 3. Laboratory services paid under the clinical laboratory fee schedule (CLFS);
 - a. Excludes venipuncture, CPT 36415;
 - 4. Hospital based care;
 - 5. Group services; and
 - 6. Non-face-to-face services.

IV. Special Billing Considerations

A. 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.

B. 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.

V. Medicaid Claims Submission – Medi-Cal

1. Provider Manuals specific to FQHCs and RHCs is available for review and can be found at <https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx#>
2. Timely Filing
 - a. Original (initial) Medi-Cal Claims
 - i. Six month billing limit
 - (a) Six months following the month in which the services were rendered.
 1. Example: Services are provided on April 15th; the claim must be received prior to October 31st to avoid payment reduction or denial for late billing.
 - b. Reduced Reimbursement for Late Filing
 - i. Claims received 7th -9th month after the service month are reduced by 75 percent of the payable amount.
 - ii. Claims received 10th-12th month after the service month are reduced by 50 percent of the payable amount.

- iii. Claims received after the 12th month following the service month are denied.

3. FQHC Services

- a. Freestanding FQHC services are priced at an encounter rate.
 - i. All routine services are included in the encounter rate.
- b. FQHC submission on the CMS-1450 (UB04) or the 837 transaction.
- c. Appropriate Revenue Code
 - i. 0521
 - (a) Medical Visit – T1015
 - (b) Medicare Crossover Claims
 - 1. New Patient G0466
 - 2. Established Patient – G0497
 - 3. Initial Preventive Physician Exam or Annual Wellness Exam- G0468
 - (c) Clinic Visit, Optometry
 - 1. Facility Specific All Inclusive Rate – New Patient – 92004
 - 2. Facility Specific All Inclusive Rate – Established Patient – 92014
 - (d) 0527
 - 1. Medicare Crossover Claim, Visiting Nurse
 - a. New patient to home – G0466
 - b. Established patient to home – G0467
 - c. IPPE or AWW to home – G0468
 - (e) 0900
 - 1. Medicare Crossover Claim, Mental Health
 - a. New Patient - G0469

b. Established Patient – G0470

(f) 3103

1. Community-Based Adult Services (CBAS), Initial assessment day (with subsequent attendance) – 99205
2. Community-Based Adult Services (CBAS), Initial assessment day (without subsequent attendance) – T1015

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Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Page updated: December 2020

This section includes information for billing services rendered by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). RHCs and FQHCs provide ambulatory health care services to recipients in rural and non-rural areas.

Rural Health Clinics

«RHCs» extend Medicare and Medi-Cal benefits to cover health care services provided by clinics operating in rural areas. Specifically trained primary care practitioners administer the health care services needed by the community when access to traditional physician care is difficult.

Federally Qualified Health Centers

«FQHCs» were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989.

RHC and FQHC: Enrollment

Providers should enroll in the RHC and FQHC programs through the Department of Health Care Services (DHCS) Audits and Investigations «(A&I) Division». As facilities enroll in the RHC and FQHC programs, they will receive a new National Provider Identifier (NPI) and their current provider numbers will be inactivated.

Physician Defined

The inclusion of a professional category within the term “physician” is for the purpose of defining the professionals and not for the purpose of defining the types of services that these professionals may render during a visit for RHC and FQHC services.

The following providers are defined as “physicians.”

- A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license
- A medical resident in a federally or state sponsored Teaching Health Center Graduate Medical Education (THCGME) Program, under the supervision of a designated teaching physician, who is acting within his/her «Postgraduate» Training License (PTL) «issued by the Medical Board of California». The THCGME Program is required to be accredited by the Accreditation Council for Graduate Medical Education.

Note: Subject to limitations as described in the Teaching Health Center Graduate Medical Education (THCGME) subheading on a following page.

- A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license
- A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license
- A doctor of chiropractic authorized to practice chiropractic by the State and who is acting within the scope of his/her license
- A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license

CPSP Practitioner Defined

A Comprehensive Perinatal Services Program (CPSP) practitioner is defined in *Welfare and Institutions Code*, Section 14134.5, and *California Code of Regulations (CCR)*, Title 22, Section 51179.7.

RHC/FQHC Covered Services

RHCs and FQHCs may bill for the following:

- Physician services
- Physician assistant services
- Nurse practitioner services
- Certified nurse midwife services
- Visiting nurse services (as defined in *Code of Federal Regulations* [CFR], Title 42, Section 405.2416)
- Comprehensive Perinatal Services Program (CPSP) practitioner services, if the clinic has an approved application on file with the California Department of Public Health, Maternal, Child and Adolescent Health Division
- Licensed clinical social worker services
- «Associate clinical social worker (ASW) services (when supervised by a licensed billable behavioral health practitioner)»
- Marriage and family therapist services
- «Associate marriage and family therapist (AMFT) services (when supervised by a licensed billable behavioral health practitioner)»
- Clinical psychologist services
- Optometry services
- Acupuncture services
- Registered dental hygienist services

Dental Services Defined

FQHCs and RHCs may render any dental service in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice, complies with the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances

(https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Provider_Handbook/), and determined to be medically necessary pursuant to *California Welfare and Institutions Code* (W&I code), Section 14059.5. Each provider shall develop a treatment plan that optimizes preventative and therapeutic care and that is in the patient's best interest, taking into consideration their overall health status. All phases of the treatment plan shall be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner.

For dental services, documentation should be consistent with the standards set forth in the *Manual of Criteria for Medi-Cal Authorization* of the *Medi-Cal Dental Provider Handbook* and all state laws.

Authorization and Documentation Requirements

RHCs and FQHCs services do not require a *Treatment Authorization Request* (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that would be needed for authorization approval.

Documentation for all RHC and FQHC encounters must be sufficiently detailed as to clearly indicate the medical reason for the visit.

Required documentation includes:

- A complete description of the medical services provided
- The full name professional title of the person providing the service
- The pertinent diagnosis(es) at the conclusion of the visit
- Any recommendations for diagnostic studies, follow up or treatments, including prescriptions

Note: The documentation must be kept in writing for a minimum of three years from the date of service.

DHCS A&I Division may recover payments that do not meet the requirements under CCR, Title 22, Section 51458.1 "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."

CPSP Services: TAR and Reporting Requirements

Claims for Comprehensive Perinatal Service Program (CPSP) services in excess of the basic allowances will not be denied for the absence of a TAR. RHCs and FQHCs, however, must maintain in the patient's medical record the same level of documentation that would be needed for authorization approval. DHCS A&I Division may recover payments that do not meet the requirements under CCR, Title 22, Section 51458.1 "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."

Required documentation includes:

- Expected date of delivery
- Clinical findings of the high-risk factors involved in the pregnancy
- Explanation of why basic CPSP services are not sufficient
- Description of the services being requested
- Length of visits and frequency with which the requested services are provided, and
- Anticipated benefit of outcome of additional services

RHC and FQHC: Medi-Services

Medi-Service limitations (two services per month) apply when rendered in an RHC or FQHC.

"Visit" Defined

«A visit is a face-to-face encounter or an interaction using a telehealth modality (synchronous video, synchronous audio-only or asynchronous store and forward) between an RHC or FQHC recipient and a physician (refer to "Physician Defined" on a previous page in this section), physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, marriage and family therapist, licensed acupuncturist, registered dental hygienist or visiting nurse (as defined in *Code of Federal Regulations*, Title 42, Section 405.2416), hereafter referred to as a "health professional," to the extent the services are reimbursable under the State Plan and the interactions meet the applicable standards of care.

A face-to-face encounter or an interaction using a telehealth modality with a Comprehensive Perinatal Services Program (CPSP) practitioner also qualifies as a visit. Refer to "CPSP Practitioner Defined" on a previous page in this section.»

Qualifying Visits

Encounters with more than one health «care» professional and multiple encounters with the same health «care» professional that take place on the same day and at a single location constitute a single visit. «More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:»

- When a patient, after the first visit, suffers illness or injury that requires another health diagnosis or treatment
- When a patient is seen by a health «care» professional or CPSP practitioner and also receives dental services on the same day

Clinic visits at which the patient receives services “incident to” physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits.

Community-Based Adult Services (CBAS)

Community-Based Adult Services (CBAS) are not FQHC and/or RHC services; however, CBAS is a Medi-Cal waiver benefit which may be provided by an FQHC and/or an RHC and compensated at the appropriate CBAS rate. CBAS offers a package of health, therapeutic and social services in a community-based day health care program. The CBAS benefit is described in the *Community-Based Adult Services* section of this manual. The CBAS reimbursement rate is described in the *Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates* section of this manual.

For a reimbursable CBAS visit, FQHCs and RHCs must render CBAS pursuant to the requirements in the *Community Based Adult Services (CBAS)* section of this manual for a minimum of four hours per billable day.

- For billing codes to be used by FQHCs and RHCs providing CBAS, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* section in this manual.
- Beneficiary eligibility for CBAS provided by an FQHC or RHC shall be determined in the same manner as in the *Community-Based Adult Services (CBAS)* section of this manual except that the FQHC or RHC providing CBAS need not submit a TAR for approval. FQHCs and RHCs providing CBAS must meet the same record-keeping requirements as all other CBAS providers as described in the *Community-Based Adult Services* section of this manual, in addition to record keeping requirements for FQHCs and RHCs as described in *Community-Based Adult Services (CBAS): IPC and TAR Form Completion* section of this manual.

- FQHCs and RHCs providing CBAS must submit an Individual Plan of Care as described in *Community-Based Adult Services (CBAS): IPC and TAR Form Completion* section of this manual for each participant upon initial intake for approval of CBAS eligibility and CBAS service level by DHCS or a managed care plan that contracts with the FQHC or RHC for the provision of CBAS. FQHCs and RHCs shall accompany the IPC with a request that DHCS or contracting managed care plan schedule a face-to-face assessment of new CBAS participants for a determination of CBAS eligibility and CBAS service level need by DHCS or the contracting managed care plan. Additionally, the FQHCs and RHCs shall submit an updated IPC every six months for CBAS enrollees to DHCS or the contracting managed care plan.
- FQHCs and RHCs shall insert the Client Identification Number (CIN) in place of the TAR Control Number (TCN) in the top line of the IPC to be submitted to DHCS or contracting managed care plan.

Note: For more information on the new requirements, refer to the requirements in the settlement agreement in the *Darling, et al. v. Douglas, et al.* litigation, C09-03798 SBA, on the Community-Based Adult Services page of the DHCS website (www.dhcs.ca.gov) under the “ADHC Transition Information” heading.

Billing Services for Health Care Plan Recipients

RHCs and FQHCs must bill the appropriate Health Care Plan (HCP) when rendering services to HCP recipients. The California MMIS Fiscal Intermediary does not accept these claims unless the billed services are contractually excluded from the plan. Providers should contact the plan for plan-specific prior authorization and billing information.

«If a Medi-Cal patient presents themselves to the clinic for treatment and the clinic finds the patient is enrolled in a Medi-Cal Managed Care Plan, or if located in Los Angeles County or Sacramento County, and the patient is enrolled in a Medi-Cal Dental managed care plan*, the clinic can render services and submit a claim to Medi-Cal.» However, the RHC and FQHC facility is required to redirect the patient to their “in-network” managed care provider and document this referral in the patient’s medical/dental records. «While Medi-Cal beneficiaries enrolled in both Medi-Cal and Medi-Cal Dental managed care plans are required to be treated by in-network providers, except in emergencies or other isolated instances, RHC and FQHC facilities that provide services in these circumstances must maintain proof of payment or denial from the managed care plan.

Refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* section in this manual for codes to use when billing for services rendered to recipients of Medi-Cal and Medi-Cal Dental managed care plans.»

Riverbend Government Benefits Administrator

The Riverbend Government Benefits Administrator (RGBA) is the Part A Medicare Intermediary for free-standing RHCs. Questions may be directed to RGBA at (423) 763-3400 or (423) 752-6518 (fax). Correspondence may be sent to:

Riverbend Government Benefits Administrator
Medicare
730 Chestnut Street
Chattanooga, TN 37402-1790

Reimbursement

Effective January 1, 2001, Federal legislation repealed the reasonable cost-based reimbursement requirements for services to Medicaid RHC and FQHC patients and is now requiring a payment for these services under a Prospective Payment System (PPS).

Los Angeles Demonstration Waiver Project

Cost-based reimbursement clinics that are participating in the Section 1115 Medicaid Waiver Demonstration Extension project are not affected by PPS rate determinations.

IHS-MOA 638 Clinics

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* section in this manual for billing details.

Crossover Claims

In the past, RHC and FQHC crossover claims were reimbursed at a rate of 20 percent of the provider's interim rate. Reimbursement adjustments, due either to the provider or DHCS, were determined through cost reports submitted by providers to the «A&I Division» staff at the end of the provider's fiscal year.

Under PPS, RHCs and FQHCs are not required to file cost reports. Therefore, to ensure full reimbursement for crossover claims, «A&I Division» will set the reimbursement rate for crossover claim codes at an amount that equals the difference between the Federal Medicare payments and the provider's PPS rate. This can only be accomplished if the provider is an RHC or FQHC for Federal Medicare as well as for DHCS Medi-Cal. Providers electing to remain fee-for-service for Federal Medicare will not receive their PPS rate for crossover claims.

EPSDT/CHDP Reporting Requirements and Billing

FQHC and RHC providers bill Early and Periodic Screening, Diagnostic and Treatment/Child Health and Disability Prevention (EPSDT/CHDP) services using the *UB-04* claim «form». Effective September 1, 2019, FQHCs and RHCs no longer submit the *Confidential Screening/Billing Report* Information Only (PM 160 Information Only) with claims to fulfill reporting purposes. Instead, providers fulfill reporting requirements by including informational lines on their «claim form». Required reporting data will be extrapolated from the informational lines.

Providers submitting paper «claim forms» can refer to a sample *UB-04* claim «form» populated with an informational line in the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Examples* provider manual section. Instructions for submitting informational lines on electronic claims is available in the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*, “Special Billing Instructions: Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services-Memorandum of Agreement” section.

Version 05/15/2020
Check for Updates

Teaching Health Center Graduate Medical Education (THCGME)

FQHC and RHC THCGME programs sponsored by Health Resources and Services Administration (HRSA) or state sponsored THCGME programs (Primary Care Residency Programs) may seek reimbursement for primary care services furnished by a medical resident when billed by a teaching physician, if all of the following conditions are met:

- THCGME programs must have an existing GME accreditation from the Accreditation Council for Graduate Medical Education (ACGME).
- Types of services furnished by residents include:
 - Primary care services
 - Acute care for undifferentiated problems or chronic care for ongoing conditions, including chronic mental illness
 - Coordination of care furnished by other physicians and providers
 - Comprehensive care not limited by organ system or diagnosis
- The teaching physician must have the primary medical responsibility for patients cared for by residents, and ensure the care provided is reasonable and necessary.
- The teaching physician must not supervise more than four residents at any given time.
- Residents with less than six months experience in a THCGME program must have the teaching physician physically present for critical or key portions of services.
- Teaching physicians must review the patient health record and document the teaching physician's participation in direction of services.

«ASW and AMFT Services

FQHCs and RHCs may seek reimbursement for ASW or AMFT services under the following conditions:

- The ASW and AMFT requires supervision by a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, or a licensed physician and surgeon certified in psychiatry by the American Board of Psychiatry and Neurology.
- The licensed practitioner must also comply with supervision requirements established by the California Board of Behavioral Sciences (BBS).
- Services are billed under the National Provider Identification (NPI) of the licensed billable behavioral practitioner supervising the ASW or AMFT.
- These services are billed utilizing existing claiming processes that includes billing managed care plans first, followed by billing DHCS for the rate wrap payment, if applicable.»

End of Life Services

Refer to the *End of Life Option Act Services* section of the appropriate Part 2 manual for additional information.

Telehealth

Overview

«Policy related to telehealth is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011 Welfare and Institutions Code 14132.100. Providers should refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual for additional information.»

Definitions

For purposes of this policy, the following definitions shall apply:

Telehealth and Other Terms

«For definitions of “telehealth,” “audio-only,” “asynchronous store and forward,” “synchronous interaction,” “distant site” and “originating site,” providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.»

Visit

«Providers should refer to “Visit Defined” in this manual section.

Note: Telehealth services must meet all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter with a billable provider and meet the applicable standard of care.

An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to Health Resources Services Administration requirements.»

Billable Provider

Providers may refer to “RHC/FQHC Covered Services” in this manual section.

«New Patient

FQHCs and RHCs are not precluded from establishing a new patient relationship through a synchronous video interaction or asynchronous store and forward if all the following conditions are met:

- The patient is physically present at an originating site that is a licensed or intermittent site of the FQHC or RHC at the time the service is performed.
- The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.
- The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.
- An FQHC or RHC patient who receives telehealth services shall otherwise be eligible to receive in-person services.»

Established Patient

A Medi-Cal eligible recipient who meets one or more of the following conditions:

- The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years.
- The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the originating site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented.
- The patient is assigned to the FQHC or RHC by their managed care plan (MCP) pursuant to a written agreement between the plan and the FQHC or RHC.

«Originating Site and Transmission Fee

FQHCs and RHCs are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the PPS/AIR rate, as applicable.»

Documentation Requirements

«Providers should refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.

Documentation of telehealth visits follows the same documentation practices in place for in-person visits. The billable provider must satisfy all of the procedural and technical components of the Medi-Cal covered service or benefit being provided, except for the face-to-face component, which would include, but not be limited to:

- A detailed patient history
- A complete description of what Medi-Cal covered benefit or service was provided
- An assessment/examination of the following:
 - issues being raised by the patient,
 - medical decision-making by the health care practitioner of low, moderate, or high complexity, as applicable, which should include items such as pertinent diagnosis(es) at the conclusion of the visit, and
 - any recommendations for diagnostic studies, follow-up, or treatments, including prescriptions.

Documentation for any type of non-face to face service should also include the method of telehealth, provider and patient locations, clinical participants, and patient consent.

Consent

Providers should refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.»

Covered Services

Services rendered via telehealth must be FQHC or RHC covered services.

Non-Covered Services

«An e-consult, e-visit, or remote patient monitoring is not a reimbursable telehealth service for FQHCs or RHCs.

Providers should also refer to “Examples of Services Not Appropriate for Telehealth” in the *Medicine: Telehealth* section in the appropriate Part 2 manual.»

«Synchronous Telehealth Reimbursement Requirements

Synchronous interaction means a real-time audio-visual, two-way interaction between a new or established patient and an FQHC or RHC billable provider at a distant site.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from the FQHC pursuant to the federal Health Resources Services Administration requirements.

A patient may be “established” via synchronous interaction if all of the conditions of the “New Patient” requirements in this manual section are met.

Asynchronous Store and Forward Reimbursement Requirements

Asynchronous store and forward means the transmission of a patient’s medical information from an originating site to the billable provider at a distant site.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

A patient may be “established” on an asynchronous store and forward service, if all of the conditions of the “New Patient” requirements in this manual section are met.

Note: Providers should note “Non-Covered Services” in this manual section.

Audio Only Reimbursement Requirements

An audio-only synchronous interaction is eligible for reimbursement if provided by a billable provider and FQHC or RHC patient.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter

A patient may not be “established” using an audio-only synchronous interaction unless the visit is related to a “sensitive service”, as defined in the California Civil Code, section 56.05, subdivision (n), or if the patient requests “audio only” or does not have access to video.>>

«Additional Billing and Reimbursement Policy

Services provided through telehealth are subject to the same program restrictions, limitations, and coverage that exist when the service is provided in-person.

Telehealth services are billed utilizing existing claiming processes that include billing the appropriate managed care plan first. If applicable, once the managed care plan payment is received, submit the claim to the Medi-Cal Fiscal Intermediary for the Prospective Payment System (PPS) rate wrap.

Only one visit or store and forward service may be billed at the PPS rate when there is a service payment contract with a non-FQHC/RHC, contractor, or another FQHC or RHC. Conversely, the non-FQHC/RHC or contractor may request fee-for-service reimbursement for a visit or store and forward service directly from the appropriate managed care plan or the Medi-Cal Fiscal Intermediary if no service payment contract exists with the FQHC or RHC.

FQHCs and RHCs must use the appropriate telehealth modifier when billing for the covered service. For more information on appropriate modifiers, providers should refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* manual section and “Billing Requirements” in the *Medicine: Telehealth* manual section in the appropriate Part 2 manual.

Providers should also refer to “Reimbursable Telehealth Services”, and “Examples of Services Not Appropriate for Telehealth” in the *Medicine: Telehealth* manual section in the appropriate Part 2 manual.

Location of Provider or Patient

The billable provider, employed or under direct contract with an FQHC or RHC can respond from any location, including their home, during a time that they are scheduled to work for the FQHC or RHC.

For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.»

Synchronous Telehealth

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corporation (Corp) A – Site 1 «New or established patient with non-billable provider»	FQHC/RHC Corp A – Site 2 <i>Billable provider</i>	FQHC/RHC Corp A – Site 2 can bill one visit at the PPS rate.
FQHC/RHC Corp A – Site 1 «New or established patient with billable provider»	FQHC/RHC Corp A – Site 2 <i>Billable provider</i>	Only one site can bill one visit at the PPS rate.
FQHC/RHC Corp A «New or established patient with non-billable provider»	FQHC/RHC Corp B <i>Billable provider</i>	FQHC/RHC Corp B can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.
FQHC/RHC Corp A «New or established patient with billable provider»	FQHC/RHC Corp B <i>Billable provider</i>	FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present. FQHC/RHC Corp B can bill one visit at the PPS rate.
FQHC/RHC Corp A «New or established patient with non-billable provider»	Non-FQHC/RHC Medi-Cal Provider <i>Billable provider (no service payment contract)</i>	The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.

Synchronous Telehealth (continued)

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corp A «New or established patient with billable provider»	Non-FQHC/RHC Medi-Cal Provider <i>Billable provider</i> (no service payment contract)	FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present. The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.
Non-FQHC/RHC Medi-Cal Provider «New or established patient with non-billable provider»	FQHC/RHC Corp A <i>Billable provider</i>	FQHC/RHC Corp A can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for the non-FQHC/RHC.
Non-FQHC/RHC Medi-Cal Provider «New or established patient with billable provider (no service payment contract)»	FQHC/RHC Corp A <i>Billable provider</i>	The non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider. FQHC/RHC Corp A can bill one visit at the PPS rate.

Asynchronous Store and Forward Telehealth

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corp A – Site 1 «New or established patient with non-billable provider»	FQHC/RHC Corp A – Site 2 Billable provider	FQHC/RHC Corp A – Site 2 can bill one visit at PPS rate.
FQHC/RHC Corp A – Site 1 «New or established patient with billable provider»	FQHC/RHC Corp A – Site 2 Billable provider	Only one site can bill one visit at the PPS rate.
FQHC/RHC Corp A – Site 1 «New or established patient with non-billable provider»	FQHC/RHC Corp B Billable provider	FQHC/RHC Corp B can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.
FQHC/RHC Corp A «New or established patient with billable provider»	FQHC/RHC Corp B «Billable provider (with or without service payment contract)»	Only one site can bill one visit at the PPS rate.
FQHC/RHC Corp A «New or established patient with non-billable provider»	Non-FQHC/RHC Medi-Cal Provider Billable provider (no service payment contract)	The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider. No PPS rate reimbursement is permitted for FQHC/RHC Corp A.
«FQHC/RHC Corp A New or established patient with non-billable provider	Non-FQHC/RHC Medi-Cal Provider Billable provider (with service payment contract)	FQHC/RHC Corp A can bill PPS rate on behalf of the non-FQHC/RHC Medi-Cal provider since the distant site's billable provider has a payment contract. Note: The non-FQHC/RHC provider cannot bill the MCP or fee-for-service directly.»

Asynchronous Store and Forward Telehealth (continued)

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
FQHC/RHC Corp A «New or established patient with billable provider»	Non-FQHC/RHC Medi-Cal Provider <i>Billable provider</i> (no service payment contract)	FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present. The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.
Non-FQHC/RHC Medi-Cal Provider «New or established patient with non-billable provider»	FQHC/RHC Corp A «Billable provider (service payment contract)»	FQHC/RHC Corp A can bill one visit at the PPS rate. No PPS rate reimbursement is permitted for the non-FQHC/RHC.
Non-FQHC/RHC Medi-Cal Provider «New or established patient with billable provider (no service payment contract)»	FQHC/RHC Corp A <i>Billable provider</i>	«The non-FQHC/RHC can bill the MCP or fee-for-service directly if a Medi-Cal covered service is performed and if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.» FQHC/RHC Corp A can bill one visit at the PPS rate.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	If the patient is not enrolled in a Medi-Cal Dental managed care plan, a straight Medi-Cal dental visit may be billed, per visit code 03.

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Check for Updates

Claim Submission and Timeliness Overview

Page updated: December 2021

This section includes information about claim forms that providers use to bill services rendered to recipients of the programs listed in this manual. In addition, this section includes basic claim form preparation instructions, claim submission deadline information and a brief description of claims processing procedures.

Introduction

Claim Forms Used to Bill Medi-Cal

The claim forms that providers use to bill Medi-Cal are listed below. The form a provider submits is determined by their Medi-Cal designated provider category and the service they render.

«Table of Claim Forms Used to Bill Medi-Cal»

Claim Form Used by (Provider Type)	Submit When Billing for:
CMS-1500 Claim: Allied Health, Medical Services Pharmacy, Vision Care	Medical services and supplies Vision Care services/eye appliances
Payment Request for Long Term Care (25-1): Long Term Care	Long term care services rendered in either a free-standing facility or distinct part of an acute inpatient facility
UB-04 Claim: Inpatient, Outpatient	Inpatient and outpatient services as follows: <ul style="list-style-type: none"> • Inpatient services for acute hospital accommodations and ancillary charges • Outpatient services for institutional facilities and for others, such as Rural Health Clinics (RHCs) and chronic dialysis services

ANSI and Medi-Cal Forms

The *CMS-1500* and *UB-04* claim forms were adopted by Medi-Cal in 2007 to comply with Federal and State regulations promoting uniformity in billing. These claim forms use the widely accepted American National Standards Institute (ANSI) format. «The 25-1 claim form is unique to the Medi-Cal program and does not use the ANSI format.»

Processing Claims

Introduction

Medi-Cal fee-for-service claims are processed by the California MMIS Fiscal Intermediary using the Medi-Cal claims processing system. It is the intent of DHCS and the FI to process claims as accurately, rapidly and efficiently as possible. A brief description of claims processing methods follows.

Computer Media Claims (CMC)

«Computer Media Claims (CMC) are submitted on the Medi-Cal Providers website via Transactions Services or the Provider Portal or on the [Medi-Cal Rx website](#).» CMC bypass the claims preparation and data entry processes of hard copy claims and go directly into the claims processing system. This significantly reduces adjudication time.

Point of Service (POS) Network Claims

«Some *CMS-1500* claims are submitted through the Medi-Cal Providers website or Medi-Cal Rx website. The *CMS-1500* online claim format includes an 80-character remarks field. Claims requiring additional documentation must be billed “hard copy” or through CMC.»

Enrollment

«To submit POS or CMC transactions on the Medi-Cal Providers website on behalf of a provider, submitters must register in the Medi-Cal Provider Portal and be affiliated to the provider.»

Paper Claims

All incoming paper claims and other documents are pre-sorted by the U.S. Postal Service by P.O. Box and delivered to the FI mailroom by the Postal Service or FI couriers.

All submitted forms must be on standard paper claim forms. Standard claim forms can be purchased from authorized vendors. Accuracy, completeness and clarity of the form are necessary to ensure that the information is scanned correctly into the system.

Paper Claim Preparation

Paper claims routed to the Claims Preparation Unit are examined for acceptability and sorted for data entry. Claims and attachments are scanned, assigned a unique 13-digit Claim Control Number (CCN) and routed for either Optical Character Recognition (OCR) or Key Data Entry (KDE).

Neatly typed or computer-filled claim forms that have data within the boxes on the form are sorted for data entry by OCR scanners. All other claim forms are entered manually by KDE operators.

Claim Control Number

The CCN is used to identify and track Medi-Cal claims as they move through the claims processing system. This number contains the Julian date, which indicates the date a claim was received by the FI and is used to monitor timely submission of a claim. See Figures 1 and 2.

Julian Date

The Julian date within the CCN indicates the date a claim was received by the FI and is used to monitor timely submission. See Figure 1.

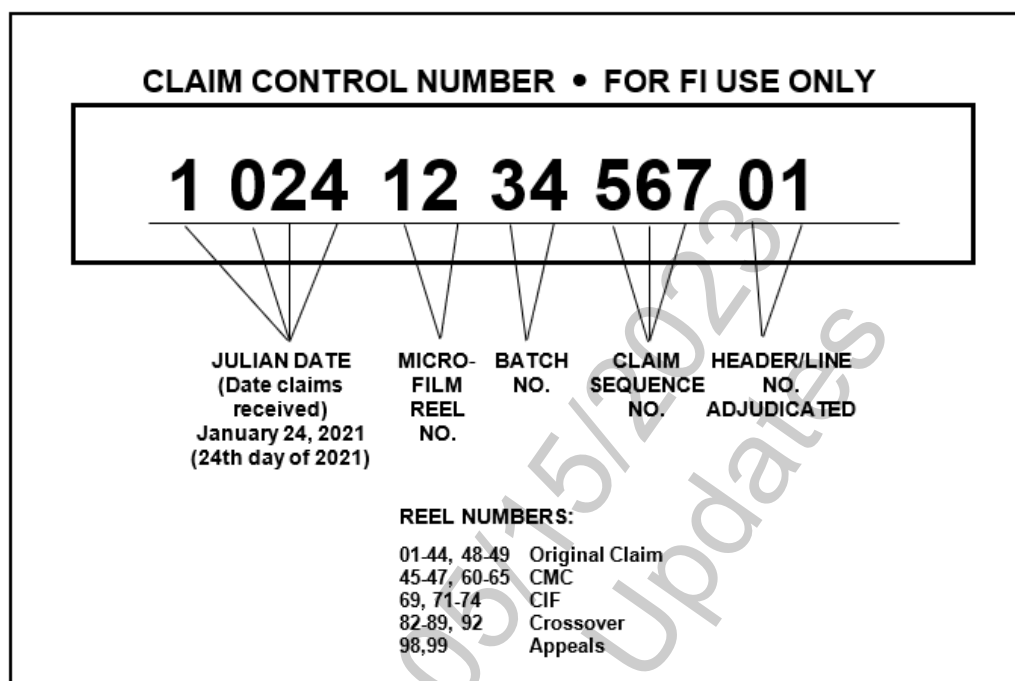


Figure 1: Claim Control Number (CCN)

Day Month	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
1.	1	32	60	91	121	152	182	213	244	274	305	335
2.	2	33	61	92	122	153	183	214	245	275	306	336
3.	3	34	62	93	123	154	184	215	246	276	307	337
4.	4	35	63	94	124	155	185	216	247	277	308	338
5.	5	36	64	95	125	156	186	217	248	278	309	339
6.	6	37	65	96	126	157	187	218	249	279	310	340
7.	7	38	66	97	127	158	188	219	250	280	311	341
8.	8	39	67	98	128	159	189	220	251	281	312	342
9.	9	40	68	99	129	160	190	221	252	282	313	343
10.	10	41	69	100	130	161	191	222	253	283	314	344
11.	11	42	70	101	131	162	192	223	254	284	315	345
12.	12	43	71	102	132	163	193	224	255	285	316	346
13.	13	44	72	103	133	164	194	225	256	286	317	347
14.	14	45	73	104	134	165	195	226	257	287	318	348
15.	15	46	74	105	135	166	196	227	258	288	319	349
16.	16	47	75	106	136	167	197	228	259	289	320	350
17.	17	48	76	107	137	168	198	229	260	290	321	351
18.	18	49	77	108	138	169	199	230	261	291	322	352
19.	19	50	78	109	139	170	200	231	262	292	323	353
20.	20	51	79	110	140	171	201	232	263	293	324	354
21.	21	52	80	111	141	172	202	233	264	294	325	355
22.	22	53	81	112	142	173	203	234	265	295	326	356
23.	23	54	82	113	143	174	204	235	266	296	327	357
24.	24	55	83	114	144	175	205	236	267	297	328	358
25.	25	56	84	115	145	176	206	237	268	298	329	359
26.	26	57	85	116	146	177	207	238	269	299	330	360
27.	27	58	86	117	147	178	208	239	270	300	331	361
28.	28	59	87	118	148	179	209	240	271	301	332	362
29.	29	N/A	88	119	149	180	210	241	272	302	333	363
30.	30	N/A	89	120	150	181	211	242	273	303	334	364
31.	31	N/A	90	N/A	151	N/A	212	243	N/A	304	N/A	365

Figure 2: Julian Date Calendar.

For Leap Year, add one day to the number of days after February 28.

Leap years: 2000, 2004, 2008

Claims Adjudication

Claims entering the Medi-Cal system are processed on a line-by-line basis except for inpatient claims. Inpatient claims are processed on an entire claim basis. Each claim is subject to a comprehensive series of checks called “edits” and “audits.” The checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit/audit checks include verification of:

- Data item validity
- Procedure/diagnosis compatibility
- Provider eligibility on date of service
- Recipient eligibility on date of service
- Other insurance coverage or Medicare
- Claim duplication
- Authorization requirements

Inpatient claims are processed on an entire-claim basis and also are subject to edits and audits.

Claims in Suspense

Claims that fail an edit or audit will suspend for review by a claims examiner who will identify the reason for suspense and examine the scanned image of the claim and attachments. If input errors are detected, the examiner will correct the error and the claim will continue processing. Claims requiring medical judgment will be reviewed by a physician or other qualified medical professional in accordance with the provisions of *California Code of Regulations* (CCR), Title 22 and policies established by the Department of Health Care Services.

Payment

Claims that pass edits and audits are listed on a payment tape and sent to the State Controller's Office (SCO). The SCO generates a warrant and accompanying Remittance Advice Details (RAD).

Claim Denial

Claims that fail edits and audits are denied.

Preparing Claims

Paper Claims and Submission

When providers submit paper claims, they should send the original claim form to the FI and retain the copy for their records. Carbon copies and photocopies are not acceptable for claims processing.

Billing Services and Provider Responsibility

Providers are responsible for all claims submitted with their provider number regardless of who completed the claim. Providers using billing services must ensure that their claims are handled properly. Entities submitting claims for services rendered by a health care provider are subject to Medi-Cal suspension if they submit claims for a provider who is suspended from Medi-Cal. Medi-Cal applies the same claim preparation and submission policies to providers and provider billing services for all claims. For details about required registration with DHCS on hard copy billing, refer to “Enrolling Hard Copy Billing Intermediaries” in the *Provider Guidelines* section of this manual.

Submission Standards

Providers should not submit multiple claims stapled together. Each form is processed separately and it is important not to batch or staple original forms together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.

Postage and Surcharges

Correct postage must be affixed to all envelopes mailed to the FI. The FI cannot accept postage-due mail. Postal regulations require a surcharge for any envelope larger than 6 1/8 x 11 1/2 inches and weighing less than one ounce. The claims envelopes furnished by the FI are subject to this surcharge. To avoid the surcharge on claims envelopes, providers should enclose several claim forms per envelope, increasing the weight to one ounce or more. It is also recommended that envelopes be no more than 1/4-inch thick.

Courier Services

Courier services should deliver to the FI:

California MMIS Fiscal Intermediary
820 Stillwater Road
West Sacramento, CA 95605

Telecommunication Claims

Telecommunication claims may be submitted Monday through Friday, 6 a.m. through 10 p.m. Claims received after 2 p.m. will be entered into the system for processing during the next business day. The telecommunications system is open on legal holidays but unattended by help desk personnel. For assistance, providers must call on the next business day, between the hours listed.

«**Note:** Medi-Cal does not accept walk-up claims delivery service.»

Timelines for Claims

Six-Month Billing Limit

Original (or initial) Medi-Cal claims must be received by the FI within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. For example, if services are provided on April 15, the claim must be received by the FI prior to October 31 to avoid payment reduction or denial for late billing. See *Figure 3*. *Figure 4* diagrams the claim timeline that includes not only the initial claim submission but also follow up requests. Refer to the *CIF Overview and Appeal Process Overview* sections in this manual for more information.

Note: For the purpose of adjudicating claims, the "through" date of service will be used to determine timeliness of submission.

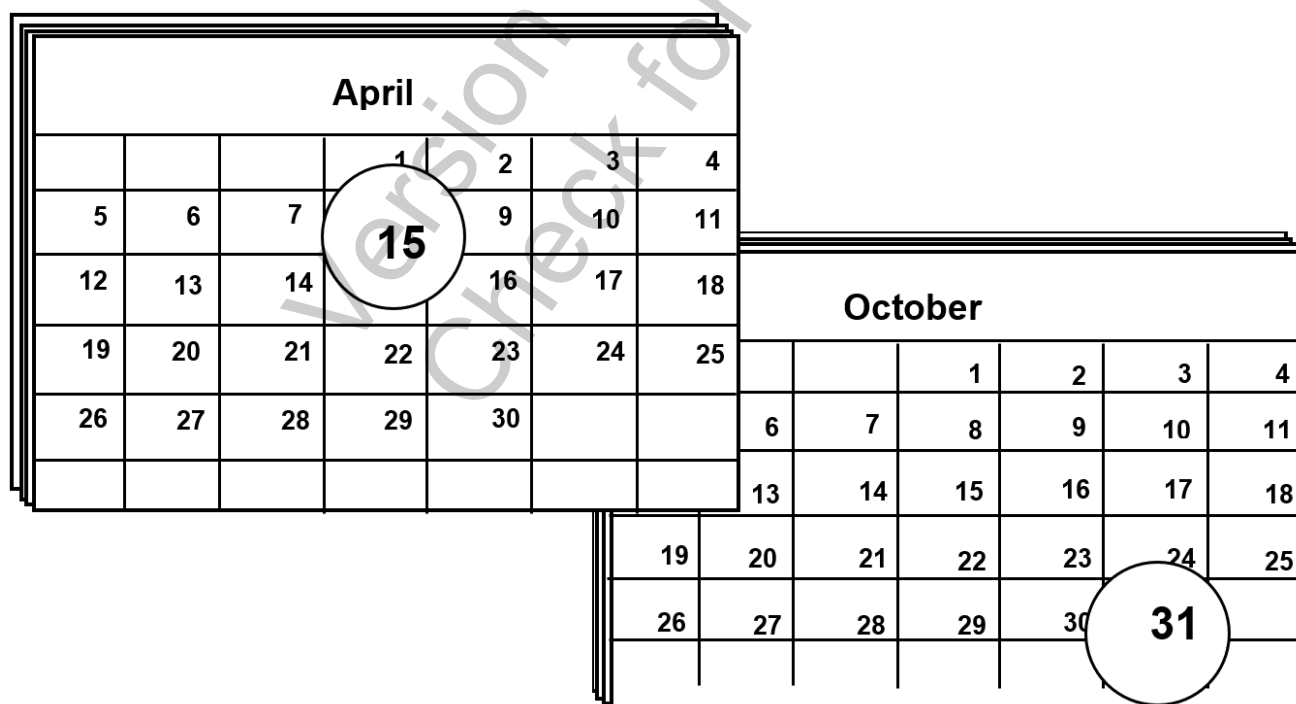


Figure 3: Six-month billing limit illustration

Delay Reason Codes

Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Delay reason codes are used on claims to designate approved reasons for late claim submission. These delay reasons also have time limits. See the claim submission and timeliness instructions section of the appropriate Part 2 manual for details regarding delay reason codes.

Beginning with the month of service:

1. Submit the Original Claim within six months following the month of service
2. If the claim is denied, submit CIF within six months from date of the RAD
3. If the RAD is denied, submit the Appeal within 90 days from the date on the RAD, Claims Inquiry Response Letter or Claims Inquiry Acknowledgement

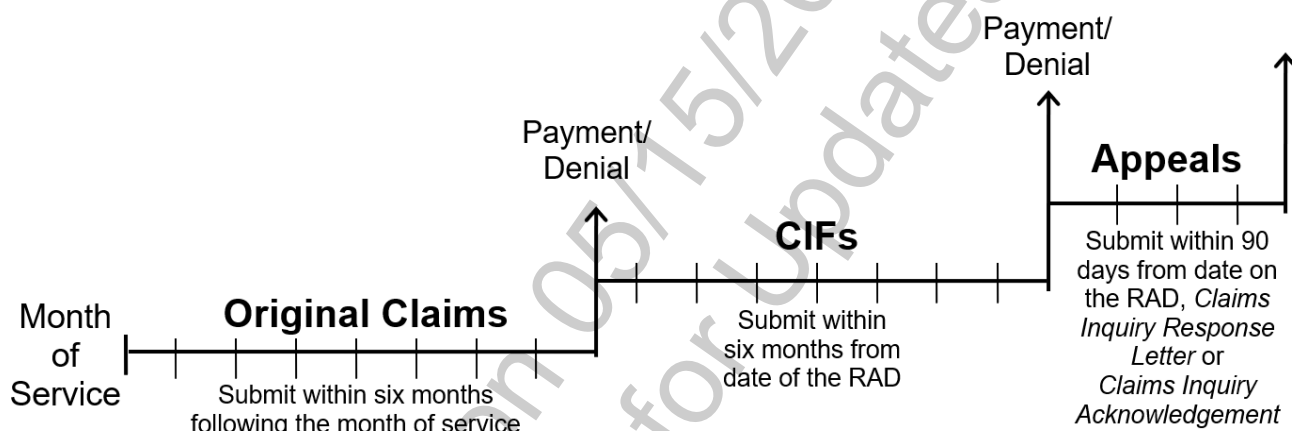


Figure 4: Claim Timeline Chart

Reimbursement Reduced

Claims that are not received by the FI within the for Late Claims six-month billing limit and do not meet any of the other delay reasons will be reimbursed at a reduced rate or will be denied as follows. See *Figure 5*.

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

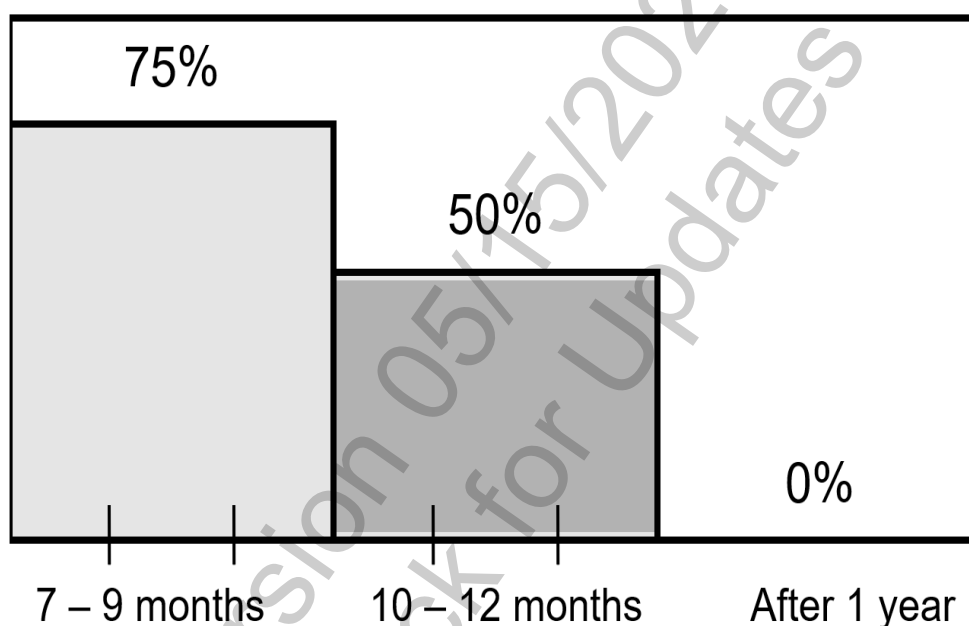


Figure 5: Claim reimbursement percentages when none of the delay reason codes apply.

Source: *Welfare and Institutions Code Section 14115*

Legend

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Version 05/15/2023
Check for Updates

Claim Submission and Timeliness Overview

Page updated: December 2021

This section includes information about claim forms that providers use to bill services rendered to recipients of the programs listed in this manual. In addition, this section includes basic claim form preparation instructions, claim submission deadline information and a brief description of claims processing procedures.

Introduction

Claim Forms Used to Bill Medi-Cal

The claim forms that providers use to bill Medi-Cal are listed below. The form a provider submits is determined by their Medi-Cal designated provider category and the service they render.

«Table of Claim Forms Used to Bill Medi-Cal»

Claim Form Used by (Provider Type)	Submit When Billing for:
CMS-1500 Claim: Allied Health, Medical Services Pharmacy, Vision Care	Medical services and supplies Vision Care services/eye appliances
Payment Request for Long Term Care (25-1): Long Term Care	Long term care services rendered in either a free-standing facility or distinct part of an acute inpatient facility
UB-04 Claim: Inpatient, Outpatient	Inpatient and outpatient services as follows: <ul style="list-style-type: none"> • Inpatient services for acute hospital accommodations and ancillary charges • Outpatient services for institutional facilities and for others, such as Rural Health Clinics (RHCs) and chronic dialysis services

ANSI and Medi-Cal Forms

The *CMS-1500* and *UB-04* claim forms were adopted by Medi-Cal in 2007 to comply with Federal and State regulations promoting uniformity in billing. These claim forms use the widely accepted American National Standards Institute (ANSI) format. «The 25-1 claim form is unique to the Medi-Cal program and does not use the ANSI format.»

Processing Claims

Introduction

Medi-Cal fee-for-service claims are processed by the California MMIS Fiscal Intermediary using the Medi-Cal claims processing system. It is the intent of DHCS and the FI to process claims as accurately, rapidly and efficiently as possible. A brief description of claims processing methods follows.

Computer Media Claims (CMC)

«Computer Media Claims (CMC) are submitted on the Medi-Cal Providers website via Transactions Services or the Provider Portal or on the [Medi-Cal Rx website](#).» CMC bypass the claims preparation and data entry processes of hard copy claims and go directly into the claims processing system. This significantly reduces adjudication time.

Point of Service (POS) Network Claims

«Some *CMS-1500* claims are submitted through the Medi-Cal Providers website or Medi-Cal Rx website. The *CMS-1500* online claim format includes an 80-character remarks field. Claims requiring additional documentation must be billed “hard copy” or through CMC.»

Enrollment

«To submit POS or CMC transactions on the Medi-Cal Providers website on behalf of a provider, submitters must register in the Medi-Cal Provider Portal and be affiliated to the provider.»

Paper Claims

All incoming paper claims and other documents are pre-sorted by the U.S. Postal Service by P.O. Box and delivered to the FI mailroom by the Postal Service or FI couriers.

All submitted forms must be on standard paper claim forms. Standard claim forms can be purchased from authorized vendors. Accuracy, completeness and clarity of the form are necessary to ensure that the information is scanned correctly into the system.

Paper Claim Preparation

Paper claims routed to the Claims Preparation Unit are examined for acceptability and sorted for data entry. Claims and attachments are scanned, assigned a unique 13-digit Claim Control Number (CCN) and routed for either Optical Character Recognition (OCR) or Key Data Entry (KDE).

Neatly typed or computer-filled claim forms that have data within the boxes on the form are sorted for data entry by OCR scanners. All other claim forms are entered manually by KDE operators.

Claim Control Number

The CCN is used to identify and track Medi-Cal claims as they move through the claims processing system. This number contains the Julian date, which indicates the date a claim was received by the FI and is used to monitor timely submission of a claim. See Figures 1 and 2.

Julian Date

The Julian date within the CCN indicates the date a claim was received by the FI and is used to monitor timely submission. See Figure 1.

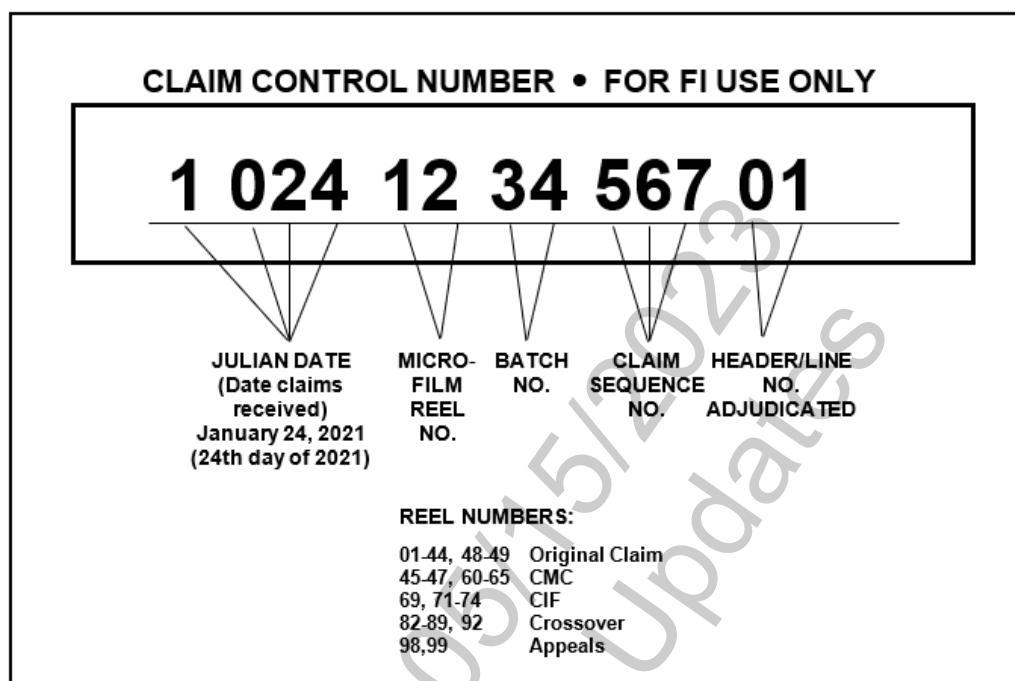


Figure 1: Claim Control Number (CCN)

Day Month	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
1.	1	32	60	91	121	152	182	213	244	274	305	335
2.	2	33	61	92	122	153	183	214	245	275	306	336
3.	3	34	62	93	123	154	184	215	246	276	307	337
4.	4	35	63	94	124	155	185	216	247	277	308	338
5.	5	36	64	95	125	156	186	217	248	278	309	339
6.	6	37	65	96	126	157	187	218	249	279	310	340
7.	7	38	66	97	127	158	188	219	250	280	311	341
8.	8	39	67	98	128	159	189	220	251	281	312	342
9.	9	40	68	99	129	160	190	221	252	282	313	343
10.	10	41	69	100	130	161	191	222	253	283	314	344
11.	11	42	70	101	131	162	192	223	254	284	315	345
12.	12	43	71	102	132	163	193	224	255	285	316	346
13.	13	44	72	103	133	164	194	225	256	286	317	347
14.	14	45	73	104	134	165	195	226	257	287	318	348
15.	15	46	74	105	135	166	196	227	258	288	319	349
16.	16	47	75	106	136	167	197	228	259	289	320	350
17.	17	48	76	107	137	168	198	229	260	290	321	351
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25.	25	56	84	115	145	176	206	237	268	298	329	359
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For Leap Year, add one day to the number of days after February 28.

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Claims entering the Medi-Cal system are processed on a line-by-line basis except for inpatient claims. Inpatient claims are processed on an entire claim basis. Each claim is subject to a comprehensive series of checks called “edits” and “audits.” The checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit/audit checks include verification of:

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«**Note:** Medi-Cal does not accept walk-up claims delivery service.»

Timelines for Claims

Six-Month Billing Limit

Original (or initial) Medi-Cal claims must be received by the FI within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. For example, if services are provided on April 15, the claim must be received by the FI prior to October 31 to avoid payment reduction or denial for late billing. See *Figure 3*. *Figure 4* diagrams the claim timeline that includes not only the initial claim submission but also follow up requests. Refer to the *CIF Overview and Appeal Process Overview* sections in this manual for more information.

Note: For the purpose of adjudicating claims, the "through" date of service will be used to determine timeliness of submission.

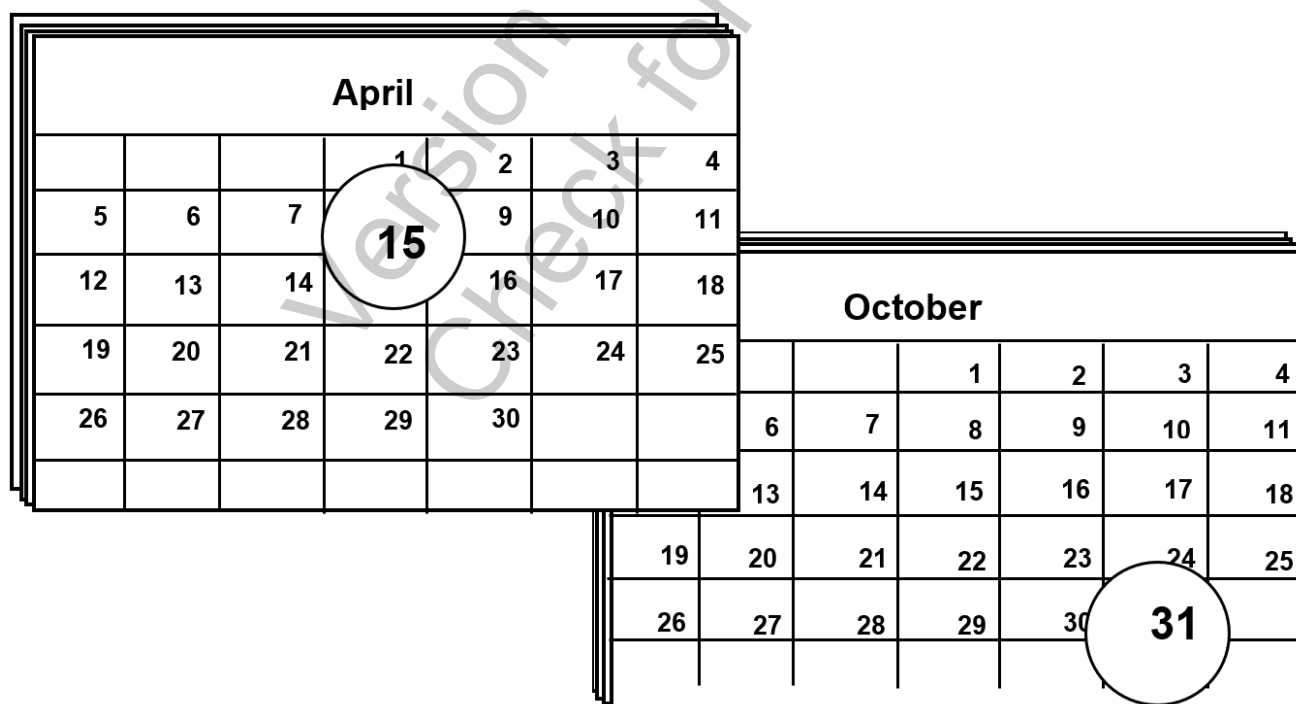


Figure 3: Six-month billing limit illustration

Delay Reason Codes

Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Delay reason codes are used on claims to designate approved reasons for late claim submission. These delay reasons also have time limits. See the claim submission and timeliness instructions section of the appropriate Part 2 manual for details regarding delay reason codes.

Beginning with the month of service:

1. Submit the Original Claim within six months following the month of service
2. If the claim is denied, submit CIF within six months from date of the RAD
3. If the RAD is denied, submit the Appeal within 90 days from the date on the RAD, Claims Inquiry Response Letter or Claims Inquiry Acknowledgement

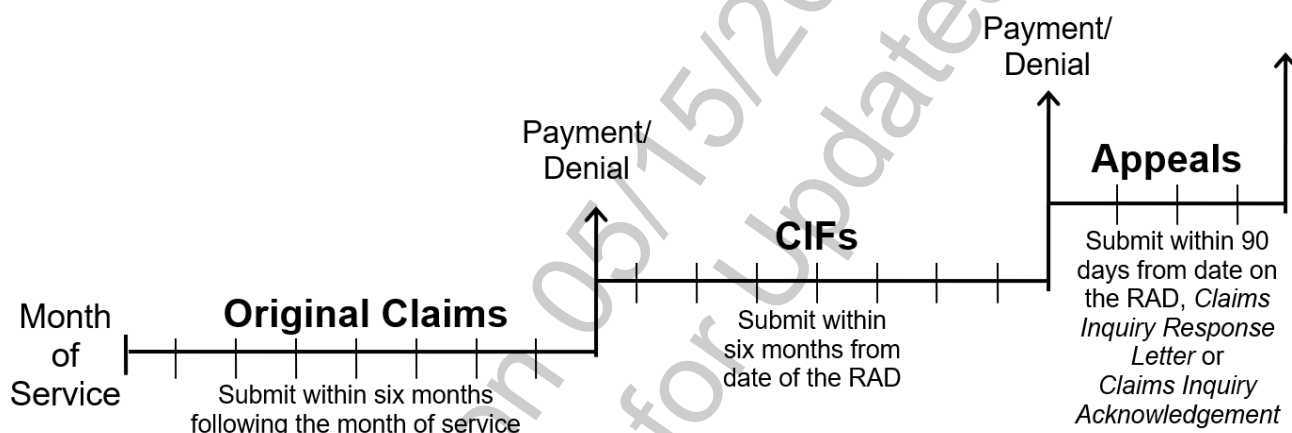


Figure 4: Claim Timeline Chart

Reimbursement Reduced

Claims that are not received by the FI within the for Late Claims six-month billing limit and do not meet any of the other delay reasons will be reimbursed at a reduced rate or will be denied as follows. See *Figure 5*.

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

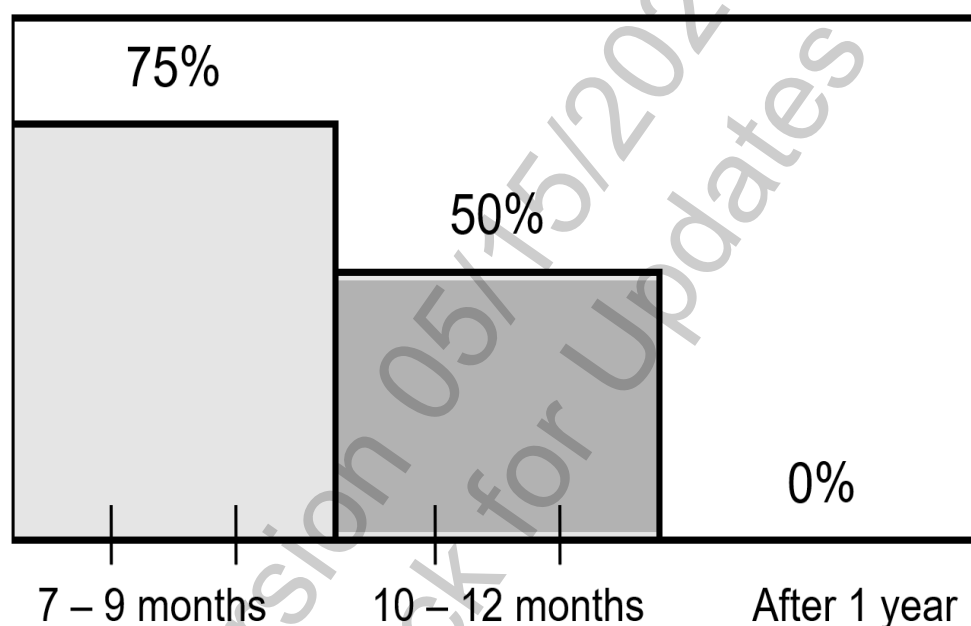


Figure 5: Claim reimbursement percentages when none of the delay reason codes apply.

Source: *Welfare and Institutions Code Section 14115*

Legend

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Version 05/15/2023
Check for Updates

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Examples

Page updated: December 2020

The example in this section is to help providers bill Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHCs) services on the *UB-04 Claim Form*. Refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section in this manual for general billing information. Refer to the *UB-04 Completion: Outpatient Services* section of this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Remarks* field (Box 80) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim <<form>>.

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Check for Updates

Managed Care Differential Rate

Figure 1. Managed Care differential rate billing code set.

This is a sample only. Please adapt to your billing situation.

John Doe visited a «RHC» for evaluation of his recent chest pain. He is enrolled in a Medi-Cal managed care plan «(MCP)» and the service is covered under the plan. The RHC bills the «MCP» for the encounter. The clinic may submit a «managed care differential rate claim (also known as the “wrap”)» to Medi-Cal with revenue code 0521, procedure code with modifier T1015E and an informational line specific to his visit, which in this case is procedure code 99214.

On claim line 1, enter the revenue code 0521 in the *Revenue Code* field (Box 42), the description of the code (Managed Care Differential Rate) in the *Description* field (Box 43) and the corresponding procedure code with modifier (T1015E) in the *HCPES/Rate* field (Box 44). Enter the date of service in the *Service Date* field (Box 45) in six-digit format. A “1” is entered in the *Service Units* field (Box 46) for Managed Care Differential Rate billing code set to indicate the billing is for the differential for one visit (more than one visit can be billed with medical justification). Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 2, enter the revenue code and procedure code specific to the visit in *Revenue Code* field (Box 42) and *HCPES/Rate* field (Box 44) respectively, followed by the date of service in the *Service Date* field (Box 45). A “1” is entered in the *Service Units* field (Box 46) for the number of service units provided for the procedure code. When filling out an informational line, Box 47 must be zeros because this line is not payable. Enter Code 001 in the *Revenue Code* column (Box 42, line 23) to designate that this is the total charge line and enter the totals of all charges in the *Total Charges* field (Box 47, line 23).

Note: When billing for the managed care differential rate, Box 39 and Box 54 on the *UB-04* claim must be left blank, as these fields are reserved respectively for Share of Cost (SOC) and Other Health Care Coverage (OHC) only.

If billing the Managed Care Differential Rate for both a medical and dental visit, or for a third visit (allowable only in special circumstances) on the same dates of service, billers should refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes* section for billing instruction.

Enter "O/P Medi-Cal" to indicate the type of claim and payer in the *Payer Name* field (Box 50). The NPI is placed in the *NPI* field (Box 56).

Enter an appropriate ICD-10-CM diagnosis code. Because this claim is submitted with a diagnosis code, an ICD indicator is required in the white space below the *DX* field (Box 66). An indicator is required when an ICD-10-CM/PCS code is entered on the claim.

Enter the rendering physician's NPI in the *Operating* field (Box 77). «or the Ordering Referring or Prescribing (ORP) provider's individual (Type 1) NPI in *Attending* field (Box 76).»

Refer to the *UB-04 Completion: Outpatient Services* section of this manual for instructions to complete the remaining fields.

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Check for Updates

Figure 1: Managed Care Differential Rate Billing Code Set

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Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
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Version 05/15/2023
Check for Updates

Health Insurance Portability and Accountability Act (HIPAA) mandated changes to billing requirements for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Services – Memorandum of Agreement (IHS-MOA) 638. Clinic providers will become effective on October 1, 2017. These changes include the use of Healthcare Common Procedure Coding System (HCPCS) Level I and Level II national codes. The following Frequently Asked Questions (FAQs) will provide an overview of this transition and point to resources for additional information.

1. What does the transition from the HCPCS Level III local per visit codes to HIPAA-compliant billing code sets mean?

Transition from the HCPCS Level III local per visit codes to HIPAA-compliant billing code sets means that FQHC/RHC/IHS-MOA providers who currently submit HCPCS Level III local per visit codes when billing for their services will be required to submit claims using specified HIPAA-compliant Current Procedural Terminology (CPT®) Level I and HCPCS Level II code sets, effective for dates of service on or after October 1, 2017.

For dates of service on or after October 1, 2017, claims submitted with local per visit codes, with the exception of local per visit code 03 (dental services), will be denied. Local per visit code 03, which is used when billing dental services, is not affected by the transition to HIPAA-compliant billing code sets.

2. Who is affected by the transition to the HIPAA-compliant billing code sets?

All FQHC/RHC/IHS-MOA providers submitting claims for services rendered on or after October 1, 2017, will be required to use the HIPAA-compliant billing code sets identified in the FQHC/RHC and IHS-MOA code conversion crosswalks in the FQHC/RHC/IHS-MOA section of the [HIPAA: Code Conversions](#) page.

3. What is HIPAA and how does it relate to CPT Level I and HCPCS Level II codes?

HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. In addition to eliminating the use of Level III local codes, HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information.

4. Why is the transition to CPT Level I and HCPCS Level II codes happening?

California has historically used many thousands of HCPCS Level III or local codes (also known as interim codes) for billing and reimbursement of services and supplies. National codes, such as CPT Level I and HCPCS Level II codes, typically are more general in nature compared to local codes. Using CPT Level I and HCPCS Level II code sets will:

- Simplify the processes and decrease the costs associated with payment for health care services;
- Improve the efficiency and effectiveness of the health care system and decrease administrative burdens on providers (for example, medical practices, hospitals and health care plans);
- Provide standardization and consistency in medical service coding; and
- Characterize a general administrative situation, rather than a medical condition or service, by using non-clinical or non-medical code sets.

5. When will this transition take place?

The effective date for this transition to the HIPAA-compliant billing code sets will take place for services rendered on or after October 1, 2017.

6. What is a HIPAA-compliant billing code set and why does the conversion require use of a revenue code, or revenue code with procedure code and sometimes a modifier?

A HIPAA-compliant billing code set is a unique combination of service codes used to identify the face-to-face (one-on-one) encounter between the FQHC/RHC/IHS-MOA patient and the FQHC/RHC/IHS-MOA provider, during which time one or more services are furnished. The code set may consist of one of the following:

- Revenue code;
- Revenue code and CPT Level I or HCPCS Level II code; or
- Revenue code and CPT Level I or HCPCS Level II code with a modifier.

The use of a HIPAA-compliant billing code set is required to bill for the global visit with the patient, and the accompanying informational lines will detail the specific services provided during the global visit.

Billing local per visit code 03 for dental services is not affected by the transition to HIPAA-compliant billing code sets. Claims for dental services submitted with local per visit code 03 may be submitted on the same claim form as other services billed with HIPAA-compliant billing code sets and informational lines.

Other than the transition from local codes to the HIPAA-compliant billing code sets, no other policy for FQHC/RHC/IHS-MOA providers is affected.

7. What is a revenue code and why is it used?

Revenue codes are published by the National Uniform Billing Committee (NUBC) and used by facilities to identify specific accommodation, ancillary services, unique billing calculations or arrangements. HIPAA mandates that payers, including Medi-Cal, accept revenue codes and utilize them in claim adjudication.

Revenue codes will be used by FQHC/RHC/IHS-MOA providers to bill for services rendered, which includes use of the facility. Each service should be assigned a revenue code, but not every revenue code will utilize an accompanying procedure code or a modifier to define the global billing code set for the face-to-face encounter.

Submitting claims with a service code combination that does not match the HIPAA-compliant billing code set for the services rendered may result in underpayments, overpayments or claim denials.

8. What happens if a revenue code is not included on the claim for a date of service on or after October 1, 2017?

Claims submitted by FQHC/RHC/IHS-MOA providers without a revenue code for dates of service on or after October 1, 2017, will be denied. Providers have three options for countering a denied claim:

- Submit a new claim with corrected information if the dates of service are within the six month billing limit;
- Submit an appeal within 90 days of the date on a *Remittance Advice Details* (RAD) form showing the claim denial;
- Submit a *Claims Inquiry Form* (CIF) within six months of the date on the RAD form showing the claim denial.

For more information, providers should refer to the *Claim Submission and Timeliness Overview* (claim sub) section of the Part 1 provider manual and the *Appeal Form Completion* (appeal form) and *CIF Completion* (cif co) sections of the appropriate Part 2 provider manual.

9. What is an "informational line" and why should I include this when billing for services?

An informational line is an associated line item or line items listed immediately following the HIPAA-compliant global billing code set used to bill the face-to-face encounter with the patient. Informational lines **are not separately reimbursed**. When submitting informational lines providers should remember:

- The *Revenue Code* field (Box 42) on the informational line must always be a four-digit revenue code. Reference ASC X12N 837 v.5010 Loop 2400 Segment SV201.
- Entering a service date in the *Service Date* field (FL 45) on the informational line is optional.
- The *Service Units* field (Box 46) on the informational line may contain the number of service units provided for the procedure code on paper claim forms (NUBC). For Electronic Data Interchange (EDI) transactions, reference ASC X12N 837 v.5010 Loop 2400 Segment SV205.
- The *Total Charges* field (Box 47) on paper claims for each informational line must always be zeros. For EDI transactions, reference ASC X12N 837 v.5010 Loop 2400 Segment SV203.

Example of billing a HIPAA-compliant billing code set with informational lines:

	42 Rev.CD	43 Description	44 HCPCS/RATE/ HIPPS Code	45 Serv.Date	46 Serv. Units	47 Total Charges	48 Non-covered charges
1	0520	Clinic Visit	T1015	030120	01	10000	<- payable line
2	0520		80018	030120	01	000	<- informational
3	0520		99213	030120	01	000	<- informational
4	0520	Optometry	92004	030120	01	20000	<- payable line
5	0520		92002	030120	01	000	<- informational
6	Optional	Virtual/Telephonic Communication Services	G0071	030120	01	02476	<- payable line

Note: Computer Media Claims (CMC) submitted with an informational line on the first detail line of the claim will be rejected. CMC claim detail line 01 must include only HIPAA-compliant billing code sets.

Informational line examples are published in the *Medi-Cal Computer Media Claims (CMC) Billing and Technical manual*, "Special Billing

Instructions: FQHC/RHC/IHS-MOA.”

10. How many services can I bill on one claim?

A single paper claim cannot be billed with more than 22 claim lines. When billing an electronic (CMC) claim, if the addition of informational lines causes the claim to exceed 22 lines, the claim must be split and services billed on separate claims. Electronic claims that exceed 22 claim lines with informational lines will be denied in their entirety.

11. How will the HCPCS Level III code transition impact my SARs October 1, 2017?

Effective for dates of service on or after October 1, 2017, FQHC/RHC providers may no longer submit Service Authorization Requests (SARs) with HCPCS Level III local per visit codes. All SARs submitted for FQHC/RHC Service Code Group (SCG) 08 must be submitted with the appropriate HIPAA-compliant billing code set. The only exception is for local per visit code 03 for dental services.

All SARs with HCPCS Level III local per visit codes, except for local per visit code 03, regardless of status (approved, retroactive or deferred), will be end-dated for dates of service on or after October 1, 2017. Providers are encouraged to submit new SARs with the appropriate CPT Level I or HCPCS Level II codes prior to October 1, 2017, for services that will be provided on or after October 1, 2017.

12. How will the HCPCS Level III local per visit code transition impact claims billed with dates of service on or after October 1, 2017?

Effective for dates of service on or after October 1, 2017, claims billed with HCPCS Level III local per visit codes, except for local per visit code 03 for dental services, will no longer be eligible for reimbursement and will be denied.

Providers have three options for following up a denied claim:

- Submit a new claim with corrected information if the dates of service are within the six month billing limit;
- Submit an appeal within 90 days of the date on a RAD form showing the claim denial;
- Submit a CIF within six months of the date on the RAD form showing the claim denial.

13. How do I use modifier codes?

Specific HIPAA-compliant billing code sets require the use of a modifier to identify the type of face-to-face encounter. The specific code sets requiring the use of a specific modifier are listed in the code conversion crosswalks located in the FQHC/RHC/IHS-MOA section of the [HIPAA: Code Conversions](#) page.

14. Do I need to use modifier 99 to indicate multiple modifiers?

No, claims using modifier 99 will be denied. HIPAA-compliant billing code sets that do not require a modifier should not be billed with modifier 99 or any other modifier.

15. What changes should I expect to see with the HIPAA-compliant billing code sets on or after October 1, 2017?

For dates of service on or after October 1, 2017, FQHC/RHC/IHS-MOA billing policy will be updated to accommodate one of the following:

- Revenue code;
- Revenue code and CPT Level I or HCPCS Level II code; or
- Revenue code and CPT Level I or HCPCS Level II code with a modifier.

The billing policy update will also allow each claim to be submitted with one of the HIPAA-compliant billing code sets followed by one or more informational claim lines.

A complete listing of the new HIPAA-compliant billing code sets is available in the FQHC/RHC/IHS-MOA section of the [HIPAA: Code Conversions](#) page.

16. Will the FQHC/RHC/IHS-MOA claims transition from HCPCS Level III local per visit codes to HIPAA-compliant billing code sets impact current rates and change how my claims are reimbursed?

The change to the use of the HIPAA-compliant billing code sets is intended to be budget-neutral and rates will not change as a result of this code conversion. The rates used to reimburse the HCPCS Level III local per visit codes will also be reimbursed for the crosswalked HIPAA-compliant billing code sets.

17. Do I need to enter the Prospective Payment System (PPS) rate or the total charges in the *Total Charges* field (Box 47) of the claim form, or is there an option to choose?

Providers will be reimbursed the PPS rate or differential rate on file for the service billed whether they bill an amount greater than or less than the PPS rate or differential rate.

18. Can I enter an amount other than zero (for example, \$0.01) for the total charges on informational lines?

No, the *Total Charges* field (Box 47) for each information claim detail line must always be zeroes on paper claim forms; blanks (spaces) or zeroes are accepted in Box 47 field for CMC.

19. Is testing available for electronic claims submissions?

Yes, submitters are encouraged to visit the [Testing and Activation Procedures](#) section of the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual* to ensure accurate file format, completeness and validity.

A new test must be submitted when software is upgraded or the submission method changes. Submitters may test status for HIPAA-related compliant claims transactions through the [Medi-Cal test site](#).

20. How does this code conversion effect how we currently bill CHDP claims?

FQHC/RHC/IHS-MOA providers that want to bill for a Child Health and Disability Prevention (CHDP) visit should bill the corresponding code set (found on the FQHC/RHC and IHS-MOA crosswalks). Accompanying informational lines that identify the actual service(s) provided should include CPT Level I or HCPCS Level II code(s).

Additionally, the information-only *Confidential Screening/Billing Report* (PM 160) is used to meet federal Medicaid requirements for reporting preventative health services rendered to Medi-Cal recipients who are receiving services from FQHC/RHC/IHS-MOA providers should be included.

NOTE: Do not physically attach the *UB-04* claim form to the PM 160 or vice versa. The PM 160 should be sent hard copy via mail.

Mailing and form retention instructions for the Information-only PM 160 can be found in the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* (rural) and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* (ind health) provider manuals.

21. Where can I find additional information related to the FQHC/RHC/IHS-MOA claims transition from HCPCS Level III local per visit codes to HIPAA-compliant billing code sets?

Providers may request additional onsite or telephone support via the Telephone Service Center (TSC) at 1-800-541-5555, from 8 a.m. to 5 p.m., Monday through Friday. Border Providers and Out-of-State Billers billing for In-State Providers call 1-916-636-1200. Providers calling from outside of California call the Out-of-State Provider Unit at 1-916-636-1960 from 8a.m. to 12 p.m. Monday through Friday, except holidays.

For additional information, providers may:

- Routinely check the *Medi-Cal Update* provider bulletins
- Routinely check the [Medi-Cal Learning Portal Training Calendar](#) for announcements of upcoming training and webinars developed specifically for FQHC/RHC/IHS-MOA providers
- Refer to the [FQHC/RHC Code Conversion Crosswalk](#) or the [IHS-MOA Code Conversion Crosswalk](#) for a full description of the new HIPAA-compliant billing code sets

Providers who would like to receive monthly email notification for newly published *Medi-Cal Update* bulletins should complete the [MCSS Subscriber Form](#).

Questions may also be submitted via email to CAMMISCodeConversion@dx.com.

22. Who can I contact if I'm having issues with my Computer Media Claims (CMC) submissions?

The CMC Help Desk can be accessed by calling the Telephone Service Center (TSC) at 1-800-541-5555 and select the option POS, Internet, LSRS and CMC inquiries.

**INSTRUCTIONS FOR MEDI-CAL
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)/RURAL HEALTH CLINIC (RHC)
PROSPECTIVE PAYMENT SYSTEM (PPS) RECONCILIATION REQUEST**

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Please read all instructions carefully before completing the form.

Benefits Improvement and Protection Act (BIPA), Welfare and Institutions (W&I) Code Section 14132.100 and the 42 U.S.C. section 1396a (bb) authorize FQHCs/RHCs to receive payment for providing covered services to Medi-Cal eligible individuals under a Prospective Payment System (PPS) methodology. The PPS rate covers 100 percent of the FQHC's/RHC's reasonable costs for providing services to Medi-Cal beneficiaries.

For beneficiaries who participate in Medi-Cal Managed Care and/or are enrolled in Medicare, the Department of Health Care Services (DHCS) pays the FQHC/RHC a supplemental payment, commonly referred to as the wrap payment, that is equal to the difference between visits reimbursed at the FQHC's/RHC's PPS rate and the amount received by third-party payers. DHCS pays the supplemental payment in two stages – an interim payment, referred to by DHCS as a differential rate, is paid on a per visit basis each time the FQHC/RHC files a claim, and, if necessary, a final payment once the reconciliation process is complete. If the amount of Medi-Cal Program interim payments and third party payments received by the FQHC/RHC is less than the amount of actual visits reimbursed at the PPS rate, the FQHC/RHC will be paid the difference. However, if the amount of Medi-Cal Program interim payments and third party payments is more than the amount of actual visits reimbursed at the PPS rate, the FQHC/RHC must repay DHCS the difference. California's State Plan Amendment (SPA) at [Attachment 4.19-B](#) describes the PPS reimbursement methodology DHCS must follow with respect to FQHCs/RHCs.

At the end of each FQHC's/RHC's fiscal year, FQHCs/RHCs must file a Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Prospective Payment System (PPS) Reconciliation Request. The total amount of Medi-Cal interim payments and third party payments received by the FQHC/RHC, e.g. Medicare, Managed Care Organization (MCO), and other party third party payments, if applicable, will be reviewed against the amount of the actual number of visits the FQHC/RHC reimbursed by the Medi-Cal Program.

Only the FQHC's/RHC's visits that were adjudicated by the Medi-Cal Fiscal Intermediary (FI) will be included in the reconciliation calculation to determine the difference between visits reimbursed at the FQHC's/RHC's PPS rate and the amount received by third-party payers.

Pursuant to W&I Code section 14132.100(h), FQHCs/RHCs must disclose all payments received from Medicare, Medi-Cal Managed Care Plans (capitated and fee-for-service), and all other third party sources for the provision of FQHC/RHC services to Medi-Cal beneficiaries, regardless of whether services were rendered and regardless of whether the third party payments resulted in a billable visit to the Medi-Cal Program. Financial incentive payments that meet the requirements of federal and state law may be excluded from the annual Reconciliation Request. Verification of third party payments are subject to the Medicare reasonable cost principles found in 42 CFR, Part 413, and in accordance with California's FQHC/RHC policies and procedures.

If an FQHC/RHC bills the Medi-Cal Program for services rendered to a Medi-Cal managed care beneficiary, all Medi-Cal managed care plan payments received for all Medi-Cal beneficiaries will be

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included in the determination of final reimbursement on the annual Reconciliation Request. There may be occurrences where the Medi-Cal managed care plan reimbursement for some Medi-Cal beneficiaries exceeds the Medi-Cal PPS, while the Medi-Cal managed care plan reimbursement for other Medi-Cal beneficiaries does not exceed the Medi-Cal PPS rate. In these occurrences, it would be inappropriate to bill the Medi-Cal Program for only the Medi-Cal beneficiaries that received less than the Medi-Cal PPS rate, and then to not also bill the Medi-Cal Program for the Medi-Cal beneficiaries that received more than the Medi-Cal PPS rate.

Only if a FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, do they not need to include all the reimbursement for pharmacy services the FQHC/RHC received from a Medi-Cal managed care plan on behalf of Medi-Cal beneficiaries.

A Reconciliation Request must be submitted for each separate National Provider Identifier (NPI) number annually, within 150 days after the end of the provider's fiscal year. Please note: DHCS will **NO LONGER** accept consolidated reconciliation forms with multiple NPIs.

Incomplete forms will be returned for correction. If returned, an explanation will be provided identifying the deficiencies and corrective action needed. It is important that all FQHC/RHC providers follow the [Electronic Submission Protocol](#) when submitting Reconciliation Requests. Upon submission of the Reconciliation Request to Reconciliation.Clinics@dhcs.ca.gov you will receive an email response confirming receipt. For questions or assistance, contact the FQHC/RHC Section at (916) 322-1681 or Clinics@dhcs.ca.gov.

RECONCILIATION PROCESS

The Reconciliation Request forms consist of a Cover Sheet, Statistical Data and Certification Statement, Request to Update Differential Rates, Reconciliation Request Summary (Worksheet 1), and Worksheets 2, 3, and 4 which requests detailed visit and payment information for Medi-Cal Non-Managed Care Crossovers, Medi-Cal Managed Care, and Medi-Cal Non-Managed Care Crossovers with Capitated Medicare Advantage Plans (MAP), respectively. Worksheet 3A must be completed to provide DHCS the necessary information regarding managed care plans. Worksheet 5, Summary of Services and Worksheet 6, Productivity for Health Care Practitioners worksheets must be filled out and included in the reconciliation submittal.

The data reported on the Reconciliation Request forms is subject to audit by DHCS. In accordance with [42 CFR § 413.20](#), DHCS reserves the right to request supporting documentation such as remittance advices, explanation of benefits, or other relevant and verifiable evidence to minimize the need for onsite reviews. The Department has 3 years from the date the Reconciliation Request forms are received and accepted to determine if the total payments were greater or less than the provider's allowable PPS reimbursement.

To assist the Department in their review, supporting documentation may be submitted with the Reconciliation Request forms. This is optional and is useful in determining revenue from payers other than Medi-Cal. For example, revenue received from Medicare for those services covered both by Medicare and

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Medi-Cal can be supported by data from the practice management system. The data would still be subject to audit and additional verification by the department, if deemed necessary.

STATISTICAL DATA AND CERTIFICATION STATEMENT – PAGE 2

Complete Part A, lines 1 through 11 with the requested information. If you need additional space to identify entities that you owned and billed under the same NPI, attach a page with the provider name and location. Complete Part B, Certification Statement with the requested information. The individual signing this statement must be an officer or other authorized responsible person.

REQUEST TO UPDATE DIFFERENTIAL RATES – PAGE 3

This page is only used to request updates to differential rates. Please enter “X” under the YES box for any differential rate you wish to have changed and complete the applicable forms. Enter the Fiscal Period and the remaining worksheets will populate automatically. If you wish to update the Medi-Cal Non-Managed Care Crossover rate, no special form is necessary. DHCS will contact you to obtain the relevant information.

SUMMARY OF VISITS AND PAYMENTS WITH SETTLEMENT DETERMINATION – WORKSHEET 1

This page summarizes Worksheets 2, 3, and 4 and will populate automatically when those worksheets are completed by the provider.

Note:

- 1) Date of Service should be used as the basis for reporting visits and payments.
- 2) PPS rates increase on October 1st of each year based on an inflation factor known as the Medicare Economic Index. The time interval before the increase is Period 1 and after the increase is Period 2.

Please enter the applicable PPS rates for Period 1 and Period 2 in the yellow boxes on Line 16.

Please specify if the rates entered are FINAL rates or NOT FINAL rates (ie: a new facility awaiting the establishment of a permanent PPS rate), by placing either a “Y” or “N” in the yellow area to the left of the PPS rate cells.

MEDI-CAL NON-MANAGED CARE CROSSOVER DETAIL – WORKSHEET 2

Beginning with the column on the left:

1. Enter the months included in the fiscal period beginning with the first month of the fiscal period.

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2. Enter the number of visits next to the appropriate month. Report only adjudicated visits during the reporting period for dual eligible beneficiaries **not** enrolled in any Medi-Cal Managed Care plan and **not** paid using a capitated MAP arrangement.
3. Enter the payments that correspond to the monthly visits in the appropriate payment column. Report all payments received from the Medi-Cal FI for dual eligible beneficiaries **not** enrolled in any Medi-Cal Managed Care plan and **not** paid by Medicare using a capitated MAP arrangement.

Payment Explanations

- **PPS/Upper Payment Limit (UPL)/Fee for Service (FFS)** – Combine payments received from the Medicare Administrative Contractor (MAC) whether from a PPS, UPL, or FFS arrangement for dual eligible patients **not** enrolled in a Medi-Cal Managed Care plan, and **not** participating in any MAP arrangement.
- **FFS MAP** – Input payments received from MAP for beneficiaries enrolled in a FFS arrangement and **not** enrolled in a Medi-Cal Managed Care plan.
- **CODE 519** – Input only wrap-around payments received from the MAC for beneficiaries enrolled in any MAP arrangement, and **not** enrolled in a Medi-Cal Managed Care plan.
- **PART D** – Input payments received from Medicare prescription drug plans for beneficiaries **not** enrolled in a Medi-Cal Managed Care plan. Only if the FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, does the FQHC/RHC not need to include Medicare Part D payments. Otherwise, Part D payments must be reported.
- **3rd PARTY PAYER** – Input all payments received for FQHC/RHC services from any other source not already reported.

Only include payments related to Medi-Cal beneficiaries for all types listed above.

4. Enter a formula for Period 1 Total and Period 2 Total in the “VISITS” column to calculate the appropriate visits for each period.

For example: if the provider's fiscal year is July through June, in the “Period 1 Total” box, enter the formula to sum July, August, and September. In the “Period 2 Total” box, enter the formula to sum October through June.

5. Copy the appropriate Period 1 and Period 2 formulas to the “PAYMENTS” columns to calculate Period 1 and Period 2 payments for all types.

MEDI-CAL MANAGED CARE DETAIL – WORKSHEET 3

Beginning with the column on the left:

1. Enter the months included in the fiscal period beginning with the first month of the fiscal period.
2. Enter the number of visits next to the appropriate month. Report only adjudicated visits for all Medi-Cal Managed Care plan beneficiaries who received services.

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3. Enter the Medi-Cal interim payments that correspond to the monthly visits in the “MEDI-CAL INTERIM” column. This should be payments received from the Medi-Cal FI.
4. Enter all Medi-Cal Managed Care plan payments in the appropriate “MEDI-CAL MANAGED CARE PLANS” column. This should be the amount received from all managed care plans. If the provider contracts with multiple managed care plans, the amount received from all plans should be combined into the appropriate columns. All capitation payments received, regardless of whether services were ever rendered and resulted in a billable visit, must be reported. All fee-for-service payments received from a Medi-Cal Managed Care Plan, including payments received for services when a billable visit does not occur, must be reported. Financial incentive payments that meet the requirements of federal and state law may be excluded from the annual Reconciliation Request.

Payment Explanations

- **PPS/UPL/FFS** – Combine revenue received from the MAC whether from a PPS, UPL, or FFS arrangement for dual eligible patients enrolled in a Medi-Cal Managed Care plan and **not** participating in any MAP arrangement.
- **FFS/CAPITATED MAP** – Input payments received from MAP for beneficiaries enrolled in a FFS or Capitated arrangement and enrolled in a Medi-Cal Managed Care plan.
- **CODE 519** – Input only wrap-around payments received from the MAC for beneficiaries enrolled in any MAP arrangement and enrolled in a Medi-Cal Managed Care plan.
- **PART D** – Input payments received from Medicare prescription drug plans for beneficiaries enrolled in a Medi-Cal Managed Care plan. Only if the FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, does the FQHC/RHC not need to include Medicare Part D payments. Otherwise, Part D payments must be reported.
- **3rd PARTY PAYER** – Input all payments received for reported visits from all other sources not already reported, only if applicable.

Only include payments related to Medi-Cal beneficiaries for all types listed above.

5. Enter a formula for Period 1 Total and Period 2 Total in the “VISITS” column to calculate the appropriate visits for each period.
6. Copy the appropriate Period 1 and Period 2 formulas to the “PAYMENTS” columns to calculate Period 1 and Period 2 payments for all types.

MEDI-CAL MANAGED CARE PLAN INFORMATION – WORKSHEET 3A

Enter the name of each Medi-Cal Managed Care Plan the provider contracted with during the reconciliation

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period.

MEDI-CAL NON-MANAGED CARE CROSSOVERS WITH CAPITATED MAP DETAIL-WORKSHEET 4

Beginning with the column on the left:

1. Enter the months included in the fiscal period beginning with the first month of the fiscal period.
2. Enter the number of visits next to the appropriate month. Report only adjudicated visits for dual eligible beneficiaries **not** enrolled in any Medi-Cal Managed Care plan and paid using a capitated MAP arrangement.
3. Enter the Medi-Cal crossover payments that correspond to the monthly visits in the “MEDI-CAL CROSSOVER” column. This should be payments received from the Medi-Cal FI for dual eligible beneficiaries **not** enrolled in any Medi-Cal Managed Care plan and paid by Medicare using a capitated MAP arrangement.
4. Enter the Medicare Advantage Plan payments that correspond to the monthly visits in the appropriate “MEDICARE ADVANTAGE PLANS” column.

Payment Explanations

- **CAPITATED MAP** – Enter capitated payments received from MAP arrangements.
- **CODE 519** – Input only wrap-around payments received from the MAC for beneficiaries enrolled in any type MAP arrangement and **not** in a Medi-Cal Managed Care plan.
- **PART D** – Input payments received from Medicare prescription drug plans for beneficiaries **not** enrolled in a Medi-Cal Managed Care plan. Only if the FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, does the FQHC/RHC not need to include Medicare Part D payments. Otherwise, Part D payments must be reported
- **3rd PARTY PAYER** – Input all payments received for reported visits from all other sources not already reported, only if applicable.

Only include payments related to Medi-Cal beneficiaries for all types listed above.

5. Enter a formula for Period 1 Total and Period 2 Total in the “VISITS” column to calculate the appropriate visits for each period.
6. Copy the appropriate Period 1 and Period 2 formulas to the “PAYMENTS” columns to calculate Period 1 and Period 2 payments for all types.

SUMMARY OF SERVICES – WORKSHEET 5

Complete this worksheet and include with your submission of reconciliation data. For practitioners in which services are performed outside of the four walls and PPS is billed (ie: contracted dental services), please include the contractor name and location (physical address) where the services are performed. For practitioner referral services only in which PPS is **NOT** billed, you only need to include the contractor

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name. If you need additional space to identify contractor's names, attach a page with the provider name and services provided. Do not list satellite clinics on worksheet 5. Satellite clinics must be listed on certification page 2.

PRODUCTIVITY FOR HEALTH CARE PRACTITIONERS – WORKSHEET 6

Complete this worksheet and include with your submission of reconciliation data.

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Appendix A - Glossary

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Capitation – Payments used by managed care organizations to control health care costs. Capitation is a fixed amount of money per patient per unit of time paid in advance for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and therefore can vary from one region to another.

Code 519 – A Medicare wrap-around rate which makes FQHCs whole to the Medicare FQHC Rate for beneficiaries enrolled in Medicare Advantage Plans.

Crossover Payment – Payment for a beneficiary who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining portion.

FFS – Fee for Service, a payment model where services are unbundled and paid for separately.

MAC – Medicare Administrative Contractor, a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment claims for Medicare fee-for-service beneficiaries.

MAP – Medicare Advantage Plan, a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Most Medicare Advantage Plans offer prescription drug coverage.

Medi-Cal Fiscal Intermediary – A fiscal agent who is a private contractor to the state, normally selected through a competitive procurement process. The FI's contract requires them to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligible beneficiaries.

Medi-Cal Managed Care – Provides high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal managed care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

Medicare Part D – An optional federal government program to help Medicare beneficiaries pay for self-administered prescription drugs through prescription drug insurance premiums.

MEI – Medicare Economic Index, an index of physician's practice costs developed and updated by the Centers for Medicare and Medicaid Services. FQHC/RHC PPS Rates are increased by the MEI percentage annually on October 1st.

PPS – Prospective Payment System, a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system.

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State Plan Amendment – The state plan is an agreement between a state and the Federal government describing how the state administers its Medicaid and CHIP programs. It gives assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state. When a state is planning to make a change to its program policies or operational approach, states send state plan amendments to the Centers for Medicare and Medicaid Services (CMS) for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information.

Third Party Payer – Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. Third party payments are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing the service (the second party), and organization paying for it (the third party).

UPL – Upper Payment Limit, a per visit rate that CMS establishes to reimburse RHC providers for their services to Medicare eligible beneficiaries.

Visit – A face to face encounter between an FQHC/RHC patient and any provider as specified in [W&I Code § 14132.100](#) and [Attachment 4.19-B, Page 6B.1](#) of the SPA.

Wrap-Around Payment – A payment from Medi-Cal or Medicare to an FQHC/RHC equal to the amount or difference between the payment under the PPS methodology and the payment provided under the managed care contract.

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Appendix B – Billing Rates/Codes

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Table B-1

The table below illustrates the different Medicare and Medi-Cal arrangements and the billing codes used for each.

Type of Medicare Arrangement	Type of Medi-Cal Arrangement	Former Billing Code	New Billing Codes		
			Revenue Code	HCPCS/CPT	Modifier
Not Qualified	Straight Medi-Cal	Code 01	521	T1015	
Not Qualified	Managed Care Plan	Code 18	521	T1015	SE
Straight Medicare	Straight Medi-Cal	Code 02	521, 900, 522, 524, 525, 527	G0466 -G0470	
Straight Medicare	Managed Care Plan	Code 18	521	T1015	SE
Medicare Advantage Plan • Capitated Arrangement	Medi-Cal • Non-Managed Care	Code 20	529	G0466 -G0470	
Medicare Advantage Plan • Fee for Service Arrangement	Medi-Cal • Non-Managed Care	Code 02	521, 900, 522, 524, 525, 527	G0466-G0470	
Medicare Advantage Plan • Capitated Arrangement	Medi-Cal • Managed Care	Code 18	521	T1015	SE
Medicare Advantage Plan • Fee for Service Arrangement	Medi-Cal • Managed Care	Code 18	521	T1015	SE

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The Health Insurance Portability and Accountability Act (HIPAA) mandated changes to billing requirements for FQHCs/RHCs. The changes became effective October 1, 2017 and include the use of Healthcare Common Procedure Coding System (HCPCS) Level I and Level II national codes. Transition from the HCPCS Level III local per visit codes to HIPAA-compliant billing code sets means FQHC/RHC providers who previously submitted HCPCS Level III local per visit codes when billing for their services are required to submit claims using the specified HIPAA-compliant Common Procedural Terminology – 4th Edition (CPT-4) Level I and HCPCS Level II code sets for dates of service on or after October 1, 2017.

Table B-2

The table below illustrates the HIPAA-compliant codes to be used for billing straight Medi-Cal beneficiaries not enrolled in a managed care plan and where Medicare is not the primary payer.

Description	Revenue Code	HCPCS/CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
01-FQHC/RHC Clinic Visit Medical Visit	521	T1015		
04-FQHC/RHC Clinic Visit Optometry-New Patient	521	92004		
04-FQHC/RHC Clinic Visit Optometry-Established Patient	521	92014		
06-CBAS Regular day of Service	3103			
07-CBAS Initial Assess. Day w/Subsequent attend.	3101	99205		
08-CBAS Initial Assess. Day w/o Subsequent attend.	3101	T1015		
09-CBAS Transition Day	3103	T1023		
21-End of Life	521	S0257		

- Codes 06-09 should only be used when billing for CBAS

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Table B-3

The table below illustrates the HIPAA-compliant codes to be used when billing for Medicare beneficiaries not enrolled in a Managed Care Plan.

Description	Revenue Code	HCPCS/CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
02-Crossover Clinic Visit New Patient	521	G0466		
02-Crossover Clinic Visit Established Patient	521	G0467		
02-Crossover Clinic Visit IPPE or AWW	521	G0468		
02-Crossover Clinic Visit Mental Health New Patient	900	G0469		
02-Crossover Clinic Visit Mental Health Established Patient	900	G0470		
02-Crossover Home Visit New Patient	522	G0466		
02-Crossover Home Visit Established Patient	522	G0467		
02-Crossover Home Visit IPPE or AWW	522	G0468		
02-Crossover Visit in Covered Part A Stay at SNF New Patient	524	G0466		
02-Crossover Visit in Covered Part A Stay at SNF Estab. Pt.	524	G0467		
02-Crossover Visit in Covered Part A Stay at SNF IPPE or AWW	524	G0468		
02-Crossover Visit to member in SNF (Not cov. Part A) New Patient	525	G0466		
02- Crossover Visit to member in SNF (Not cov. Part A) Est. Patient	525	G0467		
02- Crossover Visit to member in SNF (Not cov. Part A) IPPE or AWW	525	G0468		
02- Crossover Visiting Nurse to home New Patient	527	G0466		
02- Crossover Visiting Nurse to home Established Patient	527	G0467		
02- Crossover Visiting Nurse to home IPPE or AWW	527	G0468		

Table B-4

The table below illustrates the HIPAA-compliant codes to be used when billing for all Medi-Cal Managed Care Plan enrollees, including beneficiaries where Medicare is the primary payer.

Description	Revenue Code	HCPCS/ CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
18- Medi-Cal Managed Care Differential Rate	521	T1015	SE	
Carve-Out Services (Not covered by Managed Care Plan)				
11-Licensed Clinical Social Worker	900	T1015	AJ	
12-Psychologist	900	T1015	AH	
13-Psychiatrist	900	T1015	AG	
15-Acupuncture-One or more needles w/o Electrical Stimulation Initial 15 min of Service*	2101	97810	SE	
15-Acupuncture-One or more needles w/o Electrical Stimulation Each Additional 15 min of Service*	2101	97811	SE	
15-Acupuncture-One or more needles with Electrical Stimulation Initial 15 min of Service*	2101	97813	SE	
15-Acupuncture-One or more needles with Electrical Stimulation Additional l 15 min of Service*	2101	97814	SE	
16-Chiropractic – one to two regions*	940	98940	SE	
16-Chiropractic – three to four regions*	940	98941	SE	
16-Chiropractic – five regions*	940	98942	SE	
17-Heroin Detox	521	H0014		

- Codes 11-17 should only be used when the Medi-Cal Managed Care Plan does not cover these services.

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Table B-5

The table below illustrates the HIPAA-compliant codes to be used when billing for Medi-Cal Managed Care with a Capitated Medicare Advantage Plan arrangement.

Description	Revenue Code	HCPCS/CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
20-Capitated Medicare Advantage Plans New Patient	529	G0466		
20-Capitated Medicare Advantage Plans Established Patient	529	G0467		
20-Capitated Medicare Advantage Plans IPPE or AWV	529	G0468		
20-Capitated Medicare Advantage Plans Mental Health New Patient	529	G0469		
20-Capitated Medicare Advantage Plans Mental Health Established Patient	529	G0470		

SDN 13013 – Crosswalk FQHC/RHC

***Subject to visit limitations – 2 per month w/o medical necessity**

Please refer to the [Provider Billing Manual](#) for detailed billing instructions.