



Federally Qualified Health Center Version

KEY CONCEPTS OUTLINE
Module 5: Coverage and Billing of FQHC Visits
Federally Qualified Health Centers

I. FQHC Qualifying Visit

- A. 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*; >
1. 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).
 - a. In certain circumstances, multiple medically necessary visits with an FQHC practitioner on the same day may be billed separately (discussed later in this module).
 - b. 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).
 - c. 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*,>
 - d. 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>

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

A. Qualifying Visit

1. FQHCs must use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates <See *Medicare Claims Processing Manual*, Chapter 9 § 60.2>
2. The Specific Payment Codes for Federally Qualified Health Center Prospective Payment System (FQHC PPS) document provides a list of the FQHC payment codes and contains a list of Qualifying Visit HCPCS codes. To qualify as a FQHC visit, the encounter must include one of the services listed under Qualifying Visits. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40>
3. As noted earlier, a qualifying visit is typically a medically necessary one-on-one face-to-face medical or mental health visit, or a covered preventive health visit between the patient and a qualified FQHC practitioner, such as a physician, NP, PA, CNM, CP, CSW, or visiting registered professional or licensed practical nurse during which one or more FQHC services are rendered. <42 C.F.R. 405.2463; see *Medicare Benefit Policy Manual*, Chapter 13 § 40; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.2, 30.1>
 - a. A qualifying medical visit includes medically necessary evaluation and management (E/M) services or certain covered preventive services and is reported with revenue code 052X. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40; 42 C.F.R. § 405.2463>
 - b. A qualifying mental health visit is typically a psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis between the patient and a clinic practitioner such as a CP or CSW and is reported with revenue code 0900. <See *Medicare Benefit Policy Manual*, Chapter 13 § 170; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.2, 30.1>
 - c. In general, multiple visits with more than one FQHC practitioner on the same day, or multiple encounters with the same practitioner on the same day, constitute a single visit and are only payable as one qualifying visit, subject to certain exceptions discussed in more detail below.

4. Multiple Qualifying Visits on the Same Date of Service

- a. Multiple qualifying visits on the same day of service within the FQHC are only payable:
 - i. After the first qualifying visit, the patient suffers an illness or injury that requires additional diagnosis or treatment on the same day.
 - ii. The patient has a medical and mental health visit on the same day. *<See Medicare Claims Processing Manual, Chapter 9 §30.1>*
- b. Separate payment is not made for Initial Preventive Physical Exam (IPPS) or Diabetes Self-Management Training (DSMT) or Medical Nutrition Therapy (MNT) (DSMT/MNT) when furnished on the same day as another FQHC medical Visit. *< See Medicare Claims Processing Manual, Chapter 9 §30.1>*

5. Billing FQHC Visits

- a. A specific FQHC payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment.
- b. The FQHC visit corresponds to the appropriate prospective payment system rate *<See Medicare Claims Processing Manual, Chapter 9 §60.2>*
- c. The charges billed for the FQHC visit code must reflect the sum of regular rates charged to both beneficiaries and other patients for the bundle of services that would be furnished to a Medicare beneficiary.
- d. Medical Visits
 - i. FQHC payment specific codes for medical visits and preventive services, G0466, G0467, and G0468 respectively must be reported under revenue code 052X (free-standing clinic) or 0519 (clinic).

Note: Revenue code 0519 is only used for Medicare Advantage (MA) supplemental claims to be discussed in a later module.

- ii. Each FQHC payment code must have a corresponding service line with a HCPCS code that describes the qualifying visit.
- iii. HCPCS codes that describe all services furnished during the FQHC encounter must be reported on the claim.

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



Qualifying Medical Visit Example

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

e. Mental Health Visits

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

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

Qualifying Mental Health Visit Example

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

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

Medical and Mental Health Visit Furnished on the Same Day Example

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

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

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

A. Preventive Services

1. FQHCs must provide preventive health services on site or by arrangement with another provider. *<Medicare Benefit Policy Manual, Chapter 13 §220.3>*
 - a. Preventive Services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW.
 - b. Required preventive health services include:
 - i. Prenatal and perinatal services;
 - ii. Appropriate cancer screening;
 - iii. Well-child services;
 - iv. Immunizations against vaccine-preventable diseases;
 - v. Screenings for elevated blood lead levels, communicable diseases, and cholesterol;

- vi. Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- vii. Voluntary family planning services; and
- viii. Preventive dental services.

(a) The list of preventive health services can be found at:
<http://bphc.hrsa.gov/policiesregulations/legislation/index.html>,

2. An FQHC is paid for the professional component of a preventive service, when all the conditions of coverage are met, and frequency limits have not been exceeded. <See *Medicare Benefit Policy Manual*, Chapter 13 § 220; see *Medicare Claims Processing Manual*, Chapter 9 § 70>
3. Under the Affordable Care Act and where applicable, the patient's deductible and/or coinsurance are waived for the IPPE and AWW, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B. <*Medicare Claims Processing Manual*, Chapter 18 § 1.2>
 - a. Handout CMS Federally Qualified Health Center (FQHC) Preventive Services Chart, revised August 10, 2016, provides a table of preventive services indicating if the deductible and/or coinsurance are waived. The table also identifies if the preventive service is paid under FQHC PPS methodology when billed without another covered visit, and the preventive services that have the coinsurance waived.
 - b. A complete list of covered preventive services, including coding and billing requirements, and statutorily waived deductible and coinsurance amounts, can be found in the *Medicare Claims Processing Manual*, Chapter 18.
 - i. Other helpful resources for the coverage and billing of preventive services can be found in the MLN catalog found on the CMS MLN

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

4. Billing Preventive Services

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

- i. The IPPE, also known as the “Welcome to Medicare Preventive Visit” is a preventive visit offered to newly enrolled Medicare beneficiaries. The service is focused on health promotion and disease prevention and detection.
- ii. The IPPE includes the following services:
 - (a) Review of the individual’s medical and social history, risk factors for depression and mood disorders, and the individual’s ability and level of safety;
 - (b) Examination which includes measurement of the individual’s height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary’s medical and social history;
 - (c) End-of-life planning if the beneficiary agrees;
 - (d) Education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B. *<Medicare Claims Processing Manual, Chapter 18 § 80>*
- iii. The IPPE does not include other preventive services covered separately covered and paid under Medicare Part B:
- iv. Medicare will cover one IPPE for a new beneficiary within the first 12 months of eligibility. The IPPE is payable once per beneficiary lifetime. *<Medicare Claims Processing Manual, Chapter 18 §80>*
 - (a) Face-to-face one-time exam,
 - (b) IPPE may be billed as a stand-alone visit, when it is the only medical service provided by the FQHC practitioner on that calendar date.
- v. The IPPE is a qualifying visit when billed under the FQHC specific payment code, G0468.

- (a) HCPCS G0468 - A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWV, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467. <See: Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS), 12-06-17>
- (b) Both the FQHC specific payment code (G0468) and the qualifying visit HCPCS code (G0402) are reported under revenue code 0521.

IPPE Visit Example

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

b. EKG – HCPCS G0403, G0404, and G0405

- i. When an EKG is performed in conjunction with the IPPE, the professional component of the diagnostic test is part of the qualifying visit. <See *Medicare Claims Processing Manual*, Chapter 9, § 70.6; see *Medicare Claims Processing Manual*, Chapter 18, § 80>
 1. However, the technical component of the EKG is a non-FQHC service and cannot be billed on TOB 077X.
 2. The technical component or tracing of the EKG performed as part of the IPPE is reported with HCPCS G0404.

- a. If an EKG is performed in conjunction with the IPPE at an independent FQHC, the practitioner who performs the service may bill the A/B MAC for the technical component on the 1500 claim form.
 - b. If an EKG is performed in conjunction with the IPPE at a provider based FQHC, the technical component may be billed to the A/B MAC by the main provider on their usual outpatient bill type (i.e., TOB 0851 CAH or 0131 OPPS).
- c. Annual Wellness Visit – HCPCS G0438 and G0439
 - i. The AWW is a personalized prevention plan for beneficiaries who are not within the first 12 months of Medicare eligibility and have not received an IPPE or AWW within the past 12 months. <Medicare Claims Processing Manual, Chapter 18, § 140.4>
 - ii. The AWW can be billed as a stand-alone visit, if it is the only medical service provided on that day. When furnished on the same day as another medical visit, it is not a separately billable visit. <See Medicare Benefit Policy Manual, Chapter 13 § 220.3>
 - iii. The AWW is a qualifying visit when billed under the FQHC specific payment code, G0468.
 - 1. HCPCS G0468 - A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWW, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467. <See: Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS), 12-06-17>
- (b) Both the FQHC specific payment code (G0468) and the qualifying visit HCPCS codes (G0438/G0439) are reported under revenue code 0521
- (c) The patient's coinsurance will be waived for the AWW. <See Medicare Benefit Policy Manual, Chapter 13 §220.3>

AWV Visit Example

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

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

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

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

- a. Voluntary advance care planning is a face-to-face visit between the patient and a physician or other qualified healthcare professional to discuss advance directives, with or without completing relevant legal forms. <*Medicare Benefit Policy Manual*, Chapter §280.5.1>
- b. ACP can be offered as either:
 - i. An optional element of a Medical Wellness Visit:
Per the Annual Wellness Visit (AWV) or the Initial Preventive Physical Examination (IPPE); or
 - ii. A separate Medicare Part B medically necessary service.
- c. ACP may be furnished alone or as a stand-alone service. When performed on the same date as another FQHC services, the ACP will not be separately reimbursed.
- d. When ACP is furnished with a Medicare wellness visit (MWV), only the MWV will be paid under FQHC PPS.
 - i. When ACP is furnished as part of a MWV (G0402, G0438 or G0439), the coinsurance is waived for both the ACP and the MWV.

1. The ACP HCPCS code must be billed with modifier -33 (preventive services) to waive the coinsurance.
 - a. Do not append modifier -33 to the MWV codes.
- ii. When ACP furnished outside of a MWV (G0402, G0438, or G0439), the Part B cost sharing (coinsurance) applies.
 1. Modifier -33 should not be appended to the ACP HCPCS code.

7. Vaccines and Injections

a. Influenza and Pneumococcal Vaccines

- i. FQHCs are reimbursed for influenza and pneumonia vaccines and their administration at 100 percent of reasonable cost through the cost report. <See *Medicare Benefit Policy Manual*, Chapter 13, § 220.3>
 - (a) Coinsurance and deductible do not apply.
- ii. HCPCS Coding
 - (a) Coding vaccine administration requires both the administration and the vaccine (product) to be reported.
 1. Administration Codes
 - a. Pneumococcal – G0008
 - b. Influenza – G0009
 2. Vaccine
 - a. The CPT/HCPCS code reported is dependent upon specific product.
 1. Example: CPT 90686 - Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use

iii. Vaccine and Administration Furnished as Part of an Encounter

- (a) If there was another reason for the visit, the FQHC should bill for the visit without adding the cost of the influenza virus and pneumococcal vaccines to the charge for the visit on the bill.

1. FQHCs must include the charges on the claim.
 - a. The information is submitted for informational and data
- iv. When an FQHC practitioner sees the patient for the sole purpose of administering the influenza or pneumonia vaccine, a qualifying visit cannot be separately billed.

Pneumococcal Vaccine and Annual Wellness Visit Example

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

- b. Hepatitis B Vaccine and Administration
 - i. Hepatitis B vaccine and its administration is included in the FQHC visit and is not separately billable. <See *Medicare Benefit Policy Manual*, Chapter 13, § 220.3>
 - (a) Coinsurance and deductible do not apply.
 - ii. HCPCS Coding
 - (a) Coding vaccine administration requires both the administration and the vaccine (product) to be reported.
 1. Hepatitis vaccine administration – G0010
 2. Vaccine
 - a. The CPT/HCPCS code reported is dependent upon specific product.
 - iii. Example: CPT 90746 - Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use.

- iv. Hepatitis B vaccine and its administration is included in the FQHC visit and is not separately billable.
- v. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit.
 - 1. FQHCs must include the charges on the claim.
 - a. The information is submitted for informational and data
- vi. When an FQHC practitioner sees the patient for the sole purpose of administering the influenza or pneumonia vaccine, a qualifying visit cannot be separately billed.

Hepatitis Vaccine and a Medical Visit Example

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

c. Other Injections

- i. The charge for an injection that is provided incident to a qualifying visit performed on a different day may be included in the charge for the qualifying visit. The conditions of coverage must be met, and the service must be furnished in a “medically appropriate” timeframe. <See *Medicare Benefit Policy Manual*, Chapter 13 § 120.3>

- (a) CMS does not define what it considers to be a medically appropriate time frame. An FQHC should develop a policy for consistent billing practices.
- ii. If a qualifying visit was previously billed and the injection occurred within a medically appropriate timeframe, the FQHC may correct the original claim using TOB 0777 (replacement claim).
 - a) The charges for the injection can be added to the qualifying visit charge and the claim rebilled using the date of service for the qualifying visit.
 - b) The coinsurance will be based on the total amount for the rebilled qualifying visit. The FQHC will not receive an additional PPS for the replacement claim.
 - c) If an injection is the only service that was provided on a specific date of service and a qualifying visit does not occur within the FQHC's medically appropriate timeframe policy, the charge for the injection is not eligible to be separately billed as a qualifying visit.
 - a. The cost of the injection can be reported on the cost report.
- d. COVID -19 Vaccine and Administration
 - i. Any vaccine that receives FDA authorization (through EUA or licensed under BLA) will be covered under Medicare at no cost to beneficiaries (Original Medicare and MA). <CMS.gov "Medicare Billing for COVID-19 Vaccine Shot Administration">
 - ii. For FQHCs, costs should generally be reported on the cost report and will be paid at 100% of reasonable costs through the cost report settlement process.
 - iii. Alternatively, FQHCs may request lump-sum payments in advance of cost report settlement, which will be paid at 100% of reasonable costs.
- e. Monoclonal Antibodies to treat COVID-19 and Administration
 - i. Although treated as preventive vaccines, and, therefore, not subject to cost-sharing, a physician order is required for the administration, unlike other COVID-19 vaccines.

- ii. Costs should be reported on the cost report and will be paid at 100% through the cost report settlement process.

8. Billing for Other "Incident to" Services without a Qualifying Visit

- a. All services and supplies provided incident to an FQHC practitioner's visit must meet the following requirements:
 - i. Be a result of the patient's encounter with an FQHC practitioner;
 - ii. Be performed under the appropriate level of supervision;
 - iii. Be performed by a nurse, a medical assistant, or other qualified auxiliary personnel who is an employee of or working under contract to the FQHC;
 - (a) Services that are not considered incident to include services furnished by a nurse, a medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the FQHC, including services provided by a third party under contract.
- b. The service must be provided in a medically appropriate timeframe. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120.1, 120.3>
 - i. Examples of incident-to services furnished by FQHC staff include blood pressure checks, wound care, and other routine nursing services. These types of services do not generate a separately billable qualifying visit alone; however, the costs can be reported on the cost report.
 - ii. Incident to services provided on a different day as a separately billable qualifying visit may be included in the charge for the qualifying visit if they are furnished in a medically appropriate timeframe like injections (see above).

9. Drugs Provided During a Qualifying Visit or Incident to a Qualifying Visit

- a. HCPCS codes
 - i. Drugs and biologicals are billed with a HCPCS code, if one exists, and units of service consistent with the HCPCS code description. <*Medicare Claims Processing Manual*, Chapter 17 § 10, 90.2>

- ii. If the provider furnishes a dose of a drug that does not equal a multiple of the units specified in the HCPCS code for the drug, the provider should round to the next highest unit when reporting the drug. <Medicare Claims Processing Manual, Chapter 17 § 10, 40>

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

b. Revenue codes

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

c. Drug administration

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

d. Billing for non-covered drugs

- i. Non-covered self-administered drugs may be billed to Medicare under revenue code 0637 (“Self-administrable Drugs”), with or without a HCPCS code. <NUBC Official UB-04 Specifications Manual; IOCE Specification, Appendix F(a)>

- (a) If no drug HCPCS code is available for the self-administered drug, and the provider wishes to bill with a modifier (e.g., -GY indicating an item or service is statutorily excluded from the Medicare benefit), the provider may use HCPCS code A9270 ("Non-covered Item or Service"). <Medicare Claims Processing Manual, Chapter 1 § 60.4.2>
 - ii. The DHHS Office of Inspector General has stated that hospitals will not be subject to administrative sanctions if they discount or waive amounts owed for non-covered self-administered drugs, subject to the following conditions:
 - 1. The discounts or waivers are for drugs received for ingestion or administration in outpatient settings;
 - 2. The policy is uniformly applied without regard to diagnosis or type of treatment;
 - 3. The policy is not marketed or advertised; and
 - 4. The hospital does not claim the discounted or waived amounts as bad debt or otherwise shift the burden of these costs to the Medicare or Medicaid program, other payers, or individuals. <OIG Policy Statement Regarding Hospitals That Discount or Waive Amounts Owed by Medicare Beneficiaries for Self-Administered Drugs Dispensed in Outpatient Settings, dated October 29, 2015>
- F. Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)
 - 1. DSMT and MNT services that are provided by a certified DSMT and MNT providers are billable visits in the FQHC <42 C.F.R. 405.2463; see *Medicare Benefit Policy Manual*, Chapter 13 § 220.1; see *Medicare Claims Processing Manual*, Chapter 9, § 70.5>
 - 2. DSMT and MNT services are qualifying visits when billed under FQHC payment codes G0466 or G0467.
 - 3. DSMT and MNT do not qualify for separate payment when billed on the same day as another qualifying visit.
 - a. DSMT must be provided by a certified DSMT practitioner.
 - b. A registered dietitian or nutrition professional must provide MNT services .

- c. The service must be provided as a one-to-one face-to-face encounter; and all other program requirements must be met.
- e. Other diabetic counseling or medical nutrition services provided by a registered dietician at the FQCH may be considered incident to a visit with the FQHC practitioner.
- f. Coinsurance and Deductible
 - i. MNT services - coinsurance is waived
 - ii. DSMT services – coinsurance is applied
- g. HCPCS coding
 - i. DSMT – G0108
 - ii. MNT – 97802, 97803, G0207
- h. Revenue code – 052X

Medial Nutrition Therapy Example

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

G. Transitional Care Management (TCM)

1. TCM may be provided in and when all the coverage requirements are met.
<See *Medicare Benefit Policy Manual*, Chapter 13 § 230.1>
 - a. TCM must be furnished within 30 days of the date of the patient's discharge from:

- i. A hospital, including outpatient observation or partial hospitalization;
 - ii. A SNF; or
 - iii. A community mental health center (CMHC).
- b. Discharge from the appropriate setting must be to the patient's home (i.e., actual residence, assisted living facility, rest home or domiciliary care).
- c. Communication with the patient or caregiver by direct contact, telephone, or electronic media must start within 2 business days of discharge.

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

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

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

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

- e. Only one TCM visit may be paid per beneficiary for services furnished during a 30-day post-discharge period, regardless of which practitioner provides the service (e.g., FQHC or non-FQHC provider).
- i. The period begins on the day of discharge from a qualifying setting.
 - ii. The period ends 30 calendar days after discharge.

- f. If the TCM visit is the only service provided on that day, the FQHC can bill the service as a qualifying visit using revenue code 052X, the appropriate HCPCS code and the date of the face-to-face visit. TCM will be paid a PPS rate and coinsurance applies.
- g. If the TCM visit occurs on the same day as another qualifying medical visit, preventive visit, or mental health visit, only one is paid.
- h. For dates of service on and after January 1, 2022, FQHCs may bill for both TCM and other care management services (i.e., GCM CoCM) provided during the same month for the same beneficiary. In this case, the use of modifier -59 would apply. <See *CY 2023 Medicare Physician Fee Schedule Fact Sheet*>

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

K. General Care Management (GCM)

1. General care management (GCM) includes Chronic Care Management (CCM), Principal Care Management (PCM), and General Behavioral Health Integration (BHI) services. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2; see *Medicare Benefit Policy Transmittal 10729*;
 - a. Effective for dates of service on or after January 1, 2018, Medicare will pay FQHCs for certain general care management services (chronic care management [CCM], pain care management [PCM], and behavioral health integrated [BHI] services) when there are 20 or more minutes of such services provided during that month by clinical staff.
 - b. Effective for dates of service on or after January 1, 2021, Medicare will also pay FQHCs for principal care management (PCM) services when there are 30 or more minutes of such services provided during that month by clinical staff.
 - c. Incident-to GCM services are generally performed by auxiliary staff and are subject to the general supervision of an FQHC practitioner. General supervision does not require the FQHC practitioner to be in the same building or immediately available.
2. All three types of GCM services are covered when applicable criteria are met.

- a. An FQHC may bill for CCM services for non-face-to-face care coordination when a minimum of 20 minutes of CCM services are provided during the calendar month and these coverage requirements are met:
 - i. The patient must have multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, which place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline;
 - ii. The patient must consent (verbally or in writing) to receive CCM from the FQHC; and
 - iii. A separately billable initiating visit (no more than one year before start of care) with an FQHC practitioner (physician, NP, PA, or CNM) is required, but CCM does not need to be discussed during the visit.
- b. An FQHC may bill for PCM services when a minimum of 30 minutes of PCM services are provided during the calendar month and these coverage requirements are met:
 - i. The patient has a single complex chronic condition lasting at least three months, which is the focus of the care plan;
 - ii. The condition is of sufficient severity to place the patient at risk of hospitalization or have been the cause of a recent hospitalization;
 - iii. The condition requires development or revision of a disease-specific care plan;
 - iv. The condition requires frequent adjustments in the medication regimen;
 - v. The condition is unusually complex due to comorbidities;
 - vi. The patient must consent (verbally or in writing) to receive PCM from the FQHC; and
 - vii. A separately billable initiating visit (no more than one year before start of care) with an FQHC practitioner (physician, NP, PA, or CNM) is required, but PCM does not need to be discussed during the visit.
- c. An FQHC may bill for BHI services when a minimum of 20 minutes of BHI services are provided during the calendar month and these coverage requirements are met:

- i. A patient must have one or more new or pre-existing behavioral health or psychiatric conditions, including substance use disorders;
- ii. BHI requires an initial assessment, ongoing monitoring, continuity of care and coordination of treatment (psychotherapy, pharmacotherapy, counseling and/or psychiatric consultations);
- iii. The patient must consent (verbally or in writing) to receive BHI from the FQHC; and
- iv. A separately billable initiating visit (no more than one year before start of care) with an FQHC practitioner (physician, NP, PA, or CNM) is required, but BHI does not need to be discussed during the visit.

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

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

Example for Chronic Care Management (CCM)

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

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

Example General Behavioral Health Integration (BHI)

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

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

Example Principal Care Management:

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

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

Psychiatric Collaborative Care Model (CoCM)

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

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

- a) Psychiatric CoCM services do not need to be discussed during the initiating visit. The same initiating visit can be used for psychiatric CoCM and GCM services if it occurs with an FQHC primary care practitioner within one year of the start of psychiatric CoCM services.
- ii. Although CoCM is an FQHC service, it is paid under the MPFS
 - a) For CY 2023, the national payment rate is \$147.07.
 - b) MPFS coinsurance applies.
- iii. CoCM can be billed alone or with another qualifying visit on the same date of service.
- iv. For dates of service on or after January 1, 2022, FQHCs may bill for both TCM and other care management services (e.g., GCM, CoCM) provided during the same month. <See *CY 2022 Medicare Physician Fee Schedule Fact Sheet*>
- v. CoCM costs are reported in the non-reimbursable section of the cost report.

Example Psychiatric Collaborative Care Model (CoCM)

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

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

O. Services Provided to Hospice Patients

1. An FQHC may provide care to a hospice patient for any medical condition that is not related to their terminal illness. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
 - a. In most cases, if the patient receives care from an FQHC practitioner during clinic hours for a condition that is related to the terminal illness, the FQHC cannot separately bill for or be reimbursed for the face-to-face visit, even if it is medically necessary.
 - b. Two exceptions
 - i. The FQHC has a contract with the hospice provider to furnish core hospice services when extraordinary circumstances exist within the hospice such as temporary staffing shortages, unanticipated high census, or temporary travel by the patient outside of their hospice's service area. <42 C.F.R. 418.64; see *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
 - ii. The FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are not usually provided by the hospice and for the hospice to employ a nurse with that skill would be impractical and expensive. <42 C.F.R. 418.64; see *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
 - a) Costs associated with these hospice exceptions should not be reported on the clinic's cost report since the FQHC is reimbursed by the hospice under its contract.
2. Unless prohibited by their employment contract or scope of practice, a practitioner who is employed by the FQHC can provide hospice services when he or she is not working at the FQHC. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.1>

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

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

Hospice Service Example

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

- i. When the FQHC furnishes a hospice attending physician service that has a technical component, the technical component must be billed separately to the hospice for payment.
 - b. Coinsurance applies.
- P. Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) Services
1. PT, OT, and SLP services may be performed by a physician, NP, or PA when the services provided are within their scope of practice and state law. <See *Medicare Benefit Policy Manual*, Chapter 13 § 180>
 - a. A physician, NP, or PA may also supervise a therapist who provides services incident to a qualifying visit in the FQHC.
 - i. A therapist providing incident to services may be employed or contracted by the FQHC.
 - b. The charges for the therapy services are included in the qualifying visit if:

- i. The therapy services are furnished by a qualified therapist as part of an otherwise billable visit, and the service is within the scope of practice of the therapist.
- ii. If the services are provided by a therapist on a day when a qualifying visit was not provided, the therapy service would only be reported on the cost report.

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

Q. Podiatry, Chiropractic, Optometry, and Dental Services

1. FQHCs can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is on the list of qualifying visits for the FQHC and all other requirements are met.
 - a. All services furnished must be within the state scope of practice for the practitioner and all HCPCS codes must reflect the actual services that were furnished.
2. FQHCs are required to provide primary healthcare; however, dentists, podiatrists, optometrists, and chiropractors are not considered primary care physicians.
3. The dentist, podiatrist, optometrist, or chiropractor can only provide a medically necessary face-to-face visit with an FQHC patient when statutory and regulatory staffing requirements are met. <Medicare Benefit Policy Manual, Chapter 13 § 110.1>
 - a. Dental Services –
 - (i) Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered <Medicare Benefit Policy Manual, Chapter 15 § 150>
 - (ii) Beginning January 1, 2023, Medicare has expanded dental service coverage to include dental or oral examinations prior to any organ transplant surgery, cardiac valve replacement or valvuloplasty procedures.

(iii) Medicare coverage of dental and oral examinations prior to treatment for head and neck cancer will begin in CY 2024. <2023 Medicare Physician Fee Schedule Final Rule>

b. Medicare Coverage of chiropractic care extends only to treatment by means of manual manipulation of the spine to correct subluxation.

(i) All other services furnished or ordered by chiropractors are not covered. under Medicare.

c. Optometry Services

(i) Must be medically reasonable and necessary for the diagnosis or treatment of illness or injury and must meet all applicable coverage requirements. <Medicare Benefit Policy Manual, Chapter 15 § 30.3>

(a) Vision care is excluded from Medicare coverage

V. General Billing Requirements for Diagnostic Tests and Laboratory Services

A. Diagnostic Tests

1. Generally, only the professional component of a diagnostic test is a benefit in an FQHC. The technical component of a diagnostic test is not a benefit of an FQHC and cannot be billed on TOB 077X. <See Medicare Claims Processing Manual, Chapter 9, §§ 60, 90>

a. Technical services/components of diagnostic tests performed by an independent FQHC are billed to the Part B MAC on the CMS-1500 claim form. <Medicare Claims Processing Manual, Chapter 12, § 80.2>

b. Technical services/components of diagnostic tests performed by a provider-based FQHC are billed to the Part A MAC on the UB-04 claim form with an appropriate base-provider bill type (i.e., TOB 085X CAH or TOB 0131 OPPS). <Medicare Claims Processing Manual, Chapter 4, § 280>

2. Laboratory Services

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

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

VI. Special Billing Considerations

A. Exclusion from the Three-Day Payment Window

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

B. FQHC Practitioner Visits to Swing Bed Patients

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

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

C. Application of Global Surgery Concept

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

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

A. General Overview

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

B. Applicable Settings and Payment Systems

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

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

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

C. Ordering Practitioner Requirements

1. When ordering an advanced imaging service that will be furnished in an applicable setting and paid under an applicable payment system, the ordering practitioner must consult a CDSM, unless an exception applies. <See *Medicare One Time Notification Transmittal 2404*; 42 C.F.R. § 414.94(j) and (k)>

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