CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13200	**Date: May 1, 2025**
	Change Request 13964

SUBJECT: Updates to Medicare Claims Processing Manual for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) Chapter 9

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet Only Manual (IOM), Publication100-04, Chapter 9 - Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to ensure consistency with previously approved change requests and the Medicare Benefit Policy Manual.

EFFECTIVE DATE: June 2, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 2, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	TOC/9/Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)
R	9/10/10.2/FQHC General Information
R	9/20/RHC All-Inclusive Rate (AIR) Payment System
R	9/20/20.1/Per Visit Payment and Exceptions under the AIR
R	9/20/20.2/Payment Limit under the AIR
R	9/30/FQHC PPS Payment System
R	9/30/30.1/Per-Diem Payment and Exceptions under the PPS
R	9/40/Deductible and Coinsurance
R	9/40/40.1/Part B Deductible
R	9/40/40.2/Part B Coinsurance
R	9/50/General Requirements for RHC and FQHC Claims
R	9/60/Billing Requirements for RHCs and FQHCs
R	9/60/60.1/Billing Guidelines for RHCs Claims under the AIR System
R	9/60/60.2/Billing for FQHC Claims Paid under the PPS
R	9/60/60.3/Payments for FQHC PPS Claims
R	9/60/60.4/Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans
R	9/60/60.5/PPS Payments to FQHCs under Contract with MA Plans
R	9/70/General Billing Requirements for Preventive Services
R	9/70/70.1/RHCs Billing Approved Preventive Services
R	9/70/70.2/FQHC Billing Approved Preventive Services under the PPS
R	9/70/70.3/Vaccines
R	9/70/70.4/Diabetes Self-Management Training (DSMT) and Medical Nutrition Services (MNT)
R	9/70/70.5/Initial Preventive Physical Examination (IPPE)
R	9/70/70.6/Virtual Communication Services
R	9/70/70.7/Care Coordination Services – Chronic Care or Psychiatric Collaborative Care Model (CoCM) Services
R	9/80/Telehealth Services
R	9/90/Services non-Covered on RHC and FQHC Claims
N	9/110/Intensive Outpatient Program (IOP) Services

III. FUNDING:
For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13200	Date: May 1, 2025	Change Request: 13964

SUBJECT: Updates to Medicare Claims Processing Manual for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) Chapter 9

EFFECTIVE DATE: June 2, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 2, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet Only Manual (IOM), Publication100-04, Chapter 9 - Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to ensure consistency with previously approved change requests and the Medicare Benefit Policy Manual.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update and enhance sections in Publication 100-04, Chapter 9 of the Medicare Claim Processing Manual to align with the current policy.

B. Policy: N/A

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13964.1	Contractors shall be aware of the updates to the Medicare Claims Processing Manual 100-04, Chapter 9 - Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).	X								

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

Table of Contents
(Rev. 13200, Issue: May 1, 2025)

Transmittals for Chapter 9

10 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) General Information
- 10.1 - RHC General Information
- 10.2 - FQHC General Information

20 - RHC All-Inclusive Rate (AIR) Payment System
- 20.1 - Per Visit Payment and Exceptions under the AIR
- 20.2 - Payment Limit under the AIR

30 - FQHC Prospective Payment System (PPS) Payment System
- 30.1 - Per-Diem Payment and Exceptions under the PPS
- 30.2 - Adjustments under the PPS

40 - Deductible and Coinsurance
- 40.1 - Part B Deductible
- 40.2 - Part B Coinsurance

50 - General Requirements for RHC and FQHC Claims

60 - Billing and Payment Requirements for RHCs and FQHCs
- 60.1 - Billing Guidelines for RHC Claims under the AIR System
- 60.2 - Billing for FQHC Claims Paid under the PPS
- 60.3 - Payments for FQHC PPS Claims
- 60.4 - Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans
- 60.5 - PPS Payments to FQHCs under Contract with MA Plans
- 60.6 - RHCs and FQHCs for Billing Hospice Attending Physician Services

70 - General Billing Requirements for Preventive Services
- 70.1 - RHCs Billing Approved Preventive Services
- 70.2 - FQHCs Billing Approved Preventive Services under the PPS
- 70.3 - Vaccines
- 70.4 - Diabetes Self-Management Training (DSMT) and Medical Nutrition Services (MNT)
- 70.5 - Initial Preventive Physical Examination (IPPE)
- 70.6 -Virtual Communication Services
- 70.7 – Care Coordination Management Services – Chronic Care and Psychiatric Collaborative Care Model (CoCM) Services

80 – Telehealth Services

90 - Services Non-covered on RHC and FQHC Claims

100 - Frequency of Billing and Same Day Billing

110 - *Intensive Outpatient Program (IOP) Services*

10.2 - FQHC General Information

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

FQHCs are facilities that provide services that are typically furnished in an outpatient clinic setting. FQHC services consist of services that are similar to those furnished in RHCs. The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in §1861(aa) (4) of the Act. An entity that qualifies as a FQHC is assigned a CCN in the range of XX1000-XX1199 or XX1800-XX1989.

NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees, Health Center Program Look-Alikes, *and Tribal and Urban Indian organization FQHCs*. It does not necessarily apply *to historically excepted tribal* FQHCs.

20 - RHC All-Inclusive Rate (AIR) Payment System

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

20.1 - Per Visit Payment and Exceptions under the AIR

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

RHCs are paid an AIR *payment* per visit. *For* RHCs billing under the AIR, more than one medically necessary face-to-face visit with a RHC practitioner on the same day is payable as one visit, except for the following circumstances:

- 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 RHC).
- The patient has a medical visit and a mental health visit on the same day.
- The patient has an Initial Preventive Physical Examination (IPPE) and a separate qualified medical and/or mental health visit on the same day.
- *The patient has an IOP service and medical visit on the same day.*
- *The patient has a dental visit and a medical visit on the same day.*

20.2 - Payment Limit under the AIR

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

For RHCs that bill under the AIR, Medicare pays 80 percent of the RHC AIR, subject to a payment limit. At the end of the cost reporting period, the MAC determines the total payment due and reconciles payments made during the period with the total payments due.

RHCs *that receive payments* under the AIR *must submit an annual* cost report *to establish* their payment rate. If a RHC is in its initial reporting period, the MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

For information on cost reporting requirements, see the Medicare Provider Reimbursement Manual (PRM), at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

30 - FQHC PPS Payment System

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

30.1 - Per-Diem Payment and Exceptions under the PPS

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added section 1834(o) of the Social Security Act to establish a Medicare PPS for FQHC services. FQHCs transition to the

Medicare PPS beginning on October 1, 2014, based on their cost-reporting period. All FQHCs *were* transitioned to the PPS by December 31, 2015.

FQHC *payments are made* under the PPS, *the* Medicare payment is based on the lesser of the FQHC actual charge or the PPS rate, as determined by the MAC. The FQHC PPS rate will be updated annually beginning January 1, 2016.

For FQHCs billing under the PPS, more than one medically necessary face-to-face visit with a FQHC practitioner on the same day is payable as one visit, except for the following circumstances:

- The patient, after 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).
- *The patient has a medical visit and a mental health visit on the same day.*
- *The patient has an IOP service and medical visit on the same day.*
- *The patient has a dental visit and a medical visit on the same day.*

Separate payment is not made to FQHCs under the PPS for an IPPE or DSMT/MNT visit that is furnished on the same day as another FQHC medical visit.

40 - Deductible and Coinsurance

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

40.1 - Part B Deductible

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

RHC services are subject to an annual deductible of twenty percent of charges for covered services. Effective for dates of service on or after January 1, 2011, the deductible is not applicable for certain preventive services. Please see section *70* for more information on how to bill for preventive services. RHCs collect the patient's deductible or the portion of the patient's deductible that has not already been met. Once RHCs have billed the MAC for services, they do not collect or accept any additional money from the patient for their deductible until the MAC notifies the RHC of how much of the deductible has been met.

The Part B deductible does not apply to FQHC services.

40.2 - Part B Coinsurance

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

After any applicable deductibles have been satisfied, RHCs paid under the AIR system will be paid 80 percent of their AIR. The patient is responsible for a coinsurance amount of 20 percent of the charges after deduction of the deductible, where applicable.

Effective for dates of service on or after January 1, 2011, coinsurance is not applicable for certain preventive services. See section *70* of this manual for information on how to bill for preventive services on a RHC and FQHC claims.

FQHCs paid under the PPS will be paid 80 percent of the lesser of the FQHC actual charge for the specific payment code or the adjusted PPS rate. The patient is responsible for a coinsurance amount of 20 percent of the lesser of the FQHCs actual charge for the specific payment code or the adjusted PPS rate. See section 60.2 for more information on the FQHC specific payment codes.

50 - General Requirements for RHC and FQHC Claims

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 for coverage requirements for RHCs and FQHCs. This section addresses requirements for claim submission only.

Section §1862 (a)(22) of the Act requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic format required for billing RHC and FQHC services is the ASC X12 837 institutional claim transaction. Instructions relative to the data element names on the Form CMS-1450 hardcopy form are described below. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names is found in Chapter 25.

Not all data elements are required or utilized by all payers. Detailed information is given only for items required for Medicare RHC and FQHC claims. Only the items listed below are required for RHCs and FQHCs.

Provider Name, Address, and Telephone Number, Form Locator

The RHC/FQHC enters this information for their agency.

Type of Bill

This four-digit alphanumeric code gives three specific pieces of information. The first digit is a leading zero. CMS ignores the first digit. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular benefit period. It is referred to as a "frequency" code.

Code Structure

1st **Digit – Leading Zero**
CMS ignores the first digit

2nd **Digit - Type of Facility**
7 - Special facility (Clinic)

3rd **Digit - Classification (Special Facility Only)**
1 – Rural Health Clinic
7 – Federally Qualified Health Centers

4th **Digit – Frequency**	**Definition**
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
1 - Admit Through Discharge Claim	This code is used for a billing for a confined treatment.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or "new" bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

Statement Covers Period (From-Through)
The RHC/FQHC shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY).

Patient Name/Identifier
The RHC/FQHC enters the beneficiary's name exactly as it appears on the Medicare card.

Patient Address
The RHC/FQHC enters the mailing address of the patient. Enter the complete mailing address.

Patient Birth date
The RHC/FQHC enters the date of birth of the patient.

Patient Sex
The RHC/FQHC enters the sex of the patient as recorded at the start of care.

Priority (Type) of Admission or Visit
The RHC/FQHC enters the most appropriate NUBC approved code indicating the priority of the visit.

Point of Origin for Admission or Visit
The RHC/FQHC enters the most appropriate NUBC approved code indicating the point of origin for this admission or visit.

Patient Discharge Status
The RHC/FQHC enters the most appropriate NUBC approved code indicating the patient's status as of the "Through" date of the billing period.

Condition Codes
The RHC/FQHC enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing.

Value Codes and Amounts
The RHC/FQHC enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing.

Revenue Codes
The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge.

For FQHC claims with dates of service on or after January 1, 2010, FQHCs may report additional revenue codes when describing services rendered during an encounter. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in the following table:

Rev **Code**	**Description**
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility

Rev Code	Description
0527	RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)
0519	Clinic, Other Clinic (only for the FQHC supplemental payment)
0900	Mental Health Treatment/Services

When billing for additional services rendered during the FQHCs encounter *or RHC visit, a* valid revenue *code is required* with *an appropriate* HCPCS code. However, the following revenue codes are not allowed on FQHC or RHC claims:
002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x.

HCPCS/Accommodation Rates/HIPPS Rate Codes
For all services provided in a FQHC on or after January 1, 2010, and for approved preventive services provided in a RHC, HCPCS codes are required to be reported on the service lines.
The following HCPCS codes must be reported on FQHC PPS claims:

HCPCS Code	Definition
G0466	FQHC visit, new patient 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.
G0467	FQHC visit, established patient 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.
G0468	FQHC visit, IPPE or AWV A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
G0469	FQHC visit, mental health, new patient 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.
G0470	FQHC visit, mental health, established patient 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.

Modifiers
The FQHC *or RHC* reports modifier 59 when billing for a subsequent injury or illness. This is not to be used when a patient sees more than one practitioner on the same day or has multiple encounters with the same practitioner on the same day, unless the patient, subsequent to the first visit, leaves the FQHC *or RHC* and then suffers an illness or injury that requires additional diagnosis or treatment on the same day.

Modifier 59 is the FQHC *and RHC's* attestation that the patient, after the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left the FQHC *or RHC* and returned later in the day for an unscheduled visit for a condition that was not present during the first visit).

For claims subject to the FQHC PPS, modifier 59 is only valid with FQHC Payment Code G0467. Please see section 60.2 of this manual for more information on the FQHC Payment Codes.

Modifier CG - RHCs should report modifier CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit.

Service Date
Medicare requires a line-item date of service for all outpatient claims. Medicare classifies RHC/FQHC claims as outpatient claims. Non-payment service revenue codes – report dates as described in the table above under Revenue Codes.

Line items on outpatient claims under HIPAA require reporting of a line-item service date for each iteration of revenue code. A single date must be reported on a line item for the date the service was provided, not a range of dates.

For services that do not qualify as a billable visit, the usual charges for the services are added to those of the qualified visit. RHCs/FQHCs use the date of the visit as the single date on the line item. If there is no is billable visit associated with the services, then no claim is filed.

Service Units
The RHC/FQHC enters the number of units for each type of service. Units represent visits, which are paid based on the AIR or the FQHC PPS, no matter how many services are delivered. Only one visit is billed per day unless the patient leaves and later returns with a different illness or injury suffered later the same day.

Total Charges
The RHC/FQHC enters the total charge for the service described on each revenue code line.

Payer Name
The RHC/FQHC identifies the appropriate payer(s) for the claim.

National Provider Identifier (NPI) – Billing Provider
The RHC/FQHC enters its own NPI. When more than one encounter/visit is reported on the same claim i.e., medical and mental health visits, please choose the NPI of the provider that furnished most of the services.

Principal Diagnosis Code
The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

Other Diagnosis Codes
The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

Attending Provider Name and Identifiers

The RHC/FQHC enters the NPI, and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care.

Other Provider Name and Identifiers
The RHC/FQHC enters the NPI and name
NOTE: For electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

See the link to Publication 100-04, Medicare Claims Processing Manual, Chapter 25 for additional information on form 1450:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

60 - Billing Requirements for RHCs and FQHCs

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

RHCs and FQHCs are institutional claims and are submitted to the MAC on TOB 71*X* and 77*X*. Generally, only those services that are included in the RHC and FQHC benefits are billed on these claims.

- The RHC and FQHC benefits are defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf.)

All professional services in the RHC and FQHC benefit are paid through the AIR system or the FQHC PPS payment for each patient encounter or visit. Technical services (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims.

60.1 - Billing Guidelines for RHCs Claims under the AIR System

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

When billing Medicare, *RHCs* must report all services provided during the encounter/visit by listing the appropriate *revenue and* HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes.

Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location generally constitute a single visit. *For* RHCs, the payment is applied to the service line with revenue code 052X for medical and revenue code 0900 for mental health visits *with modifier (MOD) CG.*

For *example*:

Appropriate Rev Code	***Appropriate HCPCS code***	***MOD***	***DOS***	***Charges***
0521	*99213 - Evaluation and Management (E&M)*	*CG*	*01/01*	*300.00*

Note: The examples in this chapter may vary and are subject to change as needed.

Please see section 50 for more information on reporting modifier CG.

For *example*:

***Appropriate Rev* Code**	***Appropriate* HCPCS *Code***	***MOD***	***DOS***	**Charges**
0521	*99213 - E&M*	*CG*	01/01	300.00

0770	*G0402 -* Preventive Service *(PS)*		01/01	50.00

Medicare will make an additional AIR payment for IPPE, when billed on the same day with a qualified encounter/visit. When reporting an additional encounter/visit for IPPE, the RHC reports the Appropriate HCPCS Code for the service. The revenue lines should be reflected as follows:

For *example*:

Appropriate **Rev Code**	***Appropriate*** **HCPCS code**	***MOD***	***DOS***	**Charges**
0521	*99213 - E&M*	*CG*	01/01	75.00
0419	*94640 -* Breathing treatment		01/01	75.00
0521	*G0402* - Initial Preventive Physical Examination *(IPPE)*		01/01	150.00

For *RHCs,* Medicare will make an additional AIR payment for a subsequent illness or injury that occurs on the same day. This is reported on the claim with an additional service line with revenue code 052X, a valid HCPCS code and modifier 59. Please see section 50 for more information on reporting modifier 59.

For *example*:

Appropriate **Rev Code**	***Appropriate*** **HCPCS code**	***MOD***	***DOS***	**Charges**
0521	*99213 - E&M*	CG	01/01	150.00
0479	*69209 -* Removal of Wax from Ear		01/01	50.00
0521	*99212 - OV (Office Visit)*	59	01/01	135.00
0272	*A6402 - Surgical Dressing*		01/01	25.00
0279	*29130 - Finger Split*		01/01	95.00

60.2 - Billing for FQHC Claims Paid under the PPS

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

CMS established five FQHC payment specific codes to be used by FQHCs submitting claims under the PPS. When reporting an encounter/visit for payment, the FQHC must bill on the claim (77X TOB) a FQHC specific payment code.

FQHC Specific Payment Codes

G0466 – FQHC visit, new patient

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.

G0467 – FQHC visit, established patient

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.

G0468 – FQHC visit, IPPE or AWV
A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

G0469– FQHC visit, mental health, new patient
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.

G0470 – FQHC visit, mental health, established patient
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.

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. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052X or 0519.

NOTE: Revenue code 0519 is used for Medicare Advantage (MA) Supplemental claims only.

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must report HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges. The additional services reported on the claim that are part of the FQHC encounter, will not be paid. The payment for these services is included in the payment under the FQHC payment code.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit. The link below contains the list of the qualifying visits for each payment specific code:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf
https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center

For *example*:

***Appropriate Rev* Code**	***Appropriate* HCPCS *Code***	***MOD***	***DOS***
0521	G0467 - FQHC *Specific* Payment code *(FSPC)*		10/01
0521	99213 - Qualifying visit *(QV)*		10/01

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

For *example*:

Appropriate Rev Code	*Appropriate* HCPCS *Code*	*MOD*	*DOS*
0521	G0468 - *FSPC*		10/01
0521	G0439 - *QV*		10/01
0900	G0470 - *FSPC*		10/01
0900	90832 - QV		10/01

When submitting a claim for a subsequent illness or injury, the FQHC reports G0467 for a medical visit), with modifier 59. A qualifying visit is still required when reporting modifier 59 with G0467.

Appropriate Rev Code	*Appropriate* HCPCS *Code*	*MOD*	*DOS*
0521	G0468 - *FSPC*		10/01
0521	G0439 - *QV*		10/01
0521	G0467 - *FSPC*	59	10/01
0900	99211 - *QV*		10/01

FQHCs must report all services that occurred on the same day on one claim. FQHCs may submit claims that span multiple days of service.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

60.3 - Payments for FQHC PPS Claims

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Payment for FQHC PPS claims is made by comparing the adjusted FQHC PPS rate to the total submitted covered charges reported for the specific payment codes G0466, G0467, G0468, G0469, and G0470.

To calculate payment, follow the steps below:

Step 1: Determine the lesser of the provider's submitted charges for the specific payment code(s) and the fully adjusted PPS rate.

Step 2: Determine if preventive services for which the coinsurance is waived are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.
(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: If no preventive services are present, use the lesser of the providers charge for the specific payment code(s) or the PPS rate as the Step 3 total.

Step 4: Multiply the total from Step 3 by 80%.
*Step 3 total * 80% = Step 4 total*

Note: If no preventive services are present, contractors will pay this amount and skip step 5.

Step 5: Add the charges for the approved preventive services to the total from step 4. Contractors will pay this amount.
Step 4 total + preventive services charges = Medicare Payment

Note: *If the charges for the approved preventive services are greater than the total payment amount identified in Step 1 (i.e., the lesser of the charges for the specific payment code or the PPS rate), pay 100% of the total payment amount determined in Step 1 and do not apply coinsurance. (Please see example 3)*

To calculate coinsurance, follow the steps below:
Step 1: Determine the lesser of the submitted charges for the G-code (s) and the PPS rate.

Step 2: Determine if approved preventive services (i.e., preventive services for which coinsurance is waived) are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.
(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: If no approved preventive services are present, use the lesser the provider's charge for the specific payment code(s) or the PPS rate as the Step 3 total.

Step 4: Multiply the total from Step 3 by 20%.
*Step 3 total * 20% = Coinsurance*

Example: Payment based on the charges
PPS rate = 160.00

Note: *The examples below may vary by description or HCPCS.*
Provider's actual charge for the specific payment code, G0467 = $150

***Appropriate Rev* Code**	***Appropriate HCPCS* Code**	**MOD**	***DOS***	***Total Charge***	***Covered Charge***
0521	G0467 - *FQHC Specific Payment Code (FSPC)*		10/01	150.00	150.00
0521	99213 - *Qualifying Visit* (QV)		10/01	135.00	135.00
0300	36415 - *Venipuncture (VP)*		10/01	25.00	25.00
0001				310.00	310.00

The comparison is between the PPS rate and the provider's $150 actual charge for the specific payment code, G0467. In this case, the sum of the line items exceeds the provider's actual charge for the payment code.

Payment based on the provider's charge of 150.00

***Appropriate Rev* Code**	***Appropriate HCPCS Code***	**MOD**	***DOS***	***Total Charge***	***Covered Charge***	**Payment**	**Coinsurance**
0521	G0467 - *FSPC*		10/01	150.00	150.00	120.00	30.00
0521	99213 - *QV*		10/01	135.00	135.00	CO 97*	0

0300	36415 - *VP*		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = 150.00 (charges) * 80%

Coinsurance = 150.00 (charges) * 20%

For service lines that do not receive payment, group code CO- contractual obligation and the appropriate claim adjustment reason code (CARC) will be used.

* CARC 97 – the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Example: Payment based on the charges with approved preventive service
PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = $150
Preventive Service *(PS)* = 135.00

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	**DOS**	***Total Charge***	***Covered Charge***
0521	G0468 - *FSPC*		10/01	150.00	150.00
0521	G0439 - *PS*		10/01	135.00	135.00
0300	36415 - *VP*		10/01	25.00	25.00
0001				310.00	310.00

Payment based on the provider's actual charge of 150.00 for the specific payment code, G0468.

Appropriate Rev Code	***Appropriate HCPCS Code***	**MOD**	**DOS**	***Total Charge***	***Covered* Charge**	**Payment**	***Coinsurance***
0521	G0468 - *FSPC*		10/01	150.00	150.00	147.00	3.00
0521	G0439 - *PS*		10/01	135.00	135.00	CO 97*	0
0300	36415 - *VP*		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 135.00 (preventive service G0439)) * 80% + 135.00 preventive service.
Coinsurance = (150.00 (charges) – 135.00 (preventive service G0439)) * 20%

- PS – Preventive Service -These are approved preventive services where the coinsurance is waived based on the USPSTF recommendation.

Example: Payment based on the charges when preventive service is greater than G-code

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = $150 Preventive Service = 155.00

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	***DOS***	***Total Charge***	***Covered Charge***
0521	G0468 - *FSPC*		10/01	150.00	150.00
0521	G0439 - *PS*		10/01	155.00	155.00
0300	36415 - *VP*		10/01	25.00	25.00
0001				330.00	330.00

Payment based on charges of 150.00

Appropriate Rev Code	*Appropriate HCPCS Code*	**MOD**	*DOS*	*Total Charge*	*Covered Charge*	**Payment**	*Coinsurance*
0521	G0468 - *FPSC*		10/01	150.00	150.00	150.00	0
0521	G0439 - *PS*		10/01	155.00	155.00	CO 97*	0
0300	36415 - *VP*		10/01	25.00	25.00	CO 97	0
0001				330.00	330.00		

Payment = (150.00 (charges) * 100% = 150.00

Since the charges for the preventive service, G0439 are greater than the provider's actual charge for the specific payment code G0468, Medicare pays 100% of the provider's actual charge for the specific payment code, G0468.

Reporting Multiple G-codes

When a FQHC reports multiple specific payment codes (G-codes) on the same day, the total payment amount will be determined by comparing the sum of the charges for all the G-codes reported to the PPS rate. When a qualified mental health visit occurs on the same day as a qualified medical visit, the G-codes will be totaled separately (see example 8).

Listed below is the order in which payment will be applied when multiple G-codes are reported on the same day:

Medical visits:

- G0468-IPPE or AWV
- G0466-Medical, new patient
- G0467-Established patient

Mental health visits:

- G0469-Mental health, new patient
- G0470- Mental health, established patient

When G0466 (Medical, new patient) and G0468 (IPPE or AWV) are reported together, the add-on payment will be applied to G0468.

Example: Payment based on PPS rate with multiple G-codes and preventive services

Because this scenario does not qualify for an exception to a per diem payment, the system will calculate and apply a PPS rate to only one of the specific payment codes. However, the FQHC may list its actual charges for both specific payment codes, and the comparison would be between the PPS rate and the total of the provider's charges for the specific payment codes. Payment would be based on the lesser amount.

PPS RATE, reflecting a 1.3416 adjustment for new patients or a visit including an IPPE or AWV = 215.00

Total of provider charges for the specific payment codes (170.00 + 65.00) = 235.00
Provider's charge for the Preventive Service = 135.00

Appropriate Rev Code	*Appropriate HCPCS Code*	**MOD**	*DOS*	*Total Charge*	*Covered Charge*
0521	G0468 - *FSPC*		10/01	170.00	170.00
0521	G0438 - *PS*		10/01	135.00	135.00
0300	36415 - *VP*		10/01	25.00	25.00
0521	G0466 - *FSPC*		10/01	65.00	65.00
0521	92004 - *Ophthalmo-*		10/01	45.00	45.00

	logical Exam				
0001				440.00	440.00

Payment based on adjusted PPS rate of 215.00

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	***DOS***	***Total Charge***	***Covered Charge***	**Payment**	**Coinsurance**
0521	G0468 - *FSPC*		10/01	170.00	170.00	199.00	16.00
0521	G0438 - *PS*		10/01	135.00	135.00	CO 97	0
0300	36415 - *VP*		10/01	25.00	25.00	CO 97	0
0521	G0466 - *FSPC*		10/01	65.00	65.00	CO 97	0
0521	92004 - *Ophthalmo-logical Exam*		10/01	45.00	45.00	CO 97	0
0001				440.00	440.00		

Payment = (215.00 (PPS rate) – 135.00 (preventive service G0438) * 80% + 135.00 preventive service

Coinsurance = (215.00 (PPS rate) – 135.00 (preventive service G0438)) * 20%

Reporting Multiple Preventive Services

When multiple preventive services are reported on the same day, the coinsurance will be determined by carving out the total preventive services charges.

Example: Payment based on PPS rate with multiple G-codes and multiple preventive services

PPS RATE =225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00

Total Preventive Services (135.00 +60.00) =195.00

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	***DOS***	***Total Charge***	***Covered Charge***
0521	G0468 - *FSPC*		10/01	140.00	140.00
0521	G0439 - *PS*		10/01	135.00	135.00
0300	36415 - *VP*		10/01	25.00	25.00
0521	G0467 - *FSPC*		10/01	75.00	75.00
0521	97802 - *PS*		10/01	60.00	60.00
0521	G0466 - *FSPC*		10/01	55.00	55.00
0521	92004 - *Ophthalmological Exam*		10/01	45.00	45.00
0001				535.00	535.00

Payment based on PPS rate of 225.00

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	***DOS***	***Total Charge***	***Covered Charge***	***Payment***	***Coinsurance***
0521	G0468 - *FSPC*		10/01	140.00	140.00	219.00	6.00
0521	G0439 - *PS*		10/01	135.00	135.00	CO 97	0
0300	36415 - *VP*		10/01	25.00	25.00	CO 97	0
0521	G0467 - *FSPC*		10/01	75.00	75.00	CO 97	0
0521	97802 - *PS*		10/01	60.00	60.00	CO 97	0
0521	G0466 - *FSPC*		10/01	55.00	55.00	CO 97	0

0521	92004 - *Ophthalmo-logical Exam*		10/01	45.00	45.00	CO 97	0
0001				535.00	535.00		

Payment = (225.00 – (135.00 +60.00)) * 80% + 135.00 + 60.00

Coinsurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%

Influenza and Pneumococcal Pneumonia Vaccination (PPV)

Flu and PPV vaccines and their administration will continue to be paid through the cost report. However, these services should be reported on the claim for information purposes only. Flu and PPV vaccines and their administration codes will not be carved out of the coinsurance calculation.

Example: Payment based on charges with Flu and Flu administration code services

PPS rate = 160.00

Preventive Service = 135.00

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*
0521	G0468 - *FSPC*		10/01	150.00	150.00
0521	G0438 - *PS*		10/01	135.00	135.00
0636	90655 - *Vaccine*		10/01	15.00	15.00
771	G0008 - *Admin Vaccine*		10/01	5.00	5.00
0001				305.00	305.00

Payment based on charges of 150.00

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*	**Payment**	*Coinsurance*
0521	G0468 - *FSPC*		10/01	150.00	150.00	150.00	0
0521	G0438 - *PS*		10/01	135.00	135.00	CO 97	0
0636	90655 - *Vaccine* ****		10/01	15.00	15.00	CO 246***	0
0771	G0008 *Admin Vaccine* ****		10/01	5.00	5.00	CO 246	0
0001				305.00	305.00		

Because flu and PPV are reported on the claim for information purposes only, G0438 remains as the only service payable on this claim. Because the claim consists solely of preventive services for which coinsurance is waived, the contractor will pay 100% of the provider's actual charge for the specific payment code, G0468.

*** CARC 246- This non-payable code is for required reporting only.

**** Flu/PPV are reported on the claim for information purposes only, the payment and coinsurance are not impacted by the charges associated with the Flu/PPV vaccine and their administration code.

Hepatitis B *(prior to January 1, 2025)*

Hepatitis B should be reported on the claim and is included in the claim payment. These services will be carved out of the coinsurance calculation.

Effective January 1, 2025, Hepatitis B is treated like flu, PPV and COVID.

Example: Payment based on charges with Hepatitis B

PPS rate= 160.00

Preventive Services = 20.00 (15.00 +5.00)

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*
0521	G0467 - *FSPC*		10/01	150.00	150.00
0521	99213 - *E&M*		10/01	135.00	135.00
0300	36415 - *VP*		10/01	5.00	5.00
0636	90746 - *PS Vaccine*		10/01	15.00	15.00
771	G0010 - PS *Admin Vaccine*		10/01	5.00	5.00
0001				310.00	310.00

Payment based on charges of 150.00

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*	**Payment**	*Coinsurance*
0521	G0467 - *FSPC*		10/01	150.00	150.00	124.00	26.00
0521	99213 - *E&M*		10/01	135.00	135.00	CO 97	0
0300	36415 - *VP*		10/01	5.00	5.00	CO 97	0
0636	90746 - *PS Vaccine*		10/01	15.00	15.00	CO 97	0
0771	G0010 - *PS Admin Vaccine*		10/01	5.00	5.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 80% + 20.00 preventive

Coinsurance = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 20%

Mental Health Services

Qualified mental health visits billed under revenue code 0900 receive an additional payment when billed on the same day as a medical visit.

Example: Mental Health Services

PPS RATE for G0468: $225.00

PPS rate for G0470: $160

Total of provider's actual charges for the specific payment codes representing medical visits (140.00 + 75.00 + 55.00) = 270.00- This does not include charges for G0470

Provider's charge for the specific payment code representing mental health services = 159.00

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*
0521	G0468 - *FSPC*		10/01	140.00	140.00
0521	G0439 - *PS*		10/01	135.00	135.00
0300	36415 - *VP*		10/01	25.00	25.00
0521	G0467 - *FSPC*		10/01	75.00	75.00

0521	97802 - *PS*		10/01	60.00	60.00
0521	G0466 - *FSPC*		10/01	55.00	55.00
0521	92004 - *Ophthalmo-logical Exam*		10/01	45.00	45.00
0900	G0470 - *FSPC*		10/01	159.00	159.00
0900	90832 - *Psychotherapy*		10/01	139.00	139.00
0636	J3490 - *Injection*		10/01	15.00	15.00
0001				848.00	848.00

Payment based on PPS rate of 225.00 for the specific payment codes describing the medical visits and based on the provider's actual charges for the specific payment code describing the mental health visit.

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	***DOS***	***Total Charge***	***Covered Charge***	**Payment**	***Coinsurance***
0521	G0468 - *FSPC*		10/01	140.00	140.00	219.00	6.00
0521	G0439 - *PS*		10/01	135.00	135.00	CO 97	0
0300	36415 - *VP*		10/01	25.00	25.00	CO 97	0
0521	G0467 - *FSPC*		10/01	75.00	75.00	CO 97	0
0521	97802 - *PS*		10/01	60.00	60.00	CO 97	0
0521	G0466 - *FSPC*		10/01	55.00	55.00	CO 97	0
0521	92004 - *Ophthalmo-logical Exam*		10/01	45.00	45.00	CO 97	0
0900	G0470 - *FSPC*		10/01	159.00	159.00	127.20	31.80
0900	90832 - *Psychotherapy*		10/01	139.00	139.00	CO 97	0
0636	J3490 - *Injection*		10/01	15.00	15.00	CO 97	0
0001				848.00	848.00		

For Medical visit with revenue code 052X
Payment = (225.00 – (135.00 +60.00)) * 80% + 135.00 + 60.00
Coinsurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%

For Mental Health visit with revenue code 0900
Payment = 159.00 *80% = 127.20
Coinsurance =159.00 * 20% = 31.80

Modifier 59

Medicare allows for an additional payment when an illness or injury occurs after the initial visit, and the FQHC bills these visits with the specific payment codes and modifier 59. Services billed with a modifier 59 will be paid an additional per diem rate

Example: Modifier 59

PPS rate for G0468 = 225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00 – This does not include charges for G0470 and G-code charges for modifier 59

Total mental Health Services = 159.00

PPS rate for G0467 (billed with Modifier 59) = 160.00

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*
0521	G0468 - *FSPC*		10/01	140.00	140.00
0521	G0438 - *PS*		10/01	135.00	135.00
0300	36415 - *VP*		10/01	25.00	25.00
0521	G0467 - *FSPC*		10/01	75.00	75.00
0521	97802 - *PS*		10/01	60.00	60.00
0521	G0466 - *FSPC*		10/01	55.00	55.00
0521	92004 - *Ophthalmological Exam*		10/01	45.00	45.00
0900	G0470 - *FSPC*		10/01	159.00	159.00
0900	90832 - *Psychotherapy*		10/01	139.00	139.00
0636	J3490 - *Injection*		10/01	15.00	15.00
0521	G0467 - *FSPC*	59	10/01	165.00	165.00
0521	99211 - *E&M*		10/01	105.00	105.00
0001				1118.00	1118.00

Payment based on PPS rate of 225.00 for the G-codes, based on the charges for the mental health visit and based on the PPS rate for G0467 billed with modifier 59.

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*	**Payment**	*Coinsurance*
0521	G0468 - *FSPC*		10/01	140.00	140.00	219.00	6.00
0521	G0438 - *PS*		10/01	135.00	135.00	CO 97	0
0300	36415 - *VP*		10/01	25.00	25.00	CO 97	0
0521	G0467 - *FSPC*		10/01	75.00	75.00	CO 97	0
0521	97802 - *PS*		10/01	60.00	60.00	CO 97	0
0521	G0466 - *FSPC*		10/01	55.00	55.00	CO 97	0
0521	92004 - *Ophthalmological Exam*		10/01	45.00	45.00	CO 97	0
0900	G0470 - *FSPC*		10/01	159.00	159.00	127.20	31.80
0900	90832 - *Psychotherapy*		10/01	139.00	139.00	CO 97	0
0636	J3490 - *Injection*		10/01	15.00	15.00	CO 97	0
0521	G0467 - *FSPC*	59	10/01	165.00	165.00	128.00	32.00
0521	99211 - *E&M*		10/01	105.00	105.00	CO 97	0
0001				1118.00	1118.00		

For Medical visit with revenue code 052X
Payment = (225.00 – (135.00 +60.00)) * 80% + 135.00 + 60.00
Coinsurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%

For Mental Health visit with revenue code 0900
Payment = 159.00 *80% = 127.20
Coinsurance =159.00 * 20% = 31.80

For G0467 billed with modifier 59
Payment = 160.00 * 80% = 128.00
Coinsurance = 160.00 * 20% = 32.00

60.4 - Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Section 237 of the Medicare Modernization Act (MMA) requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

This supplemental payment for covered FQHC services furnished to MA enrollees augments the direct payments made by the MA organization to FQHCs for all covered FQHC services. The Medicare per diem payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare program, is based on the FQHCs unique cost-per-visit as calculated by the MAC. The MAC determines if the Medicare payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC.

FQHCs seeking the supplemental payment are required to submit (for the first two rate years) to the MAC an estimate of the average MA payments (per visit basis) for covered FQHC services. They are required to submit a documented estimate of their average per visit payment for their MA enrollees, for each MA plan they contract with, and any other information as may be required to enable the MAC to accurately establish an interim supplemental payment.

Expected payments from the MA organization would only be used until actual MA revenue and visits collected on the FQHCs cost report can be used to establish the amount of the supplemental payment.

Effective January 1, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the MAC shall use actual MA revenue and visit data along with the FQHCs final all-inclusive payment rate, to determine the FQHCs final actual supplemental per visit payment. Once this amount (per visit basis) is determined it will serve as the interim rate for the next full rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment thereon will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, clinical social workers or *a certified diabetes self-management training/medical nutrition therapy (DSMT/MNT) provider.* The supplemental payment is made directly to each qualified FQHC through the MAC.

Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the MAC on type of bill (TOB) 77*X* with revenue code 0519 for the interim supplemental payment rate (FQHC interim all-inclusive rate – estimated average payment from the MA plan plus any beneficiary cost sharing = billed amount > 0). Do not submit revenue codes 052X and/or 0900 on the same claim as revenue code 0519.

For services of plan years beginning on and after January 1, 2006 and before, an interim supplemental rate can be determined by the MAC based on cost report data, MACs shall calculate an interim supplemental payment for each MA plan the FQHC has contracted with using the documented estimate provided by the FQHC of their average MA payment (per visit basis) under each MA plan they contract with. Once an interim supplemental rate is determined for a previous plan year based on cost report data, use that interim rate until the MAC receives information that changes in service patterns that will result in a different interim rate. MACs shall calculate an interim supplemental payment rate for each MA plan the FQHC has contracted with. Reconcile all interim payments at cost settlement.

Do not apply the Medicare deductible when calculating the FQHC interim supplemental payment. Do not apply the original Medicare co-insurance (20%) to the FQHC *PPS* rate when calculating the FQHC interim supplemental payment. Any beneficiary cost sharing under the MA plan is included in the calculation of the FQHC interim supplemental payment rate.

MACs shall submit all claims to CWF for approval. CWF will verify each beneficiary's enrollment in an MA plan for the line-item date of service (LIDOS) on the claim. CWF shall reject all claims for the FQHC interim supplemental payment for beneficiaries who are not MA enrollees on the same date as the LIDOS on the claim. MACs shall RTP such claims to the FQHCs. MACs shall accept TOB 77*X* with revenue code 0519 and pay the interim supplemental payment rate for each qualified visit billed.

Billing for Supplemental Payments under the PPS

When billing for supplemental payment to the MAC under the PPS, a FQHC payment specific code and a qualifying visit must be reported under revenue code 0519.

For *example*:

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	***DOS***
0519	G0467 – FQHC Payment code		10/01
0519	99213 – Qualifying visit		10/01

60.5 - PPS Payments to FQHCs under Contract with MA Plans

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

For claims with the 0519-revenue code, the wraparound payment is based on the PPS rate without comparison to the provider's charge. The rate is also NOT adjusted for coinsurance or preventive services as the MA plan would have already assessed any applicable coinsurance and related waivers of coinsurance.

Medicare will compare the PPS rate with the MA contract rate for a FQHC visit.

When the MA contract rate is lower than the applicable PPS rate that would otherwise have been paid by traditional Medicare had the beneficiary not been covered by the MA plan, the contractor will pay the difference as a supplemental wraparound payment.

The FQHC does not qualify for a supplemental wraparound payment when the MA contract rate is higher than the applicable PPS rate that would otherwise have been paid by traditional Medicare had the beneficiary not be covered by the MA plan.

Example: MA Claim that Qualifies for a Supplemental Wraparound Payment

PPS Rate = $225

Appropriate Rev Code	***Appropriate HCPCS Code***	***MOD***	***DOS***	***Total Charge***	***Covered Charge***
0519	G0468 - ***FSPC***		10/01	170.00	170.00
0519	G0439 - *PS*		10/01	150.00	150.00
0001				320.00	320.00

If the MA contract rate is lower than the applicable PPS rate – e.g., $200:

Wraparound payment = PPS rate – MA contract rate = $225 - $200 = $25

Note that the charge of $170 would reflect the FQHCs typical charge for G0468 but would not be used to calculate the supplemental payment.

Example: MA Claim that Does Not Qualify for a Supplemental Wraparound Payment

PPS Rate = $225

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Total Charge*	*Covered Charge*
0519	G0468 - *FSPC*		10/01	170.00	170.00
0519	G0439 - *PS*		10/01	150.00	150.00
0001				320.00	320.00

If the MA contract rate was higher than the applicable PPS rate – e.g., the MA contract rate was $250- no wraparound payment is due to the FQHC.

70 - General Billing Requirements for Preventive Services

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Professional components of preventive services are covered under the RHC and FQHC benefit. The payment for most preventive services is included with a qualified visit as part of the overall encounter/visit. To ensure coinsurance and deductible (deductible applies to RHC claims only) are applied correctly, detailed HCPCS coding is required for approved preventive services recommended by the USPSTF with a grade of A or B for TOBs 71*X* or 77*X*. *Additionally, there are some preventive services which are subject to frequency limitations.*

70.1 - RHCs Billing Approved Preventive Services

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service HCPCS code and the associated charges. For example, if the total charge for the visit is $150.00, and $50.00 of that is a qualified preventive service, the service lines should be coded as follows:

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Charges*
0521	*99212 - Encounter Visit*	*CG*	10/01	100.00
0521	G0439 - Preventive Service Code *(PS)*		10/01	50.00

In the example above, the encounter service line will receive the AIR payment. The charges reported on this line should not include the charges for the approved preventive service. Coinsurance and deductible will be accessed based on the charges reported on this service line. The qualified preventive service reported on the additional service line will not receive payment, as payment is made under the AIR for the services reported under the encounter service line. Coinsurance and deductible are accessed based on the charges reported on the preventive services line.

70.2 - FQHC Billing Approved Preventive Services under the PPS

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service *(PS)* HCPCS code and the associated charges. For example, if the total

charge for the visit is $150.00, report the total charges for the encounter. **NOTE:** Do not carve out the charges for the approved preventive services. The service lines should be coded as follows:

Appropriate Rev Code	*Appropriate HCPCS Code*	*MOD*	*DOS*	*Charges*
0521	*G0468 -* FQHC Payment Code (G-code)		10/01	150.00
0771	*G0439 - PS* code		10/01	75.00

In the example above, the services reported under the encounter/visit service line will receive the PPS payment. The charges reported on this line should include the charges for the approved preventive service. The coinsurance will be applied to the charges reported on the encounter service line. Coinsurance will not be applied to the charges reported for the approved preventive service. The qualified preventive service reported on the second revenue line will not receive payment. **NOTE:** A qualified HCPCS code visit must be reported if the preventive service is not a qualified visit.

70.3 - Vaccines

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Influenza virus, pneumococcal, COVID-19, *and hepatitis B* vaccines do not count as RHC/FQHC visits. The cost for these vaccines is included in the cost report and a visit is not billed for these services. RHCs do not report vaccines on the claim, TOB 71*X*. However, for FQHCs, if there was another reason for the visit, the vaccine and the administration code should be reported on the claim, TOB 77*X*, for informational and data collection purposes only. Coinsurance and deductible do not apply to these vaccines.

Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government), and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

*The h*epatitis B vaccine *was* included in the RHC all-inclusive and the FQHC /PPS rate *through December 31, 2024*. The charges of the vaccine and its administration *were* included in the line item for the otherwise qualifying visit. A visit *could not* be billed if *the* vaccine and its administration *was* the only service the RHC/FQHC provides.

Additional information on vaccines can be found in Chapter 18, section 10 of this manual. Additional coverage requirements for pneumococcal vaccine, hepatitis B vaccine, *COVID-19,* influenza virus vaccine can be found in Publication 100-02, the Medicare Benefit Policy Manual, Chapter 13.

70.4 - Diabetes Self-Management and Training (DSMT) and Medical Nutrition Services (MNT)

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

FQHCs billing under the PPS

DSMT and MNT are qualifying visits when billed under G0466 or G0467. For additional information on the payment specific codes and qualifying visits, see section 60.2 of this manual. Under the FQHC PPS, DSMT and MNT do not qualify for a separate payment when billed on the same day with another qualified visit.

RHCs

RHCs are not paid separately for DSMT and MNT services. All line items billed on TOB 71*X* with HCPCS codes for DSMT and MNT services will be denied.

70.5 - Initial Preventive Physical Examination (IPPE)
(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

RHCs billing under the AIR system
Medicare provides for coverage for one IPPE for new beneficiaries only, subject to certain eligibility and other limitations.

Payment for the professional services will be made under the *RHC* AIR. However, RHCs can receive a separate payment for an encounter in addition, to the payment for the IPPE when they are performed on the same day.

When IPPE is provided in an RHC, the professional portion of the service is billed on TOBs 71X, respectively, and the appropriate site of service revenue code in the 052X revenue code series and must include HCPCS code G0402. Additional information on IPPE can be found in Chapter 18, section 80 of Pub. 100-04 *of the Medicare Claims Processing Manual*.

EKGs
The professional component is included in the *RHC* AIR or FQHC PPS and is not separately billable.

The technical component of an EKG performed at an RHC/FQHC is billed to Medicare on professional claims (Form CMS-1500 or 837P) under the practitioner's ID following instructions for submitting practitioner claims for independent/freestanding clinics. Practitioners at provider-based clinics bill the applicable TOB to the A/B MAC using the base provider's ID.

FQHCs billing under the PPS:
IPPE is qualifying visit when billed under G0468, for additional information on the payment specific codes and qualifying visits, please refer to section 60.2 of this manual. Under the FQHC PPS, IPPE does not qualify for a separate payment when billed on the same day with another encounter/visit.

70.6 - Virtual Communication Services
(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

In the CY 2019 PFS final rule, CMS finalized a policy for payment to RHCs and FQHCs for communication technology-based services ("virtual check-in") or remote evaluation services, effective January 1, 2019. CMS created a new Virtual Communications G Code, G0071 for use by RHCs and FQHCs only, with the payment rate set at the average of the PFS non-facility payment rate for communication technology-based services and remote evaluation services.
RHCs and FQHCs receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR or the FQHC PPS payment when the requirements for these services are met. Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

RHCs and FQHCs can bill HCPCS code G0071 alone or with other payable services on an RHC or FQHC claim. The services should be billed with a revenue code 052x and should not be billed with modifier CG for payment on RHC claims. HCPCS codes G0071 are paid based on the lesser of the charges or the rate from the Medicare Physician Fee Schedule (MPFS).

70.7 - Care Coordination Services – Chronic Care or Psychiatric Collaborative Care Model (CoCM) Services
(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Effective for services furnished on or after January 1, 2018, RHCs and FQHCs are paid for Care *Coordination Services* or Psychiatric CoCM services when G0511 or G0512 is billed alone or with other payable services on an RHC or FQHC claim. HCPCS code G0511 or G0512 can only be billed once per

month per beneficiary and cannot be billed if other care management services are billed for the same time *frame.*
HCPCS codes G0511 and G0512 are subject to coinsurance and deductibles on RHC claims. Only coinsurance applies on FQHC claims. Coinsurance is 20 percent of the lesser of the RHC or FQHC charge for HCPCS codes G0511 and G0512, or the corresponding rate.
The allowable revenue code is 052X. These HCPCS codes of G0511 or G0512 should not be billed with modifier CG for payment on RHC claims.
Effective for services furnished on or after January 1, 2025, RHCs and FQHCs shall bill the individual CPT and HCPCS codes that describe care coordination services instead of the single HCPCS G0511. However, there is a delay in compliance of this requirement for 6 months at least until July 1, 2025, for RHCs and FQHCs to update their billing systems if necessary. During the 6-month delay (January 1, 2025 – July 1, 2025), RHCs and FQHCs may continue to bill HCPCS G0511 for care coordination services, after which they will be required to bill the individual HCPCS codes.
RHCs and FQHCs shall determine on a facility level basis whether they are continuing to bill G0511 or the individual HCPCS codes and not by a claim by claim or patient by patient basis.
Since the Advanced Primary Care Management (APCM) services are not included in G0511, when furnishing APCM, RHCs and FQHCs shall report G0556, G0557, G0558 as appropriate effective January 1, 2025.
The services should be submitted as:

- *Type of bill (TOB) 71X (RHC) or 77X (FQHC)*
- *Revenue code 052X,*
- *The care coordination services HCPCS codes,*
- *for TOB 71X with or without modifier CG*

Care coordination services that can be furnished and paid separately in RHCs and FQHCs effective January 1, 2025:

- *Chronic Care Management (CCM) – 99437, 99439, 99487, 99489, 99490, 99491*
- *Principal Care Management (PCM) - 99424, 99425, 99426, 99427*
- *Chronic Pain Management (CPM) - G3002, G3003*
- *General Behavioral Health Integration (BHI) - 99484, G0323*
- *Remote Physiological Monitoring (RPM) - 99453, 99454, 99457, 99458, 99474, 99091*
- *Remote Therapeutic Monitoring (RTM) - 98975, 98976, 98977, 98980, 98981*
- *Community Health Integration (CHI) - G0019, G0022*
- *Principal Illness Navigation (PIN) - G0023, G0024*
- *PIN-Peer Support (PS)- G0140, G0146*
- *Advanced Primary Care Management (APCM) – G0556, G0557, G0558*

Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

80 - Telehealth Services

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

RHCs and FQHCs may bill the Telehealth originating site facility fee on a RHC or FQHC claim under revenue code 0780 and HCPCS code Q3014. Telehealth services are the only services billed on FQHC claims that are subject to the Part B deductible. Additionally, a FQHC payment code and qualifying visit HCPCS code are not required when the only service reported on the claim is for Telehealth services.

Before March 27, 2020, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) were not permitted to serve as distant sites for telehealth consultations, meaning they could not bill for these visits or include their costs in the cost report.

CMS introduced a new HCPCS code G2025, which allows payment for non-behavioral telehealth services provided when RHCs or FQHCs serve as the distant site.

RHCs and FQHCs can temporarily continue offering non-behavioral health visits via telecommunication technology under the existing methodology established during the COVID-19 Public Health Emergency (PHE) until December 31, 2025, or later date if extended. Specifically, they can bill for services delivered through telecommunication technology by using HCPCS code G2025 on claims, which includes services provided through audio-only communications technology until December 31, 2025, or later date if extended.

Beginning January 1, 2023, RHCs and FQHCs may report and receive payment for mental health visits furnished via telehealth. These services are billed in the same manner as in-person visits, rather than using HCPCS code G2025.

For more information on Telehealth services please see *Pub. 100-04, Medicare Claims Processing Manual*, *Chapter* 12, *Section* 190: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf *and Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 200:* https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf.

90 - Services non-Covered on RHC and FQHC Claims

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Technical Services

RHCs/FQHCs do not bill using TOBs 71*X* or 77*X* for technical components of services because they are not within the scope of Medicare-covered RHC/FQHC services. The associated technical components of services furnished by the RHC/FQHC are billed on other types of claims that are subject to applicable frequency limits edits.

For services that can be split into professional and technical components, RHCs and FQHCs bill for the professional component as part of the AIR or the FQHC PPS payment and bill the MAC separately for the technical component. See *Pub. 100-04, Medicare Claims Processing Manual* Chapter 16, *Section* 30.1.1, for more information on how RHCs and FQHCs can bill the MAC for laboratory service: (http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf*) and* see *Pub. 100-02, Medicare Benefit Policy Manual,* Chapter 13, *Section 60*, for more information on how to bill the MAC for technical components of diagnostic services: *(*https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf*.)*

Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are submitted to the MAC in the designated claim format (837P or Form CMS-1500.) See *Pub. 100-04, Medicare Claims Processing Manual, Chapter* 12 (http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf) and *Chapter* 26 (http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf) of this manual for billing instructions.

Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are submitted by the base-provider on the appropriate TOB to the MAC in the designated claim format (837I or the UB-04 claim form); see the applicable chapter*s* of this manual based on the base-provider type, such as *for outpatient hospital services, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4 (*http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf*), for inpatient SNF services, chapter 6 (*http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf*),* and for *outpatient* SNF services*, Chapter* 7 *(*http://www.cms.hhs.gov/manuals/downloads/clm104c07.pdf*)*

Laboratory Services

RHCs must furnish the following lab services to be approved as an RHC. However, these and other lab services that may be furnished are not included in the encounter rate and must be billed separately.

- Blood sugar.
- Pregnancy tests; and
- *Collection of patient specimens to send to a certified lab for culturing.*

RHCs/FQHCs bill all laboratory services to their MAC under the host provider's bill type and payment is made under the fee schedule. HCPCS codes are required for lab services.

Venipuncture is included in the AIR and the PPS per diem payment and is not separately billable.

Refer to *Pub. 100-04, Medicare Claims Processing Manual*, Chapter 16 for general billing instructions, (http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf.)

Durable Medical Equipment (DME), ambulance services, hospital-based services, group services, and non-face-to-face services are also non-covered and are billed separately.

110 - Intensive Outpatient Program (IOP) Services

(Rev. 13200, Issued: 5-1-25, Effective:6-2-25 Implementation:6-2-25)

Effective January 1, 2024, section 4124 of the Consolidated Appropriations Act of 2023 (CAA, 2023) establishes Medicare coverage and payment for Intensive Outpatient Program (IOP) services for individuals with mental health needs when furnished by hospital outpatient departments, Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs).

Section 4124(c) of the CAA, 2023 requires payment for IOP services furnished by RHCs and FQHCs to be made at the same payment rate as if it were furnished by a hospital.

For additional information regarding IOP benefits and services, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 250.

A. Billing Requirements

- *TOB: 71X (RHC) or 77X (FQHC)*
- *Date of services for 3 or less services: on or after 01/01/24*
- *Date of services for 4 or more: on or after 01/01/25*
- *Revenue codes: 0905 or 0519 (MA claim).*
- *Condition code 92.*
- *HCPCS codes listed below for (a) primary services and (b) other services.*
    a. *Primary Services:*
    90832, 90834, 90837, 90845, 90846, 90847, 90853, 90880, 96112, 96116, 96130, 96132, 96136, 96138, G0410, G0411
    b. *Other Services:*
    90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839 ,90840, 90845, 90846, 90847, 90849, 90853, 90880, 90899, 96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96164, 96167, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, G0129, G0176, G0177, G0410, G0411, G0451

    c. *At least one IOP HCPCS code from the (a) Primary Services above must be included on the claim for payment. Additional IOP services listed on the claim will be bundled for that specific day.*
- *A FQHC payment code and qualifying visit is not required with a IOP visit.*
- *FQHCs must report charges on the primary service line for all IOP services furnished that day to be included in the calculation for coinsurance.*
- *RHCs must also report the CG modifier on the line for payment along with the charges.*

B. Multiple Visits

- *Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and a single location constitute a single visit, except when a patient has a medical visit and a mental health visit on the same day or when a patient has an initial preventive physical exam and a separate medical or mental health visit on the same day. Since IOP services are behavioral health services, payment for a mental health visit and IOP services on the same day is allowed but paid a single payment based on the IOP rate. In the case of a medical visit, an encounter can include a medical visit and a mental health visit or a medical visit and IOP services on the same day. However, an encounter cannot include two mental health visits on the same day.*

  ***Note:** Report a line-item date of service per revenue code line for IOP claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.*

Examples:

- *IOP services are furnished on the same day as a mental health visit, only one payment will be considered at the IOP rate. That is, payment for the mental health visit will be included under the IOP rate.*
- *IOP services are furnished on the same day as a medical visit, there will be one payment for the medical visit under the FQHC PPS or under the RHC AIR methodology and one payment for IOP services at the IOP rate.*

Mental health services should continue to be reported with revenue code 0900. Do not report IOP services with revenue code 0900. IOP services should be billed with revenue code 0905.

C. FQHC Supplement Payments

To receive the wrap-around payment, FQHCs that contract with MA organizations must report condition code 92, revenue code 0519 and a HCPCS code from the Primary List A.

Please see section 60.4 of this chapter for additional information on Supplement Payments.

D. Payment

Payment for Intensive Outpatient (IOP) services provided by Rural Health Clinics (RHCs) will be based on the rate established for hospital-based IOPs, which is the per diem payment amount for three services per day or four or more-day services, rather than the RHC All-Inclusive Rate (AIR).

Payment for IOP services furnished in FQHC will be the lesser of a FQHC actual charges or the rate determined for hospital-based IOPs and not the FQHC PPS. Additionally, historically excepted tribal FQHCs will have their payment based on the IHS Medicare outpatient per visit rate when furnishing IOP services. That is, payment is based on the lesser of a historically excepted tribal FQHC actual charges or the IHS Medicare outpatient per visit rate.

Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

Only one payment rate is allowed per day for the IOP services.