CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13803	**Date: May 28, 2026**
	Change Request 14452

Transmittal 13772 issued May 07, 2026, is being rescinded and replaced by Transmittal 13803, dated May 28, 2026, to revise business requirement 14452.2 to include FQHCs (77X TOB). All other information remains the same.

SUBJECT: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Updates for Shared System Edits for Category II Codes, Care Coordination Services and Revisions to the Internet Only Manual (IOM) Publications (Pub.) 100-04, Chapter 9

I. SUMMARY OF CHANGES: The Change Request (CR) provides instructions to bypass edits for Category II Codes and Care Coordination Services on RHC and FQHC claims. CR also updates IOM Pub.100-04, Chapter 9.

EFFECTIVE DATE: October 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2026

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	9/60/60.2 - Billing for FQHC Claims Paid under the PPS
R	9/60/60.3 - Payments for FQHC PPS Claims
N	9/60/60.7- Virtual Communication Services
N	9/60/60.8 - Care Coordination Services – Chronic Care or Psychiatric Collaborative Care Model (CoCM) Services
D	9/70/70.6 -Virtual Communication Services
D	9/70/70.7 – Care Coordination Management Services – Chronic Care and Psychiatric Collaborative Care Model (CoCM) Services
D	9/70/70.8 – General Care Management Services – Chronic Care and Psychiatric Collaborative Care Model (CoCM) Services
R	9/80/Telehealth 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: 13803**	**Date: May 28, 2026**	**Change Request: 14452**

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I. SUMMARY OF CHANGES: The Change Request (CR) provides instructions to bypass edits for Category II Codes and Care Coordination Services on RHC and FQHC claims. CR also updates IOM Pub.100-04, Chapter 9.

II. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) has been made aware that when Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) bill Category II Codes and Care Coordination Services, with a status indicator ‘M’ or ‘E1’, reason code 31836 and/or 31837 is assigned. As a result, CMS instructed in a previously issued technical direction to temporarily bypass reason code 31836 and 31837. With the implementation of this Change Request (CR), reason code 31836 and 31837 will be permanently bypassed. In addition, this instruction updates Internet Only Manual (IOM) Publications (Pub.) 100-04, Chapter 9.

B. Policy: No change in policy.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14452.1	Contractors shall allow Care Coordination Service HCPCS codes (from the user control file in FISS) with a status indicator of ‘M’ or ‘E1’ to be submitted on RHC claims, 71X type of bill (TOB).					X				
14452.2	Contractors shall modify their system to bypass FISS reason code 31837 (and any other applicable reason codes) for					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	FQHC claims, 77X TOB and RHC claims, 71X TOB.									
14452.3	Contractors shall modify their system to bypass any reason code (for example, 31836 and 31837) that prevents FQHCs (77X TOB) from billing Category II HCPCS codes with a status indicator of 'M' or 'E1'. Note: This does not include W7112, the line should be rejected with W7112. Note: FISS shall continue to also reject RHC claims, 71X TOB with reason code W7112.					X				
14452.4	Contractors shall be in compliance with the updates to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9.	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

Pre-Implementation Contact(s): Teira Canty, teira.canty@cms.hhs.gov

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. 13803; Issued: 05-28-26)

Transmittals for Chapter 9

60.7 - Virtual Communication Services

60.8 - Care Coordination Services – Chronic Care or Psychiatric Collaborative Care Model (CoCM) Services

60.2 - Billing for FQHC Claims Paid under the PPS

(Rev. 13803; Issued: 05-28-26; Effective: 10-01-26; Implementation: 10-05-26)

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

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	9921*4* - 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.

Beginning in 2020, FQHCs must report HCPCS codes for COVID-19 vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall pay for the COVID-19 vaccines and their administration through the cost report.

Effective January 1, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the FQHC PPS rate. Therefore, FQHCs must report HCPCS codes for the hepatitis B vaccine and their administration on a FQHC claim, and these HCPCS codes will be considered informational only.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, hepatitis B, and COVID-19 -- on the claim for payment at the time of service. A visit/encounter is not required for these services; however, if reported on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance does not apply to these vaccines or their administration. Although paid at the time of service, payments for these services must be

annually reconciled with the FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing to reflect the seasonal influenza virus vaccines and their applicable payment allowances that are effective August 1 through July 31 of the following year. FQHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season.

Note: FQHCs can bill HCPCS code M0201 for an in-home additional payment for influenza, pneumococcal, hepatitis B, COVID-19 vaccine administration, provided that a home visit meets all the requirements of both part 405, subpart X, for FQHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E for more information.

60.3 - Payments for FQHC PPS Claims

(Rev. 13803; Issued: 05-28-26; Effective: 10-01-26; Implementation: 10-05-26)

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-logical Exam		10/01	45.00	45.00
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%

<u>Reporting Multiple Preventive Services</u>
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%

<u>Influenza and Pneumococcal Pneumonia Vaccination (PPV)</u> (Prior to July 1, 2025)
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. See section 60.2 for updates regarding billing requirements for Medicare Part B preventive vaccines and their administration.

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.

<u>Hepatitis B (prior to January 1, 2025)</u>
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. See section 60.2 for updates regarding billing requirements for Medicare Part B preventive vaccines and their administration.

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%

<u>Mental Health Services</u>
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	99214 - 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	99214 - 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

60.7 - Virtual Communication Services

(Rev. 13803; Issued: 05-28-26; Effective: 10-01-26; Implementation: 10-05-26)

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).

Effective January 1, 2026, RHCs and FQHCs shall no longer report HCPCS code G0071, the individual CPT/HCPCS base codes and add-on codes for each of the virtual communication services should be used.

60.8 - Care Coordination Services – Chronic Care or Psychiatric Collaborative Care Model (CoCM) Services

(Rev. 13803; Issued: 05-28-26; Effective: 10-01-26; Implementation: 10-05-26)

Effective for services furnished on or after January 1, 2018, RHCs and FQHCs are paid for Care Coordination Services (previously referred to as "General Care Management") 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. RHCs and FQHCs may continue to bill HCPCS G0511 for care coordination services through September 30, 2025, 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.

Effective January 1, 2026, RHCs and FQHCs can bill care coordination services established under the Physician Fee Schedule (PFS) as designated care management services. These care coordination codes can be found in the table entitled Designated Care Management Services, which is published annually with the PFS Final Rule Addenda on the CMS website. The allowable revenue code for these services is 052X. RHCs should not bill care coordination codes with modifier CG for payment. Coinsurance is 20 percent of the lesser of the RHC or FQHC charge for each individual HCPCS code, or the corresponding rate.*

**Transitional Care Management services can be an RHC or FQHC visit (see section 10.1 of this Chapter and Pub. 100-02, Chapter 13, section 230.1).*

The services should be submitted as:

TOB	***Appropriate Rev Code***	***Appropriate HCPCS Code***	***MODIFIER***
77X	*052X*	*Care Coordination Services HCPCS Codes*	*No Modifier*
71X	*052X*	*Care Coordination Services HCPCS Codes*	*With or Without CG modifier*

A list of all care coordination services for RHCs and FQHCs are available on the RHC and FQHC websites at https://www.cms.gov/Center/Provider-Type/RuralHealth-Clinics-Center and https://www.cms.gov/medicare/payment/prospectivepayment-systems/federally-qualified-health-centers-fqhc-center, respectively.

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

Please see Pub. 100-02, Chapter 13, Section 230 for more information on when Care Coordination Services, including Psychiatric CoCM services, are furnished by RHCs and FQHCs.

80 - Telehealth Services

(Rev. 13803; Issued: 05-28-26; Effective: 10-01-26; Implementation: 10-05-26)

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. *Section 3704 of the CARES Act authorized RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Since then, there have been several extensions of this authority through legislation.*

For the duration of the extension, CMS is required to make payment for distant site telehealth services that is similar to the national average payment rates for comparable telehealth services under the Physician Fee Schedule (PFS). In 2021, CMS introduced a new HCPCS code G2025 *(payment for a telehealth distant site service furnished by a RHC or FQHC only)*, which allows payment for non-behavioral telehealth services. *Certain services on the telehealth list waive cost sharing; RHCs and FQHCs identify these services by utilizing the CS modifier with HCPCS G2025.*

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, 202*7*, 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, 202*7*, or later date if extended.

Beginning January 1, 2022, RHCs and FQHCs may report and receive payment for mental health visits furnished via *telecommunication technology*. These services are billed in the same manner as in-person visits, rather than using HCPCS code G2025.

RHCs and FQHCs are instructed to append modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) in instances where the mental health visit was furnished using audio-video communication technology and to append modifier 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System) in cases where the service was furnished using audio only communication.

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