Medi-Cal Provider Training 2022

FQHC, RHC, Tribal FQHC & IHS-MOA Services

DHCS

The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at www.learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

Table of Contents

FQHC, RHC, Tribal FQHC & IHS-MOA Services

Introduction

Purpose

The purpose of this module is to provide information for billing services rendered by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Tribal FQHCs and Indian Health Services-Memorandum of Agreement (IHS-MOA) clinics to participants in the Medi-Cal program.

Module Objectives

- Define FQHC and RHC
- Introduce Tribal Federally Qualified Health Centers (Tribal FQHCs)
- Explain the IHS-MOA program
- Provide billing tips to prevent claim denials
- Identify billing codes
- Review billing examples

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Description

FQHCs and RHCs provide outpatient health care services to recipients in rural and non-rural areas.

FQHC Program

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

Tribal Federally Qualified Health Centers (Tribal FQHCs)

Background:

The Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) to establish Tribal FQHCs as a provider type, per State Plan Amendment (SPA) 20-0044. The SPA outlines Tribal FQHC eligibility, payment methodology and allowable visit combinations.

Outpatient health care programs operated by a tribe or tribal organization are eligible to enroll as a Tribal FQHC in Medi-Cal. Tribal FQHCs provide covered primary care clinic services to Medi-Cal beneficiaries. Tribal FQHC services may be provided in a clinic or off site by tribal providers and non-tribal providers that are contractors of the Tribal FQHC.

Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Services All-Inclusive Rate (AIR)

Enrollment

Existing Medi-Cal Providers:

Under Section 1905(I)(2)(B) of the Social Security Act, outpatient health care programs operated by a tribe or a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA) may request designation as a Tribal FQHC by completing an *"Elect to Participate" Indian Health Services Memorandum of Agreement (IHS/MOA) and Tribal Federally Qualified Health Center (FQHC)* (form DHCS 7108). The DHCS 7108 form is available on the Medi-Cal Provider website, *www.medi-cal.ca.gov.*

1. From the Medi-Cal Provider website home page, select **Resources**.

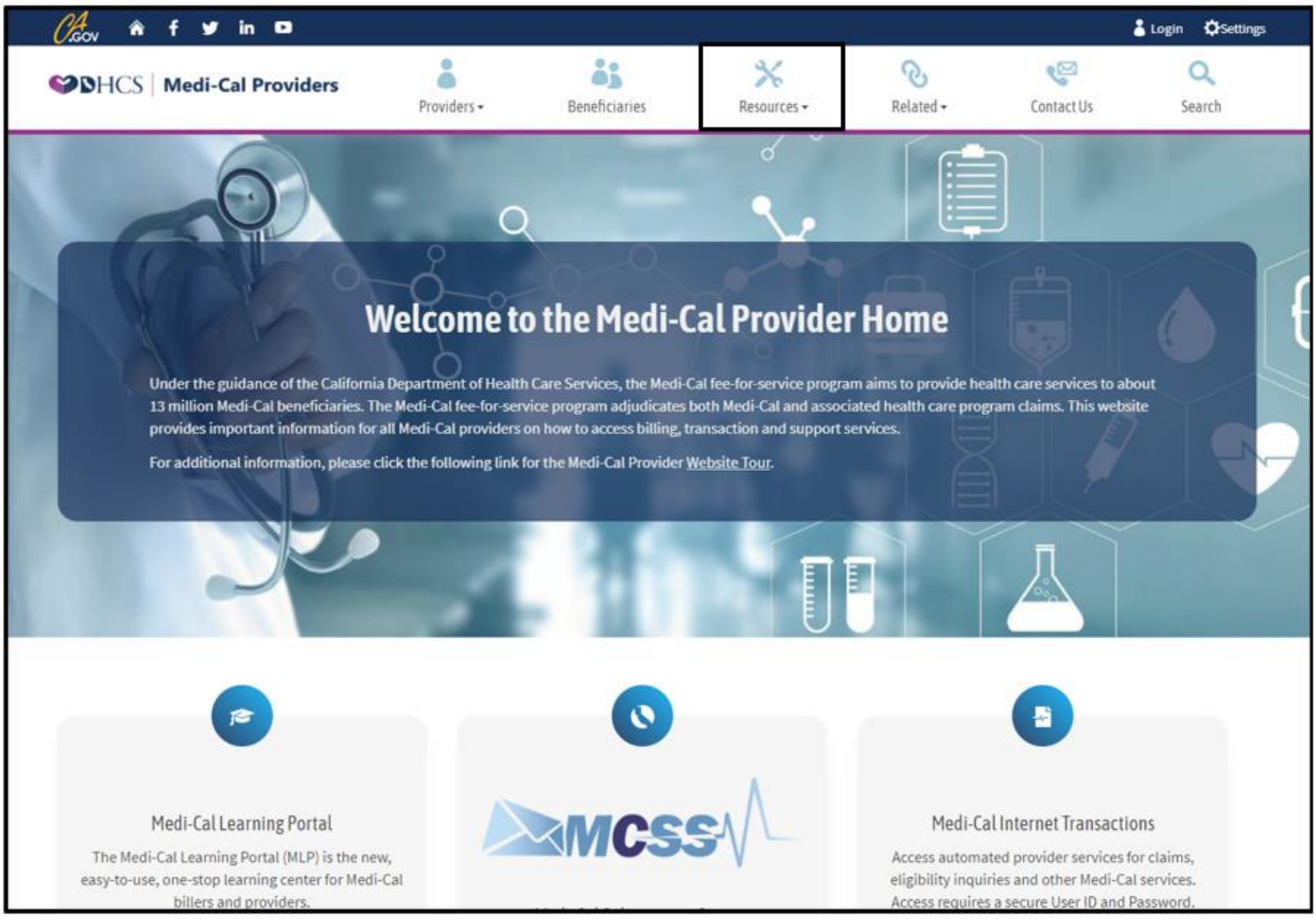

Figure 1: The Resources tab is located within the navigation bar.

2. Next, select **References**

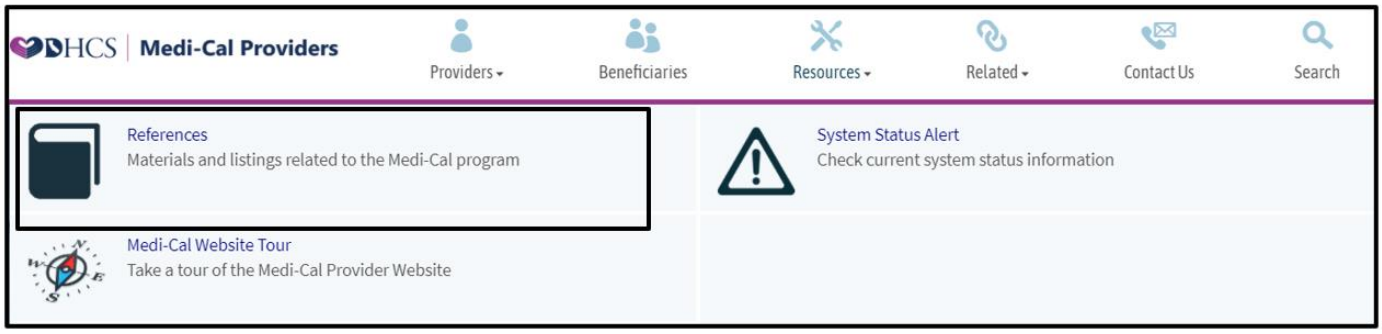

Figure 2: Medi-Cal References contains an assortment of helpful links to facilitate participation in the Medi-Cal program.

3. Scroll to the Billing section located under **Forms** and select **Provider Enrollment.**

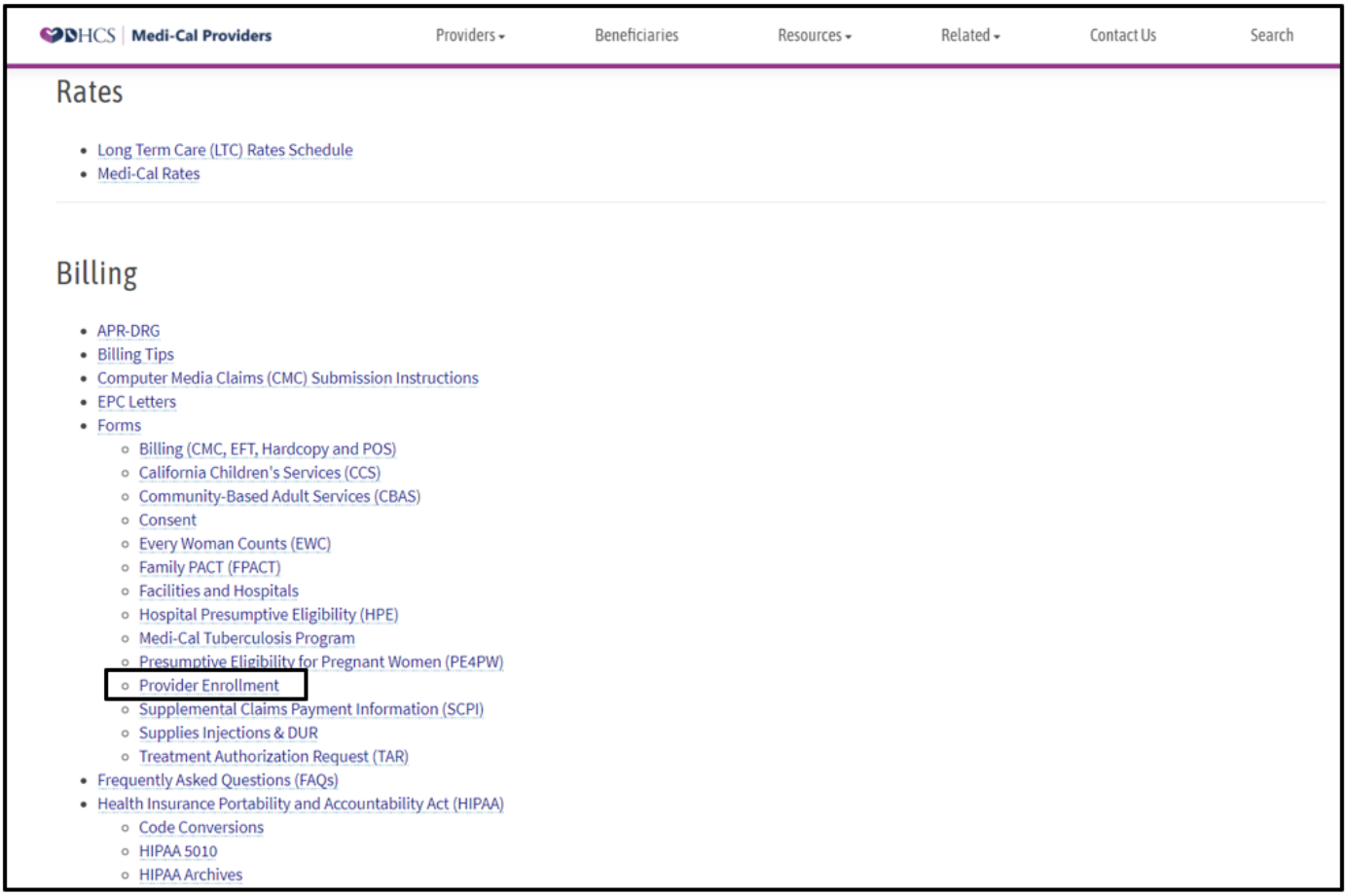

Figure 3: Medi-Cal Forms.

4. Under Applications, select “Elect to Participate” Indian Health Services Memorandum of Agreement (IHS-MOA) Application (DHCS 7108)

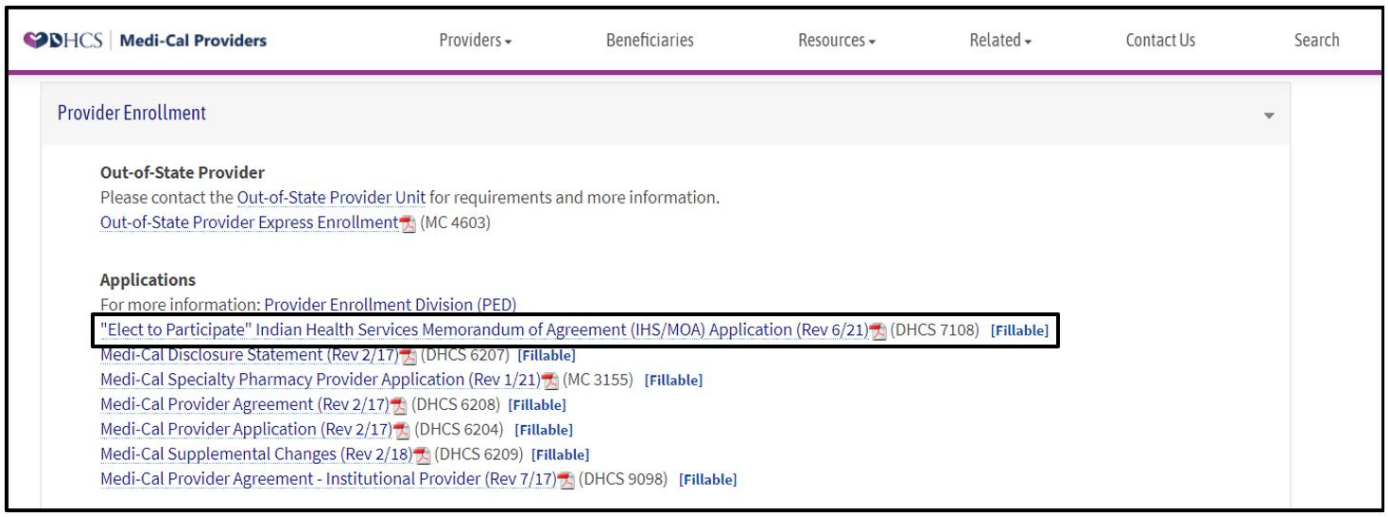

Figure 4: “Elect to Participate” Indian Health Services Memorandum of Agreement (IHS-MOA) Application link.

New Medi-Cal Providers

Eligible tribal health programs requesting initial enrollment in the Medi-Cal program as a Tribal FQHC must apply through the DHCS electronic application system, Provider Application and Validation for Enrollment (PAVE), and complete DHCS 7108 form. To be eligible to enroll as a Tribal FQHC provider, the health programs must be operated by a tribe or a tribal organization under P.L. 93-638. Providers may contact the DHCS Provider Enrollment Division (PED) at (916) 323-1945 or visit the DHCS PAVE website for all applicable enrollment forms.

RHC Program

A RHC extends Medicare and Medi-Cal benefits to cover health care services provided by clinics operating in rural areas. RHCs are located in federally designated medically underserved areas (MUA) or medically underserved population (MUP) locations as specified by the Health Resources and Services Administration (HRSA).

RHCs must meet certain federal requirements to be certified. A RHC employs or contracts with nurse practitioners, physician assistants and certified nurse midwives who provide services at the clinic at least 50 percent of the time the RHC is open. RHC physicians may work less than full-time as long as the physician is present in the clinic during operating hours.

IHS-MOA Services

On April 21, 1998, Department of Health Care Services (DHCS) implemented the IHS-MOA program between the federal IHS and the Centers for Medicare & Medicaid Services. The IHS-MOA changed the reimbursement policy for services provided to Medi-Cal recipients within American Indian or Alaskan native health care facilities identified as 638 facilities. DHCS compiled a list of IHS-MOA clinics and mailed a letter to each provider, informing them of the option to participate as a 638 clinic under the MOA. Providers electing to participate were asked to complete and return an *"Elect to Participate" Indian Health Services Memorandum of Agreement (IHS/MOA) Application* (DHCS 7108) to the DHCS Provider Enrollment Division (PED).

Provider Enrollment

FQHC and RHC Enrollment

Providers must first contact the Department of Public Health, Licensing and Certification Program to obtain clinic licensure. After obtaining licensure, the provider must contact DHCS Audits and Investigations (A&I) Division to enroll as a FQHC or RHC. The Initial Rate Setting Application forms are located on the DHCS website.

Authorized Physicians

For FQHC and RHC purposes, the following providers are defined as “physicians”:

Authorized Physician Table

Type of Physician	Program Requirements
General Medicine or Osteopathy	The physician is authorized to practice medicine and surgery by the state while acting within the scope of his/her license.
Podiatrist	The physician is authorized to practice podiatric medicine by the state while acting within the scope of his/her license.
Optometrist	The physician is authorized to practice optometry by the state while acting within the scope of his/her license.
Chiropractor	The physician is authorized to practice chiropractic by the state while acting within the scope of his/her license.
Dental Surgeon (Dentist)	The physician is authorized to practice dentistry by the state while acting within the scope of his or her license.

Tribal FQHC Authorized Physicians

The following providers are defined as “physicians”:

Authorized Physician Table

Type of Physician	Program Requirements
General Medicine or Osteopathy	A physician or osteopath authorized to practice medicine and surgery by the state while acting within the scope of his/her license.
Podiatrist	A doctor of Podiatry authorized to practice podiatric medicine by the state while acting within the scope of his/her license.
Optometrist	A doctor of Optometry authorized to practice optometry by the state while acting within the scope of his/her license.
Chiropractor	A doctor of Chiropractic is authorized to practice chiropractic by the state while acting within the scope of his/her license.
Dental Surgeon (Dentist)	The physician is authorized to practice dentistry by the state while acting within the scope of his/her license.
Medical Resident	Medical Resident in Tribal FQHC that operates a federal or state sponsored Teaching Health Center Graduate Medical Education (THCGME) grant program, under the supervision of a designated teaching physician, who is acting within his/her Postgraduate Training License (PTL) issued by the Medical Board of California. The THCGME Program is required to be accredited by the Accreditation Council for Graduate Medical Education.

IHS-MOA Enrollment

FQHCs, RHCs and certain Primary Care Clinics (PCCs) designated by the federal IHS as eligible to participate in the IHS-MOA may enroll as IHS-MOA clinic providers.

Clinics cannot be designated as both an IHS-MOA and a FQHC/RHC/Tribal FQHC/PCC provider. Any other current provider numbers, or National Provider Identifier (NPI) numbers, are deactivated at the time of enrollment. Medi-Cal will recognize these providers as IHS-MOA providers only. All Medi-Cal providers must have a valid NPI to submit claims to Medi-Cal for services rendered.

Providers may enroll as an IHS-MOA clinic by completing an *"Elect to Participate" Indian Health Services Memorandum of Agreement (IHS/MOA) Application* (DHCS 7108). The application must be photocopied and mailed to:

Attn: Provider Enrollment Division
Department of Health Care Services
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Faxed applications will not be considered.

Scope of Coverage

Program Type

FQHC/RHC Programs

Types of Services Covered

- Physician services
- Physician assistant services
- Nurse practitioner services
- Certified nurse midwife services
- Visiting nurse services (as defined in *Code of Federal Regulations* [CFR], Title 42, Section 405.2416)
- Comprehensive Perinatal Services Program (CPSP) practitioner services
- Licensed clinical social worker services
- Marriage and family therapist services
- Clinical psychologist services
- Optometry
- Acupuncture
- Chiropractic
- Podiatry
- Dental (For additional dental services information, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section (rural) in the Part 2 provider manual).
- End of life services

Tribal FQHC Services Covered

In addition to the types of services covered for FQHC/RHC, are services covered for Tribal FQHC:

Ambulatory Services

- Acupuncture (subject to CCR, Title 22, Section 51309)
- Chiropractor services (subject to CCR, Title 22, Section 51309)
- Physical therapy
- Occupational therapy (subject to CCR, Title 22, Section 51309)
- Speech pathology (subject to CCR, Title 22, Section 51309)
- Audiology (subject to CCR, Title 22, Section 51309)

Dental Services

- Dental hygienist services

IHS-MOA Program

Types of Services Covered

- Physician services
- Physician assistant services
- Nurse practitioner services
- Nurse midwife services
- Visiting nurse services (if services are provided in the Tribal facilities)
- Clinical psychologist services (Interns must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws).
- Clinical social worker services (Interns must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws).
- Marriage and family therapist services (Interns must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws).
- Services and supplies incidental to physician services
- Comprehensive Perinatal Services Program (CPSP) services: registered nurse, dietitian, health educator, certified childbirth educator, licensed vocational nurse and comprehensive perinatal health worker, if the clinic has an approved application on file with the California Department of Public Health, Maternal, Child and Adolescent Health Division.
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services: licensed marriage, family and child counselors (available to persons younger than 21 years of age as another health visit if an EPSDT screening identified the need for a service necessary to correct or ameliorate a mental illness or condition)
- Medi-Cal ambulatory services
- Optometry
- Dental (For additional dental services information, refer to the *Indian Health Services (IHS) Memorandum of Agreement (MOA) 638, Clinics* section (ind health) of the Part 2 provider manual).
- End of life services

FQHC or RHC Medical Visits

A visit is a face-to-face encounter between a FQHC or RHC Medi-Cal recipient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, marriage and family therapist, acupuncturist or visiting nurse (as defined in CFR, Title 42, Section 405.2416), referred to as a "health professional," to the extent the services are reimbursable under the Medi-Cal State Plan.

Reimbursable Visit Criteria

Reimbursable Criteria Table

One Visit	Encounters with more than one health professional, or multiple encounters with the same health professional that take place on the same day, at a single location, constitute a single visit.
Two Visits	More than one visit may be counted on the same day (which may be at a different location) when a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment. When a patient receives CBAS services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day.

Coverage Limitations

FQHC/RHC providers may be reimbursed for up to:

- Two visits per day, per recipient, if one is a medical visit or mental health visit, and the other is a dental visit.

Note: For recipients who are enrolled in a dental Managed Care Plan in Sacramento County or Los Angeles County, dental services are billed with the Medi-Cal Managed Care Differential Billing Code set. For recipients not enrolled in a dental Managed Care Plan, a dental visit should be billed using per-visit local code 03.

These visits do not require medical justification in the *Remarks* field of the *UB-04* claim form.

- An additional visit is allowed if the recipient suffers illness or injury that requires a different health diagnosis or treatment from the original visit.

  Medical justification is required in the *Remarks* field.

Tribal FQHC Visit Defined

Tribal FQHC clinic encounter (visit) is defined as a face-to-face encounter between a tribal clinic patient and the health professional of the clinic.

Tribal FQHC Reimbursement Visit Criteria

Tribal FQHCs may be reimbursed for up to three visits per day, per recipient, in any combination of three different medical, mental health, dental and ambulatory services listed in the “Tribal FQHC Services Available” section in this manual. When billing for services rendered to Medi-Cal managed care members, and the services are covered by the Managed Care Plan (MCP), Tribal FQHC providers must bill the MCP. No differential billing is required. Reimbursement for services provided outside the clinic facility by clinic providers and contracted providers is allowable.

A visit with a CPSP support staff and/or a pregnancy-related physician encounter on the same day constitutes a single medical visit if the CPSP mental health visit was related to the pregnancy. If the other health visit is unrelated to the pregnancy, an additional visit is allowed and must be billed with the appropriate HIPAA-compliant billing code set.

Tribal FQHC reimbursement is based on Alternative Payment Methodology (APM), which is payable at the Federal IHS All-Inclusive Rate.

IHS-MOA Medical Visit

IHS-MOA clinics may be reimbursed for up to three visits a day for one recipient: a medical visit, a mental health visit and a Medi-Cal ambulatory/dental visit. A medical visit is a face-to-face encounter, occurring at a clinic or center between a recipient and physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse (if services are provided in the Tribal facilities.)

A visit with a CPSP support staff and/or a pregnancy-related physician encounter on the same day constitutes a single medical visit if the CPSP mental health visit was related to the pregnancy. If the other health visit is unrelated to the pregnancy, an additional visit is allowed and must be billed with the appropriate HIPAA-compliant billing code set.

When billing for services rendered to Medi-Cal managed care members, and the services are covered by the Managed Care Plan (MCP), IHS-MOA providers must bill the MCP. No differential billing is required.

Notes:

Treatment Authorization

A *Treatment Authorization Request* (TAR) is not required for services rendered by FQHC, RHC, Tribal FQHC or IHS-MOA providers, but the following conditions apply:

Conditions Table

FQHC and RHC	Providers must maintain the same level of documentation that is needed for authorization approval in the patient's medical record. DHCS A&I Division may recover reimbursements that do not meet the requirements under California Code of Regulations (CCR), Title 22, Section 51458.1, "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."
Tribal FQHC	Providers must maintain the same level of documentation that is needed for authorization approval in the patient's medical record. DHCS A&I Division may recover reimbursements that do not meet the requirements under California Code of Regulations (CCR), Title 22, Section 51458.1, "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."
IHS-MOA	Providers are required to meet the same documentation requirements that are necessary in a TAR for the same service under Medi-Cal. DHCS A&I Division may recover reimbursements that do not meet the requirements under CCR, Title 22, Section 51458.1, "Cause for Recovery for Provider Overpayments" and Section 51476, "Keeping and Availability of Records."

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

Comprehensive Perinatal Services Program (CPSP) Support Services and TARs

CPSP support services in excess of the basic allowances will not be denied for the absence of a TAR; however, the provider is required to maintain the same level of documentation required for authorization. DHCS A&I Division may recover reimbursements that do not meet the requirements under CCR, Title 22, Sections 51458.1 and 51476.

Required documentation includes:

- Expected date of delivery
- Clinical findings and high-risk factors involved in the pregnancy
- Explanation of why basic CPSP services are not sufficient
- Description of the services that are requested
- Anticipated benefit (or result) and outcome (or additional services)
- Length of the visit(s) and frequency with which the requested services were provided

The recipient’s medical records should be available for review by DHCS. Refer to the specific claim completion section in the appropriate Part 2 Medi-Cal provider manual for more instructions.

IHS-MOA: Medi-Cal Ambulatory Visit

A Medi-Cal ambulatory visit is a face-to-face encounter between an IHS-MOA recipient and a health care professional other than a physician or mid-level practitioner and is included in the Medi-Cal State Plan. This encounter must occur in an outpatient setting. Medi-Cal ambulatory visit services are reimbursed at the IHS-MOA all-inclusive rate and are as follows:

Medi-Cal Ambulatory Visit

Visit Type:	Subject to:
Acupuncture	CCR, Title 22, Section 51309
Audiology	CCR, Title 22, Section 51309
Chiropractic (Optional Benefit Exclusion: See the *Optional Benefits Exclusion* (opt ben exc) section of the Part 2 provider manual for more information about optional benefits).	CCR, Title 22, Section 51309
Occupational Therapy	CCR, Title 22, Section 51309
Physical Therapy	CCR, Title 22, Section 51309
Podiatry	None
Speech Pathology	CCR, Title 22, Section 51309
Drug and Alcohol Visits	CCR, Title 22, Section 51309
Dental	CCR, Title 22, Section 51309

Medi-Service Limitations

FQHC, RHC, IHS-MOA and Tribal FQHC

The following Medi-Services are services that are limited to a maximum of two services in any one calendar month or any combination of two services per month, although additional services can be provided based upon medical necessity. All services listed are subject to CCR, Title 22, Section 51309.

- Acupuncture
- Occupational Therapy
- Speech Therapy
- Audiology
- Chiropractor Services

Notes:

Dental Services

Dental services are a covered benefit for FQHC, RHC and IHS-MOA providers. FQHCs and RHCs may render dental services in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice, complies with the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances (*https://www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/Provider_Handbook),* and determined to be medically necessary pursuant to California *Welfare and Institutions Code* (W&I Code), Section 14059.5. Documentation should be consistent with the standards set forth in the Manual of Criteria for Medi-Cal Authorization of the Medi-Cal Dental Program Provider Handbook and all state laws. Dental services are payable using per-visit local code 03.

Claims submitted with per-visit local code 03 (dental services) may be submitted on the same claim form as other services billed with HIPAA-compliant billing code sets and informational lines.

Comprehensive Services for Pregnant Recipients

Comprehensive services for pregnant recipients, regardless of age, aid code and/or scope of benefits, are eligible to receive all dental procedures listed in the Denti-Cal Manual of Criteria (MOC) that are covered by the Medi-Cal program as long as all MOC procedure requirements and criteria are met. Recipients are also eligible to receive these services for 60 days postpartum, including any remaining days in the month in which the 60th day falls.

Community-Based Adult Services (CBAS) Visit

To qualify as a reimbursable Community-Based Adult Service (CBAS) visit, four or more hours of CBAS services must be provided per day. FQHCs and RHCs must render CBAS services according to the requirements of *Welfare and Institutions Code* (W&I Code), Section 14550.5 and CCR, Title 22, Sections 54001 through 54113. In addition, the FQHC or RHC providing care must have approval from the Federal Health Resources and Services Administration (HRSA) to provide the CBAS services, and then, only to the extent the CBAS services are included in the DHCS Medi-Cal State Plan.

Health Care Plans

1. FQHCs and RHCs must bill the appropriate Health Care Plan (HCP) when rendering services to HCP recipients.
2. Providers should contact the appropriate HCP for plan specific authorization and billing information.

FQHC Billing Instructions for Dual-Eligible Members

On October 1, 2014, the Affordable Care Act (ACA) mandated the transition from the Medicare FQHC cost-based reimbursement system to a new Medicare reimbursement methodology that is unique for each FQHC.

This new methodology may result in Medicare reimbursement for a given service that is greater or less than the current Medi-Cal Prospective Payment System (PPS) rate for the FQHC.

Consequently, a FQHC seeking reimbursement for services rendered to Medi-Cal recipients who are also covered by Medicare shall not bill Medi-Cal for Medicare cost-sharing amounts, or crossover reimbursements, when the Medicare reimbursement is equal to or exceeds the Medi-Cal PPS rate, for one of the following per-visit codes:

- Crossover claims
- Managed care differential rate
- Capitated Medicare Advantage plans

For IHS-MOA providers that participate in Medicare as a FQHC, this new methodology may result in a Medicare reimbursement for a given service that is greater or less than the current Medi-Cal IHS-MOA per-visit all-inclusive reimbursement rate (AIR). IHS-MOAs (if a Medicare FQHC) seeking reimbursement for services rendered to Medi-Cal recipients who are also covered by Medicare shall not bill Medi-Cal for Medicare cost-sharing amounts or crossover reimbursements when the Medicare reimbursement is equal to or exceeds the Medi-Cal IHS-MOA AIR.

Reconciliations

DHCS is required to perform an annual reconciliation of Managed Care, Medicare crossover and Medicare Advantage Plan visits to ensure the FQHC or RHC was paid an amount equal to its PPS rate. IHS-MOA providers are reimbursed an amount equal to the federal Indian Health Service AIR.

Crossover Claim and Managed Care Differential Rate billing code set rates may be adjusted to more accurately reflect the difference between the Medicare and HCP reimbursements and the PPS/IHS-MOA rate after A&I reviews the Reconciliation Request form.

Providers are notified when the *Annual Reconciliation Request* forms (DHCS 3097) are due 150 days after the providers' fiscal year ends and should be directed to the DHCS website for the most current forms and instructions. For additional questions, email *clinics@dhcs.ca.gov*.

Notes:

FQHC/RHC Services Billing Code Sets

Claims submitted with per-visit local code 03 (dental services) may be submitted on the same claim form as other services billed with HIPAA-compliant billing code sets and informational lines.

FQHC/RHC Services Billing Code Sets

National Code Description	Revenue Code	Procedure Code and Modifier
Medical, per visit	0521	T1015
Crossover claims New patient	0521	G0466
Crossover claims Established patient	0521	G0467
Crossover claims Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0521	G0468
Crossover claims Home visit New patient	0522	G0466

FQHC/RHC Services Billing Code Sets (continued)

National Code Description	Revenue Code	Procedure Code and Modifier
Crossover claims Home visit Established patient	0522	G0467
Crossover claims Home visit Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0522	G0468
Crossover claims Visit covered Part A stay at SNF New patient	0524	G0466
Crossover claims Visit covered Part A stay at SNF Established patient	0524	G0467
Crossover claims Visit (covered part A stay) at SNF Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0524	G0468
Crossover claims FQHC Visit (not covered Part A stay) at SNF New patient	0525	G0466

FQHC/RHC Services Billing Code Sets (continued)

National Code Description	Revenue Code	Procedure Code and Modifier
Crossover claims FQHC Visit (not covered Part A stay) at SNF Established patient	0525	G0467
Crossover claims FQHC Visit (not covered Part A stay) at SNF Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0525	G0468
Crossover claims FQHC Visiting nurse to home New patient	0527	G0466
Crossover claims FQHC Visiting nurse to home Established patient	0527	G0467
Crossover claims FQHC Visiting nurse to home IPPE or AWV	0527	G0468
Crossover claims Mental health visit New patient	0900	G0469
Crossover claims Mental health visit Established patient	0900	G0470

FQHC/RHC Services Billing Code Sets (continued)

National Code Description	Revenue Code	Procedure Code and Modifier
Clinic visit optometry Facility-specific all-inclusive rate New patient	0521	92004
Clinic visit optometry Facility-specific all-inclusive rate Established patient	0521	92014
Community-Based Adult Services (CBAS) Regular day of service	3103	Not Applicable
Community-Based Adult Services (CBAS) Initial assessment day (with subsequent attendance)	3101	99205
Community-Based Adult Services (CBAS) Initial assessment day (without subsequent attendance)	3101	T1015

FQHC/RHC Services Billing Code Sets (continued)

National Code Description	Revenue Code	Procedure Code and Modifier
Community-Based Adult Services (CBAS) Transition day	3103	T1023
Capitated Medicare Advantage Plans New patient	0529	G0466
Capitated Medicare Advantage Plans Established patient	0529	G0467
Capitated Medicare Advantage Plans Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0529	G0468
Capitated Medicare Advantage Plans Mental health New patient	0529	G0469
Capitated Medicare Advantage Plans Mental health Established patient	0529	G0470

Notes:

Tribal FQHC Billing Code Sets

Please use the following HIPPA-compliant billing code sets unless otherwise advised by the Managed Care Plan (MCP). For managed care billing codes, please contact the MCP directly.

Claims submitted with per-visit local code 03 (dental services) may be submitted on the same claim form as other services billed with HIPAA-compliant billing code sets and informational lines.

Tribal FQHC Billing Code Sets Table

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Medical visit	0520	T1015
Mental health visit Psychiatrist	0561	T1015 AG
Mental health visit Clinical social worker	0561	T1015 AJ
Mental health visit Marriage and family therapist	0561	T1015 HR
Mental health visit Clinical psychologist	0561	T1015 AH
Ambulatory visit, optometry services, per visit New patient	0520	92004
Ambulatory visit, optometry services, per visit Established patient	0520	92014
Ambulatory visit Physical therapy	0420	T1015
Ambulatory visit Occupational therapy	0430	T1015

Tribal FQHC Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Speech pathology	0440	T1015
Ambulatory visit Audiology	0470	T1015
Ambulatory visit Podiatry	0510	T1015
Ambulatory visit Chiropractic manipulative treatment, spinal one or two regions See the *Chiropractic Services* section in the *Allied Health – Chiropractic* section of the appropriate Part 2 manual for complete policy details.	0940	98940
Ambulatory visit Chiropractic manipulative treatment, spinal three or four regions See the *Chiropractic Services* section in the *Allied Health – Chiropractic* section of the appropriate Part 2 manual for complete policy details.	0940	98941

Tribal FQHC Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Chiropractic manipulative treatment, spinal five regions See the *Chiropractic Services* section in *the Allied Health – Chiropractic* section of the appropriate Part 2 manual for complete policy details.	0940	98942
Ambulatory visit Acupuncture, one or more needles, without electrical stimulation, initial 15-minute service	2101	97810
Ambulatory visit Acupuncture, one or more needles, without electrical stimulation, each additional 15-minute service	2101	97811
Ambulatory visit Acupuncture, one or more needles, with electrical stimulation, initial 15-minute service	2101	97813
Ambulatory visit Acupuncture, one or more needles, with electrical stimulation, each additional 15-minute service	2101	97814
End of Life Option Act	0520	S0257
Capitated Medicare Advantage Plans New patient	0529	G0466

Tribal FQHC Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Capitated Medicare Advantage Plans Established patient	0529	G0467
Capitated Medicare Advantage Plans Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0529	G0468
Capitated Medicare Advantage Plans Mental health visit, new patient	0529	G0469
Capitated Medicare Advantage Plans Mental health visit, established patient	0529	G0470
Crossover claims New patient	0520	G0466
Crossover claims Established patient	0520	G0467
Crossover claims Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0520	G0468
Crossover claims Mental health visit New patient	0900	G0469
Crossover claims Mental health visit Established patient	0900	G0470

IHS-MOA Services Billing Code Sets

Claims submitted with local per-visit code 03 (dental services) may be submitted on the same claim form as other services billed with HIPAA-compliant billing code sets and informational lines.

IHS-MOA Billing Code Sets Table

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Medical, per visit	0520	T1015
Crossover claims New Patient	0520	G0466
Crossover claims Established patient	0520	G0467
Crossover claims Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0520	G0468
Crossover claims Mental health visit New patient	0900	G0469
Crossover claims Mental health visit Established patient	0900	G0470
Optometry services, per visit New patient	0520	92004
Optometry services, per visit Established patient	0520	92014
Capitated Medicare Advantage Plans New patient	0529	G0466

IHS-MOA Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Capitated Medicare Advantage Plans Established patient	0529	G0467
Capitated Medicare Advantage Plans Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0529	G0468
Capitated Medicare Advantage Plans Mental health visit New patient	0529	G0469
Capitated Medicare Advantage Plans Mental health visit Established patient	0529	G0470
Mental health visit Psychiatrist	0561	T1015 AG
Mental health visit Clinical psychologist	0561	T1015 AH
Mental health visit Licensed Clinical social worker	0561	T1015 AJ
Mental health visit Marriage and Family Therapist	0561	T1015 HR
Ambulatory visit Physical therapy	0420	T1015
Ambulatory visit Occupational therapy	0430	T1015
Ambulatory visit Speech pathology	0440	T1015

IHS-MOA Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Audiology	0470	T1015
Ambulatory visit Podiatry	0510	T1015
Ambulatory visit Drug and alcohol	0520	H0047
Ambulatory visit Chiropractic manipulative treatment, spinal, one to two regions Optional Benefit Exclusion: See the *Optional Benefits Exclusion* (opt ben exc) section of the Part 2 provider manual for more information about optional benefits).	0940	98940
Ambulatory visit Chiropractic manipulative treatment, spinal, three to four regions Optional Benefit Exclusion: See the *Optional Benefits Exclusion* (opt ben exc) section of the Part 2 provider manual for more information about optional benefits).	0940	98941
Ambulatory visit Chiropractic manipulative treatment, spinal, five regions Optional Benefit Exclusion: See the *Optional Benefits Exclusion* (opt ben exc) section of the Part 2 provider manual for more information about optional benefits).	0940	98942
Ambulatory visit Acupuncture one or more needles Without electrical stimulation, initial 15-minute service	2101	97810

IHS-MOA Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Acupuncture one or more needles, Without electrical stimulation, each additional 15-minute service	2101	97811
Ambulatory visit Acupuncture one or more needles With electrical stimulation, initial 15-minute service	2101	97813
Ambulatory visit Acupuncture one or more needles With electrical stimulation, each additional 15-minute service	2101	97814

Notes:

COVID-19 Telephonic Communications for FQHC/RHC, Tribal FQHC and IHS-MOA Billing Requirements

In response to the coronavirus disease 2019 (COVID-19) public health emergency, the Department of Health Care Services (DHCS) has instituted **temporary** policies and procedures which are distinct from the Medicaid State Plan.

Effective for dates of service on or after March 1, 2020, **HCPCS code G0071** is reimbursable for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication, between a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) practitioner and RHC or FQHC patient, occurring in lieu of a visit *that does not meet the criteria of a face-to-face visit and results in a determination that a face-to-face visit is unnecessary.* The change also pertains to Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics and Tribal FQHCs (see the following exceptions).

- Service is only reimbursable when initiated by the patient contacting the RHC, FQHC, Tribal FQHC or IHS-MOA Clinic
- Service is only reimbursable when billed as an outpatient service on the *UB-04* claim form
- Service is only reimbursable per patient per day
- A *Treatment Authorization Request* (TAR) is not required
- Clinics can bill directly to Medi-Cal for Managed Care Plan (MCP) covered beneficiaries unless telehealth or virtual communication services are otherwise agreed to between the MCP and the provider. The MCPs must reimburse Medi-Cal providers at the same rate
- For the Medi-Cal fee-for-service rate when billing HCPCs code G0071, clinics should only list the HCPCs code on the “payable” claim line and should not include a corresponding CPT code
- Other Health Coverage (OHC) will apply

Note: HCPCS Code G0071 is not covered by any Service Code Grouping (SCG) authorization, including SCG 08. FQHC/RHC and IHS-MOA providers should submit a separate Service Authorization Request (SAR) and all supporting documentation when requesting G0071.

An Erroneous Payment Correction (EPC) will be implemented to reprocess affected claims.

IHS-MOA will bill the Fiscal Intermediary (FI) for HCPCS code G0071 for Medi-Cal and MCP beneficiaries.

Additional billing instructions for HCPCS code G0071 can be found on the HIPAA: FQHC/RHC/IHS-MOA Code Conversion page on the Medi-Cal Providers website.

Additional service requirements relative to this service may be found on the DHCS website: Telehealth Other Virtual Telephonic Communications.

COVID-19 related guidance is located on the COVID-19 Medi-Cal Response page on the Medi-Cal Providers website.

COVID-19 Vaccine Administration for FQHC, RHC and Tribal FQHC Providers

Effective retroactively for dates of service on or after the respective dates for each approved COVID-19 vaccine, FQHC, RHC and Tribal FQHC providers, may receive reimbursement for administration of the COVID-19 vaccines during vaccine-only encounters.

Vaccine-only encounters are visits where the administration of the vaccine does not otherwise meet the criteria for a qualifying office visit. These vaccine-only encounters are not reimbursable at the Prospective Payment System (PPS) rate for FQHC/RHC providers, nor the Alternative Payment Methodology (APM) for Tribal FQHC providers.

Reimbursement

FQHC, RHC, and Tribal FQHC providers may receive reimbursement up to a maximum allowable rate of $67.00 for COVID-19 vaccines administered during a vaccine-only encounter. FQHC, RHC and Tribal FQHC providers should refer to the webpages below on the Medi-Cal Providers website for billing guidance and effective dates for each vaccine and dose:

- Pfizer-BioNTech COVID-19 Vaccine
- Moderna COVID-19 Vaccine
- Janssen COVID-19 Vaccine

Claims submitted for COVID-19 vaccine-only encounters do not currently require revenue codes for reimbursement and utilize the appropriate CPT code for the vaccine manufacturer and dose provided.

Medi-Cal Managed Care Billing Code Services

Medi-Cal Managed Care Billing – FQHC/RHC Providers

Managed Care Code Sets (Enrolled Recipients)

FQHC/RHC providers should use the following code set when billing for services rendered to Medi-Cal Managed Care Plan enrollees and the service is covered by the plan, including dental services for recipients enrolled in a dental Managed Care Plan (applicable to Sacramento County and Los Angeles County only).

Enrolled Recipients Table

National Code Descriptions	Revenue Code	Procedure Code and Modifier
Managed care differential rate, covered by Managed Care Plan and rendered to recipients enrolled in Medi-Cal managed care plans and dental Managed Care Plans	0521	T1015 SE

Medi-Cal Managed Care Billing – IHS-MOA Providers

Managed Care Code Sets (Enrolled Recipients)

When billing for services rendered to Medi-Cal managed care members, and the services are covered by the Managed Care Plan (MCP), IHS-MOA providers must bill the MCP. No differential billing to Medi-Cal is required.

Notes:

_____

_____

_____

_____

Informational Lines

Informational lines should be included when billing for FQHC/RHC/IHS-MOA services.

An informational line is an associated line item or line items listed immediately following the HIPAA-compliant billing code set used to bill the face-to-face encounter with the recipient. Informational lines contain only the specific CPT-4 Level I or HCPCS Level II code(s) which identifies the actual service(s) provided and **are not separately reimbursed.** When submitting informational lines, providers should remember the following:

- The *Revenue Code* field (Box 42) on the information claim detail line must be a 4-digit revenue code. Blank (spaces) and zeros are accepted for Computer Media Claims (CMC).
- The *Service Date* field (Box 45) is optional.
- The *Service Units* field (Box 46) on the informational line may contain the number of service units provided for the procedure code or may be zeroes.
- The *Total Charges* field (Box 47) for each informational line must always be zeroes on paper claim forms; blank (spaces) or zeroes are accepted in the *Total Charges* field for CMC.

For additional CMC billing instructions, refer to the CMC Technical Manual.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0520	MEDICAL VISIT	T1015	100120	1	100 00		
2	0520		80018	100120	00	0 00		
3	0520		99213	100120	00	0 00		
4	0520	OPTOMETRY	92004	100120	1	200 00		
5	0520		92002	100120	00	0 00		

Example: Billing a HIPAA-Compliant Billing Code Set with Informational Lines

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

When billing an electronic (CMC) claim, if the addition of informational lines causes the claim to exceed 22 lines, the claim must be split, and services billed on separate claims. Electronic claims that exceed 22 claim lines with informational lines will be denied in their entirety.

Test Medi-Cal CMC submissions to ensure accurate file format, completeness and validity for HIPAA-related compliant claims transactions by logging into the Medi-Cal test site (sysdev.medi.cal.ca.gov) using submitter ID and password.

A new claims submission test must be submitted when software is upgraded, or the submission method changes for CMC.

Report any testing issues to the CMC Help Desk at 1-800-541-5555 and select the option Point of Service (POS), internet, Laboratory Services Reservation System (LSRS) and CMC inquiries

Managed Care Differential Rate Billing Scenario

FQHC/RHC Providers

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

John Doe visited a Rural Health Clinic for evaluation of his recent chest pain. He is enrolled in a Medi-Cal Managed Care Plan (MCP) and the service is covered under the plan. The RHC bills the MCP for the encounter and submits a claim to Medi-Cal for the managed care differential rate, with revenue code 0521, procedure code with modifier T1015SE and an informational line specific to his visit, which in this case is procedure code 99214.

This code set is used for FQHC/RHC providers.

Notes:

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL #

b. MED. REC. #

4 TYPE OF BILL: 711

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a

b DOE, JOHN

9 PATIENT ADDRESS a b c d e

10 BIRTHDATE: 08241980

11 SEX: M

12 DATE / ADMISSION 13 HR 14 TYPE 15 SRC / 16 DHR / 17 STAT / CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 / 29 ACDT STATE / 30

31 OCCURRENCE CODE DATE / 32 OCCURRENCE CODE DATE / 33 OCCURRENCE CODE DATE / 34 OCCURRENCE CODE DATE / 35 OCCURRENCE SPAN CODE FROM THROUGH / 36 OCCURRENCE SPAN CODE FROM THROUGH / 37

38

39 VALUE CODES CODE AMOUNT / 40 VALUE CODES CODE AMOUNT / 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0521	MANAGED CARE DIFFERENTIAL RATE	T1015 SE	100120	1	45 00		
2	0521		99214	100120	00	0 00		
23	001	PAGE ___ OF ___	CREATION DATE		TOTALS	45 00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789
A	O/P MEDI-CAL					45 00	57
B							OTHER
C							PRV ID

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			90000000A95001		
B					
C					

63 TREATMENT AUTHORIZATION CODES / 64 DOCUMENT CONTROL NUMBER / 65 EMPLOYER NAME

66 DX: D1D1D1D

0

67 A B C D E F G H / I J K L M N O P Q / 68

69 ADMIT DX / 70 PATIENT REASON DX a b c / 71 PPS CODE / 72 ECI a b c / 73

74 PRINCIPAL PROCEDURE CODE DATE / a. OTHER PROCEDURE CODE DATE / b. OTHER PROCEDURE CODE DATE / 75

c. OTHER PROCEDURE CODE DATE / d. OTHER PROCEDURE CODE DATE / e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI 1234567890 QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS

81CC a b c d

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Example: Billing Managed Care Differential Rate Code Sets for FQHC/RHC.

Resource Information

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

OBRA and IRCA (obra)

Part 2

Community-Based Adult Services (CBAS) (community)

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics (ind health)

Medicare/Medi-Cal Crossover Claims: Outpatient Services (medi cr op)

Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples (medi cr op ex)

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

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

Tribal Federally Qualified Health Centers (Tribal FQHCs) Tribal FQHCs

Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes Tribal FQHCs cd

Appendix

Acronyms

Acronym	Description
A&I	Audits and Investigations
ADHC	Adult Day Health Care
AEVS	Automated Eligibility Verification System
BIC	Benefits Identification Card
CCR	California Code of Regulations
CCS	California Children's Services
CFR	Code of Federal Regulations
CHDP	Child Health and Disability Prevention
CHIP	Children's Health Insurance Program
CIN	Client Index Number
CMC	Computer Media Claims
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
FQHC	Federally Qualified Health Center
FRADS	Federally Required Adult Dental Services
HCP	Health Care Plan
HMO	Health Maintenance Organization
IHS/MOA	Indian Health Services, Memorandum of Agreement
LCSW	Licensed Clinical Social Worker

Acronym	Description
LTC	Long Term Care
MFCC	Marriage, Family and Child Counselor
MRMIB	Managed Risk Medical Insurance Board
MRN	Medical Remittance Notice
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NPI	National Provider Identifier
OBRA	Omnibus Budget Reconciliation Act
PCC	Primary Care Clinic
PHP	Prepaid Health Plan
PHS	Public Health Service
POE	Proof of Eligibility
POS	Point of Service
PPS	Prospective Payment System
RA	Remittance Advice
RAD	Remittance Advice Details
RHC	Rural Health Clinic
RTD	Resubmission Turnaround Document
SMA	Schedule of Maximum Allowance
SOC	Share of Cost
TAR	Treatment Authorization Request
TCN	TAR Control Number
THP	Tribal Health Program
W&I	Welfare and Institutions

Page updated: October 2020

Enter Notes Here