

Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)

(Rev. 12-06-17)

In accordance with Section 1834(o)(1)(A) and 1834(o)(2)(C) of the Social Security Act, we established specific payment codes that FQHCs must use when submitting a claim for FQHC services for payment under the FQHC PPS. Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other FQHC services furnished during the encounter are also required.

FQHC Visits

A FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between a FQHC patient and a FQHC practitioner during which time one or more FQHC services are furnished. A FQHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW), or a certified diabetes self-management training/medical nutrition therapy (DSMT/MNT) provider.

A FQHC visit can also be a visit between a home-bound patient and a RN or LPN under certain conditions. Outpatient DSMT/MNT, and transitional care management (TCM) services also may qualify as a FQHC visit when furnished by qualified practitioners and the FQHC meets the relevant program requirements for provision of these services. If these services are furnished on the same day as an otherwise billable visit, only one visit is payable.

The PPS is designed to reflect the cost for all the services associated with a comprehensive primary care visit, even if not all the services occur on the same day. Stand-alone billable visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. The professional component of a procedure is usually a covered service, but is not a stand-alone billable visit, even when furnished by a FQHC practitioner.

To qualify for Medicare payment, all the coverage requirements for a FQHC visit must be met. A FQHC visit must be furnished in accordance with the applicable regulations at 42 CFR Part 405 Subpart X, including 42 CFR 405.2463 that describes what constitutes a visit. For additional information on FQHC policies and requirements, see CMS Pub 100-02, Chapter 13, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>.

Effective January 1, 2016 *through December 31, 2017* CPT code 99490 (chronic care management *CCM*) is paid based on the PFS non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a FQHC claim. When reporting this service as a stand-alone billable visit a FQHC payment code is not required. *Service lines reported with CPT code 99490 will be denied for dates of service on or after January 1, 2018.*

Effective January 1, 2018 HCPCS code G0511 is reported for CCM or general Behavioral Health Integration (BHI). Payment is set annually at the average of the national non-facility PFS payment

rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services). When reporting HCPCS code G0511 as a stand-alone billable visit a FQHC payment code is not required.

Effective January 1, 2018 HCPCS code G0512 is reported for psychiatric Collaborative Care Model (CoCM) services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services). When reporting HCPCS code G0512 as a stand-alone billable visit a FQHC payment code is not required.

Specific Payment Codes

Following are the specific payment codes and the appropriate descriptions of services that correspond to these payment codes. FQHCs must use these codes when submitting claims to Medicare under the FQHC PPS:

G0466 – FQHC visit, new patient

A medically-necessary, face-to-face (one-on-one) encounter between a new patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services. A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.

To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”

If a new patient is also receiving a mental health visit on the same day, the patient is considered “new” for only one of these visits, and FQHCs should use G0466 to bill for the medical visit and G0470 to bill for the mental health visit.

Additional information on new patient determinations is available on the CMS FQHC PPS website (<http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.htm>) under “Frequently Asked Questions” (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf>).

G0467 – FQHC visit, established patient

A medically-necessary, face-to-face (one-on-one) encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services. An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.

To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”

If an established patient is also receiving a mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit.

G0468 – FQHC visit, IPPE or AWW

A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWW, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467.

G0469 – FQHC visit, mental health, new patient

A medically-necessary, face-to-face (one-on-one) mental health encounter between a new patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving a mental health visit.

A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.

To qualify as a FQHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy. If a new patient is receiving both a medical and mental health visit on the same day, the patient is considered “new” for only one of these visits, and FQHCs should not use G0469 to bill for the mental health visit; instead, FQHCs should use G0466 to bill for the medical visit and G0470 to bill for the mental health visit.

G0470 – FQHC visit, mental health, established patient

A medically-necessary, face-to-face (one-on-one) mental health encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving a mental health visit. An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.

If an established patient is receiving both a medical and mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit.

To qualify as a FQHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy.

Adjustments Applicable to Specific Payment Codes¹

¹ This section does not apply to grandfathered tribal FQHCs

New Patient Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC. For medical visits, use G0466 only if the beneficiary is new to the FQHC or any of its sites for any professional services. For mental health visits, use G0469 only if the beneficiary is new to the FQHC or any of its sites for any professional services.

IPPE and AWW Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary. A FQHC that furnishes an IPPE or AWW would include all medical services in G0468. FQHCs would not bill G0466 or G0467 on the same day, unless there was a subsequent illness or injury that would qualify for additional payment, which the FQHC would attest to by submitting the claim with modifier 59.

Qualifying Visits

The qualifying visits that correspond to the specific payment codes are as follows:

G0466 - FQHC visit, new patient

| HCPCS | Qualifying Visits for G0466 |
|--------------|------------------------------------|
| 92002 | Eye exam new patient |
| 92004 | Eye exam new patient |
| 97802 | Medical nutrition indiv in |
| 99201 | Office/outpatient visit new |
| 99202 | Office/outpatient visit new |
| 99203 | Office/outpatient visit new |
| 99204 | Office/outpatient visit new |
| 99205 | Office/outpatient visit new |
| 99304 | Nursing facility care init |
| 99305 | Nursing facility care init |
| 99306 | Nursing facility care init |
| 99324 | Domicil/r-home visit new pat |
| 99325 | Domicil/r-home visit new pat |
| 99326 | Domicil/r-home visit new pat |
| 99327 | Domicil/r-home visit new pat |
| 99328 | Domicil/r-home visit new pat |
| 99341 | Home visit new patient |
| 99342 | Home visit new patient |
| 99343 | Home visit new patient |
| 99344 | Home visit new patient |
| 99345 | Home visit new patient |
| 99406 | Behav chng smoking 3-10 min |
| 99407 | Behav chng smoking > 10 min |
| 99497 | Advncd care plan 30 min |
| G0101 | Ca screen; pelvic/breast exam |
| G0102 | Prostate ca screening; dre |
| G0108 | Diab manage trn per indiv |

HCPCS Qualifying Visits for G0466

| | |
|-------|---------------------------------|
| G0117 | Glaucoma scrn hgh risk direc |
| G0118 | Glaucoma scrn hgh risk direc |
| G0296 | Visit to determ LDCT elig |
| G0442 | Annual alcohol screen 15 min |
| G0443 | Brief alcohol misuse counsel |
| G0444 | Depression screen annual |
| G0445 | High inten beh couns std 30 min |
| G0446 | Intens behave ther cardio dx |
| G0447 | Behavior counsel obesity 15 min |
| G0490 | Home visit RN, LPN by RHC/FQ |
| Q0091 | Obtaining screen pap smear |

G0467 – FQHC visit, established patient:

HCPCS Qualifying Visits for G0467

| | |
|-------|-------------------------------|
| 92012 | Eye exam establish patient |
| 92014 | Eye exam & tx estab pt 1/>vst |
| 97802 | Medical nutrition indiv in |
| 97803 | Med nutrition indiv subseq |
| 99212 | Office/outpatient visit est |
| 99213 | Office/outpatient visit est |
| 99214 | Office/outpatient visit est |
| 99215 | Office/outpatient visit est |
| 99304 | Nursing facility care init |
| 99305 | Nursing facility care init |
| 99306 | Nursing facility care init |
| 99307 | Nursing fac care subseq |
| 99308 | Nursing fac care subseq |
| 99309 | Nursing fac care subseq |
| 99310 | Nursing fac care subseq |
| 99315 | Nursing fac discharge day |
| 99316 | Nursing fac discharge day |
| 99318 | Annual nursing fac assessmnt |
| 99334 | Domicil/r-home visit est pat |
| 99335 | Domicil/r-home visit est pat |
| 99336 | Domicil/r-home visit est pat |
| 99337 | Domicil/r-home visit est pat |
| 99347 | Home visit est patient |
| 99348 | Home visit est patient |
| 99349 | Home visit est patient |
| 99350 | Home visit est patient |
| 99406 | Behav chng smoking 3-10 min |
| 99407 | Behav chng smoking > 10 min |

HCPCS Qualifying Visits for G0467

99495 Trans care mgmt 14 day disch
99496 Trans care mgmt 7 day disch
99497 Advncd care plan 30 min
G0101 Ca screen; pelvic/breast exam
G0102 Prostate ca screening; dre
G0108 Diab manage trn per indiv
G0117 Glaucoma scrn hgh risk direc
G0118 Glaucoma scrn hgh risk direc
G0270 Mnt subs tx for change dx
G0296 Visit to determ LDCT elig
G0442 Annual alcohol screen 15 min
G0443 Brief alcohol misuse counsel
G0444 Depression screen annual
G0445 High inten beh couns std 30 min
G0446 Intens behave ther cardio dx
G0447 Behavior counsel obesity 15 min
G0490 Home visit RN, LPN by
RHC/FQ
Q0091 Obtaining screen pap smear

G0468 – FQHC visit, IPPE or AWW:

HCPCS Qualifying Visits for G0468

G0402 Initial preventive exam
G0438 Ppps, initial visit
G0439 Ppps, subseq visit

G0469 – FQHC visit, mental health, new patient:

HCPCS Qualifying Visits for G0469

90791 Psych diagnostic evaluation
90792 Psych diag eval w/med srvcs
90832 Psytx pt &/family 30 minutes
90834 Psytx pt &/family 45 minutes
90837 Psytx pt &/family 60 minutes
90839 Psytx crisis initial 60 min
90845 Psychoanalysis

G0470 – FQHC visit, mental health, established patient:

HCPCS Qualifying Visits for G0470

90791 Psych diagnostic evaluation
90792 Psych diag eval w/med srvcs
90832 Psytx pt &/family 30 minutes

HCPCS Qualifying Visits for G0470

90834 Psytch pt &/family 45 minutes

90837 Psytch pt &/family 60 minutes

90839 Psytch crisis initial 60 min

90845 Psychoanalysis

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