



## Federally Qualified Health Center



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## What's Changed?

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- Added marriage and family therapists and mental health counselors as practitioners (page 4)
- Added services (pages 5, 9)
- Updates to mental health in-person visit rules (page 5)
- COVID-19 and other vaccine billing instructions (page 9)

Substantive content changes are in dark red.

Federally Qualified Health Centers (FQHCs) are safety net providers that give services in an outpatient clinic setting. Section 1861(aa) of the [Social Security Act](#) allows additional FQHC Medicare payments.

FQHCs may be in rural or urban areas and include:

- Community health centers
- Migrant health centers
- Homeless health centers
- Public housing primary care centers
- Health center program “look-alikes”
- Outpatient health programs or facilities operated by a tribe or tribal organization or an urban Indian organization

**Note:** The information in this publication may not apply to [Grandfathered Tribal FQHCs](#).

Together we can advance health equity and help eliminate health disparities in rural communities, territories, Tribal nations, and geographically isolated communities. Find these resources and more from the [CMS Office of Minority Health](#):

- [Rural Health](#)
- [CMS Framework for Rural, Tribal, and Geographically Isolated Areas](#)
- [Data Stratified by Geography \(Rural/Urban\)](#)
- [Health Equity Technical Assistance Program](#)

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View [infectious diseases](#) for a list of waivers and flexibilities that were in place during the PHE.

## Practitioners

You and your staff must comply with all licensure and certification laws and regulations. We pay FQHCs based on the [FQHC Prospective Payment System](#) (PPS) for medically necessary, primary health services, and qualified preventive health services from an FQHC practitioner, including:

- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- **Marriage and family therapists (MFTs)**
- **Mental health counselors (MHCs)**



## FQHC Patient Services

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FQHCs provide:

- Physician services.
- Services and supplies [incident to](#) physician services like taking blood pressure or administering shots.
- Services and supplies incident to NP, PA, CNM, CP, CSW, MHC, and MFT services.
- Medicare Part B-covered drugs supplied incident to FQHC practitioner services.
- Medicare patient homebound visiting nurse services when a registered nurse (RN) or licensed practical nurse (LPN) provides them in an area we certify as having a shortage of home health agencies. [Check eligibility](#) before providing visiting nurse services to make sure the patient isn't already under a home health plan of care.
- Outpatient [diabetes self-management training](#) (DSMT) and [medical nutrition therapy](#) (MNT) from qualified DSMT and MNT practitioners in a 1-on-1, face-to-face visit for patients with diabetes or renal disease.
- Certain care management services like [transitional care management](#) (TCM), [chronic care management](#) (CCM), general [behavioral health integration](#) (BHI), principal care management (PCM), chronic pain management (CPM) and psychiatric collaborative care model (CoCM) services.
- **Effective January 1, 2024, remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI), principal illness navigation (PIN) and PIN-Peer Support (PIN-PS) are payable by billing the general care management code, G0511.**
- [Virtual communication services](#) like communication-based technology and remote evaluation services.
- Mental health services using [telehealth](#). **Effective January 1, 2022, you may provide mental health visits using interactive, real-time telecommunications technology. Section 4113 of the [Consolidated Appropriations Act](#) (CAA), 2023, delayed the in-person visit requirements under Medicare for mental health visits that FQHCs provide via telecommunications technology. In-person visits won't be required until January 1, 2025.**
- Hospice attending physician services from an FQHC physician, NP, or PA employed or working under contract for an FQHC, instead of employed by a hospice program. During a hospice election, attending physician services can take place at the patient's home, a Medicare-certified hospice freestanding facility, skilled nursing facility (SNF), or hospital.
- **Intensive outpatient program (IOP) services provide treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a partial hospitalization program. See CR 13496 for details.**

## Certification

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To qualify as an FQHC, you must meet 1 of these requirements:

- Get a grant under Section 330 of the [Public Health Service \(PHS\) Act](#) or be funded by the same grant contracted to the recipient
- Get a grant as an FQHC "look-alike" based on a [Health Resources & Services Administration](#) (HRSA) recommendation

- Be treated by the HHS Secretary as a comprehensive federally funded health center since January 1, 1990, under Part B
- Operate as an outpatient health program or tribe or tribal organization facility under the [Indian Self-Determination Act](#) or as an urban Indian organization getting funds under [Title V of the Indian Health Care Improvement Act](#)

Health Center Program look-alikes are HRSA-designated health centers that provide comprehensive, culturally competent, high-quality primary health care services while meeting all [Health Center Program requirements](#), but they don't receive federal award funding.

FQHC certification requires you meet these requirements:

- Provide comprehensive services, including an ongoing quality assurance program and an annual review
- Meet all health and safety requirements
- Not be approved as a [rural health clinic](#) (RHC)
- Meet **all** Section 330 of the PHS Act requirements, including:
  - Serve a designated medically underserved area (MUA) or medically underserved population (MUP)
  - Offer people with incomes below 200% of the federal poverty guidelines a sliding fee scale
  - Be governed by a board of directors, where most members get care at the FQHC

## Visits

FQHC visits **must**:

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC where the practitioner provides 1 or more qualified FQHC services
- Include a registered nurse or licensed practical nurse homebound patient visit in certain limited situations
- Meet certain conditions when a qualified practitioner offers outpatient DSMT or MNT services and the FQHC meets the requirements to provide these services

FQHC visits **can** take place at:

- An FQHC
- A patient's home, including an assisted living facility
- A Medicare-covered Part A SNF
- The scene of an accident
- A hospice facility (when an FQHC physician, NP, or PA who's employed or working under contract for an FQHC but isn't employed by a hospice program provides them)



FQHC visits **can't** take place at:

- An inpatient or outpatient hospital department, including a [critical access hospital](#) (CAH)
- A facility with specific requirements excluding FQHC visits

### Multiple Visits on the Same Day

Visits with more than 1 FQHC practitioner on the same day, or multiple visits with the same FQHC practitioner on the same day, count as a single visit, except when a patient:

- Returns to the FQHC to diagnose or treat an injury or illness that happened after the initial visit (for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the FQHC)
- Has a qualified medical and mental health visit on the same day
- Has IOP services on the same day with a medical visit

## Payments

- FQHC claims must include an FQHC payment code.
- We pay claims at 80% of the lesser of the FQHC charges or the FQHC PPS rate for the specific payment code, which is the national encounter-based rate with geographic and other adjustments.
- We annually update the FQHC PPS base payment rate using the FQHC market basket.
- Coinsurance is 20% of the lesser of the FQHC charges or the PPS rate for the specific payment code, except for certain preventive services. We waive the [Part B coinsurance and deductible](#) for certain preventive services, including specific [Medicare Wellness Visits](#).
- Effective January 1, 2024, payment for social determinants of health (SDOH) risk assessments (G0136), which you must provide in conjunction with a qualifying visit, including an evaluation and management (E/M) visit or the Annual Wellness Visit (AWV) and is included in the payment for the visit. When you provide SDOH services with the AWV, there's no patient cost sharing. When provided with other visits, cost sharing does apply.

Visit the [FQHC Center](#) for more information on PPS rates.

### Payment Adjustments

These adjustments apply to the FQHC PPS base payment rate:

- FQHC geographic adjustment factor
- New patient adjustment
- Initial preventive physical exam (IPPE) or AWV adjustment



## Charges & Payment

FQHCs set their own service charges and decide which services to include with each FQHC G code. Patient charges must be uniform.

The FQHC Center has more information about submitting claims with FQHC PPS payment codes and lists of billable visits.

We'll pay for:

- Professional services only.
- Lab tests, excluding venipuncture, and the technical component of billable visits separately.
- Billable procedures that aren't separately in the payment of an otherwise qualified visit. If a procedure is associated with a qualified visit, include procedure charges on the visit's claim.

## Cost Reports

FQHCs must file an annual cost report that includes graduate medical education adjustments, bad debt, flu and pneumococcal shots, and your administration payments. Use [FQHC Cost Report Form \(CMS-224-14\)](#) to determine your payment rate and reconcile interim payments.

- See [Telehealth](#) to learn more about reporting telehealth costs
- See the [Provider Reimbursement Manual – Part 2](#) for more cost reports and forms information

## Care Management Services

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- Effective January 1, 2024, we pay general care management services at the weighted average for the **national non-facility Physician Fee Schedule (PFS) payment rate by taking the utilization of the base code for the services provided and any applicable add-on codes** when general care management HCPCS code G0511 is on an FQHC claim, either alone or with other payable services, which is updated annually based on these codes' PFS amounts.
- You can bill TCM services with other care management services, starting January 1, 2022.
- The 20% coinsurance is the lesser of submitted charges or G0511's payment rate for general care management services.
- You can report care management costs in the cost report's non-reimbursable section and these costs are not taken into account under the FQHC PPS.
- **Don't** include administrative activities like transcription or translation services.
- RHCs and FQHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below as long as they've met all requirements and there isn't double counting. For example, RHCs and FQHCs can bill HCPCS code G0511 twice for 20 minutes of qualifying CCM services and 30 minutes of qualifying PCM services, as long as the clinical staff minutes don't overlap.



General Care Management Services	HCPSC/CPT Codes
CCM	99487, 99490, 99491
PCM	99424, 99426
CPM	G3002
General BHI	99484
RPM	99453, 99454, 99457, 99091
RTM	98975, 98976, 98977, 98980
CHI	G0019
PIN	G0023
PIN-PS	G0140

**Note:** The table doesn't include add-on code pairs or codes that describe additional minutes. These codes were only used to calculate the weighted average payment rate for HCPCS code G0511.

### Psychiatric CoCM

- We pay at the national non-facility PFS payment rate for CPT code 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when HCPCS code G0512 is on an FQHC claim either alone or with other payable services
- You must provide at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services to bill for this service
- 20% coinsurance is the lesser of submitted charges or G0512's payment rate for care management services coinsurance
- You can report care management costs in the cost report's non-reimbursable section and these costs aren't taken into account under the FQHC PPS
- You can bill G0512 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services, and your services meet all other requirements
  - You can count only FQHC practitioner or auxiliary personnel services within the scope of service elements toward the 60-minute psychiatric CoCM billing minimum
  - **Don't** include administrative activities like transcription or translation services

### Flu, Pneumococcal, and COVID-19 Shots

Influenza virus, pneumococcal, and COVID-19 vaccines don't count as FQHC visits. The cost for these vaccine products and the service for their administration is included in the cost report and a visit isn't billed for these services. For FQHCs, if there was another reason for the visit, the vaccine and the administration code should be reported on the claim, using Type of Bill 77x, for informational and data collection purposes only. Coinsurance and deductible don't apply to these vaccine products or their administration.

## COVID-19 Monoclonal Antibody Therapies

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For **Original Medicare patients**, we pay for administering COVID-19 monoclonal antibody products and the service for their administration at 100% of reasonable cost through the cost report.

**Note:** We updated the FQHC cost report to show costs related to COVID-19 shots, COVID-19 monoclonal antibody products, and how you administer them.

For COVID-19 [monoclonal antibodies](#) used for post-exposure prophylaxis or treatment of COVID-19, we'll continue to pay at 100% of reasonable cost through the cost report through the end of the CY in which the Emergency Use Authorization (EUA) declaration for COVID-19 drugs and biologicals ends. The EUA declaration is distinct from, and not dependent on, the COVID-19 PHE.

Starting January 1 of the year after the EUA declaration ends:

- We'll pay you for monoclonal antibody products used for **post-exposure prophylaxis or treatment** of COVID-19 in the same way we pay for other Part B drugs and biological products (through the FQHC PPS)
- We'll continue to pay for covered monoclonal antibody products and their administration when used as **pre-exposure prophylaxis for prevention** of COVID-19 at 100% of reasonable cost through the cost report

For **Medicare Advantage (MA) patients**, submit claims for administering COVID-19 vaccines and COVID-19 monoclonal antibody products to the MA Plan. Original Medicare won't pay these claims. To learn more about billing and payment, including MA wrap-around payments, visit the [FQHC Center](#), or review our [FAQs](#).

## Hepatitis B Shot Administration & Payment

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We include the hepatitis B shot and its administration in the FQHC visit. They aren't separately billable. If you provide a qualifying FQHC visit on the same day as the hepatitis B shot, report the charges for the shot and related administration as a separate line item to ensure we don't apply coinsurance. You can't bill a visit if shot administration is the only service you provided.

## Telehealth

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Telehealth substitutes for an in-person visit, and generally involves 2-way, interactive technology that permits communication between the practitioner and patient. FQHCs can provide telehealth to extend care when a patient is in a different place.

During the COVID-19 PHE, we used emergency waiver and other regulatory authorities so you could provide more services to your patients via telehealth. Section 4113 of the [CAA, 2023](#), extended many of these flexibilities through December 31, 2024, and made some of them permanent. Learn more about Medicare [telehealth services](#), including technology and other requirements.

## Originating Sites

An originating site is the location where a patient gets physician or practitioner medical services through telehealth. Before the COVID-19 PHE, patients needed to get telehealth at an originating site located in a certain geographic location.

Through December 31, 2024, all patients can get telehealth wherever they're located. They don't need to be at an originating site, and there aren't any geographic restrictions.

FQHCs can be originating sites for telehealth if they're in a qualifying area. FQHCs serving as telehealth originating sites get an originating site facility fee. You may include the originating site facility fee charges on the claim. Although FQHC services aren't subject to a deductible, the facility fee isn't considered an FQHC service. So, you must apply the deductible when billing the telehealth originating site facility fee.

## Distant Sites

A distant site is the location where a physician or practitioner provides telehealth. Before the COVID-19 PHE, only certain types of distant site providers could provide and get paid for telehealth. Through December 31, 2024, all providers who are eligible to bill Medicare for professional services, including FQHCs, can provide distant site telehealth.

Practitioners can provide telehealth from any distant site location, including their home, during the time they're working for the FQHC, and they can provide any distant site-approved telehealth under the PFS. You can't bill the visit's cost or include it on the cost report.

**Note:** Section 4113 of the [CAA, 2023](#) extends the telehealth policies enacted in the [CAA, 2022](#) through December 31, 2024.

## Virtual Communication Services

You can also provide virtual communication services. FQHCs bill virtual communication services differently than telehealth.

Virtual communication services are services where a practitioner meets with a patient for at least 5 minutes to decide if the patient needs a visit. There are 2 ways to provide virtual communication services:

1. Through communication-based technology
2. With remote evaluation services

We pay for virtual communication services when an FQHC practitioner meets certain requirements, including:

- Practitioner provides at least 5 minutes of billable FQHC virtual communications, either through communication-based technology or remote evaluation services
- Patient had at least 1 face-to-face billable visit within the previous year

- Virtual visit isn't related to services provided within the last 7 days
- Virtual visit doesn't lead to an in-person FQHC service within the next 24 hours or at the next appointment

When the virtual communication HCPCS code G0071 is on an FQHC claim alone or with other payable services, we require FQHCs to submit HCPCS code G2012 (communication technology-based services) or HCPCS code G2010 (remote evaluation services).

When an FQHC practitioner provides virtual communication services, they don't need to meet face-to-face, so the coinsurance doesn't apply.

See [Virtual Communication Services FAQs](#) for more information.

## Consent for Chronic Care Management & Virtual Communication Services

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We require patient consent for all services, including non-face-to-face services. You may get patient consent at the same time you initially provide the services. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the FQHC practitioner can get patient consent for these services.

## Resources

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- [FQHC Center](#)
- [Medicare Benefit Policy Manual, Chapter 13](#)
- [Medicare Claims Processing Manual, Chapter 9](#)

## Regional Office Rural Health Coordinators

Get contact information for [CMS Regional Office Rural Health Coordinators](#) who offer technical, policy, and operational help on rural health issues.

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