Coding Guide

Coding for Federally Qualified Health Centers (FQHCs)

CodingIntel
AT THE CORNER OF CODING AND GETTING PAID

About the Author

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What is an FQHC?

According to the Department of Health and Human Services, "Federally Qualified Health Centers are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.

Federally Qualified Health Centers may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing."[1]

FQHCs provide primary care services in underserved areas. They are not paid based on the Medicare Fee Schedule from Medicare or state Medicaid program fee schedules, but instead are paid based on an annually updated Prospective Payment System rate for services provided at a visit. The FQHC uses HCPCS codes to report their services, along with the CPT or HCPCS code that defines the service. The payment for the visit is the same whether the patient has a minor illness or significant, complicated problems. FQHCs provide medical care for acute and chronic conditions, behavioral health care, dental and eye services, domiciliary and home services. This document describes coding for medical services.

These health centers are mission driven, and care for patients without regard for their ability to pay. For Medicaid and Medicare patients, the center is paid based on the PPS rate. The center is required to have a sliding fee scale, that sets the fee based on family size and income. In addition, the health center can accept commercial payers and may have contracts with private payers to provide services for their members, and accept Medicare Advantage patients. When reporting services to commercial payers, use CPT codes reported on a CMS 1500 form.

Visits

FQHC's are paid when the FQHC performs a qualified visit. A visit is a medically necessary face-to-face medical, preventive health service or a one-to-one mental health service. This must be a face-to-face visit between a patient and a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker.

Who may provide a visit

Services may be provided by physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the center provides diabetes self-management and medical nutrition therapy for beneficiaries, registered dietitians and nutritionists can also provide services. However, the FQHC must meet the program requirements for those services.

[1] Health Resources and Services Administration, US government, accessed 6/2/2021 https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html

Qualifying visits

CMS has developed HCPCS codes for reporting services in an FQHC. These qualifying visits are reported, along with the CPT or other HCPCS code for the services provided. CMS provides a list of CPT and HCPCS codes that may be reported with each of these qualifying visits. These are listed at the end of this guide.

If a physician sees an established patient, and selects 99213 as the level of service, two-line items are reported. Payment is based on the rate for the qualifying visit. The CPT code is provided for information.

G0467 FQHC visit, established patient
99213 Level 3 established patient visit

The center receives payment at the PPS rate for the qualifying visit, G0467. The line item for 99213 isn't separately paid, and the EOB comment will be "the benefit for this service is included in the payment/allowance for another service/procedure."

- One qualified medical visit is paid per day, unless the patient returns to the center on the same day for a different problem. For example, the patient is treated for asthma in the morning, and returns in the afternoon for a fall for treatment of a laceration, a condition that is unrelated.
- The center receives the same payment for all services. It doesn't change based on the level of E/M service provided, the time it takes, or the complexity of the patient.
- Both a medical and a behavioral health service are payable on the same day.

HCPCS codes for FQHC visits

G0466 FQHC visit, new patient
G0467 FQHC visit, established patient
G0468 FQHC visit, IPPE or AWV
G0469 FQHC visit, mental health, new patient
G0470 FQHC visit, mental health, established patient

Minor procedures

Report a minor procedure with a qualifying visit code, and add the CPT code for the procedure. The center will be paid the PPS rate for the service. Payment for the procedure is included in the PPS rate for the qualified visit, and is not paid separately. Add the procedure code to the claim form with the visit. The health center will be paid the PPS rate, but CMS wants service that are performed listed on the claim form.

Patient presents for an abscess. The clinician evaluates the site, decides to prescribe antibiotics and does an I&D of the abscess. It is an established patient, billed as a level three visit.

G0467 FQHC visit, established patient
99213 Level 3 established patient visit
10061 I&D, simple

- *"The Medicare global billing requirements do not apply to RHCs and FQHCs and global billing codes are not accepted for RHC or FQHC billing or payment." Medicare Benefit Policy Manual, Chapter 13, Section 40.4*
- Patients who had surgery elsewhere, seen during the global period, may be paid "*if the visit is for a service not included in the global billing package.*"

How services are paid/PPS rate

CMS annually sets the Prospective Payment System (PPS) rate, the allowance is the PPS rate or the actual charge, whichever is lower. The PPS rate is paid for all services done at the visit, without regard to the complexity of the care, or the CPT code submitted with the qualifying visit, with the exception of new patients and wellness visits. In 2021, the PPS rate is $176.45. CMS pays 80% of the lower of the actual charge or the PPS rate, and the patient due amount is the co-insurance of 20%. The patient isn't charged a Part B deductible for services in an FQHC.

Patient due amounts:

- No Part B deductible is charged for Medicare services done at an FQHC
- Co-insurance is 20% of the allowed charge
- No co-insurance is applied for preventive services with an A/B rating by the US Preventive Services Task Force
- No co-insurance is applied for the Welcome to Medicare visit, or the initial or subsequent wellness visits

New patient definition

"A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service."
Medicare Benefit Policy Manual, Ch. 13, Section 70.3

- Uses the CPT/CMS rule of 3 years
- Doesn't use the CPT specialty rule
- Doesn't differentiate between services done by medical practitioner and behavioral health practitioner
- Seen by either means the next visit is established

Example:
June 12, patient seen by CSW. First visit to FQHC; Use qualifying visit code G0469, FQHC visit, mental health, new patient

July 14, patient seen by nurse practitioner. Use qualifying visit code G0467, FQHC visit, established patient

Payment for new patient visits, definition of new

New patient visits are paid at 134% of the PPS rate. Use **G0466** for an FQHC visit, new patient (medical) or **G0469** for an FQHC visit, mental health, new patient.

Wellness visits are also paid at 134% of the PPS rate by Medicare. This includes the Welcome to Medicare visit and the initial and subsequent wellness visits.

"The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived."

Medicare Benefit Policy Manual, Chapter 13 Section 220.3

- If the components of the Welcome to Medicare visit or wellness visit are documented, use the G0468, FQHC visit, IPPE or AWV and the HCPCS code for the visit G0402 for the Welcome to Medicare visit, G0438 for the initial annual wellness visit, or G0439 for the subsequent wellness visit. If medical problems are also managed, do not also report an established patient visit code.

FQHC preventive care services

Preventive services in an FQHC

- Influenza, Pneumococcal, Hepatitis B vaccinations;
- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.
- Screening mammography;
- Screening pap smear and screening pelvic exam;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- DSMT services;
- Diabetes screening tests;
- MNT services;
- Bone mass measurement;
- Screening for glaucoma;
- Cardiovascular screening blood tests; and
- Ultrasound screening for abdominal aortic aneurysm.

Influenza and pneumococcal vaccines and their administration are paid through the cost report, and payment for the hepatitis B vaccine and its administration is included in an otherwise billable visit. The professional component of the IPPE, AWV, and other qualified preventive services is paid based on the lesser of the FQHC's charge or the PPS rate for the specific payment code, with an adjustment for IPPE and AWV.

Some of these services are provided by the FQHC and for some, a patient receives the service at another hospital, testing facility or lab.

Virtual check in

Virtual check in has its own HCPCS code

G0071 Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC)practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

- Use G0071, not G2010 or G2012 in an FQHC
- Use the requirements for G2010 (store and forward) or G2012 (virtual check-in) for G0071
- Non-face-to-face communication
- Remote evaluation
- Co-insurance applies
- Allowance is about $24

Care Management

Transitional Care Management (TCM)

"can also be an RHC or FQHC service"

- For established patients, codes 99495 and 99496 are listed as qualifying visits for G0467
- Use G0467 as the qualifying visit, add the CPT code for the TCM
- Payment is at the PPS rate—no additional revenue
- Since it requires more work to bill compliantly, not much incentive to do it

Chronic Care Management has its own HCPCS code

G0511 Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month

- Option A: Two or more chronic conditions expected to last 12 months or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation of functional decline

OR

- Option B: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that in the clinical judgement of the RHC or FQHC practitioner warrants BHI services

For Option B there are additional requirements:

- Initial assessment or follow up monitoring, including the use of applicable validated rating scales
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revisions for patients who are not progressing or whose status changes
- Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
- Continuity of care with a designated member of the care team

G0511

- Allowance about $65
- CMS based the payment rate on the average of 99490, 99487, 99484, but don't report those CPT codes, use the HCPCS code G0511 that CMS developed
- Don't report CPT codes for CCM
- Requires an initiating visit if patient hasn't been seen in a year (FQHC qualifying visit)
- Requires beneficiary consent
- 20 minutes in a calendar month by clinical staff or practitioner

G0511 has the same requirements as CPT CCM codes.

- Structured recording of patient health information
- 24/7 access to coverage, with designated provider
- Comprehensive care management
- Comprehensive care plan
- Care information available electronically
- Management of care transitions
- Coordination with home/community providers
- Enhanced opportunity for communication (secure messaging, portals)

Psychiatric collaborative care

G0512 Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

Allowance about $154

Corresponds to the CPT psychiatric collaborative care codes, and have the same requirements

- CMS set the rate for this HCPCS code based on the average of 99492 and 9493.
- Requires an initiating visit if patient hasn't been seen in a year (FQHC qualifying visit)
- Beneficiary consent
- 70 minutes in first calendar month, 60 minutes in subsequent months of coordination by practitioner or behavioral health care manager, under general supervision
- Patient must have a behavioral or psychiatric condition being treated, can include substance use
- Physician, NP/PA/CNM directs care of behavioral care manager, oversees the care, prescribes, makes referrals
- Remains involved in oversight, management, collaboration, reassessment

Behavioral health manager

- Behavioral health care manager administers validated rating scales, does health care planning, provision of brief, psychosocial interventions, ongoing collaboration, maintenance of registry, is available to provide service, is available to contact patient outside of regular hours as needed

And

- Psychiatric consultant participates in regular review of patients receiving CoCM services, advises practitioner, facilitates referrals

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

HCPCS	**Qualifying Visits** for **G0466**
G0108	Diab manage trn per indiv
G0117	Glaucoma scm hgh risk direc
G0118	Glaucoma scm 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 estabpt 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

HCPCS	**Qualifying Visits** for **G0467**
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessment
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
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 14 day disch
99497	Advncd care plan 30 min
G0101	Ca screen; pelvic/breast exam
G0102	Prostate ca screening; dre
G0108	Diab manage tm per indiv
G0117	Glaucoma scm hgh risk direc
G0118	Glaucoma scm 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 AWV:

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
90834	Psytx pt &/family 45 minutes
90837	Psytx pt &/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis