Page updated: November 2023

Rural Health Clinics and Federally Qualified Health Centers

Introduction

Purpose

The purpose of this module is to provide information for billing services rendered by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

Module Objectives

- Define RHC and FQHC
- Describe Scope of Coverage
- Identify billing code sets
- Review billing examples
- Provide References

Acronyms

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

Description

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

RHCs

RHCs extend Medicare and Medi-Cal benefits to cover health care services provided by clinics operating in rural areas. Specifically trained primary care practitioners administer the health care services needed by the community when access to traditional physician care is difficult. 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 fifty percent of the time the RHC is open. RHC physicians may work less than full-time if the physician is present in the clinic during operating hours.

FQHCs

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

RHC and FQHC Enrollment

Providers should enroll in the RHC and FQHC programs through the Department of Health Care Services (DHCS) Audits and Investigations (A&I) Division. As facilities enroll in the RHC and FQHC programs, they will receive a new National Provider Identifier (NPI) and their current provider numbers will be inactivated.

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.
Medical Resident	A medical resident in a federally or state sponsored Teaching Health Center Graduate Medical Education (THCGME) 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.

Covered Service

RHCs and FQHCs may bill for the following:

- 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 if the clinic has an approved application on file with the California Department of Public health, Maternal, Child and Adolescent Health Division
- Licensed clinical social worker services
- Associate clinical social worker (ASW) services (when supervised by a licensed billable behavioral health practitioner
- Marriage and family therapist services
- Associate marriage and family therapist (AMFT) services (when supervised by a licensed billable behavioral health practitioner)
- Clinical psychologist services
- Optometry services
- Acupuncture services
- Registered dental hygienist services

Dental Services Defined

Dental services are a covered benefit for FQHC and RHC providers. They may render dental services in a face-to-face encounter between a billable treating provider and an eligible patient when the services are within the scope of the treating provider's practice, comply with the Medi-Cal Dental Manual of Criteria (MOC) and Schedule of Maximum Allowances (SMA) and are determined to be medically necessary pursuant to California Welfare and Institutions Code (W&I code), Section 14059.5.

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.

Authorization and Documentation Requirements

RHCs and FQHCs services do not require a *Treatment Authorization Request* (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that would be needed for authorization approval.

Documentation for all RHC and FQHC encounters must be sufficiently detailed as to clearly indicate the medical reason for the visit.

Required documentation includes:

- A complete description of the medical services provided,
- The full name professional title of the person providing the service,
- The pertinent diagnosis(es) at the conclusion of the visit, and
- Any recommendations for diagnostic studies, follow up or treatments, including prescriptions.

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

DHCS A&I Division may recover payments 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."

Comprehensive Perinatal Services Program (CPSP) Services: TAR and Reporting Requirements

Claims for Comprehensive Perinatal Service Program (CPSP) services in excess of the basic allowances will not be denied for the absence of a TAR. RHCs and FQHCs, however, must maintain in the patient's medical record the same level of documentation that would be needed for authorization approval. DHCS A&I Division may recover payments 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."

Required documentation includes:

- Expected date of delivery,
- Clinical findings of the high-risk factors involved in the pregnancy,
- Explanation of why basic CPSP services is not sufficient,
- Description of the services being requested,
- Length of visits and frequency with which the requested services are provided, and
- Anticipated benefit of outcome of additional services.

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.

Comprehensive Services for Pregnant Recipients

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.

RHC and FQHC: Medi-Services

Medi-Service limitations (two services per month) apply when rendered in an RHC or FQHC.

“Visit” Defined

A visit is a face-to-face encounter or an interaction using a telehealth modality (synchronous video, synchronous audio-only or asynchronous store and forward) between a RHC or FQHC Medi-Cal recipient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, marriage and family therapist, licensed acupuncturist, registered dental hygienist 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 and the interactions meet the applicable standards of care.

A face-to-face encounter or an interaction using a telehealth modality with a Comprehensive Perinatal Services Program (CPSP) practitioner also qualifies as a visit.

Qualifying Visits

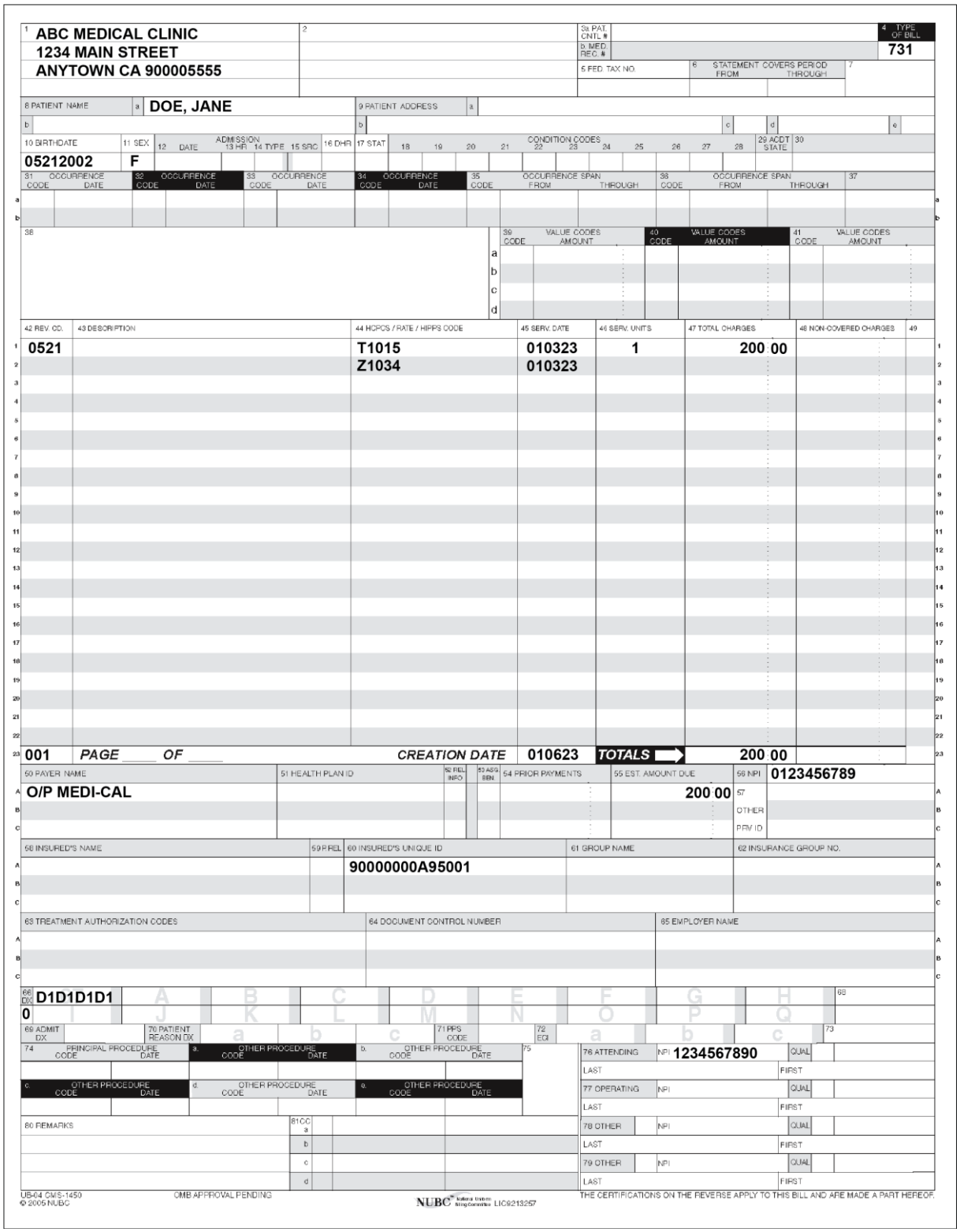
Reimbursable Criteria Table

One Visit	Encounters with more than one health care professional, and multiple encounters with the same health care 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 or when a patient is seen by a health care professional or CPSP practitioner and also receives dental services on the same day.

Note: FQHCs/RHCs (Provider Type 035) in the counties of San Mateo, Sacramento, and Los Angeles will be able to bill for differential payments for one medical and one dental visit for the same recipient on the same day of service.

Clinic visits, at which the patient receives services “incident to” physician services (for example, a laboratory or X-ray appointment), do not qualify as reimbursable visits.

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



1	0521		T1015	010323	1	200 00	
2			Z1034	010323			
23	001	PAGE ____ OF ____	CREATION DATE	010623	TOTALS	200 00	

1 ABC MEDICAL CLINIC
1234 MAIN STREET
ANYTOWN CA 900005555

4 TYPE OF BILL: 731

8 PATIENT NAME: DOE, JANE

10 BIRTHDATE: 05212002 | 11 SEX: F

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES

50 PAYER NAME: O/P MEDI-CAL | 55 EST. AMOUNT DUE: 200 00 | 56 NPI: 0123456789

66 DX: D1D1D1D1 0

76 ATTENDING NPI: 1234567890

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: Medical visit pregnancy service claim example.

Coverage Limitations

FQHC/RHC providers may be reimbursed for up to:

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

  These visits do not require medical justification in field 80 *Remarks* 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 field 80 *Remarks* of the *UB-04* claim form.

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.

Treatment Authorization

A *Treatment Authorization Request* (TAR) is not required for services rendered by FQHC 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."

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

Medi-Service Limitations

FQHC and RHC

The following Medi-Services are services that are limited to a maximum of two services per month. However, 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:

Billing Services for Health Care Recipients

RHCs and FQHCs must bill the appropriate Health Care Plan (HCP) when rendering services to HCP recipients. The CA-MMIS Fiscal Intermediary does not accept these claims unless the billed services are contractually excluded from the plan. Providers should contact the plan for plan-specific prior authorization and billing information.

If a Medi-Cal patient presents themselves to the clinic for treatment and the clinic finds the patient is enrolled in a Medi-Cal Managed Care Plan, or if located in Los Angeles County, San Mateo County, or Sacramento County and the patient is enrolled in a Medi-Cal Dental managed care plan, the clinic can render services and submit a claim to Medi-Cal. However, the RHC and FQHC facility is required to redirect the patient to their in-network managed care provider and document this referral in the patient's medical/dental records.

While Medi-Cal beneficiaries enrolled in both Medi-Cal and Medi-Cal Dental managed care plans are required to be treated by in-network providers, except in emergencies or other isolated instances, RHC and FQHC facilities that provide services in these circumstances must maintain proof of payment or denial from the managed care plan.

FQHC Billing Instructions for Dual-Eligible Members

The Affordable Care Act (ACA) mandated the transition from the Medicare FQHC cost-based reimbursement system to a Medicare reimbursement methodology that is unique for each FQHC.

This 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 the following per-visit codes:

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

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. RHC & FQHC providers are reimbursed an amount equal to the PPS rate.

Crossover Claim and Managed Care Differential Rate billing code set rates may be adjusted to reflect the difference more accurately between the Medicare and HCP reimbursements and the PPS 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 provider's 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*.

Telehealth Overview

Policy related to telehealth is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011 *Welfare and Institutions* Code 14132 100. Providers should refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual for additional information. Updated references and instructions regarding telehealth and virtual telephonic communication policy are available for FQHCs, RHCs, Tribal FQHCs and IHS-MOA 638 clinic providers.

Definitions

For the purposes of this policy, the following definitions shall apply:

- **Telehealth and Other Terms**: For definitions of “telehealth,” “audio-only,” “asynchronous store and forward,” “synchronous interaction,” “distant site” and “originating site,” providers may refer to the Medicine: Telehealth section in the appropriate Part 2 manual.
- **Visit**: Providers should refer to “Visit Defined” in Part 2 – Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) rural 5.

Note: Telehealth services must meet all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter with a billable provider and meet the applicable standard of care. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to Health Resources Services Administration requirements.

The Department of Health and Human Services (HHS) announced that the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service Act, expired on May 11, 2023. FQHC, RHC, providers can no longer bill HCPCS code G0071 for dates of services on or after the public health emergency ended.

Additionally, providers are encouraged to refer to the *Medicine: Telehealth* section in the Part 2 provider manual for billing with required telehealth modifiers.

Telehealth Modifiers for FQHC and RHC Providers

Table of Telehealth Modifiers for FQHC and RHC Providers

Modifier	Description
93	Synchronous, Telephone or Other Interactive Audio-only Telecommunications Systems
95	Synchronous, Interactive Audio and Telecommunications Systems
GQ	Asynchronous Store and Forward Telecommunications Systems

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

Box	Entry
1	ABC MEDICAL CLINIC 1234 MAIN STREET ANYTOWN CA 900005555
4 TYPE OF BILL	731
8 PATIENT NAME	DOE, JANE
10 BIRTHDATE	01241987
11 SEX	F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0521		T1015SE	010323	1	100 00	
		G044295	010323			
		9616095	010323			
		9920595	010323			
001	PAGE ____ OF ____	CREATION DATE	010423	TOTALS	100 00	

Box	Entry
50 PAYER NAME	O/P MEDI-CAL
55 EST. AMOUNT DUE	100 00
56 NPI	0123456789
60 INSURED'S UNIQUE ID	90000000A95001
66 DX	D1D1D1D1
66 DX (ICD indicator)	0
76 ATTENDING NPI	1234567890

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Example: Telehealth billing example.

RHC and FQHC Billing Code Sets

RHC and FQHC facilities use the following all-inclusive billing code sets and per visit codes:

Table of All-Inclusive Billing Code Sets

Revenue Code	Procedure Code and Modifier	Description	Explanation
0521	T1015	Medical, per visit	Requires medical justification for more than one visit per recipient per day
0521	G0466	Crossover claims – FQHC/RHC clinic visit New patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0521	G0467	Crossover claims – FQHC/RHC clinic visit Established patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0521	G0468	Crossover claims – FQHC/RHC clinic visit Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV)	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.

Table of All-Inclusive Billing Code Sets (Continued)

Revenue Code	Procedure Code and Modifier	Description	Explanation
0522	G0466	Crossover claims – Home visit New patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0522	G0467	Crossover claims – Home visit Established patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0522	G0468	Crossover claims – Home visit Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV)	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0524	G0466	Crossover claims – Visit covered Part A stay at SNF New patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0524	G0467	Crossover claims – Visit covered Part A stay at SNF Established patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.

Table of All-Inclusive Billing Code Sets (Continued)

Revenue Code	Procedure Code and Modifier	Description	Explanation
0524	G0468	Crossover claims – Visit (covered Part A stay) at SNF Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV)	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0525	G0466	Crossover claims – FQHC visit (not covered Part A stay) at SNF New patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0525	G0467	Crossover claims – FQHC visit (not covered Part A stay) at SNF Established patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0525	G0468	Crossover claims – FQHC visit (not covered Part A stay) at SNF Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV)	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.
0527	G0466	Crossover claims – FQHC visiting nurse to home New patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 24-30) for Medicare status.

Table of All-Inclusive Billing Code Sets (Continued)

Revenue Code	Procedure Code and Modifier	Description	Explanation
0527	G0467	Crossover claims – FQHC visiting nurse to home Established patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 2430) for Medicare status.
0527	G0468	Crossover claims – FQHC visiting nurse to home Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV)	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 2430) for Medicare status.
0900	G0469	Crossover claims – Mental health visit New patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 2430) for Medicare status.
0900	G0470	Crossover claims – Mental health visit Established patient	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do no complete *Condition Codes* fields (Boxes 2430) for Medicare status.

Table of All-Inclusive Billing Code Sets (Continued)

Revenue Code	Procedure Code and Modifier	Description	Explanation
0521	92004	Clinic visit optometry – Facility-specific all-inclusive rate New patient	None.
0521	92014	Clinic visit optometry – Facility-specific all-inclusive rate Established patient	None.
3101	99205	Community-Based Adult Services (CBAS) Initial assessment day (with subsequent attendance)	Limit of up to three assessment days. Same center may not bill for assessment days again within 12 months of the last day of service. If the participant transfers to another center, up to three assessment days may be billed by the second center without the 12-month restriction of the previous center's assessment.
3101	T1015	Community-Based Adult Services (CBAS) Initial assessment day (without subsequent attendance)	A statement explaining why the participant did not attend the center subsequent to assessment must be entered in the *Remarks* area of the claim (samne limitations as for the other billing code sets associated with revenue code 3101).
3103	None	Community-Based Adult Services (CBAS) Regular day of service	Minimum four-hour day at the center, excluding transportation time. Refer to *Community-Based Adult Services (CBAS)* section of the appropriate Part 2 manual.
3103	T1023	Community-Based Adult Services (CBAS) Transition day	Limit of five days per participant's lifetime. A statement that the *Physician Authorization and Medical Information* form is on file at the center must be entered in the *Remarks* area of the claim.

Note: CBAS is not an FQHC or RHC service; however, CBAS is a Medi-Cal waiver benefit that an FQHC or RHC may provide and is reimbursable at the CBAS rate. The CBAS benefit billing codes and rates are described in the Community-Based Adult Services section of the appropriate Part 2 provider manual.

For a reimbursable CBAS visit, FQHCs and RHCs must render a service for a minimum of four hours per billable day, pursuant to requirements in the Community-Based Adult Services provider manual section.

COVID-19 Vaccine Administration for FQHC and RHC Providers

Effective January 1st, 2023, RHC and FQHC providers may receive reimbursement for administration of 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.

Reimbursement

RHC and FQHC providers may receive reimbursement at the Medicare National Equivalent Rates for COVID-19 vaccines administered during a vaccine-only encounter. RHC and FQHC providers should refer to the DHCS website for billing guidance and effective dates.

Medi-Cal Managed Care Billing Code Services

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, San Mateo 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

Managed Care Differential Rate Billing Scenario

FQHC/RHC Providers

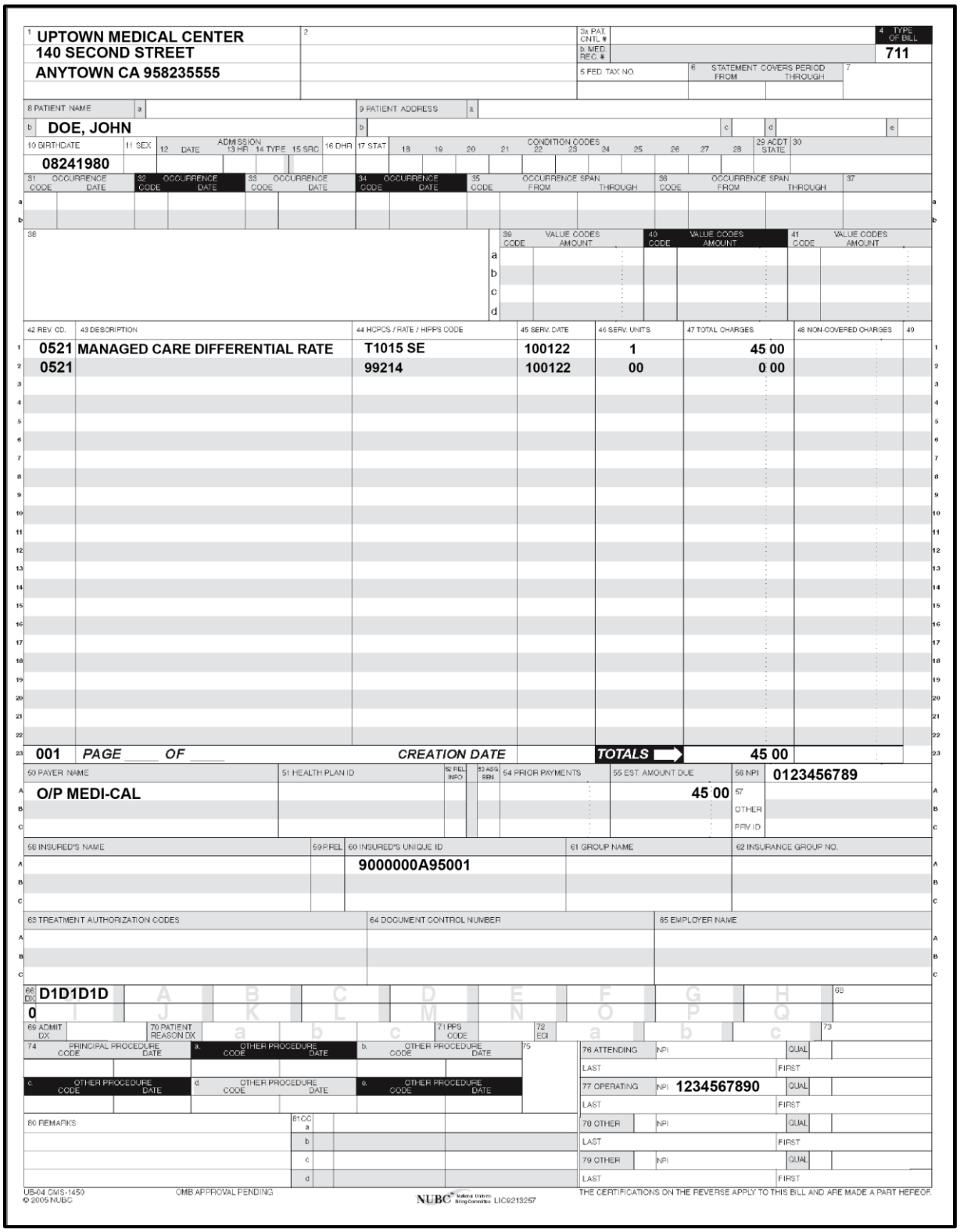
This is a sample only. Please adapt to your billing situation.

John Doe visited a Rural Health Clinic (RHC) 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:

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



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 711

8 PATIENT NAME: DOE, JOHN
10 BIRTHDATE: 08241980

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0521	MANAGED CARE DIFFERENTIAL RATE	T1015 SE	100122	1	45 00	
0521		99214	100122	00	0 00	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	45 00	

50 PAYER NAME: O/P MEDI-CAL
54 PRIOR PAYMENTS:
55 EST. AMOUNT DUE: 45 00
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 9000000A95001

66 DX: D1D1D1D
0

77 OPERATING NPI: 1234567890

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

Informational Lines

Informational lines should be included when billing for FQHC/RHC 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.

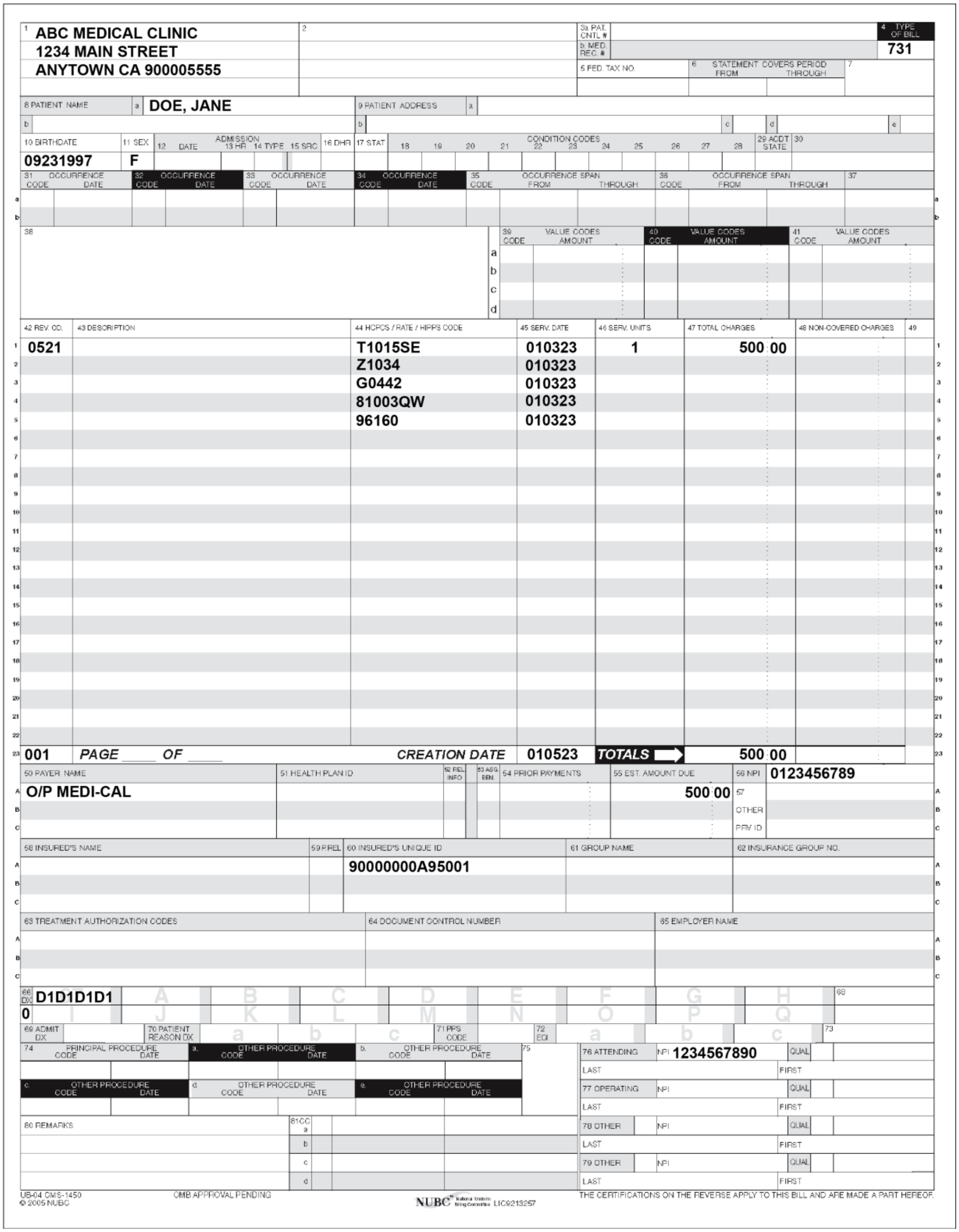
Note: Computer Media Claims (CMC) submitted with an informational line on the first detail line of the claim will be rejected. CMC claim detail line 01 must include only HIPAA-compliant billing code sets.

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.

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.

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



1 ABC MEDICAL CLINIC
1234 MAIN STREET
ANYTOWN CA 900005555

4 TYPE OF BILL: 731

8 PATIENT NAME: a DOE, JANE

10 BIRTHDATE: 09231997

11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0521		T1015SE	010323	1	500 00	
		Z1034	010323			
		G0442	010323			
		81003QW	010323			
		96160	010323			
001	PAGE ___ OF ___	CREATION DATE	010523	TOTALS	500 00	

50 PAYER NAME: A O/P MEDI-CAL

55 EST. AMOUNT DUE: 500 00

56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D1 0

76 ATTENDING NPI: 1234567890

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

Example: Informational lines claim example.

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)

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

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

Medicine: Telehealth (medne tele)

Non-Specialty Mental Health Services: Psychiatric and Psychological Services (non spec mental)

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)

Additional Resources

All of these resources can be found at the Medi-Cal and DHCS websites:

5010 CMC Billing and Technical manual

DHCS Approved State Plan Amendments (SPA) - Approved SPA

DHCS Managed Care All Plan Letters (APL) – Managed Care All Plan Letters – 1998 to Current