Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Billing Codes

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This section contains Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) per visit billing codes and rules for reimbursement requirements. These codes sets apply to claims reimbursed at the all-inclusive Medi-Cal Prospective Payment System (PPS) rate on file with the Department of Health Care Services (DHCS) Medi-Cal Program, unless indicated otherwise.

RHC and FQHC providers must use these per-visit billing codes when submitting reimbursement claims to the Medi-Cal Fiscal Intermediary (FI).

For more information on RHC and FQHC policy and billing instructions, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section of this manual.

Note: Medi-Cal policy material is updated periodically by DHCS. All providers are responsible for ensuring that the policy they are following the most current versions of Medi-Cal coverage and reimbursement policy.

General Information

Medi-Cal reimburses RHC and FQHC providers in accordance with California's Medicaid State Plan as approved by the federal Centers for Medicare & Medicaid Services (CMS) under Title XIX of the Social Security Act.

Section 702 of the Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) established the Medicaid PPS rate for FQHCs and RHCs. This reimbursement structure is a fixed, all-inclusive per-visit rate. DHCS sets and maintains PPS rates.

When RHCs or FQHCs provide services to Medi-Cal managed care members, the member's Medi-Cal managed care plan (MCP) pays the RHC or FQHC provider a negotiated contracted rate. Pursuant to Welfare and Institutions Code (WIC) section 14087.325(d), and Social Security Act § 1903(m)(2)(A)(ix) Medi-Cal MCPs must reimburse contracted RHCs or FQHCs in a manner that is no less than the level and amount of payment that the Medi-Cal MCP would make for the same scope of services if the services were furnished by another provider type that is not an RHC or FQHC.

Additionally, under 42 United States Code (U.S.C.) section 1396a(bb)(5)(A), if this negotiated contracted rate is less than the RHC's or FQHC's PPS rate, the state must make a supplemental "wrap" payment equal to the difference. This ensures that RHCs and FQHCs are fully reimbursed at their federally mandated PPS rate, regardless of whether services are delivered through the fee-for-service or managed care delivery system.

Note: The supplemental payment is also referred to as the MCP differential rate (wrap).

RHC and FQHC providers must adhere to DHCS policy requirements when submitting reimbursement claims to the Medi-Cal FI for services rendered to Medi-Cal fee-for-service members. Similarly, RHC and FQHC providers must adhere to both DHCS policy requirements as well as any additional Medi-Cal MCP guidance when submitting reimbursement claims for services rendered to Medi-Cal members in managed care.

Note: In addition to DHCS policies, Medi-Cal MCPs may establish their own specific billing and reimbursement procedures, documentation standards, and submission protocols that providers must follow. These can include verifying member eligibility, electronic claim or other submission requirements, claim formatting, coding standards, utilization management (UM) controls, including prior authorization (PA) requirements, out-of-network coordination, and more. Medi-Cal MCP requirements should align with DHCS policies and may include additional operational or documentation requirements. RHC and FQHC providers are encouraged to consult the respective Medi-Cal MCP's guidance and policies for detailed guidance and requirements, as these may vary by plan.

Member Eligibility

To prevent billing denials, RHC and FQHC providers must check the member's Medi-Cal eligibility prior to scheduling services and at the time of the service.

Note: Refer to the *Eligibility: Recipient Identification or AEVS: General Instructions* section of the Part 1 manual for instructions on how to verify a members eligibility.

Qualifying Visits

Qualifying visits occur when an RHC or FQHC provides medically necessary primary or preventive outpatient services to eligible members, either face-to-face or via an approved telehealth modality, which are delivered by providers authorized under the Medi-Cal State Plan and acting within their scope of practice.

Under the existing Medi-Cal reimbursement policy, RHC and FQHC providers may bill one (1) medical or mental health visit and one (1) dental visit at the Medi-Cal PPS rate per member per day when RHC and FQHC covered services are rendered by authorized providers acting within their scope of practice.

Multiple services and supplies furnished “incidents to” a billable practitioner’s service may be provided during a single visit. However, a visit consisting solely of “incident to” service(s) does not constitute a qualifying visit eligible for PPS reimbursement.

Consistent with 42 Code of Federal Regulations (CFR) sections 405.2413 and 405.2415, and Section 1395x(s)(2)(A) of Title 42 of the United States Code, “incident to” services are those furnished as an integral, though incidental part of a billable practitioner’s services and are included with the PPS rate rather than billed as a separate encounter. Examples can include the administration of injections (such as vaccines), routine clinical services furnished by clinic staff (such as laboratory services, x-rays, etc.). These services must be furnished under appropriate supervision and within applicable scope of practice requirements.

Exceptions: Two visits can be billed on the same day (which may be at a different location) only in the following situations:

- When a member, after the first visit, suffers illness or injury that requires another health diagnosis or treatment, two visits may be counted. Medical justification is required in the *Remarks* field (Box 80) or on an attachment to the claim. Refer to Figure 1 in the Rural Health Clinics (RHCs) and *Federally Qualified Health Centers (FQHCs) Billing Example* section in this manual. For example, a member sees their provide in the morning for a medical condition and later in the day falls and returns to the clinic);
- When a member is seen by a provider or a Comprehensive Perinatal Services Program (CPSP) practitioner and also receives dental services on the same day.

Note: A second visit can only be counted under the exceptions noted above.

For more information on the definition of an RHC and FQHC visit, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section in this manual.

Documentation Requirements

Under Title 22 of the California Code of Regulations (CCR) section 51476 and existing DHCS policy, Medi-Cal providers must maintain complete, accurate, and timely documentation that fully discloses the type and extent of services rendered to Medi-Cal members. Records should be created at or near the time of service and include patient identification, date of service, provider credentials and signature, clinical details (such as history, diagnosis or treatment plan), progress notes, and any prescribed medications or devices. Documentation must also capture consent forms, interpreter use, advance directives, and coordination of care activities, such as referrals and follow-ups.

In addition, providers are required to keep copies of billing records, including supporting documents (for example, authorization approvals, lab orders and results, and invoices for drugs or supplies). All documentation must be legible, dated, timed, and authenticated by the rendering provider, with supervising signatures when required. Pursuant to WIC section 14124.1 records must be readily retrievable and retained for at least 10 years or longer if mandated by DHCS and/or applicable state or federal requirements. Failure to meet these standards can result in claim denials or audit findings, as DHCS considers proper documentation of Medi-Cal services essential for verifying medical necessity and compliance with Medi-Cal policies.

For additional information, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section of this manual.

Billing Forms

When submitting claims directly to DHCS, RHC and FQHC providers should submit the ASC X12N 837I standard electronic form through the Computer Media Claims (CMC) system or use the CMS Form 1450 (UB-04) paper claim form, unless otherwise instructed. For more information on how to complete the forms, refer to the *UB-04 Completion: Outpatient Services* and *UB-04 Submission and Timeliness Instructions* section of this manual or *Special Billing Instructions: Federally Qualified Health Centers Rural Health Clinics and Indian Health Services Memorandum of Agreement*.

Note: Services billed to Medi-Cal MCPs must use the billing forms required by the individual Medi-Cal MCP.

National Provider Identifier (NPI)

RHC and FQHC providers must submit all claims under the enrolled NPI (*UB-04 Box 56*) and must include the physical address of the location where services were rendered (*UB-04 Box 1*). This requirement is mandated to ensure compliance with Medi-Cal billing standards and to accurately attribute the service to the appropriate location for crossover, Medi-Cal MCP, and Medi-Cal fee-for-service claims.

‹‹ICD-10-CM Code Requirement

RHC and FQHC providers must include at least one clinically appropriate ICD-10-CM code when completing a *UB-04* claim form or the 837I electronic form. Providers can include ICD-10-CM codes in Box 67 of the *UB-04* claim form.

For *UB-04* claim completion instructions, refer to the *UB-04 Completion: Outpatient Services* section of the provider manual.››

Informational Lines

An informational line is an associated line item(s) listed immediately following the Health Insurance Portability and Accountability Act (HIPAA)-compliant RHC or FQHC per-visit billing code set used to bill the visit with the Medi-Cal member. Informational lines contain all CPT-4 Level I or HCPCS Level II code(s) that identify the actual service(s) provided.

When billing for RHC or FQHC covered services, informational lines should be included in addition to the RHC or FQHC per visit billing code sets included in this manual.

Note: Informational lines are not separately reimbursed.

When submitting informational lines, RHC and FQHC providers should remember the following:

- The *Revenue Code* field on the information claim detail line must be a four-digit revenue code. Blank spaces and zeros are accepted for CMC.
- The *Service Date* field is optional but recommended.
- The *Service Units* field on the informational line may contain the number of service units provided for the procedure code.
- The *Total Charges* field for each informational line must always be zero.

Telehealth Modalities and Required Modifiers

RHC and FQHC covered services may be provided via allowable telehealth modalities including synchronous audio-only (modifier 93), synchronous audio-visual (video) (modifier 95), or Asynchronous Store and Forward (modifier GQ), consistent with all of the requirements outlined in the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section in this manual. RHC and FQHC providers will submit claims for telehealth services with the applicable telehealth modifiers and the specific CPT-4 Level I or HCPCS Level II code(s) that identify the actual service(s) on the informational line of the claim.

The modifiers shall be used with the appropriate billing codes when submitting claims to the Medi-Cal MCP. For RHC and FQHC telehealth policy, including non-covered telehealth modalities, and billing scenarios, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)(rural)* sections of this manual.

Out-of-Network (OON) Medi-Cal MCP Services

In accordance with 42 CFR section § 438.206 (b)(5), OON providers (for example, RHC or FQHC providers not assigned as the member's primary care physician or clinic) are required to coordinate with the Medi-Cal member's MCP for authorization and payment. The clinic must obtain prior authorization to act as an OON provider and redirect the member to their in-network provider or request reassignment from MCP to their clinic.

Members enrolled in a Medi-Cal MCP or Medi-Cal Dental Managed Care (DMC) plan must receive services from in-network MCP providers, except in urgent or other isolated circumstances. If the member is not enrolled in a Medi-Cal Dental managed care plan, a straight Medi-Cal dental visit may be billed, per-visit code 03.

If an RHC or FQHC delivers an urgent or isolated medical, mental health, or dental service to a member not assigned to them, the RHC or FQHC must:

- Document and retain records of all efforts to obtain OON authorization from the member's assigned MCP.
- Redirect the member back to their in-network MCP provider or request reassignment from the MCP to their clinic.
- Document these actions in the member's medical or dental record.

Other Health Care (OHC) Coverage/Payer of Last Resort

In accordance with applicable federal Medicaid requirements and state statute (WIC section 14124.90), Medi-Cal is designated as the payer of last resort. All providers including RHCs and FQHCs must make reasonable efforts to identify and bill OHC coverage including but not limited to commercial health insurance and Medicare before submitting reimbursement or differential rate wrap claims directly to DHCS. Note the following:

- DHCS will assume financial responsibility for covered services only after OHC and coverage by the Medi-Cal MCP has been fully exhausted, or if services are listed on the exclusions list (for example, the Medicare Non-Covered Provider Manual).
- Reimbursement will be limited to the lesser of the Medi-Cal allowable amount or the remaining balance after third-party payment, up to the PPS per-visit rate.
- Providers must also generally submit supporting documentation (for example, receipt of OHC reimbursement or a denial for coverage) when submitting claims to DHCS, unless the service is listed on the exclusions list.
- Providers must make reasonable efforts to identify and bill the OHC. All OHC reimbursement must be reported on the annual reconciliation report.

Note: Failure to comply with these requirements may result in claim denials, recoupment actions, or other enforcement measures as permitted under state and federal law.

For more information on OHC and related policies, refer to the following sections in the provider manual:

- Other Health Coverage (OHC)
- Other Health Coverage (OHC) Guidelines for Billing
- Provider Regulations
- Provider Guidelines

Annual Reconciliation

An annual reconciliation request is submitted to DHCS Audits and Investigations (A&I) Financial Review – Outpatient and Behavioral Health Division (FROBHD). The purpose of the annual reconciliation request is to reconcile the difference between reimbursements from Medicare, Medi-Cal MCPs, OHC payments, and the Medi-Cal PPS rates of the RHC and FQHC providers. Medi-Cal MCP differential rates and Medicare differential rates are adjusted upon request to A&I FROBHD by RHC or FQHC providers.

Note: Only adjudicated RHC or FQHC visits will be reconciled through the annual Reconciliation Request.

RHCs and FQHCs should regularly consult the DHCS Audits & Investigations (A&I) forms webpage for updated instructions, forms, and documents related to:

- Annual reconciliation submissions
- Differential payment adjustments
- Medicare Advantage (MA) Plan Code 529
- Other A&I Forms and Documents

All questions and correspondence should be directed to DHCS' A&I Division, FROBHD, via email at: clinics@dhcs.ca.gov.

Medical or Mental Health Services for Medi-Cal Fee-For-Service Members

Table of Per-Visit Billing Code Set: Medical or Mental Health Services for Fee-For-Service Members

Revenue Code	Procedure Code and Modifier	Description	Explanation
0521	T1015	Medical or Mental Health per visit	Requires medical justification for more than one visit per member per day

RHC and FQHC providers must use this per-visit billingcode set when a covered service is rendered by a billable health care professional to Medi-Cal fee-for-service members. The per-visit billing code set rate is based on the Medi-Cal PPS rate currently on file for the RHC or FQHC provider. Therefore, the services are not eligible for the Medi-Cal MCP differential rate (wrap) payment. The Informational line(s) should contain the specific CPT-4 Level I or HCPCS Level II code(s) that identify the actual service(s) provided.

Table of Per-Visit Billing Code Sets: Optometry services for Fee-For-Service Members

Revenue Code	Procedure Code and Modifier	Description
0521	92004	Clinic visit optometry – Facility-specific Medi-Cal PPS rate. New patient
0521	92014	Clinic visit optometry – Facility-specific Medi-Cal PPS rate. Established patient

RHC and FQHC providers must use the appropriate per-visit billing code set as shown in the above table when a licensed optometrist acting within their scope of practice renders a covered service to Medi-Cal fee-for-service members. Optometry service is considered a medical visit for billing purposes.

A second eye examination with refraction within twenty-four months is covered only when a sign or symptom indicates a need for this service, per 22 CCR Section 51306.

The per-visit billing code set rate is based on the Medi-Cal PPS rate currently on file for the RHC or FQHC provider. Therefore, this service is not eligible for the MCP differential rate (wrap) payment. Refer to the *Reimbursement for Optometry Services* section of the Vision Care provider manual for additional information.

Dental Services for Medi-Cal Fee-For-Service or Dental Managed Care (DMC) Members

RHC and FQHC providers may render dental services through a face-to-face encounter or via an approved telehealth modality. Services must be delivered by dental providers authorized under the Medi-Cal State Plan and acting within the scope of practice. All services must comply with the *Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances* and be determined to be medically necessary pursuant to WIC Section 14059.5. Each provider must develop a treatment plan that optimizes preventative and therapeutic care and that is in the members best interest, taking into consideration their overall health status. All phases of the treatment plan shall be rendered in a safe, effective, equitable, member-centered, timely, and efficient manner.

Table of Per Visit Billing Code Set: Dental Services for Fee-For-Service Members or MCP Members Not Enrolled in a DMC Plan

Per Visit Code	Procedure	Description
03	Dental Services	This code is for fee-for service members or MCP members NOT enrolled in a DMC plan

RHC and FQHC providers must use this per-visit local code for dental services rendered to a fee-for service member who is not enrolled in a DMC plan.

RHC and FQHC providers must include the ICD-10 diagnosis code Z29.3 (encounter for prophylactic fluoride administration) as a secondary diagnosis code (not the principal diagnosis) when submitting claims for dental services that include fluoride varnish applications during an eligible dental visit for Medi-Cal members. This requirement applies to *UB-04* claim forms to improve documentation and reporting of preventive dental services.

The RHC or FQHC would also include the applicable Current Dental Terminology (CDT) code(s) on the claim's information line(s) of the *UB-04* claim form to ensure accurate utilization tracking.

The per-visit local code rate is based on the Medi-Cal PPS rate currently on file for the RHC or FQHC provider.

Table of Per Visit Billing Code Set: Dental Services for MCP Members Enrolled in a DMC Plan

Revenue Code	Procedure Code and Modifier	Description
0521	T1015 SE	Dental services that are delivered to members enrolled in a Medi-Cal DMC plan

RHC and FQHC providers must use this MCP differential rate (wrap) per-visit billing code set (revenue and procedure codes with modifier) for dental services rendered to an MCP member enrolled in a DMC Plan.

RHC and FQHC providers must include the ICD-10 diagnosis code Z29.3 (encounter for prophylactic fluoride administration) as a secondary diagnosis code (not the principal diagnosis) when submitting claims for dental services that include fluoride varnish applications during an eligible dental visit for Medi-Cal members. This requirement applies to *UB-04* claim forms to improve documentation and reporting of preventive dental services.

The RHC or FQHC providers would also include the applicable Current Dental Terminology (CDT) code(s) on the claim's information line(s) of the *UB-04* claim form to ensure accurate utilization tracking.››

RHC and FQHC providers are eligible for a differential rate(wrap) payment when submitting claims for services rendered to members enrolled in a DMC plan. These payments are intended to cover the difference between the amount paid by the DMC plan and the RHC or FQHC's Medi-Cal PPS per-visit rate for eligible visits. The per-visit billing code set is based on the Medi-Cal PPS differential rate currently on file for RHC or FQHC providers.

The RHC or FQHC provider would bill the DMC plan and separately submit a reimbursement claim to the Medi-Cal FI using the per-visit billing code set above. The RHC or FQHC would also include the applicable CDT code(s) on the claim's informational line(s) of the *UB-04* claim form accurate utilization tracking.

Documentation for dental services should be consistent with the standards set forth in the *Manual of Criteria and Schedule of Maximum Allowances* of the Medi-Cal Dental Provider Handbook and all state laws. Also refer to the *Safety Net Clinic (SNC) Dental Frequently Asked Questions* on the Medi-Cal Dental Service Division webpage.

Note: Providers must submit claims to the Medi-Cal FI using the MCP differential per visit billing code set for members enrolled in DMC plans in Sacramento County, Los Angeles County or Health Plan of San Mateo County (see the above table).

Medical or Mental Health Services for Managed Care Members

The majority of members are enrolled in a Medi-Cal MCP, and RHCs and FQHCs typically serve as contracted network providers within Medi-Cal MCPs to deliver covered health care services.

Table of Per-Visit Billing Code Set: Medi-Cal MCP Differential Rate (Wrap) Payment for Medical Services for MCP Members

Revenue Code	Procedure Code and Modifier	Description	Explanation
0521	T1015 SE	Services rendered to members enrolled in a Medi-Cal MCP	Requires medical justification for more than one visit per member per day

RHC and FQHC providers must use this MCP differential rate (wrap) per-visit billing code set for services rendered to Medi-Cal members enrolled in a Medi-Cal MCP. This differential rate (wrap) is intended to approximate the difference between the weighted average payments received from the MCPs and the provider's established Medi-Cal PPS rate. The reimbursement for this per-visit billing code set is based on the Medi-Cal PPS differential rate currently on file for the RHC or FQHC provider.

To complete the MCP differential rate (wrap) payment process for the eligible visit, the RHC or FQHC provider must submit a claim to the MCP for payment or adjudication even if the service is rendered to an OON member, there is no contract in place, or other circumstances such as OHC. A separate reimbursement claim must then be submitted to the Medi-Cal FI for the differential rate (wrap) payment using the per-visit billing code set above. The RHC or FQHC would also include the applicable CPT® or HCPCS code(s) on the claim's informational line(s), of the *UB-04* claim form for accurate utilization tracking.

Note: Incident-to services must be billed to the MCP if they are covered under the MCP's contract. However, incident-to services are not eligible for differential rate (wrap) payments because the PPS differential rate (wrap) is intended only for qualifying visits. Since incident-to services do not meet this definition and are already reimbursed through the MCP, there is no additional differential payment owed. MCP payments for incident-to services are subject to reconciliation regardless of whether or not a billable RHC or FQHC visit is rendered.

Billing for Medi-Cal Covered Services Provided to Dually Eligible Members

A member who is enrolled in both federal Medicare and Medi-Cal who qualifies for benefits under both programs is known as a "dually eligible"/dual-eligible member.

Billing for dually eligible members involves coordination of benefits and billing through Medicare, Medi-Cal, and Medi-Cal MCPs for managed care members.

When billing for services provided to dually eligible members, claims may either automatically crossover from Medicare to Medi-Cal or Medi-Cal MCP or need to be billed directly to Medi-Cal. Refer to the following manuals for additional information:

- *Medicare/Medi-Cal Crossover Claims Overview*
- *Medicare Non-Covered Services: CPT Codes*
- *Medicare Non-Covered Services: HCPCS Codes*
- *Medicare/Medi-Cal Crossover Claims: Outpatient Services*

Crossover Claims for Dually Eligible Members

Table of Per-Visit Billing Code Sets: Crossover Claims for Fee-For-Service Members Enrolled in Original Medicare or Medicare Advantage Plan (MA) (Non-Capitated Arrangement)

Revenue Code	Procedure Code and Modifier	Description
0521	G0466	Crossover claims, clinic visit, new patient
0521	G0467	Crossover claims, clinic visit, established patient
0521	G0468	Crossover claims, clinic visit Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
0522	G0466	Crossover claims, home visit, new patient
0522	G0467	Crossover claims, home visit, established patient
0522	G0468	Crossover claims, home visit Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
0524	G0466	Crossover claims, visit covered Part A stay at a Skilled Nursing facility, new patient
0524	G0467	Crossover claims, visit covered Part A stay at a Skilled Nursing facility, established patient
0524	G0468	Crossover claims, visit covered Part A stay at a Skilled Nursing facility, Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
0525	G0466	Crossover claims, visit (not covered Part A stay) at a Skilled Nursing facility, new patient
0525	G0467	Crossover claims, visit (not covered Part A stay) at a Skilled Nursing facility, established patient
0525	G0468	Crossover claims, visit (not covered Part A stay) at a Skilled Nursing facility, Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
0527	G0466	Crossover claims, visiting nurse to home, new patient (as defined in Code of Federal Regulations (CFR), Title 42, Section 405.2416)
0527	G0467	Crossover claims, visiting nurse to home, established patient (as defined in Code of Federal Regulations (CFR), Title 42, Section 405.2416)
0527	G0468	Crossover claims, FQHC visiting nurse to home IPPE or AWV
0900	G0469	Crossover claims, mental health visit, new patient
0900	G0470	Crossover claims, mental health visit, established patient

RHC or FQHC providers, when submitting a crossover claim, must use the appropriate per-visit billing code set, shown in the table above, that most accurately describes the service rendered to a fee-for-service member who is dually enrolled in Original Medicare or in a Medicare Advantage Plan (Non-Capitated Arrangement). In this circumstance, Original Medicare or in a Medicare Advantage Plan (Non-Capitated Arrangement) is the primary coverage and Medi-Cal fee-for-service is secondary coverage.

The reimbursement rate for crossover claim codes are set at an amount that is intended to cover the difference between the Medicare payment and the Medi-Cal PPS rate currently on file for the RHC and FQHC provider.

The above codes require the Medicare Explanation of Medical Benefits (EOMB), Medicare Remittance Advice Notice (MRN), or Remittance Advice (RA) to be attached to the claim.

When the Medi-Cal eligibility verification system indicates a member has original Medicare coverage, Medicare must be billed first to the appropriate Medicare Administrative Contractor (MAC) for processing.

For members enrolled in a Medicare Advantage non-capitated arrangement, the clinic must bill the Medicare Advantage plan first, then the MAC, for the Medicare Advantage Wrap-Around Payment (Revenue Code 519) before billing Medi-Cal.

Note: (For *UB-04* claim forms): Do not enter Medicare status information in *Condition Codes* (boxes 24-30) fields. The following statement must be included in the *Remark*s (Box 80) field of the claim or submit it as an 8 1/2" x 11" attachment: “For a fee-for-service Medi-Cal member enrolled in a fee-for-service Medicare Advantage Plan.”

Table of Per Visit Billing Code Sets: Cross Over Claims Payment for Fee-For-Service Members Enrolled in Medicare Advantage Plan (Capitated Arrangement)

Revenue Code	Procedure Code and Modifier	Description
0529	G0466	Capitated Medicare Advantage Plans clinic visit, new patient
0529	G0467	Capitated Medicare Advantage Plans clinic visit, established patient
0529	G0468	Capitated Medicare Advantage Plans clinic visit Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
0529	G0469	Capitated Medicare Advantage Plans Mental Health visit, new patient
0529	G0470	Capitated Medicare Advantage Plans Mental Health visit established patient

RHC or FQHC providers, when submitting a crossover claim, must us the appropriate per-visit billing code set, shown in the table above, that most accurately describes the service rendered to a fee-for-service member who is dually enrolled in a Medicare Advantage Plan (Capitated Arrangement). In this circumstance the Medicare Advantage Plan (Capitated Arrangement) is the primary coverage and Medi-Cal fee-for-service is secondary coverage.››

The reimbursement rate for crossover claim codes are set at an amount that is intended to cover the difference between the Medicare payment and the Medi-Cal PPS rate currently on file for the RHC or FQHC provider.

For claims submitted using Capitated MA plans per visit billing code sets where no EOB, MRN or RA are provided, and where the service is not reflected on the current Medicare Non-Covered Services list, the RHC or FQHC provider must include documentation of Medicare denial or attempts to bill Medicare and receive a denial. The RHC or FQHC provider should keep the documentation of Medicare non-payment on file, which must be made available upon DHCS request, for the Annual Reconciliation, or in the event of a state or federal audit.

Table of Per-Visit Billing Code Set for MCP Differential Rate Payment for MCP Members Enrolled in Original Medicare or MA Plan (Fee-For Service or Capitated Arrangements)

Revenue Code	Procedure Code and Modifier	Description
0521	T1015 SE	Services rendered to members enrolled in a Medi-Cal MCP

RHC and FQHC providers must use this MCP differential rate (wrap) per-visit billing code set after billing Original Medicare MA Plan or Medicare Advantage Wrap-Around Payments (Revenue Code 519) and Medicare Part D as applicable. This applies when services are rendered to Medi-Cal MCP enrollees who are dually enrolled in original Medicare or a MA an MA Plan (fee-for-service or Capitated Arrangement) and the service qualifies as a covered RHC or FQHC visit.

The reimbursement for the billing code set is based on the Medi-Cal PPS rate currently on file for the RHC or FQHC provider.

Billing Example

When a member has Medicare as primary insurance and a Medi-Cal MCP as secondary insurance, the RHC and FQHC provider would bill as follows:

- Medicare
  - Medicare is billed first. Medicare payments include Original Medicare, Medicare Advantage Plan, Medicare Advantage Wrap-Around Payments (Revenue Code 519) and Medicare Part D (where applicable)
- Medi-Cal MCP
  - After Medicare pays its portion, the claim is sent to the Medi-Cal MCP for secondary coverage
- MCP Differential Rate Payment: Submit claim to the Medi-Cal FI
- RHC and FQHC providers are entitled to the Medi-Cal PPS rate for a qualifying visit. Medi-Cal is the payer of last resort. All third-party payers must be billed

Dual Special Needs Plans (D-SNPs)

D-SNPs are MA plans that provide specialized care to dually eligible members who have Medicare and offer care coordination and wrap-around services. For more information, visit the Dual Eligible Special Needs Plans in California webpage on the DHCS website.

For information on the Senior Care Action Network (SCAN) Health Plan, a Medicare Advantage Special Needs Plan with a comprehensive risk-managed care contract to serve the Medicare-Medi-Cal dual eligible population, refer to the MCP: Special Projects section in the Part 1 manual.

Billing for Primary Care Services Rendered by a Medical Resident

Teaching Health Center Graduate Medical Education (THCGME) programs sponsored by the Health Resources and Services Administration (HRSA) or state-sponsored programs (Primary Care Residency Programs) may seek reimbursement for primary care services furnished by a medical resident when billed by a teaching physician. Refer to the *Teaching Health Center Graduate Medical Education* (THCGME) section of the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* manual for specific reimbursement requirements.

Special Billing Circumstances Requirements for Other Health Medi-Cal Covered Services

This subsection provides guidance for providers on other Medi-Cal covered services that are subject to special billing requirements and/or may have different reimbursement rates.

Dyadic Services

For billing for dyadic services, refer to the *Dyadic Services and the Dyadic Services Billing Examples for Federally Qualified Health Center and Rural Health Clinic Providers* sections of the Part 2 manual.

Justice-Involved (JI) Reentry Initiative

For billing JI services, refer to the *JI Pre-Release Services, Federally Qualified Health Centers, and Rural Health Clinic Services* section of the Part 2 manual.

Specialty Mental Health Services (SMHS)

Pursuant to WIC section 14132.100 (m) if the costs associated with providing SMHS are within the RHC's or FQHC's per-visit PPS rate, as determined by DHCS and the RHC or FQHC contracts with a county Mental Health Plan (MHP) for SMHS services, the SMHS costs shall be adjusted out of the RHC's or FQHC's per-visit PPS rate as a change in scope of service.

When Contracted with a County Mental Health Plan (MHP)

RHCs and FQHCs that have an active contract with a county MHP are authorized to provide SMHS to members within that county. In these cases:

- The provider is reimbursed at the contracted rate negotiated with the county MHP. This rate is specific to the county and may differ from standard Medi-Cal reimbursement rates.
- Claims for SMHS are submitted through the Short-Doyle system, which is managed by the county. Providers shall not submit claims through either the Medi Cal FI or the Short Doyle system using RHC and FQHC specific billing code sets, including HCPCS code T1015, legacy local codes (11, 12, 13), or any other legacy crosswalk codes or modifiers.

When Not Contracted with a County MHP

If an RHC or FQHC or RHC does not have a contract with the county MHP, they may still provide emergency or isolated SMHS to Medi-Cal members under limited circumstances:

- These are one-time or urgent services provided when a member presents with a mental health need and no immediate access to county services is available.
- The provider may submit a claim to Medi-Cal using Revenue Code 0521, and HCPCS code T1015 with modifier SE (and should indicate an isolated or emergency visit).
- The claim is processed through the standard Medi-Cal FI and any necessary reimbursement adjustments are made during the reconciliation process.
- After an initial emergency or isolated service, the provider is required to refer the member back to the county MHP for ongoing or follow-up care.
- The referral must be clearly documented in the member's medical record to ensure compliance with all applicable Medi-Cal policy and continuity of care.

Community- Based Adult Services

For billing for Community-Based Adult Services, refer to the *Community-Based Adult Services (CBAS)* (community) section of the Part 2 manual.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.