Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes

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This section contains per-visit billing code sets for Tribal Federally Qualified Health Centers (Tribal FQHCs) to submit claims to the Medi-Cal Fiscal Intermediary. For general Tribal FQHC information, providers may refer to the *Tribal Federally Qualified Health Centers (Tribal FQHCs)* section in this manual.

When a Tribal FQHC bills for recipients enrolled in a Managed Care Plan (MCP) or for a recipient that is enrolled in both a Medicare and an MCP and the service is covered by the MCP, Tribal FQHCs must bill the MCP. The MCP reimburses the Tribal FQHC at the full Alternative Payment Methodology (APM) rate, which is set at the Federal Indian Health Services All-Inclusive Rate (AIR).

Tribal FQHC Per-Visit Billing Code Sets

Please use the following HIPAA-compliant billing code sets unless otherwise advised by the Managed Care Plan (MCP). For managed care billing codes, please contact the MCP directly.

Table of Per-Visit Billing Codes

Revenue Code	Procedure Code and Modifier (as applicable)	Description of Service	Explanation
‹‹None	G0071	Telephonic evaluation discussion – established patient	Telephone evaluation discussion of five minutes or more between a billable Tribal FQHC practitioner and established patient.››
0520	T1015	Medical visit	Submit claims using this billing code set for medical services provided by physicians, specialists, physician assistants, nurse practitioners, certified nurse midwives, visiting nurses and Comprehensive Perinatal Services Program (CPSP) Services as described in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* section in the appropriate Part 2 manual.

Table of Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code and Modifier (as applicable)	Description of Service	Explanation
0561	T1015 AG	Mental health visit – psychiatrist	Code combination may also be used for the mental health services provided as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. A visit with CPSP support staff and/or a pregnancy-related physician encounter on the same day would constitute a single medical visit if the CPSP mental health visit was related to the pregnancy. If the other health visit is unrelated to the pregnancy, an additional visit is allowed with revenue code 0561.
0561	T1015 AJ	Mental health visit – clinical social worker	Code combination also used for mental health services provided as part of EPSDT benefit. A visit with CPSP support staff and/or a pregnancy-related physician encounter on the same day constitutes a single medical visit if the CPSP mental health visit was related to the pregnancy. If the other health visit was unrelated to the pregnancy, an additional visit is allowed with revenue code 0561. ‹‹**Note:** An Associate Clinical Social Worker (ASW) must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws.››

Table of Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code and Modifier (as applicable)	Description of Service	Explanation
‹‹0561	T1015 HO	Mental health visit – Licensed Professional Clinical Counselor (LPCC)	Limited to three visits per day, per recipient; any combination of three medical, mental health, dental and ambulatory services. Multiple services in the same category are allowed.››
0561	T1015 HR	Mental health visit – marriage and family therapist	Code combination also used for mental health services provided as part of EPSDT benefit. A visit with CPSP support staff and/or a pregnancy-related physician encounter on the same day constitutes a single medical visit if the CPSP mental health visit was related to the pregnancy. If the other health visit was unrelated to the pregnancy, an additional visit is allowed with revenue code 0561. **Note:** An Associate Marriage and Family Therapist (AMFT) must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws.

Table of Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code and Modifier (as applicable)	Description of Service	Explanation
0561	T1015 AH	Mental health visit – clinical psychologist	Code combination also used for mental health services provided as part of EPSDT benefit. A visit with CPSP support staff and/or a pregnancy-related physician encounter on the same day constitutes a single medical visit if the CPSP mental health visit was related to the pregnancy. If the other health visit was unrelated to the pregnancy, an additional visit is allowed with revenue code 0561.
0520	92004	Ambulatory visit, optometry services, per visit – new patient	Limited to one optometry visit per day, per recipient.
0520	92014	Ambulatory visit, optometry services, per visit – established patient	Limited to for one optometry visit per day, per recipient.
0420	T1015	Ambulatory visit – physical therapy	Limited to one physical therapy visit per day, per recipient.
0430	T1015	Ambulatory visit – occupational therapy	Limited to one occupational therapy visit per day, per recipient.

Table of Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code and Modifier (as applicable)	Description of Service	Explanation
0440	T1015	Ambulatory visit – speech pathology	Limited to one speech pathology visit per day, per recipient.
0470	T1015	Ambulatory visit – audiology	Limited to one audiology visit per day, per recipient.
0510	T1015	Ambulatory visit – podiatry	Limited to one podiatry visit per day, per recipient.
0940 *	98940	Ambulatory visit – chiropractic manipulative treatment, spinal, one or two regions	Limited to one chiropractic visit per day, per recipient. Only one chiropractic procedure code is allowed for reimbursement in a single day.
0940 *	98941	Ambulatory visit – chiropractic manipulative treatment, spinal, three to four regions	Limited to one chiropractic visit per day, per recipient. Only one chiropractic procedure code is allowed for reimbursement in a single day.
0940 *	98942	Ambulatory visit – chiropractic manipulative treatment, spinal, five regions	Limited to one chiropractic visit per day, per recipient. Only one chiropractic procedure code is allowed for reimbursement in a single day.

Table of Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code and Modifier (as applicable)	Description of Service	Explanation
2101	97810	Ambulatory visit – acupuncture, one or more needles, without electrical stimulation, initial 15-minute service	Limited to one acupuncture visit per day, per recipient. Only one acupuncture procedure code is allowed for reimbursement in a single day.
2101	97811	Ambulatory visit – acupuncture, one or more needles, without electrical stimulation, each additional 15-minute service	Limited to one acupuncture visit per day, per recipient. Only one acupuncture procedure code is allowed for reimbursement in a single day.
2101	97813	Ambulatory visit – acupuncture, one or more needles, with electrical stimulation, initial 15-minute service	Limited to one acupuncture visit per day, per recipient. Only one acupuncture procedure code is allowed for reimbursement in a single day.
2101	97814	Ambulatory visit – acupuncture, one or more needles, with electrical stimulation, each additional 15-minute service	Limited to one acupuncture visit per day, per recipient. Only one acupuncture procedure code is allowed for reimbursement in a single day.
0520	S0257	End of Life Option Act	An end of life service rendered in accordance with End of Life Option Act (Health and Safety Code, Division 1, Part 1.85, Section 443).

Dental Per-Visit Codes

Tribal FQHCs can bill Medi-Cal for dental services using the *UB-04* claim form and per-visit code 03 for all Medi-Cal recipients not enrolled in a Dental MCP.

When billing for services rendered to an American Indian dental MCP recipient (Los Angeles and Sacramento counties only), and the services are covered, the Tribal FQHC must first bill the dental MCP and then bill Medi-Cal. When billing Medi-Cal, enter the following on the *UB-04* claim form: per-visit code 03, the dental MCP as a payer in Boxes 50 thru 55 and the full dollar amount of the payment received from the dental MCP in Box 54A. If no payment was received from the dental MCP, enter a "0" in Box 54A, and Medi-Cal will reimburse the clinic at the full APM rate, which is set at the AIR. If the dental MCP pays a portion of the claim, Medi-Cal will reduce the reimbursement, so the amount from the dental MCP and the amount from Medi-Cal equal the full APM rate.

If a Medi-Cal recipient who is not American Indian is located in Los Angeles or Sacramento County and the recipient is enrolled in a dental MCP, the Tribal FQHC can render services and submit a claim to Medi-Cal. However, the Tribal FQHC is required to redirect the recipient to their "in-network" managed care provider and document the referral in the recipient's medical records. Medi-Cal recipients in dental MCPs are required to be treated by in-network providers, except in emergencies or other isolated instances. Tribal FQHCs can provide services in such circumstances, but must maintain proof of payment or denial from the dental MCP.

Per-Visit Dental Billing Code Table

Per-Visit Code	Description of Service	Explanation
03	Dental services	Per-visit code 03 is used to bill dental services provided by a dentist or dental hygienist.

Services for Recipients in Managed Care and Medicare

When Tribal FQHCs bill for recipients enrolled in both Medicare and a managed care plan and the service is covered by the plan, Tribal FQHCs must bill the managed care plan. Managed care plans are required to reimburse Tribal FQHCs for the full APM rate, which is set at the Federal AIR.

Table of Crossover Claim Per-Visit Billing Codes

Revenue Code	Procedure Code	Description of Service	Explanation
0520	G0466	Crossover claims – new patient	Requires the Medicare Explanation of Medicare Benefits (EOMB), Medicare Remittance Notice (MRN) or Remittance Advice (RA) to be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 18 thru 24) for Medicare Status. For crossover claims, providers do not complete the *Payer Name* field (Box 50) or *Prior Payments* field (Box 54) with prior payment amounts from Medicare or the Medicare carrier. Additional information is available in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the appropriate Part 2 manual.
0520	G0467	Crossover claims – established patient	Requires the Medicare EOMB, MRN or RA to be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 18 thru 24) for Medicare Status. For crossover claims, providers do not complete the *Payer Name* field (Box 50) or *Prior Payments* field (Box 54) with prior payment amounts from Medicare or the Medicare carrier. Additional information is available in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the appropriate Part 2 manual.

Table of Crossover Claim Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code	Description of Service	Explanation
0520	G0468	Crossover claims – Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	Requires the Medicare EOMB, MRN or RA to be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 18 thru 24) for Medicare Status. For crossover claims, providers do not complete the *Payer Name* field (Box 50) or *Prior Payments* field (Box 54) with prior payment amounts from Medicare or the Medicare carrier. Additional information is available in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the appropriate Part 2 manual.
0900	G0469	Crossover claims – mental health visit, new patient	Requires the Medicare EOMB, MRN or RA to be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 18 thru 24) for Medicare Status. For crossover claims, providers do not complete the *Payer Name* field (Box 50) or *Prior Payments* field (Box 54) with prior payment amounts from Medicare or the Medicare carrier. Additional information is available in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the appropriate Part 2 manual.

Table of Crossover Claim Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code	Description of Service	Explanation
0900	G0470	Crossover claims – mental health visit, established patient	Requires the Medicare EOMB, MRN or RA to be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 18 thru 24) for Medicare Status. For crossover claims, providers do not complete the *Payer Name* field (Box 50) or *Prior Payments* field (Box 54) with prior payment amounts from Medicare or the Medicare carrier. Additional information is available in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the appropriate Part 2 manual.

Capitated Medicare Advantage Plans

Tribal FQHCs use Capitated Medicare Advantage Plan billing code sets for services rendered to Medi-Cal recipients enrolled in capitated Medicare Advantage Plans.

American Indians can elect to receive services at a Tribal FQHC rather than their assigned "in-network" managed care provider per California Code of Regulations, Title 22, Section 55110.

Additional information is available in the *Tribal Federally Qualified Health Centers (Tribal FQHCs)* section of this manual.

Table of Capitated Medicare Advantage Plans Per-Visit Billing Codes

Revenue Code	Procedure Code	Description of Service	Explanation
0529	G0466	Capitated Medicare Advantage Plans – new patient	Requires justification for the absence of the Medicare EOMB, MRN or RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete the *Condition Codes* fields (Boxes 24 and 25) for Medicare status.
0529	G0467	Capitated Medicare Advantage Plans – established patient	Requires justification for the absence of the Medicare EOMB, MRN or RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete the *Condition Codes* fields (Boxes 24 and 25) for Medicare status.

Table of Capitated Medicare Advantage Plans Per-Visit Billing Codes (continued)

Revenue Code	Procedure Code	Description of Service	Explanation
0529	G0468	Capitated Medicare Advantage Plans – initial preventive physical exam (IPPE) or Annual Wellness Visit (AWV)	Requires justification for the absence of the Medicare EOMB, MRN or RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete the *Condition Codes* fields (Boxes 24 and 25) for Medicare status.
0529	G0469	Capitated Medicare Advantage Plans – mental health visit, new patient	Requires justification for the absence of the Medicare EOMB, MRN or RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete the *Condition Codes* fields (Boxes 24 and 25) for Medicare status.
0529	G0470	Capitated Medicare Advantage Plans – mental health visit, established patient	Requires justification for the absence of the Medicare EOMB, MRN or RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete the *Condition Codes* fields (Boxes 24 and 25) for Medicare status.

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.
*	See the *Chiropractic Services* section in the *Allied Health – Chiropractic* section of the appropriate Part 2 manual for complete policy details.