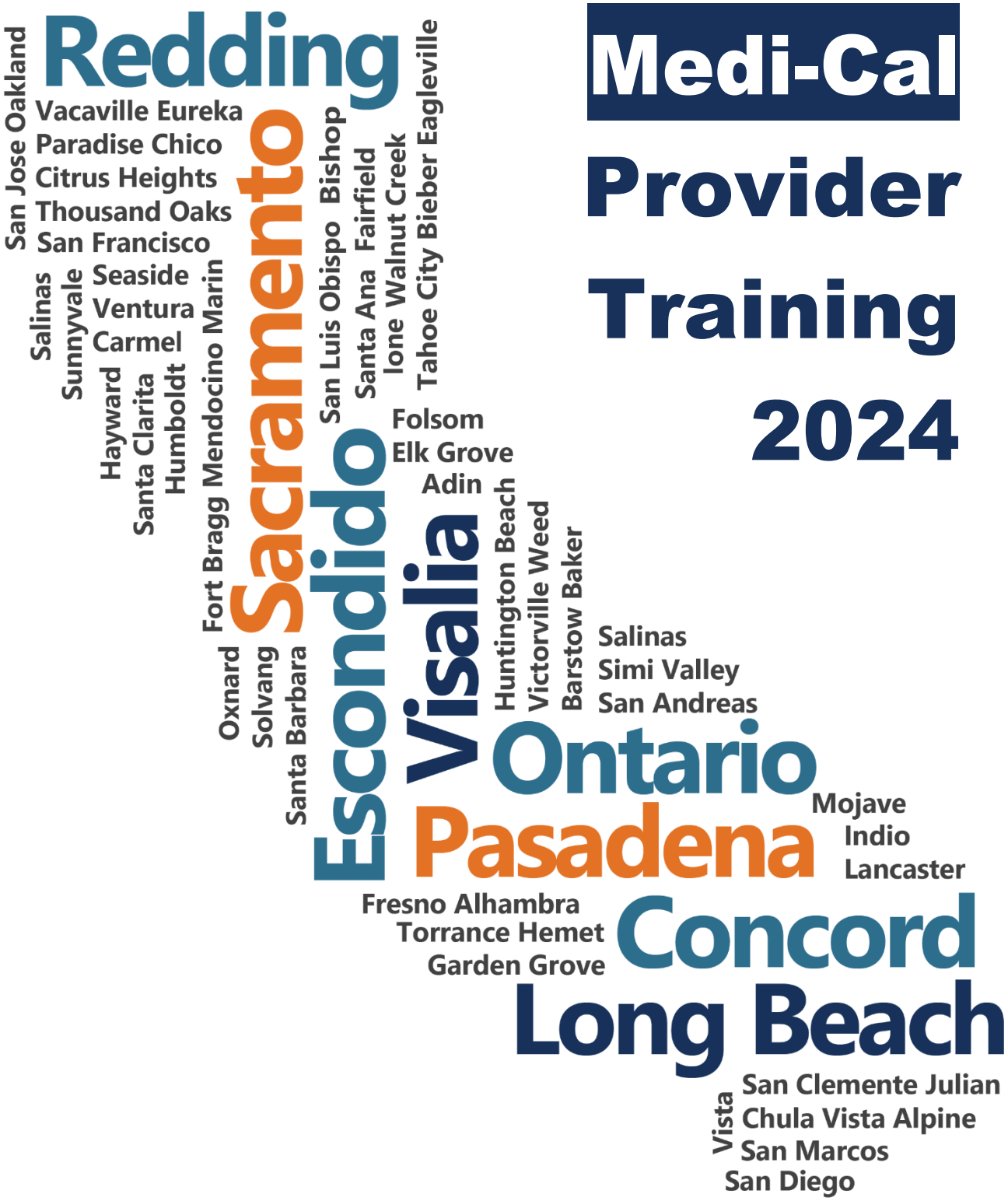


Medi-Cal Provider Training 2024

Tribal FQHC & IHS-MOA Services

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at www.learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

Table of Contents

Tribal FQHC and IHS-MOA Services

Introduction

Purpose

The purpose of this module is to provide information for billing services rendered by Tribal Federally Qualified Health Centers (FQHCs) and Indian Health Services-Memorandum of Agreement (IHS-MOA) clinics to participants in the Medi-Cal program.

Module Objectives

- Define Tribal FQHC and IHS-MOA
- Illustrate accessing Provider Enrollment Form
- Introduce Community Health Worker (CHW) preventative services.
- Discuss Doula services.
- Examine Asthma Preventative Services
- 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.

Background

Tribal FQHCs

The Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) to establish Tribal FQHCs as a provider type, per State Plan Amendment (SPA) 20-0044. The SPA outlines Tribal FQHC eligibility, payment methodology and allowable visit combinations.

Outpatient health care programs operated by a tribe or tribal organization are eligible to enroll as a Tribal FQHC in Medi-Cal. Tribal FQHCs provide covered primary care clinic services to Medi-Cal beneficiaries. Tribal FQHC services may be provided in a clinic or off site by tribal providers and non-tribal providers that are contractors of the Tribal FQHC.

Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Services All-Inclusive Rate (AIR).

IHS-MOA Services

DHCS implemented the IHS-MOA program between the federal IHS and the Centers for Medicare & Medicaid Services. The IHS-MOA changed the reimbursement policy for services provided to Medi-Cal recipients within American Indian or Alaskan native health care facilities identified as 638 facilities. DHCS compiled a list of IHS-MOA clinics and mailed a letter to each provider, informing them of the option to participate as a 638 clinic under the MOA. Providers electing to participate were asked to complete and return an “Elect to Participate” Indian Health Services Memorandum of Agreement (IHS/MOA) Application (DHCS 7108) to the DHCS Provider Enrollment Division (PED).

Provider Enrollment

Tribal FQHC – Existing Medi-Cal Providers:

Under Section 1905(I)(2)(B) of the Social Security Act, outpatient health care programs operated by a tribe or a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA) may request designation as a Tribal FQHC by completing the "Elect to Participate" Indian Health Services Memorandum of Agreement (IHS-MOA) and Tribal Federally Qualified Health Center (FQHC) form (DHCS 7108) located on the Medi-Cal Provider website.

New Medi-Cal Providers

Eligible tribal health programs requesting initial enrollment in the Medi-Cal program as a Tribal FQHC must apply through the DHCS electronic application system, Provider Application and Validation for Enrollment (PAVE) and complete form DHCS 7108; to be eligible to enroll as a Tribal FQHC provider, the health programs must be operated by a tribe or a tribal organization under P.L. 93-638. Providers may contact the DHCS Provider Enrollment Division (PED) at (916) 323-1945 or visit the DHCS PAVE website for all applicable enrollment forms.

IHS-MOA Enrollment

FQHCs, RHCs and certain Primary Care Clinics (PCCs) designated by the federal IHS as eligible to participate in the IHS-MOA may enroll as IHS-MOA clinic providers.

Clinics cannot be designated as both an IHS-MOA and a FQHC/RHC/Tribal FQHC/PCC provider. Any other current provider numbers or National Provider Identifier (NPI) numbers are deactivated at the time of enrollment. Medi-Cal will recognize these providers as IHS-MOA providers only.

Providers may enroll as an IHS-MOA clinic by completing an *"Elect to Participate" Indian Health Services Memorandum of Agreement (IHS/MOA) and Tribal Federally Qualified Health Center (Tribal FQHC) Application* (DHCS 7108). The application must be mailed to:

Attn: Provider Enrollment Division
Department of Health Care Services
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Faxed applications will not be considered.

Requirements and Procedures for Reporting of Intermittent Clinics and Mobile Health Units

The following are the requirements and procedures for reporting intermittent clinic sites pursuant to Welfare & Institutions (W&I) Code Section 14043.15(e). This update only applies to intermittent clinic sites that are operated by a licensed (parent) primary care clinic and this does not apply to unlicensed clinics reporting an intermittent clinic site. Intermittent clinic sites of unlicensed clinics must submit a full application through PAVE to enroll. W&I Code Section 14043.15(e) states “Notwithstanding subdivisions (a), (b), (c) and (d), an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code and that is operated by a licensed primary care clinic and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary care clinic operating the applicant, provider clinic, or mobile health care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.”

Reporting New Intermittent Clinic Sites and Mobile Health Units

To properly report intermittent clinic sites operated by licensed (parent) primary care clinics, as defined above, written notifications must be sent to DHCS PED at the following address:

Department of Health Care Services Provider Enrollment Division

P.O. Box 997412, MS 4704
Sacramento, CA 95899-7412

Written notifications of intermittent clinics operated by licensed (parent) primary care clinics must be on letterhead and include the following information:

Licensed (parent) Primary Care Clinic Information:

- License number
- Facility name and address
- Federal Employer Identification Number
- National Provider Identifier (NPI)
- Contact Information (name, title, phone number and email address)

Intermittent Clinic Information:

- Facility name and address
- National Provider Identifier (NPI)
- Operational start date
- Hours of operation
- Contact Information (name, title, phone number and email address)

Reporting a Conversion of a Licensed (Parent) Primary Care Clinic to an Intermittent Clinic

To report a licensed (parent) primary care clinic that is requesting to convert to an intermittent clinic site, the notification must be sent to DHCS PED and the California Department of Public Health, Centralized Applications Branch at the following addresses:

Department of Health Care Services
Provider Enrollment Division P.O. Box 997412, MS 4704
Sacramento, CA 95899-7412

and:

California Department of Public Health
Centralized Applications Branch
P.O. Box 997377, MS 3207
Sacramento, CA 95899-7377

Written notifications of intermittent clinics surrendering their license must be on letterhead and include the following information:

- Name and physical address of the licensed clinic that is surrendering their license;
- Name and physical address of the new parent clinic;
- Name, NPI and physical address of the new site(s);
- Hours of operation of the new site(s); and
- A statement that the licensed clinic is requesting to surrender their license.

Medi-Cal Provider Website Homepage

1. From the Resources drop-down menu, select References to locate “Forms” link.

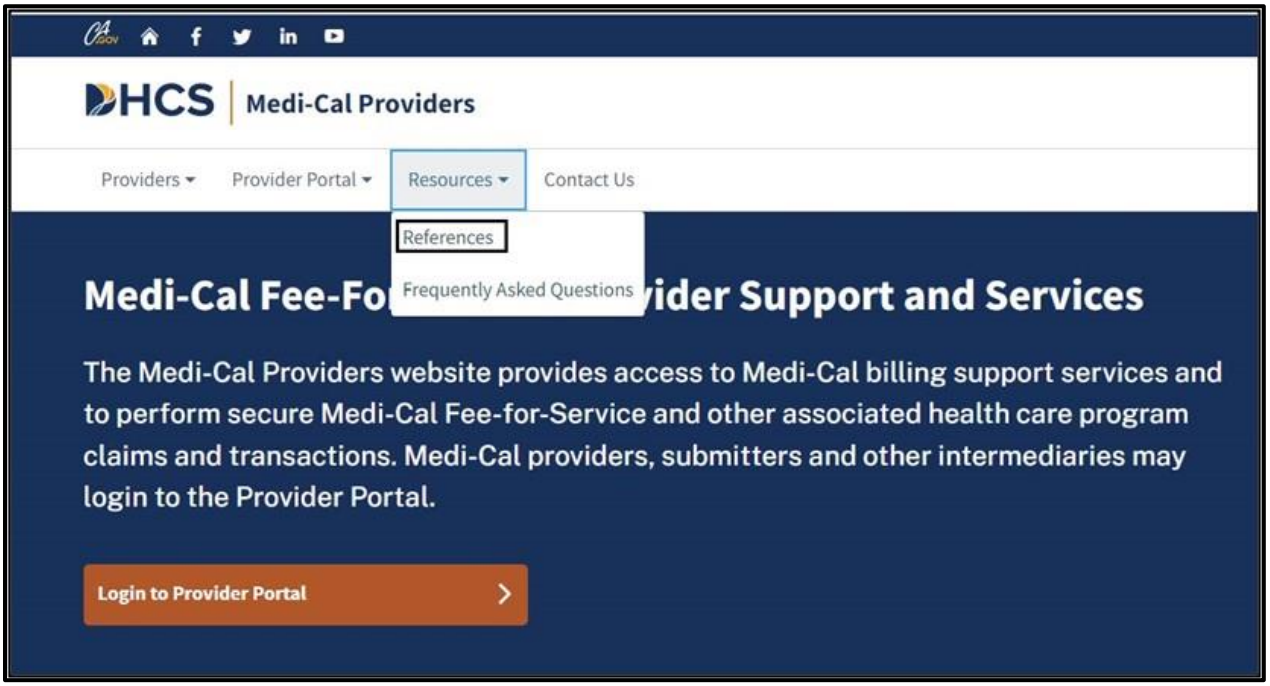


Figure 1.1: Select Resources and References.

2. Located on the Resources page, scroll down and select “Forms.”

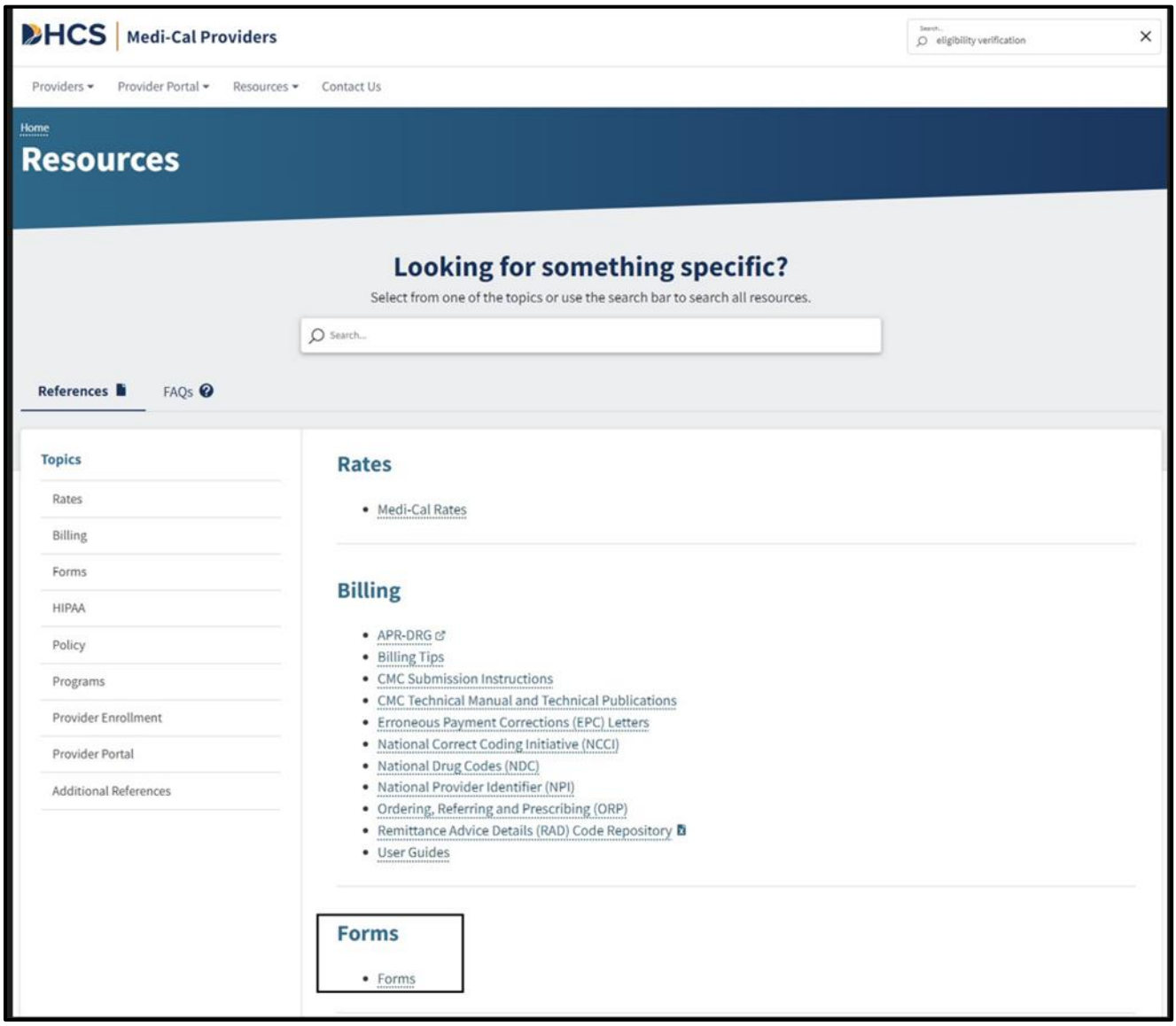


Figure 1.2: Resources.

3. “Elect to Participate” Indian Health Services Memorandum of Agreement (IHS/MOA) Application (Rev. 6/21) (DHCS 7108) (Fillable).

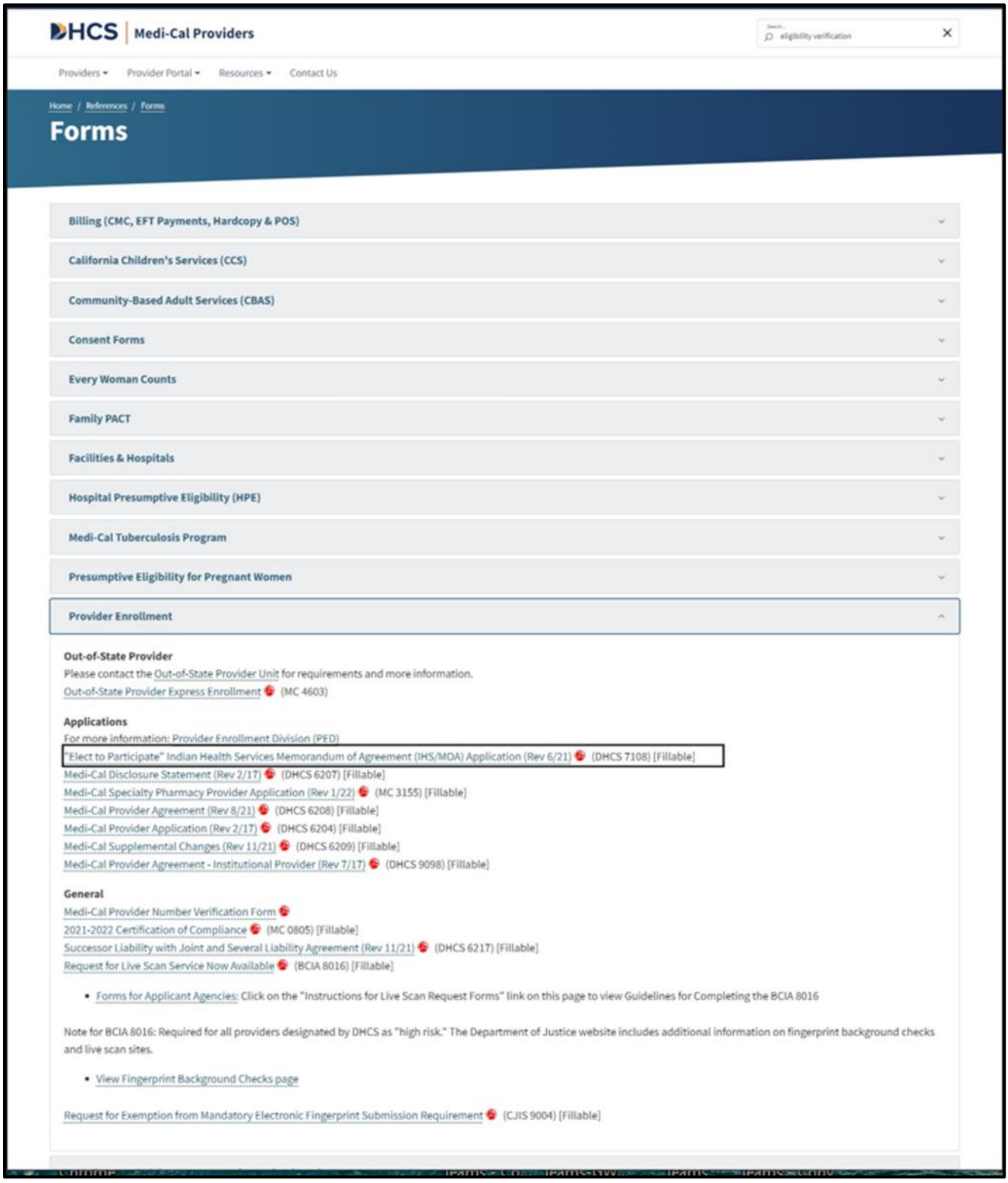


Figure 1.3: Applications.

Authorized Physicians

Tribal FQHC

The following providers are defined as “physicians”:

Authorized Physician Table

Type of Physician	Program Requirements
General Medicine or Osteopathy	A physician or osteopath authorized to practice medicine and surgery by the state while acting within the scope of his/her license.
Podiatrist	A doctor of Podiatry authorized to practice podiatric medicine by the state while acting within the scope of his/her license.
Optometrist	A doctor of Optometry authorized to practice optometry by the state while acting within the scope of his/her license.
Chiropractor	A doctor of Chiropractic 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/her license.
Medical Resident	Medical Resident in Tribal FQHC that operates a federal or state sponsored Teaching Health Center Graduate Medical Education (THCGME) grant 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. The THCGME Program is required to be accredited by the Accreditation Council for Graduate Medical Education.

IHS-MOA

The following providers are defined as “physicians”:

Authorized Physician Table

Type of Physician	Program Requirements
General Medicine or Osteopathy	A physician or osteopath authorized to practice medicine and surgery by the state while acting within the scope of his/her license.
Podiatrist	A doctor of Podiatry authorized to practice podiatric medicine by the state while acting within the scope of his/her license.
Optometrist	A doctor of Optometry authorized to practice optometry by the state while acting within the scope of his/her license.
Chiropractor	A doctor of Chiropractic 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/her license.

Scope of Coverage

Tribal FQHC

Types of Services Covered

- 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
- 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
- Clinical psychologist services
- Optometry
- Podiatry
- Dental Services
- Community Health Worker Preventative Services
- Asthma Preventative Services
- Doula Services
- End of life services

Types of Services Covered

Ambulatory Services

- Acupuncture (subject to California Code of Regulations (CCR), Title 22, Section 51309)
- Chiropractor services (subject to CCR, Title 22, Section 51309)
- Physical therapy
- Occupational therapy (subject to CCR, Title 22, Section 51309)
- Speech pathology (subject to CCR, Title 22, Section 51309)
- Audiology (subject to CCR, Title 22, Section 51309)

Dental Services

- Dental hygienist services

IHS-MOA

Types of Services Covered

- Physician services
- Physician assistant services
- Nurse practitioner services
- Nurse midwife services
- Visiting nurse services (if services are provided in the Tribal facilities)
- Clinical psychologist services (Interns must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws).
- Clinical social worker services (Interns must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws).
- Marriage and family therapist services (Interns must be under the supervision of a licensed mental health professional in accordance with the requirements of applicable state laws).
- Services and supplies incidental to physician services.
- Comprehensive Perinatal Services Program (CPSP) services: registered nurse, dietitian, health educator, certified childbirth educator, licensed vocational nurse and comprehensive perinatal health worker, if the clinic has an approved application on file with the California Department of Public Health, Maternal, Child and Adolescent Health Division.
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services: licensed marriage, family and child counselors (available to persons younger than 21 years of age as another health visit if an EPSDT screening identified the need for a service necessary to correct or ameliorate a mental illness or condition)
- Medi-Cal ambulatory services
- Optometry
- Dental (For additional dental services information, refer to the *Indian Health Services (IHS) Memorandum of Agreement (MOA) 638, Clinics* section (ind health) of the Part 2 provider manual).
- End of life services
- Doula Services
- Community Health Worker Preventative Services (CHW)
- Asthma Preventative Services

IHS-MOA: Medi-Cal Ambulatory Visit

A Medi-Cal ambulatory visit is a face-to-face encounter between an IHS-MOA recipient and a health care professional other than a physician or mid-level practitioner and is included in the Medi-Cal State Plan. This encounter must occur in the tribal health facility.

Medi-Cal ambulatory visit services are reimbursed at the IHS-MOA all-inclusive rate and are as follows:

Medi-Cal Ambulatory Visit

Visit Type:	Subject to:
Acupuncture	CCR, Title 22, Section 51309
Audiology	CCR, Title 22, Section 51309
Chiropractic	CCR, Title 22, Section 51309
Occupational Therapy	CCR, Title 22, Section 51309
Physical Therapy	CCR, Title 22, Section 51309
Podiatry	None
Speech Pathology	CCR, Title 22, Section 51309
Drug and Alcohol Visits	Subject to Medi-Cal participation requirements
Dental	None
Telemedicine	None

Community Health Worker Preventative Services (CHW)

Tribal FQHC and IHS-MOA Providers

Effective for dates of service on or after July 1, 2022, community health worker (CHW) preventive services are reimbursable at a **fee-for-service rate** when rendered by Tribal Federally Qualified Health Centers (Tribal FQHC) and Indian Health Services Memorandum of Agreement (IHS-MOA) providers.

Program Coverage

Medi-Cal covers community health worker (CHW) services, pursuant to Title 42 of the Code of Federal Regulations, Section 440,130 (c), as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

CHW services may address issues that include, but are not limited to, the control and prevention of chronic conditions or infectious diseases: mental health conditions and substance use disorders; need for preventive services, perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and violence prevention.

Definition

CHW services are preventive health services to prevent disease, disability and other health conditions or their progressions: to prolong life; and promote physical and mental health.

The plan of care is a written document that is developed by one or more licensed providers to describe the supports and services a CHW will provide to address ongoing needs for a beneficiary. A CHW may assist in developing a plan of care with the licensed provider.

Covered CHW Services

- **Health education** to promote the beneficiary's health or address barriers to physical and mental health care, including providing information or instruction on health topics. Health education may include coaching and goal setting to improve a beneficiary's health or ability to self-manage health conditions.
- **Health navigation** to provide information, training, referrals, or support to assist beneficiaries to:
  - Access health care, understand the health care system, or engage in their own care.
  - Connect to community resources necessary to promote a beneficiary's health-related social needs.
- **Screening and assessment** that does not require a license and that assists a beneficiary to connect to appropriate services to improve their health.
- **Individual support or advocacy** that assists a beneficiary in preventing the onset or exacerbation of a health condition or preventing injury or violence.

Reimbursable CHW Billing Codes

Tribal FQHC and IHS-MOA providers may be reimbursed for the following CPT codes.

Table of Reimbursable CHW Billing Codes

CPT Code	Description	Modifier
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes, individual patient	U2
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	U2
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	U2

For additional information on covered services, documentation requirements, eligibility criteria and claim submission, refer to the *Community Health Worker (CHW) Preventative Services* manual section. For managed care beneficiaries, refer to the most recent Managed Care All Plan letter for CHW services on the DHCS website and contact the Managed Care Plan for appropriate billing codes.

Field	Entry
1	ABC MEDICAL CLINIC 1234 MAIN STREET ANYTOWN CA 900005555
2	
3a PAT. CNTL #	
b. MED. REC. #	
4 TYPE OF BILL	731
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	
7	
8 PATIENT NAME	a DOE, JOHN
9 PATIENT ADDRESS	
10 BIRTHDATE	05212002
11 SEX	M
12 DATE / ADMISSION 13 HR / 14 TYPE / 15 SRC / 16 DHR / 17 STAT	
18–28 CONDITION CODES	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39–41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0520	COMMUNITY HEALTH WORKER	98962U2	010323	1	45 00		
001	*PAGE ____ OF ____*	*CREATION DATE*	010623	***TOTALS***	45 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A O/P MEDI-CAL					45 00	0123456789

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		90000000A95001		

Field	Entry
57 OTHER PRV ID	
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	0
67	D1D1D1D1
68	
69 ADMIT DX	
70 PATIENT REASON DX	
71 PPS CODE	
72 ECI	
73	
74 PRINCIPAL PROCEDURE CODE / DATE; OTHER PROCEDURE a.–e.	
75	
76 ATTENDING NPI	1234567890
77 OPERATING NPI	
78 OTHER NPI	
79 OTHER NPI	
80 REMARKS	
81CC a–d	

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: Community Health Worker Group billing example only. Please adapt to your billing situation.

CHW *Treatment Authorization Request* (TAR Requirements)

CPT codes 98960, 98961 and 98962 require a TAR when the maximum frequency is exceeded. For information on submitting TARs online, refer to the electronic TAR (eTAR) workbooks on the Medi-Cal Provider Training Workbooks page. For information on submitting paper TARs, refer to the *TAR Overview* sections of the Part 1 manual and the *TAR Completion* section of the appropriate Part 2 manual.

Asthma Preventative Services (APS)

Tribal FQHC and IHS-MOA providers may be reimbursed for APS. APS comprise of clinic-based asthma self-management education, home-based asthma self-management education and in-home environmental trigger assessments for eligible beneficiaries of any age, as medically necessary, subject to applicable utilization controls. APS that are provided based on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law are reimbursable at the fee-for-service rate.

Table of APS CPT Codes and Modifiers

CPT Code	Description	Modifier
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	U3
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	U3
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	U3
T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs	U3

APS (TAR) Requirements

CPT codes 98960, 98961, 98962 and T1028 require a TAR when the maximum frequency is exceeded. Refer to the *Asthma Preventive Services (APS)* manual sections for frequency limitations, covered services and eligibility criteria. For information on submitting TARs online, refer to the electronic TAR (eTAR) workbooks on the Medi-Cal Provider Training Workbooks page. For more information on submitting paper TARs, refer to the *TAR Overview* section of the Part 1 manual and the *TAR Completion* section of the appropriate Part 2 manual.

Documentation Requirements

CHW services require a written recommendation by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, licensed educational psychologists, licensed vocational nurses and pharmacists.

CHWs are required to document the dates and time/duration of services provided to beneficiaries. Documentation should reflect information on the nature of the service provided and support the length of time spent with the patient that day. For example, documentation might state, “Discussed the patient’s challenges accessing healthy food and options to improve the situation for 15 minutes. Assisted with Supplemental Nutrition Assistance Program (SNAP) application previously known as the Food Stamp Program for 30 minutes.”

Claim Submission

Claims for CHW services must be submitted by the Medi-Cal enrolled supervising provider.

Doula Services Tribal FQHC and IHS-MOA

Tribal FQHC and IHS-MOA providers may be reimbursed for doula services at the Fee-For-Service (FFS) rate. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants. The Tribal FQHC provider must bill for doula services under the billing clinic National Provider Identifier (NPI). The doula provider must be enrolled in Medi-Cal as an individual doula provider and listed on the claim as a rendering provider. Doula providers must not bill Medi-Cal as an individual practitioner for services provided to a patient of the Tribal FQHC. For a full list of definitions, billing codes, documentation requirements and more, providers may refer to the *Doula Services* section in the appropriate Part 2 manual.

Field	Entry
1	ABC MEDICAL CLINIC 1234 MAIN STREET ANYTOWN CA 900005555
4 TYPE OF BILL	731
8 PATIENT NAME (a)	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	49
0520	DOULA SERVICES	59612XP	010323	1	100 00		
001	PAGE ____ OF ____	CREATION DATE	010623	TOTALS	100 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
O/P MEDI-CAL					100 00	0123456789

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		90000000A95001		

Field	Entry
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	0
67	D1D1D1D1
76 ATTENDING NPI	1234567890
77 OPERATING	
78 OTHER	
79 OTHER	
80 REMARKS	

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: Doula services billing example only. Please adapt to your billing situation.

Tribal FQHC Medical Visit Defined

Tribal FQHC clinic encounter (visit) is defined as a face-to-face encounter between a tribal clinic patient and the health professional of the clinic.

Tribal FQHC Reimbursement Visit Criteria

Tribal FQHCs may be reimbursed for up to three visits per day, per recipient, in any combination of three different medical, mental health, dental and ambulatory services listed in the *Tribal FQHC Services Available* section in this manual. When billing for services rendered to Medi-Cal managed care members and the services are covered by the Managed Care Plan (MCP), Tribal FQHC providers must bill the MCP. No differential billing is required. Reimbursement for services provided outside the clinic facility by clinic providers and contracted providers is allowable.

A visit with a 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 is unrelated to the pregnancy, an additional visit is allowed and must be billed with the appropriate HIPAA-compliant billing code set.

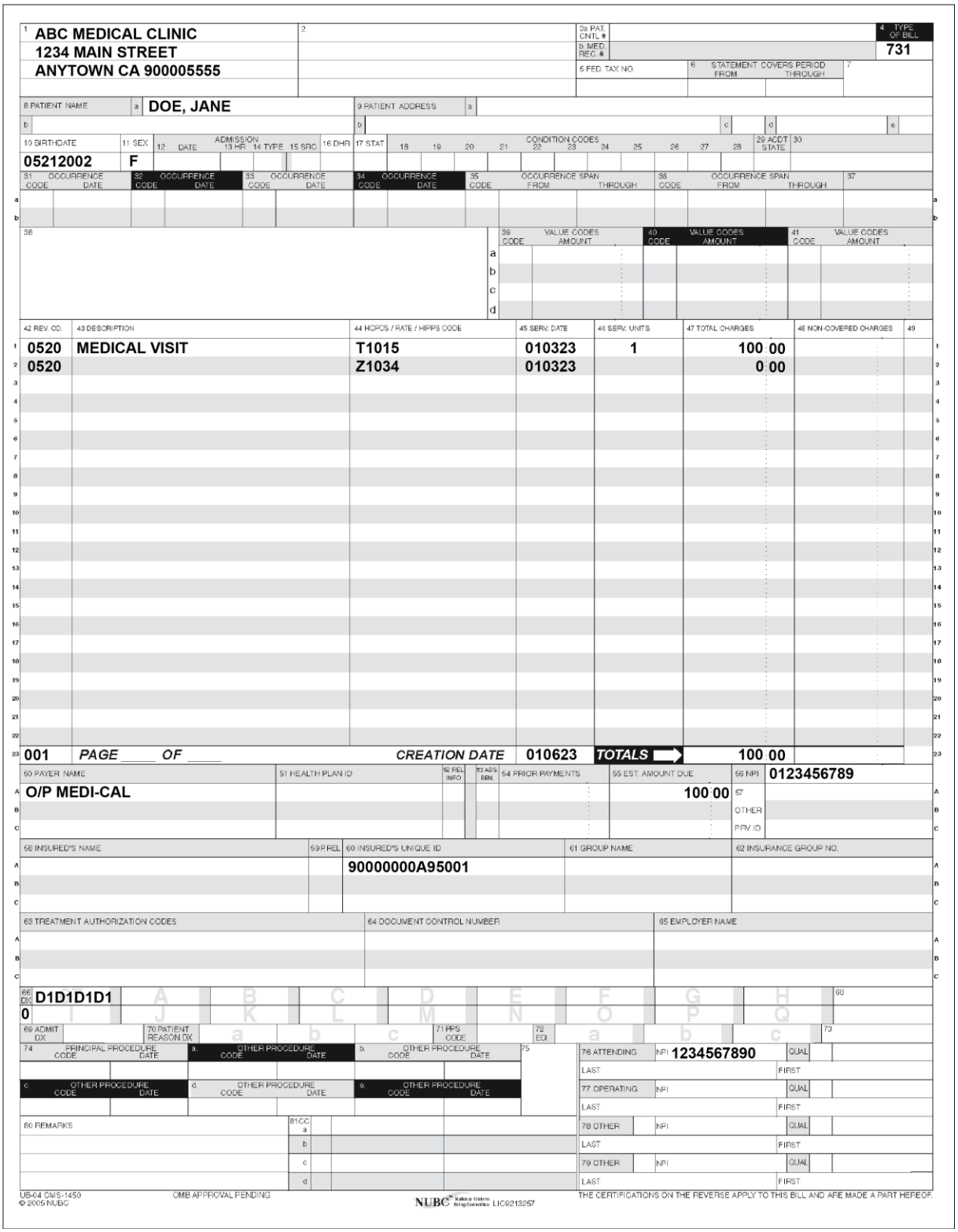
Tribal FQHC reimbursement is based on Alternative Payment Methodology (APM), which is payable at the Federal IHS All-Inclusive Rate.

IHS-MOA Medical Visit Defined

IHS-MOA clinics may be reimbursed for up to three visits a day for one recipient: a medical visit, a mental health visit and a Medi-Cal ambulatory/dental visit. A medical visit is a face-to-face encounter, occurring at a clinic or center between a recipient and physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse (if services are provided in the Tribal facilities).

A visit with a 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 is unrelated to the pregnancy, an additional visit is allowed and must be billed with the appropriate HIPAA-compliant billing code set.

When billing for services rendered to Medi-Cal managed care members, and the services are covered by the Managed Care Plan (MCP), IHS-MOA providers must bill the MCP. No differential billing is required.



1 ABC MEDICAL CLINIC 1234 MAIN STREET ANYTOWN CA 900005555	2	3a PAT. CNTL #		4 TYPE OF BILL	731		
		b MED. REC. #					
		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	THROUGH	7	
8 PATIENT NAME a DOE, JANE		9 PATIENT ADDRESS a					
b		b		c	d	e	
10 BIRTHDATE 05212002	11 SEX F	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
18	19	20	21	CONDITION CODES 22	23	24	25
26	27	28	29 ACDT STATE	30			
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37	
a						a	
b						b	
38	39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0520	MEDICAL VISIT	T1015	010323	1	100 00		1
2	0520		Z1034	010323		0 00		2
3								3
4								4
5								5
6								6
7								7
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19								19
20								20
21								21
22								22
23	001	PAGE ____ OF ____	CREATION DATE	010623	TOTALS	100 00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0123456789	
A	O/P MEDI-CAL					100 00	57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			90000000A95001		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX	D1D1D1D1	A	B	C	D	E	F	G	H	68	
0		I	J	K	L	M	N	O	P	Q	
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73	

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI 1234567890	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

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Example: Medical visit example only. Please adapt to your billing situation.

Treatment Authorization

A TAR is not required for services rendered by Tribal FQHC or IHS-MOA providers, but the following conditions apply:

Conditions Table

Tribal FQHC	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."
IHS-MOA	Providers are required to meet the same documentation requirements that are necessary in a TAR for the same service under Medi-Cal. DHCS A&I Division may recover reimbursements 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."

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

Comprehensive Perinatal Services Program (CPSP) Support Services and TARs

CPSP support services in excess of the basic allowances will not be denied for the absence of a TAR; however, the provider is required to maintain the same level of documentation required for authorization. DHCS A&I Division may recover reimbursements that do not meet the requirements under CCR, Title 22, Sections 51458.1 and 51476.

Required documentation includes:

- Expected date of delivery
- Clinical findings and high-risk factors involved in the pregnancy
- Explanation of why the basic CPSP service is not sufficient
- Description of the services that are requested
- Anticipated benefit (or result) and outcome (or additional services)
- Length of the visit(s) and frequency with which the requested services were provided

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 additional instructions.

Medi-Service Limitations

Tribal FQHC and IHS-MOA

The following Medi-Services are services that are limited to a maximum of two services in any one calendar month or any combination of two services per month, although 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:

Dental Services

Dental services are a covered benefit for Tribal FQHC and IHS-MOA providers. These providers may render dental services in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice, complies with the Medi-Cal Dental Manual of Criteria and Schedule of Maximum Allowances and determined to be medically necessary pursuant to California *Welfare and Institutions Code* (W&I Code), Section 14059.5. Documentation should be consistent with the standards set forth in the Manual of Criteria for Medi-Cal Authorization of the Medi-Cal Dental Program Provider Handbook and all state laws. Dental services are payable using per-visit local code 03.

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.

Comprehensive services for pregnant recipients, regardless of age, aid code and/or scope of benefits, are eligible to receive all dental procedures listed in the MOC that are covered by the Medi-Cal program if all MOC procedure requirements and criteria are met. Recipients are also eligible to receive these services for sixty days postpartum, including any remaining days in the month in which the 60th day falls.

Managed Health Care Plans (MCPs)

Tribal FQHC

Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care which emphasize primary and preventive care. Tribal FQHCs can contract with MCPs to be a network provider. Tribal FQHCs that contract with an MCP must bill the MCP when rendering services to MCP recipients. Providers contact the MCP for plan-specific authorization and billing information. Tribal FQHC services are paid by the MCP at the APM, which is set at the AIR. Refer to the *Tribal Federally Qualified Health Centers (FQHCs): Billing Codes* section in the appropriate Part 2 manual for codes to use when billing for services rendered to recipients in MCPs.

IHS-MOA

When billing for services rendered to Medi-Cal Managed Care members and the services are covered by the MCP, IHS-MOA providers must bill the MCP. No differential billing is required.

Crossover Claims

Tribal FQHC

Billing Managed Care/Medicare Crossover Claims

Tribal FQHCs follow the same process as described under the heading “Services for Recipients in MCPs” (*Tribal Federally Qualified Health Centers [tribal fqhc])* when rendering services to a recipient enrolled in both Medi-Cal Managed Care and Medicare. Medicare crossover claims reimburse providers for the difference between the APM rate and the Medicare reimbursement rate for recipients with both Medicare and Medi-Cal coverage. To ensure full reimbursement for crossover claims, the APM reimbursement rate for crossover claim codes is set at an amount that approximates the difference between the Federal Medicare payments and the Tribal FQHC APM rate.

Billing and Rate Determination for Fee-For-Service Medi-Cal with Medicare Advantage Health Maintenance Organization (HMO) Plans

This section provides billing guidance for recipients enrolled in both a Medicare Advantage HMO plan (Medicare Part C) and fee-for-service Medi-Cal. Medicare Advantage HMO plans offer expanded Medicare services through private insurance companies approved by Medicare.

Tribal FQHCs submitting claims for fee-for-service Medi-Cal recipients in a Medicare Advantage Plan should first bill the plan and then submit claims for unpaid amounts to Medi-Cal using the crossover claims billing code sets listed in the *Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes* section of this manual. Additionally, the phrase "for a fee-for-service Medi-Cal recipient in a fee-for-service Medicare Advantage Plan" must be included in the *Remarks* (Box 80) field of the claim or in an attachment to the claim.

The reimbursement rate for crossover claim codes for recipients not enrolled in an MCP is set at an amount that approximates the difference between the Federal Medicare payments and the Tribal FQHC APM rate. The crossover rate for services provided to fee-for-service recipients can be adjusted upon request by the Tribal FQHC. DHCS A&I has posted forms on the "Audits and Investigations – Financial Audits Branch Cost Reports Forms and Documents" page of the DHCS website (www.dhcs.ca.gov). Tribal FQHCs can request to change crossover rates any time their Medicare Advantage Plan contract changes. Alternatively, the Tribal FQHC can include the crossover rate change form with their annually filed reconciliation request. Forms are available on the "Forms" page of the DHCS website (www.dhcs.ca.gov).

Billing and Rate Determination for Services Provided to Capitated Medicare Advantage Plan Recipients

This section provides billing guidance for recipients enrolled in both a Capitated Medicare Advantage HMO plan (Medicare Part C) and fee-for-service Medi-Cal. The Capitated Medicare Advantage Plan rate reimburses a provider the difference between the Tribal FQHC APM rate and the Medicare Advantage Plan (capitated) average reimbursement.

Tribal FQHCs submitting claims for recipients enrolled in a Capitated Medicare Advantage Plan should first bill the plan and then bill Medi-Cal using the Capitated Medicare advantage plans billing code sets listed in the *Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes* section in the appropriate Part 2 manual.

Additionally, the phrase "for a fee-for-service Medi-Cal recipient in a Medicare Advantage Plan" must be included in the *Remarks* (Box 80) field of the claim or in an attachment to the claim.

Rates for Capitated Medicare Advantage Plans are adjusted upon request by the Tribal FQHC In the same way as indicated in this section under "Billing and Rate Determination for Fee-For-Service Medi-Cal with Medicare Advantage Health Maintenance Organization (HMO) Plans."

Documentation Requirements for Medicare Denials

Medicare Advantage Plan billing code sets must include documentation of Medicare denial in one of the following ways:

- Enter three key facts in the *Remarks* field (Box 80) of the claim:
  - Whether the facility is Tribal FQHC
  - That the recipient is a managed care patient
  - One of the following: No *Explanation of Medicare Benefits* (EOMB), No *Medicare Remittance Notice* (MRN), or No *Remittance Advice* (RA)

Or

- On an 8 1/2" x 11" attachment to the claim, specify the following: Tribal FQHC Medi-Cal patient enrolled in a Capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the Capitated Medicare Advantage HMO.

IHS-MOA

Crossover Claim Completion Instructions

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.

Services for Recipients in Managed Care Plans

When billing for services rendered to Medi-Cal managed care members and the services are covered by the Managed Care Plan (MCP), IHS-MOA providers must bill the MCP. No differential billing is required.

Billing for Straight Medi-Cal with Medicare Advantage HMO Plans

Facilities submitting claims for fee-for-service Medi-Cal recipients in a fee-for-service Medicare Advantage Plan should bill with Crossover Claims billing code sets. Also, the phrase “For a fee-for-service Medi-Cal recipient in a fee-for-service Medicare Advantage Plan” must be included in the *Remarks* (Box 80) field of the claim or in an attachment to the claim.

Providers submitting claims for fee-for-service Medi-Cal recipients in a Capitated Medicare Advantage Plan should bill with Capitated Medicare Billing Code Sets.

Billing for Managed Care and Medicare

IHS-MOA facilities bill using the same process as described in the previous heading “Services for Recipients in Managed Care Plans” when rendering services to a recipient enrolled in Medi-Cal managed care and Medicare.

Billing for Capitated Medicare Advantage Plans

Generally, claims submitted to Medi-Cal for Crossover Claims and Capitated Medicare Advantage Plan billing code sets must include documentation of Medicare denial in one of the following ways:

- • Enter three key facts in the *Remarks* field (Box 80) of the claim:
  - Whether the facility is IHS-MOA
  - That the recipient is a managed care patient
  - One of the following: No EOMB/No MRN/No RA

Or

- On an 8 1/2" x 11" attachment to the claim, specify the following: MOA Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

Reconciliations

DHCS is required to perform an annual reconciliation of Managed Care, Medicare crossover and Medicare Advantage Plan visits to ensure Tribal FQHCs and IHS-MOA providers are reimbursed an amount equal to the federal Indian Health Service APM and AIR rates.

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 Tribal FQHCs and IHS-MOA 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.

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. Providers may refer to the *Medicine: Telehealth* section of the appropriate Part 2 manual for additional information.

Definitions

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

- **Telehealth and Other Terms:** For definitions of “telehealth,” “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 may refer to “Medical Visit,” “Mental Health Visits” and “Ambulatory Visit” in this manual section.
- **Billable Provider:** Providers may refer to “Services Available” in this manual section.
- **Established Patient:** A Medi-Cal eligible recipient who meets one or more of the following conditions:
  - The patient has a health record with the IHS-MOA clinic that was created or updated during a visit that occurred in the clinic. The patient’s health record must have been created or updated within the previous three years.
  - The patient is homeless and has an established health record that was created from a visit occurring within the last three years that was provided within or outside of the IHS-MOA clinic. All consent for telehealth services for these patients must be documented.
  - The patient is assigned to the IHS-MOA clinic by their MCP pursuant to a written agreement between the plan and the IHS-MOA clinic.

- **Documentation Requirements**: Providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.
- **Covered Services:** Services rendered via telehealth must be IHS-MOA covered services.
- **Non-Covered Services:** An e-consult is not a reimbursable telehealth service for IHS-MOA clinics.
- **Synchronous Telehealth Reimbursement Requirements:** Services provided through synchronous telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person.
  - Tribal FQHCs may bill for a telehealth visit if it is medically necessary for a billable provider to be present with a patient during the telehealth visit.
  - IHS-MOA clinics must submit claims for telehealth services using the appropriate per visit IHS-MOA billing codes, modifiers and related claims submission requirements. Providers may refer to *the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes* section in the appropriate Part 2 manual.
  - Tribal FQHCs must submit claims for telehealth services using the appropriate all-inclusive billing code sets and related claims submission requirements. For more information, providers may refer to the *Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes* section in the appropriate Part 2 manual.
  - IHS-MOA clinics are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the IHS-MOA rate.

  Tribal FQHCs are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the APM.
- **Synchronous Audio-Only Requirements**: An audio-only visit is eligible for reimbursement if provided by a billable provider, regardless of the location of the patient or provider.
- **Asynchronous Store and Forward Reimbursement Requirements**: A patient may not be “established” on an asynchronous store and forward service except for a homeless patient. Reimbursement is permitted for an established patient by a billable provider at the distant site.

Note: Providers should note “Non-Covered Services” in this manual section

Telehealth Modifiers

Table of Telehealth Modifiers

93	Synchronous telehealth medicine service rendered via telephone or other real-time interactive audio-only telecommunications system.
95	Synchronous telehealth medicine service rendered via a real-time interactive audio and video telecommunications system.
GQ	Via asynchronous telecommunications system.

1 ABC MEDICAL CLINIC
1234 MAIN STREET
ANYTOWN CA 900005555

2

3a PAT. CNTL #

b. MED. REC. #

4 TYPE OF BILL: 731

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a DOE, JOHN

9 PATIENT ADDRESS

10 BIRTHDATE: 11271972

11 SEX: M

12 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18–28 CONDITION CODES | 29 ACDT STATE | 30

31–34 OCCURRENCE CODE DATE | 35–36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39–41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0520		T1015	010323	1	100 00		
		9921393	010323				
		9083293	010323				
001	PAGE ____ OF ____	CREATION DATE	010623	TOTALS	100 00		

50 PAYER NAME: A O/P MEDI-CAL

51 HEALTH PLAN ID | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS

55 EST. AMOUNT DUE: 100 00

56 NPI: 0123456789

57 OTHER PRV ID

58 INSURED'S NAME | 59 P REL

60 INSURED'S UNIQUE ID: 90000000A95001

61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: D1D1D1D1
0

67 A–Q | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a.–e. OTHER PROCEDURE CODE DATE | 75

76 ATTENDING NPI 1234567890 QUAL
LAST FIRST

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS | 81CC a b c d

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: Telehealth modifier 93 audio only example only. Please adapt to your billing situation.

Field	Value
1	ABC MEDICAL CLINIC 1234 MAIN STREET ANYTOWN CA 900005555
4 TYPE OF BILL	731
8 PATIENT NAME	a DOE, JANE
10 BIRTHDATE	11271972
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
0520		T1015	010323	1	100 00	
		99213GQ	010323			
		90832GQ	010323			
001	PAGE ____ OF ____	CREATION DATE	010423	TOTALS	100 00	

Field	Value
50 PAYER NAME	A O/P MEDI-CAL
55 EST. AMOUNT DUE	100 00
56 NPI	0123456789
60 INSURED'S UNIQUE ID	90000000A95001
66 DX	0
67	D1D1D1D1
76 ATTENDING NPI	1234567890

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Example: Telehealth modifier GQ asynchronous example only. Please adapt to your billing situation.

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.

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.

An *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN) is not required for Licensed Marriage Family Therapist (LMFT) services provided to recipients covered under Medi-Cal and Medicare when billed by Tribal FQHC providers.

LMFT services are billed by Tribal FQHC providers utilizing **Revenue Code 0561 and Procedure code T1015** modifier **HR.**

Tribal FQHC Billing Code Sets Table

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Medical visit	0520	T1015
Mental health visit Psychiatrist	0561	T1015 AG
Mental health visit Clinical social worker	0561	T1015 AJ
Mental health visit Marriage and family therapist	0561	T1015 HR
Mental health visit Clinical psychologist	0561	T1015 AH
Ambulatory visit, optometry services, per visit New patient	0520	92004
Ambulatory visit, optometry services, per visit Established patient	0520	92014
Ambulatory visit Physical therapy	0420	T1015
Ambulatory visit Occupational therapy	0430	T1015

Tribal FQHC Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Speech pathology	0440	T1015
Ambulatory visit Audiology	0470	T1015
Ambulatory visit Podiatry	0510	T1015
Ambulatory visit Chiropractic manipulative treatment, spinal one or two regions See the *Chiropractic Services* section in the *Allied Health – Chiropractic* section of the appropriate Part 2 manual for complete policy details.	0940	98940
Ambulatory visit Chiropractic manipulative treatment, spinal three or four regions See the *Chiropractic Services* section in the *Allied Health – Chiropractic* section of the appropriate Part 2 manual for complete policy details.	0940	98941

Tribal FQHC Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Chiropractic manipulative treatment, spinal five regions See the *Chiropractic Services* section in *the Allied Health – Chiropractic* section of the appropriate Part 2 manual for complete policy details.	0940	98942
Ambulatory visit Acupuncture, one or more needles, without electrical stimulation, initial 15-minute service	2101	97810
Ambulatory visit Acupuncture, one or more needles, without electrical stimulation, each additional 15-minute service	2101	97811
Ambulatory visit Acupuncture, one or more needles, with electrical stimulation, initial 15-minute service	2101	97813
Ambulatory visit Acupuncture, one or more needles, with electrical stimulation, each additional 15-minute service	2101	97814
End of Life Option Act	0520	S0257
Capitated Medicare Advantage Plans New patient	0529	G0466

Tribal FQHC Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Capitated Medicare Advantage Plans Established patient	0529	G0467
Capitated Medicare Advantage Plans Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0529	G0468
Capitated Medicare Advantage Plans Mental health visit, new patient	0529	G0469
Capitated Medicare Advantage Plans Mental health visit, established patient	0529	G0470
Crossover claims New patient	0520	G0466
Crossover claims Established patient	0520	G0467
Crossover claims Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0520	G0468
Crossover claims Mental health visit New patient	0900	G0469
Crossover claims Mental health visit Established patient	0900	G0470

IHS-MOA Services Billing Code Sets

Claims submitted with local per-visit 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.

An *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN) is not required for Licensed Marriage Family Therapist (LMFT) services provided to recipients covered under Medi-Cal and Medicare when billed by Indian Health Services – Memorandum of Agreement (IHS-MOA) providers.

LMFT services are billed by IHS-MOA providers utilizing **Revenue Code 0561 and Procedure code T1015** modifier **HR.**

IHS-MOA Billing Code Sets Table

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Medical, per visit	0520	T1015
Crossover claims New Patient	0520	G0466
Crossover claims Established patient	0520	G0467
Crossover claims Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0520	G0468
Crossover claims Mental health visit New patient	0900	G0469
Crossover claims Mental health visit Established patient	0900	G0470
Optometry services, per visit New patient	0520	92004
Optometry services, per visit Established patient	0520	92014
Capitated Medicare Advantage Plans New patient	0529	G0466

IHS-MOA Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Capitated Medicare Advantage Plans Established patient	0529	G0467
Capitated Medicare Advantage Plans Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)	0529	G0468
Capitated Medicare Advantage Plans Mental health visit New patient	0529	G0469
Capitated Medicare Advantage Plans Mental health visit Established patient	0529	G0470
Mental health visit Psychiatrist	0561	T1015 AG
Mental health visit Clinical psychologist	0561	T1015 AH
Mental health visit Licensed Clinical social worker	0561	T1015 AJ
Mental health visit Licensed Professional Clinical Counselor (LPCC)	0561	T1015 HO
Mental health visit Marriage and Family Therapist	0561	T1015 HR
Ambulatory visit Physical therapy	0420	T1015
Ambulatory visit Occupational therapy	0430	T1015
Ambulatory visit Speech pathology	0440	T1015

IHS-MOA Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Audiology	0470	T1015
Ambulatory visit Podiatry	0510	T1015
Ambulatory visit Drug and alcohol	0520	H0047
Ambulatory visit Chiropractic manipulative treatment, spinal, one to two regions.	0940	98940
Ambulatory visit Chiropractic manipulative treatment, spinal, three to four regions.	0940	98941
Ambulatory visit Chiropractic manipulative treatment, spinal, five regions.	0940	98942
Ambulatory visit Acupuncture one or more needles Without electrical stimulation, initial 15-minute service	2101	97810

IHS-MOA Billing Code Sets Table (continued)

National Code Description	Revenue Code	Procedure Code and Modifier (as applicable)
Ambulatory visit Acupuncture one or more needles, Without electrical stimulation, each additional 15-minute service	2101	97811
Ambulatory visit Acupuncture one or more needles With electrical stimulation, initial 15-minute service	2101	97813
Ambulatory visit Acupuncture one or more needles With electrical stimulation, each additional 15-minute service	2101	97814

Notes:

COVID-19 Vaccine Administration for Tribal FQHC and IHS MOA Providers

Effective retroactively for dates of service on or after the respective dates for each approved COVID-19 vaccine, Tribal FQHC and IHS-MOA providers may receive reimbursement for administration of the 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 Alternative Payment Methodology (APM) for Tribal FQHC providers or All-Inclusive Rate (AIR) for IHS-MOA.

Reimbursement

Tribal FQHC and IHS-MOA providers may receive reimbursement up to a maximum allowable rate of $67.00 for COVID-19 vaccines administered during a vaccine-only encounter. Tribal FQHC and IHS-MOA providers should refer to the webpages on the Medi-Cal Providers website for billing guidance and effective dates for each vaccine and dose.

Claims submitted for COVID-19 vaccine-only encounters do not currently require revenue codes for reimbursement and utilize the appropriate CPT code for the vaccine manufacturer and dose provided.

Medi-Cal Managed Care Billing – Tribal FQHC Providers

Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Tribal FQHCs can contract with MCPs to be a network provider. Tribal FQHCs that contract with an MCP must bill the MCP when rendering services to MCP recipients. Providers contact the MCP for plan-specific authorization and billing information. Tribal FQHC services are paid by the MCP at the APM, which is set at the AIR. Refer to the *Tribal Federally Qualified Health Centers (FQHCs): Billing Codes* section in the appropriate Part 2 manual for codes to use when billing for services rendered to recipients in MCPs.

Medi-Cal Managed Care Billing – IHS-MOA Providers

When billing for services rendered to Medi-Cal managed care members and the services are covered by the MCP, IHS-MOA providers must bill the MCP. No differential billing to Medi-Cal is required.

Notes:

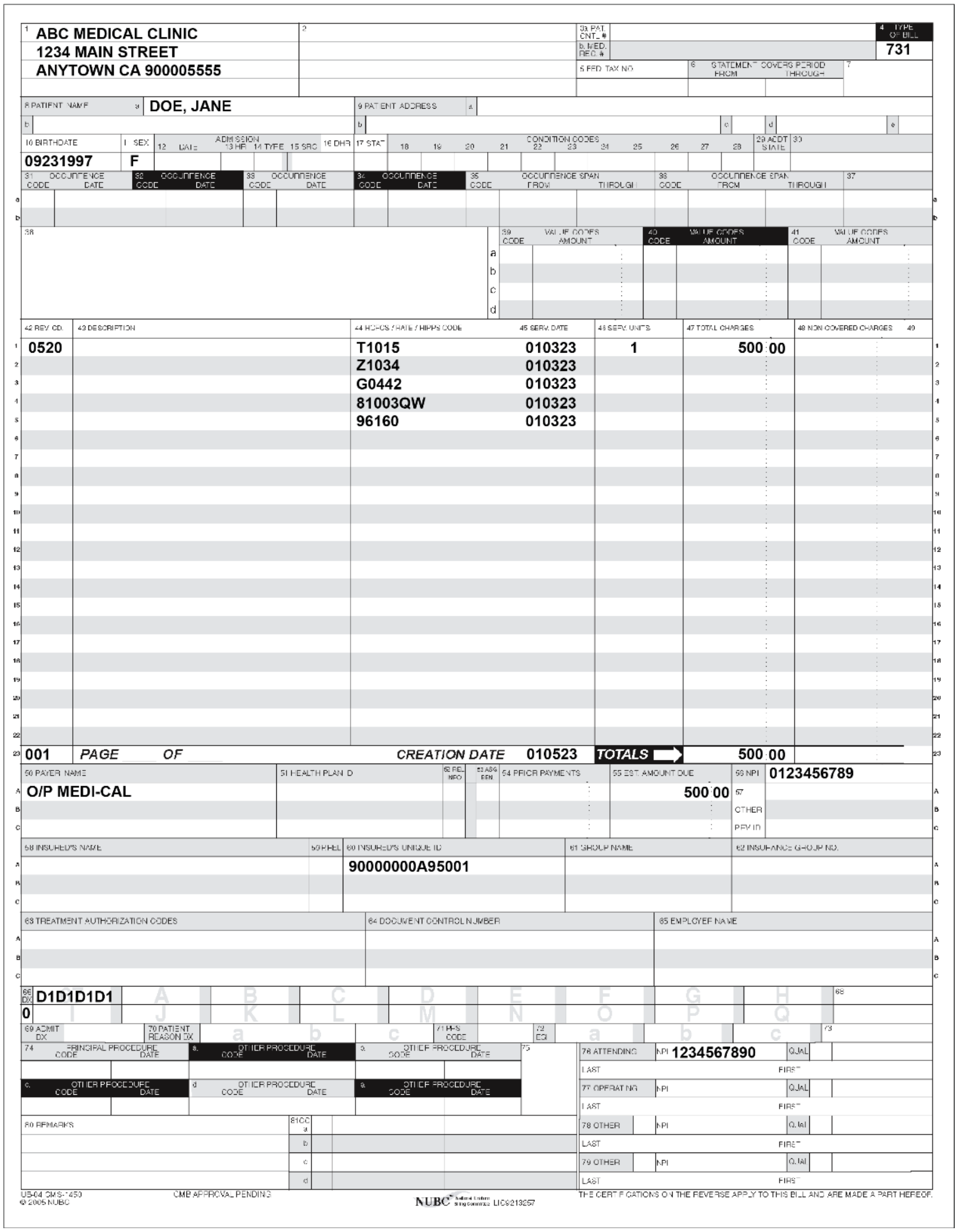
Informational Lines

Informational lines should be included when billing for Tribal FQHC and IHS-MOA 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.



ABC MEDICAL CLINIC
1234 MAIN STREET
ANYTOWN CA 900005555

Type of Bill: 731

Patient Name: DOE, JANE

Birthdate: 09231997 Sex: F

Rev. Cd.	HCPCS / Rate / HIPPS Code	Serv. Date	Serv. Units	Total Charges
0520	T1015	010323	1	500 00
	Z1034	010323		
	G0442	010323		
	81003QW	010323		
	96160	010323		
001 PAGE OF	CREATION DATE	010523	TOTALS	500 00

Payer Name: O/P MEDI-CAL — Est. Amount Due: 500 00 — NPI: 0123456789

Insured's Unique ID: 90000000A95001

DX: D1D1D1D1 — 0

Attending NPI: 1234567890

Example: Billing a HIPAA-Compliant Billing Code Set with Informational Lines. This is an example only. Please adapt to your billing situation.

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.

Resource Information

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 2

Asthma Preventative Service (APS) (asth prev)

Community Health Worker (CHW) Preventive Services (chw prev)

Doula Services (doula)

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics (ind health)

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics:Billing Codes (ind health cd)

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)

Tribal Federally Qualified Health Centers (Tribal FQHCs) Tribal FQHCs (tribal fqhc)

Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes (tribal fqhc cd)

Additional Resources

Medi-Cal Dental Provider Handbook

Managed Care All Plan Letters

Appendix

Acronyms

Acronym	Description
A&I	Audits and Investigations
CCR	California Code of Regulations
CCS	California Children's Services
CFR	Code of Federal Regulations
CIN	Client Index Number
CMC	Computer Media Claims
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
FQHC	Federally Qualified Health Center
HCP	Health Care Plan
HMO	Health Maintenance Organization
IHS/MOA	Indian Health Services, Memorandum of Agreement
MRN	Medical Remittance Notice
NPI	National Provider Identifier
PCC	Primary Care Clinic
POS	Point of Service
RA	Remittance Advice
RAD	Remittance Advice Details
RHC	Rural Health Clinic

Acronym	Description
SMA	Schedule of Maximum Allowance
TAR	Treatment Authorization Request
THP	Tribal Health Program
W&I	Welfare and Institutions

Page updated: November 2023

Enter Notes Here