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

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This section contains Rural Health Clinic (RHCs) and Federally Qualified Health Center (FQHC) billing codes and per visit codes. For general RHC and FQHC information, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section in this manual.

## RHC and FQHC: All Inclusive Billing Code Sets

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

**‹‹Table of All-Inclusive Billing Code Sets››**

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0521 | T1015 | Medical, per visit | Requires medical justification for more than one visit per recipient per day |
| 0521 | G0466 | Crossover claims – FQHC/RHC clinic visit New patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0521 | G0467 | Crossover claims – FQHC/RHC clinic visit Established patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0521 | G0468 | Crossover claims – FQHC/RHC clinic visit Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |

‹‹**Table of All-Inclusive Billing Code Sets (continued)**››

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0522 | G0466 | Crossover claims – Home visit New patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0522 | G0467 | Crossover claims – Home visit Established patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0522 | G0468 | Crossover claims – Home visit Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0524 | G0466 | Crossover claims – Visit covered Part A stay at SNF<br>New patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0524 | G0467 | Crossover claims - Visit covered Part A stay at SNF<br>Established patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |

‹‹**Table of All-Inclusive Billing Code Sets (continued)**››

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0524 | G0468 | Crossover claims - Visit (covered Part A stay) at SNF Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0525 | G0466 | Crossover claims - FQHC visit (not covered Part A stay) at SNF<br>New patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0525 | G0467 | Crossover claims - FQHC visit (not covered Part A stay) at SNF<br>Established patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0525 | G0468 | Crossover claims - FQHC visit (not covered Part A stay) at SNF<br>Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0527 | G0466 | Crossover claims – FQHC visiting nurse to home<br>New patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |

‹‹**Table of All-Inclusive Billing Code Sets (continued)**››

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0527 | G0467 | Crossover claims – FQHC visiting nurse to home Established patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0527 | G0468 | Crossover claims – FQHC visiting nurse to home IPPE or AWV | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0900 | G0469 | Crossover claims – Mental health visit New patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |
| 0900 | G0470 | Crossover claims – Mental health visit Established patient | Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24-30) for Medicare status. |

‹‹**Table of All-Inclusive Billing Code Sets (continued)**››

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

**Table of All-Inclusive Billing Code Sets (continued)**

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 3103 | T1023 | Community-Based Adult Services (CBAS) Transition day | Limit of five days per participant's lifetime. A statement that the *Physician Authorization and Medical Information* form is on file at the center must be entered in the *Remarks* area of the claim. |

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

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

## Dental Services Provided

‹‹FQHC and RHC clinic providers may render any dental service 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*

(*https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Provider_Handbook/*), and determined to be medically necessary pursuant to California *Welfare and Institutions Code* (W&I Code), Section 14059.5.›› Each provider shall develop a treatment plan that optimizes preventative and therapeutic care and that is in the patient's best interest, taking into consideration their overall health status. All phases of the treatment plan shall be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner.

For dental services, documentation 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.

## RHC and FQHC: All-Inclusive Per Visit Codes

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

**Table of Per Visit Codes**

| Per Visit Code | Description | Explanation | Program |
|---|---|---|---|
| 03 | Dental Services | This code is for FFS beneficiaries. For recipients enrolled in Medi-Cal Dental managed care plans, providers can bill the managed care differential rate. | RHC, FQHC |

## Services for Recipients In Managed Care and Capitated Medicare Advantage Plans

RHC and FQHC facilities use Managed Care Differential rate billing code sets when billing for services rendered to enrollees of Medi-Cal and Medi-Cal Dental managed care plans (and the service is covered by the plan).

RHC and FQHC facilities use the appropriate Capitated Medicare Advantage Plans billing code sets when billing for services rendered to Medi-Cal-only recipients enrolled in capitated Medicare Advantage Plans.

‹‹If a Medi-Cal recipient presents themselves to the clinic for treatment and the clinic finds the recipient is enrolled in a Medi-Cal Managed Care Plan, or if located in Los Angeles County, Sacramento County, or San Mateo County and the recipient also is enrolled in a Medi-Cal Dental managed care plan*, the clinic can render services and submit a claim to Medi-Cal.›› However, the RHC and FQHC facility is required to redirect the recipient to their “in-network” managed care provider and document this referral in the recipient’s medical records. While Medi-Cal beneficiaries in managed care plans and Medi-Cal Dental managed care plans are required to be treated by in-network providers, except in emergencies or other isolated instances, RHC and FQHC facilities that provide services in these circumstances must maintain proof of payment or denial from the managed care plan.

**Table of Codes for Services for Recipients In Managed Care and Capitated Medicare Advantage Plans**

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0521 | T1015<br>SE | Managed care differential rate, covered by managed care and rendered to recipients enrolled in Medi-Cal managed care plans and Medi-Cal Dental managed care plans | ‹‹RHC and FQHC services covered by and rendered to recipients enrolled in Medi-Cal managed care plans or Medi-Cal Dental managed care plan (Los Angeles, Sacramento, or San Mateo Counties)››.The rate for this code approximates the difference between weighted average payments received from the managed care plan(s) and Medicare (for dual eligibles) rendered on a per visit basis, versus the Prospective Payment System (PPS) rate. Two Managed Care Differential Rate services with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. |

## Services for Recipients In Managed Care and Capitated Medicare Advantage Plans

RHC and FQHC facilities use Managed Care Differential rate billing code sets when billing for services rendered to enrollees of Medi-Cal and Medi-Cal Dental managed care plans (and the service is covered by the plan).

RHC and FQHC facilities use the appropriate Capitated Medicare Advantage Plans billing code sets when billing for services rendered to Medi-Cal-only recipients enrolled in capitated Medicare Advantage Plans.

‹‹If a Medi-Cal recipient presents themselves to the clinic for treatment and the clinic finds the recipient is enrolled in a Medi-Cal Managed Care Plan, or if located in Los Angeles County, Sacramento County, or San Mateo County and the recipient also is enrolled in a Medi-Cal Dental managed care plan*, the clinic can render services and submit a claim to Medi-Cal.›› However, the RHC and FQHC facility is required to redirect the recipient to their “in-network” managed care provider and document this referral in the recipient’s medical records. While Medi-Cal beneficiaries in managed care plans and Medi-Cal Dental managed care plans are required to be treated by in-network providers, except in emergencies or other isolated instances, RHC and FQHC facilities that provide services in these circumstances must maintain proof of payment or denial from the managed care plan.

**Table of Codes for Services for Recipients In Managed Care and Capitated Medicare Advantage Plans**

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0521 | T1015<br>SE | Managed care differential rate, covered by managed care and rendered to recipients enrolled in Medi-Cal managed care plans and Medi-Cal Dental managed care plans | ‹‹RHC and FQHC services covered by and rendered to recipients enrolled in Medi-Cal managed care plans or Medi-Cal Dental managed care plan (Los Angeles, Sacramento, or San Mateo counties).›› The rate for this code approximates the difference between weighted average payments received from the managed care plan(s) and Medicare (for dual eligibles) rendered on a per visit basis, versus the Prospective Payment System (PPS) rate. Two Managed Care Differential Rate services with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit.<br>**(continued on next page)** |

**Table of Codes for Services for Recipients In Managed Care and Capitated Medicare Advantage Plans (continued)**

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0521 | T1015<br>SE | ‹‹Managed care differential rate, covered by managed care and rendered to recipients enrolled in Medi-Cal managed care plans and Medi-Cal Dental managed care plans›› | The exception is that two visits may be billed in the following instances; when a patient is seen by a health professional or CPSP practitioner and also receives dental services on the same day are reimbursable per day, per recipient, one medical and one dental, without medical justification; and when a patient – 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 (RHC) and Federally Qualified Health Centers (FQHC) Billing Example* section in this manual. |

**‹‹Table of Codes for Services for Recipients In Managed Care and Capitated Medicare Advantage Plans (continued)››**

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0529 | G0466 | Capitated Medicare Advantage Plans New patient | Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24 and 25) for Medicare status. |
| 0529 | G0467 | Capitated Medicare Advantage Plans Established patient | Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24 and 25) for Medicare status. |
| 0529 | G0468 | Capitated Medicare Advantage Plans Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) | Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24 and 25) for Medicare status. |
| 0529 | G0469 | Capitated Medicare Advantage Plans Mental health New patient | Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24 and 25) for Medicare status. |

‹‹**Table of Codes for Services for Recipients In Managed Care and Capitated Medicare Advantage Plans (continued)**››

| Revenue Code | Procedure Code and Modifier | Description | Explanation |
|---|---|---|---|
| 0529 | G0470 | Capitated Medicare Advantage Plans Mental Health<br>Established patient | Requires justification for absence of the Medicare EOMB/MRN/RA from the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24 and 25) for Medicare status. |

## Billing for Straight Medi-Cal with Medicare Advantage HMO Plans

Providers submitting claims for fee-for-service Medi-Cal recipients in a fee-for-service Medicare Advantage Plan should bill with a crossover claim billing code set. 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 the appropriate Medicare Advantage Plan code sets.

## Billing for Capitated Medicare

RHCs and FQHCs bill with the managed care differential rate code set when rendering services to a recipient enrolled in Medi-Cal managed care regardless of Medicare eligibility. Refer to “Billing for Capitated Medicare advantage plans billing code sets” for required remarks and/or attachments.

## Billing for Capitated Medicare Advantage Plans

Generally, claims submitted to Medi-Cal for either crossover claims or capitated Medicare advantage plans billing code sets must include documentation of Medicare denial in one of the following ways:

- Enter three keys facts in the *Remarks* field (Box 80) of the claim:
  - Whether the facility is an RHC or FQHC
  - That the recipient is a managed care recipient
  - 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: FQHC (or RHC) Medi-Cal recipient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

## Billing for Primary Care Services Rendered by a Medical Resident

Teaching Health Center Graduate Medical Education (THCGME) programs sponsored by the 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 “Teaching Health Center Graduate Medical Education (THCGME)” in the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* section in this manual for specific reimbursement requirements.

## 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.

## Rate Determination

Under the Prospective Payment System (PPS) reimbursement rate, cost reports are not required. An annual revenue reconciliation is made by Audits and Investigations (A&I Division) staff to equalize the difference between reimbursements from managed care plans and providers' PPS reimbursement rates.

Rates for managed care differential rates and capitated Medicare advantage plans sets are adjusted upon request by the FQHC/RHC. A&I Division sends forms for annual distribution to each RHC and FQHC to facilitate this reconciliation.

## Telehealth Modifiers – Billing Requirements

FQHCs and RHCs rendering Medi-Cal covered benefits or services via a telehealth modality must identify the specific services with the appropriate telehealth modifier listed under "Billing Requirements" in the *Medicine: Telehealth* manual section.

## 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. |
| * | If the recipient is not enrolled in a Medi-Cal Dental managed care plan, a straight Medi-Cal dental visit may be billed, per visit code 03. |