April 25, 2022

HIGHMARK HEALTH OPTIONS

PROVIDER UPDATE

Updated Billing Guidelines for Federally Qualified Health Centers (FQHC)

Effective April 25, 2022, Federally Qualified Health Centers (FQHC) claims not containing the encounter G code and associated Qualified Visit services code will be denied. Rendering providers must be enrolled as an in-network provider with the billing FQHC. To receive reimbursement for FQHC claims, providers must bill HHO using the appropriate FQHC encounter code.

The FQHC claim must include the following:

- Appropriate FQHC encounter G code for each payable encounter visit:
  - G0466
  - G0467
  - G0468
  - G0469
  - G0470
- Associated Qualified Visit services code for encounter provided.
- All other services performed.

The claim will be denied if either the G code or the Qualified Visit service code is missing.

Providers will be reimbursed for one encounter code per day, with the exception of a medical and a mental health encounter billed on the same day on a separate claim form.

If you have questions, contact Provider Services at 1-844-325-6251, Monday through Friday, from 8 a.m. to 5 p.m.

Billing Guidelines

FQHC Medical Encounter Billing Guidelines

Medical Encounter must be billed on its own claim form, without a mental health claim. One of the encounter codes below must be listed in addition to the related fee-for-service procedure codes:

- G0466: New Patient
- G0467: Established Patient

The encounter must include at least one of the Qualifying Visit services listed below:

- G0466**:** FQHC visit, new patient
  - 92002: Eye exam new patient
  - 92004: Eye exam new patient
  - 97802: Medical nutrition indiv in
  - 99201: Office/outpatient visit new
  - 99202: Office/outpatient visit new
  - 99203: Office/outpatient visit new
  - 99204: Office/outpatient visit new
  - 99205: Office/outpatient visit new
  - 99304: Nursing facility care init
  - 99305: Nursing facility care init
  - 99306: Nursing facility care init
  - 99324: Domicil/r-home visit new pat
  - 99325: Domicil/r-home visit new pat
  - 99326: Domicil/r-home visit new pat
  - 99327: Domicil/r-home visit new pat
  - 99328: Domicil/r-home visit new pat
  - 99341: Home visit new patient
  - 99342: Home visit new patient
  - 99343: Home visit new patient
  - 99344: Home visit new patient
  - 99345: Home visit new patient
  - 99406: Behav chng smoking 3-10 min
  - 99407: Behav chng smoking > 10 min
  - 99497: Advanced care plan 30 min
  - G0101: Ca screen; pelvic/breast exam
  - G0102: Prostate ca screening; dre
  - G0108: Diab manage trn per indiv
  - G0117: Glaucoma scrn hgh risk direc
  - G0118: Glaucoma scrn hgh risk direc
  - G0296: Visit to determ LDCT elig
  - G0442: Annual alcohol screen 15 min
  - G0443: Brief alcohol misuse counsel
  - G0444: Depression screen annual
  - G0445: High inten beh couns std 30 min
  - G0446: Intens behave ther cardio dx
  - G0447: Behavior counsel obesity 15 min
  - G0490: Home visit RN, LPN by RHC/FQ
  - Q0091: Obtaining screen pap smear

- G0467: FQHC visit, established patient
  - 92012: Eye exam establish patient
  - 92014: Eye exam & tx estab pt 1/>vst
  - 97802: Medical nutrition indiv in
  - 97803: Med nutrition indiv subseq
  - 99212: Office/outpatient visit est
  - 99213: Office/outpatient visit est
  - 99214: Office/outpatient visit est
  - 99215: Office/outpatient visit est
  - 99304: Nursing facility care init
  - 99305: Nursing facility care init

- 99306: Nursing facility care init
- 99307: Nursing fac care subseq
- 99308: Nursing fac care subseq
- 99309: Nursing fac care subseq
- 99310: Nursing fac care subseq
- 99315: Nursing fac discharge day
- 99316: Nursing fac discharge day
- 99318: Annual nursing fac assessment
- 99334: Domicil/r-home visit new pat
- 99335: Domicil/r-home visit new pat
- 99336: Domicil/r-home visit new pat
- 99337: Domicil/r-home visit new pat
- 99347: Home visit est patient
- 99348: Home visit est patient
- 99349: Home visit est patient
- 99350: Home visit est patient
- 99406: Behav chng smoking 3-10 min
- 99407: Behav chng smoking > 10 min
- 99495: Trans care mgmt 14-day disch
- 99496: Trans care mgmt 7-day disch
- 99497: Advanced care plan 30 min
- G0101: Ca screen; pelvic/breast exam
- G0102: Prostate ca screening; dre
- G0108: Diab manage trn per indiv
- G0117: Glaucoma scrn hgh risk direc
- G0118: Glaucoma scrn hgh risk direc
- G0270: Mnt subs tx for change dx
- G0296: Visit to determ LDCT elig
- G0442: Annual alcohol screen 15 min
- G0443: Brief alcohol misuse counsel
- G0444: Depression screen annual
- G0445: High intens beh couns std 30 min
- G0446: Intens behave ther cardio dx
- G0447: Behavior counsel obesity 15 min
- G0490: Home visit RN, LPN by RHC/FQ
- Q0091: Obtaining screen pap smear

FQHC Mental Health

Mental Health Encounter must be billed on its own claim form, without medical claim. One of the encounter codes below must be listed in addition to the related fee-for-service procedure codes:

- G0469: New patient
- G0470: Established patient

The encounter code G0469 or G0470 must be accompanied by at least one of the Qualifying Visit services listed below:

- 90791: Psych diagnostic evaluation
- 90792: Psych diag eval w/ med srvcs
- 90832: Psytx pt &/family 30 minutes
- 90834: Psytx pt &/family 45 minutes
- 90837: Psytx pt &/family 60 minutes
- 90839: Psytx crisis initial 60 minutes
- 90845: Psychoanalysis

FQHC Medical and Mental Health Billing Guidelines for the same date of service.
In order to be reimbursed for a medical and mental health encounter billed on the same day, the following conditions must be met:

1. For the medical claim:
    - G0466: New patient **or**
    - G0467: Established patient
    - Qualified Visit services code
2. For the mental health claim:
    - G0470 for the mental health visit
    - Qualified Visit services code

FQHC Well Visit/Preventive Visit
Providers should use the encounter code below and list the related procedure codes to process a claim:

- G0468: FQHC visit, that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV).

In addition to the G0468 encounter code, at least one of the following Qualifying Visit servicecodes must be listed:

- G0402: Initial preventitive exam
- G0438: Ppps, initial visit
- G0439: Ppps, subseq visit
- Codes for all other services performed

FQHC LARC Billing and Claims Guidelines
LARC claims can be submitted in two ways:

1. Claim with J-Code, but no encounter code (G0466, or G0467), submitted separately. To be paid, this claim must find a paid Medical claim with encounter Code G0466, or G0467 submitted for same date of service already. The J-Code claim will be denied if no corresponding claim is found.
2. Claim with both encounter code (G0466, or G0467) and J-Code (J7296, J7297, J7298, J7300, J7301, or J7307) with associated NDC number on the same claim will be paid.

Regardless of the claim submission selected, an associated NDC number must be included with each J-Code submitted.

Reimbursement will be based on HCPCS code for LARCs being one of the following:

- J7296: Levonorgestrel: Releasing Intrauterine Contraceptive System, (Kyleena), 19.5 mg
- J7297: Levonorgestrel: Releasing Intrauterine Contraceptive System, (Liletta), 52 mg
- J7298: Levonorgestrel: Releasing Intrauterine Contraceptive System, (Mirena), 52 mg
- J7300: Intrauterine Copper Contraceptive

- J730: Levonorgestrel: Releasing Intrauterine Contraceptive System, (Skyla), 13.5 mg
- J7307: Etonogestrel (Contraceptive) Implant System, including implant and supplies

A charge amount must be included on the J-Code line.

Chronic Care Management
HHO follows the CMS FQHC Prospective Payment System requirements for claim submissions under Chronic Care Management (CCM). Effective Jan. 1, 2018, HCPC Code G0511 is reported for CCM. Payment is set annually at the average of the national non-facility PFS payment rate for CPT Codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services, and 99484 (20 minutes or more of general behavioral health integration services).

Non-Covered Services
- Physician telephone services
- Physician prescription services (visits for the sole purpose of obtaining or renewing a prescription)
- Drugs and biologics that can be self-administered
- Eyeglasses
- Hearing aids
- Group or mass information programs, health education classes, or group education activities, including media productions and publications
- Screening mammography (unless service meets the applicable requirements specified in 42 CFR §410.34)
- Preventive dental services with the exception of fluoride varnish (administered for children age 18 and under through DMAP)

FQHC Telemedicine Billing and Claims Guidelines

Telemedicine or telehealth FQHC services must be billed with the appropriate G-Code, along with the corresponding telemedicine/telehealth procedure code to fulfill all billing and encounter requirements. Place of Service “02” (Telehealth) must be used when reporting professional telehealth services (1500/837P form). In addition, facility claims (UB-04/837I form) must also use the GT modifier in addition to other modifiers as appropriate and applicable based on coding guidelines.

Additionally, CMS approved Medicare telehealth codes added for the duration of the COVID-19 Public Health Emergency, G2025 and G0071, are to be billed as part of the standard encounter G codes and not billed separately, as per state guidance.

For Medicare Prime claims, HHO follows and imburses based on CMS guidance for the utilization of G2025 and G0071.

Real-time Audio (Telephonic only) Visits

Professional services (1500/837P) must be billed using one following CPT codes 99441, 99442, 99443, 98966, 98967, or 98968 and submit a 02 place of service to qualify the G encounter code.

Facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, or 98968 with the appropriate revenue code and a GT modifier.

- Physician or other qualified health professional:
  - 99441: 5-10 minutes of medical discussion
  - 99442: 11-20 minutes of medical discussion
  - 99443: 21-30 minutes of medical discussion
- Qualified Non-Physician:
  - 98966: 5-10 minutes of medical discussion
  - 98967: 11-20 minutes of medical discussion
  - 98968: 21-30 minutes of medical discussion

COVID-19 Vaccine Coverage and Claims Information for Providers

- Providers must bill using an FQHC HCPCS "G" visit payment code for each payable encounter visit, along with a HCPCS code for each service provided. Claims must be submitted with the correct Place of Service (POS).
- FQHC providers must provide the vaccine code and vaccine administration code on each claim and encounter.
- FQHC services will be billed per medical encounter.
- Claims are limited to one all-inclusive encounter per day, to include all services received by an eligible recipient on a single day or relevant to the encounter.
  - If one encounter is a medical visit and the second encounter is a mental health visit, there is an exception that allows two encounters to be billed in one day.

FQHC Vaccination administration only; claims submission process

- Submit with the appropriate FQHC Encounter Visit "G" Code (see previous chart) along with a **U4** Informational Modifier at the end.
- Submit with the appropriate Vaccine CPT Code 91300, 91301, or 91303, 91306, 91307 depending on the vaccine type provided.
- Submit the appropriate Vaccine Administration CPT Code 0001A, 0002A, 0011A, 0012A, or 0031A, 0034A, 0064A, 0071A, 0072A depending on the vaccine type provided.
- For appropriate Vaccine CPT and Admin associations, visit https://hho.fyi/covid.

U4 Modifier (FQHC Only)

- This modifier indicates that on the date of service the COVID-19 vaccine was the **only service** administered.
- If other services were performed on the same date, there should be no modifier.

FQHC vaccination when other medical/dental/behavioral health services are provided on the same date.

- Submit with the appropriate FQHC Encounter Visit "G" Code (see previous chart), **do not include U4** Informational Modifier at the end.
- Submit with the appropriate Qualifying Visit 90000 series CPT service code.
- Submit with the appropriate Vaccine CPT Code 91300, 91301, or 91303, depending on the vaccine type provided.
- Submit the appropriate Vaccine Administration CPT Code 0001A, 0002A, 0011A, 0012A, or 0031A, 0034A, 0064A, 0071A, 0072A depending on the vaccine type provided.
- For appropriate Vaccine CPT and Admin associations, visit https://hho.fyi/covid.