Provider Billing Communication

Federally Qualified Health Center Services (FQHC)/Rural Health Clinic (RHC)

WellCare of Georgia will be paying Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) based on a Prospective Payment System (PPS) rate provided by the Department of Community Health.

This update is being implemented based on recent contract changes from the Department of Community Health directing all Care Management Organizations (CMOs) to adjust contracts with FQHC and RHC providers to reimburse based on the PPS rate.

Billing Guidelines

Commonly Used Modifiers

- FP=Family Planning
- EP=Service provided as part of Medicaid EPSDT program
- AJ=Clinical social workers rendering services

Place of Service Code

When billing CPT and HCPCS codes, the FQHC/RHC should bill the appropriate Place of Service Code on the claim form.

- Enter Place of Service code **50** (Federally Qualified Health Center [FQHC]) in Block 24B (Place of Service) on CMS 1500 claim form.
- Enter Place of Service code **72** (Rural Health Clinic [RHC]) in Block 24B (Place of Service) on CMS 1500 claim form.
- Place of Service codes **11** (Office) or **99** (Other Place of service) are not accepted when rendering service in a FQHC/RHC.

Revenue Codes

- Provider-Based (Hospital-Based) rural health clinics must identify services provided on the UB-92 form by using Revenue code **521** for rural health services, Revenue code **522** for home visit services by a practitioner and Revenue code **527** for Visiting Nurse services to a member's home when in a home health storage area.
- Revenue code **636** should be used for reporting injectable drugs.

Providers will receive the all–inclusive Prospective Payment System (PPS) rate per FQHC/RHC visit. A service visit must be reported in order for a provider to be paid a PPS rate. Services and supplies incident to a service visit include those services commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications, supplies used in a patient service visit.

Coding Instructions

Multiple encounters with the same health professional on the same day at a single location constitute a single visit for billing purposes. If separate reimbursement is warranted and a denial is received, the provider must submit Medical Records for payment reconsideration.

- NPI number must be reported in the appropriate field on the CMS 1500 and UB-04 Form.
- Codes deleted from the previous editions of the CPT Manual are not reimbursable and should not be submitted.
- Codes deleted for the previous ICD-9-CM Manual are not reimbursable and should not be submitted.
- Code to the highest level of specificity when reporting ICD-9-CM diagnostic codes.
- "E" (E8000-E9999) and "M" (M8000-M9970/1) are not acceptable when reporting services rendered in the FQHC/RHC.
- Codes for "Unlisted Procedures" which ends in "99" are not accepted and should not be submitted.
- National Drug Code (NDC) number is required along with the injectable drug code on the claim form.

Evaluation and Management Services

Office or Other Outpatient Services	
New Patient	99201 - 99205
Established Patient	99211 - 99215
Hospital Observation Services	
Hospital Observation Discharge Services	99217
Initial Hospital Observation Services	99218 - 99220
Hospital Observation or Inpatient Care Services	
(Including Admission and Discharge Services)	99234 - 99236
Hospital Inpatient Services	
Initial Hospital Care	99221 - 99223
Subsequent Hospital Care	99231 – 99233
Hospital Discharge Services	99238
Consultations	
Office Consultations	99241 - 99245
Initial Inpatient Consultations	99251 – 99255
Emergency Department Services	
New or Established patient	99281 – 99285
Critical Care Services	
Adult (over 24 months of age)	99291 - 99292
Pediatric	99471 - 99472
Neonatal	99468 - 99469
Nursing Facility Services	
Initial Nursing Facility Care	99304 - 99306
Subsequent Nursing Facility Care	99307 - 99310
Other Nursing Facility services	99318

Home Services

New Patient	99341 - 99345
Established Patient	99347 - 99350

Preventive Medicine Services - (Health Check Visits)

Please refer to Health Check Manual Appendix C for proper billing with **EP** modifier, when appropriate

New Patient	99381 - 99385
Established Patient	99391 - 99395

Newborn Care 99460 – 99465

Antepartum and Postpartum Care:

Antepartum Care	59425 - 59426
Postpartum Care	59430

Services of Clinical Psychologists and Licensed Clinical Social Workers:
Central Nervous System Assessment/Test
96101, 96102

Psychiatric Diagnostic or Evaluative Interview Procedures
90801, 90802

Psychiatric Therapeutic Procedures
90804 – 90814, 90846, 90853

Office or Other Outpatient Services

New Patient	99201 - 99205
Established Patient	99211 - 99215

Vision Care Services (One encounter per member per day):
Ophthalmological Services
92002, 92004, 92012, 92014

Office or Other Outpatient Services

New Patient	99201 - 99205
Established Patient	99211 – 99215

Podiatry Services:
Office or Other Outpatient Services

New Patient	99201 - 99205
Established Patient	99211 - 99215

Office or Other Outpatient Services

New Patient	99201 - 99205
Established Patient	99211 – 99215

Pregnancy –Related Services:
99342, 99347, 99348

Perinatal Case Management: T2022

Family Planning

- Modifier "FP" (Family Planning) should be entered in Block 24H on the CMS 1500 claim form.
- The appropriate diagnostic code indicating family planning service should be entered in Block 24E on the CMS 1500 claim form.
- Appropriate CPT codes for reporting family planning visits are located within the range of 99201-99215.

Laboratory Services

- Laboratory services are not separately reimbursable. Laboratory services must be listed on the claim form in conjunction with the FQHC/RHC visit.
- Centers collecting specimens and forwarding them to an independent or public health laboratory may not bill for the collecting and handling (99001) or for the test procedures as well.
- Laboratory procedures required to be sent to the State laboratories are not separately reimbursable and must performed by the State laboratory.

Obstetrical Services

- Services for antepartum and postpartum care must be reported using the appropriate CPT code indicating the services provided. These services will be reimbursed at the PPS rate for the FQHC/RHC per visit.
- Global OB CPT codes should not be billed by the FQHC/RHC.
- The FQHC/RHC will be reimbursed at the Fee for Service rate for the applicable delivery only CPT code.

Radiology Services

- Radiology services are not separately reimbursable. Radiology services must be listed on the claim form in conjunction with the FQHC/RHC visit.

Health Check Visits

- To report Health Check visits, use the appropriate CPT codes listed within the range of 99381-99385 and 99391-99395.
- Modifier "EP" (Service provided as part of Medicaid EPSDT program) must be reported in Block 24H on the CMS claim form
- Health check codes are reimbursable at the PPS rate for each visit

Health Check Codes Separately Billable at Fee for Services (FFS) Rate

Listed below are the Inter-periodic Vision Only and Hearing Only Procedure Codes that are separately reimbursable outside of an EPSDT service. (See Appendix D in the Health Check Manual)

Service	CPT Description	CPT-4
Screening test of visual acuity, quantitative, bilateral	Screening test of visual acuity, quantitative, bilateral	99173
Screening test, pure tone, air only	Screening test, pure tone, air only	92551
Pure tone audiometry (threshold); air only	Pure tone audiometry (threshold); air only	92552
Pure tone audiometry (threshold); air and bone	Pure tone audiometry (threshold); air and bone	92553
Speech audiometry threshold	Speech audiometry threshold	92555
Speech audiometry threshold; with speech recognition	Speech audiometry threshold; with speech recognition	92556

Listed below are Immunization, Tuberculin Skin Test, and Blood Lead Level Screening Procedure Codes that are separately Reimbursable with a Health Check visit. (See Appendix E in the Health Check Manual)

HIPAA Proc Code	HIPAA Modifier	Procedure Code Description	Diagnosis Code
90633	EP	Hep A	V053
90647	EP	HIB Haemophilus b Conjugate Vaccine (PedvaxHib) 3 dose	V0381
90648	EP	HIB Haemophilus b Conjugate Vaccine (ACTHIB) 2months-18 months	V0381
90649	EP	Human Papilloma virus (HPV) (quadrivalent, 3 dose schedule) Girls 9-18 years	V04.89 or V05.8
90655 90656 90657 90658 90660	EP	Influenza (preservative free) (split virus) 6-35 month Influenza (split virus) (preservative free) 3 years and above Influenza ages 6 – 35 months (split virus) Influenza ≥ ages three (3) years (split virus) Influenza (FluMist) intranasally	V0481
90669	EP	(Prevnar) Pneumococcal Conjugate	V0382
90680 90681	EP	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use Rotarix (Rotavirus vaccine, 2 dose)	V04.89
90698	EP	Pentacel (DTAP-Hib-IPV) 6 weeks thru 5 years)	V06.8
90700	EP	DTAP	V061
90702	EP	DT	V065
90707	EP	MMR	V064
90710	EP	Measles, mumps, rubella. and varicella vaccine (MMRV) live	V06.8
90713	EP	IPV	V040
90714	EP	Decavac ® (preservative free TD)	V065
90715	EP	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), 7yrs-18yrs, 11months	V06.1
90716	EP	Varicella	V054
90718	EP	Td Tetanus and diphtheria toxoids adsorbed 7 years and older	V065
90723	EP	DTAP, Hep B, and IPV)	V068
90732	EP	(Pneumovax 23) Pneumococcal Polysaccharide	V0382
90734	EP	Menactra ® (Meningococcal Conjugate) (2 yrs – 18 yrs, 11 mths)	V03.89
90744	EP	Hepatitis B	V053
90748	EP	Combination HEP B and HIB	V068
86580	EP	TB Skin Test	V741
36415	EP	Blood Lead Test Venous	V825
36416	EP	Blood Lead Test Capillary	V825