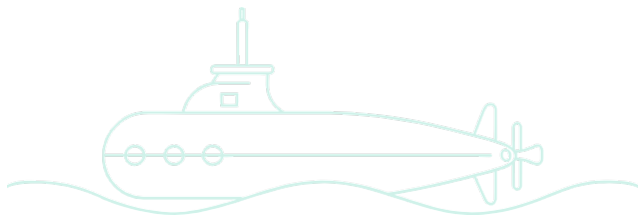
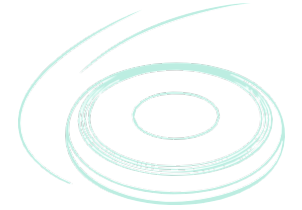


WELCOME!



Community Health Center Association of Connecticut



Community Health Center Association of Connecticut
2025 Education

November 13, 2025

Agenda

1. FQHC Visits
2. E/M Services
 - Time Based Methodology
 - Medical Decision Methodology
3. ICD-10-CM Diagnosis Coding
4. Social Determinants of Health
5. Additional FQHC Services
6. Billing



Meet the Presenters



Stacey Gee, COC, CRCR

Managing Consultant

FQHC Visits



FQHC Visits

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC practitioner (physician, NP, PA, CNM, CP, or CSW), and the practitioner gives one or more qualified FQHC services
- In certain limited situations, include a registered nurse or a licensed practical nurse visit to a homebound patient
- Under certain conditions, a qualified practitioner gives outpatient DSMT or MNT services when the FQHC meets the relevant program requirements to provide these services

FQHC Eligible Providers

Physicians (MD or DO)

The term 'physician' includes:

- Doctor of medicine
- Osteopathy
- Dental surgery
- Dental medical
- Podiatry
- Optometry
- Chiropractic
- Clinical Psychologist
- Nurse Practitioners
- Physician Assistants
- Clinical Psychologist
- Certified Nurse Midwives
- Clinical Social Worker
- Licensed Clinical Social Worker

Qualifying Visits

- FQHCs report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the FQHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line
- A list of qualifying visits for FQHCs is located on the FQHC web page at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhcpps-specific-payment-codes.pdf>

G0466 - FQHC visit, new patient

HCPCS	Qualifying Visits for G0466
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
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
99408	Behav chng smoking > 20 min

Sample of Qualifying Visits

FQHC G Codes

- G0466: New patient, medical visit
- G0467: Established patient, medical visit
- G0468: Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
- G0469: New patient, mental health visit
- G0470: Established patient, mental health visit

Applicable Revenue Codes

- 0519 Used for Medicare Advantage (MA) supplemental claims only – check with specific payor(s)
- 0521 All Clinic Visits and Professional Services by qualified FQHC provider
- 0522 Home visit by FQHC provider
- 0524 Visit by FQHC provider to a Part A SNF bed
- 0525 Visit by FQHC provider to a SNF (not in a covered Part A stay), NF or ICF or other residential facility
- 0527 Visiting Nurse service(s) to a member's home when in home health shortage area
- 0528 Visit by FQHC provider to other non-FQHC site (i.e., scene of an accident)
- 0250 Drugs (not requiring HCPC code assignment)
- 0900 Behavioral Health

G0466 – FQHC visit, new patient

- A medically-necessary, face-to-face (one-on-one) encounter between a new patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services.
 - A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.
- To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”
- If a new patient is also receiving a mental health visit on the same day, the patient is considered “new” for only one of these visits, and FQHCs should use G0466 to bill for the medical visit and G0470 to bill for the mental health visit.

G0467 – FHCQ visit, established patient

- A medically-necessary, face-to-face (one-on-one) encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services.
 - An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.
- To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”
- If an established patient is also receiving a mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit

G0468 – FQHC visit, IPPE or AWW

- A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWW, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467

G0469 – FHCQ visit, mental health, new patient

- A medically-necessary, face-to-face (one-on-one) encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving mental health services.
 - An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.
- To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”
- If an established patient is also receiving a mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit

G0470 – FHCQ visit, mental visit, established patient

- A medically-necessary, face-to-face (one-on-one) encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving mental health services.
 - An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.
- To qualify as a FQHC visit, the encounter must include one of the services listed under “Qualifying Visits.”
- If an established patient is also receiving a mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit

FQHC Bill Types

- TOB = 077X
- 0770 = nonpayment/zero claim (all charges are noncovered)
- 0771 = admit through discharge – used for an original claim
- 0777 = claim adjustment
- 0778 = void/cancel claim
- DOS cannot overlap calendar years
- Split billing periods that overlap calendar year

New vs Established Patients

- New patient: has not received any professional medical or mental health services from any sites within the FQHC organization within the past 3 years
 - If a new patient is receiving mental health services and medical services on the same day, the patient is considered 'new' for only of these visits

Evaluation & Management Leveling



E&M Time Based Coding



Time Based Coding – Minutes Revised for 2024

- Time Based Coding takes minutes spent with the patient to determine the E&M level
- When using total time on the date of the encounter for code selection:

New	Minutes
99202	15 mins must be met or exceeded
99203	30 mins must be met or exceeded
99204	45 mins must be met or exceeded
99205	60 mins must be met or exceeded

Established	Minutes
99212	10 mins must be met or exceeded
99213	20 mins must be met or exceeded
99214	30 mins must be met or exceeded
99215	40 mins must be met or exceeded

Time Based Coding – Included

- Preparing to see the patient, e.g., review of tests
- Obtaining &/or reviewing separately obtained history
- Performing a medically appropriate examination &/or evaluation
- Counseling & educating the patient/family/caregiver
- Ordering medications, tests or procedures
- Referring & communicating with other health care professionals
- Documenting clinical information in the EMR/medical record
- Independently interpreting results (not separately reported) & communicating results
- Care coordination (not separately reported)
- Time spent on date of service/encounter only



Time Based Coding – Not Included

- When calculating the total time, carve out any time spent on a separately reported or ineligible service
- Ancillary staff time (*i.e.*, rooming patient)
- Travel
- Separately Reportable Diagnostic Service(s)
- In-office procedures
- Psychiatric testing
- Teaching that is not related to the management of the specific patient



Time Based Coding – Example

- If the separately reportable service will not be billed
 - Patient is face to face with the provider 10 mins
 - Tobacco cessation counseling 10 mins
 - Provider documents encounter in EHR 5 mins
 - Total mins spent = 25

- If the separately reportable service will be billed
 - Patient is face to face with the provider 10 mins
 - Tobacco cessation counseling (CPT 99604 3-10 mins) 10 mins – reporting separately, do not include
 - Provider documents encounter in EHR 5 mins
 - Total mins spent = 15

New	Minutes
99202	15 mins must be met or exceeded
99203	30 mins must be met or exceeded
99204	45 mins must be met or exceeded
99205	60 mins must be met or exceeded

Established Minutes	
99212	10 mins must be met or exceeded
99213	20 mins must be met or exceeded
99214	30 mins must be met or exceeded
99215	40 mins must be met or exceeded

E&M MDM Leveling



2023 E/M Revisions

- Comprehensive restructure of the general E/M Guidelines now that include the entire set of E/M services will use a single set of guidelines
- Four types of MDM are recognized: straightforward, low, moderate and high. The concept of the level of MDM does not apply to 99211 and 99281 (these codes, the face-to-face services may be performed by clinical staff)
- Addition of guidelines clarifying the following concepts: analyzing a test, defining a unique test, discussion requiring an interactive exchange between QHPs and reporting a combination of data elements

Medical Decision Making (MDM)

- MDM takes three elements to determine the E&M level that is appropriate for each encounter.
 - Number and Complexities and Problems addressed
 - Complexity of Data to be Reviewed and Analyzed
 - Risk of Complications
- The EM level will be based on 2 out of 3 elements of the MDM Grid.

Emergency Room E/M Code Assignment

- Emergency Room E/M level code assignment
 - Time cannot be used as a key criteria for level assignment
 - Use current AMA Medical Decision-Making tool

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed		Risk of Complications and/or Morbidity or Mortality of Patient Management
		*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.		
N/A	N/A	N/A		N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none		Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness; or • acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)		Low risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)		Moderate risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)		High risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Additional Rationale – Prescription Drug Management

- Prescription medication is still listed under “moderate” risk
- OTC medication are assumed to be in the “straightforward” risk category but could also be moderate or high. The decision is left to the rendering provider to determine the level of risk based on the clinical judgement and the context. Recommendation is to not automatically assign the risk level based on whether OTC medications or prescription medications are part of the decision making.
 - Example: A patient who is on an anticoagulant with a history of congestive heart failure (CHF) and chronic kidney disease (CKD) from hypertensive heart disease would fall under a moderate or high risk if OTC NSAID was prescribed
- Documentation of a medication list (counted toward past history) is not automatically assigned to medical decision making. If documentation supports a treatment plan of medication management, the medication and a mapping to the condition treated, then it can be captured.
- A drug that requires “intensive monitoring” is not one that is assessed for therapeutic efficacy (i.e., levels). Rather, the monitoring is for adverse effects of a medication that has the “potential to cause serious morbidity or death.” Monitoring should be within accepted practice, not less than quarterly for long-term monitoring, and may be accomplished by lab test(s), physiologic test or imaging



Clinical Notes - Scenario 1

- Seen in follow-up clinic, migraines stable at two monthly migraine days, takes Rizatriptan for acute treatment, Nortriptyline 10mg nightly, no side effects on these medications.
- Pre-Visit: You review your past clinic note and recent PCP notes, and TSH (**2 MINS**)
- Visit: You obtain a history from the patient, focused exam, triggers, lifestyle modifications (sleep hygiene, fluid hydration, caffeine intake) (**20 MINS**)
- Post-Visit: You document the encounter, reordering the Rizatriptan and Nortriptyline prescriptions for her migraines (**3 MINS**)
- Total minutes = **25 minutes**

Medical Decision Making – Scenario 1

99213

Problems Addressed:

- 1 stable chronic – migraines
- **Low**


Data Reviewed:

- Review of PCP notes
- Review of recent TSH
- **Moderate**

Patient Management Risk of Complications:

- Prescriptions re-ordered
- **Moderate**

Level of Medical Decision Making (MDM) | Revisions effective January 1, 2023 are noted in red text



Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness; or • acute, uncomplicated illness or injury requiring hospitalization or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
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Time vs MDM – Scenario 1

Problems Assessed	Data Reviewed	Patient Management Risk of Complications
One stable chronic illness	Review PCP notes Review of recent TSH	Prescription drug management Nortriptyline and Rizatriptan use
Low	Moderate	Moderate
MDM = CPT 99214		

Time

Total time of visit (includes pre-visit and post-visit time on calendar day (25 mins))

Established patient, level 3 = 20 mins must be met or exceeded

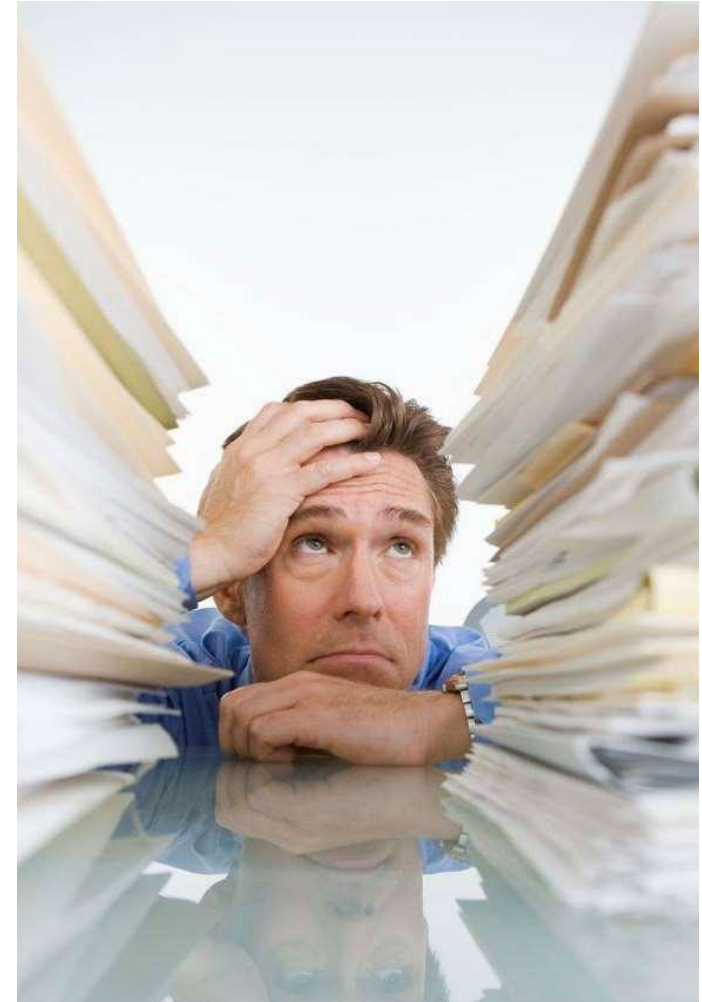
Time Based CPT = 99213

ICD-10-CM Coding Guidelines



If it wasn't documented...

- The Golden Rule of coding...If it wasn't documented, it didn't happen.
- Good documentation captures the great work done by the provider and captures the true condition of the patient.
- Appropriate and accurate documentation within the health record supports
 - Severity of Illness
 - Quality Indicators
 - Coding Accuracy
 - Accuracy of Publicly Reported Data



ICD-10-CM Classification System

ICD-10-CM is a medical diagnosis classification system

- WHO (World Health Organization) released in 2015
- Started with approximately 16k dx codes
- Now includes over 70k dx codes
- Have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM:
 - The American Hospital Association (AHA)
 - The American Health Information Management Association (AHIMA)
 - The Centers for Medicare & Medicaid Services (CMS)
 - The National Center for Health Statistics (NCHS)

ICD-10-CM Diagnosis Coding Tips

- Report Dx codes at the highest level of specificity
- Code all documented chronic conditions that coexist at the time of the encounter/visit if they impact/affect your plan of treatment
- Report status conditions that impact risk adjustment: i.e., transplant status, long term (current) insulin use, current ostomies, ventilator status, etc.
- Coders cannot infer or assume anything, nor can they make assumptions regarding the acuity of a condition; it has to be explicitly stated in the medical record documentation by the provider
 - Clinical documentation should reflect the providers thought/logic process
 - Providers should document the whats and whys
- Document the anatomical site
- Document laterality (side of body affected)
- Document etiology
- Document manifestation/complication
- Document severity of illness
- Document the episode of care (initial, subsequent, sequela)

Problem Lists

Never code directly from the problem list

Problem lists should be reviewed and update routinely

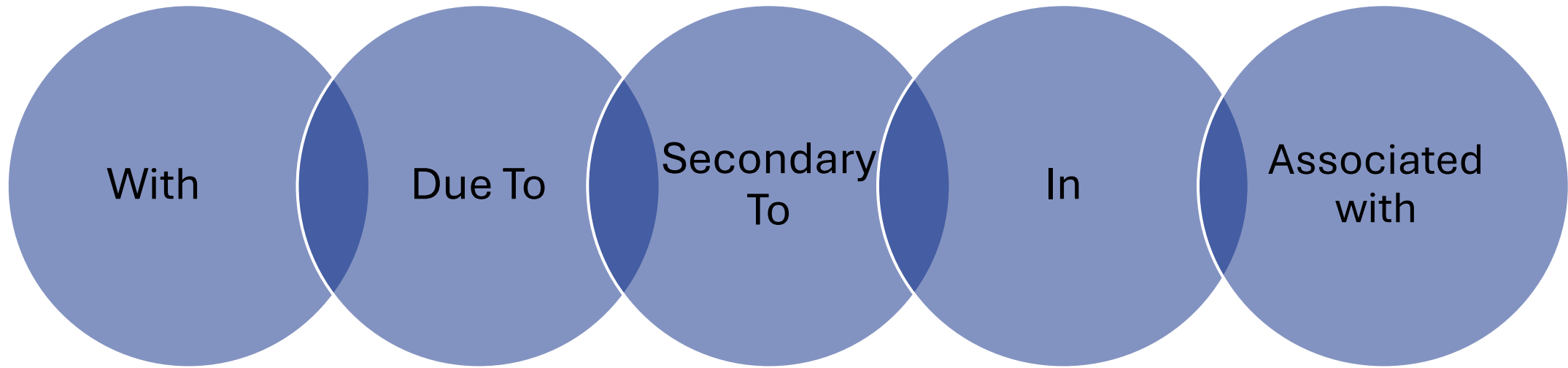
Remove any conditions that are not current or relevant

Perception vs. Reality

Clinical Documentation States...	CMS Interpretation
H/O COPD	COPD has resolved
Pulmonary edema	Non-cardiac pulmonary edema
H/O lung cancer	Lung cancer cured
H/O tracheostomy	Patient no longer has tracheostomy
Asthma on Albuterol	Asthma is stable on current treatment

If the patient has an active condition, documentation should state the correct story, 'history of' verbiage should not be utilized

Connecting Words



Coding Example: UTI

UTI due to *Escherichia coli*

- N39.0 Urinary tract infection, site not specified
 - *Use additional code (B95-B97), to identify infectious agent*
- B96.20 Unspecified *Escherichia coli* (*E. coli*) as the cause of diseases classified elsewhere

Diagnosis Code Example

No relation/documentation in the plan specific to:
Fibromyalgia
Chronic pain syndrome

Assessment

Assessment Notes

Diagnosis Codes

C.S. Code	Description	Status	Diagnosed	Education	Cog.	Func.
ICD10F17.200	Nicotine dependence, unspecified, uncomplicated	ACTIVE	02/06/2023	No	No	No
ICD10J44.9	Chronic obstructive pulmonary disease, unspecified	ACTIVE	02/06/2023	No	No	No
ICD10G89.4	Chronic pain syndrome	ACTIVE	02/06/2023	No	No	No
ICD10I10	Essential (primary) hypertension	ACTIVE	02/06/2023	No	No	No
ICD10K21.9	Gastro-esophageal reflux disease without esophagitis	ACTIVE	02/06/2023	No	No	No
ICD10M79.7	Fibromyalgia	ACTIVE	02/06/2023	No	No	No
ICD10Z99.81	Dependence on supplemental oxygen	ACTIVE	02/06/2023	No	No	No

Procedure

Procedure Notes

Procedure Codes

C.S.Code	Description	Start Time	End Time	Units	Mods	Status	Notes
----------	-------------	------------	----------	-------	------	--------	-------

CPT 99214OV EST PT LEVEL 02/06/2023 03:20:00 PM 02/06/2023 03:40:00 PM 1 CG
4 CST CST

Plan

Plan Notes

ENCOURAGED COMPLIANCE WITH OXYGEN THERAPY
DISCUSSED & ENCOURAGED LIFESTYLE MODIFICATIONS
SCHEDULE WITH CARDIOLOGY
CONTINUE CARE
RTC 3 MONTHS
CHANGE BREZTRI TO TRELEGY
Patient Referred Out and Summary of Care Provided: No
Clinical Summary Provided: No

Additional SOAP Comments

Social Determinants of Health – Professional Encounters



What are Social Determinants?

The World Health Organization defines social determinants as the conditions in which people are born, grow, live, work and age.

Social determinants are shaped by the distribution of money, power and resources available to individuals at the global, national, and local level.

Social determinants are the **PRIMARY DRIVERS** of poor health outcomes, disability, health disparities and early death in the United States.

Common Social Risk Factors

Food Insecurity

- Onset of chronic conditions
- Inability to control chronic conditions
- Increased risk behavioral health risk factors

Housing Instability

- Increased risk of chronic health conditions
- Inability to properly recover from procedures
- Increased trauma experienced by children

Transportation Needs

- Inability to seek health care services
- Inability to obtain medication
- Less likely to maintain steady income

Financial Resource Strain

- Increase risk of developing depression, anxiety and other behavioral health conditions
- Poor Medication adherence

Social Connections

- Leads to increased risk for all-cause mortality and range of disease morbidities
- Results in 40% increase in chance of dying early

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
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High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive <i>(Must meet the requirements of at least 2 out of 3 categories)</i> Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Social Determinants of Health – G0136

- When the SDOH Risk Assessment is furnished as an additional element of the AWW, practitioners shall report HCPCS code G0136 for the SDOH Risk Assessment with the Modifier – 33, on the same claim with the same date of service as a payable Initial AWW (G0438) or a Subsequent AWW (G0439).
- Documentation within the SDOH Risk Assessment should include at a minimum:
 - Housing Insecurity
 - Food Insecurity
 - Transportation Needs
 - Utility Difficulty

Social Determinants of Health – G0136

What is G0136?

- Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months

When can I provide G0136?

- An E&M visit, which can include hospital discharge or transitional care management services
- Behavioral health office visits
- Annual Wellness Visit

Who can perform the SDOH Assessment?

- Treating physician or NP, CNS, CNM, PA, or by auxiliary personnel under the general supervision of the billing practitioner incident to their professional services

How do I bill for G0136?

- Part B deductible and coinsurance apply except when the SDOH risk assessment is furnished as an optional element of the AWW

Additional Services Reportable by FQHCs

Other Services Reportable by FQHCs

Annual Wellness Visits (AWV)	
Transitional Care Management (TCM)	
Chronic Care Management (CCM)	
Complex Chronic Care Management (CCCM)	
Principal Care Management (PCM)	
Behavioral Health Integration (BHI)	
Psychiatric Collaborative Care Model	
Remote Therapeutic Monitoring (RTM)	
Virtual Communication Services	

Service	CPT/HCPCS Code	Short Descriptor	Coinsurance
DSMT	G0108	DM mgt tr per ind	Not waived
MNT	97802	Med Nutrition ind initial	Waived
	97803	Med Nutrition ind subsequent	Waived
	G0270	Med Nutrition subs tx change dx	Waived
AWV	G0438	Initial visit	Waived
	G0439	Subsequent visit	Waived
Screening Pelvic Exam	G0101	Ca screen; pelvic/breast exam	Waived
Prostate Ca Screening	G0102	Prostate Ca screening	Not waived
Glaucoma Screening	G0117	Glauc screen high risk opt/opthal	Not waived
	G0118	Glauc screen high risk direct supv	Not waived
Screening Pap Test	Q0091	Screen pap smear	Waived
Alcohol Screening & Beh Counseling	G0442	Annual alcohol screen 15 mins	Waived
	G0443	Brief alcohol screen misuse counsel	Waived
Screening for Depression	G0444	Depression screen annual	Waived

FQHC Preventive Services Chart Continued

Service	CPT/HCPCS Code	Short Descriptor	Coinsurance
Screen for STD and high intensity beh counseling	G0445	High inten beh couns std 30 mins	Waived
Intensive beh ther for cardiovascular disease	G0446	Intensive beh therapy cardio dx	Waived
Intensive beh ther for obesity	G0447	Beh counseling obesity 15 mins	Waived
Smoking & tobacco cessation	99406	Beh change smoking 3-10 mins	Waived
	99047	Beh change smoking >10 mins	Waived
Lung Ca screen w/low dose CT	G0296	Visit to determine LDCT elig	Waived

Behavioral Health via Telehealth 2025

Telehealth is an effective tool that expands access to behavioral health services. To support access to telebehavioral health care, telehealth policies allow:

- FQHCs and RHCs can permanently serve as a Medicare distant site provider for behavioral/mental telehealth services.
- Medicare patients can permanently receive telehealth services for behavioral/mental health care in their home.
- There are no geographic restrictions for originating site for Medicare behavioral/mental telehealth services on a permanent basis.
- Behavioral/mental telehealth services in Medicare can permanently be delivered using audio-only communication platforms.
- Marriage and family therapists and mental health counselors can permanently serve as Medicare distant site providers.
- For FQHCs and RHCs, the in-person visit requirement for mental health services furnished via communication technology to beneficiaries in their homes is not required until January 1, 2026.

FQHC Billing



Example of Qualifying Visit List

G0466 - FQHC visit, new patient

HCPCS Qualifying Visits for G0466

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
99407	Behav chng smoking > 10 min

FQHC Bill Types

- ❑ TOB = 077X
- ❑ 0770 = nonpayment/zero claim (all charges are noncovered)
- ❑ 0771 = admit through discharge – used for an original claim
- ❑ 0777 = claim adjustment
- ❑ 0778 = void/cancel claim
- ❑ DOS cannot overlap calendar years
- ❑ Split billing periods that overlap calendar year

Reference: [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 9](#), Section 100A

FQHC Applicable Revenue Codes

- 0521 All Clinic Visits and Professional Services by qualified FQHC provider
- 0522 Home visit by FQHC provider
- 0524 Visit by FQHC provider to a Part A SNF bed
- 0525 Visit by FQHC provider to a SNF (not in a covered Part A stay), NF or ICF or other residential facility
- 0527 Visiting Nurse service(s) to a member's home when in home health shortage area
- 0528 Visit by FQHC provider to other non-FQHC site (i.e., scene of an accident)
- 0250 Drugs (not requiring HCPC code assignment)
- 0900 Behavioral Health

Multiple Encounters – Same Day, Modifier 59

- ❑ Modifier-59 indicates that separate conditions are treated on the same date of service as a previous encounter and are unrelated to the initial encounter. This is used only if a subsequent illness or injury on the same day as another visit
- ❑ Modifier-59 is only on the subsequent service line item UB-04 on a claim form

Modifier Example – Subsequent Visit

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS Code	FL45 Date of Service	FL46 Units
0521	Office Visit Est III	99213	08/12/2021	1
0521	Est pt, med visit	G0467	08/12/2021	1
0521	Laceration repair	12002 59	08/12/2021	1

- Modifier 59 is NOT reported on the first service line (99213)
- Assign modifier 59 to the subsequent service line to indicate the subsequent medically necessary visit

Mental Health & Medical Visit- Same Day

Revenue Code	CPT/HCPCS Code	Modifier	Date of Service
0521	G0468 - FQHC Payment code	N/A	8/12/2021
0521	G0438 – AWW	N/A	8/12/2021
0900	G0470 – FQHC Payment code	N/A	8/12/2021
0900	90832 – Psy therapy, 30 mins	N/A	8/12/2021

- G0468 = FQHC payment code, medical visit
- G0438 = Annual wellness visit (AWV)

- G0470 = FQHC payment code, mental health, established patient
- 90832 = Psychotherapy, 30 minutes with patient

References



References

- AMA Evaluation & Management Coding Guidance: <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf>
- CMS ICD-10-CM Official Coding Guidelines: <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf>
- CMS Annual Wellness Visits, IPPE Visits Guidance: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html>
- Medlearn E/M Level Guidance: MLN006764_Evaluation_and_Management_Services_Guide_2024-09
- America Dental Association: https://www.ada.org/join-the-ada/nm-membership-engagement?utm_source=cpc&utm_content=d2d24-MEM-NM-Renew&utm_campaign=membervalue-rr-MEM-NM&gad_source=1&gclid=EAlaIQobChMI1bDLk9_fiwMVHA5ECB1xIC
- FQHC Preventive Services Chart: <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-preventive-services.pdf>

References

- National Association of Community Health Centers Guidance: <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.nachc.org/wp-content/uploads/2023/06/1-19-23-MOBILE-Health-Care-Act-Explainer-Final.pdf>
- CMS SDOH Guidance: <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cms.gov/files/document/zcodes-infographic.pdf>
- Medlearn TCM Services Guidance: MLN908628 <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf>
- CMS IOM Chapter 13 Section 250 [Medicare Benefit Policy Manual](#)

