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

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Description</th>
<th>CPT-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening test of visual acuity, quantitative, bilateral</td>
<td>Screening test of visual acuity, quantitative, bilateral</td>
<td>99173</td>
</tr>
<tr>
<td>Screening test, pure tone, air only</td>
<td>Screening test, pure tone, air only</td>
<td>92551</td>
</tr>
<tr>
<td>Pure tone audiometry (threshold); air only</td>
<td>Pure tone audiometry (threshold); air only</td>
<td>92552</td>
</tr>
<tr>
<td>Pure tone audiometry (threshold); air and bone</td>
<td>Pure tone audiometry (threshold); air and bone</td>
<td>92553</td>
</tr>
<tr>
<td>Speech audiometry threshold</td>
<td>Speech audiometry threshold</td>
<td>92555</td>
</tr>
<tr>
<td>Speech audiometry threshold; with speech recognition</td>
<td>Speech audiometry threshold; with speech recognition</td>
<td>92556</td>
</tr>
</tbody>
</table>

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)
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)

<table>
<thead>
<tr>
<th>HIPAA Proc Code</th>
<th>HIPAA Modifier</th>
<th>Procedure Code Description</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90633</td>
<td>EP</td>
<td>Hep A</td>
<td>V053</td>
</tr>
<tr>
<td>90647</td>
<td>EP</td>
<td>HIB Haemophilus b Conjugate Vaccine (PedvaxHib) 3 dose</td>
<td>V0381</td>
</tr>
<tr>
<td>90648</td>
<td>EP</td>
<td>HIB Haemophilus b Conjugate Vaccine (ACTHIB) 2months-18 months</td>
<td>V0381</td>
</tr>
<tr>
<td>90649</td>
<td>EP</td>
<td>Human Papilloma virus (HPV) (quadrivalent, 3 dose schedule) Girls 9-18 years</td>
<td>V04.89 or V05.8</td>
</tr>
<tr>
<td>90655</td>
<td>EP</td>
<td>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</td>
<td>V0481</td>
</tr>
<tr>
<td>90656</td>
<td>EP</td>
<td>(Prevax) Pneumococcal Conjugate</td>
<td>V0382</td>
</tr>
<tr>
<td>90657</td>
<td>EP</td>
<td>Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use Rotarix (Rotavirus vaccine, 2 dose)</td>
<td>V04.89</td>
</tr>
<tr>
<td>90658</td>
<td>EP</td>
<td>Pentacel (DTAP-Hib-IPV) 6 weeks thru 5 years</td>
<td>V06.8</td>
</tr>
<tr>
<td>90659</td>
<td>EP</td>
<td>DTAP</td>
<td>V061</td>
</tr>
<tr>
<td>90700</td>
<td>EP</td>
<td>DT</td>
<td>V065</td>
</tr>
<tr>
<td>90707</td>
<td>EP</td>
<td>MMR</td>
<td>V064</td>
</tr>
<tr>
<td>90710</td>
<td>EP</td>
<td>Measles, mumps, rubella, and varicella vaccine (MMRV) live</td>
<td>V06.8</td>
</tr>
<tr>
<td>90713</td>
<td>EP</td>
<td>IPV</td>
<td>V040</td>
</tr>
<tr>
<td>90714</td>
<td>EP</td>
<td>Decavac © (preservative free TD)</td>
<td>V065</td>
</tr>
<tr>
<td>90715</td>
<td>EP</td>
<td>Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), 7yrs-18yrs, 11months</td>
<td>V06.1</td>
</tr>
<tr>
<td>90716</td>
<td>EP</td>
<td>Varicella</td>
<td>V054</td>
</tr>
<tr>
<td>90718</td>
<td>EP</td>
<td>Td Tetanus and diphtheria toxoids adsorbed 7 years and older</td>
<td>V065</td>
</tr>
<tr>
<td>90723</td>
<td>EP</td>
<td>DTAP, Hep B, and IPV)</td>
<td>V068</td>
</tr>
<tr>
<td>90732</td>
<td>EP</td>
<td>(Pneumovax 23) Pneumococcal Polysaccharide</td>
<td>V0382</td>
</tr>
<tr>
<td>90734</td>
<td>EP</td>
<td>Menactra © (Meningococcal Conjugate) (2 yrs – 18 yrs. 11 months</td>
<td>V03.89</td>
</tr>
<tr>
<td>90744</td>
<td>EP</td>
<td>Hepatitis B</td>
<td>V053</td>
</tr>
<tr>
<td>90748</td>
<td>EP</td>
<td>Combination HEP B and Hib</td>
<td>V068</td>
</tr>
<tr>
<td>86580</td>
<td>EP</td>
<td>TB Skin Test</td>
<td>V741</td>
</tr>
<tr>
<td>36415</td>
<td>EP</td>
<td>Blood Lead Test Venous</td>
<td>V825</td>
</tr>
<tr>
<td>36416</td>
<td>EP</td>
<td>Blood Lead Test Capillary</td>
<td>V825</td>
</tr>
</tbody>
</table>