

# Community Health Centers

### Policy

Mass General Brigham Health Plan reimburses participating Community Health Centers (CHC) and Federally Qualified Health Centers (FQHC) for the provision of medically necessary administration, professional, and related supporting services associated with member care as set forth in the policy.

### Membership Limitations

- This policy is applicable to government payers only (**Medicaid and Medicare Advantage**).

### Authorization, Notification and Referral

Service	Requirement
Specialty Visits	<ul style="list-style-type: none"><li>• Referral is required for Mass General Brigham Health Plan contracted specialists.</li><li>• Non-Contracted specialists must have a referral from the member's PCP and must obtain Prior Authorization from Mass General Brigham Health Plan.</li></ul>
OB/GYN services including routine services, preventive services, acute and emergency services, maternity services, and subsequent care when rendered in an outpatient setting, excluding Observation.	<ul style="list-style-type: none"><li>• No referral, authorization, or notification required.</li><li>• Please refer to the Observation Services Provider Payment Guideline for additional information.</li></ul>

### Policy Limitations

- This policy applies to places of service in accordance with the National POS code set.

### Member Cost Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs;

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copayments, coinsurance, and deductible required, if any. Mass General Brigham Health Plan suggests that providers do not bill the member for services prior to adjudication of claim(s) in order for the accurate member responsibility to be calculated. Any member responsibility for copayments, coinsurance and/or deductible will be reflected on the Explanation of Payment (EOP) and the member's Explanation of Benefits (EOB).

### Provider Limitations

Reimbursement is limited to E/M services rendered by physicians and qualified non-physician practitioners who are legally authorized to perform these medical services in compliance with the Commonwealth of Massachusetts laws and any limitations set forth in this policy.

### Service Limitations for Medicaid Claims

The codes in the table below are subject to the requirements set forth in this policy, in conjunction with Mass General Brigham Health Plan Provider Manual and Subchapters 1 through 6 of the Mass Health Community Health Center Provider Manual.

CHC/FQHC must bill using current industry standard CPT/HCPCS established for all outpatient E/M visits. Any visit in which a member is seen by more than one healthcare professional, for the same medical problem or general purpose, must be submitted as only one visit regardless of the number of clinicians seen. A CHC/FQHC may bill for a visit, a treatment, and/or a procedure, but may not bill for more than one of these services when provided to the same member, on the same date, when the services are performed in the same location. This limitation does not apply to tobacco cessation counseling services provided by a physician or other qualified staff member under the supervision of a physician on the same day as a visit.

CHC/FQHC may submit for two different E/M services on the same day, only when a provider submits a problem-focused office visit procedure code with a preventive medicine procedure code and the appropriate modifier is appended to the problem-focused service code. If the appropriate modifier is not submitted, the problem-focused visit will be denied as included in the preventive medicine visit.

The EPSDT add-on code S0302 should only be reported only when all components of an EPSDT visit have been performed. S0302 may be reported in conjunction with a problem focused E/M service (99201- 99215), only when an unrelated diagnosis or treatment service is rendered, Modifier 25 must be appended to the E/M code.

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CPT 99050 should only be reported when urgent care services are provided and according to the time when the patient is rendered services. CPT 99050 can be used when urgent services are rendered; Monday through Friday, from 5:00 p.m. to 6:59 a.m., and from Saturday at 7:00 a.m. through Monday at 6:59 a.m.

### Service Limitations for Medicaid Claims 2 (continued)

Category	CPT/HCPCS Codes	Short Descriptor	Comments
Clinic Visit	<ul style="list-style-type: none"> <li>T1015</li> </ul>	Clinic visit/encounter, all-inclusive	Report one clinic visit per day, regardless of the number of clinicians seen. Cannot be billed in conjunction with an E&M, regardless of modifier 25
EPSTD Add on	<ul style="list-style-type: none"> <li>S0302</li> </ul>	Completed early periodic screening diagnosis and treatment (EPSDT) service	Report only when all components of an EPSDT visit have been performed
Developmental Testing	<ul style="list-style-type: none"> <li>96110</li> </ul>	Developmental testing; limited	Reporting with appropriate modifier is <b>required</b>

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Category	CPT/HCPCS Codes	Short Descriptor	Comments
Urgent Care	<ul style="list-style-type: none"> <li>99050</li> </ul>	Services provided in the office at times other than regularly scheduled office hours	Can be used for urgent care rendered between 5:00 PM and 6:59 AM, Monday through Friday, and Saturday from 7:00 AM to 4:00 PM
Urgent Care	<ul style="list-style-type: none"> <li>99050-TV</li> </ul>		Can be used for urgent care rendered between 4:01 PM on Saturday through 6:59 AM Monday
HIV Counseling-Pre/Post Testing	<ul style="list-style-type: none"> <li>99402</li> </ul>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes	Report 99402 when the sole purpose of the visit is for HIV counseling services
Smoking Cessation	<ul style="list-style-type: none"> <li>99407</li> </ul>	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	Report with appropriate modifier

### Vaccine and Vaccine Administration

Vaccine(s) and vaccine administration will be reimbursed when rendered as the only service or when performed in conjunction with an E/M. If the only service being rendered is the vaccine administration, CHC/FQHC should not submit for an outpatient E/M service. When the vaccine is administered in conjunction with an E/M visit provider must append Modifier-25 to receive

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reimbursement. Vaccine administration reimbursement is included in the reimbursement for all E/M services, except for those E/M services outlined in the following table.

Providers are to report the appropriate CPT corresponding to the vaccine(s) administered, regardless if they are state supplied or privately purchased. Vaccine(s) will only be reimbursed when they are not state supplied.

Category	CPT Codes	Short Descriptor	Comments
Vaccine Administration	<ul style="list-style-type: none"> <li>• 90460</li> <li>• 90461</li> <li>• 90471</li> <li>• 90472</li> <li>• 90473</li> <li>• 90474</li> <li>• G0008</li> <li>• G0009</li> <li>• G0010</li> </ul>	Immunization administration	Vaccine administration is separately reimbursed only with the following E/M codes: <ul style="list-style-type: none"> <li>• 99218-99226</li> <li>• 99231-99233</li> <li>• 99304-99310</li> <li>• 99324-99327</li> <li>• 99334-99337</li> </ul>

### Medicare Advantage Claims

CHCs and FQHCs are paid an All-Inclusive Rate (AIR) per visit, except for FQHCs that have transitioned to the Medicare Prospective Payment System (PPS). For CHCs and FQHCs billing under the AIR, more than one medically necessary face-to-face visit with a CHC or FQHC practitioner on the same day is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the CHC/FQHC);
- The patient has a medical visit and a mental health visit on the same day;
- The patient has an Initial Preventive Physical Examination (IPPE) and a separate qualified medical and/or mental health visit on the same day;
- The patient has a Diabetes Self-Management Training (DSMT) or Medical Nutrition Therapy

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(MNT) visit on the same day as an otherwise payable medical visit. DSMT and MNT apply to FQHCs only

The following HCPCS codes must be reported on FQHC PPS Medicare claims:

HCPCS Code	Definition
G0466	FQHC visit, new patient A medically necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
G0467	FQHC visit, established patient A medically necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
G0468	FQHC visit, IPPE or AWW
G0469	FQHC visit, mental health, new patient A medically necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
G0470	FQHC visit, mental health, established patient A medically necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving a mental health visit.

For additional information regarding FQHC revenue codes, bill type, and place of service, please refer to:

- [MGBHP Medicare Advantage FQHC & RHC Billing Guide](#)
- [Medicare Claims Processing Manual, Chapter 9 – RHC/FQHC, Section 50 - General Requirements](#)

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[for RHC and FQHC Claims](#)

### Billing Limitations

All claims must be filed within (90) calendar days of the date of service.

### Modifiers

Apply modifiers in accordance with CPT and correct coding guidelines. Modifiers and descriptors are available in current CPT/HCPCS Manuals or refer to Mass General Brigham Health Plan Modifier Provider Payment Guidelines.

### Mass General Brigham Health Plan Does *Not* Reimburse

- E/M services within the global period of a procedure, as they are considered inclusive to the procedure.
- Established patient E/M services on the same day as a surgical procedure with a 0-day post op period unless there is a significant, separately identifiable E/M service, or above and beyond the usual preoperative and postoperative care associated with the procedure documented in the medical record and the appropriate modifier appended to the E/M code.
- Consultation codes (CPT 99242-99245, 99252-99255) which is no longer recognized by Mass General Brigham Health Plan.
- Inpatient or observation consultations billed with 99221-99223, 99231-99233, when the consulting physician is not face-to-face with the patient in the facility, e.g. conducted via telephone, or video-conferencing.
- An emergency department E/M service billed with critical care services rendered by the same provider on the same date of service.
- Services identified by CPT as included in the descriptor of pediatric critical care services.
- Prolonged physician services (99417 - 99418) in the office or other outpatient setting.

### Mass General Brigham Health Plan Does *Not* Reimburse (continued)

- Generic and/or special supplies are not reimbursed. (*Note:* Please submit the most specific HCPCS code for consideration.)
- Handling fees, device fees- considered part of the services/procedures rendered.
- Out-of-hospital on-call services.
- Adjunct codes reported in addition to the basic service rendered, including codes for medical services provided from 10:00 PM to 8:00 AM at a 24-hour facility (e.g. an

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emergency department); or out-of- the- office; or on an emergency basis out-of-the-office.

- Medical testimony, special reports or forms, or computer data analysis.
- Unusual physician travel.
- Moderate (conscious sedation).

### Definitions

**Consultation Service:** A type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. When requested by a physician or other appropriate source, a consultation may be provided by a physician or qualified non-physician practitioner (NPP). In order to be a qualified NPP, performing a consultation service must be within the scope of practice and licensure in the state in which the NPP practices.

**Evaluation and Management Service:** Visits and consultations furnished by physicians and qualified Non-physician practitioners practicing within the scope of practice and licensure in the state in which the NPP practices.

**Established patient:** A patient who has received professional services from the provider or another provider of the same specialty who belongs to the same group practice (same tax ID number) within the past three years.

**Global period:** Surgical procedures are assigned a global day period of 0, 10, or 90 day(s) by CMS based on the complexity of the procedure. Services related to the surgery, rendered within the assigned specified number of global days, including E/M services are considered inclusive to the primary procedure and are not eligible for separate reimbursement.

**ICF/LTCF:** Intermediate care facility/Long-term care facility

**Modifier-25:** Defined by the American Medical Association, as an indicator of a significant, separately identifiable E/M service performed by the same provider on the same day as a procedure or other service. The significant, separately identifiable E/M service goes above and beyond the other service provided, or beyond the usual pre-operative and post-operative care associated with the primary procedure.

**National Correct Coding Initiative (NCCI):** National Correct Coding Initiative (NCCI) was developed by



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CMS to promote national correct coding methodologies. The coding policies are based on the following coding conventions, including but not limited to; the American Medical Association's (AMA) CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

**New patient:** A patient who has *not* received any professional services from the same provider or another provider of the same specialty who belongs to the same group practice (same tax ID number), within the past three years.

**Office or other outpatient visit:** An evaluation and management (E/M) service with history, examination, and medical decision making considered as the key components, provided in the physician's office or in an outpatient or other ambulatory facility.

**Office or other outpatient-setting:** The physician's office or in an outpatient or other ambulatory facility where the patient is considered an outpatient until inpatient admission to a health care facility occurs.

**Physician Telephone Services:** Non-face-to-face E/M services provided by a physician to a patient using the telephone. Codes 99441, 99442, 99443, are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested, or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure.

**PCP:** Primary care provider

**Preventative medicine visit:** A comprehensive, preventative medical E/M of an individual including an age-appropriate history, exam, counseling, anticipatory guidance, risk factor reduction intervention(s), and the ordering of laboratory and / or diagnostic procedures.

**Specimen handling:** The handling and /or conveyance of a specimen/device from the physician's office, or other setting, to a laboratory.

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**SNF:** Skilled Nursing Facility

**Urgent Care provided at a Mass General Brigham Health Plan site:** Circumstances when services are provided by a Mass General Brigham Health Plan PCP; in the office at times other than regularly scheduled office hours, or on days when the office is normally closed; provided in the office during regularly scheduled evening, weekend, or holiday office hours; or provided on an emergency basis in the office that disrupts other scheduled office services.

### References

Current year CPT, Professional Edition published by the AMA (American Medical Association) Evaluation & Management Service Guide

[CMS Evaluation and Management Services Guide, MLN006764, August 2023](#)

[Mass Health Physician Manual, Transmittal Letter PHY-111](#), dated 07/01/06, page 4-30/31:

Tobacco Cessation Services and Mass General Brigham Health Plan Summary of Benefits for GIC HMO Plan effective 7/1/2013

[Mass Health Physician Manual -Non-payable CPT Codes -603 Codes- Requirements or Limitations](#)

[MassHealth Community Health Center Manual; Subchapter 6](#)

Mass General Brigham Health Plan [Medicare Advantage FQHC/RHC Billing Guide](#)

Mass General Brigham Health Plan [Professional Evaluation & Management](#) Payment Guideline

Mass General Brigham Health Plan [Modifier](#) Payment Guideline

[Medicare Claims Processing Manual, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers](#)

### Publication History

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**January 1, 2019**

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*Annual review, no policy change*

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*Annual review, no policy change*

## Provider Payment Guidelines

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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers' contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.