INSTRUCTIONS
MEDI-CAL FEDERALLY QUALIFIED HEALTH CENTER (FQHC) RURAL HEALTH CLINIC (RHC)/INDIAN HEALTH SERVICES MEMORANDUM OF AGREEMENT (IHS/MOA) PROSPECTIVE PAYMENT SYSTEM (PPS) 638 CLINIC RECONCILIATION REQUEST

Table of Contents

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Please read all instructions carefully before completing the form.

Benefits Improvement and Protection Act (BIPA), Welfare and Institutions (W&I) Code Section 14132.100 and the 42 USC section 1396a (bb) authorize FQHCs/RHCs to receive payment for providing covered services to Medi-Cal eligible individuals under a Prospective Payment System (PPS) methodology. The PPS rate covers 100 percent of the FQHC's/RHC's reasonable costs for providing services to Medi-Cal beneficiaries.

For beneficiaries who participate in Medi-Cal Managed Care and/or are enrolled in Medicare, the Department of Health Care Services (DHCS) pays the FQHC/RHC a supplemental payment, commonlyreferred to as the wrap payment, that is equal to the difference between visits reimbursed at the FQHC's/RHC's PPS rate and the amount received by third-party payers. DHCS pays the supplemental payment in two stages—an interim payment, referred to by DHCS as a differential rate, is paid on a per-visit basis each time the FQHC/RHC files a claim, and, if necessary, a final payment once the reconciliation process is complete. If the amount of Medi-Cal Program interim payments and third party payments received by the FQHC/RHC is less than the amount of actual visits reimbursed at the PPS rate, the FQHC/RHC will be paid the difference. However, if the amount of Medi-Cal Program interim payments and third-party payments is more than the amount of actual visits reimbursed at the PPS rate, the FQHC/RHC must repay DHCS the difference. California's State Plan Amendment (SPA) at Attachment 4.19-B describes the PPS reimbursement methodology DHCS must follow with respect to FQHCs/RHCs.

At the end of each FQHC's/RHC's fiscal year, FQHCs/RHCs must file a Federally Qualified Health Center(FQHC)/Rural Health Clinic (RHC) Prospective Payment System (PPS) Reconciliation Request. The total amount of Medi-Cal interim payments and third party payments received by the FQHC/RHC, e.g., Medicare, Managed Care Organization (MCO), and other third party payments, if applicable, will be reviewed against the amount of the actual number of visits the FQHC/RHC reimbursed by the Medi-Cal Program.

Only the FQHC's/RHC's visits that were adjudicated by the Medi-Cal Fiscal Intermediary (FI) will be included in the reconciliation calculation to determine the difference between visits reimbursed at the FQHC's/RHC's PPS rate and the amount received by third-party payers.

Pursuant to W&I Code section 14132.100(h), FQHCs/RHCs must disclose all payments received from Medicare, Medi-Cal Managed Care Plans (capitated and fee-for-service), and all other third party sources for the provision of FQHC/RHC services to Medi-Cal beneficiaries, regardless of whether services were rendered and irrespective of whether the third party payments resulted in a billable visit to the Medi-Cal Program. Financial incentive payments that meet the requirements of

federal and state law may be excluded from the annual Reconciliation Request. Verification of third-party payments is subject to the Medicare reasonable cost principles found in 42 CFR, Part 413, and in accordance with California's FQHC/RHC policies and procedures.

If an FQHC/RHC bills the Medi-Cal Program for services rendered to a Medi-Cal managed care beneficiary, all Medi-Cal managed care plan payments received for all Medi-Cal beneficiaries will be included in the determination of final reimbursement on the annual Reconciliation Request. There may be occurrences where the Medi-Cal managed care plan reimbursement for some Medi-Cal beneficiaries exceeds the Medi-Cal PPS, while the Medi-Cal managed care plan reimbursement for other Medi-Cal beneficiaries does not exceed the Medi-Cal PPS rate. In these occurrences, it would be inappropriate to bill the Medi-Cal Program for only the Medi-Cal beneficiaries that received less than the Medi-Cal PPS rate and then to not also bill the Medi-Cal Program for the Medi-Cal beneficiaries that received more than the Medi-Cal PPS rate.

Only if an FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, do they not need to include all the reimbursement for pharmacy services the FQHC/RHC received from a Medi-Cal managed care plan on behalf of Medi-Cal beneficiaries.

A Reconciliation Request must be submitted for each separate National Provider Identifier (NPI) number annually, within 150 days after the end of the provider's fiscal year. Please note: DHCS will **NO LONGER** accept consolidated reconciliation forms with multiple NPIs.

Incomplete forms will be returned for correction. If returned, an explanation will be provided, identifying the deficiencies and corrective action needed. It is important that all FQHC/RHC providers follow the Electronic Submission Protocol when submitting Reconciliation Requests. Upon submission of the Reconciliation Request to Reconciliation.Clinics@dhcs.ca.gov, you will receive an email response confirming receipt. For questions or assistance, contact the FQHC/RHC Section at (916) 322-1681 or Clinics@dhcs.ca.gov.

RECONCILIATION PROCESS

The Reconciliation Request forms consist of a Cover Sheet, Statistical Data and Certification Statement, Request to Update Differential Rates, Reconciliation Request Summary (Worksheet 1), and Worksheets 2, 3, and 4, which requests detailed visit and payment information for Medi-Cal Non-Managed Care Crossovers, Medi-Cal Managed Care, and Medi-Cal Non-Managed Care Crossovers with Capitated Medicare Advantage Plans (MAP), respectively. Worksheet 3A must be completed to provide DHCS the necessary information regarding managed care plans. Worksheet 5, Summary of Services and Worksheet 6, Productivity for Health Care Practitioners worksheets must be filled out and included in the reconciliation submittal.

The data reported on the Reconciliation Request forms is subject to audit by DHCS. In accordance with 42 CFR § 413.20, DHCS reserves the right to request supporting documentation such as remittance advices, explanation of benefits, or other relevant and verifiable evidence to minimize the need for onsite reviews.

The Department has three years from the date the Reconciliation Request forms are received and accepted todetermine if the total payments were greater or less than the provider's allowable PPS reimbursement.

To assist the Department in their review, supporting documentation may be submitted with the Reconciliation Request forms. This is optional and is useful in determining revenue from payers other than Medi-Cal. For example, revenue received from Medicare for those services covered both by Medicare and Medi-Cal can be supported by data from the practice management system. The data would still be subject to audit and additional verification by the Department if deemed necessary.

PAGE 1—COVER SHEET

This Worksheet will automatically populate based on the information entered on Statistical Data Certification Page 2.

PAGE 2—STATISTICAL DATA AND CERTIFICATION STATEMENT

PART A—GENERAL INFORMATION

The purpose of this page is to collect licensee information, the licensee's mailing address, and the name of the person to contact for necessary information and to have the contents of the report certified. A licensee is defined as a legal entity, e.g., the organization to which the actual license is issued.

1. Enter FQHC/RHC Legal Name
2. Enter Doing Business as (DBA)
3. Enter National Provider Identifier (NPI)
4. Enter Type of Control (Select from drop-down menu)
5. Enter FQHC/RHC Street Address
6. Enter City, State, Zip Code
7. Enter Fiscal Year Begin (mm/dd/yyyy)
8. Enter Fiscal Year End (mm/dd/yyyy)
9. Enter Preparer Name or Contact Person
10. Enter Contact Person E-mail Address
11. Enter FQHC/RHC Owned by
12. Enter Business Phone Number (xxx) xxx-xxxx
13. Enter Offsite Provider Name(s)
14. Enter Offsite Provider Address(s)
15. Enter Offsite Provider NPI(s)

PART B—CERTIFICATION STATEMENT

Refer to the Certification Statement located on the DHCS Forms & Publications webpage. We will reject any cost report filed without a completed certification statement signed through DocuSign. The individual E-signing this statement must be an Administrator, Controller, Corporate Officer, or

member of the Board of Directors. The official signing the report must have the legal capacity to make commitments for the organization.

PAGE 3—REQUEST TO UPDATE DIFFERENTIAL RATES

This page is only used to request updates to differential rates. Use the drop-down menu to select "Yes" or "No" in the column if rate updates are required to complete the applicable forms. Enter the Fiscal Period, and the remaining worksheets will populate automatically. No special form is necessary to update the Medi-Cal Non-Managed Care Crossover rate. DHCS will contact you to obtain the relevant information.

SUMMARY OF VISITS AND PAYMENTS WITH SETTLEMENT DETERMINATION—WORKSHEET 1

This page summarizes Worksheets 2, 3, and 4 will populate automatically when the provider completes the Worksheet.

Note:

1. The date of service should be used as the basis for reporting visits and payments.

2. PPS rates increase on October 1st of each year based on an inflation factor known as the Medicare Economic Index. The time interval before the increase in Period 1 and after the increase in Period 2.

Please enter the applicable PPS rates for Period 1 and Period 2 in the yellow boxes on Line 16.

Please specify if the rates entered are FINAL rates or NOT FINAL rates (i.e., a new facility awaiting the establishment of a permanent PPS rate) by placing either a "Y" or "N" in the yellow area to the left of the PPS rate cells.

MEDI-CAL NON-MANAGED CARE CROSSOVER DETAIL—WORKSHEET 2

Beginning with the column on the left:

Enter the months included in the fiscal period beginning with the first month of the fiscal period. Enter the month and year (i.e., January 2020.)

Enter the number of visits next to the appropriate month. Report only adjudicated visits during the reporting period for dual-eligible beneficiaries not enrolled in any Medi-Cal Managed Care plan and not paid using a capitated MAP arrangement.

Enter the payments that correspond to the monthly visits in the appropriate payment column. Report all payments received from the Medi-Cal FI for dual-eligible beneficiaries not enrolled in any Medi-Cal Managed Care plan and not paid by Medicare using a capitated MAP arrangement.

Payment Explanations

- **PPS/Upper Payment Limit (UPL)/Fee for Service (FFS)—**Combine payments received from the Medicare Administrative Contractor (MAC) whether from a PPS, UPL, or FFS arrangement for dual-eligible patients **not** enrolled in a Medi-Cal Managed Care plan, and **not** participating in any MAP arrangement.
- **FFS MAP—**Input payments received from MAP for beneficiaries enrolled in an FFS arrangement and **not** enrolled in a Medi-Cal Managed Care plan.
- **CODE 519—**Input-only wrap-around payments received from the MAC for beneficiaries enrolled in any MAP arrangement and **not** enrolled in a Medi-Cal Managed Care plan.
- **PART D—**Input payments received from Medicare prescription drug plans for beneficiaries **not** enrolled in a Medi-Cal Managed Care plan. Only if the FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, does the FQHC/RHC not need to include Medicare Part D payments. Otherwise, Part D payments must be reported.
- **3rd PARTY PAYER—**Input all payments received for FQHC/RHC services from any other source not already reported.

Only include payments related to Medi-Cal beneficiaries for all types listed above.

1. Enter a formula for Period 1 Total and Period 2 Total in the "VISITS" Column to calculate the appropriate visits for each period.

For example: If the provider's fiscal year is July through June, in the "Period 1 Total" box, enter the formula to sum July, August, and September. In the "Period 2 Total" box, enter the formula to sum October through June.

2. Copy the appropriate Period 1 and Period 2 formulas to the "PAYMENTS" Columns to calculate Period 1 and Period 2 payments for all types.

MEDI-CAL MANAGED CARE DETAIL—WORKSHEET 3

Beginning with the column on the left:

1. The months included in the fiscal period beginning with the first month of the fiscal period. (Automatically populates from Worksheet 2.)

2. Enter the number of visits next to the appropriate month. Report only adjudicated visits for all Medi-Cal Managed Care plan beneficiaries who received services.

3. Enter the Medi-Cal interim payments that correspond to the monthly visits in the "MEDI-CAL INTERIM" Column. These should be payments received from the Medi-Cal FI.

4. Enter all Medi-Cal Managed Care plan payments in the appropriate "MEDI-CAL MANAGED CARE PLANS" Column. This should be the amount received from all managed care plans. If the provider contracts with multiple managed care plans, the amount received from all plans should be combined into the appropriate columns. All capitation payments received, regardless of whether services were ever rendered and resulted in a billable visit, must be reported. All fee-for-service payments received from a Medi-Cal Managed Care Plan, including payments received for services when a billable visit does not occur, must be reported. Financial incentive payments that meet the requirements of federal and state law may be excluded from the annual Reconciliation Request.

Payment Explanations

- **PPS/UPL/FFS**—Combine revenue received from the MAC, whether from a PPS, UPL, or FFS arrangement for dual-eligible patients enrolled in a Medi-Cal Managed Care plan and **not** participating in any MAP arrangement.
- **FFS/CAPITATED MAP**—Input payments received from MAP for beneficiaries enrolled in an FFS or Capitated arrangement and enrolled in a Medi-Cal Managed Care plan.
- **CODE 519**—Input-only wrap-around payments received from the MAC for beneficiariesenrolled in any MAP arrangement and enrolled in a Medi-Cal Managed Care plan.
- **PART D**—Input payments received from Medicare prescription drug plans for beneficiaries enrolled in a Medi-Cal Managed Care plan. Only if the FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, the FQHC/RHC does not need to include Medicare Part D payments. Otherwise, Part D payments must be reported.
- **3rd PARTY PAYER**—Input all payments received for reported visits from all other sources not already reported, only if applicable.

Only include payments related to Medi-Cal beneficiaries for all types listed above.

5. Enter a formula for Period 1 Total and Period 2 Total in the "VISITS" Column to calculate the appropriate visits for each period.

6. Copy the appropriate Period 1 and Period 2 formulas to the "PAYMENTS" Columns to calculate Period 1 and Period 2 payments for all types.

MEDI-CAL MANAGED CARE PLAN INFORMATION—WORKSHEET 3A

Enter the name of each Medi-Cal Managed Care Plan the provider contracted with during the reconciliation period.

MEDI-CAL NON-MANAGED CARE CROSSOVERS WITH CAPITATED MAP DETAIL—WORKSHEET 4

Beginning with the column on the left:

1. The months included in the fiscal period beginning with the first month of the fiscal period. (Automatically populates from Worksheet 2.)

2. Enter the number of visits next to the appropriate month. Report only adjudicated visits for dual-eligible beneficiaries **not** enrolled in any Medi-Cal Managed Care plan and paid using a capitated MAP arrangement.

3. Enter the Medi-Cal crossover payments that correspond to the monthly visits in the "MEDI-CAL CROSSOVER" column. These should be payments received from the Medi-Cal FI for dual-eligible beneficiaries **not** enrolled in any Medi-Cal Managed Care plan and paid by Medicare using a capitated MAP arrangement.

4. Enter the Medicare Advantage Plan payments that correspond to the monthly visits in the appropriate "MEDICARE ADVANTAGE PLANS" Column.

Payment Explanations

- **CAPITATED MAP**—Enter capitated payments received from MAP arrangements.
- **CODE 519**—Input-only wrap-around payments received from the MAC for beneficiaries enrolled in any MAP arrangement and **not** in a Medi-Cal Managed Care plan.
- **PART D**—Input payments received from Medicare prescription drug plans for beneficiaries **not** enrolled in a Medi-Cal Managed Care plan. Only if the FQHC/RHC has filed a Change in Scope of Service Request to carve pharmacy services out of their PPS rate, in accordance with W&I Code Section 14132.100, the FQHC/RHC does not need to include Medicare Part D payments. Otherwise, Part D payments must be reported
- **3rd PARTY PAYER**—Input all payments received for reported visits from all other sources not already reported, only if applicable.

Only include payments related to Medi-Cal beneficiaries for all types listed above.

5. Enter a formula for Period 1 Total and Period 2 Total in the "VISITS" Column to calculate the appropriate visits for each period.

6. Copy the appropriate Period 1 and Period 2 formulas to the "PAYMENTS" Columns to calculate Period 1 and Period 2 payments for all types.

SUMMARY OF SERVICES—WORKSHEET 5

Complete this Worksheet and include it with your submission of reconciliation data. For practitioners in which services are performed outside of the four walls and PPS is billed (i.e., contracted dental services), please include the contractor name and location (physical address) where the services are performed. For practitioner referral services only in which PPS is **NOT** billed, you only need to include the contractor name. If you need additional space to identify contractor's names, attach a page with the provider name and services provided. Do not list satellite clinics on Worksheet 5. Satellite clinics must be listed on certification page 2.

PRODUCTIVITY FOR HEALTH CARE PRACTITIONERS—WORKSHEET 6

Complete this Worksheet and include it with your submission of reconciliation data.

Appendix A—Glossary

Capitation—Payments used by managed care organizations to control health care costs. Capitation is a fixed amount of money per patient per unit of time paid in advance for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and therefore, can vary from one region to another.

Code 519—A Medicare wrap-around rate which makes FQHCs whole to the Medicare FQHC Rate for beneficiaries enrolled in Medicare Advantage Plans.

Crossover Payment—Payment for a beneficiary who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining portion.

FFS—Fee for Service, a payment model where services are unbundled and paid for separately.

MAC—Medicare Administrative Contractor, a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment claim for Medicare fee-for-service beneficiaries.

MAP—Medicare Advantage Plan, a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Most Medicare Advantage Plans offer prescription drug coverage.

Medi-Cal Fiscal Intermediary—A fiscal agent who is a private contractor to the state, normally selected through a competitive procurement process. The FI's contract requires them to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligible beneficiaries.

Medi-Cal Managed Care—Provides high-quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal managed care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure the quality of care.

Medicare Part D—An optional federal government program to help Medicare beneficiaries pay for self-administered prescription drugs through prescription drug insurance premiums.

MEI—Medicare Economic Index, an index of physician's practice costs developed and updated by the Centers for Medicare and Medicaid Services. FQHC/RHC PPS Rates are increased by the MEI percentage annually on October 1st.

PPS—Prospective Payment System, a reimbursement method in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system.

State Plan Amendment—The state plan is an agreement between a state and the Federal government describing how the state administers its Medicaid and CHIP programs. It gives assurance that a state will abide by Federal rules and may claim Federal matching funds for its

program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state. When a state is planning to make a change to its program policies or operational approach, states send state plan amendments to the Centers for Medicare and Medicaid Services (CMS) for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information.

Third-Party Payer—Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. Third-party payments are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing the service (the second party), and organization paying for it (the third party).

UPL—Upper Payment Limit, a per-visit rate that CMS establishes to reimburse RHC providers for their services to Medicare-eligible beneficiaries.

Visit—A face-to-face encounter between an FQHC/RHC patient and any provider as specified in W&I Code § 14132.100 and Attachment 4.19-B, Page 6B.1 of the SPA.

Wrap-Around Payment—A payment from Medi-Cal or Medicare to an FQHC/RHC equal to the amount of difference between the payment under the PPS methodology and the payment provided under the managed care contract.

Appendix B—Billing Rates/Codes

Table B-1

The table below illustrates the different Medicare and Medi-Cal arrangements and the billing codes used for each.

Type of Medicare Arrangement	Type of Medi-Cal Arrangement	Former Billing Code	New Billing Codes		
			Revenue Code	HCPCS /CPT	Modifier
Not Qualified	Straight Medi-Cal	Code 01	521	T1015	
Not Qualified	Managed Care Plan	Code 18	521	T1015	SE
Straight Medicare	Straight Medi-Cal	Code 02	521, 900, 522, 524, 525, 527	G0466 - G0470	
Straight Medicare	Managed Care Plan	Code 18	521	T1015	SE
Medicare Advantage Plan • Capitated Arrangement	Medi-Cal • Non-Managed Care	Code 20	529	G0466 - G0470	
Medicare Advantage Plan • Fee for Service Arrangement	Medi-Cal • Non-Managed Care	Code 02	521, 900, 522, 524, 525, 527	G0466- G0470	
Medicare Advantage Plan • Capitated Arrangement	Medi-Cal • Managed Care	Code 18	521	T1015	SE
Medicare Advantage Plan • Fee for Service Arrangement	Medi-Cal • Managed Care	Code 18	521	T1015	SE

The Health Insurance Portability and Accountability Act (HIPAA) mandated changes to billing requirementsfor FQHCs/RHCs. The changes became effective October 1, 2017 and included the use of Healthcare Common Procedure Coding System (HCPCS) Level I and Level II national codes. The transition from the HCPCS Level III local per visit codes to HIPAA-compliant billing code sets means FQHC/RHC providers who previously submitted HCPCS Level III local per visit codes when billing for their services are required to submit claims using the specified HIPAA-compliant Common Procedural Terminology—4th Edition (CPT-4) Level I and HCPCS Level II code sets for dates of service on or after October 1, 2017.

Table B-2

The table below illustrates the HIPAA-compliant codes to be used for billing straight Medi-Cal beneficiaries not enrolled in a managed care plan and where Medicare is not the primary payer.

Description	Revenue Code	HCPCS/ CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
01-FQHC/RHC Clinic Visit Medical Visit	521	T1015		
04-FQHC/RHC Clinic Visit Optometry-New Patient	521	92004		
04-FQHC/RHC Clinic Visit Optometry-Established Patient	521	92014		
06-CBAS Regular day of Service	3103			
07-CBAS Initial Assess. Day w/Subsequent attend.	3101	99205		
08-CBAS Initial Assess. Day w/o Subsequent attend.	3101	T1015		
09-CBAS Transition Day	3103	T1023		
21-End of Life	521	S0257		

- Only use Codes 06-09 should when billing for CBAS

Table B-3

The table below illustrates the HIPAA-compliant codes to be used when billing for Medicare beneficiaries not enrolled in a Managed Care Plan.

Description	Revenue Code	HCPCS/ CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
02-Crossover Clinic Visit New Patient	521	G0466		
02-Crossover Clinic Visit Established Patient	521	G0467		
02-Crossover Clinic Visit IPPE or AWV	521	G0468		
02-Crossover Clinic Visit Mental Health New Patient	900	G0469		
02-Crossover Clinic Visit Mental Health Established Patient	900	G0470		
02-Crossover Home Visit New Patient	522	G0466		
02-Crossover Home Visit Established Patient	522	G0467		
02-Crossover Home Visit IPPE or AWV	522	G0468		
02-Crossover Visit in Covered Part A Stay at SNF New Patient	524	G0466		
02-Crossover Visit in Covered Part A Stay at SNF Estab. Pt.	524	G0467		
02-Crossover Visit in Covered Part A Stay at SNF IPPE or AWV	524	G0468		
02-Crossover Visit to member in SNF (Not cov. Part A) New Patient	525	G0466		
02-Crossover Visit to member in SNF (Not cov. Part A) Est. Patient	525	G0467		
02-Crossover Visit to member in SNF (Not cov. Part A) IPPE or AWV	525	G0468		
02-Crossover Visiting Nurse to home New Patient	527	G0466		
02-Crossover Visiting Nurse to home Established Patient	527	G0467		
02-Crossover Visiting Nurse to home IPPE or AWV	527	G0468		

Table B-4

The table below illustrates the HIPAA-compliant codes to be used when billing for all Medi-Cal Managed Care Plan enrollees, including beneficiaries where Medicare is the primary payer.

Description	Revenue Code	HCPCS/ CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
18-Medi-Cal Managed Care Differential Rate	521	T1015	SE	

Table B-5

The table below illustrates the HIPAA-compliant codes to be used when billing for Medi-Cal Managed Care with a Capitated Medicare Advantage Plan arrangement.

Description	Revenue Code	HCPCS/ CPT	Modifier	List additional CPT codes on subsequent lines without a revenue code, quantity, or amount billed for informational purposes only
20-Capitated Medicare Advantage Plans New Patient	529	G0466		
20-Capitated Medicare Advantage Plans Established Patient	529	G0467		
20-Capitated Medicare Advantage Plans IPPE or AWV	529	G0468		
20-Capitated Medicare Advantage Plans Mental Health New Patient	529	G0469		
20-Capitated Medicare Advantage Plans Mental Health Established Patient	529	G0470		

SDN 13013—Crosswalk FQHC/RHC
***Subject to visit limitations—2 per month w/o medical necessity**

Please refer to the Provider Billing Manual for detailed billing instructions.