**Federally Qualified Health Center 'G' Codes**

FQHCs must use the codes below when submitting claims to Medicare under the FQHC PPS. Be sure to maintain records of the services and charges associated with each 'G' code.

**G0466** – FQHC visit, new patient

medically-necessary medical, or a qualified preventive health, 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

medically-necessary medical, or a qualifying preventive health, 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 AWV

FQHC visit that includes an initial preventive physical exam (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

**G0469**– FQHC visit, mental health, new patient

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

medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and an 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.

**G0511** - General care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directly by an FQHC practitioner (physician, NP, PA, or CNM), per calendar month. **(Effective January 1, 2018)**

**G0512** - Psychiatric collaborative care model (psychiatric CoCM), 60 minutes or more of clinical staff time for psychiatric CoCM services directed by an FQHC practitioner (physician, NP, PA or CNM) and including service furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month. **(Effective January 1, 2018)**

**References**

Centers for Medicare & Medicaid Services, [Internet Only Manual, Publication 100-04, Claims Processing Manual, Chapter 9](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf)

[Medicare Learning Network (MLN) Matters Article, MM10175 - Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf)

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

For example:

**Revenue Code**

0521

0521 0900

0900

**HCPCS code**

G0468 – FQHC Payment code
G0439 – Qualifying visit G0470 – FQHC Payment code

90832 -Qualifying visit

**Modifier**

**Service Date**

10/01

10/01 10/01

10/01

When submitting a claim for a subsequent illness or injury, the FQHCs reports G0467 for a medical visit), with modifier 59. A qualifying visit is still required when reporting modifier 59 with G0467.

**Revenue Code**

0521

0521 0521

0900

**HCPCS code Modifier**

G0468 – FQHC Payment
code
G0439 – Qualifying visit
G0467 – FQHC Payment 59 code

99211 -Qualifying visit

**Service Date**

10/01

10/01 10/01

10/01



FQHCs must report all services that occurred on the same day on one claim. FQHC may submit claims that span multiple days of service. However, for FQHCs transitioning to the PPS, a separate claim must be submitted for services subject to the PPS and services paid based on the AIR. MACs will reject claims with multiple dates of service that include both PPS and non-PPS dates, as determined based on the individual FQHC’s cost reporting period.