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Behavioral Health Billing & Coding for FQHCs:

Maximizing Reimbursement While Maintaining Compliance

Jamela T. Hillary-Harris, MBA
Senior Provider Relations Representative

September 16–18, 2026 | Williamsburg, Virginia

Notice

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Acronym	Description
ADR	Additional Documentation Request
AFR	Agency Financial Report
BCRC	Benefits Coordination & Recovery Center
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
FFS	Fee-for-Service
IOM	Internet-Only Manual
JJA	Jurisdiction J Part A
JMA	Jurisdiction M Part A
LOB	Line of Business
MAC	Medicare Administrative Contractor
MLN	Medicare Learning Network®

Agenda

- Updates
- Federally Qualified Health Centers (FQHC) Overview
- Claim Denials and Resolutions
- Medicare Compliance
- Best Practices
- Resources

Learning Objectives

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Updates

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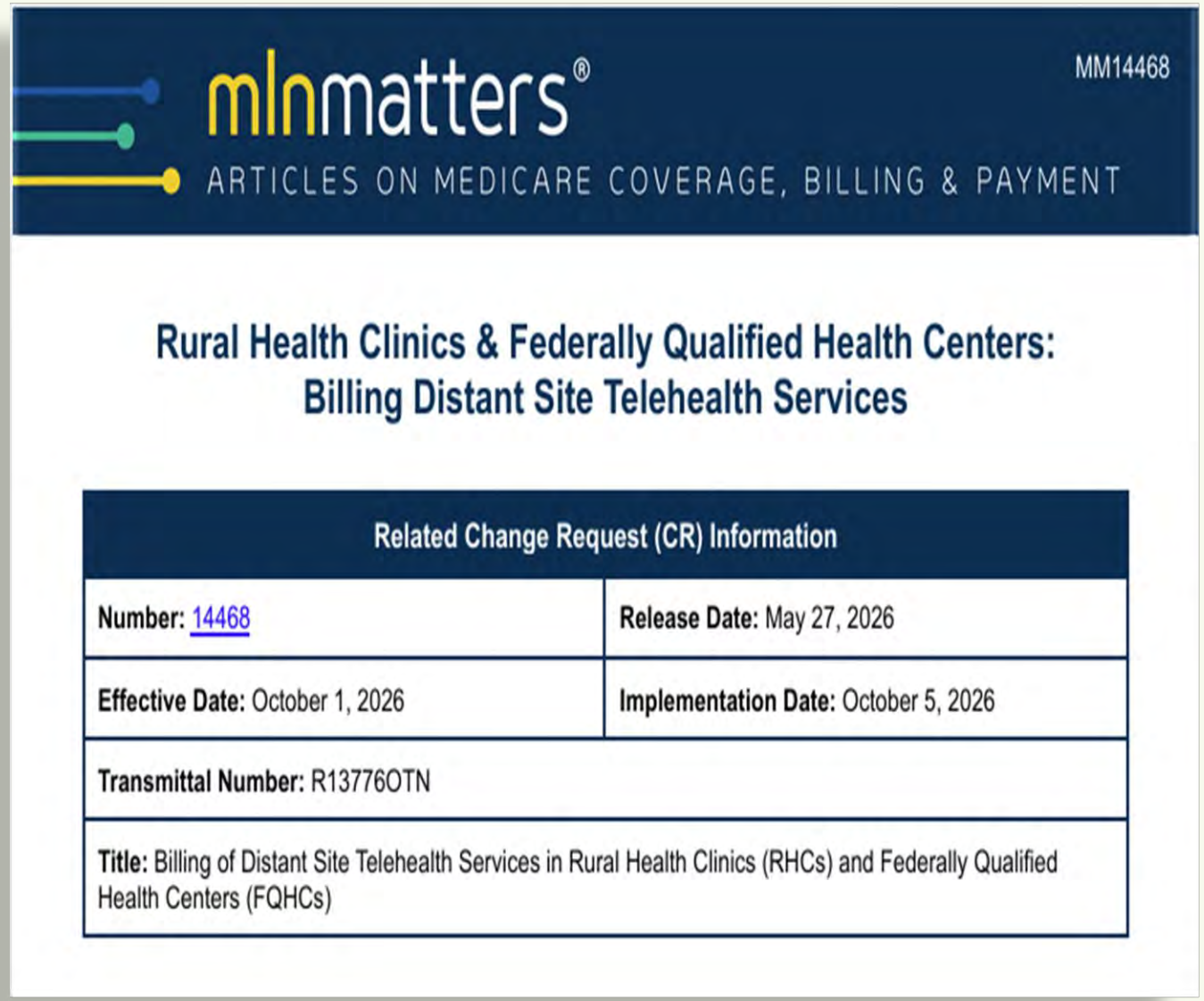

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MM14468

ARTICLES ON MEDICARE COVERAGE, BILLING & PAYMENT

Rural Health Clinics & Federally Qualified Health Centers: Billing Distant Site Telehealth Services

Related Change Request (CR) Information	
Number: 14468	**Release Date:** May 27, 2026
Effective Date: October 1, 2026	**Implementation Date:** October 5, 2026
Transmittal Number: R13776OTN	
Title: Billing of Distant Site Telehealth Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	

Required Action

Make sure your billing staff knows that RHCs and FQHCs must bill the individual CPT® or HCPCS code for distant site telehealth services they provide instead of HCPCS code G2025, effective October 1, 2026.

Transmittal Number: R13776OTN

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About the Rural Health Information Hub

The Rural Health Information Hub is funded by the Federal Office of Rural Health Policy to be a national clearing-house on rural health issues.

Rural Health Information Hub

FQHC/RHC News & Announcements

Highlights for CY 2026 include: CY 2026 Physician Fee Schedule (PFS) Final Rule Effective January 1, 2026.

- **Telecommunications Services** — Permanently adopted a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only)
- **Telecommunications Services —** Non-behavioral health visits furnished via telecommunication technology can continue to be reported with HCPCS code G2025, including services furnished using audio-only communications technology through December 31, 2027
- **Telecommunications Services** — The requirement that an in-person mental health visit must occur within six months before a telehealth mental health service at least every 12 months while a beneficiary receives telecommunications services for diagnosis, evaluation, or treatment of mental health disorders in RHCs and FQHCs will not take effect until after January 1, 2028. The CY 2026 payment rate for G2025 is $97.53.
- **Telecommunications Services** — See the Telehealth FAQs (PDF) for additional telehealth-related updates

FQHC/RHC News & Announcements

Highlights for CY 2026 include: CY 2026 Physician Fee Schedule (PFS) Final Rule Effective January 1, 2026.

- **Advanced Primary Care Management** — New optional add-on codes are available that would facilitate billing for Behavioral Health Integration (BHI) and/or Psychiatric Collaborative Care Model (CoCM) using HCPCS codes G0568, G0569, and G0570. These services when furnished are paid at the national non-facility rate.
- **G0512 and G0071 Changes** — Report individual codes that make up both the CoCM and the Communications Technology-Based Services (CTBS) and Remote Evaluation Services, previously reported under HCPCS codes G0512 and G0071, respectively. G0512 and G0071 are no longer reportable beginning January 1, 2026. A reminder that G0511 is also terminated.
- **Care Coordination Services —** Going forward, CMS will pay the national non-facility rate for services that are established under the PFS and designated as care management services as care coordination services for purposes of separate payment for RHCs and FQHCs. Please see the CY 2026 Designated Care Management Services Assigned General Supervision table on the CY 2026 PFS Final Rule page.

Payment Rates

- Get the RHC/FQHC CY 2026 Non-Facility Payment Rates (ZIP)

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Federally Qualified Health Centers (FQHC) Overview

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Federally Qualified Health Centers (FQHCs) History

1990: Established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act (OBRA), of 1990

1991: They were effective beginning on October 1, 1991

2014: FQHCs were paid an All-Inclusive Rate (AIR) for primary health services and qualified preventive health services until October 1, 2014

2016: Beginning on January 1, 2016, all FQHCs are paid under the provisions of the FQHC PPS, as required by Section 10501(i)(3)(B) of the Affordable Care Act

FQHC General Information

The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in section 1861(aa)(4) of the Act. No Part B deductible is applied to expenses for services that are payable under the FQHC benefit.

An entity that qualifies as an FQHC is assigned a CCN in the range 1800–1989 and 1000–1199.

FQHC Requirements

Provide comprehensive services and have an ongoing quality assurance program;

Meet other health and safety requirements;

Not be concurrently approved as an RHC; and

Meet all requirements contained in section 330 of the Public Health Service Act, including:

- Serve a designated Medically-Underserved Area (MUA) or Medically-Underserved Population (MUP)
- Offer a sliding fee scale to persons with incomes below 200% of the federal poverty level; and
- Be governed by a board of directors, of whom a majority of the members receive their care at the FQHC

Eligible Organizations

Health Center Program Grantees

Health Center Program Look-Alikes

Outpatient health programs/facilities operated by a tribe or tribal organization (under the Indian Self Determination Act) or by an urban Indian organization (under Title V of the Indian Health Care Improvement Act)

FQHC Services

Defined as:

- Physician services
- Services and supplies furnished incident to a physician's services
- Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwife (CNM), Clinical Psychologist (CP), Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), and Mental Health Counselor (MHC) Services
- Services and supplies furnished incident to an NP, PA, CNM, CP, MFT or MHC services; and
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for beneficiaries with diabetes or renal disease

Preventive Services

The law defines Medicare-covered preventive services provided by an FQHC as the preventive primary health services that an FQHC is required to provide under section 330 of the Public Health Service (PHS) Act.

Medicare may not cover some of the preventive services that FQHCs provide, such as dental services, which are specifically excluded under Medicare law.

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Payments and Billing

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Coding

- Healthcare Common Procedure Coding System (HCPCS)
- ICD-10
- Specific Payment Codes for the Federally Qualified Health Center
- Federally Qualified Health Center (FQHC) Preventive Services Chart: Information on preventive services in FQHCs including HCPCS coding, same day billing, and waivers of co-insurance

Billing

FQHC Type of Bill-77x

Following are the specific payment codes and the appropriate descriptions of services that correspond to these payment codes

FQHCs must use these codes when submitting claims to Medicare under the FQHC PPS (see code examples below):

- G0466 – FQHC visit, new patient
- G0467 – FQHC visit, established patient
- G0468 – FQHC visit, IPPE or AWV
- G0469 – FQHC visit, mental health, new patient
- G0470 – FQHC visit, mental health, established patient

Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)

Global Billing

The Medicare global billing requirements do not apply to FQHCs, and global billing codes are not accepted for FQHC billing or payment.

If a FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the FQHC must determine if these services have been included in the surgical global billing.

Services not included in the global surgical package are listed in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 40.1.B.

Key Points to Remember

- FQHC claims must include an FQHC payment code
- CMS annually update the FQHC PPS base payment rate using the FQHC market basket
- Coinsurance is 20% of the lesser of the FQHC charges or the PPS rate for the specific payment code, except for certain preventive services
- FQHC services are not subject to the Medicare 3-day payment window requirements
- **FQHC services furnished by an FQHC practitioner may not be billed separately** by the FQHC practitioner, or by another practitioner or an entity other than the FQHC, even if the service is not a stand-alone billable visit
- **Services furnished to patients in any type of hospital setting** (inpatient, outpatient, or emergency department) are statutorily excluded from the RHC/FQHC benefit and **may not** be billed by the RHC or FQHC

Claim Submission

- Statement Covers Period (From – Through)
- The RHC/FQHC shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY)
- Patient Name/Identifier
- The RHC/FQHC enters the beneficiary's name exactly as it appears on the Medicare card
- Patient Address
- The RHC/FQHC enters the mailing address of the patient. Enter the complete mailing address.
- Patient Birth Date
- The RHC/FQHC enters the date of birth of the patient
- Patient Sex
- The RHC/FQHC enters the sex of the patient as recorded at the start of care
- Priority (Type) of Admission or Visit
- The RHC/FQHC enters the most appropriate NUBC approved code indicating the priority of the visit
- Point of Origin for Admission or Visit
- The RHC/FQHC enters the most appropriate NUBC approved code indicating the point of origin for this admission or visit

Claim Submission

- Patient Discharge Status
- The RHC/FQHC enters the most appropriate NUBC approved code indicating the patient's status as of the "Through" date of the billing period
- Condition Codes
- The RHC/FQHC enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing
- Value Codes and Amounts
- The RHC/FQHC enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing
- Revenue Codes
- The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge

Revenue Codes

Revenue Code	Description
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)
0519	Clinic, Other Clinic (only for the FQHC supplemental payment)
0900	Mental Health Treatment/Services

Prohibited Revenue Codes

The following revenue codes are not allowed on FQHC or RHC claims
002x-024x
029x
045x
054x
056x
060x
065x
067x-072x
080x-088x
093x
096x--310x

HCPCS/Accommodation Rates/HIPPS Rate Codes

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 AWV A FQHC visit that includes an IPPE or 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 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.

Encounter Claims

FQHCs must report HCPCS coding on the claim to describe all services that occurred during the encounter

All service lines must be reported with their associated charges. The additional services reported on the claim that are part of the FQHC encounter, will not be paid

The payment for these services is included in the payment under the FQHC payment code

Payment for a FQHC encounter requires a medically necessary face-to-face visit

Each FQHC specific payment code (G0466–G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit

The link below contains the list of the qualifying visits for each payment specific code:

- Specific Payment Codes for the Federally Qualified Health Center

Modifiers

CPT® modifier 59 is the FQHC and RHC's attestation that the patient, after the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day

CPT® modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left the FQHC or RHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit)

For claims subject to the FQHC PPS, CPT® modifier 59 is only valid with HCPCS FQHC Payment Code G0467

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Mental Health Services

- 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**
- Qualified mental health visits billed under revenue code 0900 receive an additional payment when billed on the same day as a medical visit
- **Example: Mental Health Services**
  - PPS RATE for G0468: $225.00 PPS rate for
  - G0470: $160.00 Total of provider's actual charges for the specific payment codes representing medical visits (140.00 + 75.00 + 55.00) = 270.00. This does not include charges for G0470 Provider's charge for the specific payment code representing mental health services = 159.00.
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

The Medicare Learning Network®

MLN909432 January 2026

Behavioral Health Integration (BHI) Eligibility

Your patients may be eligible for BHI services if they have an identified mental, behavioral, or psychiatric health condition, including substance use disorder, and require:

- A Behavioral Health Care Assessment
- Behavioral Health Care Planning
- Provision of Interventions

BHI Service Requirements

An initiating visit

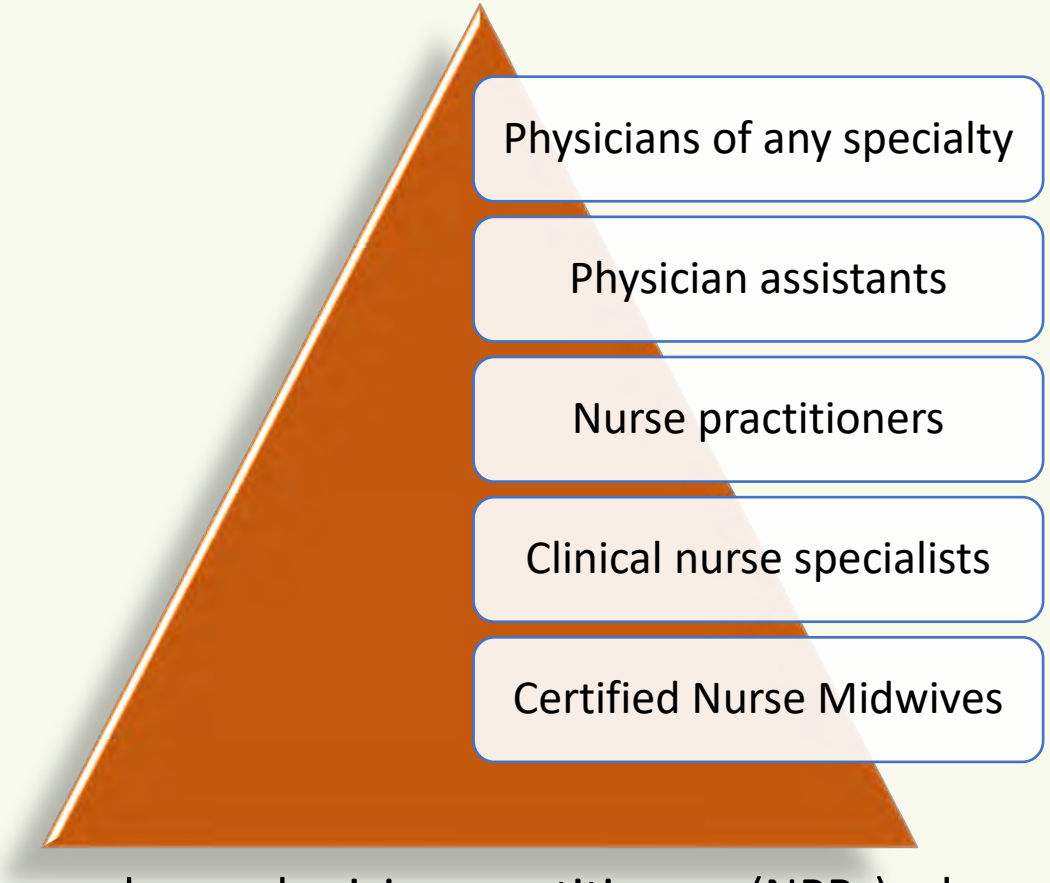
Qualifying initiating visits include:

- Annual wellness visit (AWV)
- Initial preventive physical exam (IPPE)
- Comprehensive evaluation and management (E/M) visit
- Transitional care management (TCM) visit
- Direct patient contact, face-to-face services or services without direct patient contact
- BHI services “incident to” (as an integral part of) services by the billing practitioner. These services are provided by other members of the care team under the direction of the billing practitioner and are subject to applicable state law, licensure, and scope of practice. Care team members are either employees or working under contract with the billing practitioner whom Medicare directly pays for BHI

A single encounter, a monthly service, or both

Specific conditions related to mental, behavioral, or psychiatric health

BHI Providers



Note: CMS allows physicians and non-physician practitioners (NPPs) whose scope of practice includes E/M services to bill BHI services.

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
BHI initiating visit (AWV, IPPE, TCM, or other qualifying E/M; psychiatric diagnostic evaluation	N/A	Usual work for the visit code
CoCM first month (CPT® code 99492)	70 minutes initial calendar month	30 minutes
CoCM subsequent months (CPT® code 99493)	60 minutes per subsequent calendar month	26 minutes
Add-on CoCM (any month) (CPT® code 99494)	Each additional 30 minutes per calendar month	13 minutes
Initial or subsequent psychiatric CoCM (HCPCS code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code
General BHI (CPT® code 99484)	At least 20 minutes per calendar month	15 minutes
Care management services for general behavioral health conditions (HCPCS code G0323)	At least 20 minutes of clinical psychologist or clinical social worker time per calendar month	15 minutes

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Key Points to Remember

FQHCs must report all services that occurred on the same day on one claim.

FQHCs may submit claims that span multiple days of service.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only.

MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

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Claim Denials and Resolutions

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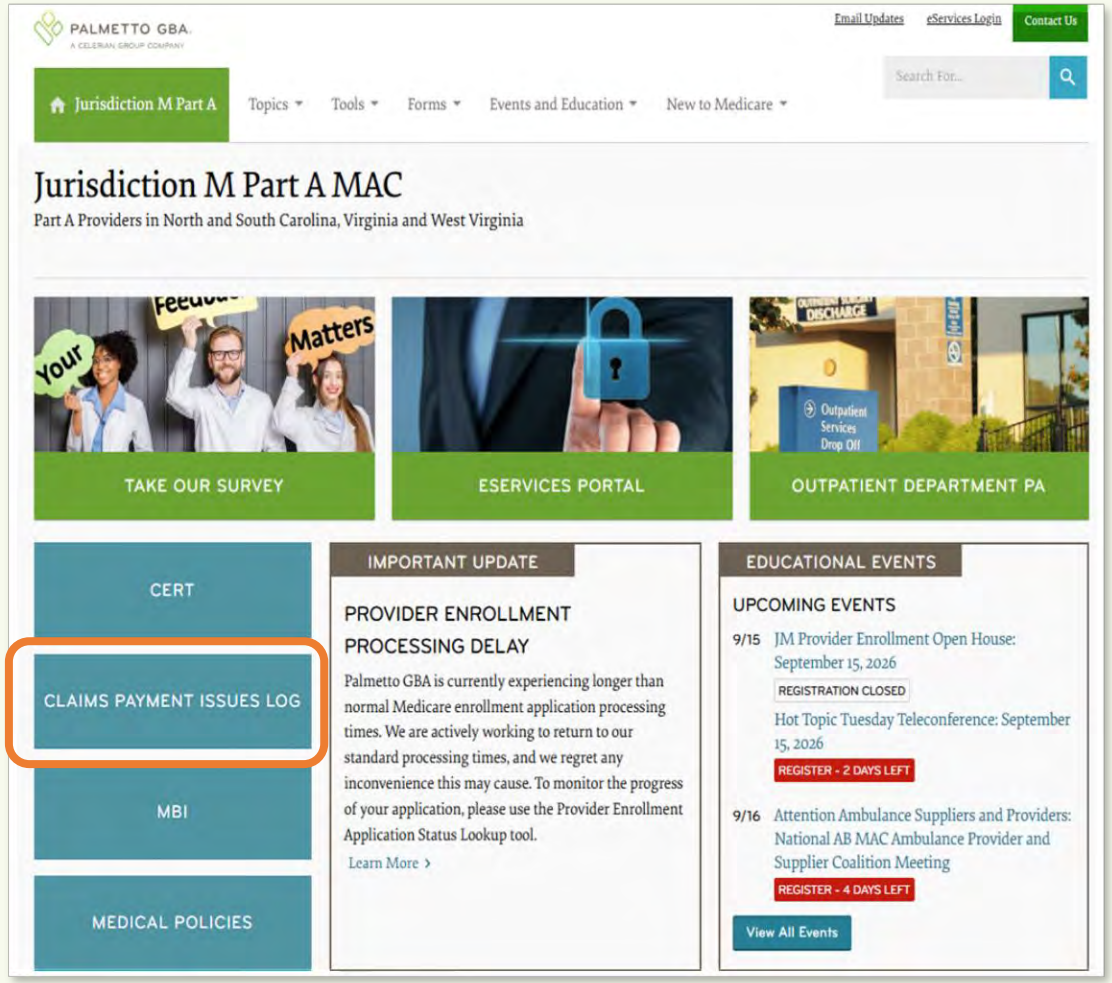
Claims Payment Issues Log



- Here is a list of system-related claims payment and processing issues. These issues have been reported to the Centers for Medicare & Medicaid Services (CMS) and/or the Fiscal Intermediary Standard System (FISS)
- Please check often for updates before contacting the provider contact center
- The issues are identified by stand alone articles and will be updated as needed

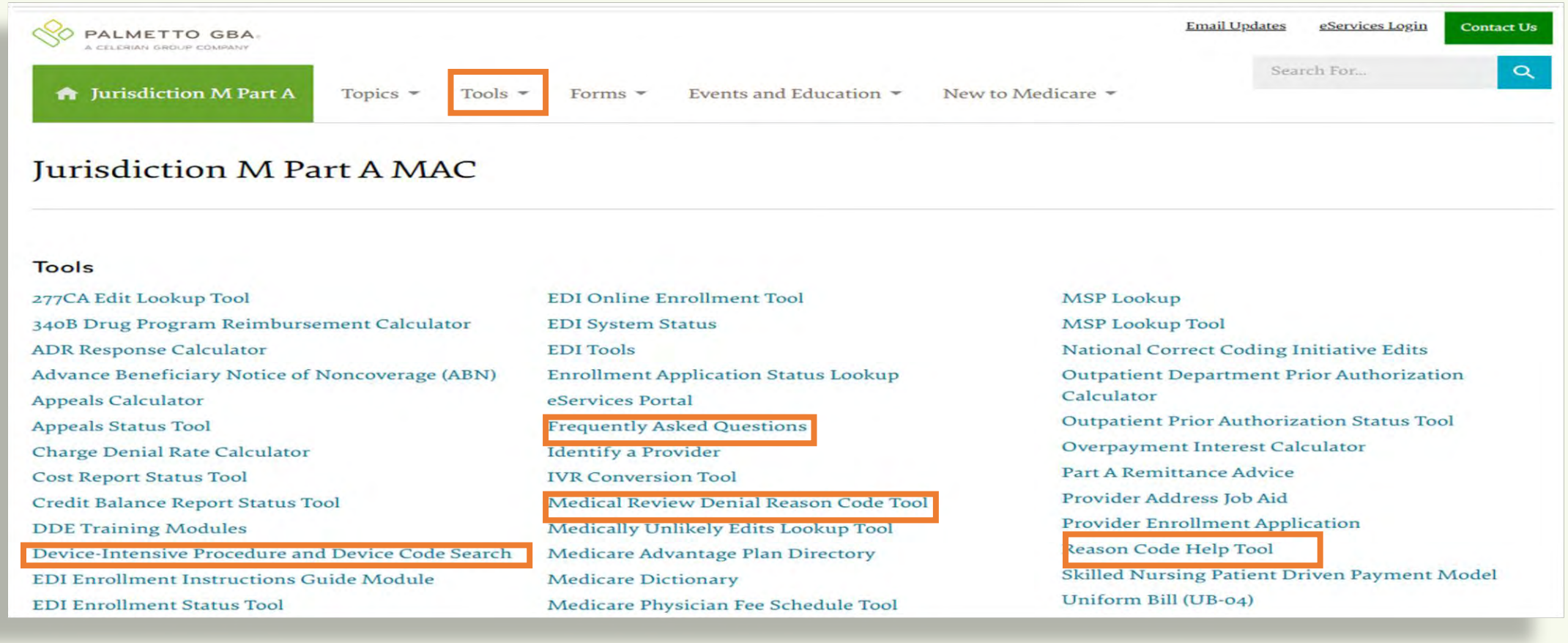
Reason Code Overview

IF Position 1 is:	THEN the Type of Edit is:	AND Positions 2–5 Can Be:
1	Consistency Edits	0125–9999
3	Online System Edits	0000–9799
4	File Maintenance	Alpha 001– Alpha 899
5	Medical Review	0001–9999
7	Site-Specific (non-medical)	0001–9999
A – Z (except W)	CWF	Current CWF 4-Digit Error Codes
W	OCE/MCE and Grouper	0001–2999

2026 2ND Quarter Top 10 JMA PCC Reason Code	2026 2ND Quarter JMA Reason Code Explanation
37192	This claim has been approved for payment. Please see the Reason Code Help Tool for the extended definition.
37205	Previous processed claim have been adjusted. Please see the Reason Code Help Tool for the extended definition.
39011	Timely Filing Edit. Please see the Reason Code Help Tool for the extended definition.
34538	MSP Edit. Please see the Reason Code Help Tool for the extended definition.
39929	All claim lines have rejected. Please see the Reason Code Help Tool for the extended definition.
30928	An adjustment is being submitted against a record in a post-pay location.
E7272	Inpatient PPS Claim with incorrect patient status due to transfer to another facility. Please see the Reason Code Help Tool for the extended definition.
34002	The claim was submitted as Medicare Primary, and a positive Working Elderly Record exists on the Common Working file (CWF).
34145	• A positive Workers' Compensation Record exists at CWF, which is indicated • As having an Ongoing Responsibility to Medicals (ORM). • MEDICARE is not permitted to make payment for such associated • claims with records that contain ORM; therefore. this claim has been rejected
W7047	The billed service is not separately payable, often because it's considered bundled into another procedure's payment or is informational only, especially in the Outpatient Prospective Payment System (OPPS).

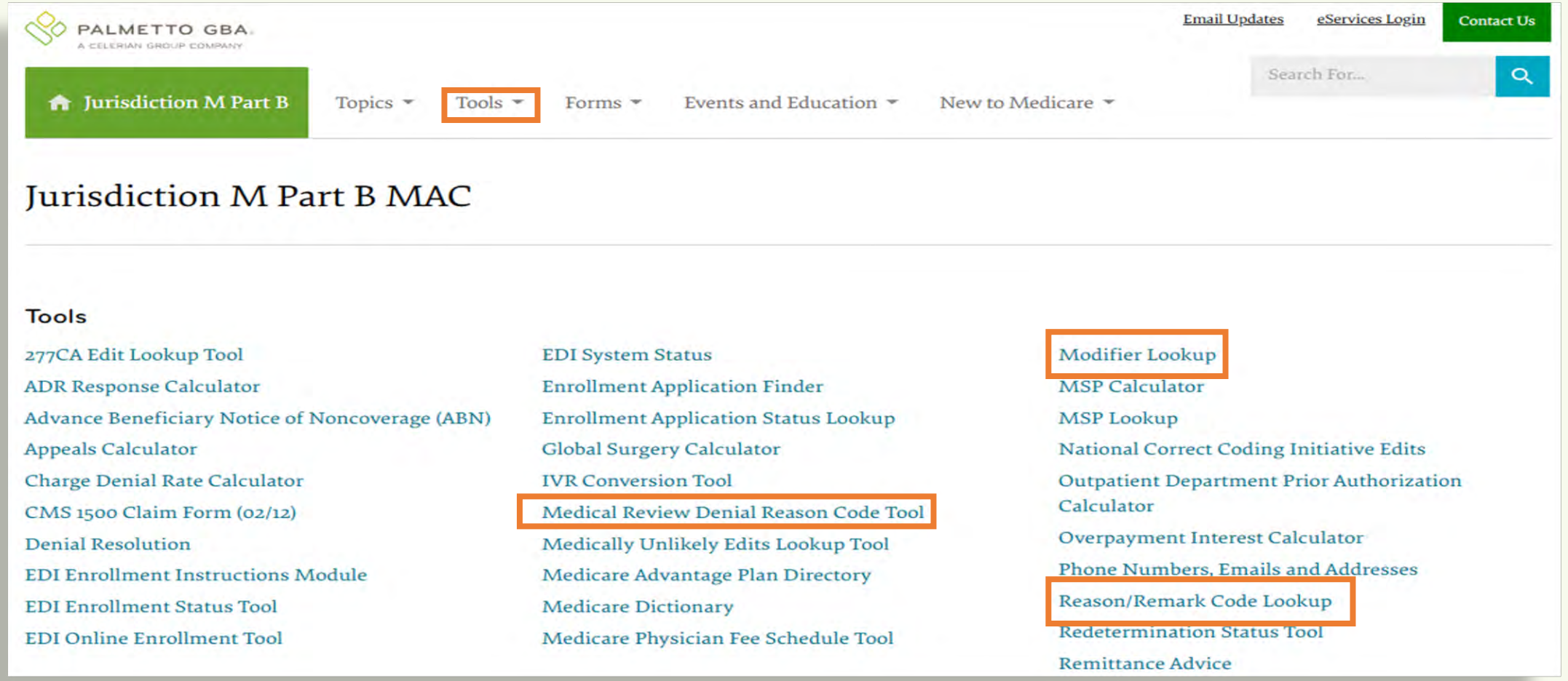
Virginia Rank	April 2026 Codes and Claim Total with the Denial Code	Affected Bill Types	May 2026 Top 5 Denial Codes and Claim Total with the Denial Code	Affected Bill Types	June 2026 Top 5 Denial Codes and Claim Total with the Denial Code	Affected Bill Types
1	31241	12x, 13x, 14x and 85x	31241	12x, 13x, 14x and 85x	31241	12x, 13x, 14x and 85x
2	31324	13x	31324	12x, 13x and 85x	31324	12x, 13x, 74x and 85x
3	38200	11x, 13x, 18x, 21x, 22x, 23x, 34x and 71x	31837	71x	31837	71x
4	31837	71x	31947	12x, 13x, 71x, 72x and 85x	31947	12x, 13x, 71x, 72x and 85x
5	31947	12x, 13x, 71x and 72x	38200	11x, 12x, 13x, 18x, 21x, 22x, 23x, 34x, 71x and 74x	W7112	71x and 77x

Website Tools



https://palmettogba.com/jma/admin/tools

Website Tools



https://palmettogba.com/jmb/admin/tools

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Medicare Compliance

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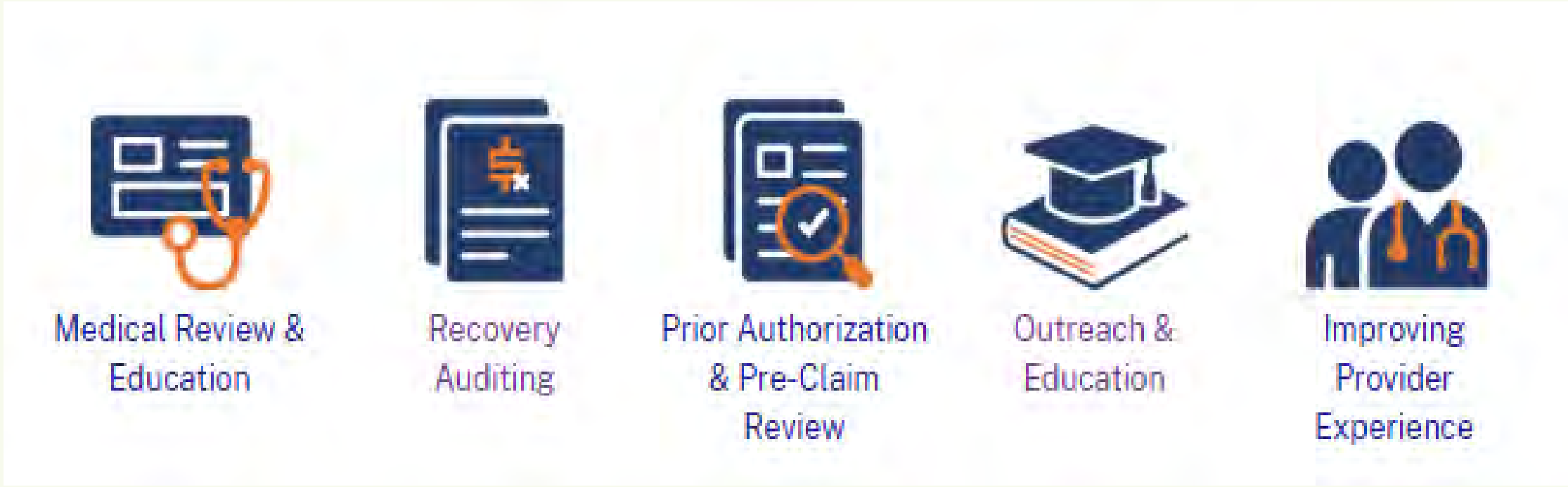
The Medicare Learning Network®

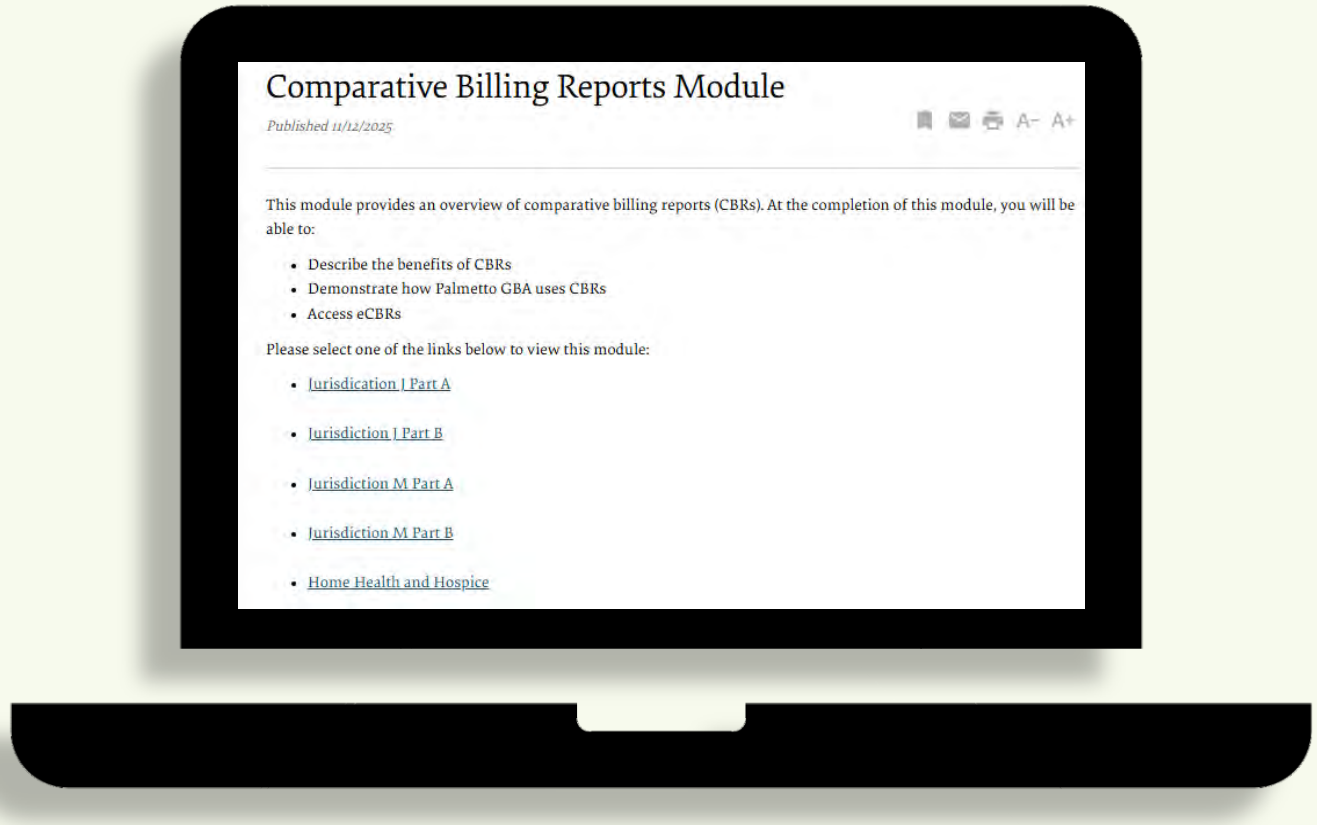
The Medicare Learning Network® (cms.gov)

Medicare Fee-for-Service Compliance Programs



Medicare Fee-for-Service Compliance Programs (cms.gov)

Comparative Billing Reports (CBR)

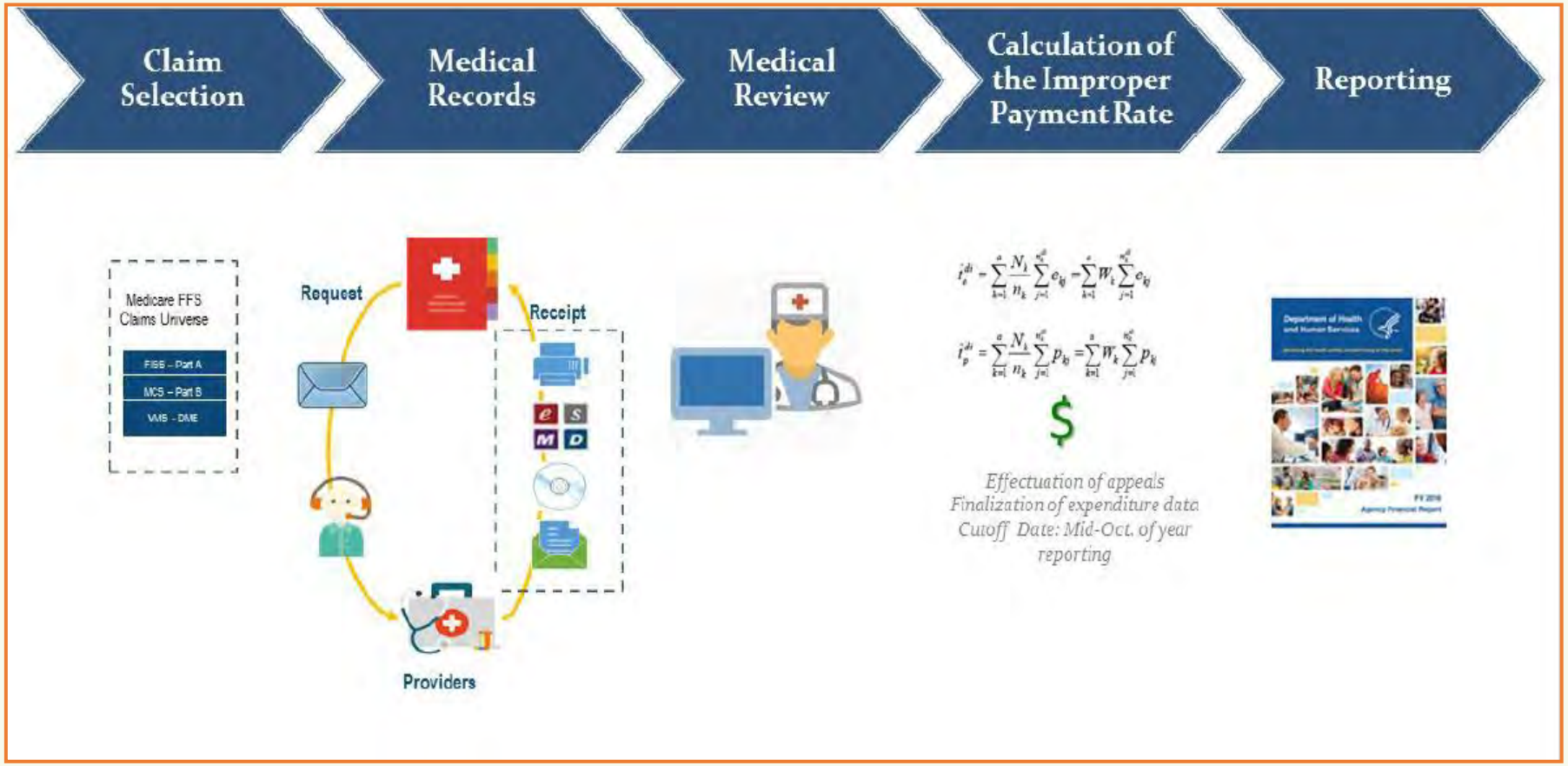


- A CBR provides data on Medicare billing trends, allowing a health care provider to compare their billing practices to peers in the same state and across the nation
  - Jurisdiction M Comparative Billing Reports Module

Program to Evaluate Payment Patterns Electronic Report – PEPPER

- Facilities can utilize PEPPER data to identify areas where they need to modify billing practices, pinpoint areas requiring auditing and monitoring, including potential Diagnosis-Related Groups (DRGs) at risk for under-coding or over-coding issues, and target areas where the length of stay is increasing
  - For more information and helpful resources about PEPPER, go to https://cbrpepper.org

Comprehensive Error Rate Testing (CERT)



Purpose

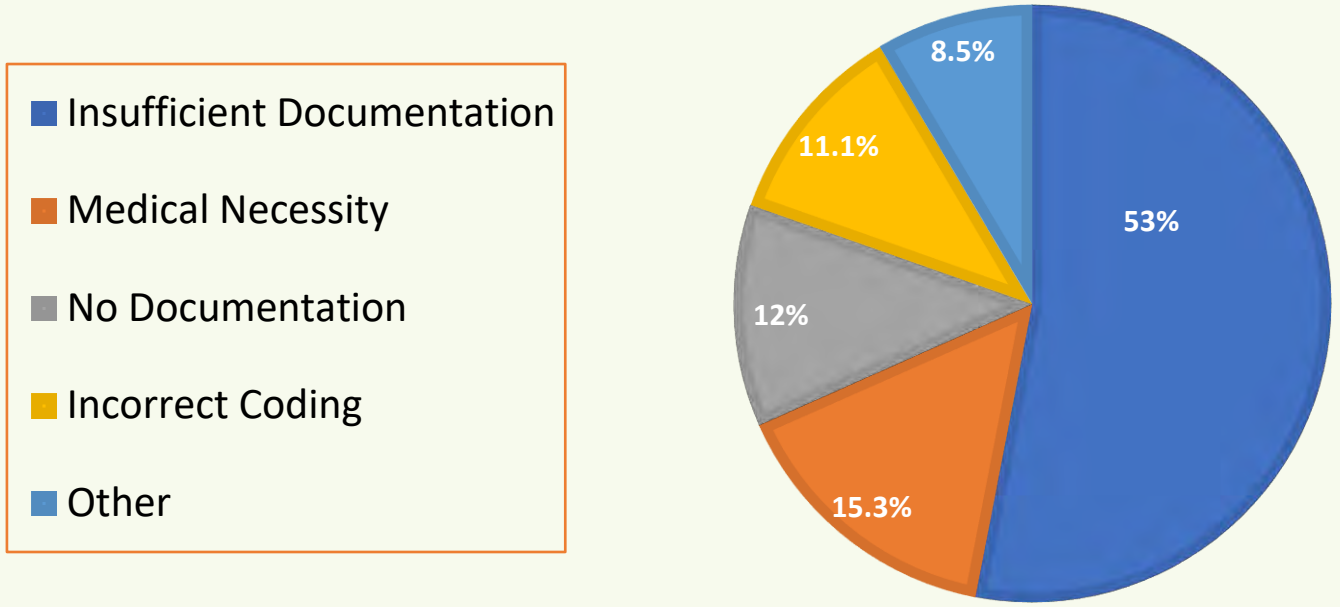
To measure the accuracy of Medicare's payments, on a national level for each MAC region

To assist CMS in understanding the educational needs, of the provider community and their contractors

To prevent Improper Payments

Improper Payment Categories

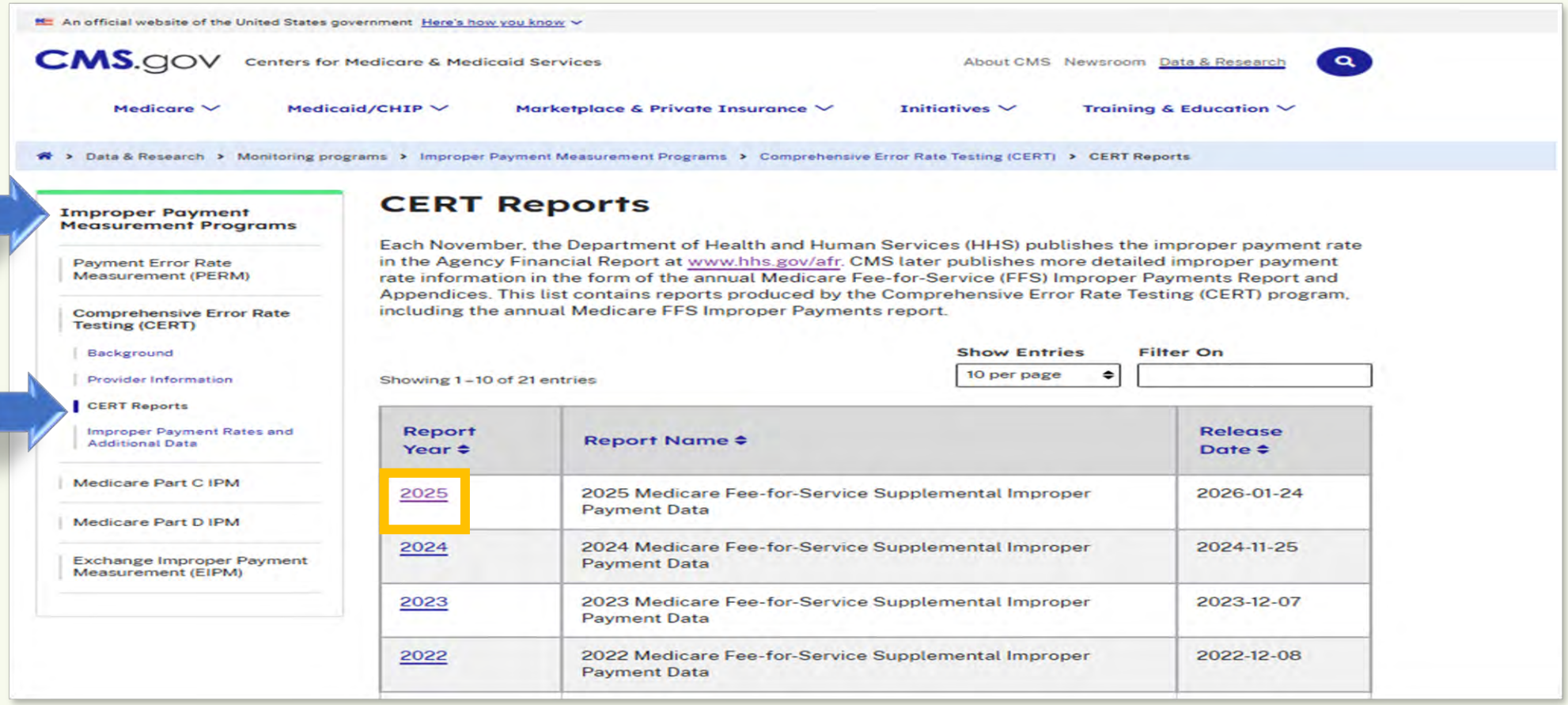
COMPREHENSIVE ERROR RATE TESTING CONTRACTOR'S 2025 NATIONAL IMPROPER PAYMENT RATE ERRORS DEFINED BY CATEGORY



Each reporting year contains claims submitted **July 1 two years before the report through June 30 one year before the report**. For example, reporting year 2025 contains claims submitted July 1, 2023 through June 30, 2024.

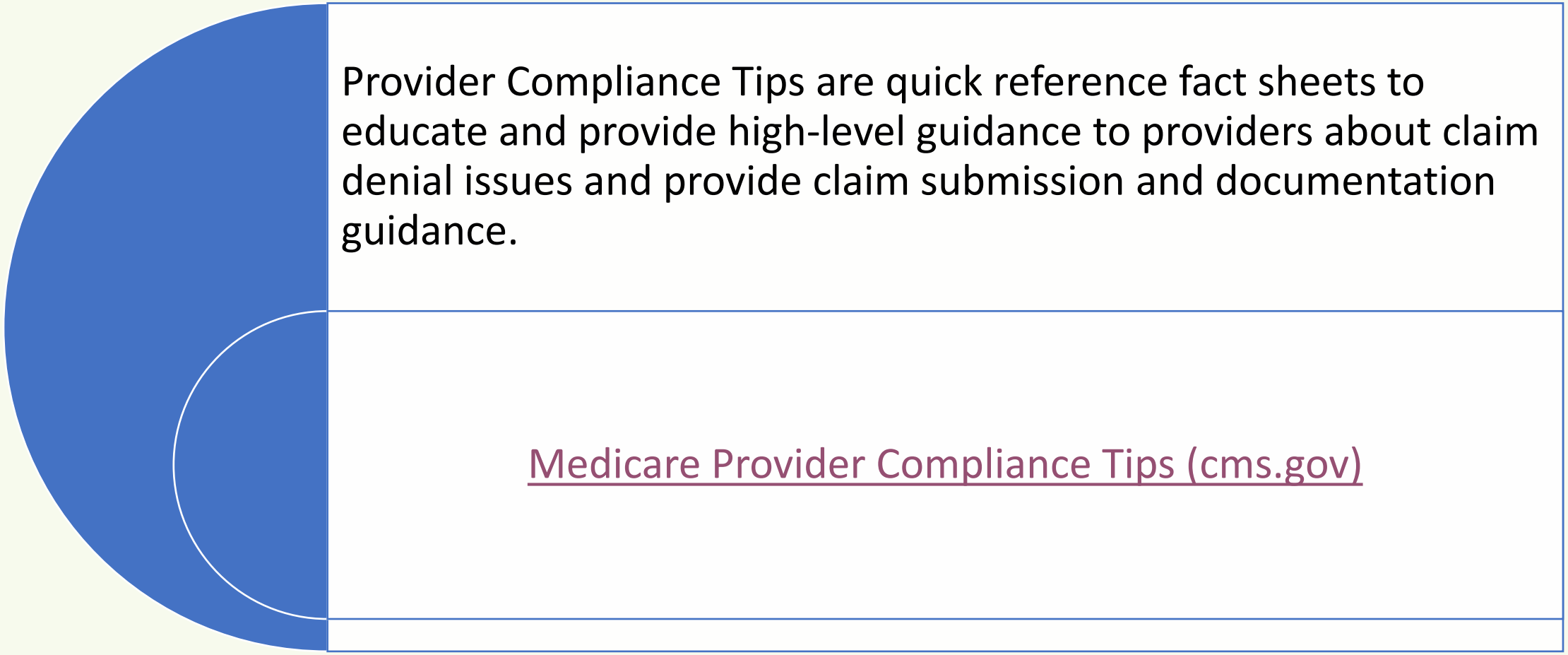
2025 Medicare-Fee-for-Service Improper Payments

CERT Reports

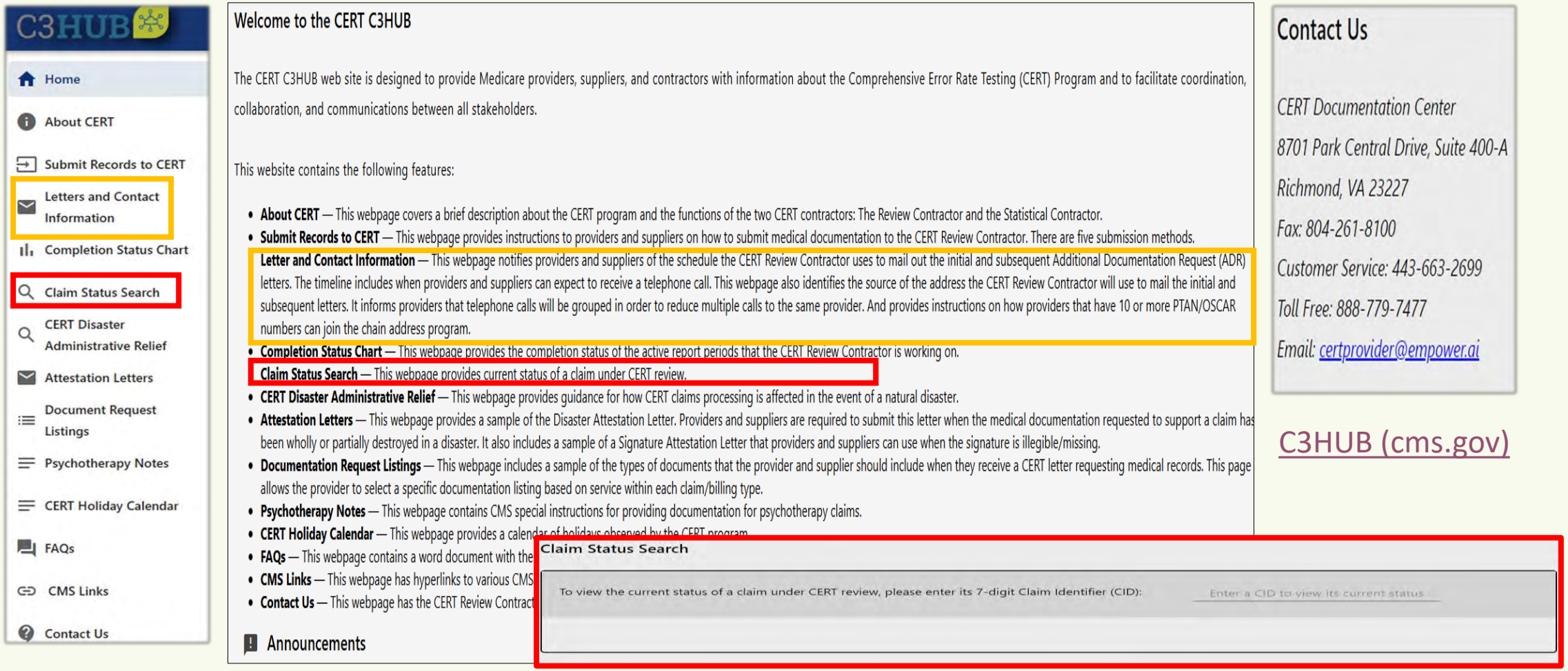


CERT Reports

Medicare Provider Compliance Tips



Welcome to the CERT C3Hub



C3HUB (cms.gov)

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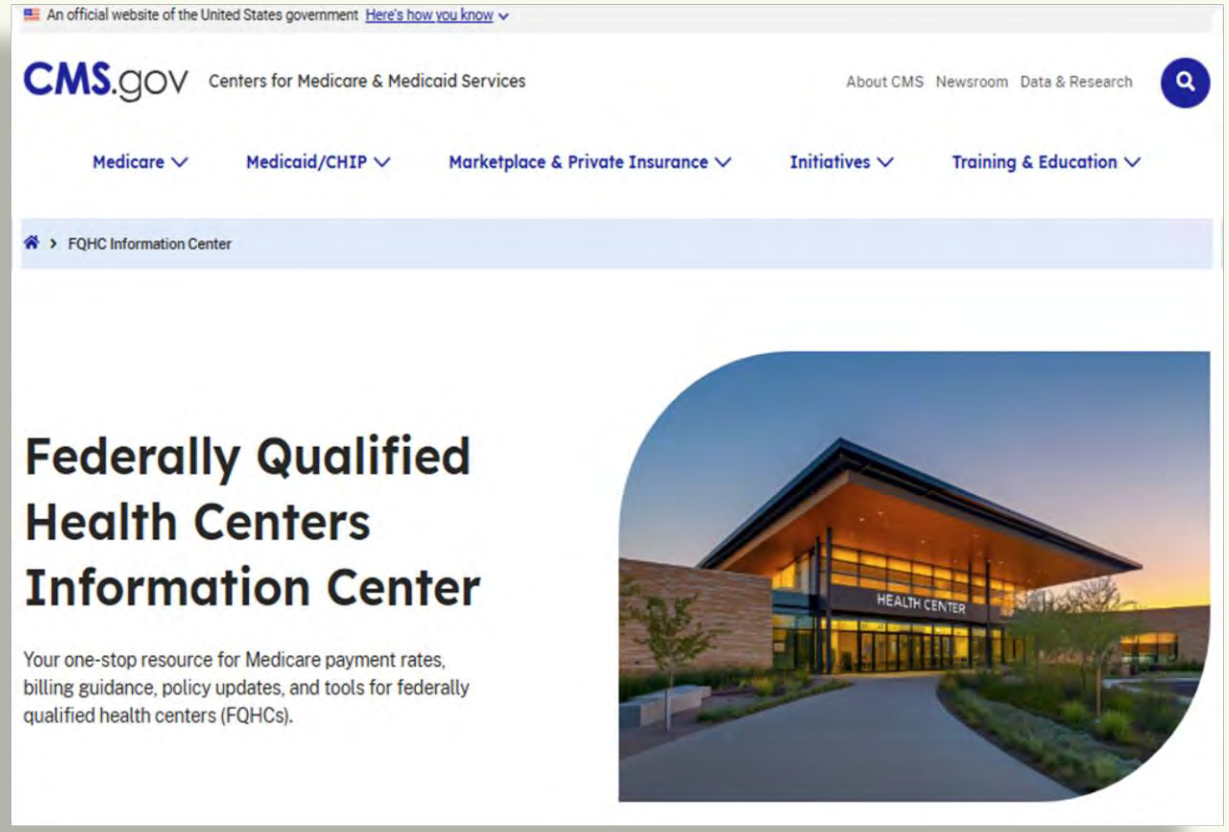
Best Practices

September 16–18, 2026 | Williamsburg, Virginia

Federally Qualified Health Centers Information Center



Your one-stop resource for Medicare payment rates, billing guidance, policy updates, and tools for federally qualified health centers (FQHCs).

Identify Your Top Errors

Generate and review monthly reports

- Saves time used to track errors
- Reduces submission of multiple claims

Monitor trends

- Utilize remittance advice

Identify and resolve problems promptly

Communicate information

Palmetto GBA's Website

Relevant self-service tools and information include:

- **eServices Portal**: A free, feature-rich online portal that allows users to manage Medicare information, submit appeals, voluntary refunds, check eligibility, and more. It is recommended as a simple alternative to calling the Provider Contact Center (PCC).
- **Forms Access**: All Palmetto GBA forms and CMS enrollment forms are available online for easy access
  - Jurisdiction J Part A Forms
  - Jurisdiction M Part A Forms
- **Provider Enrollment Application Status Tools**: Online tools to check the status of provider enrollment applications
  - Jurisdiction J Part A Provider Enrollment Application Status Lookup Tool
  - Jurisdiction M Part A Provider Enrollment Application Status Lookup Tool
- **Interactive Voice Response (IVR) System**: Required by CMS for checking claim status
- **ePass**: A feature to save time and avoid authentication with every call to Palmetto GBA. Users can obtain ePass through the IVR system or by requesting it verbally from a Customer Service Agent after first-time authentication.
- **Outsourced Agencies**: Encouraged to use self-service tools and have access to Medicare remittance advice rather than calling for claim status

These tools help reduce call volume and provide efficient access to needed information and services.

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Resources

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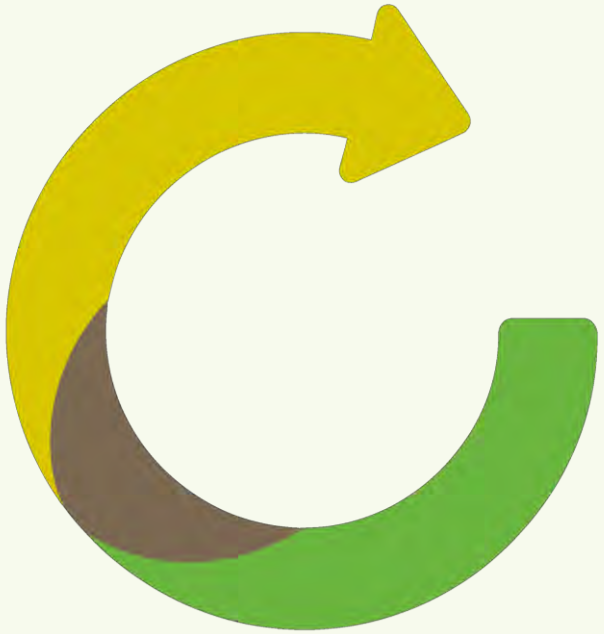
PECOS

Have You Updated PECOS?



- Supports Medicare Provider and Supplier enrollment process
- Allows registered users to securely and electronically submit and manage Medicare enrollment information

Educational Resources

- Chronic Care Management Services (PDF) booklet
- CY 2025 Medicare PFS Fee Schedule Final Rule fact sheet
- CY 2026 Medicare PFS Fee Schedule Final Rule fact sheet
- FQHC Center
- Medicare Benefit Policy Manual, Chapter 13
- Medicare Claims Processing Manual, Chapter 9
- Medicare Learning Network®
- MLN006397 March 2026
- JJA Federally Qualified Health Centers (FQHCs) palmettogba.com
- JMA Federally Qualified Health Centers (FQHCs) palmettogba.com
- SE22001: Mental Health Visits via Telecommunications for RHCs & FQHCs

Additional Supportive Resources

- https://palmettogba.com/
- Medicare Revalidation List (data.coms.gov)
- MLN9658742 (cms.gov)
- National Plan and Provider Enumeration System (NPPES) (cms.gov)
- National Plan and Provider Enumeration System (NPPES/NPI) nber.org
- Provider Enrollment, Chain, and Ownership System (PECOS) cms.hhs.gov
- Pub. 100-08-Medicare Program Integrity Manual, Chapter 10 (cms.gov)
- Revalidations (Renewing Your Enrollment) cms.gov

Additional Supportive Resources

- **20.2.1 Admission Questions to Ask Medicare Beneficiaries (cms.gov)**
  - http://tinyurl.com/4tvf67k2
- **CMS IOM Pub 100-05 — Medicare Secondary Payer Manual, Chapter 3**
  - http://tinyurl.com/mr3smcft
- **CMS IOM Pub. 100-05 Chapter 5, Contractor MSP Claims Prepayment Processing Requirements**
  - http://tinyurl.com/3sjy2prm
- **External Code Lists | X12**
  - http://tinyurl.com/mu9nvpme
- **Internet Only Manual (IOM) 100-05, Chapter 1, section 10**
  - http://tinyurl.com/bdh88uzj
- **IOM Chapter 2, section 60**
  - http://tinyurl.com/bder6hkv
- **IOM Chapter 3, section 30.2**
  - http://tinyurl.com/5c2t7935
- **IOM Chapter 5, section 40.6**
  - http://tinyurl.com/ykue7v3c

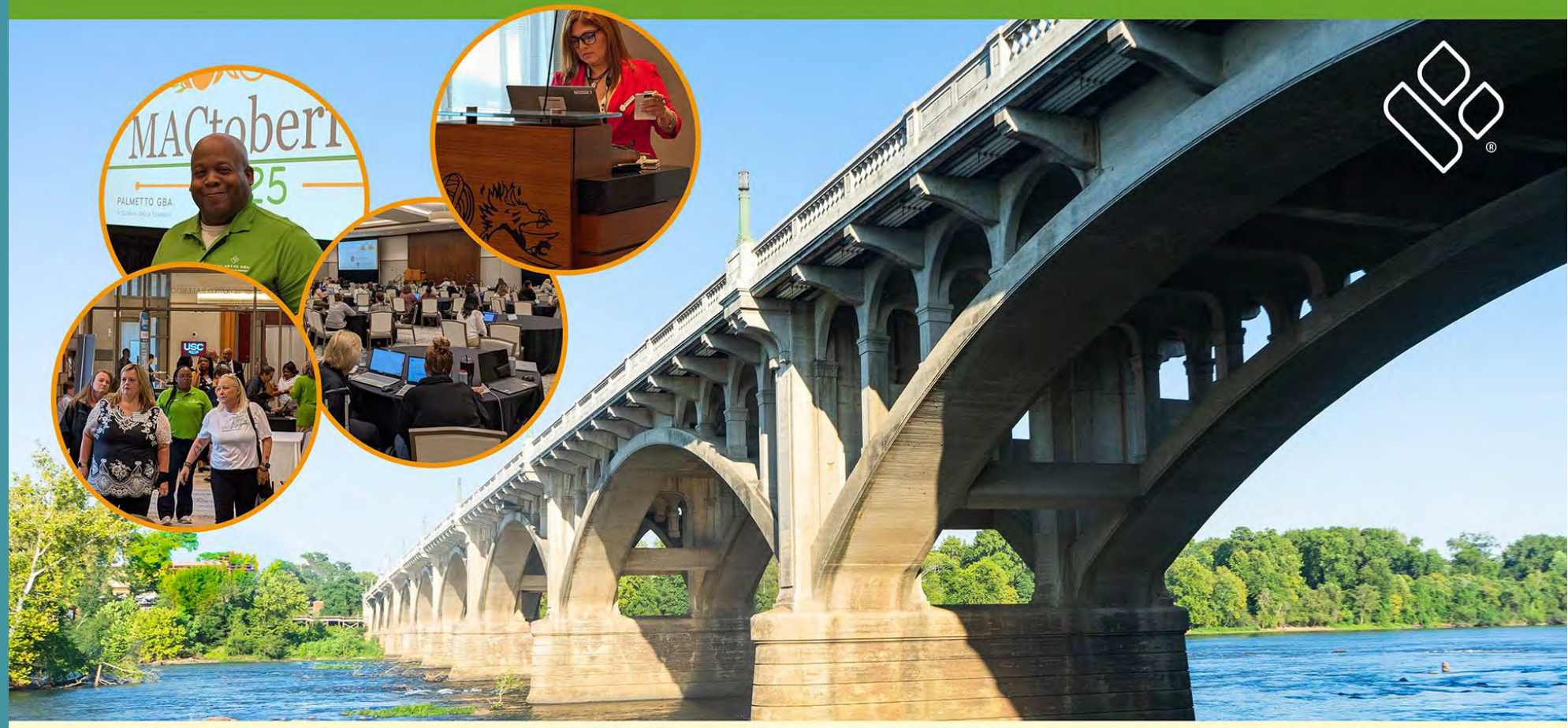
Additional Supportive Resources

- JJA Medicare Secondary Payer (MSP) Overpayments
- JJA Overpayments and Recoupment
- **Medicare Contractor Beneficiary and Provider Communications Manual**
  - http://tinyurl.com/4s9phesx
- **MLN006903 — Medicare Secondary Payer (cms.gov)**
  - http://tinyurl.com/3x695s7k
- **MLN006926 Medicare Billing: 837I & Form CMS-1450**
  - http://tinyurl.com/mszc7fha
- **National Uniform Billing Committee | NUBC**
  - http://tinyurl.com/bddmkdmh
- Self-Disclosure Information (oig.hhs.gov)
- Self-Referral Disclosure Protocol (cms.gov)

Contact Us

Our Provider Contact Center (PCC) Representatives can be reached at:

- Jurisdiction J
  - 877–567–7271
  - Monday – Friday, 8 a.m. to 6 p.m. ET
- Jurisdiction M
  - 855–696–0705
  - Monday – Friday, 8 a.m. to 4:30 p.m. ET



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Thank You!

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