

Federally Qualified Health Center Billing (100)

1. As a federally qualified health center (FQHC) can we bill for a license medical social worker?

The core practitioner must be a licensed or certified clinical social worker (CSW) in your state. Unless your state does not have a licensing program, licensed clinic social workers are required. Clinical social workers are permitted if the state does not have a licensing requirement for social workers. The criteria for a CSW can be found at <http://www.cms.hhs.gov/manuals> go to the The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 110.

2. Are nursing visits for things like injections and blood draws billable under the FQHC benefit by the medical doctor or nurse practitioner?

The nurse practitioner services must be provided along with other covered and billable services during the clinic visit in order to bill and be paid under all-inclusive rate. Otherwise, include the injections and blood draw in the next visit or prior visit by the beneficiary.

3. If a patient comes in twice in one day for two separate problems, is a modifier needed for a visit in order for it to process?

Modifiers are not required for FQHC claims. They are not recognized in the claims process within the Fiscal Intermediary Standard System (FISS); however infusion therapy provided by a registered nurse without an encounter with a core practitioner is not billable. Physician oversight of the service is not considered an encounter.

4. Is infusion therapy included in a FQHC visit or can it be billed to Medicare Part B?

If a core practitioner performs the infusion therapy, it is billed as an FQHC encounter to the fiscal intermediary.

5. Where are the revenue codes for FQHC billing?

Providers may find the revenue codes in the CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100 at <http://www.cms.hhs.gov/manuals>.

6. Can a medical visit under revenue code 52X and a mental health visit under revenue code 900 be billed on the same day? How is it billed?

Submit both visits on one claim. Each line will be calculated for reimbursement by the claims processing system. The diagnosis codes should support both visits.

7. Are hospital services billed as FQHC services for any of the practitioners?

The hospital bundling provisions in Section 1862(a) (14) of the Social Security Act provides that Medicare payment may not be made to a FQHC for services provided to hospital inpatients and outpatients.

If the FQHC practitioner should provide services to a hospital patient, these services are not covered under the FQHC benefit. For additional information see the CMS IOM, Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 30.4.

8. When a patient comes in for a visit with the provider and also has a blood draw because we are sending it out to a laboratory, do we include 36415 (collection of venous blood venipuncture) in the office visit or bill it to the Part B carrier?

Roll the blood draw into the face-to-face encounter to the fiscal intermediary. No coding is required.

9. Are home health visits covered?

The FQHC must be authorized by CMS to provide home health visits. The only states that qualified at this time are Alaska and CMS IOM, Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 90.4.

10. Is current procedural code 94664 billed in addition to the office visit code on the same date of service?

The services are billed as one encounter on the same day. Teaching of nebulizer use would be rolled into the face to face encounter visit.

11. If a patient comes in today for an electrocardiogram (EKG) only and a nurse visit then comes back in a week to see a core practitioner and they go over the EKG, do we bill the EKG on the date it was done or do we need to bill it when the patient comes in to see the doctor?

If the facility owns the equipment and performs the EKG, bill the carrier for the technical component of the service that day. When the patient returns and sees the physician for a consultation of the results, bill the consultation to the fiscal intermediary as long as it meets the definition of an encounter. Otherwise, include the results in the prior visit's record.

12. Can we bill supplies such as bandages in addition to an office visit?

No, the supplies are included in the payment for the office visit.

13. If a physical therapist is practicing under general supervision of a physician, can we bill for the services?

No, the services are covered as part of a billable encounter with the physician. Physical therapists are not core practitioners and cannot bill the service as an encounter.

14. If a patient is seen by two different practitioners, same date, different specialty, what kind of remarks should be recorded, and what field would the remarks be recorded in on the claim?

Encounters with (1) more than one health professional; and (2) multiple encounters with the same health professional which take place on the same day and at a single location, constitute a single visit. An exception occurs in cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment. Also include anything that helps adjudicate the claim in the remarks field (field locator [FL] 80 of the UB-04 and in loop 2300 of the 837I.)

15. What is the appropriate revenue code if a patient is in a certified skill nursing facility (SNF) bed, benefits are exhausted under Medicare and/or criteria is no longer being met, and the physician visits the patients in the facility and provides FQHC services?

The revenue code is 525. All of the appropriate revenue codes for billing are in the CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100 at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> Internet Only Manual 100-4.

16. What is FISS?

The fiscal intermediary standard system is the acronym for FISS. It is the claim system that processes the fiscal intermediary claims for FQHCs.

17. Do we bill under the mental health provider's national provider identifier (NPI) or the physician's NPI?

Remember bill only for CSW or clinical psychologists under the FQHC benefit when mental services are provided by them. Use the rendering practitioner's NPI number on the claim.

18. Is diabetes self-management training (DSMT) billed to the fiscal intermediary (FI)/Medicare administrative contractor (MAC)?

When provided in a FQHC setting, bill it to the FI with revenue code 52x and Healthcare Common Procedure Coding System (HCPCS) code G0108. The CMS *Medicare Learning Network* (MLN) article MM6445 on the CMS or the National Government Services Web site is an excellent resource.

19. Exactly how should an encounter claim (UB-04) look when billing for an office and medical nutrition therapy (MNT) visit on the same day?

Bill the medical encounter with revenue code 52x without HCPCS code, and bill the MNT encounter with revenue code 52x and HCPCS code 97802, 97803, or G0270 as appropriate.

20. Is a cholesterol screening billed to Medicare Part A or B?

When provided in a FQHC setting it is billed to Medicare Part A.

21. Is a tuberculosis test payable?

It is covered and reimbursed with an otherwise billable visit. Include the cost of the immunization into the encounter services on the claim.

22. What procedure code would be used to report a screening clinical breast exam only (in absence of pap and pelvic exam), and is this a Medicare-covered service when provided alone?

A screening clinical breast examination is included in the clinic visit by the patient; as long as the entire visit meets the definition of a face-to-face encounter.

23. Is there a way to determine who has just been approved for Medicare so that we can send them a letter about the welcome to Medicare physical?

No, there is no way to determine new Medicare beneficiaries unless they show up at the clinic with their Medicare card. Once the beneficiary is a new patient in the clinic, check the Medicare card is part of the patient files which has the effective dates on it.

24. Do we bill under their NPI number when the physician assistant and nurse practitioner provide services?

Yes, since they are considered core practitioners; their individual NPI would be the rendering provider on the claim.

25. How do we bill Medicare when a patient is enrolled in hospice and we see them for something unrelated to the hospice illness?

Use condition code 07 in Field Locator 18 on the UB-04 claim. If the claim is rejected because it did not have the code, do an adjustment to the rejected claim.

26. Do we bill the MNT services under an enrolled provider's NPI number?

The MNT services are provided by certified provider through the American Diabetes Association, Indian Health Services, or American Association of Diabetes Educators. Once certified to provide

services and bill Medicare for covered MNT services, the nutritionist or registered dietician must have an individual NPI number.

27. Are routine lab work/x-rays and preventive labs considered inclusive?

National Government Services is not sure what the question is referring to when routine labs are mentioned. Specific examples are needed. Please contact customer care at 877-702-0990 for assistance.

28. Is the licensed clinical social worker (LCSW) considered the same as a CSW and is a clinical psychologist required on staff in order to see patients?

No, they are not the same. A CSW is not necessarily licensed. A clinical psychologist does not have to be on staff unless the LCSW's license or state regulations require it.

29. Is it a requirement to enroll a LCSW practicing in a clinic setting? Can the LCSW supervise and bill for the services performed by a counselor or licensed clinical professional counselor (LCPC)?

There is no requirement to enroll an LCSW; however LCSWs, nurse practitioners (practicing within the scope of their license if mental health services are allowed), and psychologists are the only practitioners able to bill Medicare for mental health services. Family, marriage, and chemical dependency counselors may provide services, but they are not billable since they do not meet the definition of a core practitioner.

30. Can National Government Services comment on the new proposal of HIV infection screening as a preventive covered service, FQHC?

National Government Services has no comment at this time.

31. If a patient comes in and sees a nurse only who draws blood and takes a basic urine test or blood sugar check and the patient does not see a core practitioner, is it billable to Part B?

No, the services are not billable to Part B. Include them as part of the prior or next visit.

32. In order to bill for a diagnostic Clinical Laboratory Improvement Amendment (CLIA) waived test, it must be provided as part of a face-to-face encounter, and should the clinic report the evaluation and management code for the lab test performed in the encounter?

The FQHCs are only reimbursed for the professional component of these tests, that is, the physician professional opinion on the result of the test. That is included in the face-to-face encounter. The laboratory would bill the carrier for the technical component of the lab test.

33. If a patient has a well woman exam today, and the provider adds modifier 25 for other issues addressed, do we bill the code for both or does it automatically become a sick visit?

Modifier 25 is not recognized on FQHC claims. If a “well” and “sick” visit occurred on the same day the patient was not “well” and the code for the illness should be documented for the visit. All services provided in that encounter (either the preventive or the “sick visit” services) would be paid through the one encounter rate.

34. Is the bill type for FQHCs changing in 2010?

Yes, the bill type is changing to 77x, as of this date the change is scheduled for April 2010.

35. What is the difference between a free standing and provider-based FQHC?

A provider-based clinic is attached to a main provider such as a hospital, SNF, or home health agency. A free standing clinic is not it stand alone.

36. Are FQHCs eligible for physician quality and reporting initiative (PQRI) and e-scribe bonus payments?

Not to our knowledge, view the information regarding the initiative at <http://www.outcome.com/pqri.htm>.

37. Where do Medicare secondary payer (MSP) claims go to Part A or Part B?

All Part A Medicare Secondary Payer claims go to the FI/MAC.

38. Does the clinic bill HCPCS system code 94664 to the Part B carrier?

All professional services provided in a FQHC setting are part of the face-to-face encounter. The service is paid in the all-inclusive rate.

39. Are self injections billed with revenue code or billed to Part B?

Providers are not reimbursed for injecting a patient’s own medication.

40. Does the clinic continue to code all services performed by the clinic and then let the FQHC payment system bundle things into its all inclusive rate (i.e., patient is seen for evaluation and management.) Are both codes 99213 and 81002 reported and paid?

The FQHCs are not paid by the FI through current procedural terminology (CPT) codes so reporting them on the Part A claim is not required.

41. How do you bill for a noncovered diagnosis code? We need a denial so we can forward it to the secondary payer?

Submit the claim with condition code 21, and submit the charges in the noncovered field. All other billing requirements remain the same.

42. If the clinic has a 'covered' but nonbillable FQHC service (e.g., physical therapy [PT]), how is it added to a previous or future visit? The previous visits are billed out daily so it would be too late to add the charge and the future visits might not happen.

The charges must be included in the earliest/closest visit that qualifies as an encounter. It is understood that many times the claims are already billed, but in that case the next encounter should include the charges. Or submit an adjustment to the prior claim if the charges are substantial.

43. When I get denials as MA130 (incomplete/missing information) the remittance advice is not specific on what information is missing. How can I find out more?

The Interactive Response Voice (IVR) system should help with specific data. To receive more information on how to use the IVR, visit

<http://www.ngsmedicare.com/content.aspx?CatID=5&DOCID=2988>. If the information is not available contact the Provider Contact Center and let them know that you have been to the IVR, but need additional help.

44. Where can we find guidelines for documentation requirements for diagnostic procedures?

Documentation for diagnostic procedures would be anything that supports medical necessity (e.g., doctor's orders, patient history, verification the procedure was done [reports/results]). However, the procedures are paid for in the all-inclusive rate, not separately.

45. Are obstetrics/gynecology doctors considered part of the all-inclusive rate for office visits as well as surgeries performed in and out of the clinic?

When a gynecologist provides a covered service, it is billable to the FI. Minor surgeries provided during a face-to-face encounter are paid as part of the all-inclusive rate. When surgeries are performed outside of the clinic, it is not considered a FQHC service and not billed by the FQHC.

46. In order to bill for a licensed independent social worker do you have to have a clinical psychologist on staff?

Make sure the social work is qualified to provide services in the FQHC setting by going to the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 110-110 at

<http://www.cms.hhs.gov/manuals>. Once you have established that the person may provide the

services in an FQHC setting and all state laws are being followed a clinical psychologist does not have to be on staff.

47. Is there a list of procedures that are payable outside the encounter fee? Can a doctor bill for the technical component of a diagnostic test?

There is not a list of procedures that are payable outside the encounter fee. The encounter rate includes covered professional services provided by an FQHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, CSW, or visiting nurse; and related services and supplies. The rate does not include services that are not defined as FQHC services.

48. How do we handle the documentation requirements for billing a PT session that was actually provided on one day, but billed on another?

The PT services are professional services covered by Medicare but not billable as an encounter by an FQHC since physical therapists are not “core providers”. If no core practitioner encounter occurs on the date of the therapy services, that service is to be applied on the next core practitioner visit. Please access the local coverage determination (LCD) for outpatient PT and the supplemental instructions article on the CMS Medicare Coverage Database (MCD) to review the documentation requirements for therapy services.

49. Is the patient’s co-payment 20 percent of the total rolled into the visit if a patient is seen and has an office visit and a procedure done that “rolls” into the visit?

For FQHC services, the Part B deductible does not apply. Coinsurance is 20 percent of the billed charges. A reference for this is the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, and Section 20 at <http://www.cms.hhs.gov/manuals>.

50. If we have three PT visits in a week and if they see core practitioners the next week, can we bill the three PT visits with the physician visit?

Therapy services are covered FQHC services. Because physical and occupational therapists are not FQHC core practitioners, the provision of their services does not constitute a billable visit. If a core practitioner encounter does not occur on the day the therapy services are provided add them to the next core practitioner visit. That means that a provider documents them in the patient records along with the cost.

51. Is a FQHC required to have a compliance plan for CPT coding levels?

No, because Medicare does not pay by or require CPT codes on the claim. It is always a good idea to have a compliance program in place.

52. How would you bill a visit by two providers so the claim does not deny as a duplicate?

When a specific claim issue occurs, please contact customer care at 877-702-0990, but if the services are related, the claim should deny as a duplicate.

53. The clinic cannot bill the technical component of a diagnostic test but can it bill an electrocardiogram?

The FQHC providers do not bill the technical component of test to Part A. If a laboratory exist in your facility, and the test is performed there; bill the carrier for the technical component of the services. The test must be in the Medicare physician fee schedule, have a distinct technical and professional component, and the facility must provide the complete technical component. Billers should consult with a coder or the core practitioner' recommended before billing.

54. Optometry visits seen by an optometrist doctor is this billable to FQHCs?

They must be a physician (OD). Medicare covers Optometrists per the CMS IOM Publication 100-02 *Medicare Benefit Policy Manual*, Chapter 15 Section 30.4 "...a doctor of optometry is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation. To be covered under Medicare, the services must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements."

See the CMS IOM Publication 100-02 *Medicare Benefit Policy Manual*, Chapter 16, "General Exclusions from Coverage," for exclusions from coverage that apply to vision care services, and the CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, "Physician/Practitioner Billing," for information dealing with payment for items and services furnished by optometrists.

Code of Federal Regulations 42, Section 405.2401, Part 405 Scope and Definitions Subpart X—Rural Health Clinic and FQHC Services define a physician as the following:

Physician means the following: (1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the function is performed. (2) Within limitations as to the specific services furnished a doctor of dentistry or dental or oral surgery, a doctor of optometry, a doctor of podiatry or surgical chiropody, or a chiropractor. (See Section 1861(r) of the Social Security Act for specific limitations)

55. As a doctor of podiatry medicine (DPM) am I to understand that a DPM is not reimbursed under the FQHC encounter rate?

The podiatrist must be a physician providing covered FQHC services.

56. What is billable to Medicare B if we are a FQHC?

Technical services/components associated with a test performed by independent FQHCs may be billed to Medicare carrier on the Medicare CMS-1500 claim form if the facility is providing the technical component. Note that some tests do not have a technical component to them, therefore providers are only reimbursed for the practitioner's professional service.

57. Can National Government Services clarify the part about the patient coming in to only have labs done? Are we not able to bill labs to Part B such as an 83036 or 85610?

Items and services that are covered under Part B Medicare, but are not included in the definition of FQHC services (e.g., routine diagnostic, laboratory services, independent laboratory services, durable medical equipment, and ambulance services) are not allowable on the cost report. However, the provider of these services may bill for these items separately to the appropriate Medicare contractor.

58. How about H1N1 administration billing?

The H1N1 virus vaccine will be provided to Medicare Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the administration of the H1N1 vaccine when provided free of charge. Include the H1N1 shot and/or administration on the cost report.

59. Can a physician do initial preventative physical examination or does it have to be a nutritionist?

A physician or another core practitioner that is authorized to do physical exams can do initial preventative physical examination. A nutritionist is not a core practitioner. Please refer to the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13 for coverage information on the CMS Web site at <http://www.cms.hhs.gov/manuals>.

60. The HCPCS code 93000 includes interpretation and report. How would you separate its technical and professional components?

The HCPCS 93005 is for tracing only; no interpretation only—break the technical and professional apart. Bill the technical component to the carrier and the professional component is covered in the encounter rate. As an FQHC with a laboratory enrollment is set up through the carrier to bill the technical component.

61. According to your answer, billing Medicare for medical services and mental health services for psychotherapy is done separately and both are reimbursable. I am not the only one that cannot make this happen, please explain.

1. They are billed on the same claim with two different revenue codes. The 52X for medical and the 900 for mental health. The difference in revenue codes allows payment for both. There is a guide

to determine if the mental health services that are being provided should be billed under revenue code 900. It is located at <http://www.ngsmedicare.com/content.aspx?CatID=5&DOCID=21205>.

62. Can we bill for substance abuse services for a licensed alcohol and drug counselor?

These are not core providers; therefore their services are not billable to Medicare for reimbursement in a FQHC.

63. Can we use health and behavior codes such as 96150?

The CPT codes are not required by Medicare; we do not pay by the codes, Medicare pays based on a covered visit that is medically necessary. If the code is needed to bill to a secondary payer, the code must be valid when submitted on a claim. Mental health services are represented on a claim by revenue code 900.

64. Does the educator or the program or both have to be certified to bill nutrition services?

The educator must be certified to bill the Medicare Program for diabetes self-management or medical nutrition services.

65. For our LCSW and clinical psychologist, can we enroll them as providers or do we bill under an enrolled provider, such as one of our physicians?

These providers are considered core practitioners under the FQHC benefit and their professional services under their NPIs are billed for payment to the FI or MAC.

66. Does the FQHC have to bill physician hospital visits to the Part B carrier for reimbursement?

Physician hospital services are billed by the physician to the carrier, not the FQHC. The clinic with permission of the physician may act as a billing agent on his/her behalf and bill the carrier.

67. We were told at the convention last year that we should not be billing the Part B carrier for our providers seeing patients in the hospital, that these services were not billable to either the FI or the Part B carrier. We have since been holding all claims.

That is correct. The physician should bill their own services to the carrier since hospital visits are not FQHC services. As noted above, the physician can give permission to bill the carrier on his/her behalf.

68. Can a CSW bill with the 900 revenue code without a clinical psychologist on staff?

Yes, because a CSW is considered a core practitioner.

69. Can we draw labs and just bill for the 36415 and not the 99211 and still get paid?

No, a face-to-face encounter is required in order to bill Medicare. The encounter must include covered services by a core practitioner.

70. Will Medicare pay for a 99211?

Medicare will pay for a medically necessary visit; if the definition of 99211 defines the service provided submit a claim, and are not paid by CPT codes. 99211 represent services that require no physician encounter (e.g., nurse visit); therefore the services would not meet the definition of a face-to-face encounter with a core practitioner.

71. Please post the link to the July 23, 2009 Q&As?

The document can be found at <http://www.NGSMedicare.com>.

1. Business type: Select Part A
2. State: Wisconsin—click GO
3. Accept the agreement
4. On the blue bar go to Education and Support
5. Click on Training Summaries
6. Click on Teleconference
7. Click on Ask the Contractor—find July 23, 2009

72. On the preventive services it states that the patient must be targeted to risk, what do they consider risk? Is diabetes or hypertension an example? Do they need an underlying diagnosis to be billable?

The underlying diagnosis would be the “family history of” or “personal history of” codes. For example, targeted to risk means the patient is over 50 so there is a higher incidence of colon cancer; the patient is obese so there is a higher incidence of diabetes. In other words if a patient walked into an FQHC and wanted their blood sugar checked; there would be no way to “target it towards risk” but if a 300 pound 75-year-old did the same; there would be “targeting to risk”. If the patient **has** diabetes or hypertension, then it is not preventive, it is a check up or follow up for a medical condition.

73. Is it true that if clinic sees a patient and perform labs such as alanine aminoransferase (ALT), aspartate aminotransferase (AST) or glyated hemoglobin (A1C) the clinic is able to bill the face-to-face encounter to National Government Services and the labs to the carrier?

If there is a face-to-face encounter submit a claim to National Government Services for the Part A visit. The liver function and A1C are labs for monitoring diabetes over time. Check with the carrier of your state to see if the tests are payable.

74. Can a noncertified medical assistant administer shots if they are trained by a physician?

Please check the noncertified medical assistant's scope of practice. This a legal issue not a CMS coverage issue. The services are not considered an encounter and not separately billed to the FI.

75. If a patient is here for a visit and is seen by a provider, can a noncertified medical assistant give shots?

Please see above answer related to noncertified personnel.