Federally Qualified Health Care Prospective Payment System

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Agenda:

One	Background and summary
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Three	• Editing

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Federally Qualified Health Centers (FQHCs)

Federally Qualified Health Centers (FQHCs) are safety net providers of primary care services in underserved urban and rural communities

- Community health centers
- Public housing centers
- Programs serving migrants
- Programs service the homeless

- Centers must provide:
  - Primary care services for all ages
  - Preventive health services (on-site or by arrangement)
- 20 million+ patients annually
- 10,000 sites

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Background & Summary

Oct 1991
Medicare establishes FQHC benefit

Mar 2010
Affordable Care Act requires a Medicare prospective payment system for FQHCs

Jan 2011
FQHCs begin full coding of CPT/HCPCS and revenue codes

Sep 2013
FQHC Proposed Rule

2014
April: Final Rule
May: Transmittal R1383OTN
June: CMS begins trainings

Oct 2014
FQHCs begin transitioning to the new Medicare PPS

Jan 2016
All FQHCs transitioned to calendar year 2016 Medicare PPS

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Current Medicare Reimbursement

- Currently Medicare pays FQHCs an all-inclusive per visit amount based on the cost reports.

- Calculated by dividing total allowable costs by total number of visits, subject to upper limits.

The patient pays no deductible but is responsible for coinsurance or copay, with the exception of:

- Influenza and pneumococcal vaccines
- Hepatitis B vaccine
- Personalized prevention plan services
- Services recommended by the U.S. Preventive Services Task Force
- MyCare Opt In members cannot be balance billed

Covered Service Include:

- Physician services and incidental supplies
- Nurse Practitioner, Physician Assistant, Certified Social Worker, Nurse-Midwife, clinical psychologist services and incidental supplies
- Visiting nurse services at home (if home health agency shortage)
- Preventive services
- Diabetes self-management training and medical nutrition therapy for diabetes and renal disease

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FQHC PPS Details

- National encounter-based prospective payment rate for all FQHCs (almost all other services are bundled)
- Determined based on an average of reasonable costs of all FQHCs
- Payment codes will allow accurate description of services
- Adjustments for geographic location
- Extra money for initial visits and annual wellness services
- Extra money for multiple visits in certain circumstances
- Payment is limited to actual charges

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Billing Requirements

- UB-04 type of bill 77X (required for proper editing and payment)
- Detailed HCPCS codes required for all services rendered during encounter
- Flu and PPV (pneumococcal pneumonia) vaccine and administration codes still required, informational only
- Revenue codes

  0519: Supplemental payment for visit by Medicare Advantage patient

  0521: Clinic visit by the patient to the FQHC

  0522: Home visit by the FQHC practitioner

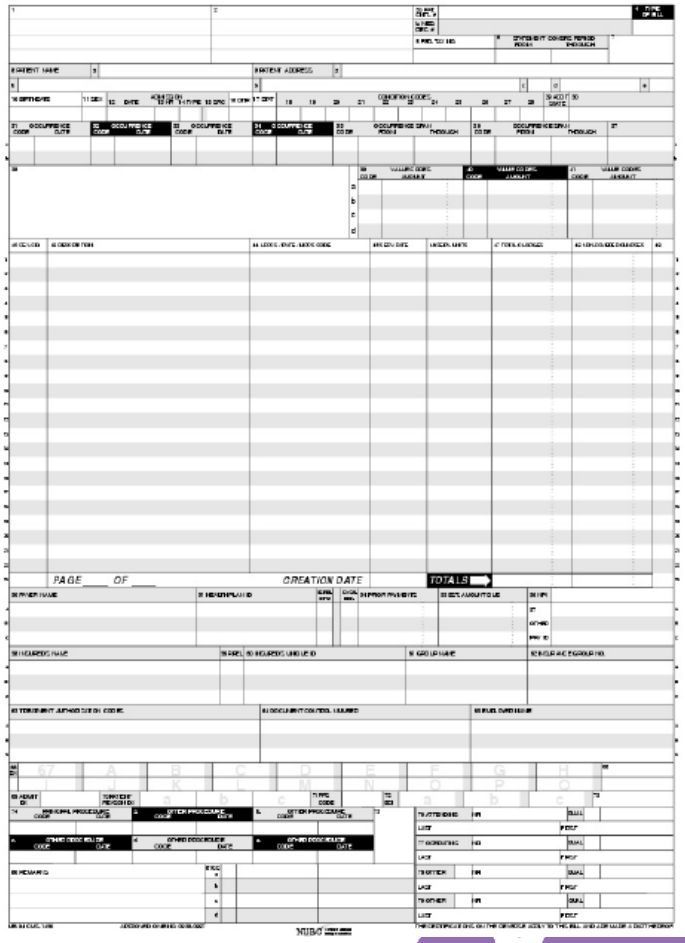
  0524: Visit by FQHC practitioner to skilled nursing facility patient (SNF) in a covered Part A stay

  0525: Visit by FQHC practitioner to SNF patient not in a covered Part A stay, or other residential facility

  0527: Home visit by Visiting Nurse Service when in a home health shortage area

  0528: Visit by FQHC practitioner to other non-FQHC site (e.g., scene of accident)

  0900: Behavioral Health Treatment Services



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Billing Requirements: G codes

FQHCs required to use one of the five payment codes to bill for a FQHC visit

G0466 *FQHC visit, new patient (new to the facility)*

G0467 *FQHC visit, established patient*

G0468 *FQHC visit, initial preventive physical exam or annual wellness visit*

G0469 *FQHC mental health visit, new patient*

G0470 *FQHC mental health visit, established patient*

- Claims that do not contain at least one of the G-codes will be returned to the FQHC

FQHCs must set charges for these payment codes (G0466–G0470):

- Based on their determination of what would be appropriate for the services normally provided, the population served, and the description of services associated with the payment code
- Charges should reflect the sum of the regular rates charged for a typical bundle of services that would be furnished per diem to a Medicare beneficiary

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Billing Requirements: Qualifying Visits

- Each of the G-codes must be accompanied by a qualifying visit code.
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

G0468 – FQHC visit, IPPE or AWV:

HCPCS	Qualifying Visits for G0468
G0402	Initial preventive exam
G0438	Ppps, initial visit
G0439	Ppps, subseq visit

G0469 – FQHC visit, mental health, new patient:

HCPCS	Qualifying Visits for G0469
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/e&m 60 min
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

Billing Requirements: Qualifying Visits cont.

Additional Payable Services

- G0071 – Virtual Communication Services
- G0511 – Chronic Care Management (CCM)
- G0512 – Psychiatric Collaborative Care Model (CoCm)
- Q3014 – Telehealth facility fee

- These codes may be billed as standalone visits, without an FQHC qualifying visit code and are not subject to geographic adjustment

Multiple same day visits and preventative services

•Except as noted below, encounters with more than one FQHC practitioner on the same day, or multiple encounters with the same FQHC practitioner on the same day, constitute a single FQHC visit *and is payable as one visit*.

This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment*, or whether the first visit is related or unrelated to the subsequent visit*. This would include situations where a FQHC patient has a medically-necessary face-to-face visit with a FQHC practitioner, and is then seen by another FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another FQHC practitioner (including a specialist) for evaluation of a different condition on the same day.

•*Exceptions are* for the following circumstances *only*:

•The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall *and returns to the FQHC*) (2 visits *can be billed*), or

•The patient has a medical visit and a mental health visit on the same day (2 visits *can be billed*), or

•The patient has his/her *initial preventive physical exam (*IPPE*)* and a separate medical and/or mental health visit on the same day (2 or 3 visits *can be billed*).

•*The patient has a DSMT/MNT visit and a separate medical and/or mental health visit on the same day (2 or 3 visits can be billed).*

•*DSMT – diabetes self-management training*

•*MNT – medical nutrition therapy*

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Multiple same day visits and preventative services

An additional payment maybe received for professional and primary services furnished on the same day at different times. These services should be billed using revenue code 052x and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.

Effective January 2015 CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure.
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner.
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available. While CMS will continue to recognize the -59 modifier in many instances, it may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a -59 modifier or a more selective - X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

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Preventative Services

FQHCs must provide preventive health services on site or by arrangement with another provider.

- Prenatal and perinatal services;
- Appropriate cancer screening;
- Well-child services;
- Immunizations against vaccine-preventable diseases;
- Screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- Voluntary family planning services; and
- Preventive dental services.

For a list of all preventative services, visit the Medicare claims processing manual by clicking on the following link:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

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Multiple same day visits and preventative services

Multiple same-day visits

- Separate billing allowed with modifier 59 when the following occurs
  - Subsequent illness or injury
- Mental health visit that occurs on the same day as a medical visit

Preventive services

- Influenza and pneumococcal vaccines
  - Administration, along with influenza and pneumococcal vaccines will continue to be paid through the cost report.
  - Optum software will return zero payment and return code 35.
- All other Medicare-covered vaccines are not separately payable and will be included in the encounter rate

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FQHC Editing

- Extensive new editing, including in the Outpatient Code Editor (OCE)
- New OCE edits specific to UB-04 Type of Bill 77X
    - G codes valid for bill type 77X only
    - If at least one G code is not included – Return to Provider (RTP)
    - If each G code is not accompanied by qualifying visit from list – RTP
    - If each G code not reported with revenue codes 052X / 0519 – RTP
- Can not mix PPS and non-PPS dates of service on the same claim
- Allow additional per-diem payments if
    - mental health plus G0466, G0467, G0468 (medical visit codes)
    - modifier 59 with G0467 or G0470 (established patient)
- Allow additional fee schedule payment for Telehealth (Q3014), Virtual Communication (G0071), Chronic Care Management (G0511), Psychiatric Collaborative Care (G0512)
- Reject claim lines containing durable medical equipment (DME), labs (except 36415), ambulance, any hospital-based services, and any group or non face-to-face encounters except telehealth
- Restrict Diabetic Self Management Training (DSMT) services to one per day, for diabetes and renal disease
- Do not allow DSMT and Medical Nutrition Therapy (MNT) services on same date of service
- Bundle all other claim lines

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Physician Billing: HCFA 1500

Non-Federally Qualified Health Center services

- Non-FQHC services include, but are not limited to: Medicare excluded services, such as routine physical checkups, dental care, hearing tests, routine eye exams, etc.
- For additional information, please visit the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, Benefit Policy Manual, Chapter 16.

Technical component

- The technical component of a FQHC service includes diagnostic tests such as x-rays, electrocardiograms and other tests authorized by Medicare statute or the National Coverage Determination process.
- These services may be billed separately.

Professional component

- The professional component is a FQHC service if performed by a FQHC practitioner or furnished incident to a FQHC service.

Laboratory services

- Although FQHCs are required to furnish certain laboratory services (section 330(b)(1)(A)(i)(II) of the PHS Act), they are not within the scope of the FQHC benefit.
- When clinics and centers separately bill laboratory services, the cost of space, equipment, supplies, facility overhead and personnel must be adjusted out of the FQHC cost report. This does not include venipuncture, which is in the per-diem payment when furnished in a FQHC by a FQHC practitioner or furnished incident to a FQHC service.

Resources

FQHC PPS website:
www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html

G-codes and qualifying codes:
www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

Medicare Benefit Policy Manual, Chapter 9
https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/Downloads/clm104c09.pdf

Federally Qualified Health Center (FQHC) Center Page
http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Noridian FQHC Billing Guide
https://med.noridianmedicare.com/web/jea/provider-types/fqhc/fqhc-billing-guide

CMS FQHC PPS Training
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/GFT-FQHC-Training.pdf

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CareSource known issues

- Professional claims billed on a HCFA are denying all services to be rebilled on a UB-04. Agreements are being corrected in the CareSource system to auto-adjudicate. In the interim claims are being manually priced expected to be complete by Jan 2021.
  - Claims will be pulled to be adjusted once the agreements are loaded. No need to rebill or send corrected claims. Claims adjustment project expected completion Jan 2021.
- Outpatient Hospital Benefit (ded/coins) applied prior to November 2020. This has been corrected.
  - Claims are in the process of being pulled to apply the correct PCP benefit. No need to rebill or send corrected claims. Expected completion Jan 2021.

Questions? Follow up?


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