Federally Qualified Health Center Overview

October – December 2016
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Novitas Solutions Education

- Education specific to FQHCs in Medicare Administrative Contractor Jurisdiction H (JH)
## Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>AWV</td>
<td>Annual Wellness Visit</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>EKG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>GAF</td>
<td>Geographic Adjustment Factor</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>IPPE</td>
<td>Initial Preventative Physical Exam</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>MEI</td>
<td>Medicare Economic Index</td>
</tr>
</tbody>
</table>
## Additional Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>PPS</td>
<td>Prospective Payment System</td>
</tr>
<tr>
<td>PTAN</td>
<td>Provider Transaction Access Number</td>
</tr>
<tr>
<td>TOB</td>
<td>Type of Bill</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>UB-04</td>
<td>Uniform Bill 04</td>
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</tbody>
</table>
Today’s Presentation

- Agenda:
  - Overview
  - FQHC PPS Reimbursement
  - FQHC Billing
  - Credit Balance Reports
  - Cost Reports
  - Medicare Updates
  - Self-Service Options
Overview
How to Become a FQHC

- FQHCs are suppliers paid by the Part B Medicare Trust Fund and file claims with the MAC.

- There are several ways to become a Medicare enrolled FQHC:
  - Receiving a Public Health Services Act Section 330 grant (administered by The Health Resources Services Administration (HRSA))
  - Contracted with the recipient of such grant and meet grant eligibility
  - Treated by CMS as a federally funded comprehensive health center as of 1/1/90
  - FQHC “Look-Alike”:
    - Different provider types
  - An outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act:
    - Different provider types
Certification

• For certification as an FQHC, the entity must meet all of the following requirements:
  • Provide comprehensive services and have an ongoing quality assurance program
  • Meet other health and safety requirements
  • Not be concurrently approved as a Rural Health Clinic
FQHCs that receive a Section 330 grant or are determined to be a FQHC look-alike must meet all requirements contained in Section 330 of the Public Health Services Act:

- Serve a designated medically-underserved area or medically-underserved population
- Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty level
- Be governed by a board of directors, of whom a majority of the members receive care at the FQHC
FQHCs seeking to enroll with Medicare must file an application and other documents, rather than go through the State Agency certification process:

- CMS will enter into an agreement with a qualified FQHC when The Health Resources Services Administration (HRSA) documentation is submitted or the applicant is confirmed as a qualifying Tribal or Urban Indian organization outpatient healthcare facility.
- Applicant files a self-attestation that it complies with regulatory requirements at 42 CFR 405 Subpart X and 42 CFR Part 491, except for Section 491.3.
- Applicant files a complete CMS-855-A paper or electronic Provider Enrollment, Chain and Ownership System (PECOS) enrollment application and supporting documentation that is approved by the MAC.
- Entity terminates other Medicare provider agreements.
Enrollment

- If a FQHC provides services in permanent units in more than one location, each unit must be separately enrolled in the Medicare program.
- Mobile units operated by the FQHC do not require separate enrollment, but are considered part of the permanent FQHC that operates them.
New Enrollment

- New FQHC applicants must submit to MAC the following information:
  - A signed and completed CMS-855A enrollment application
  - Two signed and dated copies of the attestation statement (Exhibit 177):
    - This will serve as the Medicare FQHC agreement when signed by the Regional Office (RO)
  - CMS-588 Electronic Funds Transfer (EFT) authorization Agreement
  - Clinical Laboratory Improvement Amendments (CLIA) certificate
  - State license (if applicable)
  - A copy of the National Provider Identifier (NPI) notification the applicant received from the National Plan and Provider Enumeration System (NPPES)
FQHC Covered Services

- Covered Services are the professional services of a physician, Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNW), visiting nurse, Clinical Psychologist (CP), Clinical Social Worker (CSW), Registered Dietitian (RD)/medical nutrition professional, and services and supplies rendered incident to these services (e.g., therapeutic injections):
  - Services of a visiting nurse are only covered for FQHCs located in areas where CMS has determined that there is a shortage of Home Health agencies available to provide services in the home.
Requirements for FQHC PPS

- Must establish a payment rate that accounts for the type, intensity, and duration of services furnished by FQHCs
- May include adjustments such as a geographic adjustment
- Medicare payment for FQHC services must be 80 percent of the lesser of the actual charge or the PPS amount
- Must include a process for appropriately describing services and establish payment rates for specific payment codes
- Initial PPS rate must equal in the aggregate 100% of the estimated amount of reasonable costs that would have occurred for the year if the PPS had not been implemented, and without the application of copayments, per-visit limits, or productivity adjustments
- After the first year of implementation, the PPS payment rates must be increased by the percentage increase in the MEI
- After the second year of implementation, PPS rates must be increased by either the MEI or a market basket of FQHC goods and services
FQHC Billing Services

- Medically necessary lab and technical components of diagnostic tests such as EKGs and X-rays are considered non-FQHC services and are billed to Novitas on the CMS 1500 using the Part B PTAN of the organization/group/or individual practitioner performing the test.
- Professional component (interpretation of the test) is part of the FQHC encounter.
- Certain screening tests and other preventive services have been added to the Medicare statute by Congress as preventive benefits for all beneficiaries.
- When these are provided at the FQHC, the professional component is included as part of the encounter and the technical component is billed to Novitas in the same way as diagnostic tests.
- Lab and technical components of diagnostic (or screening) tests are billed on the CMS 1500 form.
- Enroll with the Part B MAC that serves your geographic area to get PTANs for the organization/group and individual practitioners who perform these services at the center.
An FQHC encounter is a face-to-face encounter between a physician, Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNW), visiting nurse, Clinical Psychologist (CP), Clinical Social Worker (CSW), Registered Dietitian (RD)/medical nutrition professional during which an FQHC service is furnished.

An encounter with more than one health professional or multiple encounters with the same health professional, which take place on the same day and at a single location, constitute a single encounter.

FQHCs bill with Revenue Codes on the UB-04 or electronic equivalent.

All charges submitted by an FQHC will be on TOB 77X:
- 3rd digit of the TOB is the bill frequency and shows the nature or intent of the bill submitted.
FQHC PPS Reimbursement
Update to the FQHC PPS Recurring File Updates

- Change Request #9348:
  - Effective October 9, 2015
  - Implementation January 1, 2016

- Key Points:
  - 2015 Base rate $158.85
  - 2016 Base rate $160.60
  - CY 2016 base payment rate reflects a 1.1 percent increase above the CY 2015 base payment rate of $158.85.
  - Updated Annually

- Reference:
Calculated by adapting the work and practice expense indices used in the physician fee schedule for the period in which the services are furnished

Adjusted PPS Rate Calculation:
- Multiply the base rate times the FQHC GAF
- [https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html](https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html)

New patient:
- One who has not received any professional medical or mental health services from any site or from any practitioner within the FQHC organization within the past 3 years from the date of service

Payment adjustments:
- New patients, AWV and IPPE:
  - Payment rate will be increased by 1.3416% for new patients, IPPE, initial and subsequent AWVs
## G Codes

- Five G codes for billing FQHC services

<table>
<thead>
<tr>
<th>G Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0466</td>
<td>FQHC visit, new patient</td>
</tr>
<tr>
<td>G0467</td>
<td>FQHC visit, established patient</td>
</tr>
<tr>
<td>G0468</td>
<td>FQHC visit, IPPE or AWV</td>
</tr>
<tr>
<td>G0469</td>
<td>FQHC visit, mental health, new patient</td>
</tr>
<tr>
<td>G0470</td>
<td>FQHC visit, mental health, established patient</td>
</tr>
</tbody>
</table>
FQHC G Code Billing

- Claim (77X TOB) must contain a FQHC specific payment code (G0466, G0467, G0468, G0469, G0470)
- G0466, G0467, G0468 must be reported under Revenue Code 052X or 0519
- G0469 and G0470 must be reported under Revenue Code 0900 or 0519
- FQHCs must continue to report detailed HCPCS coding on the claim to describe all services during the encounter
Multiple Same Day Visits

- All services rendered on the same day must be submitted on one claim or the claim will be rejected.
- Allows for additional payment when an illness or injury occurs subsequent to the initial visit (modifier 59), or when a mental health visit (G0470) is furnished on the same day as a medical visit.
FQHC Mental Health Visits

- 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, 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.

- Revenue Code 090X:
  - Therapeutic Psychiatric or Psychological services subject to Medicare outpatient mental health treatment limitation
  - Used for services of Clinical Psychologist (CP) and Clinical Social Worker (CSW) mental health professionals and other professional staff providing psychiatric therapy services

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Coinsurance

- Coinsurance:
  - 20% of the lesser of the actual charge or the PPS rate
  - None for preventive services for which coinsurance is waived
  - For claims with a mix of preventive and non-preventive services, coinsurance will be 20% of the full payment amount after the dollar value of the preventive service charges are subtracted
 Coinsurance Waived/Bad Debt

- FQHCs can waive collection of all or part of the coinsurance for FQHC services, depending upon the beneficiary’s ability to pay.
- FQHCs may claim the waived portion as bad debt on its cost report.
- If the beneficiary is assessed as able to pay all or a portion of the coinsurance and fails to pay, the FQHC may claim this amount as bad debt only after following the usual reasonable efforts to collect the amount.
FQHC Billing
Timely Filing

- Patient Protection and Affordable Care Act, amended the time period for filing Medicare fee-for-service claims
- Claims for service, must be filed within one calendar year of the date of service
- Institutional claims with span dates of service:
  - “Through” date on the claim is used to determine timely filing
Medical Visits Billed with Preventive Services

- FQHC services also include preventive primary health services that an FQHC is required to provide, as listed in Section 330 of the Public Health Services Act, unless excluded by law:

- FQHC Billing Guide explains new billing requirements for HCPCS coding with revenue codes:
  - Applies to ALL services furnished during the FQHC encounter

- Preventive services no longer subject to coinsurance must be separately identified on the claim so these charges will not be rolled into those for the rest of the visit for coinsurance calculation

- 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
FQHC Billing Guidelines

- Split billing is required for FQHCs
- Claims cannot overlap calendar years
- “From” and “through” dates of the claim must always be in the same calendar year
- Line items on outpatient claims under HIPAA require reporting of a line-item service date for each revenue code
- A single date should be reported on a line item for the date the service was provided, not a range of dates
- For services that do not qualify as a billable visit, the usual charges for the services are added to those of the appropriate (generally previous) visit
- FQHCs use the date of the visit as the single date on the line item
## Revenue Code Billing

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>0519</td>
<td>Supplemental payment for visit in a contracted MA plan</td>
</tr>
<tr>
<td>0521</td>
<td>Clinic visit</td>
</tr>
<tr>
<td>0522</td>
<td>Home visit</td>
</tr>
<tr>
<td>0524</td>
<td>Visit to patient in SNF/swing bed covered Part A stay</td>
</tr>
<tr>
<td>0525</td>
<td>Visit to patient in SNF/swing bed non-Part A covered stay</td>
</tr>
<tr>
<td>0527</td>
<td>Visiting nurse service to members home when in a HH shortage area</td>
</tr>
<tr>
<td>0528</td>
<td>Visit to other non-FQHC site (e.g., scene of accident)</td>
</tr>
<tr>
<td>0780</td>
<td>Telehealth originating site facility fee</td>
</tr>
<tr>
<td>0900</td>
<td>Behavioral health treatment services</td>
</tr>
</tbody>
</table>
Qualifying Visit Codes

- Qualifying visit:
  - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf)

- FQHC claim must contain qualifying visit code in conjunction with G-payment code

- Qualifying visit codes do not receive reimbursement
Credit Balance Reports
What is a Medicare Credit Balance?

- Overpayments for Medicare services
- Duplicate payments
- Payment received for services not performed
- Payment received for non-covered services
- Payment received for outpatient services that should have been bundled to inpatient
- Overpayment due to deductible or coinsurance miscalculations
- Provider determines a credit is due to Medicare for an overpayment
- Medicare credit balances include money due to the Medicare program regardless of its classification in a provider’s accounting records
- Only the credit balances still outstanding as of the last day of the quarter should be reported on the Medicare Credit Balance Report
Faxing

- Preferred method of submission
- Fax all Medicare Credit Balance Reports and certification pages
- Medicare Credit Balance Report Fax Number:
  - Fax Number: 410-891-5230
  - Attention: Credit Balance
Suspension of Payment

- If your Medicare Credit Balance Report is not postmarked by the 30th day of the month following the quarter:
  - A suspension warning letter is sent
  - Intent of the letter is to inform providers of 100% suspension of payment will be initiated on the 16th day from the date of the demand letter:
    - Possible interest assessment
- Suspension will remain at 100% until the Medicare Credit Balance Report or certification page is received
Important Medicare Credit Balance Report Dates

- Due each quarter ending
- Medicare Credit Balance Report must be submitted within 30 days after the close of each calendar quarter
<table>
<thead>
<tr>
<th>Quarter End</th>
<th>Medicare Credit Balance Report Due</th>
<th>Warning Letter Mailed</th>
<th>Placed on 100% Payment Withhold</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31</td>
<td>April 30</td>
<td>May 15</td>
<td>June 03</td>
</tr>
<tr>
<td>June 30</td>
<td>July 30</td>
<td>August 15</td>
<td>September 03</td>
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<tr>
<td>September 30</td>
<td>October 30</td>
<td>November 15</td>
<td>December 03</td>
</tr>
<tr>
<td>December 31</td>
<td>January 30</td>
<td>February 15</td>
<td>March 03</td>
</tr>
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</table>
How to Locate the CMS-838 Form

- Go to the JH Home Page:

- Click on the Forms Center:
  - In the Forms Catalog, you will find the Financial & Overpayment/Refund Forms section
  - Scroll down to the form “Medicare Credit Balance Certification (CMS-838)”
  - Click on the link to open the CMS-838 Form:
Check the status of your quarterly reports by using the Medicare Credit Balance Status Tool:

- Allow 2 – 3 days for zero balance certifications
- Allow up to 2 weeks for credit balance to be added:

Tips When Filing Quarterly Medicare Credit Balance Reports:


Check the Frequently Asked Questions (FAQs):

Credit Balance Podcast:

- An informative interview on the Medicare Credit Balance Report
- Includes a tutorial on Medicare Credit Balance Reporting:
Cost Reports
FQHC Cost Reports

- FQHCs are required to file a cost report annually and are paid for the costs of Graduate Medical Education (GME), bad debt, and influenza and pneumococcal vaccines and their administration through the cost report.
- FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors.
- FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.80 for unpaid coinsurance if they can establish that reasonable efforts were made to collect these amounts:
  - Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed.
For cost reporting periods beginning on and after October 1, 2014, freestanding FQHCs, as well as those FQHCs that previously reported as part of a skilled nursing facility or home health agency must use the new form CMS-224-14:

- The instructions for form CMS-224-14 are found in Chapter 44 of the Provider Reimbursement Manual - Part 2:
Medicare Updates
FQHC Updates

- **Change Request # 9442:**
  - Effective: February 1, 2016
  - Implementation: February 1, 2016

- **Key Points:**
  - New information:
    - Overview of requirements for payment of chronic care management in FQHC
    - Lung cancer screening using low-dose computed tomography coverage requirements
  - Clarifying Information:
    - Use of Modifier 59
    - Payment for procedures
    - Description of ambulance services that are non-covered
    - Description of group services that are non-covered
    - Information on payment codes for FQHCs
    - Cost reporting requirements
    - Billable visits by dentists, podiatrist, optometrists, and chiropractors
    - Description of mental health visits, billing for mental health visits, and payment for medication management
    - Hepatitis C screening in FQHCs

- **References:**
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf)
Reorganization of Chapter 9

- Change Request # 9397:
  - Effective: March 31, 2016
  - Implementation: March 31, 2016

- Key Points:
  - Chapter 9 of the Medicare Claims Processing Manual, Rural Health Clinics and Federally Qualified Health Centers, is being revised to include more comprehensive billing information
  - No new policies are being added

- Reference:
Chronic Care Management (CCM) Services for FQHCs

- Change Request # 9234:
  - Effective: January 1, 2016
  - Implementation: January 4, 2016
- Key Points:
  - FQHCs may receive an additional payment for the costs of CCM services that are not already captured in the FQHC PPS for CCM services to Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months (or until the death of the patient), and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - CCM payment will be based on the Medicare PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a FQHC claim
- Reference:
Medicare Billing Information For Rural Providers and Suppliers

References

- CMS Fact Sheet:

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

- FQHC PPS Page:
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html)

- CMS IOM Publication:
  - 100-02 Benefit Policy Manual Chapter 13:
  - 100-04 Claims Processing Manual Chapter 9:
Self-Service Options
Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Customer Contact Center- 1-855-252-8782
- Provider Teletypewriter- 1-855-498-2447
- Self-Service Tools:
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
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    ➢ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00082787
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