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Navigating Medicare Compliance for Federally Qualified Health Centers

Part A Fall 2024 Virtual Conference:

Keeping Compliant with Medicare Starts With You

November 12th, 14th, and 19th

11/19/2024

NGSMU
NGS Medicare University

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Objective

To provide a look at compliance rules and regulations that Federally Qualified Health Centers (FQHC) must follow under Medicare.

Today's Presenter

- Provider Outreach and Education Consultant
  - Mimi Vier

Agenda

- FQHC Program Basics
- FQHC PPS Billing and Reimbursement
- FQHC PPS Reimbursement
- Other FQHC Services
- Intensive Outpatient Program
- Billing and Payment for Preventive Services
- Avoid Common Errors
- References and Resources
- Questions & Answers

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FQHC Program Basics

Who's Your A/B MAC?

- National Government Services (NGS)
  - NGS serves FQHCs in 44 states
    - J6: IL, MN, and WI and 34 states and five U.S. Territories and DC
    - JK: CT, ME, MA, NH, NY, RI, and VT
- FQHCs located in other states
  - New FQHCs will be under the A/B MAC assigned to their state
  - Out of jurisdiction providers (OJP) may have NGS as their A/B MAC for FQHC claims but another MAC that processes Part B claims (CMS 1500 form)
    - Billed through WI region
- Check Provider Enrollment Chain Ownership System (PECOS)

FQHC Encounters

Encounters Defined

Medically necessary, face-to-face interaction between patient and core practitioner during which FQHC covered service is performed

FQHC Reimbursement per Day

Encounters with more than one health professional on same day = one encounter

FQHC Core Practitioner

Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), Clinical Psychologist (CP), Clinical Social Worker (CSW), Marriage and Family Counselors (MFT), Mental Health Counselors (MHC)

FQHC Encounters

- Exceptions to one FQHC PPS payment per day
  - After initial encounter patient suffers an illness or injury requiring additional diagnosis or treatment
    - Two FQHC PPS payments may be made
  - Patient receives a medical encounter and a mental health encounter on same day
    - Two FQHC PPS payments may be made

Visiting Nurse

- Skilled nursing services may be covered if all criteria met:
  - Patient is homebound
  - FQHC located in home health shortage area
  - Services provided under plan of treatment by NP, PA, CNM, CP, CSW
  - Furnished on intermittent basis

Non-FQHC Services

- Medicare exclusions
- Group information/education/medical activities
- Services covered under Part B that are not FQHC services
  - EKG/EEG/ECG services (technical component)
  - Laboratory Services
  - DME
  - Ambulance services
  - Prosthetic devices
  - Body braces
  - Technical components of diagnostic tests

Non-FQHC Services cont.

- Technical component of preventive services
  - Screening pap smears and screening pelvic exams
  - Prostate cancer screening
  - Colorectal cancer screening tests
  - Screening mammography
  - Bone mass measurements
  - Glaucoma screening

FQHC PPS Billing and Reimbursement

FQHC Billing

- Bill Types (77X)
  - 770 = nonpayment/zero claim
  - 771 = admit through discharge
  - 777 = claim adjustment
  - 778 = claim cancel
- DOS
  - Cannot overlap calendar years
    - Billing periods that overlap calendar years should be split into two claims

FQHC Revenue Codes

Revenue code	Description
0519	Supplemental MAO Payment
0521	Clinic encounter
0522	Home encounter
0524	Encounter for beneficiary in covered Part A SNF stay
0525	Encounter for beneficiary in noncovered Part A stay (or other residential facility)
0527	Visiting nurse service at beneficiary's home when in home health shortage area
0528	Encounter at other non-FQHC site (scene of accident)
0900	Mental health services provided by CP, CSW

Reporting Incident-To Services

- Report all services provided during encounter
- All valid revenue codes may be used except:

Revenue Code	Revenue Code
002x-024x	065x
029x	067x-072x
045x	080x-088x
054x	093x
056x	096x-310x
060x	

FQHC Payment Codes

- Identify each billable encounter using appropriate FQHC G-code
  - G0466 – medical encounter, new patient
  - G0467 – medical encounter, established patient
  - G0468 – IPPE or AWV
  - G0469 – mental health encounter, new patient
  - G0470 – mental health encounter, established patient
- Report with billable encounter revenue code
  - 052X (medical encounter)
  - 0900 (mental health encounter)
  - 0519 (supplemental MAO payment)

Report Charges

- Set your charge for each payment code (G code)
  - Identify typical bundle of services furnished during encounter
  - Determine normal charges for those services
  - Sum of normal charges = facility charge for payment code
  - Reported in TOTAL CHARGE field of payment code line
  - Charges must be same for all patients

Billable Encounter

- Line one represents billable encounter
  - Billable encounter revenue code
    - 052X (medical encounter)
    - 0900 (mental health encounter)
  - Payment code in HCPCS field
    - G0466
    - G0467
    - G0468
    - G0469
    - G0470
  - One (1) unit
  - Payment code charge

Qualifying Visit

- Qualifying visit is reported on line two
  - Same billable encounter revenue code
  - Qualifying visit HCPCS code in HCPCS field
  - One (1) unit
  - Charges

Subsequent Claim Lines

- Incident-to services
  - Appropriate revenue code for the HCPCS code
  - Appropriate CPT/HCPCS code in the HCPCS code field
  - One (1) unit
  - Charges
  - Revenue code 001 = Total of all charges on claim (ensure calculated properly)

FQHC PPS Reimbursement

FQHC PPS Reimbursement

- Based on lesser of
  - FQHC's charge for billed payment code, or
  - Adjusted PPS rate
    - PPS base rate for 01/01/2024 through 12/31/2024 = $195.99, subject to
      - GAF adjustment
      - New patient/IPPE/AWV adjustment
      - Annual increase
- Medicare reimbursement = lesser amount x 80%
- Part B coinsurance = lesser amount x 20%
  - Coinsurance waived for certain preventive services

Calculating Adjusted FQHC PPS Rates

- Apply GAF adjustment
  - Multiply PPS base rate ($195.99) by GAF
- Example: Wisconsin FQHC GAF adjustment
  - PPS base rate $195.99 x .939 (WI GAF) = $184.03

Calculating Other Payment Adjustments

- New Patient
- IPPE
- AWV (Initial or subsequent)
- Multiply GAF-adjusted PPS base rate by 1.3416 (34%)
  - Accounts for greater intensity and resource use
- Example: Wisconsin FQHC New Patient/IPPE/AWV adjustment
  - Wisconsin GAF-adjusted rate $184.03 x 1.3416 (new patient adjustment) = $246.90

Definition of New Patient

- Beneficiary who
  - Has not received any professional medical or mental health services from any site or from any practitioner within FQHC organization within three years prior to DOS
  - Changes FQHC facilities
  - Transfers to new FQHC facility with practitioner

Multiple Encounters on Same DOS

- May only be reported under these scenarios
  - Medical encounter and mental health encounter on same day
  - Patient suffers illness/injury that requires additional diagnosis/treatment on same day
- Report medical encounter on same DOS as IPPE/AWV as incident-to IPPE/AWV

Reporting Multiple Billable Encounters on Same DOS

- Patient has medical and mental health encounter on same DOS
  - Report second encounter on additional claim lines
    - Payment code line
    - Corresponding qualifying visit HCPCS code line
- Patient has two medical encounters on same DOS
  - Report second encounter on additional claim lines
    - Payment code line with modifier 59
    - Corresponding qualifying visit HCPCS code lines

Other FQHC Services

Diabetes Self Management Training (DSMT)

- G0108 (Qualifying visit)
- One-on-one/face-to-face encounter
- All program requirements met and accredited
- Diabetes counseling or medical nutrition services provided by registered dietician may be considered as incident-to visit with FQHC practitioner
- Conducted by certified DSMT practitioner
- Coinsurance applied
- Not separately paid if provided on same day as another medical visit

Medical Nutrition Therapy (MNT)

- 97802/97803 (Qualifying visit)
- One-on-one/face-to-face encounter
- All program requirements met
- Diabetes counseling or medical nutrition services provided by registered dietician may be considered as incident-to visit with FQHC practitioner
- Provided by registered dietician or nutrition professional
- Not separately paid if provided on same day as another medical visit
- Coinsurance waived

Care Management Services (G0511)

- Billed alone or with other payable services
- 20% coinsurance based on lesser of charges or G0511 rate

General Care Management Services	HCPCS/ CPT Codes
Chronic Care Management (CCM)	99487, 99490, 99491
Principal Care Management (PCM)	99424, 99426
Chronic Pain Management (CPM)	G3002
General Behavioral Health Integration (BHI)	99484
Remote Psychologic Monitoring (RPM)	99453, 99454, 99457, 99091
Remote Therapeutic Monitoring (RTM)	98975, 98976, 98977, 98980
Community Health Integration (CHI)	G0019
Principal Illness Navigation (PIN)	G0023
PIN-Peer Support	G0140

Transitional Care Management (TCM)

- Services required following discharge from inpatient hospital setting
  - 30-day period beginning date of discharge
- Physician/NPP accepts care of beneficiary post-discharge from facility setting without gap
  - Takes responsibility for beneficiary's care
- Medical/psychosocial issues require moderate-high/complexity medical decision making

TCM Guidelines

- One TCM visit covered per beneficiary per post-discharge period
- Services provided not in post-op global period
- Only one health care professional may report TCM services
- If occurs same day as another billable visit, generally only one visit billed
  - As of 1/1/2022 bill TCM and general care management services for same patient during same time period
- Subject to Part B coinsurance

Billing for TCM Services

- DOS = day face-to-face visit takes place
- Revenue code = 0521
- Qualifying visit HCPCS codes
  - 99495 for moderate-complexity decision making
  - 99496 for high-complexity decision making
- One (1) unit
- Total charges
- 0001 total charges

Principal Care Management (PCM) Services

- PCM services describe comprehensive care management services of single high-risk disease or complex condition
  - Bill G0511 (general care management) either alone or other payable services
  - Payment rate includes PCM HCPCS G2064 and G2065
    - Change Request 12252: *Updates to Medicare Benefit Policy Manual for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services*
    - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 230.2

Psychiatric Collaborative Care Model (CoCM)

- HCPCS G0512
- Can only bill once per month per beneficiary
  - Do not bill if other care management services billed for same time period by any other practitioner or facility
- 70 minutes of psychiatric CoCM in first calendar month
- 60 minutes in subsequent calendar months
- Bill alone or on qualifying visit claim
- Coinsurance and deductible applied

Telehealth

- CY 2024 PFS Final Rule List of Medicare Telehealth
- FQHC is originating site (where beneficiary located)
  - Service billed separately, no other visit reported
  - Subject to Part B deductible and coinsurance
- FQHC not authorized to serve as distant site (where provider located, including their home)
  - Exception
    - Distant site telehealth services may be furnished by FQHCs through December 2024

Telehealth Billing – Originating Site

- Revenue Code 0780
- HCPCS Q3014
- Subject to Part B deductible
- FQHC G-code not required
- Qualifying visit HCPCS code not required

Telehealth: Mental Health via Telecommunications

- Mental health visits using interactive, real-time telecommunications technology
  - Report and receive payment in same way as in-person, including audio-only visits
- MLN® Matters: *SE22001: Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers*
  - In-person mental health service furnished within six months prior
  - Without use of telecommunication at least every 12 months

Telehealth: Mental Health Example

- Revenue Code 0900
- HCPCS G0469 or G0470 with modifier
  - 95 – audio-video
  - FQ or 93 – audio only
- FQHC qualifying mental health visit code

Virtual Communication Services

- At least five minutes of communication technology-based or remote evaluation services
- Patient had at least one face-to-face billable visit within previous year
- Medical discussion or remote evaluation must meet both of following requirements
  - Condition not related to FQHC service provided within last seven days
  - Does not lead to FQHC visit within next 24 hours or soonest available appointment

Virtual Communication Services

- Can be billed alone or with other payable services
- Submit claim with HCPCS G0071
- FQHC face-to-face requirement waived
- Medicare coinsurance and deductible apply
- Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions

Intensive Outpatient Program

FQHC: IOP Scope of Benefits

- Individual and group therapy
  - Physicians, psychologists or other mental health professionals authorized under state law
- Occupational therapy
  - Qualified occupational therapist or under supervision of occupational therapist by occupational therapy assistant
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients
- Drugs and biologicals for therapeutic purposes (not self-administered)

FQHC: IOP Scope of Benefits cont.

- Individualized activity therapies
  - Not primarily recreational or diversionary
- Family counseling
  - Primary purpose is treatment of patient's condition
- Patient training and education
  - Activities are closely and clearly related to the patient's care and treatment
- Diagnostic services
- Certain IOP services are **not** payable as FQHC services
  - Example: Group therapy is an IOP covered service but not covered when billed by FQHC

FQHC: List of HCPCS/CPT codes for IOP

- At least one IOP service from List A Primary Services must be included on claim for payment
  - Refer to Change Request 13264, Attachment A "IOP Codes and Services" for HCPCS/CPT codes and short descriptors
    - List A Primary Services
    - List B Services
  - At least one IOP primary service (List A) must be billed
  - Services on List B are bundled into payment for primary service

IOP Certification

- Physician certification and plan of care required
  - Physician certifies need for IOP for a minimum of nine hours per week of therapeutic services as evidenced in plan of care
  - Certification must include documentation that individual requires services for a minimum of nine hours per week
  - Recertification must occur no less frequently than every other month

FQHC IOP Billing

- FQHC must report:
  - Condition code 92 for IOP services
  - Revenue code 0905
  - At least one primary IOP service per day (List A Primary Service)
  - Charges on primary service line for all IOP services furnished that day
- FQHC payment code and qualifying visit code **not** required for IOP

FQHC: Multiple Visits on Same Day

- IOP services furnished on same day as mental health visit
  - FQHC receives **one** payment at IOP rate
    - Mental health visit is included in IOP payment
- IOP services furnished on same day as medical visit
  - FQHC receives **two** payments
    - One payment for the medical visit under FQHC PPS
    - One payment for IOP services at IOP rate
- Note:
  - Bill IOP services with revenue code 0905
  - Do not report IOP services with revenue code 0900

FQHC Payment for IOP

- Based on the lesser of actual charges or three-services per day payment amount
  - Paid at same rate as if provided by hospital
    - Per diem is $259.13
  - FQHC coinsurance is based on IOP rate or the submitted charges

Billing & Payment for Preventive Services

Billing Preventive Services

- If preventive service is only service provided, bill encounter
  - Payment code (G code) and charge,
  - Billable encounter revenue code (52X)
  - Qualifying visit HCPCS code with preventive service charge
- If performed on same day as billable encounter, report as incident-to services
  - Report preventive service on separate line
    - Appropriate revenue code (not 52X), HCPCS code and associated charges

Payment for Preventive Services

- If only service provided is preventive service - exempt from coinsurance, reimbursement lesser of facility payment code charge or adjusted PPS rate
  - Medicare payment = 100%
  - Part B coinsurance = 0%
- Coinsurance waived for most preventive services
  - Prostate cancer screening, colorectal cancer screening, and DSMT are subject to 20% beneficiary coinsurance

Payment for Preventive Services

- Reimbursement for preventive service exempt from coinsurance and reported as incident to billable encounter
  - 100% total line-item charges for preventive services and
  - Lesser of FQHC payment code charge or adjusted PPS rate
    - Minus total line-item charges for preventive services
      - Medicare payment = 80%
      - Part B coinsurance = 20%
  - Coinsurance will not apply to preventive service charge

Vaccines

- Influenza, Pneumococcal, COVID-19
  - If only service provided, do not submit claim
    - Cost of vaccine and administration reported on cost report
  - If performed on same day as billable encounter, report as incident-to services
    - Report A6 Condition Code (100% reimbursement)
    - Coinsurance/deductible waived
    - Report on the cost report
- Hepatitis B vaccination
  - If provided with qualified visit, report as incident-to service
    - Coinsurance applicable
    - Payment included in qualified visit

Avoid Common Errors

Top Return (RTP) Reason Codes

Reason Code	Description
31836	HCPC on the revenue code line has a status code of 'M', but the TOB is not equal to 85X or the TOB is 85X but the revenue code is not equal to 96X, 97X, or 98X.
34963	Attending Physician on Claim Page 05 is invalid or not present in the PECOS Enrolled Physicians file,
37098	FQHC PPS supplemental rate is not present for the Medicare Advantage plan.
W7088	FQHC PPS TOB 77X is submitted and at least one of the Specific Payment Codes G0466 – G0470 is not present
32243	Line level error due to one or more revenue code lines billed with total charges that are either blank or zero

RTP Reason Codes 31836 and 34963

- 31836
  - When billing revenue code 0521 for FQHC medical services, report the FQHC G-code and Qualifying visit
  - Incident-to services should be reported under appropriate revenue code (not 0521)
  - Claims receiving this reason code contained multiple lines with revenue code 0521 and HCPCS codes other than FQHC G-code and/or qualifying visit
- 34963
  - Verify Attending Physician reported on the claim is valid
  - Check PECOS Enrolled Physician File

How to Determine if the Provider is Active and Get the Provider Enrolled in Medicare Part B

RTP Reason Codes 37098, W7088 and 32243

- 37098
  - FQHC is only eligible to receive MAO Supplemental payment after submitting copies of contracts for each MA plan
  - Revenue Code 0519
    - FQHC G-code
    - Qualifying visit

Billing for FQHC MAO Plan Supplemental Payment (PPS Providers)

- W7088
  - FQHC PPS claims must contain FQHC payment specific code (G0466-G0470)
- 32243
  - Include charges for each claim line

Top Reject Reason Codes

Reason Code	Description
U5233	Services on this claim fall within or overlap an MA HMO enrollment period.
38312	FQHC claim contains a LIDOS that matches another LIDOS on a previously submitted claim for the same beneficiary, same PTAN, and same LIDOS.
U5210	Services were provided prior to the beneficiary's Medicare Part A or Part B entitlement date
U5200	CMS records indicate the beneficiary is not entitled to Medicare coverage for the type of services billed on the claim
34538	Claim was submitted as Medicare primary but an open MSP Working Aged record (VC = 12; Payer Code = A) is in CWF and the claim did not contain the reason Medicare is primary (such as a retirement date).

Reject Reason Codes U5233, 38312, U5210

- U5233
  - Verify from/thru date on claim and compare dates to MAO/HMO entitlement dates
  - Submit claim directly to MAO/HMO
  - Verify MAO/HMO enrollment in CWF, IVR or NGSConnex
- 38312
  - Ensure all charges are submitted on a single claim for same DOS and beneficiary
- U5210
  - Verify beneficiary eligibility to Medicare dates fall within DOS of claim

Reject Reason Code U5200 and 34538

- U5200
  - Verify eligibility ensuring DOS fall within Medicare entitlement period
  - Use FISS DDE or NGSConnex to verify eligibility
  - Beneficiary must have Medicare Part B benefits for FQHC PPS payment
- 34538
  - Submit claim to EGHP if MSP record correct
  - Rebill as MSP claim as adjustment claim (XX7 TOB) once payment is received from primary insurer
  - If MSP record is incorrect, rebill claim as Medicare primary reporting the appropriate OC with retirement date
  - See Medicare Secondary Payer resources on our website

Top Denial Reason Codes

Reason Code	Description
W7010	Provider determined that the billed services are noncovered or excluded; thus, this claim was submitted with condition code 21 to obtain a Medicare denial. The services on this “no-pay” claim may now be submitted to another insurer.
5WEXC	Claim does not qualify for Medicare payment due to the principal diagnosis code supplied.
56900	Claim is denied for payment because the provider failed to submit documentation requested by the MAC via an ADR within 45 days of the ADR date.

Denial Reason Codes W7010, 5WEXC, and 56900

- W7010
  - Claim submitted for insurance denial to bill secondary insurer
  - Denial was received as requested when billing CC 21
- 5WEXC
  - If additional medical circumstance exists or more specific diagnosis code, indicate appropriate diagnosis(s) on appeal
- 56900
  - Additional Documentation Request (ADR), when requested, due to NGS within 45 days
  - Access claims in status locations SB6001, SB6098, or SB6099 to obtain list records not received by MAC

Reference and Resources

CMS References and Resources

- Federally Qualified Health Centers (FQHC) Center
  - FQHC GAFs 1/1/24-12/31/24
  - CY 2024 Payment Rates Update to the FQHC PPS
  - FQHC PPS Payment Specific Codes
  - FQHC PPS Frequently Asked Questions
  - FQHC Preventive Services
- MLN® Booklet: *Federally Qualified Health Center* (MLN006397)
- CMS IOMs
  - Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
  - Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers

CMS References and Resources

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19
- List Telehealth Services
- MLN® Matters: *SE22001: Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers*
- MLN® Booklet: *Chronic Care Management Services* (MLN 909188)
- Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Frequently Asked Questions November 2022

CMS References and Resources

- MLN® Matters: *MM13264 - Billing Requirements for Intensive Outpatient Program Services for Federally Qualified Health Centers & Rural Health Clinics*
- MLN® Matters: *MM13496 - Billing Requirements for Intensive Outpatient Program Services with New Condition Code 92*
- Change Request: *13493 - Rural Health (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update*

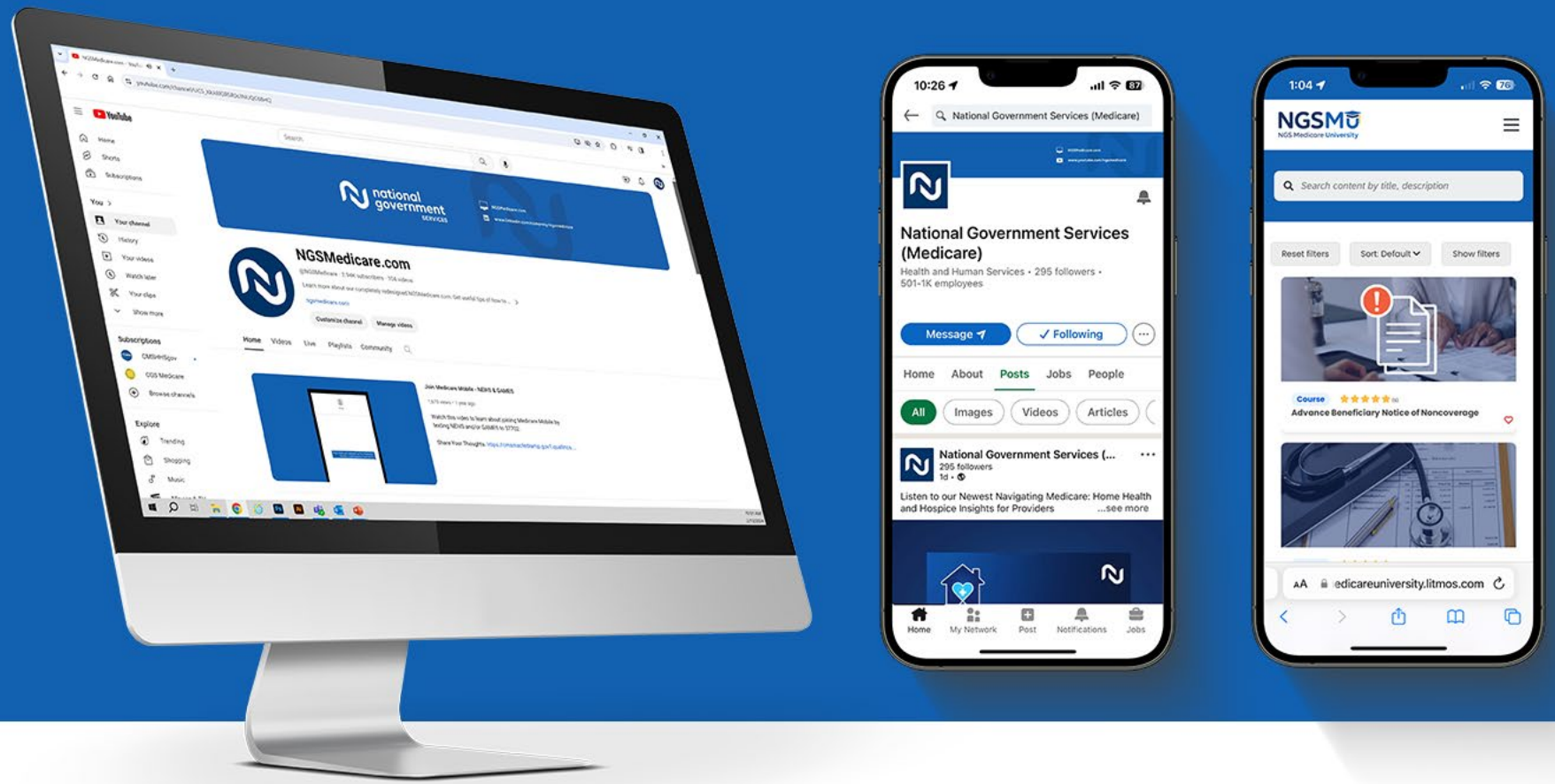
NGS Resources

- Top Claim Errors Lookup
- Billing for FQHC MAO Plan Supplemental Payment (PPS Providers)
- Medicare Secondary Payer
- How to Determine if the Provider is Active and Get the Provider Enrolled in Medicare Part B
- How to Determine if the Provider is Active and Get the Provider Enrolled in Medicare Part B

Tool: NGS FQHC PPS Calculator

- Visit our website > Resources > Fee Schedules and Pricers > FQHC PPS Calculator

FQHC PPS Calculator: January 1, 2024 through December 31, 2024			
***Complete all fields in yellow and that are immediately to the right of **.**			
***Do not change fields with dark borders in grey.**			
	1. Enter Provider Number:		
**			
	(This information is informational on the calculator and will not affect the calculation of the rate.)		
	FQHC Base Rate	$ 195.99	Per Final CR 13398 Issued 11/16/2023
	2. Select the applicable provider location. This will return the appropriate Geographic Adjustment Factor (GAF)?		
**	WISCONSIN		
	(The GAF is used to determine how the base rate is adjusted due to the geographic location of the facility. This can also be found on Page 40 of the claim record as well.)		
	PPS Rate		
	3. Is provider is eligible for a payment adjustment related to a new patient, an initial preventive physical examination (IPPE), or an annual wellness visit (AWV)?		
**	Yes	1.3416	
	(FQHCs will get a payment adjustment for claims where the patient is new to the FQHC, or if the FQHC is furnishing an IPPE, an initial AWV, or a subsequent AWV. This adjustment is calculated by mutliplying the GAF-adjusted PPS rate by 1.3416.)		
	Calculated PPS Rate		
	4. Enter the actual charges that are associated with the payment ("G") codes listed on the "Payment Adjustment" tab.		
**			
	FQHC Reimbursement*		
	(prior to Sequestration and Coinsurance)		
	*The FQHC Reimbursement is the amount of the rate that is paid to the provider prior to any coinsurance or sequestration adjustments.		



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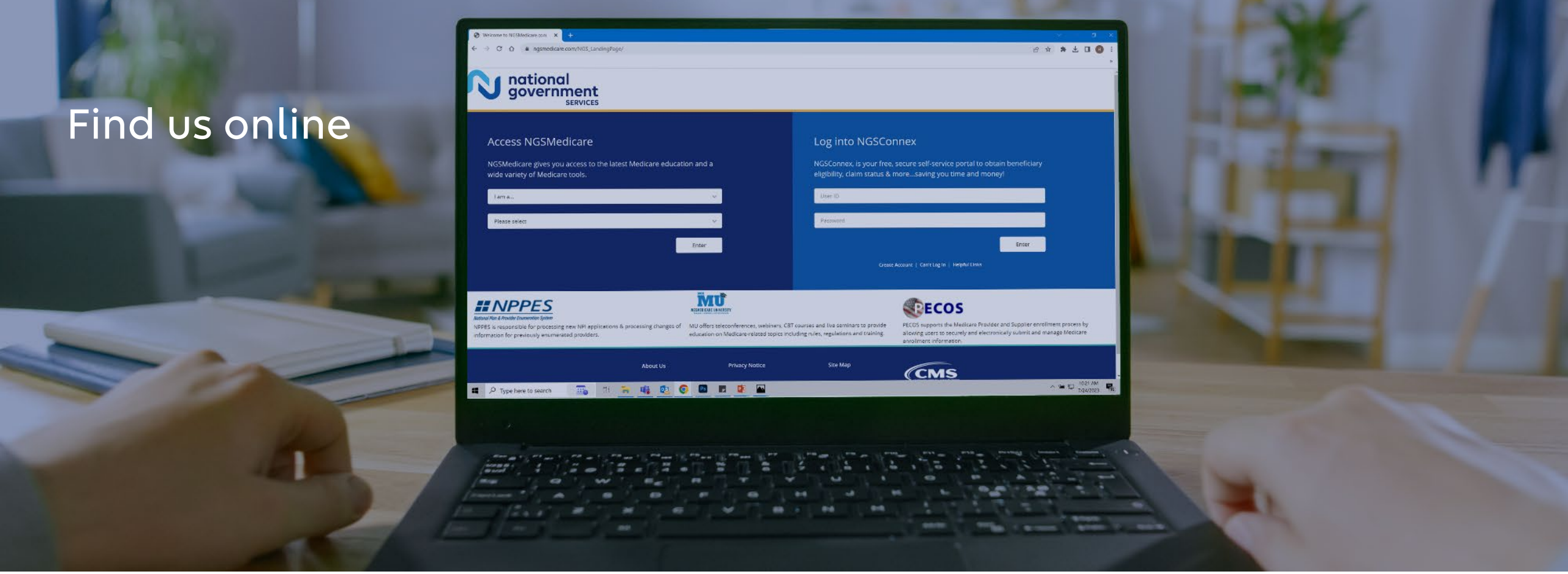

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Questions and Answers

Thank you!