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3/15/2023 J6 & JK Part A Ask-the-Contractor (ACT) Webinar Summary

Event/Question and Answer Summary

Event Summary

On 3/15/2023, the National Government Services (NGS) J6 and JK Part A Provider Outreach and Education (POE) team conducted the "Ask-the-Contractor" Teleconference (ACT) via webinar for our Part A and Federally Qualified Health Center (FQHC) providers. Please note that we conduct separate ACT calls for our Part B providers as well as for our Home Health and Hospice (HHH) providers. If you are a Part B or HHH provider please check the Events section of our website www.NGSMedicare.com for education and ACT calls specific to your line of business (LOB).

The purpose of the ACT is to provide an opportunity for providers to ask their Medicare Administrative Contractor (MAC) specific questions about Medicare billing, policies, and/or procedures. In addition, it is an opportunity for us to share updates, listen to our provider community, and relay the importance of keeping up to date with guidance from the Centers for Medicare & Medicaid Services (CMS). The target audience for ACTs includes staff members from all provider types working for Medicare Part A or FQHC.

All NGS Part A and FQHC providers may attend this session, as the information and resources available will largely apply to providers in JK and J6. However, HHH providers should attend ACTs that are specific to their line of business (LOB). The ACT serves as a venue for our providers to ask questions and discuss any issues that are of concern to them; therefore, we always encourage providers to presubmit their questions to us by the announced cutoff date prior to the event.

Providers were advised that a summary of the ACT will be posted within 30 business days post-ACT date to the Past Events section of our website.

Question and Answer Summary

Presubmitted Questions

Providers submitted the following questions in advance of the ACT webinar via e-mail. Please note we may have rewritten some questions and answers to ensure clarity.

1. **If a provider submits a question ahead of the ACT, do you still discuss it during the ACT? We find it beneficial to hear other providers' questions. Does the ACT summary include everyone's questions?**

   Answer: We typically provide answers to all presubmitted questions during the ACT and include all questions and answers in the post-event summary.

2. **What is the definition of reasonable cost?**

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Answer: Per the CMS glossary, reasonable cost is based on the actual cost of providing services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the Medicare Program. Also, reasonable cost basis is defined as: The calculation to determine the reasonable cost incurred by individual providers when furnishing covered services to beneficiaries.

42 Code of Federal Regulation (CFR) Chapter IV, section 405.502 describes the criteria for determining reasonable charges and section 413.9 discusses cost related to patient care as well as the amount of payment if customary charges for services furnished are less than reasonable costs. Note that this section also defines reasonable cost as the cost actually incurred, to the extent that cost is necessary for the efficient delivery of the service, and subject to the exclusions specified in paragraph (d) of this section.

3. **When a provider in a Rural Health Clinic (RHC) is reporting transitional care management (TCM), what documentation should be used to support the level of medical decision making (MDM) for the TCM service period? Would the provider's face-to-face (FTF) visit documentation be used to determine the number/complexity of problems addressed, amount/complexity of data reviewed/analyzed, and risk of complications and/or morbidity or mortality associated with patient management? Or would the discharge order be used to determine MDM?**

   Answer: When a patient is discharged from an approved setting, TCM services rendered are documented during the course of the 30-day TCM period. Each visit and service provided should be documented with the date and a summary of services rendered. Be sure to document any unsuccessful contact attempts. Documentation also includes the date the beneficiary was discharged; the date the health care professional providing TCM made an interactive contact as well as the date a FTF visit was furnished and the complexity of MDM.

   TCM services require either moderate MDM or high-level MDM during the 30-day service period to address the patient's medical and psychosocial needs. Thus, the complexity of MDM determines whether the TCM is moderate or high. MDM refers to the complexity of establishing a diagnosis and selecting a management option as measured by: the number of possible diagnoses and the number of management options that must be considered, the amount and complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed, and the risk of significant complications, morbidity, and mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and the possible management options. Thus, although the discharge order is required, it is the level of MDM rendered that determines whether the TCM is moderate or high.

   Pease review additional TCM information on the Part B section of the National Government Services website. Go to the Education tab > Medicare Topics > Evaluation and Management > Transitional Care Management. See the below resource for additional information.

   Resources

   - The Centers for Medicare & Medicaid Services (CMS), MLN Booklet, MLN908628, "Transitional Care Management Services"
   - CMS MLN Booklet, MLN006762, "Rural Providers & Suppliers Billing"

4. **Can you review how to code skilled nursing facility (SNF) claims during a payment ban period for residents who were already in the facility prior to the payment ban but were not necessarily on Medicare prior to the payment ban, especially if the payment ban happened during the last couple of years during which the qualifying hospital stay requirement waiver was in place?**

Answer: Beneficiaries admitted before the effective date of the denial of payment, including beneficiaries taking temporary leave, whether to receive inpatient hospital care, outpatient services or as a therapeutic leave, are not considered to be new admissions, and are not subject to the denial of payment upon return. This policy applies even if there are multiple hospitalizations and returns to the SNF during the period sanctions are in effect.
When determining if the beneficiary was admitted prior to the imposition of the ban, the actual status of the beneficiary rather than the primary payer is the determining factor. Therefore, there may be situations where the beneficiary is a private pay patient or a dual eligible who was receiving Medicaid benefits prior to the imposition of the payment ban. If this private-pay patient or dually-eligible patient goes to the hospital for needed care, and meets the Medicare Part A criteria for SNF coverage upon return to the SNF, the readmission is exempt from the denial of payment sanction.

When billing for a readmission that is **not** subject to the payment ban, providers must enter

- Occurrence span code (OSC) 80: Prior same-SNF stay dates for payment ban purposes, on the claim to identify the prior same-SNF stay dates,
- Condition code (CC) 57: SNF readmission – patient previously received Medicare covered SNF care within 30 days of this readmission
- Any additional OSCs as applicable
- Report any leave of absence (LOA) and prior hospital stay dates, using OSCs, that may affect the MAC's determination of payment ban exemption status

Resources

NGS: Billing Reminder: When a Skilled Nursing Facility Payment Ban is in Effect

CMS Internet-Only Manual (IOM) 100-04, *Medicare Claims Processing Manual,* Chapter 6 -- SNF Inpatient Part A Billing and SNF Consolidated Billing, Section 50.2 - Billing When Ban on Payment Is In Effect

CMS Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19

- FYI: The CMS temporary waiver of the three-day prior hospitalization for coverage of a SNF stay terminates at the end of the COVID-19 public health emergency (PHE)

5. After the PHE ends on 5/11/2023, will hospital outpatient provider based departments (PBDs) providing telehealth services to patients in their home still be able to request designation of the patient's home as an outpatient department of the hospital by sending a letter to the CMS Regional Office?

Answer: The temporary extraordinary circumstances relocation policy established in the 5/8/2020 IFC (85 FR 27567 through 27568) allowed hospital outpatient PBDs to relocate into more than one PBD location, and allowed PBDs to partially relocate while still maintaining the original location. Hospitals can relocate PBDs to the patient's home and continue to receive the full OPPS payment amount under the extraordinary circumstances relocation exception policy.

This temporary extraordinary circumstances relocation policy will end following the end of the COVID-19 PHE.

PBDs that relocated during the COVID-19 PHE should relocate back to their original location. However, if the PBD decides to permanently relocate to that off-campus location then that PBD location is considered a new off-campus PBD and bills with the PN modifier.

Resource
CMS: Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19

6. **If Medicare asks for a refund - what is the best process for refunding the money? Should we send a voided claim?**

Answer: The Overpayments section of our website includes the various options available as well as the forms available. An overpayment may be identified and self-reported by a provider, or it may be discovered by Medicare contractors as part of the claim and reimbursement review process. Note: The key to reporting and repaying overpayments in compliance with Medicare policies is selecting the appropriate form and submitting it to the correct address for processing. There are various options available.

- When Medicare identifies the overpayment: Follow the instructions in the demand letter
- When the provider self-identifies an overpayment: Complete a voluntary refund
- To avoid accruing interest on an overpayment: Request immediate recoupment
- In some situations you may request an extended repayment plan
- In certain circumstances NGS will set up a payment withhold: When a payment withhold occurs, a percentage of payment or set dollar amounts are deducted from the payment to the provider during claim processing. Provider level adjustment reason codes explain the basis for the withholding adjustment

7. **Is a licensed clinical professional counselor (LCPC or licensed professional counselor [LPC]) able to provide FQHC behavioral health services under a supervising licensed clinical social worker (LCSW)?**

Answer: An FQHC visit is a medically necessary medical or mental health visit, or a qualified preventive health visit. The visit is typically a face-to-face (FTF) (one-on-one) encounter between the patient and a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), or a clinical social worker (CSW) during which time one or more FQHC services are rendered. Thus, an FQHC can provide physician services as well as services and supplies provided "incident to" such physician services. In addition, an FQHC can provide NP, PA, CNM, CP and CSW services and supplies provided "incident to" NP, PA, CNM, CP and CSW services.

Medicare does not recognize an LCPC/LPC for the provision of outpatient mental health services. Therefore, an LCPC/LPC cannot bill Medicare for services rendered in an FQHC and does not qualify to provide services "incident to" physician services. Medicare currently recognizes psychiatrists, psychologists, clinical social workers, and psychiatric nurses for outpatient mental health services and does not reimburse professional counselors for behavioral health services.

Resources

- CMS MLN Booklet, MLN006397, "Federally Qualified Health Center"
- CMS MLN Booklet, MLN006762, "Rural Providers & Suppliers Billing"

- Local Coverage Determination, L33632, "Psychiatry and Psychology Services"
- Local Coverage Article, A56937, "Billing and Coding: Psychiatry and Psychology Services"

8. **We are seeing an increase in CO 151 denials on Observation claims due to exceeding the new medically unlikely edit (MUE) limit on the number of units allowed for HCPCS code G0378. Can you please advise how providers should be billing observation when the units of HCPCS code G0378 exceed 72? We have searched the outpatient code editor (OCE) documents, but it fails to guide the proper structure of a bill for this scenario. Note: NGS obtained a claim example from this provider.**

   Answer: The claim example showed 200 hours of observation provided over approximately 12 days that was denied with reason code 54MUE indicating the units of services are in excess of the medically reasonable daily allowable frequency and charges for the denied services cannot be billed to the beneficiary.

   When observation spans more than one calendar day, the provider must include all of the hours for the entire period of observation on a single line and report the date of service (DOS) using the date observation care began. Note: CMS states observation is an outpatient service used while the physician decides whether the patient requires further treatment as an inpatient or is able to be discharged. When you submit a claim for observation hours that exceed the MUE edit, your claim will always receive an MUE edit. Claim lines containing an MUE reason code cannot be processed for payment.

   CMS specifies that in the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. Only in rare and exceptional cases do reasonable and necessary (R&N) outpatient observation services span more than 48 hours. In addition, CMS issued the Two Midnight Rule establishing Medicare payment policy regarding the benchmark criteria to use when determining whether inpatient admission is R&N for purposes of payment under Medicare Part A.

   As a reminder, the Medicare Outpatient Observation Notice (MOON) must be delivered to beneficiaries in original Medicare (fee-for-service) and Medicare Advantage (MA) plan enrollees who receive observation services as outpatients for more than 24 hours. The hospital or Critical access hospital (CAH) must provide the MOON no later than 36 hours after observation services as an outpatient begin.

   Resources
   - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6 - Hospital Services Covered Under Part B, Section 20.6 - Outpatient Observation Services
   - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4 - Part B Hospital, Section 290 - Outpatient Observation Services
   - CMS Medicare Fact Sheet: Two-Midnight Rule
   - NGS Production Alert "Incorrect Billing for Part A Outpatient Observation Services"
   - CMS Beneficiary Notices Initiative (BNI) - FFS & MA MOON

9. CPT codes 99221–99223 and 99231–99233 were revised to accommodate both inpatient, and observation (initial and subsequent), encounters. CAH Method II hospital claims containing any of these professional codes, billed with a professional revenue code, are receiving denials. NGS

customer service advised that many of these new current procedural terminology (CPT) evaluation and management (E/M) codes were denied based on MUE editing.

Answer: CMS recently identified this issue and determined it is due to an issue with the January 2023 MUE file specific to edit 58MUE. Medicare contractors recently received notification that there will not be a replacement file for January 2023 and there will be no April 2023 update to the MUE files. Therefore, until the 7/1/2023 MUE file update, Medicare contractors will

- Override edit 58MUE for CAH Method II claims with revenue codes 096X, 097X or 098X, to allow payment for HCPCS/CPT Codes 99221–99223, 99231–99233, and 99238–99239
- Initiate claim adjustments, as appropriate, for DOS on/after 1/1/2023

Session Questions

10. When will Healthcare Common Procedure Coding System (HCPCS) code C9803 expire? HCPCS code C9803 is for a hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19])

Answer: HCPCS code C9803 is used to bill for a clinic visit under OPPS that was dedicated to specimen collection during the COVID-19 PHE. Per the CMS document "Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19", this temporary code expires at the end of the COVID-19 PHE for DOS on/after 5/12/2023.

11. Where is the procedure to device or device to procedure edit excel file located?

Answer: CMS no longer posts an Excel file containing a specific list of procedure to device/device to procedure edits. CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 61.2 "Edits for Claims on Which Specified Procedures are to be Reported With Device Codes and For Which Specific Devices are to be Reported With Procedure Codes" indicates that the Integrated Outpatient Code Editor (I/OCE) handles such edits. Refer to Section 5.6 "Device-Intensive Procedure Editing and Processing" in the I/OCE Specifications Manual for 1/2023 concerning devices requiring procedure coding. Note that updates are published in the quarterly outpatient prospective payment system (OPPS) change requests as needed.

12. Concerning the Inflation Reduction Act, please provide more specific information on how providers' systems will be able to identify which portion of their payment relates to the reduced co-insurance amount for specified drugs. Will there be separate payment lines on the ERA for the regular payment and one for the amount making the provider whole for the co-insurance reduction?

Answer: Information released thus far indicates the Inflation Reduction Act affects durable medical equipment (DME) suppliers and pharmacies that supply insulin pumps or the insulin for the pump. Therefore, this question should be directed to you Durable Medical Equipment Medicare Administrative Contractor (DME MAC). As an FYI: CMS recently released information specific to DME contractors and suppliers:

- Change Request (CR) 13014 "Inflation Reduction Act Section 11407: Limitations on Monthly Coinsurance and Adjustments to Supplier Payment Under Medicare Part B for Insulin Furnished Through Durable Medical Equipment (DME) – IMPLEMENTATION" - effective 7/1/2023.
- Medicare Leaning Network (MLN) Fact Sheet, MLN4443820, "Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance".

13. Has NGS imposed edits through the prior authorization (PA) process limiting the CM dose to 155u as it relates to Botox?

Answer: The PA process does not include edits concerning dosage. NGS does have a local coverage determination (L33646) and billing and coding article (A52848) on botulinum toxins. That can be accessed via the Medical Policy section of our website.

14. **What is the proper way to bill when a patient refuses to sign the Hospital-issued Notice of Noncoverage (HINN) 12?**

    Answer: The hospital must ensure proper delivery of all required notices, as they apply, to each Medicare beneficiary. The HINN 12 is used in association with the Hospital Discharge Appeal Notice to inform a beneficiary of potential financial liability for a noncovered continued stay. The Detailed Notice of Discharge is delivered by the hospital to a beneficiary who requested an expedited determination by the BFCC- Quality Improvement Organization (QIO) but does not require the beneficiary's signature. As with other CMS Medicare required notices, the hospital must ensure completion of the details necessary for the HINN 12 and explain the notice to the beneficiary or his/her representative. Note that the beneficiary must be a capable recipient of all Medicare required notices. The notifier should ensure that all questions are answered. The HINN 12 instructions specify that it be signed and dated by the beneficiary or the beneficiary's representative. However, if the beneficiary and their representative refuse to sign, the hospital should annotate the notice with the refusal and have the notifier along with two witnesses annotate the refusal. When completed, a copy of the signed and dated HINN 12 must be provided to the beneficiary or his/her representative.

15. **Regarding the answer to presubmitted question 9, do CAHs need to appeal these MUE denials or will all claims be reprocessed?**

    Answer: No appeal should be submitted for this issue as Medicare will be reprocessing all impacted claims.

16. **What can I do if payment ban claims have been denied but put in T status so I can't appeal, and they were coded according to the CMS billing manual?**

    Answer: We did not receive a claim example and reason code for this question. It would be unusual for a claim to contain both a denial and a return to provider (RTP) since an RTP is requesting correction versus a denial that is a final determination. Please review the reason code(s) on the claim to determine any next steps. If the issue remains unresolved you may need to reach out to customer service for assistance.

17. **When we report observation HCPCS code G0378 for greater than 72 hours, will the claim deny and then we need to appeal?**

    Answer: When the limit of a MUE is exceeded, CMS considers this to be a billing error that cannot be overturned on appeal. Refer to presubmitted question 8 above for additional information.

18. **Are any updates regarding Medicare Advantage Organization (MAO) plans and 340b and getting the MAO plan to pay? Is there any plan for releasing verbiage for MAO plans and their "guidance?" If not, do they have any advice for how to combat not being paid?**

    There seems to be an issue with MAO plans overpaying and then recouping constantly. Should they be doing that? Should they be using the web pricers provided by CMS?

    Non contracted Medicare replacement plans are expected to pay like "original Medicare" for CAHs, does that mean they would pay per diem rates or would it flip to APR DRG payment for inpatient claims?

    Medicare makes the guidelines for the MAO plans, so why can't our questions regarding the MAO plans be answered? Shouldn't the MAO plans be following CMS guidelines?

Answer: National Government Services, Inc. is a Medicare fee-for-service (FFS) contractor; therefore, we cannot answer questions concerning MAO plans or any other insurance coverage. Please contact the specific insurance plan for information.

19. **Why is HCPCS code 0503T denying? Our coding states that 0502T and 0503T are associated with local coverage determination (LCD) A56737 and should be covered with diagnosis code I25.10. Is it okay to override per coding management?**

    Answer: NGS Billing and Coding Article A56737, Billing and Coding: Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA), does not include either of the above listed codes. Codes 0502T and 0503T are included in LCD L39075, Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease, and Billing and Coding Article A58814, Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease. However, ICD-10 code I25.10 is not included as a covered diagnosis for 0502T or 0503T. Please visit the Medical Policy section of our website to view the LCD and article.

20. **What is the best way for a hospital to submit claims with HCPCS code C1889 IMPLANT/INSERT DEVICE? This is a device dependent procedure code. Medicare is rejecting claims with C1889. What information is needed to satisfy the claims process with this HCPCS code?**

    Answer: HCPCS code C1889 is described as an implantable/ insertable device, not otherwise classified. For procedure codes that require the use of devices that are not described by a specific HCPCS code, hospitals should report HCPCS code C1889. Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 61.1 for specific requirements for the use of C1889.

21. **Is there a place on the NGS website to tell us what is required in each/loop segment of the 837I? I looked on the claims/appeal section and did not see anything.**

    Answer: Codes used on Medicare UB-04 (1450) claims are available from the National Uniform Billing Committee (NUBC) via the "Official UB-04 Data Specifications Manual 2023" that is created and maintained by the American Hospital Association (AHA). The appendix of this manual includes a crosswalk "UB-04 Mapping to 005010 837 Claim Transition" to assist in understanding data input to the electronic version of the UB-04.
    The NGS website includes "EDI Solutions" to assist providers with electronic billing options and solutions including a section "Technical Guides and Solutions" where you can obtain additional information.

22. **Can you please clarify the comment that LCPC's cannot work incident to? NGS's article A52825 specifically states they can.**

    Answer: The response to presubmitted question 7 is specific to an FQHC and requirements specific to FQHC core practitioners. NGS medical policy article A52825 applies to hospital inpatient and outpatient services; it does not apply to services rendered in an FQHC.

23. **We are looking for information concerning how to bill for services when a beneficiary was dropped at emergency room (ER) by family who is no longer able to care for them and does not require an inpatient hospital level of care. Another scenario is when the hospital is unable to safely discharge the patient until placement can be determined. Do these situations meet the Two-Midnight Rule criteria to bill an inpatient claim? Is this an extenuating circumstance for extended observation?**

    Answer: The purpose of observation is to determine the need for further treatment or for inpatient admission. Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. The physician should use the two-midnight rule in

determining whether to admit the beneficiary to an inpatient stay and the hospital staff should immediately work on discharge planning. Also note that this does not create an extenuating circumstance for extended observation.

24. How often are ACT webinars held?

Answer: ACT sessions are conducted on a periodic basis. In addition, every webinar we conduct includes time for attendees to ask question specific to the topics discussed.

25. Can an LSCSW bill for HCPCS code G0442, since this is a qualifying visit for a G0466 and G0467, which are not Mental Health G0469 or G0470. Can an LSCSW bill the G0467 with the G0442 with REV codes 0521? The Licensed Specialist Clinical Social Worker (LSCSW) is the highest level of social work licensure in Kansas. This credential is mandatory for all clinical social workers, including those in independent private practice. This section contains information on obtaining social work licensure in Kansas.

Answer: An FQHC visit can be rendered by a clinical social worker (CSW) who meets the definition of an individual who possesses a master's or doctor's degree in social work; after obtaining the degree, has performed at least 2 years of supervised clinical social work; and is licensed or certified as a clinical social worker by the state in which the services are performed; or, in the case of an individual in a state that does not provide for licensure or certification, meets the requirements listed in 410.73(a)(3)(i) and (ii).

The CMS website provides the Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS) which includes G0466, G0467, G0468, G0469, and G0470 and confirms that G0477 can be paired with G0442 and be performed by a LCSW.

For additional information on FQHC services, refer to #7 in this document.

26. Telehealth question: Can RHCs bill both the originating site and distant site charge when the patient presents to the RHC and the RHC provider is practicing at a distance site? The RHC provider is practicing at a distant site – they are not in the same place as the patient. The patient is presenting to the RHC. Can we bill both the originating site & the distant site practitioner charges on the same claim?

Answer: Telehealth rules do not apply when the beneficiary is at the facility nor when the beneficiary and the practitioner are in the same location even if audio/video technology assists in furnishing a service. Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021 | CMS

27. Specific to an FQHC provider, what is the appropriate condition code or modifier required to receive a denial EOB statement from Medicare Part A on non-covered services? Is condition code 21? How should a claim for denial of certain Medicare noncovered services in an FQHC be submitted to Medicare to obtain a denial to then bill Medicaid?

Answer: Bill the claim with condition code 21 to obtain a denial to bill to another insurance. Refer to the answer to question 7 for additional information on FQHC LCPC services. For additional information refer to the CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 1, Section 60.1.3 - Claims with Condition Code 21.

28. Will there be a webinar to discuss the end of the COVID-19 PHE for an FQHC? What do we need to do for enrollment post pandemic?

Answer: We are in the early planning stages of providing general sessions relevant to the end of the COVID-19 PHE.

29. When a patient comes in the FQHC for an annual wellness visit (AWV) and has complaints, and then are treated for an illness would we still bill the AWV or an office visit or both?

Answer: The AWV is billed using payment code G0468 and qualifying visit HCPCS code G0438 for an initial AWV or G0479 for subsequent AWV. Any additional services are included on the claim as incident-to the AWV service. The AWV already provides additional payment for increased use of resources; therefore, any other visit on the same DOS will NOT generate an additional payment or qualify as an additional encounter.

30. **Will Medicare update the qualifying visit codes list? There have been changes made to CPT codes, but the list has not been update since December of 2017? Would Medicare consider expanding the list to provide for more services?**

    Answer: CMS has not announced any intentions to update the qualifying visit list. The CMS Rural Health Clinic Qualifying Visit List specifies that the list is intended as guidance for RHCs and consists of frequently reported HCPCS codes that qualify as a face-to-face visit between the patient and an RHC practitioner. It is not an all-inclusive list of stand-alone billable visits for RHCs.

31. **Recent guidance from NGS regarding FQHC billing for COVID vaccines, as well as pneumonia and influenza vaccines, regardless of whether there is an FQHC visit, is to bill and obtain reimbursement via the cost report. We are not to add these services to the claim. Is this correct?**

    Answer: The CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.2.2 "Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs) Clinics/Federally Qualified Health Center (RHCs/FQHCs)" provides the most current and accurate instructions. As an FQHC, you should leave these services off of the claim, whether or not there is a billable encounter on the same DOS. These vaccines are reimbursed via the cost report.

32. **If cost outlier of an inpatient acute care hospital has been met, when can I bill a type of bill (TOB) 121 claim?**

    Answer: Per CMS CR 7849 "Editing for Duplicate Payment of Nonphysician Outpatient Services Provided During an Inpatient Hospital Admission" a TOB 12X claim can be billed when benefits exhaust during a stay that qualified for a high cost outlier (HCO) payment.
    Per business requirement two of this CR:

    > "In addition to existing bypass criteria for duplicate payment edits, CWF shall ensure that A/B crossover edits are bypassed for an incoming outpatient claim (type of bill 12X) with line item service dates that are after the Part A benefits exhaust date, occurrence code A3, B3 or C3, of an IPPS, LTCH or IRF history claim (excluding the discharge date) that includes an outlier payment."

33. **Recently we had an issue with an FQHC claim being paid when the patient had Railroad Medicare due to a registration issue we have corrected and we have completed refunds. Is there another way to catch these before they are paid?**

    Answer: The beneficiary's primary, as well as any additional, insurance should be identified as part of the eligibility verification process. Your facility should check the common working file prior to performing services to be sure the patient is eligible for the service and that you are billing the appropriate entity.

34. **As an FQHC we are receiving denials for claims that contain HCPCS codes utilized for reporting quality measures. How do we report a quality reporting code with a status indicator of M on a claim?**

    Answer: This is a claim-specific question that is not possible to resolve during a webinar. Please contact our Provider Contact Center (PCC) with a claim example.

35. **Where does telehealth services in an FQHC stand after PHE for office visits? I know that telehealth will be allowed for mental health services.**

Answer: Per CMS Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19: Payment for Medicare Telehealth Services: Section 3704 of the CARES Act authorized RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (Some telehealth services can be furnished using audio-only technology.) RHCs and FQHCs with this capability could provide and be paid for telehealth services furnished to Medicare patients located at any site, including the patient's home, through December 31, 2024. Telehealth services could be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners could furnish telehealth services from any distant site location, including their home, during the time that they are working for the RHC or FQHC, and could furnish any telehealth service that is included on the list of Medicare telehealth services under the Physician Fee Schedule (PFS), including those that have been added on an interim basis during the PHE. A list of these services, including which could be furnished via audio-only technology, is available at List of Telehealth Services..

36. **Per MM13017 do we add the modifier KX exclusively to HCPCS codes G0105 and G0121 if a screening colonoscopy becomes a diagnostic and is the PT modifier added to the CPT/HCPCS code or KX?**

Answer: Per MLN Matters article MM13017, if during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code G0105. Per the CMS Publication IOM 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 1.2 – Table of Preventive and Screening Services: Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.

37. **What is the correct way to bill CPT code J7189 (hemophilia blood clotting factor) when the units exceed 400K on an inpatient claim. MEDICARE returned the claim stating to verify units and charges when billed on one line.**

Answer: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, section 20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients discusses how to bill clotting factors. J7189 is described as one billing unit of J7189 equals one microgram (mcg). When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 99,999, the hospital reports the excess as a second line for revenue code 0636 and repeats the HCPCS code. Therefore, 100,050 units are reported on one line as 99,999 units, and a second line as 1,051 units.

38. **As an FQHC there were changes to behavioral health (BH) telehealth billing in 2022 that advised us to use HCPCS code G0469 or G0470 with an appropriate code like 90834 with modifier 95 added to the G code. What if the provider is a physician rendering BH and bills 99213 or 99214? Do we still use the G2025 code? Also, what if it is for medication management – is it no longer considered BH?**

Answer: To bill for mental health visits furnished via telecommunications for DOS on or after 1/1/2022, FQHCs should bill revenue code 0900, along with the applicable FQHC specific payment code and the FQHC PPS qualifying payment code for mental health visits. Use modifier 95 for

services furnished via audio and video telecommunications and use modifier FQ for services that were furnished via audio-only.

Medication management, or a psychotherapy "add on" service, is not a separately billable service in an RHC or FQHC and is included in the payment of an RHC or FQHC medical visit. For example, when a medically-necessary medical visit with an RHC or FQHC practitioner is furnished, and on the same day medication management or a psychotherapy add on service is also furnished by the same or a different RHC or FQHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code. For FQHCs, an FQHC mental health payment code is not required for reporting medication management or a psychotherapy add on service furnished on the same day as a medical service.

39. I am not seeing answers in the question box.

Answer: Most of the answers during this session were provided verbally. Only a few questions were answered in the answer section of the question box. Due to time constraints, not all written answers were also provided verbally during the session. Please note that all questions will be answered in the ACT Summary that will be posted within 30 business days after today.

40. Since there were so many claims/RTP/denials on this call, maybe a webinar specific to this topic would be beneficial?

Answer: We offer a variety of webinars throughout the year that include Medicare coverage, billing, and coding as well as time for questions and answers. Providers are encouraged to review the reason code(s) on returned and denied claims for information on what the error(s) specific to each claim. Our website as well as the CMS web site are helpful resources in gaining additional information. Also when you have having trouble understanding a specific claim issue, you can direct your inquiry to our PCC for assistance.

41. Where can I find Medicare documentation requirements for medication management in an FQHC?

Answer: Refer to the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, section 170.

42. Do you have any session related to Clinical Trial Studies and Registries and where the claim should be submitted?

Answer: There are none scheduled at this time. Our website includes a section on clinical trials; to access go to Education > Medical Topics > Clinical Trials. The CMS also includes Medicare Clinical Trial Policies. Information on approved clinical trials or registry information is available at Clinicaltrials.gov.

Resources:

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 14
- CMS IOM Publication 100-03, *National Coverage Determinations (NCD) Manual*, Chapter 1, Part 4, Section 310.1
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 32, section 68
- MLN Matters Article, MM8401 – Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims
- Coverage with Evidence Development
- Medicare Approved Facilities/Trials/Registries
- Medicare Coverage Related to Investigational Device Exemption (IDE) Studies
    - Approved IDE Studies