Federally Qualified Health Centers (FQHC) Billing
Today’s Presenter

• Charles Wiley- Provider Outreach and Education Representative
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### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>CNM</td>
<td>Certified nurse midwife</td>
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<td>CP</td>
<td>Clinical psychologist</td>
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<td>Change request</td>
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<td>Calendar year</td>
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<td>DSMT</td>
<td>Diabetes self-management training</td>
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<td>E&amp;M</td>
<td>Evaluation and management</td>
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## Acronyms

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<td>EKG</td>
<td>Electrocardiography</td>
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<td>FI</td>
<td>Fiscal intermediary</td>
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<td>FISS</td>
<td>Fiscal Intermediary Standard System</td>
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<tr>
<td>FQHC</td>
<td>Federally qualified health center</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<tr>
<td>IOM</td>
<td>Internet-Only Manual</td>
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<td>IPPE</td>
<td>Initial physical preventive examination</td>
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<td>MAC</td>
<td>Medicare administrative contractor</td>
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Acronyms

MNT  Medical nutrition therapy
NF   Nursing facility
NP   Nurse practitioner
NPI  National Provider Identifier
NUBC National Uniform Billing Committee
PA   Physician assistant
PPPS Personalized Prevention Plan of Service
SNF  Skilled nursing facility
Objectives

• Provide coverage and billing instructions for FQHCs
Agenda

• FQHC Encounter
• Basic FQHC benefit
  – Core practitioners
  – Covered services and supplies
• Preventive services
• DSMT and MNT
• Telehealth services
• FQHCs and hospitals, SNFs, and hospice providers
Agenda

• Non-FQHC services
• FQHC billing
FQHC Encounters

• Face-to-face encounters between patient and:
  – Physician
  – PA
  – NP
  – CNM
  – CP or CSW

• FQHC covered service is rendered
FQHC Encounters

• Visit or billable encounter defined as: face-to-face encounter in outpatient setting between patient and FQHC core practitioner
• Encounter between CP or CSW and family member only is not billable
• Encounters with more than one health professional and multiple encounters with same health professional, which take place on same day and location is billed as one unit
FQHC Settings

- Covered only in setting outside of hospital
- Covered Part A SNF stay
- Noncovered Part A SNF setting
- Practitioners that may go to a SNF:
  - Physician, physician assistant, nurse practitioner
Core Practitioners and Services
Physician Services

• Professional services that include:
  – Diagnosis
  – Therapy
  – Surgery
  – Consultation

• FQHC physician services away from the clinic are covered services
Physician Services and Supplies

• Covered if:
  – Furnished as an incidental but integral part of physician’s professional services
  – A type commonly rendered either without charge or included in FQHC bill
NP, CNM, and PA Services

• Services are covered if:
  – Furnished by employee of clinic or is compensated as individual from clinic
  – General (or direct, if state law requires) medical supervision of physician
  – Note: Clinic policies must be in place and followed and any physician medical order for care and treatment of patient must be followed
NP, CNM, and PA Services

- Practitioners who furnish services must be legally permitted by state law to perform them.
- Services would be covered under Medicare if performed by a physician.
Services and Supplies Incident to NP, CNM, or PA

- Coverage includes the following:
  - Type commonly found in physician office
  - Rendered without charge or included in FQHC bill
  - Furnished as incidental, but integral part of professional services offered
  - Furnished under direct supervision of NP, PA, or CNM
  - Cases furnished by clinic staff
Clinical Psychologist

• Clinical psychologist must:
  – Have doctoral degree in psychology from program in clinical psychology of educational institution accredited by organization recognized by council on post-secondary accreditation
  – Meet licensing or certification standards for psychologists in independent practice in state in which he/she practices
  – Possess two years of supervised clinical experience, with one done post-degree
CP Services

• Diagnostic and therapeutic services authorized to perform
• Mental health services that are commonly found in CP’s offices
• Integral, yet incidental part of professional services
• Performed under direct supervision of the CP
Clinical Social Worker

- Possesses master or doctoral degree in social work
- Performed at least two years of supervised CSW
Clinical Social Worker

- Licensed or certified as CSW by state where services are performed, or
- In cases where state does not provide licensure or certification, CSW has completed two years or 3,000 hours of post-master degree supervised CSW practice under supervision of master’s level social worker in hospital, SNF, or clinic
CSW Services

- Covered services are:
  - Type of services otherwise covered if furnished by physician or incident to physician’s service
  - Performed by person who meets definition of CSW
  - Not otherwise excluded from coverage
  - CSW services at clinic and away from clinic are payable to clinic
Noncovered CP and CSW Services

• If services are excluded from Medicare, they are not covered
  – Authorization by state laws do not supersede this rule
  – Services must be billed to FI/MAC
    • If you are seeking a denial to bill a secondary payer
Services and Supplies

• Services and supplies are covered if they are:
  – Furnished as incidental, but integral part of physician’s professional services
  – A type commonly rendered either without charge or included in FQHC bill

• FQHC services include drugs furnished by, and incident to, services of physicians, and nonphysician practitioners

CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 40.1
Services and Supplies by Clinic Employees

- Services provided by clinic employees other than core practitioners
  - Must be furnished under direct personal supervision of physician, or
  - Furnished by member of clinic or center’s staff who is employee of clinic

CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 60.4
Preventive Services

• Effective 01/01/2011, the following services are covered:
  – Cardiovascular screening blood test
  – Diabetes screening test
  – Screening mammography
  – Screening pap smears
  – Screening pelvic exam (can include clinical breast exam)
  – Prostate cancer screening
  – Colorectal cancer screening tests
Initial Physical Preventive Exam

- Beneficiary has no later than 12 months from effective Part B coverage for exam
- Services include:
  - Patient history (height, weight, and blood pressure at a minimum)
  - Visual acuity screen
  - Measurement of body mass
Initial Physical Preventive Exam

- Other factors deemed appropriate based on the individual’s medical and social history and current clinical standards
- End of life planning
- Screening electrocardiogram (as needed)
- Patient counseling after results are received
- Wellness visit/IPPE is billable in the same day when all Medicare requirements are met
- Performed by doctor of medicine, or osteopathy, PA, NP, or CNS
Annual Wellness Visit

- Personalized prevention plan or “wellness visit” provided prior to or as part of a visit with physician
  - Includes but is not limited to
    - Health risk assessment, and may contain:
      - Establishment or updated individual medical and family history
      - List of current providers and suppliers that are regularly involved in providing medical care (list prescribed drugs)
      - Measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements
      - Detection of cognitive impairment
Annual Wellness Visit

• MedLearn Matters article #7079 give providers additional instructions on what is included in the wellness visit
  – Provided on an annual basis
  – CR notes that a separate payment is not made to FQHCs when wellness/sick visit is provided in the same day
  – Effective 1/1/2011
Diabetes Self-management Training and Medical Nutrition Therapy

• Registered dietitians or nutritional professionals that provide DSMT and MNT is billable as an encounter

• CMS will recognize registered nurses as professionals that can provide diabetes self management training if they are properly certified
Diabetes Self-management Training and Medical Nutrition Therapy

- Cannot be billed for payment when provided in a group setting
- Group services do not meet the criteria for a face-to-face encounter
- Cost of group sessions is included in the all-inclusive rate for an FQHC
- Bill either DSMT or MNT in a day
  - Claims will be returned if both services are billed to Medicare
Diabetes Self-management Training

- Bill DSMT services when it is a face-to-face encounter
- Payment is made in addition to a qualifying medical visit on the same day
Medical Nutrition Therapy

- Bill MNT services when it is a face-to-face encounter
- Payment is made in addition to a qualifying medical visit on the same day
Telehealth Services

- Telecommunications system may substitute for:
  - Face-to-face
  - Hands on encounter
  - System include tools such as two way radios
    - Permits real time communication
Telehealth Services

• Telehealth services include:
  – Consultation
  – Office visits
  – Individual psychotherapy
  – Psychiatric diagnostic interview exam
  – Pharmacological management
  – Neurobehavioral status exam
  – Individual or group MNT effective 1/1/2011
  – Individual or group health behavior and assessment and intervention effective 1/1/2011
Telehealth Services Sites

• Originating site
  – Location of eligible Medicare beneficiary at the time service furnished via telecommunications system

• Distant site
  – Site where physician or practitioner providing professional service is located at the time service is provided via telecommunications system
Telehealth Services Fee

- Originating site facility fee
  - Claims for facility fees should be submitted to FI
- Distant site fee
  - Services provided by the distant site practitioner is reimbursed under the Medicare Part B carrier system
FQHC and Hospital Services

- Inpatient and outpatient services of a hospital are not payable to FQHCs
- When agreement exists that specifically doesn’t compensate a practitioner for hospital services, payment may be sought under Part B
FQHC Services for SNF Outpatients or Inpatients

• Patient in Part A stay may bill for FQHC services to FI/MAC

• Patient lives at SNF
  – Not receiving care from SNF, but living in designated living-assist area, FQHC practitioner can bill Part A for FQHC services
  – SNF Part B patient receives FQHC services bill the FI/MAC
FQHC and Hospice

• If FQHC physician (or NP) is hospice patient’s attending physician, then FQHC claim may
  – Overlap hospice claim
  – Be related to terminal illness, and
  – Be payable
    • Not related, bill the FI/MAC
    • Related, bill the carrier
Services Provided by Clinics that are Not FQHC Services

• Leg, arm, back, and neck braces
• Artificial legs, arms, and eyes, including replacements if required, due to change in physical condition
• Services provided in hospital setting
Services Provided by Clinics that are Not FQHC Services

• Technical component of specific preventive services are not FQHC services for example:
  – Prostate cancer screening
  – Colorectal cancer screening tests
  – Screening mammography
  – Bone mass measurements
  – Screening pap smears and screening pelvic exams

CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 30.3
Employees and Non-FQHC Services

- Full and part-time physician employees non-FQHC services
  - Clinic does not compensate physicians for services furnished outside of clinic location
  - Physician may bill carrier for payment under Medicare Part B payment system
Laboratory Services

- Freestanding independent FQHCs bill laboratory services to Part B carrier for reimbursement when applicable
- Provider-based FQHCs bill laboratory services through main provider
- FQHCs with Clinic Laboratory Improvement (CLIA) waiver bill the carrier for all laboratory services
Laboratory Services

- Providers bill carrier for laboratory services performed for diagnostic purposes when HCPCS code is available

CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 30.3 & 100-04, Medicare Claims Processing Manual, Chapter 9, Section 40.1 & 130
Laboratory Services

- Reading of test may or may not be on same day as face-to-face encounter
- Bill one unit for encounter based on the clinical visit if the interpretation is not on the same day
Deductible and Coinsurance

• No Part B deductible is applied to FQHC services
• Coinsurance is 20% of FQHC charges
• FQHC can waive collection of all or part of coinsurance

Source: Change Request 7038
Bill Type

• Bill type for FQHC is 77X
  – 771 = Original claim admit through discharge (same day)
  – 777 = Replacement of original claim
  – 778 = Cancel/Void prior claim
FQHC Revenue Codes

- 0900 = Psychological services
  - Services provided by psychologist and CSW for treatment of mental illness of patient
- 0519 = FQHC supplemental payment
- 0521 = Clinic visit by member to FQHC
- 0522 = Home visit by FQHC practitioner
- 0524 = Visit by FQHC practitioner to member in covered Part A stay at SNF
FQHC Revenue Codes

- **0525** = Visit by FQHC practitioner to member in SNF (no Part A stay) or NF or ICF or other residential facility
- **0527** = FQHC visiting nurse service(s) to member’s home when in home health shortage area
- **0528** = Visit by FQHC practitioner to other non-FQHC site (e.g., scene of accident)
New Billing Requirements
01/01/2011

• CR 7038 instructs FQHCs to include covered FQHC services provided in a visit on the claim
  – This means that for each service provided and a CPT or HCPCS code is available, include it with appropriate revenue code
New Billing Requirements
01/01/2011

• Claims processing
  – Claims without HCPCS codes will be returned to the provider
  – FISS accept all valid revenue code lines for detailed coding requirements
New Billing Requirements
01/01/2011

• Claims processing
  – Providers should submit two visit on the same day on one claim
  – Visit must be independent and distinct from each other
  – Use modifier 59 on claims submitted with two clinic visits
  – Modifier 59 is defined as a condition being treated as totally unrelated and services are provided at separate times of the day
Billing

- FQHCs may submit a IPPE on the same day as a medical visit
- FQHCs may not submit a annual wellness visit on the same day as a medical visit

CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 140.3
# FQHC Billing Example #1

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*Note: The table shows entries for different billing codes, rates, and units with corresponding charges and dates.*
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Billing Clarification
01/01/2011

• Claims processing
  – Clarification of payment policies
    • DSMT will only be paid once per day
    • MNT will only be paid once per day
    • Both services will not be paid on the same day
Initial Physical Preventive Examination

HCPCS Codes

- Physical examination component
  - Revenue code 0521
  - HCPCS code G0402
  - Coinsurance is waived as of 01/01/2011
  - A sick visit is billable on the same day as the IPPE
Initial Physical Preventive Examination
HCPCS Codes

- Electrocardiography (EKG)
  - FQHCs are instructed to bill the technical component of the EKG to the carrier
    - CMS-1500 claim form or 837P
    - Use practitioner’s NPI
  - As noted in the CMS IOM Publication 100-04, Chapter 9, Section 150, the professional component is included in the all-inclusive rate for FQHCs
Annual Wellness Examination

HCPCS Codes

- G0438: Annual wellness visit, includes PPPS, first visit (annual wellness first)
- G0439: Annual wellness visit, includes PPPS, subsequent visit (subsequent)
- Revenue code from 052x series
- Will not be paid on same day as an IPPE
- Effective 1/1/2011
Telehealth Billing

- Revenue code 0780
- HCPCS Q3014
- Originating site Part B deductible
- Fee for CY 2011 is $24.10 or less of the actual charge
- Telehealth service is not FQHC service
  - Source: CMS IOM Publication 100-04, Chapter 13, Section 100
DSMT and MNT Billing

• DSMT bill with
  – Revenue code 052X
  – HCPCS G0108

• MNT
  – Revenue code 052X
  – HCPCS codes 97802, 97803, or G0270

• Use a revenue code 052x series for reimbursement on the claim
• Updated FQHC requirement for vaccines 1/1/2011
  - Pneumococcal, influenza, and hepatitis B and the administration of these drugs are billed on the UB-04/Electronic equivalent with appropriate HCPCS code/revenue code
  - Do not include cost with services on line with revenue codes in 52X series
  - Continue to include flu and pneumococcal vaccine/administration on cost report
Vaccines

- Hepatitis B is paid as part of the visit
  - It should not be included in the 521 revenue line (no coinsurance applies)
- Coding is in the CMS IOM Publication 100-04, Chapter 18, Section 10.2.1
- CR 7234 list flu and pneumococcal vaccines for the 2010-2011 season
Reminders

- Listing out the services provided within a visit does not increase the provider’s payment
- For reimbursement, certain services must have a HCPCS code, e.g., telehealth, DSMT, or MNT
- FQHCs are paid for the professional services of their core practitioners
Reminders

• Encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist
  – After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment
Reminders

– Billable Encounters
– The patient has a medical visit and a clinical psychologist or CSW visit on the same day
– The patient has a medical visit and a telehealth visit on the same day
Resources

• CMS
  – http://www.cms.gov/Transmittals/
    • Access transmittals, provider updates, and CMS forms
    • Locate CR 7038 under 2010
  – http://www.cms.gov/MLNMattersArticles/
    • Locate Medicare Learning Network Matters Special Edition article SE1039
Resources

- http://www.cms.gov/Manuals/IOM/list.asp
  - CMS IOM Publication 100-02, Chapter 13
  - CMS IOM Publication 100-04, Chapter 9
  - CMS IOM Publication 100-04, Chapter 18, Preventive Services
Resources

– NUBC Web site: http://www.nubc.org/
  • NUBC Official UB-04 Data Specifications Manual
  • Annual fee
  • Providers also receive updates throughout the year

  • Provides Grade A and B preventive services
Resources

  – Published by the American Medical Association
    • 800-621-8335 (Customer Service)

• FISS/DDE providers have revenue codes and HCPCS codes files available
Medicare University Credits

- For Medicare University credits, send e-mail to: 
  provideroutreachandeducation@wellpoint.com
- In the subject line, enter the topic name and date for today’s program