

**Grandfathered Tribal (GFT)
Federally Qualified Health Center (FQHC)
Training**

Overview of Requirements and Policies

December 14, 2015

GFT FQHC Eligibility

Effective January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations are eligible to become certified as a Grandfathered Tribal (GFT) Federally Qualified Health Center (FQHC) if the facility or organization:

- Met the Medicare provider-based requirements found in §413.65(m) on or before April 7, 2000, and
- Had a change in their status on or after April 7, 2000 from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital, and
- No longer meets the Medicare Conditions of Participation (CoPs).

FQHC Background

FQHCs were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act of 1990 and were effective beginning on October 1, 1991. FQHCs are facilities that are primarily engaged in providing services that are typically furnished in an outpatient clinic. The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in section 1861(aa)(4) of the Social Security Act (the Act). All FQHCs are subject to Medicare regulations at 42 CFR part 405, subpart X, and 42 CFR part 491.

FQHCs were paid an all-inclusive rate for primary health services and qualified preventive health services until October 1, 2014, when they began to transition to the FQHC prospective payment system (PPS). Beginning on January 1, 2016, all FQHCs are paid under the provisions of the FQHC PPS, as required by Section 10501(i)(3)(B) of the Affordable Care Act. No Part B deductible is applied for services that are payable under the FQHC benefit.

Types of FQHCs

There are 3 types of organizations that are eligible to enroll in Medicare as FQHCs:

- Health Center Program Grantees: Organizations receiving grants under section 330 of the PHS Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers;
- Health Center Program Look-Alikes: Organizations that have been identified by HRSA as meeting the definition of "Health Center" under section 330 of the PHS Act, but not receiving grant funding under section 330; and

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- Outpatient health programs/facilities operated by a tribe or tribal organization (under the Indian Self-Determination Act) or by an urban Indian organization (under Title V of the Indian Health Care Improvement Act).

FQHC Services

FQHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- Nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies furnished incident to an NP, PA, CNM, CP, or CSW services; and
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for beneficiaries with diabetes or renal disease.

FQHC Billable Visits

A FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more FQHC services are rendered. Services furnished must be within the practitioner's state scope of practice.

A FQHC visit can also be a Transitional Care Management (TCM) service, or a visit between a home-bound patient and a Registered Nurse or Licensed Practical Nurse under certain conditions. Under certain conditions, a FQHC visit also may be provided by qualified practitioners of outpatient DSMT and MNT when the FQHC meets the relevant program requirements for provision of these services.

Procedures are included in the payment of an otherwise qualified visit and are not separately billable.

A list of qualifying visits is located on the GFT Tribal FQHC link on the FQHC PPS web page: <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>.

FQHC Visit Locations

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A FQHC visit may take place in the FQHC, the patient's residence, an assisted living facility, a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1) or the scene of an accident. FQHC visits may not take place in either of the following:

- an inpatient or outpatient department of a hospital, including a critical access hospital (CAH), or
- a facility which has specific requirements that preclude FQHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).

FQHC Multiple Visits on Same Day

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

FQHC Hours of Operation

FQHCs are required to post their hours of operations at or near the entrance in a manner that clearly states the days of the week and the hours that FQHC services are furnished, and days of the week and the hours that the building is open solely for administrative or other purposes, if applicable. This information should be easily readable, including by people with vision problems and people who are in wheel chairs.

Non-FQHC Services

Certain services are not considered FQHC services either because they 1) are not included in the FQHC benefit, or 2) are not a Medicare benefit.

FQHCs may furnish services that are beyond the scope of the FQHC benefit. If these services are authorized to be furnished by a FQHC and covered under a separate Medicare benefit category, the services must be billed separately to the appropriate A/B MAC under the payment rules that apply to the service.

Non-FQHC services include, but are not limited to:

Medicare excluded services - Includes routine physical checkups, dental care, hearing tests, routine eye exams, etc. For additional information, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf>

Technical component of a FQHC service - Includes diagnostic tests such as x-rays, electrocardiograms (EKGs), and other tests authorized by Medicare statute or the National Coverage Determination (NCD) process. These services may be billed separately to the A/B MAC by the facility. (The professional component is a FQHC service if performed by a FQHC practitioner or furnished incident to a FQHC service).

Laboratory services - Laboratory services are not within the scope of the FQHC benefit. When FQHCs separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the FQHC cost report. This does not include venipuncture, which is included in the per-diem payment when furnished in a FQHC by a FQHC practitioner or furnished incident to a FQHC service.

Durable medical equipment - Includes crutches, hospital beds, and wheelchairs used in the patient's place of residence, whether rented or purchased.

Ambulance services - The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat the patient's condition, and any other methods of transportation are contraindicated. See Chapter 10, Ambulance Services, for additional information on covered ambulance services.

Prosthetic devices - Prosthetic devices are included in the definition of "medical and other health services" in section 1861(s)(8) of the Act and are defined as devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. Other examples of prosthetic devices include cardiac pacemakers, cochlear implants, electrical continence aids, electrical nerve stimulators, and tracheostomy speaking valves.

Body Braces – Includes leg, arm, back, and neck braces and their replacements.

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Practitioner services at certain other Medicare facility – Includes services furnished to inpatients or outpatients in a hospital (including CAHs), ambulatory surgical center, Medicare Comprehensive Outpatient Rehabilitation Facility, etc., or other facility whose requirements preclude FQHC services. (Note: Covered services provided to a Medicare beneficiary by a FQHC practitioner in a SNF may be a FQHC service.)

Telehealth distant-site services (Note: FQHCs are authorized to be originating telehealth sites.)

Hospice Services (Note: There are two exceptions.)

Group Services – Includes group or mass information programs, health education classes, or group education activities, including media productions and publications.

GFT FQHC Payment Rates

Medicare pays 80 percent of the lesser of the GFT FQHC's charge or the GFT FQHC PPS payment rate (as set annually by the IHS) for the specific payment code. There are no further adjustments to this rate.

FQHC Payment Codes

FQHCs must include a FQHC payment code on their claim for payment. FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G code, based on a typical bundle of services that they would furnish per diem to a Medicare beneficiary. The FQHC should maintain records of the services included in each FQHC G code and the charges associated with the service at the time the service was furnished. Each FQHC decides what documentation is appropriate to record the services included in each G-code pursuant to its own determination. Charges must be reasonable and uniform for all patients, regardless of insurance status. FQHC G code services and charges can be changed by the FQHC, but must be the same for all patients and cannot be changed retrospectively.

The five specific payment codes to be used by FQHCs submitting claims are:

1. G0466 – FQHC visit, new patient: A medically-necessary medical, or a qualified preventive health, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

2. G0467 – FQHC visit, established patient: A medically-necessary medical, or a qualifying preventive health, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
3. G0468 – FQHC visit, IPPE or AWW: A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.
4. G0469– FQHC visit, mental health, new patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient, and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
5. G0470 – FQHC visit, mental health, established patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

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.

FQHCs use Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report. Information on these cost report forms is found in Chapters 29, 32, 40, and 41 and 32, respectively, of the "Provider Reimbursement Manual - Part 2" (Publication 15-2), which can be located at on the CMS Website at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>.

FQHC Patient Charges and Coinsurance

Charges for services furnished to Medicare beneficiaries must be the same as the charges for non-Medicare beneficiaries.

Except for certain preventive services for which the coinsurance is statutorily waived, the beneficiary must pay the coinsurance amount. For GFT FQHCs, the coinsurance is 20 percent of the lesser of the GFT FQHC's charge for the specific payment code or the GFT FQHC PPS rate. For claims with a mix of waived and non-waived services, coinsurance is assessed only on the non-waived services.

FQHCs may establish a sliding fee scale to waive collection of all or part of the copayment, depending on the beneficiary's ability to pay. It must be uniformly applied to all patients and posted so that all patients are aware of the policy. If the payment policy is based on an individual's income, the must document that income information from the patient was obtained in order to determine that the patient qualified. Copies of their wage statement or income tax return are not required, and self-attestations are acceptable.

Commingling

Commingling refers to the sharing of FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- Selectively choosing a higher or lower reimbursement rate for the services.

FQHC practitioners may not furnish FQHC-covered professional services as a Part B provider in the FQHC, or in an area outside of the certified FQHC space, such as a treatment room adjacent to the FQHC, during FQHC hours of operation.

If a FQHC practitioner furnishes a FQHC service at the FQHC during FQHC hours, the service must be billed as a FQHC service. The service cannot be carved out of the cost

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report and billed to Part B.

If a FQHC is located in the same building with another entity such as another medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the FQHC space must be clearly defined. If the FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between FQHC and non-FQHC usage to avoid duplicate reimbursement.

Physician Services

The term “physician” includes a doctor of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractic who is licensed and practicing within the licensee’s scope of practice, and meets other requirements as specified.

Physician services are professional services furnished by a physician to a FQHC patient and include diagnosis, therapy, surgery, and consultation. The physician must either examine the patient in person or be able to visualize directly some aspect of the patient’s condition without the interposition of a third person’s judgment. Direct visualization includes review of the patient’s X-rays, EKGs, tissue samples, etc.

Except for services that meet the criteria for a TCM visit or the requirements for chronic care management (CCM) services, telephone or electronic communication between a physician and a patient, or between a physician and someone on behalf of a patient, are considered physicians’ services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Services that are not medically appropriate or not commonly furnished in an outpatient clinic setting are not considered physician services in a FQHC.

Qualified services furnished at a FQHC by a FQHC physician are payable only to the FQHC. FQHC physicians are paid according to their employment agreement or contract (where applicable).

Dental, Podiatry, Optometry, and Chiropractic Services

Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare

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statute, and qualified services furnished by physicians are billable visits in a FQHC. These practitioners can provide FQHC services that are within their scope of practice and not excluded from coverage (e.g., Medicare coverage of chiropractic services is limited to manual manipulation of the spine for a demonstrated subluxation).

A FQHC can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is on the list of qualifying visits for FQHCs and all other requirements are met. All services furnished must be within the state scope of practice for the practitioner, and all HCPCS codes must reflect the actual services that were furnished.

For additional information on these services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 on Covered Medical and Other Health Service at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.

Services and Supplies Furnished “Incident to” Physician’s Services

“Incident to” refers to services and supplies that are an integral, though incidental, part of the physician’s professional service and are:

- Commonly rendered without charge or included in the FQHC bill;
- Commonly furnished in an outpatient clinic setting;
- Furnished under the physician’s direct supervision; and
- Furnished by a member of the FQHC staff.

Incident to services and supplies include:

- Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal);
- Venipuncture;
- Bandages, gauze, oxygen, and other supplies; or
- Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician.

Supplies and drugs that must be billed to the DMEPOS MAC or to Part D are not included.

Provision of Incident to Services and Supplies

Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physician’s visit must result from the patient’s encounter

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with the physician and be furnished in a medically appropriate timeframe. More than one incident to service or supply can be provided as a result of a single physician visit.

Incident to services and supplies must be provided by someone who has an employment agreement or direct contract with the FQHC to provide services. Services or supplies provided by individuals who are not employed by or under direct contract with the FQHC, even if provided on the physician's order or included in the FQHC's bill, are not covered as incident to a physician's service. An example of services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the FQHC for inclusion in the entity's statement of services, services provided by an independent laboratory or a hospital outpatient department, etc.

Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service. Direct supervision does not mean that the physician must be present in the same room. However, the physician must be in the FQHC and immediately available to provide assistance and direction throughout the time the practitioner is furnishing services.

Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the FQHC

Services furnished incident to a physician's visit by FQHC auxiliary personnel in the patient's home or location other than the FQHC must have direct supervision by the physician. For example, if a nurse on the staff of a FQHC accompanies the physician on a house call and administers an injection, the nurse's services would be considered incident to the physician's visit. If the same nurse makes the call alone and administers an injection, the services are not incident to services since the physician is not providing direct supervision. The availability of the physician by telephone and the presence of the physician somewhere in the building does not constitute direct supervision. (This rule applies only to the incident to provision. It does not apply to visiting nursing services.) For additional information on supervision requirements for Part B services incident to physician services see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 60.1.

Payment for Incident to Services and Supplies

Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with a FQHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. The cost of providing these services may be included on the cost

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report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.

Incidental services or supplies must represent an expense incurred by the FQHC. For example, if a patient purchases a drug and the physician administers it, the cost of the drug is not covered and cannot be included on the cost report.

If a Medicare-covered Part B drug is furnished by a FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the FQHC's PPS payment. FQHCs may not bill separately for Part B drugs or other incident to services or supplies.

Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services

Professional services furnished by an NP, PA, or CNM to a FQHC patient are services that would be considered covered physician services under Medicare, and which are permitted by State laws and FQHC policies. Services may include diagnosis, treatment, and consultation. The NP, PA, or CNM must directly examine the patient, or directly review the patient's medical information such as X-rays, EKGs and electroencephalograms, tissue samples, etc. Telephone or electronic communication between an NP, PA, or CNM and a patient, or between such practitioner and someone on behalf of a patient, are considered NP, PA, or CNM services, and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Services performed by NPs, PAs, and CNMs must be:

- Furnished under the general (or direct, if required by State law) medical supervision of a physician;
- Furnished in accordance with FQHC policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the NP, PA, or CNM who furnished the service is legally permitted to furnish by the State in which the service is rendered;
- Furnished in accordance with State restrictions as to setting and supervision;
- Furnished in accordance with written FQHC policies that specify what services these practitioners may furnish to patients; and
- A type of service which would be covered under Medicare if furnished by a physician.

Physician Supervision

FQHCs which are not physician-directed must have an arrangement with a physician that provides for the supervision and guidance of NPs, PAs, and CNMs. The arrangement must be consistent with State law.

Services and Supplies Incident to NP, PA, and CNM Services

Services and supplies that are incident to an NP, PA, or CNM service must be:

- A type of service commonly furnished in an outpatient clinic setting;
- Furnished as an incidental, though integral, part of professional services furnished by an NP, PA, or CNM;
- Furnished under the direct supervision of an NP, PA, or CNM; and
- Furnished by a member of the FQHC staff who is an employee of the FQHC.

NOTE: The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the FQHC.

Services and supplies covered under this provision are generally the same as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.

Clinical Psychologist and Clinical Social Worker Services

A CP is an individual who:

- Holds a doctoral degree in psychology, and
- Is licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

A CSW is 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)

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Services may include diagnosis, treatment, and consultation. The CP or CSW must directly examine the patient, or directly review the patient's medical information. Telephone or electronic communication between a CP or CSW and a patient, or between such practitioner and someone on behalf of a patient, are considered CP or CSW services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service. Services that a hospital or SNF is required to provide to an inpatient or outpatient as a requirement for participation are not included.

Services performed by CPs and CSWs must be:

- Furnished in accordance with FQHC policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the CP or CSW who furnished the service is legally permitted to furnish by the State in which the service is rendered; and
- Furnished in accordance with State restrictions as to setting and supervision, including any physician supervision requirements.

Services and Supplies Incident to CP and CSW Services

Services and supplies that are incident to a CP or CSW service must be:

- A type of service or supply commonly furnished in a CP or CSW's office;
- Furnished as an incidental, though integral, part of professional services furnished by a CP or CSW;
- Furnished under the direct supervision of the CP or CSW; and
- Furnished by an employee of the FQHC.

NOTE: The direct supervision requirement is met in the case of a CP or CSW who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the FQHC.

Services and supplies covered under this provision are generally the same as incident to a physician's services and include services and supplies incident to the services of a CP or CSW.

Mental Health Visits

A mental health visit is a medically-necessary face-to-face encounter between a FQHC

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patient and a FQHC practitioner during which time one or more or FQHC mental health service is rendered. Mental health services that qualify as stand-alone billable visits are listed on the GFT Tribal FQHC link on the FQHC PPS web page:

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>.

Medicare-covered mental health services furnished incident to a FQHC visit are included in the payment for a medically necessary mental health visit when a FQHC or practitioner furnishes a mental health visit. Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in a FQHC.

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and an appropriate FQHC mental health payment code. For detailed information on reporting mental health services and claims processing, refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 9, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf>

Medication management, or a psychotherapy “add on” service, is not a separately billable service in a FQHC. Rather, they are included in the payment of a FQHC medical visit. For example, when a medically-necessary medical visit with a 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 FQHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code. A mental health payment code is not necessary for reporting medication management or a psychotherapy add on service furnished on the same day as a medical service.

Physical and Occupational Therapy

Physical Therapy (PT) and Occupational Therapy (OT) may be provided in the FQHC directly by a physician, NP, or PA, if included in the practitioner’s scope of practice. A physician, NP, or PA may also supervise the provision of PT and OT services provided incident to their professional services in the FQHC by a PT or OT therapist. PT and OT therapists who provide services incident to a physician, NP, or PA visit may be an employee of the FQHC or directly contracted to the FQHC. PT and OT services furnished by a FQHC practitioner acting within their state scope of practice may be billed as a FQHC visit.

PT and OT services furnished incident to a visit with a FQHC practitioner are not billable visits but the charges are included in the charges for an otherwise billable visit if both of the following occur:

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- The PT or OT is furnished by a qualified therapist incident to a professional service as part of an otherwise billable visit, and
- The service furnished is within the scope of practice of the therapist.

If the services are furnished on a day when no otherwise billable visit has occurred, the PT or OT service provided incident to the visit would become part of the cost of operating the FQHC. The cost would be included in the costs claimed on the cost report and there would be no billable visit.

Visiting Nursing Services

A visiting nurse provides skilled nursing services. A service that can be safely and effectively self-administered or performed by a nonmedical person without the direct supervision of a nurse, is not considered a skilled nursing service, even if provided by a nurse. The determination of whether visiting nurse services are reasonable and necessary is made by the physician based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

All of the following requirements must be met for visiting nursing services to be considered a FQHC visit:

- The patient is considered homebound as defined in chapter 7, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>;
- The FQHC is located in an area that has a shortage of home health agencies;
- The services and supplies are provided under a written plan of treatment;
- Nursing services are furnished on a part-time or intermittent basis only; and
- Drugs and biological products are not provided.

FQHCs that are located in an area that has not been determined to have a current HHA shortage and are seeking to provide visiting nurse services must make a written request to the CMS Regional Office along with written justification that the area it serves meets the required conditions.

For services and supplies that require a treatment plan, the treatment plan must be written and reviewed by a supervising physician, NP, PA, CNM, CP, or CSW, as appropriate, at least once every 60 days; and meet other documentation requirements. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated for the purpose of Medicare coverage unless the supervising physician has reviewed the plan of treatment and made a recertification within the 60-day

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period which indicates that the lapse of visits is a part of the physician's regimen for the patient, or, even though nursing visits are required at intervals less frequently than once every 60 days, the intervals are predictable.

Telehealth Services

FQHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system. FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

Although FQHC services are not subject to the Medicare deductible, the deductible must be applied when a FQHC bills for the telehealth originating site facility fee, since this is not considered a FQHC service.

FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a FQHC practitioner who is employed by or under contract with the FQHC, or a non-FQHC practitioner furnishing services through a direct or indirect contract. For more information on Medicare telehealth services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, and Pub. 100-04, Medicare Claims Processing Manual, chapter 12.

Hospice Services

Medicare beneficiaries who elect the Medicare hospice benefit may choose either an individual physician or NP to serve as their attending practitioner (Section 1861(dd) of the Act). FQHCs are not authorized under the statute to be hospice attending practitioners. However, a physician or NP who works for a FQHC may provide hospice attending services during a time when he/she is not working for the FQHC (unless prohibited by their FQHC contract or employment agreement). These services would not be considered FQHC services, since they are not being provided by a FQHC practitioner during FQHC hours, and the physician or NP would bill for services under regular Part B rules using his/her own provider number.

FQHCs can treat hospice beneficiaries for any medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from a FQHC related to his/her terminal illness, the FQHC cannot be reimbursed for the visit, even if it is a medically necessary, face-to-face visit with an FQHC

provider, since that would result in duplicate payment for services.

The only exceptions are either of the following circumstances:

- The FQHC has a contract with the hospice provider to furnish core hospice services related to the patient's terminal illness and related conditions when extraordinary circumstances exist within the hospice. Extraordinary circumstances are described as "unanticipated periods of high patient loads; staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside the hospice's service area" (42CFR 418.64);
- The FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are provided by the hospice so infrequently that it would be impractical and prohibitively expensive for the hospice to employ a practitioner to provide these services. For example, a hospice may infrequently have a pediatric patient, and in those situations, contract with a FQHC that has a pediatric nurse on staff to furnish hospice services to the patient.

In these situations, all costs associated with the provision of hospice services must be carved out of the FQHC cost report, and the FQHC would be reimbursed by the hospice. (42 CFR 418.64(b)(3)).

Treatment Plans or Home Care Plans

Except for comprehensive care plans that are a component of CCM services, treatment plans and home care oversight provided by FQHC practitioners to FQHC patients are considered part of the FQHC visit and are not a separately billable service.

Graduate Medical Education

FQHCs may receive direct GME payment for residents if the FQHC incurs all or substantially all of the costs for the training program. "All or substantially all" means the residents' salaries and fringe benefits (including travel and lodging expenses where applicable), and the portion of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education. Allowable costs incurred by the FQHC for GME are paid on a reasonable cost basis and are not subject to the payment limit. FQHCs may claim allowable costs only while residents are on their FQHC rotation.

FQHCs that are receiving GME payment may not separately bill for a FQHC visit provided by a resident, as the cost of these practitioners is included in the GME payment. A medically-necessary medical, or a qualifying preventive health, face-to-face encounter

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with a teaching physician who is a FQHC practitioner may be a billable visit if applicable teaching physician supervision and documentation requirements are met.

For additional information, see 42 CFR 405.2468 (f) and 42 CFR 413.75(b).

Transitional Care Management Services

FQHCs can bill for qualified TCM services furnished by a FQHC practitioner. TCM services must be furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or Community Mental Health Center.

Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT code 99495), or within 7 days of discharge for high complexity decision making (CPT code 99496). The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-discharge period. The TCM visit is subject to applicable copayments.

TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

Chronic Care Management Services

FQHCs are paid for CCM services when a minimum of 20 minutes of qualifying CCM services during a calendar month is furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CCM is a FQHC benefit, but is paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a FQHC claim, and the FQHC face-to-face requirement is waived. Coinsurance is applied as applicable.

FQHCs may not bill for CCM services for a patient if another practitioner or facility has already billed for CCM services for the same beneficiary during the same time period. FQHCs may not bill for CCM and TCM services, or another program that provides additional payment for care management services (outside of the FQHC PPS payment), for the same beneficiary during the same time period.

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The CCM requirements include the beneficiary's agreement to receive CCM services for the FQHC, development of a comprehensive care plan, management of care transitions and coordination of care with other providers, secure messaging capabilities, and health IT requirements. All CCM requirements must be met for CCM payment.

Preventive Health Services

FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits have not been exceeded. The beneficiary copayment is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B.

FQHCs must provide preventive health services on site or by arrangement with another provider. These services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW.

Influenza and Pneumococcal Vaccines

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The cost is included in the cost report and no visit is billed. FQHCs must include these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance is waived.

Hepatitis B Vaccine (G0010)

Hepatitis B vaccine and its administration is included in the FQHC visit and is not separately billable. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the FQHC provides.

Initial Preventive Physical Exam (G0402)

The IPPE is a one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. The beneficiary coinsurance is waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a personalized prevention plan for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If the AWV is furnished on the

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same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Diabetes Counseling and Medical Nutrition Services

DSMT and MNT furnished by certified DSMT and MNT providers are billable visits in FQHCs when they are provided in a one-on-one, face-to-face encounter and all program requirements are met. Other diabetes counseling or medical nutrition services provided by a registered dietician at the FQHC may be considered incident to a visit with a FQHC provider. The beneficiary coinsurance is waived for MNT services and is applicable for DSMT.

DSMT must be furnished by a certified DSMT practitioner, and MNT must be furnished by a registered dietitian or nutrition professional. Program requirements for DSMT services are set forth in 42 CFR 410 Subpart H for DSMT and in Part 410, Subpart G for MNT services, and additional guidance can be found at Pub. 100-02, chapter 15, section 300.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that

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day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Note: Hepatitis C Screening (GO472) is a technical service only and therefore not paid as part of the FQHC visit.

Copayment for FQHC Preventive Health Services

When one or more qualified preventive services are provided as part of a FQHC visit, charges for these services must be deducted from the lesser of the FQHC's charge or the PPS rate for purposes of calculating beneficiary copayment. For example, if the total charge for the visit is \$150, and \$50 of that is for a qualified preventive service, the beneficiary copayment is based on \$100 of the total charge, and Medicare would pay 80 percent of the \$100, and 100 percent of the \$50. If no other FQHC service took place along with the preventive service, there would be no copayment applied, and Medicare would pay 100 percent of the payment amount.

Acronyms

AWV – annual wellness visit
CCM – chronic care management
CNM – certified nurse midwife
CP – clinical psychologist
CSW – clinical social worker
DSMT – diabetes self-management training
FQHC – Federally qualified health center
GFT – grandfathered tribal
GME – graduate medical education
HCPCS – Healthcare Common Procedure Coding System
HHA – home health agency
IPPE – initial preventive physical exam
MAC – Medicare Administrative Contractor
MNT – medical nutrition therapy
NCD – national coverage determination
NP – nurse practitioner
PA – physician assistant
PPS – prospective payment system
PHS – Public Health Service
RO – regional office
TCM – transitional care management
USPSTF – U.S. Preventive Services Task Force