DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED products from the Medicare Learning Network® (MLN)

- **"Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse",** Booklet (ICN 907798) EPUB, QR

MLN Matters® Number: MM8743 Revised **Related Change Request (CR) #: CR 8743**

Related CR Release Date: July 16, 2014 **Effective Date: : October 1, 2014**

Related CR Transmittal #: R1395OTN **Implementation Date: October 6, 2014**

Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)

Note: This article was revised on July 18, 2014, to reflect the revised CR8743 issued on July 16. In the article, the CR release date, transmittal number, and the Web address for accessing CR8743 are updated. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Federally Qualified Health Centers (FQHCs) submitting claims to Part A Medicare Administrative Contractors (A MACs) for services furnished to Medicare beneficiaries.

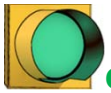
Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is establishing a Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) with specific payment codes that FQHCs must use in order to ensure payment.

CAUTION – What You Need to Know

CR 8743, from which this article is taken, implements the Federally Qualified Health Centers (FQHC) prospective payment system (PPS), effective for cost reporting periods beginning on or after October 1, 2014. This article does not apply to any FQHC claims that are not subject to the PPS. FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting period beginning on or after October 1, 2014.



GO – What You Need to Do

Make sure your billing staffs are aware of these new coding requirements.

Background

Except for services that are paid at 100 percent of costs, Medicare currently pays FQHCs 80 percent of their AIR. MACs reconcile costs and visits at year-end through cost report settlement.

In compliance with the statutory requirements of the Affordable Care Act, CMS established a national encounter-based prospective payment rate for all FQHCs, determined based on an average of the reasonable costs of all FQHCs.

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

From October 1, 2014, through December 31, 2015, the FQHC PPS base payment rate is $158.85. Updates to the FQHC PPS base payment rate and the FQHC GAF will be made available through program instruction.

The FQHC PPS rates will be calculated as follows:

Base payment rate x FQHC GAF = PPS rate

If the patient is new to the FQHC, or the FQHC is furnishing an IPPE, initial AWV, or subsequent AWV, the PPS rate will be adjusted by 1.3416. This is a composite adjustment factor and would only be applied once per day. The PPS rate in this case would be calculated as follows:

Base payment rate x FQHC GAF x 1.3416 = PPS rate

To qualify for an encounter-based payment, a FQHC visit must meet all applicable coverage requirements. Additional information on the coverage requirements for FQHC visits can be found in the "Medicare Benefit Policy Manual", Pub 100-02, Chapter 13, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf on the CMS website.

FQHC Specific Payment Codes

CMS is establishing five specific payment codes to be used by FQHCs submitting claims under the PPS:

1. G0466 – FQHC visit, new patient

A medically-necessary, 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, 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 AWV

A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

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.

FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

Basic Billing Requirements

When reporting an encounter/visit for payment, the claim (77X TOB) must contain a FQHC specific payment code (G0466, G0467, G0468, G0469 or G0470) that corresponds to the type of visit.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052X or under revenue code 0519. NOTE: Revenue code 0519 is only used for Medicare Advantage (MA) Supplemental claims.

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must continue to report detailed HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit. See Attachment A of CR8743 for a list of qualifying visits that correspond to the specific payment codes. (NOTE: A link to CR8743 is available in the "Additional Information" section at the end of this article.)

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

When submitting a claim for a subsequent illness or injury, FQHCs must report the appropriate specific payment code (G0467 for a medical visit or G0470 for a mental health visit) with modifier 59. Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left the FQHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit). NOTE: A qualifying visit is still required when reporting modifier 59 with G0467 or G0470.

FQHCs must report all services that occurred on the same day on one claim.

FQHC may submit claims that span multiple days of service. However, FQHCs transitioning to the PPS must submit separate claims for services subject to the PPS and services paid based on the AIR. MACs shall reject claims with multiple dates of service that include both PPS and non-PPS dates, as determined based on the individual FQHC's cost reporting period.

Durable Medical Equipment (DME), laboratory services (excluding 36415), ambulance services, hospital-based services, group services, and non-face-to-face services will be rejected.

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services are subject to the frequency edits described in Pub 100-04, Chapter 18, and should not be reported on the same day.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

Please refer to the examples in Attachment B of CR8743 for additional billing guidance.

Medicare Payment

The total payment amount for a FQHC visit shall be the lesser of the FQHC's reported charge for the FQHC payment code or the fully adjusted FQHC PPS rate for the specific payment code. Under the FQHC PPS, MACs shall generally pay 80 percent of the lesser of the FQHC's charge for the FQHC payment code or the corresponding FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the FQHC PPS rate.

Medicare waives coinsurance for certain preventive services. For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, MACs shall pay 100 percent of the lesser of the provider's charge for the FQHC payment code or the FQHC PPS rate, and no beneficiary coinsurance would be assessed.

For FQHC claims that include a mix of preventive and non-preventive services, MACs shall use the lesser of the provider's charge for the specific FQHC payment code or the corresponding FQHC PPS rate to determine the total payment amount. To determine the amount of Medicare payment and the amount of coinsurance that should be waived, MACs shall use the FQHC's reported line-item charges and subtract the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount. (See the "Medicare Claims Processing Manual," Pub. 100-04, chapter 18, section 1.2, for a table of preventive services that are exempt from beneficiary coinsurance. That manual chapter is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf on the CMS website.)

Claims for Medicare Advantage (MA) Supplemental Payments

FQHCs that have a written contract with a MA organization that furnishes care to beneficiaries covered by the MA plan are paid by the MA organization at the rate that is specified in their contract. If the MA contract rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary. The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate. To facilitate accurate payment, claims for MA supplemental payments under the FQHC PPS must include the specific payment codes that correspond to the appropriate PPS rates and the detailed HCPCS coding required for all FQHC PPS claims.

Additional Information

The official instruction, CR 8743, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1395OTN.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.