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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
New Medicare PPS for Federally Qualified Health Centers: Operational Requirements
MLN Connects National Provider Call
Moderator: Amanda Barnes
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects National Provider Call.

All lines will remain in a listen-only mode until the question-and- answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the conference call over to you, Amanda Barnes.

Announcements and Introduction

Amanda Barnes: Thank you Selema. Hello, I'm Amanda Barnes from the Provider Communications Group here at CMS and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the new Medicare PPS for Federally Qualified Health Centers Operational Requirement. MLN Connects Calls are part of the Medicare Learning Network.

During this call CMS subject matter experts will provide information on the new Medicare Prospective Payment System, PPS, for Federally Qualified Health Centers: Operational Requirement. As required by Section 10501 of the Affordable Care Act, Federally Qualified Health Centers, or FQHCs, will transition to a Prospective Payment System beginning on October 1st, 2014.

Today's presentation will include a review of new Medicare PPS methodology, billing and claims processing, and cross reporting. A question-and-answer session will follow the presentation. Before we get started, I have a couple of announcements. You should have received a link to the slide presentation for today's call in our previous registration email.

If you have not already done so, please review or download the presentation and article from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events, then select the date of today's call from the list. Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

At this time I would like to turn the call over to Capt. Corinne Axelrod, Senior Health Insurance Specialist in the Hospital and Ambulatory Policy Group here at CMS. Corrine?

Presentation

Corinne Axelrod: Thank you Amanda. And thanks to everybody for being on the call and to those who sent in questions and comments after our last call. The National Provider Call that we had on May 21st focused on the key policies of the new PPS for FQHCs. So today we're going to quickly review those policies and then spend most of our time on FQHC billing and claims processing under the new PPS, including the specific payment code, the FQHC G-codes, the revenue code, HCPCS billing, and Medicare Advantage.

We'll then go over some cost reporting and transition information, talk about how to access additional information, and then take your questions.

Policy Review on PPS Payment and Rate

So let's get started with slide 6, with our policy review on the PPS payment and rate. Your payment will be determined by the MAC, Medicare Administrative Contractor, based on the lesser of your FQHC's charge for the specific payment code or the PPS rate.

The PPS base rate for October 1st, 2014, through December 31st, 2015, is $158.85. FQHCs will transition to the FQHC PPS on the first day of their cost reporting period that begins on or after October 1st, 2014. The PPS base rate will be updated annually in 2016 by the MEI, the Medicare Economic Index, and in 2017, by the MEI or FQHC market basket.

The PPS base rate is adjusted by the FQHC Geographic Adjustment Factor, which we refer to as the FQHC GAF, G-A-F. And the updated FQHC GAF tables are on the CMS FQHC PPS website. Please note that the tables that were published in the final rule have already been updated. So look at the website for the most current table. We are going to rearrange the website to make it a little bit easier for you to find information that you need, but until then, just make sure you look at the dates and that you have the right file.

The FQHC GAF is applied to the PPS rate, not the FQHC charges. And since the FQHC GAF is based on where the services are furnished, payment rates may differ among FQHC sites in the same organization. Again, this is a review of the policy that we went over last time, so I'm going through these quickly just to kind of refresh everybody's memory and have the information in front of you.

There's a 34 percent increase in the PPS rate for new patients, patients receiving an initial preventive physical exam, known as the IPPE, and patients receiving an annual wellness visit, known as an AWV, and that can be either the initial or the subsequent visit.

A new patient is someone who has not received any professional medical or mental health services from any site or from any practitioner within the FQHC organizations within the past 3 years from the date of service. So we have received several questions about how a new patient is defined so we've added a couple of examples. Let's say a physician is new to the FQHC and a patient from his or her previous non-FQHC practice comes to the FQHC for the first time, this would be a new FQHC patient and the rate would be adjusted.

Another example, a patient has received FQHC medical services within the past 3 years and has his or her first visit with a mental health practitioner. This is not a new FQHC patient and the rate would not be adjusted. The point here is that a new patient is based on being new to the FQHC organization, not to any specific practitioner.

OK, we're on slide 12 now, coinsurance. Coinsurance is 20 percent of the lesser of the actual charge or the PPS rate. No coinsurance is charged for preventive services for

which the coinsurance is waived. And for claims with a mix of prevented and nonpreventive services, coinsurance will be 20 percent of the full payment amount after the dollar value of the preventive service charges are subtracted.

We have some examples of this that we're going to be going over in a few minutes. Here's a list of the G-codes, which, as you know, are required to bill for an FQHC visit under the new PPS, including those billing MA plans G0466 through G0470, and here's the list.

FQHCs set their charge for the specific payment codes based on their determination on what would be appropriate for the services normally provided and the population served, and the description of services associated with the payment code. These charges should reflect the sum of the regular rates charged for a typical bundle of services that would be furnished per diem to a Medicare beneficiary. CMS does not dictate to FQHCs how to set their charges—and we're going to keep repeating this because we keep getting asked this and we do not dictate how the – you all will set your charges.

There are some exceptions to the per diem payments. FQHCs can bill for more than one visit per day for the following circumstances. Subsequent illness or injury, for example, if someone has a FQHC visit in the morning, they leave the FQHC and later that day they fall and they go back to the FQHC. They can – the FQHC under these circumstances could actually bill for two visits. The second exception to the per diem payment is for mental health visits, and that would be with the FQHC practitioner occurring on the same day as another billable visit. In that case, the FQHC could bill for two visits.

We have also gotten several questions about billing for DSMT and MNT, Diabetes Self-Management Training and Medical Nutrition Therapy. So let's just review the billing for DSMT and MNT.

Under the FQHC PPS, a qualified DSMT/MNT visit is still a standalone billable visit. If that is the only service furnished that day, the FQHC will be paid for the visit. Once the FQHC transitions to the PPS, they will no longer be able to bill for two visits when a DSMT/MNT visit occurs on the same day as another visit. If a DSMT/MNT visit takes place on the same day as another billable visit, only one visit will be paid. The same concept applies to Transitional Care Management, TCM services. It is a standalone billable visit, but if it's furnished on the same day as another billable visit, only one visit is paid.

As a reminder, only DSMT/MNT visits that are furnished by a certified DSMT practitioner for DSMT or a qualified nutrition professional for MNT are billable visits. It doesn't matter what other credentials the person may have as long as they meet these requirements.

We just posted a list of specific payment codes for qualifying visits on the CMS FQHC PPS website. And the link to that page is at the end of this presentation. Now, I'm going

to ask Tracey Mackey, our billing and claims processing expert, to talk about billing and claims processing under the FQHC PPS. Tracey?

Billing and Claims Processing under FQHC PPS

Tracey Mackey: Hi, this is Tracey Mackey. I'm with the Provider Billing Group here at CMS Division of Institutional Claims Processing. Today I would like to highlight some of the new billing requirement for the FQHC. We think you will find that a lot of the billing requirements remain unchanged, with the most notable exception being the requirement of the FQHC G-codes and the qualifying visit. But before we talk about some of the new billing requirements, let's review some of the requirements that remain the same.

If you'll please turn to slide 19. FQHCs should continue to submit their claims to their Medicare Administrative Contractor, MAC, using a type of bill 77X. Detailed HCPCS coding is still required for all of the services rendered during the encounter. All claims should be submitted using the national billing standards in 837I guidelines. You'll hear me talk a lot about the billing standards and guidelines today.

Claim adjustments remain allowable and should be submitted using established guidelines. FQHCs should continue to submit their claims based on timely filing, which is 1 year from the date the service was rendered. FQHC claims will be submitted to the MAC, where they will be processed in subject to various claims processing edits. Once processed by the MAC, the claim will then be sent to the Common Working File, CWF, for additional processing and will post on the beneficiary's national Medicare record.

Again, based on national standards and billing guidelines, revenue codes are required for all institutional claims, including FQHC claims. We received this question, and you must, yes, still continue to report revenue codes.

Listed on slide 22 are the revenue codes that should be used to bill for an FQHC encounter. Please keep in mind that other revenue codes may be used when reporting other services rendered during the encounter. We'll go over some of these when we get to the billing and payment examples.

New Billing Requirements

Now that we talked about the billing requirements that are not changing, let's go over some of the new billing requirements. Transitions—FQHCs will transition to the PPS based on their first cost reporting period beginning on or after October 1, 2014. During this transitional period, FQHCs cannot submit claims with a mixture of PPS and non-PPS service.

If you turn to slide 25, we have an example. An FQHC's cost reporting period begins October 1, 2014. The FQHC rendered services to the beneficiary on September 30th and then again on October 1st, 2014. The services rendered on September 30th will be subject to the all-inclusive rate system. The services rendered on October 1 will be paid based on the PPS. Therefore, two separate claims must be submitted to your MAC. All services

rendered on the same day must be reported on one claim. Multiple services – multiple claims submitted with the same date of service will be rejected.

Slide 27. Earlier Corinne mentioned the new FQHC visit codes. They are G0466, G0467, and G0468. These codes represent a medical visit and must be reported with revenue code 52X or 519. Codes G0469 and G047 represent a mental health visit. These codes must be reported under revenue code 0900 or 519; 519 is for MA claims only, and we'll talk more about MA claims in a few minutes.

Each payment code, G0466 through G047, must be submitted with a corresponding service line with a HCPCS code that describes the qualifying visit. Again, at the end of the presentation is a list of the qualifying visit that can be found in the CMS FQHC PPS website. Please remember, a visit code and a qualifying visit must be on the claim in order to receive payment.

Additional billing information to consider. FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on their FQHC claims. Durable medical equipment, laboratory services, ambulance services, hospital-based services, group services, and non-face-to-face services will be rejected when submitted on a FQHC claim. As Corrine mentioned earlier, diabetes self-management training, DSMT, and medical nutrition therapy, MNT, services are subject to frequency edit and should not be reported on the same day.

Slide 29. Billing for supplemental payments to FQHCs under contract with MA plans. All the service lines on these claims must be billed under revenue code 519. Just like the regular claims, the FQHC payment code is required with the qualifying visit HCPCS code. Now I'm going to turn it back over to Amanda for some additional information.

Keypad Polling

Amanda Barnes: Thank you Tracey. At this time we will pause a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be few moments of silence while we tabulate the results. Selema, we're ready to start polling.

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please hold while we complete the polling. Please hold while we complete the polling. Please hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Amanda Barnes.

Presentation continued

Amanda Barnes: Thank you, Selema. And we will resume our presentation, Tracey.

Billing and Payment examples

Tracey Mackey: I'd like to move on to slide 30, the billing and payment examples. Please note that for the billing and payment examples, the HCPCS codes and associated charges used in the following slides are for illustrated purposes only. The amounts used are not reflective of actual charges and should not be used as a guideline for setting rates.

On slide 31 we have our first billing example, Scenario 1. An established patient comes to the FQHC for a medical visit. If you'll notice on the slide, we've included the UB-04 form locators, form locator 42, revenue code.

As we spoke earlier on slide 22, we have revenue code 521, which must be used to bill for FQHC visits. On the form locator 44, we have HCPCS code G0467 for FQHC visit. The service date is 10/1. On the next line we have the qualifying visit of 99213, an outpatient visit, established. If you'll notice, the service date for the qualifying visit and the G-code must be the same. In this example, they are both 10/01.

On the third line we've shown additional service that was rendered during an encounter and we have that under revenue code 0300, routine venipuncture, code 36415. Now Corinne will go through the payment scenario.

Corinne Axelrod: Thank you Tracey. So we have two payment scenarios for this billing example. The first one is in Baltimore surrounding counties and the – that Baltimore and the surrounding counties have a FQHC GAF of 1.059. We know that because we looked that up on the website. So their PPS rate is $158 times 85 – I'm sorry, $158.85 times 1.059, so their adjusted rate is 168.22.

In this case, the FQHC's charge of $150, which is based on their G-code, is less than the PPS rate of $168.22. So Medicare payment would be 80 percent of the $150, which is $120. So you can see in the area to the right that has the black box on top, the total payment is $150 and that's because that is less – that's the charge, which is less than the PPS rate.

In the second example, in West Virginia, there's a FQHC GAF of 0.921. So their PPS rate is $146.30. In this scenario, the PPS rate of $146.30 is less than the FQHC's charge of $150. So they would be paid based on the PPS rate $146.30, which you can see in that first box under total payment. Tracey?

Tracey Mackey: Our next billing example 2, we have a new FQHC patient that comes in for a mental health visit. Under form locator 42, we have revenue code 0900, which must be used to bill for a mental health visit.

We have G0469, new mental health patient, and a qualifying visit of 9091 on the next line. You'll note again, the qualifying visit and the G-code have the same date of service. Now Corinne will go over the billing scenario. I'm sorry, payment scenario.

Corinne Axelrod: Thanks, Tracey. So again, we have two examples. The first one is in Rhode Island, which has a FQHC GAF of 1.035 and – so we multiply the $158.85 by 1.035 and we get $164.41. Because there's a new patient, we're going to adjust that, so we're going to multiply the $164.41 by the new patient adjustment, which is 1.3416, and we get a total of $220.57.

In this scenario, the FQHC's charge of $200 is less than the PPS rate of $220.57, so that would be the payment, which again you can see in the first line in the black box area. In our second example in Oklahoma, the GAF is 0.936, so multiplying the PPS rate times the GAF, we get a $148.68. The adjustment is 1.3416, so we multiply $148.68 times 1.3416 and we get a $199.47. In this scenario, the PPS rate of $199.47 is less than the FQHC's charge of $200. So the payment would be $199.47. Tracey?

Tracey Mackey: Our next billing example, 3, on page 37, we have an established FQHC patient that comes in for a medical visit and a mental health visit on the same day. Both of these visits are eligible for payment. So on our first line under form locator 42, we have revenue code 521, which represents the medical visit under G0467. On the second line, we have, again, revenue code 521 for the qualifying visit for the G-code with 99212. So that represents the medical visit.

On the third line is the mental health. And you'll notice that's billed under revenue code 0900, FQHC mental health establish patient under G-code G0470. And then on the next line is the qualifying visit of 90791. Again, a complete listing of all of the qualifying visits are on the FQHC CMS page.

Corinne Axelrod: OK, let's look at the payment examples. As we're traveling around the country we're now in North Carolina, which has an FQHC GAF of 0.967. Medicare will allow for an additional payment when a mental health visit is furnished on the same day as a medical visit. So the PPS rate, $158.85, is multiplied times the FQHC GAF of 0.967, for a total of $153.61.

For the medical visit, the PPS rate is less than the FQHC's charge. For the mental health visit, the FQHC's charge is less than the PPS rate. So in one case, the payment would be based on the PPS rate. The second case, it would be based on the FQHC's charge. So you can see for the medical visit, the payment would be $153.61. For the mental health visit, it would be $150. OK, Tracey?

Tracey Mackey: Now we're going to turn over to billing example number 5 on slide 41. A patient comes to the FQHC for the initial preventive physical examination, also known as IPPE. This is considered a medical visit and, therefore, it's bill under revenue code 521. The G-code is G0468 and the qualifying visit is G0402. Again, both of these must have the same service date. Corinne will go over the payment scenario.

Corinne Axelrod: OK, we're now in Los Angeles, which has a FQHC GAF of 1.096, and will have the adjustment factor for the IPPE, which is 0.3416. I'm sorry, 1.3416 – you left a 1 off there, which gives us a total of $233.57. In this scenario, the FQHC's charge is less than the PPS rate.

So for FQHC claims that consist solely of preventive services are exempt from beneficiary coinsurance, Medicare will pay a 100 percent of the lesser of the FQHC's charge for the FQHC payment code or the FQHC PPS rate and no beneficiary coinsurance is assessed. You can see on the first line under total payment is $200, which would be the payment in this scenario. Tracey?

Tracey Mackey: OK. On to slide 43 for billing example number 6. An established patient comes to the FQHC for a medical visit and also receives some preventive services. The medical visit is billed under revenue code 521 G0467. The qualifying visit is billed on the 521, also with 99212. You'll notice for the Hepatitis B injection, this service is billed under revenue code 636, as additional services may be billed with other revenue codes.

The administration of the Hepatitis B shot is billed under revenue code 771. Again, the G046 – I'm sorry, the G0467 and the qualifying visit of 99212 are billed with the same date of service. Corinne?

Corinne Axelrod: OK, so we have an example here in Arkansas, FQHC GAF is 0.937. In this scenario, the PPS rate is less than the charge because we've multiplied the PPS rate of $158.85 times the FQHC GAF of 0.937 and gotten $148.84. For claims that include a mix of preventive and nonpreventive services, the MAC will pay the FQHC 100 percent of the FQHC's reported line item charge for the preventive service up to the total payment amount.

The MAC will subtract the dollar value of the FQHC's reported line item charge for the preventive services from the full payment amount before assessing coinsurance. The total payment to the FQHC, including Medicare and beneficiary liability, shall not exceed the FQHC's charge for the payment code or the fully adjusted PPS rate.

So in this scenario, the total charges for preventive services, $60 plus $20 is $80. Medicare payment, 100 percent of the $80 plus 80 percent of the $148.84 minus the $80 is $135.07. And the coinsurance would be 20 percent of the $148.84 minus the $80, which equals $13.77. So you can again see the total payment below is $148.84.

Before we go over the last example, which is for a new patient under an MA plan, I'm going to ask our Medicare Advantage expert, Marty Abeln, to talk a little bit about MA plans and FQHCs. Marty?

FQHC and Medicare Advantage Plans

Marty Abeln: Thanks Corinne. So I guess I'll just lay out the scenarios where –an FQHC could interact within an MA plan. And you know, a common one would be a noncontract

situation. A Medicare Advantage enrollee in a PPO, for example, they can go out of network to any provider who's eligible to be paid and get a Medicare covered service. So it's possible that an FQHC would have an MA enrollee show up at their facility and, you know, request to get services.

And when it's a noncontract situation, the FQHC should validate with the MA plan at the – it's an MA – that the enrollee is in a PPO and they're eligible to get services and that the FQHC will be paid. But assuming the FQHC goes ahead and provides service – services under that situation where there is no contract between the FQHC and the MA plan, the MA plan is required to pay the FQHC the amount they would have received had they furnished that service to someone in original Medicare. They're allowed to collect the plan allowed cost sharing from the MA enrollee and then they bill the MA plan for the difference. And again, that difference would equal what they have received under original Medicare, so that's the noncontracting circumstance.

Now it is also possible that the MA plan – PPOs and HMOs, which make up the bulk of MA plans are required to have networks of contracted providers who can furnish Part A and B services. So it's possible that an MA plan would approach an FQHC and negotiate with them to contract with them in order to furnish services to their enrollees.

Now the amount that the – the contracted amount is the subject of negotiations between the FQHC and the MA plan. It could be more than original Medicare, it could be less. It's whatever the market-driven rate is in that particular geographical area and what the FQHC decides to agree to accept.

Now if that payment rate is less than what they would have received under original Medicare for services, that's the scenario where the FQHC is entitled to additional payments from original Medicare to make up the difference. If the payment is at original Medicare or is greater, which it could be, then, of course, there would be no supplemental payment. So with that quick overview, and I'll be available for questions if there's aspects of this that I can clarify, but with that quick overview, I'll turn it back to Corrine.

Corinne Axelrod: OK, thanks Marty. Tracey is going to now continue with the billing example number 7 on page – on slide 45.

Tracey Mackey: So billing example 7 is our last example, and this is for a new patient that is under an MA plan and they go in for a medical visit. Again, this is a FQHC with a written contract with a MA organization. You'll notice on the form locator 42, all the services regardless are billed with revenue code 519. MA claims must only use revenue code 519. On the first line, we have the G-code, G0467. The second line is the qualifying visit, which is required on MA claims also, and we have 99212. The dates of service for the G-code and the qualifying visit must be the same. And then we have some additional services billed on the claim. Corrine will now go over to the payment scenario.

Corinne Axelrod: OK, as Marty said, FQHCs that have a written contract with a Medicare Advantage Organization are paid by the MA organization at the rate that is specified in their contract. And if that rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference less any cost sharing amounts beneficiary. The PPS rate is subject to the FQHC GAF and may also be adjusted for a new patient visit or if an IPPE or AWV is furnished.

The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate. So again, you can look on the first line in the black box area under total payment, $28.84. That is the amount that the FQHC would receive from Medicare. In this case, the $148 minus $120 equals 28.84, so that's where that came from.

Cost Reporting and Transitioning to the PPO

The next section that we're going to be talking about is on cost reporting and the transition to the PPO. FQHCs will still be required to file cost reports for several reasons. Payment of the influenza and pneumococcal vaccines and their administration are done through the cost report. Any GME cost, graduate medical education or bad debts has to be on the cost report. And if we decide in the future to develop an FQHC market basket for the annual updates, we would use the data from the cost report to develop the market basket.

So now I'm going to ask Julie from our cost reporting division to go over the next few slides with you. Julie?

Julie Stankivic: Hi, this is Julie Stankivic from the Division of Cost Reporting. Just as it has been said in the past, the basic premise here remember is that a FQHC PPS begins with your first cost reporting period that begins on or after October 1, 2014. Most providers have a 12-month cost reporting period, typically is the case. And what we did on slide 49 for you is to show you if your cost reporting period began, for example, on 10/1, your cost reporting period ends on 9/30, your next cost reporting period, of course, will begin 10/1. And, therefore, you would begin your SNF PPS on 10/1.

Now always remember that, as was indicated previously by Tracey, it's for dates of service that begin after 10/1/14 is not the key, but in your billing process, it's very important. So do recall if you have a cost reporting period that ends on 9/30 and you begin PPS on 10/1 to split those bills. All FQHCs will transition to the FQHC PPS beginning with dates of service that occur on or after their first cost reporting period that starts on or after October 1, 2014. In some cases you're going to have a short period cost report and we ask that you contact your MAC or you can contact us here at CMS so that we can help you to ascertain what date you will actually begin the PPS.

And the other thing we just want to remind you is that FQHCs are not allowed to change their cost reporting period unless they go through a change of ownership or request it specifically under the provision set forth in 42CFR413.24F3. Clearly stated in the rules is that a request to change a cost reporting period will not be approved if the effect is to increase your Medicare reimbursement. In the past under different PPS systems,

providers have attempted to transition to their PPS much quicker and that is not going to happen in this case.

So make sure that you know when you begin your SNF PPS so that you can properly bill, FQHC. Sorry, yes, all those years working on SNF. Sorry about that. And so that covers the cost reporting information that we wanted to provide for you. And again, if you have questions you can either send them to CMS or you can send them directly.

Resources

Corinne Axelrod: OK, thank you Julie. So there are some resources here for additional information. We have actually two websites, the FQHC PPS webpage and I won't read you the link, and the FQHC Center webpage. Eventually we're going to combine these two, but we thought initially it would be helpful to have the PPS completely separate. And as I mentioned earlier, we are going to rearrange a few things to make it a bit easier for you find the information that you need.

There's also the CMS Manual, Chapter 13 is the Medicare Benefit Policy Manual and Chapter 9 is the Medicare Claims Processing Manual. Both of these will be updated in the near future, but this is where you'll find the most updated and current information on our policies and our processing guidelines.

If you have questions, you can mail them to our question box, fqhc-pps@cms.hhs.gov. Many of you have been sending in questions and we appreciate that. So please have a little patience if we don't respond immediately. We're trying to answer all the questions as quickly as we can. So now I'm going to turn this back to Amanda before we start our question-and-answer session. Thank you.

Question-and-Answer Session

Amanda Barnes: Thank you Corinne. Our subject leader experts will now take questions about the new Medicare PPS for FQHC Operational Requirement. But before we begin I would like to remind everyone that this call is being recorded and transcribed. Before asking a question, please state your name and the name of your organization. In an effort to get to as many questions – callers, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back in the queue and we will address any additional questions as time permits. All right Selema, we're ready to start the Q&A.

Operator: To ask a question press star followed by the number 1 on your touchstone phone. To remove yourself from the queue please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your questions so anything that you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster. You're first question comes from the line of Susan Jacobson.

Janice Payment: Hi, my name is actually Janice Payment. I'm with Suzanne Jacobson and my question is this: If an internal medicine or family practice provider sees a patient that has a mental health diagnosis as the primary or the only diagnosis code and they're using the G0466 or 67 codes, is the requirement of medication, medical, or diagnostics still required to be put in the comment field? And will that requirement still be – will that same requirement be required for the mental health G-codes?

Corinne Axelrod: I think – this is Corinne, and thank you for your question. So I think we – it might better if you emailed us that question so we could make sure that we understand it completely and we'll get back to you as soon as possible.

Amanda Barnes: Thank you.

Janice Payment: Thank you.

Amanda Barnes: Selema, we're ready for the next question.

Operator: Your next question comes from the line of Meredith Neary.

Renee Courtney: Hi, this is Renee Courtney calling from Cass Family Clinic, and my question is regarding flu shots and the pneumonia shots. You said that they had to go on the form. However, if we do them without a qualifying visit how do we bill that?

Tracey Mackey: Hi, thank you for the question. This is Tracey Mackey. You should only report the influenza and the pneumococcal when you're billing for an encounter. If there's no encounter and they just came in for the flu or the PPV, you don't have to submit a claim for that.

Renee Courtney: OK, thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Brittany Lovejoy.

Brittany Lovejoy: Hi, a quick question. I'm wondering – the webinar's saying all services rendered on the same day must be submitted on one claim. I'm wondering if that does hold true for mental health and medical visits, if we need to submit them all on one claim or if we can submit them on two separate claims?

Tracey Mackey: Thank you for your question. This is Tracey again from the Provider Billing Group. It would be nice if you could report them on one claim because right now the system is set to reject and the reason being – and Corinne explained – you can look at billing example number 3. The reason being is because under the new PPS, the payment

is based on the lesser of. So we need to see all of the services that were rendered on one day on one claim.

Brittany Lovejoy: OK, thank you.

Amanda Barnes: Thank you.

Operator: The next question comes from the line of Sherrie Spicer. Sherrie, your line is open.

Sherrie Spicer: OK, yes, can you hear us?

Amanda Barnes: We can.

Sherrie Spicer: OK, we were – our question is regarding the Medicare Advantage plans. So for – whenever we bill Medicare for these Medicare Advantage plans we do add the – or we have the G-code in the 519 revenue code. Do we have to bill them specially to the Medicare Advantage plans also or do we just add that information after the Medicare Advantage plan pays and we're forwarding it on to Medicare?

Corinne Axelrod: Marty, can you answer that for us?

Marty Abeln: I think there's maybe a little confusion here because, so you know, the MA plan if we're – and I assume we're talking about a situation where you have a contract with an MA plan and that contract is resulting in you receiving payment less than what you would have gotten under original Medicare. So in that – in that scenario, then you do have to provide the proper codes, submit those to original Medicare. You know, there's a process that – where original Medicare can validate that, you know, you're being paid less by the MA plan and what the amount would have been that you would have received, so they can make the differential payment.

Otherwise though, you – the MA plan, you know, they will pay you whatever their contracted rate that you've negotiated with them. That would be the amount that you're going to get paid by the MA plan. And again, assuming that's different – lower than what the original Medicare payment amount would have been, then that's the scenario where you provide additional information to original Medicare.

Sherrie Spicer: Right, but just when we bill the MA plan, whenever we bill the MA plan, do we just bill under the original CPT codes or is the MA plan also expecting the CPT codes.

Marty Abeln: Well, how you bill the original Medicare – the MA plan is the – that's something that you would agree to in the contract.

Sherrie Spicer: OK, so they aren't necessarily going to …

Marty Abeln: You don't have to pay them identically the way you would original Medicare.

Sherrie Spicer: OK.

Marty Abeln: They may ask you to do that. But, you know, you do have to submit encounter data and there's other requirements …

Sherrie Spicer: Right.

Marty Abeln: … that you'll be aware of when you contract with an MA plan. But how you submit claims to them is something that you would – that would part of your contractual arrangement with the MA plan.

Cherrie Spicer: OK, thank you.

Operator: The next question comes from the line of Jasmine Chapman.

Jasmine Chapman: Hi, I need I guess clarification on billing those flu shots and pneumonia shots, if the – what is not is – you bill it then or bill it on the cost report? Can you repeat that again for me?

Tracey Mackey: Yes, this is Tracey Mackey again. If you're billing a claim to Medicare for an encounter and you administered the flu or the pneumococcal vaccine, you should report that on your claim under the HCPCS codes. If the only reason for the visit was for the shot and you wouldn't normally be submitting a claim to Medicare, you would just report that on your cost report.

Jasmine Chapman: OK, so if the patient comes in during a visit and we get a shot, we go ahead and bill you guys and don't put that on the cost report, right?

Tracey Mackey: You still report it on your cost report as well.

Jasmine Chapman: Oh, you put it on both?

Tracey Mackey: Yes.

Jasmine Chapman: OK.

Tracey Mackey: Yes. Please report it on the claim when you're billing for an encounter. Put the services listed. Again, all services rendered during the encounter must be reported on the claim. Now if the only reason for the visit was for the purposes of the vaccine, you do not have to submit a claim. You would just put that on your cost report.

Jasmine Chapman: OK. And forgive me for asking this question but I just got the – let's make sure I'm clear with this. So I'm billing that even at a cost and still put it in on the cost report, or do I just put a zero dollar?

Tracey Mackey: You would have to – according to National Billing Standards and the 837I guidelines, you would have to put associated charges for anything that you're billing on the claim.

Jasmine Chapman: OK.

Tracey Mackey: OK?

Jasmine Chapman: All right.

Tracey Mackey: And we can update our webpages with some more examples of how to bill for the influenza and pneumococcal vaccine.

Jasmine Chapman: OK.

Tracey Mackey: Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Michelle Eastman.

Michelle Eastman: I have a question on the – on the when you want us to combine the medical and mental health visits on the same encounter, the way our system's set up, that makes it very difficult because we have different providers with NPIs. So if I manually move a charge with a new encounter that goes to you with the medical provider NPI, is that – is the system going to allow that? Or is it going to recognize that a medical provider shouldn't send an 0900 rev code?

Amanda Barnes: One second.

Jason Kerr: Hi, this is Jason Kerr. By medical provider, are you're speaking of the physician?

Michelle Eastman: Yes.

Jason Kerr: Right, so in terms of the FQHC, you're going to be – you're going to be billing under that Medicare provider number and not the physician identifier. The physician identifier, the NPI, definitely goes on that claim. But …

Michelle Eastman: But in the system it's not going to kick it because it has our FQHC number as well?

Jason Kerr: Correct.

Tracey Mackey: That's correct.

Michelle Eastman: OK, that's what I want to double check. Thank you.

Amanda Barnes: Thank you.

Operator: The next question comes from the line of Dorothy White.

Dorothy White: Hi. I have a question concerning the cost reporting. Our fiscal year starts June 1st, 2014. So are you – I'm just getting clarification, so are you saying the G-codes for the PPS wouldn't begin until June 1st, 2015?

Julie Stankivic: That's correct.

Dorothy White: OK. I just wanted to make sure I was thinking correctly on that.

Julie Stankivic: Yes, it sounds like you typically have a 12-month cost reporting period, so you just look at slide 49 that'll tell your exact date that you're …

Dorothy White: Right.

Julie Stankivic: … going to have send in your bills using the PPS billing methodology.

Dorothy White: So we actually have a year to work on this.

Julie Stankivic: Yes, you do.

Dorothy White: All right. All right, we got in perfect timing. Our fiscal year just started, so.

Amanda Barnes: Thank you.

Dorothy White: All right, thank you.

Operator: You're next question comes from the line of Valerie Lowe.

Valerie Lowe: Yes, hello. I have a question as it relates to submission of the claim. I see on your examples that you show the FQHC visit G-code as well as the office outpatient visit. Do both of those codes have to be submitted on the claim?

Tracey Mackey: Hi, this Tracey Mackey again. Thanks for the question. Absolutely, under the new PPS you must report a FQHC visit code along with the qualifying visit that describes the visit that occurred – and the two must be there or otherwise your claim will be sent back to you. So you must always …

Valerie Lowe: Thank you.

Tracey Mackey: …have a FQHC visit code G0466 to G047, based on whether or not it's a medical, a new patient, an IPPE, or a mental health visit. And along with that there's a listing of qualifying visit. And again, at the end of the presentation Corinne has a link for the qualifying visit codes. And they're also posted on the FQHC web page.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Gigi Chen.

Gigi Chen: Hi. I think this question is for Marty. Hello, can you hear me?

Marty Abeln: Yes, go ahead.

Gigi Chen: OK, thank you. And I think this question is for Marty and how to view the MA and if my plan is capitation, you know, PMPM, how should I bill?

Marty Abeln: You mean if the –if you've contracted with an MA plan and they're paying you a capitated rate?

Gigi Chen: Correct. They pay me PMPM rate.

Marty Abeln: Well that is your payment rate then I mean that's – I mean, it's – you know, you – when you enter into a contract with an MA plan, you really have a lot of discretion to negotiate with them on how you're going to be paid.

They – one of the ways you might agree – and this is something you would, you know, that you all would decide whether you wanted to do or not. You may say, we're willing to see your patients, you know, for these services and we will do it for a capitated rate. So that's, if you do that, then that is your payment and, you know, that that's would you've agreed to in your contract.

Gigi Chen: So can – I'm sorry. Can I view the FQHC PPS rate and for the services, you know, of course the PMPM rate would be lower than my – FQHC PPS rate, how should I make the difference? How should I view?

Marty Abeln: Well, that's a scenario where you would submit – I think the term is the G-codes, that you know, that you would submit to original Medicare what the, you know, what you would have been paid for those services by original Medicare. And if it, you know, again as you're saying, if those rates are less than what the MA plan is paying you, then you're entitled to a differential payment. But to original Medicare you would need to submit the G-codes.

Gigi Chen: Unfortunately, every time we submitted to the Medicare they would kick out because they don't want to pay me, to save this patient this type of managed care Medicare. So will I be able to get any payment?

Marty Abeln: Well, you know, that's, you know, we may have to talk to you offline and work out exactly what the problem is or why you're have a difficulty.

Gigi Chen: I'd love that. So may I talk to you offline?

Marty Abeln: Yes. Let me – I can give you my phone number and I can work, we can talk about it and …

Amanda Barnes: Hey Marty, why don't we go ahead and have her email her question, it's on slide 54 in the resource box?

Marty Abeln: OK, that's perfect. If you email it, then it will go through the system and we can assist you in figuring out why you're having trouble submitting your claims to the MAC.

Jason Kerr: Yes, and also, I mean, Marty, I think that there's – being they're speaking about the Medicare Administrative Contractor, then really the correct approach is to go and contact the Medicare Administrative Contractor. The situation that you're dealing with right now doesn't really have to do necessarily with the new FQHC PPS that we're developing. You know, it's going to be implemented. So the best bet is to contact your Medicare Administrative Contractor and to figure out what's going on.

Amanda Barnes: Thank you.

Gigi Chen: Thank you.

Operator: Your next question comes from the line of Kimberly Lamb.

Kimberly Lamb: Hi, I have a question in regards to venipunctures. Currently what we do is that if a patient comes in and has a standalone venipuncture, we hold that cost, I guess you could say, and tie that to another visit either before or after the venipuncture date. For example, if a patient comes in on 10/1 for venipuncture and then comes back 10/10 for an office visit, we … with this PPS rate. And how would that work in regards to different dates of service on one claim?

Amanda Barnes: I'm sorry, the phone cut out, could you repeat that question?

Kimberly Lamb: Sure. So currently we have – we hold our venipunctures, our 36415 charges, standalone and we tie those to an office visit before or after the venipuncture charge. So with the new PPS rate, are we going to need to continue to do that? For example, a patient comes in on 10/1 for a venipuncture and then comes back on 10/10 for

an office visit, say 99213, we would attach the 36415 dated 10/1 to the CPT 99213 dated 10/10. Is that something we're currently going to need to do with the PPS system?

Corinne Axelrod: Hi, this is Corinne. So that is permissible to continue to do it that way, but we would just caution you that when you transition from one system to another, make sure that you don't have any carryover from services provided under the previous system to when you're transitioning to the new system. So that's just going to be a one time thing, but just whenever you're cost reporting period transitions, just be very careful about that.

Kimberly Lamb: OK, thank you.

Tracey Mackey: And also, this is Tracey, to add on to what Corinne just said, you guys are still able to submit claims that span multiple days and it probably might be a little confusing in the billing examples we did, sometimes, to use the same date of service. So you can have multiple dates of service on one claim.

Kimberly Lamb: OK, thank you.

Tracey Mackey: But please, just keep in mind that the G-code in the qualifying visit must be on the same date.

Kimberly Lamb: OK.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Dina Bell.

Dina Bell: Hi. I'm looking at these G-codes here, and say example billing 3. And so it looks like that we need to review and set our G-codes at a average rate of what our total charges are and that's what the payment is going to be based on but yet still show the appropriate charge for our 99212/213 or whatever that case may be as well as the behavioral health information. Am I correct on that?

Tracey Mackey: This is Tracey again and yes, you are correct.

Dina Bell: OK, so we have to have both of them there and then that's what – the G-code is what's going to base our payment.

Tracey Mackey: Yes.

Dina Bell: The other is for informational for you guys.

Tracey Mackey: Yes. It's very similar to the current billing process where you list out all the services ...

Dina Bell: Right.

Tracey Mackey: ... additional services. There's no additional payment for those lines. And it's pretty much informational only.

Dina Bell: OK.

Tracey Mackey: Your payment will be based on the lesser of the charges associated with your G-code and the FQHC PPS rate.

Dina Belle: OK, all right. Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Dave Macke.

Dave Macke: Yes, I just want to make sure I understand the supplemental payment. On slide 46, you give the example of the Medicare Advantage paying $120 and a supplemental payment of $28.84. What is the process that the FQ would go through to – for Medicare to get that supplemental payment of 28.84?

Tracey Mackey: This is Tracey Mackey. You would do the same process you do today. You would bill original Medicare, the only difference is now you must use a G-code and the qualifying visit. The system will verify your current rate and it will determine if the PPS rate is greater and will pay the difference.

Dave Macke: So I assume your Medicare Advantage rate will be shown on the UB claim somewhere in a field locator?

Tracey Mackey: I'm sorry, I'm not sure about that. If you want, send us an email, we can follow up.

Dave Macke: OK, thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Carol O'Hare.

Carol O'Hare: Hi, this is Carol at Lawndale Christian Health Center. I have a question about the G0466 FQHC visit and the subsequent numbers there, how those rates are established? Was that – that's going to be our FQHC PPS rate? Is that what that's going to be?

Corinne Axelrod: Are you referring to a particular slide?

Carol O'Hare: Slide 13.

Amanda Barnes: One second.

Julie Stankivic: Interest rate on a lot of our claims. I mean, almost all of them I have ...

Corinne Axelrod: So slide 13 is the list of the G-codes and what they're used for, so I guess maybe you could repeat your question.

Carol O'Hare: OK, so what – what would we set as the pricing for those codes?

Corinne Axelrod: Well, that's up to you. So that would depend on – if you look at the next slide, you would set your charge based on what's appropriate – the services normally provided, the population served, the description of the services. The charge should reflect the sum of the regular rates charge for a typical bundle of services. And beyond that, we don't – do not dictate to you how to set your charges.

Carol O'Hare: OK. So, whatever those numbers we put in for say G0466, we make up by some criteria that are shown on slide 14 that – but you're not using that number to determine what our payment rate is.

Corinne Axelrod: Yes, we are.

Carol O'Hare: You're using the PPS times the GAF.

Tracey Mackey: We – this is Tracey. So, based on the charges that are – that are reported under the G-code using your example, G0466, we will use the lesser of your charges and the PPS rate for the PPS.

Carol O'Hare: Do you mean the lesser of our charges on the G0466 or on the E/M Code?

Tracey Mackey: On the G0466.

Carol O'Hare: OK.

Tracey Mackey: So, for example, if your charge is worth $200, and say for your locality and where you are, the PPS rate was $159, your payment will be based on $159.

Carol O'Hare: OK. So our payment rate is going to be the same for all of these then, right? The PPS times the GAF, it's going to be the same for all five of these that are on slide 13.

Corinne Axelrod: Well, you will be …

Carol O'Hare: Well, you get a premium –you get a premium for some of them. Yes.

Corinne Axelrod: Yes. You will establish your …

Carol O'Hare: But the basic – the basic payment rate is going to be the same for all of them.

Corinne Axelrod: You will establish your own G-code for all of these categories based on the criteria that we mentioned and you will be able to update your G-codes whenever appropriate. So it's not like your G-code is set in stone forever. You know, you'll just have to evaluate what's appropriate for your charges and what represents a typical bundle of services.

I also wanted to mention, and I'm not sure we said this or not, that the amount that's paid when you look at the payment slide, that the lines below the payment amount, they do not have to add up to what the G-code payment is. They might add up, but that is not a requirement. So I know that's been a question that we have received in the last few days and just wanted to mention that, that the numbers on your – on each of your lines do not necessarily have to add up to your total payment.

Carol O'Hare: OK, thank you.

Operator: Your next question comes from the line of Cindy Gillespie.

Cindy Gillespie: Actually, she just answered my question. I was asking about line – I was going to ask about the line items, if they needed to add up to the G-code. So if they don't need to add up to the G-code, then that G-code we have to determine what fee we want to charge, if that's appropriate. Is that what you're saying?

Corinne Axelrod: Yes, that's correct.

Cindy Gillespie: OK, all right. Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Gayle Stephens.

Gayle Stephens: Hello. Slide 11 gave an example of a patient that receives medical service at an FQHC and now has their first visit with the mental health provider so they're not a new FQHC patient. So we would bill this with a G0470, establish mental health FQHC visit, and then the detailed line code for that service would be 99203 for the office visit code?

Tracey Mackey: Hi, this is Tracey Mackey.

Gayle Stephens: Yes.

Tracey Mackey: That's correct, but I also want to mention that if you go again to the CMS FQHC PPS website, there is a complete listing of qualifying visits for each G-code. There are multiple qualifying visits.

Gayle Stephens: Are you able to tell me where on that page the link – I can find the link for that? I kind of clicked through a few different ones and I didn't see that specific information.

Tracey Mackey: I don't have a computer in front of me, so I can't walk you through it. But what we can do is – is we can – Corinne ….

Corinne Axelrod: I'm sorry, would you mind repeating that question?

Tracey Mackey: The one exactly where the qualifying visits is on the website.

Corinne Axelrod: Oh, OK, So if you look on the FQHC PPS website, and I can – if you have the pages, it is on slide 52. So if you look on there, it's just – I don't know, about a third of the way down. It was just posted yesterday and there's a little …

Gayle Stephens: I see.

Corinne Axelrod: … Blurb and the link is on the bottom.

Gayle Stephens: I see. The title is FQHC PPS Specific Payment Code.

Corinne Axelrod: That's it, yes.

Gayle Stephens: Yes. OK, great. Thank you.

Corinne Axelrod: Thank you.

Gayle Stephens: I was looking for it yesterday and couldn't find it.

Amanda Barnes: Thank you.

Gayle Stephens: Thank you.

Operator: The next question comes from the line of Angie McClinton.

Angie McClinton: Hi, this is Angie McClinton with Sea Mar Community Health Center. And I'm confused by the examples, and I don't know if it's state specific for us, we're in Washington State, but I'm seeing outpatient visits being billed with ancillary services like blood draws and things like that. Are our claims not splitting anymore or do we have to bill that all together?

Tracey Mackey: Hi. Can you show us – are you're referring to? Are you referring to venipuncture?

Angie McClinton: Yes, I mean any – yes, pretty much any ancillary service. I heard that the flu and the pneumococcal you want going now with the office visit or, you know, if it

happens on that same day or not at all, in the cost reporting. But yes, the venipuncture, any sort of ancillary service we currently have splitting and not going with our FQHC claim and it looks like from the example that that's changing?

Tracey Mackey: Venipuncture is the exception. It is part of the FQHC benefit and should be under FQHC institutional claim. You're correct about other lab services. As I mentioned earlier, those services will be rejected if submitted on the FQHC claim.

Corinne Axelrod: And if – this is Corrine. If I can clarify that the actual drawing of blood is part of the visit. The analysis of blood would be the lab test. And that's kind of how we view all of these services when we're splitting them, that the service that is furnished by the FQHC practitioner is part of the FQHC payment. The analysis of a test is the technical component. It's not usually done by the FQHC practitioner, it may not even be done in the FQHC. So that's sort of the concept behind that.

Angie McClinton: OK. I also noticed in the examples that you have, the PPS G-code on the first line, is that required for all of them, or does it matter what line it's on – on the claim?

Tracey Mackey: It does not matter what line because the system will resort the lines. The important thing to remember is that you must have a G-code and a qualifying visit.

Angie McClinton: OK, thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Claire Kapilow.

Claire Kapilow: Hi, my question has to do with the – in the final rule, and I think also in the transmittal, you mentioned an upcoming posting of a provider-specific file that has, for example, the cost reporting start date for each Federally Qualified Health Center and also possibly a PC Pricer that approximates reimbursement under this new system. Can you tell us, if you happen to know, when those might be available?

Corinne Axelrod: Thank you. We were asked on our last call, and we have gotten some emails asking, if we could post the start – the cost reporting period, the start dates for all of the FQHCs. And what we have responded is that you'll have to contact your MAC. We do not have a file that has all of that information.

So, if you don't know when your cost reporting period starts, just please contact your MAC and they can tell you that or if you're not sure, they can verify that for you. Tracey, did you want to address the pricer?

Tracey Mackey: At this – this is Tracey. At this time, we do not have any plans for PC Pricer but listed in the final rule is the calculation and posted on the website already are all of the geographical adjustment factors.

Claire Kapilow: I see. So you don't have any plans to post the provider-specific files similar to the ones that Medicare posts for other care settings like home health or, you know, skilled nursing or acute care – a provider-specific file specifically for the Federally Qualified Health Centers?

Corinne Axelrod: We're posting as much information as we have available. So we don't have, for instance, a list of the cost reporting periods for FQHC in a nice file that we could just upload. We did, as we've mentioned a few minutes ago, post the list of qualifying visits, which I think you'll find very helpful. So if …

Claire Kapilow: Yes, that was …

Corinne Axelrod: … you have suggestions, we're happy to hear that. But it's a different system, so what's available for other systems may not be available for this system.

Claire Kapilow: Thank you.

Jason Kerr: Hi this is Jason Kerr. So I – I'm sorry. I think the reason why you're seeing the provider-specific files is because as you know there are actually PC Pricers out there for SNF, Home Health, and there's a few others. But because we're not going to have an FQHC PC Pricer, I don't think we're going to be requiring that they send us in their provider-specific files into us and that's when we actually adapt those to the PC Pricer.

Claire Kapilow: I see, OK. Thank you very much.

Jason Kerr: And I mean, you know, the PC Pricers are in general are just as a means to – kind of assist the providers with doing this. The base – the rates and to calculate the rate for each FQHC, this isn't a difficult process as it would be under SNF when you have some thousands of different codes that can price Home Health with thousands. You're talking about a base rate times your GAF and then many – and the applicable add-ons and that's it. So I don't – that's really, generally one of the reasons why we don't see the need to post the PC Pricer for one.

Amanda Barnes: Thank you.

Claire Kapilow: OK, thank you.

Operator: Your next question comes from the line of Yvonne Ketchum.

Yvonne Ketchum: Thank you. So this question has to do with slide 46 and Medicare Advantage. The question is, if the Medicare Advantage allowable that you've contracted with the private payer is $140 and they pay $120 and the patient is liable for a $20 copay, then the FQHC bills for the supplemental payment and gets the extra 28.84, does that in any way change the member obligation to go ahead and pay the $20 copay? Under original Medicare, it would've only been $13 or something. And I just want to confirm that the FQHC can still bill the original copay as their contract allows with the MA plan.

Marty Abeln: Right. I mean what should be happening is – in this scenario, is that so the MA plan, they'll have established a copay. And it's, you know, the copays can be different depending on different – MA plans may have different copays that are approved by CMS. So the MA enrollee would pay whatever their copay is, you know, it's $10, $20. The MA plan would pay you some amount per their contract, then that's the total amount you've received from the MA plan. And then, you know, the differential between that and what original Medicare would've paid you is the amount that you're entitled to receive from original Medicare. Is that clear?

Yvonne Ketchum: OK. So the amount that you're saying here that the MA paid you of $120 is not really what the MA paid you. It's the combination of the member payment and the MA payment?

Marty Abeln: That –that's really correct. Yes, I mean you need to look at it. But both those represent what your payment is. The MA plan will have the beneficiary pay you some amount and then they will pay you an additional amount. Those two pieces together represent your payment amount from the – by the MA plan and/or it includes the beneficiary, but that's the amount you're paid.

Yvonne Ketchum: OK, so it's really the allowed amount, not the paid. That's an important clarification. Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Lina Tow. Lina, your line is open.

Lina Tow: Hi. Our question got answered before. But I actually have a different question. One second, OK?

Female: We just want to clarify that for this new change, so for the inpatient hospital, we still bill to the local Part B carrier, right? There's nothing changed with that part?

Corinne Axelrod: So, FQHCs are not allowed to provide any hospital services, inpatient or outpatient. So if I …

Female: Right.

Corinne Axelrod:… misunderstood your question, please restate it.

Female: Ah, yes.

Corinne Axelrod: Does that answer your question?

Female: Yes, it does answer my question. I mean, currently we do not bill to FQHC. We are billing to the local Part B carrier. So I think that one, it's nothing changed for our side

because we never billed to your FQHC for – to the FQHC encounter. Am I confusing you?

Corinne Axelrod: Yes.

Female: Sorry about that.

Corinne Axelrod: No, that's OK. If you'd like to email the question, maybe that would work better for us.

Female: OK, OK, thanks.

Operator: The next question comes from the line of Kirsten Cowell.

Kirsten Cowell: It's already been answered. Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Jania Arnoldi.

Myra Casillas: Hi, this is Myra Casillas and I do the Medicare billing. I just have a question regarding our – the MA plans that we are not contracted and we see a patient. Are we able to bill for the RAP if we add that to our contract with our Medicare Advantage? And this is a question for Marty, is that possible?

Marty Abeln: Well, you know, I'm not sure. What I can tell you is that – so the way to think about the amount you're supposed to pay the MA plan is how much would you have gotten paid by original Medicare for someone, you know, if someone in original Medicare had come to you for the same service, how much would you have gotten paid. That's the amount that you're entitled to receive from the MA plan. I don't know if that exactly answers your question but …

Corinne Axelrod: No, Marty I think that on a noncontracted plan.

Myra Casillas: Yes, noncontracted, right.

Marty Abeln: Yes, in a noncontract situation, the MA plan is supposed to pay you the amount you would have received had the person been in original Medicare. I mean you're entitled to that now.

Myra Casillas: Oh, perfect. So we can just contact our provider rep to add that on our contract?

Marty Abeln: Well, let me just clarify. So I'm talking about a situation, as I said earlier, you know, you might see an MA enrollee who's, for example, a member of a PPO, a

Preferred Provider Organization. And enrollees in PPOs can go out of network, right, to any provider and get services basically?

So, it's possible that a PPO enrollee could come to your FQHC. You don't have a contract with the PPO. There, you know, there's no contract, in that scenario where the PPO is obligated to cover the service, they're required to pay you for the services you furnished to that PPO enrollee the same amount you would've received from original Medicare.

Myra Casillas: OK. I do understand that part. I just want to make sure that in order for Medicare to process that claim that it appears on our – on our provider MA plan …

Marty Abeln: Well, Medicare wouldn't process the claim…

Myra Casillas: … so we can add it on there.

Marty Abeln: Right. Medicare would not process the claim. You have to send your claim to the Medicare Advantage plan.

Myra Casillas: Right.

Marty Abeln: I mean the original Medicare would reject the claim.

Myra Casillas: Right. But to claim our additional …

Marty Abeln: Well, I mean you're going to have to send in, you know, tell the MA plan a bill and say this is what we get paid for furnishing this service under original Medicare and, you know, then they're required to pay you that amount. I mean assuming …

Myra Casillas: OK. I do understand that part.

Marty Abeln: Yes, I mean hopefully the MA plan follows the rules. If they don't, you can, you know, there is a process but …

Amanda Barnes: In the interest of time …

Myra Casillas: OK. So, if we need for – yes, go ahead.

Amanda Barnes: In the interest of time, we do have to move on to the next question. If you want to email your followup question, please email the FQHC resource box in slide 54. Selema, next question please.

Operator: The next question comes from the line of Robert Sager.

Robert Sager: Hi, I'm calling – my name is Robert, I'm calling from the United Indian Health Services. I had a question regarding billing multiple visits on the same day. What if a patient comes in for a medical visit and a vision visit on the same day and they see two different doctors at our FQHC, would we still put both of those encounters on one claim?

Corinne Axelrod: Hi, this is Corrine. So, as you know, in an FQHC, you would receive one payment for that. That was not qualified for two separate visits. That would be one payment. Tracey, do you want to address how it's put on the claim?

Tracey Mackey: Thanks, Corrine. This is Tracey. So, as Corrine said, since this – that does not qualify for two visits, all those services must be submitted on one claim. And again, your payment will be based on the lesser of the minute charges under the G-code or the PPS rate.

Robert Sager: So we would put – would we put just one G-code on there and then we would put two codes for each …

Tracey Mackey: Yes, that's the correct.

Robert Sager: … for each of the office visits?

Tracey Mackey: Yes, you would put the one G-code, you put the qualifying visit, and then you would put any other services that were rendered during that encounter.

Robert Sager: OK.

Tracey Mackey: OK.

Robert Sager: But I mean there's two encounters so …

Tracey Mackey: No, they're not two encounters.

Robert Sager: Well, there are. There's the 99213 and there's the 9 …

Tracey Mackey: There are two services.

Robert Sager: So, there's a vision visit, which is an encounter, like a 92014.

Corinne Axelrod: So under the current system, as you know, the all-inclusive rate system, any service provided on the same day constitutes one visit except for the exceptions, which have been mental health and subsequent injury, illness, and a few others.

Robert Sager: Right

Corinne Axelrod: So the per diem system is very similar that a patient can come in and can see the physician for one thing, another physician for another thing, a nurse practitioner for another thing. All of that will be one visit. Now all of the services would go on the claim, but that would only constitute one payable visit. It's a bundle …

Robert Sager: Even if they see. So – so do we put multiple provider information down because like right now there's a field locator for the actual physicians NPI. Would we put two down if they see a medical physician and a vision and like a vision doctor?

Corinne Axelrod: So, for FQHC would bill using the FQHCs NPI, not the individual practitioners.

Robert Sager: Right, right but it still appears on the claim.

Tracey Mackey: I do not believe there's line level NPI information on the UB04. I think …

Robert Sager: Box 76.

Tracey Mackey: I'm sorry?

Robert Sager: Box 76, that's where we put the doctor's information.

Tracey Mackey: That's the FQHC clinic? Oh, I'm sorry, you're correct. And I think in the past, what we've said, whoever performs the primary of the services, that's the NPI you would use. You're correct.

Robert Sager: How do we determine which one is primary?

Corinne Axelrod: That would be a decision based on the services that you provide. So the payment is going to be the same regardless of whichever one you put. But we do encourage people to choose the one that has provided either the bulk of the services, the most intensive services, the highest level services, if that's appropriate, but the payment is not going to be based on that.

Robert Sager: OK. And if we do that, we don't need to use the modifier 59 for medical and vision on the …

Corinne Axelrod: No.

Tracey Mackey: No.

Robert Sager: And am I correct in understanding that if we cannot code a – some kind of visit charge like a 99213 or a 92014 or what have you, if we cannot actually do that, if the

patient simply came in for a quick service like an injection or like a vaccine or therapeutic injection or – we can't actually bill Medicare at all, correct?

Corinne Axelrod: That's correct, it has to be provided with a qualified visit in order for that to be paid.

Amanda Barnes: Thank you.

Robert Sager: Thank you.

Operator: Your next question comes from the line of Terry Lawson.

Terry Lawson: Yes, hello, I'm from Zufall Health Center and I am their clinical pharmacist and certified diabetes educator. And my question is more of a clarification on the annual well visits as well as providing diabetes self-management training conducted by a clinical pharmacist in the practice.

Corinne Axelrod: Thank you for your question. We got a few of these questions on the last call and I've got some emails on that. And we have been talking with the – our colleagues in the Division of Practitioner Services who oversee the Annual Wellness Visit program for the division fee schedule just to understand better the qualifications. So – but in an FQHC, it's pretty straightforward, an FQHC practitioner would have to provide the AWV and the pharmacist is not an FQHC practitioner. So for FQHC …

Terry Lawson: And what's the definition of an FQHC practitioner?

Corinne Axelrod: So the FQHC practitioners are defined in the statute and that includes a physician, nurse practitioner, physician assistant, certified nurse, midwife, clinical psychologist, and a clinical social worker. So those are all in the statute and those are the types of practitioners that can bill for an FQHC visit.

Amanda Barnes: Selema, we have time for one last question.

Operator: Your final question comes from the line of Cora Bennett.

Cora Bennett: Hi. My question has to do with the Medicare Advantage plans. If we have a patient who has a Medicare Advantage plan and the secondary is a commercial or Medicaid, can we still bill for the supplemental payment to Medicare?

Marty Abeln: As far as I understand, yes you can.

Cora Bennett: OK, thank you.

Additional Information

Amanda Barnes: Thank you. Unfortunately, that's all the time we had for questions today. If we did not get to your question, you can email to one of the – to the email

address listed on the resource slide 54. An audio recording and written transcripts of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 56 of the presentation, you will find a URL to evaluate your experience with today's call. Evaluations are anonymous and confidential and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Amanda Barnes and I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on new Medicare PPS for Federally Qualified Health Centers Operational Requirements. Have a great day everyone.

Operator: This concludes today's call. Presenters please hold

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