



MLN ConnectsTM

National Provider Call

New Medicare Prospective Payment System (PPS) for FQHCs: Operational Requirements

Centers for Medicare and Medicaid Services

Center for Medicare

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Medicare Learning Network®



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Agenda

I. FQHC PPS Policy Review

II. FQHC Billing & Claims Processing, including:

- Specific payment codes (FQHC “G codes”)
- Revenue codes and HCPCS billing
- Medicare Advantage for FQHCs

III. FQHC Cost Reporting and Transition

IV. Additional Information

V. Question & Answer

I. FQHC PPS Policy Review

Policy Review – PPS Payment and Rate

- Payment to be determined by the MAC based on the lesser of the FQHC's charge for the specific payment code or the PPS rate
- The PPS base rate for October 1, 2014, through December 31, 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 1, 2014

Policy Review – Rate Update

- PPS base rate will be updated annually
- 2016 - by the Medicare Economic Index (MEI)
- 2017 – by the MEI or a FQHC market basket

Policy Review – FQHC GAF

- The PPS base rate is adjusted by the FQHC Geographic Adjustment Factor (FQHC GAF)
- Updated FQHC GAF tables on the CMS FQHC PPS website
- The FQHC GAF is applied to the PPS rate, not the FQHC charges
- Since the FQHC GAF is based on where the services are furnished, payment rates may differ among FQHC sites within the same organization

Policy Review – Rate Adjustment

- 34% increase in the PPS rate for:
 - New patients
 - Patients receiving an Initial Preventive Physical Examination (IPPE)
 - Patients receiving an Annual Wellness Visit (AWV) (initial or subsequent)

Policy Review – New Patient

- 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 organization within the past 3 years from the date of service

Policy Review – New Patient Examples

- Physician is new to the FQHC and a patient from his/her previous non-FQHC practice comes to the FQHC for the first time – NEW FQHC PATIENT, RATE ADJUSTED
- Patient has received FQHC medical services within the past 3 years and has his/her first visit with a mental health practitioner – NOT A NEW FQHC PATIENT, RATE NOT ADJUSTED

Policy Review – Coinsurance

- 20% of the lesser of the actual charge or the PPS rate
- No coinsurance charged for preventive services for which the coinsurance is waived
- For claims with a mix of preventive and non-preventive services, coinsurance will be 20% of the full payment amount after the dollar value of the preventive service charges are subtracted

Policy Review – G Codes

G Codes required to bill for a FQHC visit
(including MA plans)

G0466 - FQHC visit, new patient

G0467 - FQHC visit, established patient

G0468 - FQHC visit, IPPE or AWW

G0469 - FQHC visit, mental health, new patient

G0470 - FQHC visit, mental health, est. patient

Policy Review – G Codes

- FQHCs set their charge for the specific payment codes (GO466-GO470) based on their determination of what would be appropriate for the services normally provided and the population served, and the description of services associated with the payment code
- The charge 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

Policy Review – Per Diem Exceptions

FQHCs can bill for more than one visit per day for the following circumstances:

- Subsequent illness or injury
- Mental health visit occurring on the same day as another billable visit

II. FQHC PPS Billing and Claims Processing

FQHC PPS Billing & Claims Processing

- FQHC billing and coding guidelines described in this presentation are applicable for Medicare FQHC claims

FQHC PPS Billing & Claims Processing

Unchanged Billing Requirements

FQHC PPS - Unchanged Billing Requirements

- FQHC claims continue to be submitted on a 77X type of bill
- Detailed HCPCS coding continues to be required for all services rendered during the encounter
- Claims continue to be prepared using the established guidelines for general coding as defined by the national billing standards

FQHC PPS - Unchanged Billing Requirements

- Claim adjustments remain allowable and are submitted using established guidelines
- FQHC claims continue to be subject to timely filing guidelines
- FQHC claims continue to be submitted to the MAC for processing and are subjected to various claims processing edits

FQHC PPS - Unchanged Billing Requirements

- Once processed by the MAC, the FQHC claim will continue to be sent to the Common Working File (CWF) for additional edits and posting in the beneficiary's national Medicare record

FQHC PPS - Unchanged Billing Requirements

- Revenue Codes continue to be required on claims
- 0519** – Supplemental payment for visit by a beneficiary in a contracted Medicare Advantage Plan
- 0521** - Clinic visit by beneficiary to the FQHC
- 0522** - Home visit by the FQHC practitioner
- 0524** - Visit by the FQHC practitioner to a beneficiary in a covered Part A stay at the Skilled Nursing Facility (SNF)
- 0525** - Visit by FQHC practitioner to a beneficiary in a SNF (not in a covered Part A stay) or Nursing Facility (NF) or Intermediate Care Facility for Individuals with Mental Retardation (ICF/MR) or other residential facility
- 0527** - FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
- 0528** - Visit by a FQHC practitioner to other non FQHC site (e.g., scene of accident)
- 0900** - Behavioral Health Treatment Services

FQHC PPS – Billing and Claims Processing

FQHC PPS - New Billing Requirements

FQHC PPS - New Billing Requirements

- FQHCs submit claims using the current billing methodology under the All-Inclusive Rate (AIR) up to the beginning of their first costing reporting period beginning on or after October 1, 2014
- FQHCs submit claims using the revised billing methodology for the PPS beginning with their first cost reporting period beginning on or after October 1, 2014

FQHC PPS - New Billing Requirements

Example: A FQHC whose cost reporting period begins 10/1/2014:

- The FQHC rendered services to the beneficiary on September 30, 2014 and again on October 1, 2014
- Services rendered on September 30, 2014 will be paid under the AIR
- Services rendered on October 1, 2014 will be paid under the PPS
- Two separate claims must be submitted to the MAC

FQHC PPS - New Billing Requirements

- All services rendered on the same day must be submitted on one claim or the claim will be rejected
- Multiple claims submitted with the same date of service will be rejected

FQHC PPS – New Billing Requirements

- FQHC payment codes G0466, G0467, and G0468 must be reported with revenue code 052X or 0519
- FQHC payment codes G0469 and G0470 must be reported with revenue code 0900 or 0519
- Each FQHC payment code (G0466 – G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit (Complete listing of the qualifying visit codes on CMS FQHC PPS website)

FQHC PPS – Additional Billing Information

- FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on the FQHC claim
- Durable Medical Equipment (DME), laboratory services (excluding 36415), ambulance services, hospital-based services, group services, and non-face-to-face services will be rejected when submitted on the FQHC claims
- Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services are subject to frequency edits and should not be reported on the same day

Billing for Supplemental Payments to FQHCs Under Contract with MA Plans

- All services must be billed with revenue code 0519
- A FQHC payment G code and HCPCS code must be on the claim

Billing and Payment Examples

Note: The HCPCS codes and the associated charges used in the following slides are for illustration purposes only. The amounts used are not reflective of actual charges and should not be used as a guideline for setting rates.

FQHC PPS - Billing Example #1

Established patient comes to the FHQC for a routine medical visit.

42 Rev Code	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0521	FQHC visit, estab pt	G0467	10/01	1	\$150.00
0521	Office/outpatient visit est	99213	10/01	1	\$135.00
0300	Routine venipuncture	36415	10/01	1	\$15.00
0001	*	*	*	*	\$300.00

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FQHC PPS - Payment Example #1A

Carrier	Locality	State/County	FQHC GAF
12302	01	Baltimore/Surr. Cntys, MD	1.059

PPS rate = Base Rate x FQHC GAF
 PPS rate = \$158.85 x 1.059 = \$168.22

Payment is based on the lesser of the FQHC's charge for the payment code or the PPS rate
 In this scenario, the FQHC's charge of \$150 is less than the PPS rate of \$168.22
 Medicare payment = 80% of \$150.00 = \$120.00
 Coinsurance = 20% of \$150.00 = \$30.00

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0521	FQHC visit, est pt	G0467	10/01	1	\$150.00	\$150.00	\$120.00	\$30.00
0521	Office/outpatient visit est	99213	10/01	1	\$135.00	\$0.00	\$0.00	\$0.00
0300	Routine venipuncture	36415	10/01	1	\$15.00	\$0.00	\$0.00	\$0.00

FQHC PPS - Payment Example #1B

Carrier	Locality	State/County	FQHC GAF
11402	16	West Virginia	0.921

PPS rate = Base Rate x FQHC GAF

PPS rate = \$158.85 x 0.921 = \$146.30

Payment is based on the lesser of the FQHC’s charge for the payment code or the PPS rate

In this scenario, the PPS rate of \$146.30 is less than the FQHC’s charge of \$150

Medicare payment = 80% of \$146.30 = \$117.04

Coinsurance = 20% of \$146.30 = \$29.26

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0521	FQHC visit, est pt	G0467	10/01	1	\$150.00	\$146.30	\$117.04	\$29.26
0521	Office/outpatient visit est	99213	10/01	1	\$135.00	\$0.00	\$0.00	\$0.00
0300	Routine venipuncture	36415	10/01	1	\$15.00	\$0.00	\$0.00	\$0.00

FQHC PPS - Billing Example #2

New FQHC patient comes to the FQHC for a mental health visit.

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0900	FQHC visit, MH new pt	G0469	10/01	1	\$200.00
0900	Psych diagnostic evaluation	90791	10/01	1	\$135.00
0001	*	*	*	*	\$335.00

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FQHC PPS - Payment Example #2A

Carrier	Locality	State/County	FQHC GAF	Adj. Factor
14412	01	Rhode Island	1.035	0.3416

PPS rate = Base Rate x FQHC GAF

PPS rate = \$158.85 x 1.035 = \$164.41

Adjustment for new patient = \$164.41 x 1.3416 = \$220.57

Payment is based on the lesser of the FQHC's charge for the payment code or the PPS rate

In this scenario, the FQHC's charge of \$200 is less than the PPS rate of \$220.57

Medicare payment = 80% of \$200.00 = \$160.00

Coinsurance = 20% of \$200.00 = \$40.00

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0900	FQHC visit, MH new pt	G0469	10/01	1	\$200.00	\$200.00	\$160.00	\$40.00
0900	Psych diagnostic evaluation	90791	10/01	1	\$135.00	\$0.00	\$0.00	\$0.00

FQHC PPS – Payment Example #2B

Carrier	Locality	State/County	FQHC GAF	Adj. Factor
04312	00	Oklahoma	0.936	0.3416

PPS rate = Base Rate x FQHC GAF

PPS rate = \$158.85 x 0.936 = \$148.68

Adjustment for new patient = \$148.68 x 1.3416 = \$199.47

Payment is based on the lesser of the FQHC’s charge for the payment code or the PPS rate

In this scenario, the PPS rate of \$199.47 is less than the FQHC’s charge of \$200.00

Medicare payment = 80% of \$199.47 = \$159.58

Coinsurance = 20% of \$199.47 = \$39.89

42 Rev	43 DESCRIPTION	44 HCPCS/	45 SERV	46 SERV	47 Total charges	Total Payment	Medicare Payment	Coinsurance
0900	FQHC visit, MH new pt	G0469	10/01	1	\$200.00	\$199.47	\$159.58	\$39.89
0900	Psych diagnostic evaluation	90791	10/01	1	\$135.00	\$0.00	\$0.00	\$0.00

FQHC PPS - Billing Example #3

Established FQHC patient comes to the FQHC for a medical and mental health visit on the same day.

42 Rev Cd	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0521	FQHC visit, estab pt	G0467	10/01	1	\$156.00
0521	Office/outpatient visit est	99212	10/01	1	\$140.00
0900	FQHC visit, MH estab pt	G0470	10/01	1	\$150.00
0090	Psych diagnostic evaluation	90791	10/01	1	\$135.00
0001	*	*	*	*	\$581.00

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FQHC PPS - Payment Example #3A

Carrier	Locality	State/County	FQHC GAF
11502	00	North Carolina	0.967

Medicare will allow for an additional payment when a mental health visit is furnished on the same day as a medical visit.

Payment for each covered visit is based on the lesser of the FQHC's charge for the payment code or the PPS rate.

PPS rate = Base Rate x FQHC GAF

PPS rate = \$158.85 x 0.967 = \$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.

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0521	FQHC visit, estab pt	G0467	10/01	1	\$156.00	\$153.61	\$122.89	\$30.72
0521	Office/outpatient visit est	99212	10/01	1	\$140.00	\$0.00	\$0.00	\$0.00
0900	FQHC visit, MH estab pt	G0470	10/01	1	\$150.00	\$150.00	\$120.00	\$30.00
0090	Psych diagnostic evaluation	90791	10/01	1	\$135.00	\$0.00	\$0.00	\$0.00

FQHC PPS - Billing Example #4

Established FQHC patient comes to the FQHC for a medical visit in the morning and later in the day suffers a subsequent illness or injury.

42 Rev Cd	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0521	FQHC visit, estab pt	G0467	10/01	1	\$156.00
0521	Office/outpatient visit est	99214	10/01	1	\$160.00
0521	Debride nail 1-5	11720	10/01	1	\$50.00
0900	FQHC visit, estab pt	G0467 59	10/01	1	\$156.00
0090	Office/outpatient visit est	99213	10/01	1	\$135.00
0001	*	*	*	*	\$657.00

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FQHC PPS - Payment Example #4A

Carrier	Locality	State/County	FQHC GAF
08202	01	Detroit, MI	1.010

Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit. Payment for each covered visit is based on the lesser of the FQHC's charge for the payment code or the PPS rate.

PPS rate = Base Rate x FQHC GAF
 PPS rate = \$158.85 x 1.010 = \$160.44

In this scenario, for both visits, the FQHC's charge is less than the PPS rate.

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0521	FQHC visit, estab pt	G0467	10/01	1	\$156.00	\$156.00	\$124.80	\$31.20
0521	Office/outpatient visit est	99214	10/01	1	\$160.00	\$0.00	\$0.00	\$0.00
0521	Debride nail 1-5	11720	10/01	1	\$50.00	\$0.00	\$0.00	\$0.00
0900	FQHC visit, estab pt	G0467 59	10/01	1	\$156.00	\$156.00	\$124.80	\$31.20
0090	Office/outpatient visit est	99213	10/01	1	\$135.00	\$0.00	\$0.00	\$0.00

FQHC PPS - Billing Example #5

Patient comes to the FQHC for an initial preventive physical examination (IPPE).

42 Rev Cd	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0521	FQHC visit, IPPE or AWW	G0468	10/01	1	\$200.00
0521	Initial preventive exam	G0402	10/01	1	\$165.00
0001	*	*	*	*	\$365.00

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FQHC PPS - Payment Example #5A

Carrier	Locality	State/County	FQHC GAF	Adj. Factor
01182	18	Los Angeles, CA	1.096	0.3416

PPS rate = Base Rate x FQHC GAF

PPS rate = \$158.85 x 1.096 = \$174.10

Adjustment for IPPE = \$174.10 x 1.3416 = \$233.57

In this scenario, the FQHC’s charge is less than the PPS rate.

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

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0521	FQHC visit, IPPE or AWV	G0468	10/01	1	\$200.00	\$200.00	\$200.00	\$0.00
0521	Initial preventive exam	G0402	10/01	1	\$165.00	\$0.00	\$0.00	\$0.00

FQHC PPS - Billing Example #6

Established FQHC patient comes to the FQHC for a medical visit and receives preventive services.

42 Rev Cd	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0521	FQHC visit, estab pt	G0467	10/01	1	\$156.00
0521	Office/outpatient visit est	99212	10/01	1	\$100.00
0636	Hep b vacc adult 3 dose im	90746	10/01	1	\$60.00
0771	Admin hepatitis b vaccine	G0010	10/01	1	\$20.00
0001	*	*	*	*	\$336.00

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FQHC PPS - Payment Example #6A

Carrier	Locality	State/County	FQHC GAF
07102	13	Arkansas	0.937

In this scenario, the PPS rate is less than the FQHC’s charge: $\$158.85 \times 0.937 = \148.84

For claims that include a mix of preventive and non-preventive services, MACs will pay the FQHC 100% 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. 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 .

In this scenario, total charges for preventive services = $\$60.00 + \$20.00 = \$80.00$
 Medicare payment = $[100\% \text{ of } \$80.00] + [80\% \text{ of } (\$148.84 - \$80.00)] = \135.07
 Coinsurance = $20\% \text{ of } (\$148.84 - \$80.00) = \$13.77$

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0521	FQHC visit, estab pt	G0467	10/01	1	\$156.00	\$148.84	\$135.07	\$13.77
0521	Office/outpatient visit est	99212	10/01	1	\$100.00	\$0.00	\$0.00	\$0.00
0636	Hep b vacc adult 3 dose im	90746	10/01	1	\$60.00	\$0.00	\$0.00	\$0.00
0771	Admin hepatitis b vaccine	G0010	10/01	1	\$20.00	\$0.00	\$0.00	\$0.00

FQHC PPS - Billing Example #7

New patient under an MA plan comes in for a medical visit. The FQHC has a written contract with this MA organization.

42 Rev Cd	43 DESCRIPTION	44 HCPCS/ RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0519	FQHC visit, estab pt	G0467	10/01	1	\$156.00
0519	Office/outpatient visit est	99212	10/01	1	\$100.00
0519	Hep b vacc adult 3 dose im	90746	10/01	1	\$60.00
0519	Admin hepatitis b vaccine	G0010	10/01	1	\$20.00
0001	*	*	*	*	\$336.00

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FQHC PPS - Payment Scenario #7A

Carrier	Locality	State/County	FQHC GAF	MA Plan Amount
07102	13	Arkansas	0.937	\$120.00

Claims for Medicare Advantage (MA) Supplemental Payments:

- FQHCs that have a written contract with a Medicare Advantage (MA) organization are paid by the MA organization at the rate that is specified in their contract
- If the contracted 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 PPS rate is subject to the FQHC GAF, and may also be adjusted for a new patient visit or if a IPPE or AWV is furnished.
- The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate.

Using the same services and locality as Scenario #6:

Supplemental payment = PPS Rate – MA Plan Amount = \$148.84 - \$120.00 = \$28.84

42 Rev Cd	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Total Payment	Medicare Payment	Coinsurance
0519	FQHC visit, estab pt	G0467	10/01	1	\$156.00	\$28.84	\$0.00	\$0.00
0519	Office/outpatient visit est	99212	10/01	1	\$100.00	\$0.00	\$0.00	\$0.00
0519	Hep b vacc adult 3 dose im	90746	10/01	1	\$60.00	\$0.00	\$0.00	\$0.00
0519	Admin hepatitis b vaccine	G0010	10/01	1	\$20.00	\$0.00	\$0.00	\$0.00

III. Cost Reporting and Transition

FQHC PPS - Cost Reporting

- For cost reporting purposes, the Medicare program requires each FQHC to submit periodic reports of its operations that generally cover a consecutive 12-month period (ex: 1/1/14 through 12/31/14)
- All FQHCs 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
- FQHCs with a short cost reporting period (other than 12 months) should contact their MAC to determine the date the FQHC will begin PPS

FQHC PPS - Cost Reporting Timetable for Standard 12 Month Cost Reporting Period

Cost Reporting Period Begins	Cost Reporting Period Ends	Next Cost Reporting Period Begins	FQHC will Begin the PPS on
10/01/2013	09/30/2014	10/01/2014	10/01/2014
11/01/2013	10/31/2014	11/01/2014	11/01/2014
12/01/2013	11/30/2014	12/01/2014	12/01/2014
01/01/2014	12/31/2014	01/01/2015	01/01/2015
02/01/2014	01/31/2015	02/01/2015	02/01/2015
03/01/2014	02/28/2015	03/01/2015	03/01/2015
04/01/2014	03/31/2015	04/01/2015	04/01/2015
05/01/2014	04/30/2015	05/01/2015	05/01/2015
06/01/2014	05/31/2015	06/01/2015	06/01/2015
07/01/2014	06/30/2015	07/01/2015	07/01/2015
08/01/2014	07/31/2015	08/01/2015	08/01/2015
09/01/2014	08/31/2015	09/01/2015	09/01/2015

Cost Reporting Period - Changes

- A FQHC cannot change its cost reporting period once it is selected unless the FQHC undergoes a change of ownership (CHOW) or it requests a change in its cost reporting period in accordance with the requirements set forth in 42 CFR 413.24(f)(3)
- A request to change a cost reporting period will not be approved if the effect is to increase Medicare reimbursement.

IV. Additional Information

CMS Websites

FQHC PPS Webpage:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Index.html>

FQHC Center Webpage:

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

CMS Manuals

- [Chapter 13, Medicare Benefit Policy Manual](#)
- [Chapter 9, Medicare Claims Processing Manual](#)

FQHC PPS Questions

Email questions to: FQHC-PPS@cms.hhs.gov

V. Question & Answer Session

Evaluate Your Experience

- Please help us continue to improve the MLN Connects™ National Provider Call Program by providing your feedback about today's call.
- To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call.

Thank You

- For more information about the MLN Connects™ National Provider Call Program, please visit <http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html>
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