



Federally Qualified Health Center Version

KEY CONCEPTS OUTLINE

Module 7: Basic Reimbursement Principles for Federally Qualified Health Center Services

- I. Overview of Federally Qualified Health Center Prospective Payment System (FQHC PPS)
 - A. Background
 1. Historically, Medicare reimbursement of FQHCs was based on a cost-based reimbursement system. In 2014, through final rule making, a new methodology and reimbursement rate was established. Effective on the first day of the FQHCs year that began on or after October 1, 2014, FQHCs were transitioned to a prospective payment system for FQHC services under Medicare Part B.
 - B. FQHC PPS Payment Rate
 1. FQHCs are reimbursed a single per-diem rate based on a prospectively set rate for each beneficiary visit for an FQHC covered service. <See 42 C.F.R. § 405.2462 (e)>
 - a. The rate is based on 100 percent of the FQHC's reasonable costs incurred in furnishing care to Medicare beneficiaries for previous cost reporting years.
 - i. The base payment rate is established using historical data through quarter 2, 2022.
 - ii. CMS determines the average per diem cost using the following calculation:

(a) Average Per Diem Cost = Total FQHC costs /total FQHC daily encounters

- b. Beginning on January 1, 2017, PPS rates will be increased by the percentage increase in a market basket of FQHC goods and services as established through regulations, or, if not available, the Medicare economic index. < See 42 C.F.R. § 405.2467 (c)(2)>
- 2. From January 1, 2023, through December 31, 2023, the FQHC PPS base payment rate is \$187.19. < See *Medicare Claims Processing Manual Transmittal, 11677*>
 - a. The 2023 base payment rate reflects a 3.9 percent increase from the 2022 base payment rate of \$180.16.

II. Calculation of an FQHC Specific PPS Payment rate

A. The national base payment rate is adjusted by the following:

- 1. Geographic Adjustment Factor
 - a. Takes into consideration the location of where the services are furnished.
 - b. Based on the location (zip code +4) and the date of service it was furnished.
 - i. Note: Payments may differ between FQHCs within the same organization.
- 2. Composite Adjustment Factor
 - a. An adjustment applied once per day, per beneficiary taking into consideration the lengthier and more comprehensive visits.
 - b. The composite adjustment factor is 1.3416 (34.16%) and applies to:
 - i. New patient visit
 - (a) Patient is new to the FQHC and has not been seen at any FQHC locations within the organization.
 - ii. Initial Preventive Physical Examination (IPPE)
 - iii. Initial or subsequent annual wellness visit (AWV). <See 42 C.F.R.2462 (e)>

B. Total FQHC PPS Payment per Visit Calculation

1. FQHC PPS Payment = FQHC base rate X Geographic adjustment factor x Composite Adjustment factor

FQHC PPS Payment Example

Facts: An established patient presents with a complaints of cough, congestion, and fever. Physician performs an evaluation and management service of moderate complexity. Based on the physician's initial assessment antibiotics were prescribed for a sinus infection. The physician reported CPT 99213 for the evaluation and management service. What is the FQHC's reimbursement?

PPS Rate = 160.00

Provider's actual charge for payment code \$150.00

Revenue Code	HCPCS	MOD	DOS	Total Charge	Covered Charge
0519	G0467 FQHC Payment Code		01/22/2023	150.00	150.00
0519	99213 Qualifying Visit		01/22/2023	135.00	135.00
0001				285.00	285.00
PPS Rate	\$225.00				

III. FQHC Supplemental Payments

A. CMS must provide supplemental payments to FQHCs that contract with Medicare Advantage (MA) organizations to cover the difference between the MA payment and the FQHC PPS payment (per diem amount) that would be made under the traditional Medicare program. < See 42 *C.F.R* 405.2469; *Medicare Claims Processing Manual*, Chapter 9, §60.4>

1. If the MAC determines the MA payment is less than the FQHC PPS payment made under original Medicare, the MAC will pay the difference to the FQHC. < See 42 *C.F.R* 405.2469; *Medicare Claims Processing Manual*, Chapter 9, §60.4>

- a. The supplemental or wraparound payment is based on the PPS rate without comparison to the FQHC's charge.

2. The supplemental or wraparound payment are not adjusted for coinsurance or preventive services, as the coinsurance or waiver of coinsurance would have been taken into consideration in the MA payment. < *Medicare Claims Processing Manual*, Chapter 9, §60.5>

B. Per Visit Supplemental Payment

1. Per visit supplemental payments are made when a covered face-to-face encounter or an encounter furnished via two interactive technology or audio only interactions (due to the beneficiary consent or ability) for the purpose of diagnosis, evaluation, or treatment of a mental health disorder between the MA enrollee and the FQHC practitioner. <See 42 *C.F.R* 405.2469 (d)>

C. Billing for Supplemental Payments

1. Supplemental payments for an encounter are billed to the MAC, on TOB 077X with revenue code 0519.
2. The claim must contain the appropriate FQHC payment code and the HCPCS qualifying visit code. Both codes are reported under revenue code 0519.

MA Claim Qualifies for Supplemental Wraparound Payment Example

PPS Rate =225.00

MA Contract Rate = \$200.00

Revenue Code	HCPCS	MOD	DOS	Total Charge	Covered Charge
0519	G0468 FQHC Payment Code		01/22/2023	170.00	170.00
0519	G0439 Qualifying Visit		01/22/2022	150.00	150.00
0001				320.00	320.00
PPS Rate	\$225.00				

Wraparound Payment = PPS Rate- MA Contract Rate

\$225-200 =\$25.00

IV. Sliding Scale

- A. FQHCs, approved by Health Resources and Services Administration (HRSA), are required to establish a sliding fee scale in accordance with statutory and HRSA requirements. . <See *Medicare Benefit Policy Manual*, Chapter 9 § 90.2>
- B. The HRSA approved FQHC must have a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. <See HRA
 - 1. The FQHC must notify patients of the availability of the sliding fee discount.
 - 2. The fee scale/schedule must be based on the most recent Federal poverty level guidelines and be updated on an annual basis.
 - 3. Sliding Fee Discounts Must:
 - a. Provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged);
 - b. Provide varying discounts (slide) for incomes between 100% and 200% of poverty, and incorporate a sliding discount policy based on family size and income; and
 - c. No discounts are provided to patients with incomes over 200 % of the Federal poverty guidelines.

V. Calculation of Patient's Deductible and Coinsurance

C. Deductible

- 1. Each calendar year, a single deductible is established for most Medicare Part B services. <See *Medicare Claims Processing Manual*, Chapter 9 § 40.1>
 - a. For CY 2023, the Part B deductible is \$226.00.
 - a. In general, the beneficiary must pay the annual Part B deductible before Medicare begins to pay for the services. However, ***the Part B deductible does not apply to FQHC-covered services*** <See *Medicare Claims Processing Manual*, Chapter 9 § 40.1>

B. Coinsurance

1. FQHC Services

- a. The patient is responsible for a coinsurance amount of 20 percent of the lesser of the FQHC's actual charge for the specific payment code or the adjusted PPS rate <See *Medicare Claims Processing Manual*, Chapter 9 § 40.2>
 - i. Certain preventive services are statutorily waived and are not included in the calculation of coinsurance.
 - ii. For FQHC services paid under the MPFS (i.e., CCM, PCM, BHI, CoCM, VCS, and telehealth originating site fee), the calculation of coinsurance is based on 20% of the MPFS allowed amount.
 - iii. An FQHC may waive coinsurance after a good faith determination that the patient is in financial need. The waivers must not be routinely offered or advertised.

2. Non-FQHC Services

- a. When an independent FQHC bills the Part B MAC on a 1500 claim form for non-FQHC services, the coinsurance amount is usually based on 20% of the MPFS allowed amount. For more information, see *Medicare Claims Processing Manual*, Chapter 12.
 - b. When a provider-based FQHC (or the parent provider) bills the Part A MAC on the UB-04 claim form for non-FQHC services, the coinsurance amount is based on the rules applicable to the parent provider and type of bill (e.g., TOB 0851 CAH or TOB 131 OPPS). For more information, see the *Medicare Claims Processing Manual*, Chapter 4.
- C. Medicare Reimbursement of FQHC services <See *Medicare Benefit Policy Manual*, Chapter 13 § 70.1; see *Medicare Claims Processing Manual*, Chapter 9 § 40.1; see *CMS Rural Health Clinic Fact Sheet*, May 2019>
- 1. For qualifying medical or mental health visits, Medicare pays independent FQHCs and PB FQHCs, the **lesser** of :
 - a. 80% of the FQHCs actual charge for the specific payment code, **or**
 - b. 80% of the adjusted FQHC PPS rate.
 - 2. For preventive health visits for which coinsurance waived, Medicare reimbursement is the lesser of:
 - a. 100 % of the FQHCs actual charge for the specific payment code, or

- b. 100 % of the adjusted FQHC PPS rate.

D. Dually Eligible Beneficiaries

1. Beneficiaries that are generally low-income beneficiaries enrolled in both Medicare and Medicaid.

- a. Medicare enrollment may be Medicare Part A, Part B, or both.

- b. Medicaid benefits may be:

- (i) Full Medicaid benefits, or

- (ii) Limited to premium or cost sharing assistance.

- (a) Through the Medicare Savings Programs (MSP) based on one of the following eligibility groups:

1. Qualified Medicare Beneficiary (QMB) Program

- a. Covers Part A and Part B premiums, deductibles, coinsurance, and copayments.

2. Specified Low-Income Medicare Beneficiary (SLMB) Program

- a. Covers the Part B premium only

3. Qualifying Individual (QI) Program

- a. Covers the Part B premium

- b. Individuals have no other Medicaid eligibility

4. Qualified Disabled Working Individual (QDWI) Program

- a. Covers only Part A premium for certain individuals under age 65 with disabilities who have returned to work.

2. Dually Eligible Billing Requirements <MLN Fact Sheet 6977>

- a. Assignment must be accepted for Part B covered services.
- b. When an advanced beneficiary notice is provided to a dually eligible beneficiary you cannot bill the beneficiary at the time of service.
- c. Upon claim adjudication by both Medicare and Medicaid, you may only charge the beneficiary in the following situations:
 - (i) QMB coverage without full Medicaid coverage:
 - (a) The ABN is presented prior to the service, and Medicare subsequently denies the claim, the ABN could allow you to shift financial responsibility to the beneficiary under Medicare policy.
 - (ii) Beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because you do not participate in Medicaid), the ABN could allow you to shift financial responsibility to the beneficiary under Medicare policy
 - (a) Note: This is subject to state laws that limit beneficiary responsibility.

V. Cost Reporting

D. An FQHC must submit an annual Medicare cost report to their MAC.

1. The FQHC is paid for the costs of graduate medical education payments, bad debt, influenza and pneumococcal vaccines and administration through the cost report.
 - a. Independent of whether the FQHC has GME costs, bad, debt, or costs associated with influenza and pneumococcal vaccines and their administration, the FQHC must file a cost report.
 - b. An FQHC can claim bad debt for unpaid coinsurance. <See *Medicare Calculation of a Patient's Deductible and Coinsurance*

If an FQHC claims bad debt, it must be able to show that reasonable efforts were made to collect the amounts. Coinsurance that is waived, either due to a statutory waiver or a sliding fee scale, may not be claimed as allowable costs.

The Medicare principles of reimbursement for allowable costs are stated in 42 CFR 413 and in the Medicare Provider Reimbursement Manual, 15-1.

Information on cost report forms and the reporting process can be found in the Medicare Provider Reimbursement Manual, 15-2.

c. Consolidated Cost Reports

- i. FQHCs with more than one site may file consolidated cost reports if approved by the A/B MAC in advance of the reporting period for which the consolidated report is to be used.
 - (a) Once the election to use a consolidated cost report has been made, the FQHC may not revert to individual reporting without first obtaining prior approval of the A/B MAC. <See *Medicare Benefit Policy Manual*, Chapter 13, § 80.2>

Frequently Asked Questions on the Medicare FQHC PPS¹

(Rev. 11-21-19)

Topics

FQHC PPS Rate and GAFs

New Patient, IPPE, and AWW Adjustments

Per-diem Payment Exceptions

FQHC PPS Payment Codes

Preventive Services

Billing and Claims Processing

FQHC PPS Rate and GAFs

Q1. What is the PPS rate for my FQHC?

A1. There is one national PPS rate for all FQHCs. *The rate from January 1, 2020, through December 31, 2020 is \$173.50. The previous rates can be found on the [CMS FQHC Center website](#).*

Q2. How often will the rate change?

A2. The rate will be updated annually to reflect inflation, starting January 1, 2016.

Q3. Is the PPS rate the actual amount that my FQHC will receive per visit?

A3. Not necessarily. The PPS rate is a base rate for all FQHCs. Each FQHC's rate is adjusted based on the location of where the services are furnished. FQHCs will be paid based on the lesser of the adjusted PPS rate or their charges.

Q4. What is the FQHC GAF?

A4. The FQHC GAF (Geographic Adjustment Factor) is used to adjust the base FQHC PPS rate to reflect the variation in practice costs in different areas. It is an adaptation of the Geographic Practice Cost Index (GPCI) used for the Physician Fee Schedule.

Q5. What is the FQHC GAF for my FQHC?

A5. The list of FQHC GAFs is on the [CMS FQHC Center website](#). The FQHC GAF is determined based on the location of where the service is furnished.

Q6. How often will the GAFs change?

A6. The FQHC GAFs will be updated whenever the GPCI is updated, which is at least annually and occasionally more frequently.

Q7. What if the FQHC GAF changes after I submitted my claim?

A7. Your claim should reflect the FQHC GAF that was in effect when the service was furnished.

Q8. Is the FQHC GAF applied to our charges?

A8. No. The FQHC GAF is only applied to the base PPS rate.

Q9. Is the FQHC GAF based on a calendar year or fiscal year?

A9. The FQHC GAF is based on the calendar year.

Q10. How do I calculate my adjusted PPS rate?

A10. Multiply the base PPS rate times the FQHC GAF for the location where the service was furnished.

Q11. How does sequestration affect our PPS rate? Do we still face a 2% reduction?

A11. Sequestration is still in effect and there is a 2 percent reduction to the Medicare payment (after adjustments for coinsurance).

New Patient, IPPE, and AWW Adjustments

Q1. Are there any other adjustments to the rate besides the geographic adjustment?

A1. Yes. The adjusted FQHC PPS rate is increased by 34.16 percent when a patient is new to the FQHC, or an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) is furnished. Only one adjustment per day can be applied.

Q2. Does the new patient, IPPE, and AWW adjustment vary by region?

A2. No. The 34.16 percent increase is the same for all FQHCs.

Q3. Is this adjustment done before or after the base rate is adjusted by the FQHC GAF?

A3. The new patient, IPPE, and AWW adjustment is applied to the PPS rate after the PPS rate is multiplied by the FQHC GAF.

Q4. When does the 34.16 percent increase for IPPE, AWW, and new patients begin?

A4. The new patient, IPPE, and AWW adjustment begins when a FQHC transitions to the FQHC PPS.

Q5. If a patient was seen in another FQHC that is not affiliated with my FQHC, and then came to my FQHC 6 month later, would they be considered a new patient?

A5. Yes, because they would be new to your FQHC.

Q6. If my FQHC hires a new physician, and patients from the physician's previous private practice group follow the physician to our FQHC, are these patients considered "new patients"?

A6. Yes, because they are new to your FQHC.

Q7. If a patient received a service at the FQHC within the prior three years that is not covered by Medicare (such as routine dental care), and then came to the FQHC for a service that is covered by Medicare, would the person be considered a “new patient” for purposes of the adjustment?

A7. Yes. If the patient has not received any Medicare-covered services within the last 3 years, he/she would be considered a new Medicare patient.

Q8. If a patient was seen in the hospital that we are affiliated with and then came to the FQHC for follow-up, would they be a new patient?

A8. Yes. FQHCs are not authorized to furnish hospital services (inpatient or outpatient), so if the patient has not been seen in *your* FQHC within the past 3 years, he/she would be a new patient.

Q9. If a FQHC is part of a county health department, and a patient visits one of the health department clinics that are not part of the FQHC and then visits one of the health department clinics that is part of the FQHC, would that individual be considered a “new patient” for purposes of the Medicare FQHC PPS adjustment?

A9. Yes. Only patients that have been seen in the parts of the health department that are part of the FQHC organization would be considered FQHC patients. Any services received at a non-FQHC site within the health department would not be considered FQHC services.

Q10. If a FQHC is part of a larger corporate entity that includes a community mental health agency (CMHA), and no FQHC billing of the Medicare and Medicaid programs occurs at the CMHA site, would a patient be considered a new patient if they were seen at the CMHA site within the last 3 years and then went to the FQHC?

A10. Yes. As long as the CMHA is completely separate organization from the FQHC, the patient would be new to the FQHC, regardless of whether the CMHA is part of the larger corporate entity that owns the FQHC or not.

Q11. If a physician group practice gets HRSA funding as a “new start” or receives “look-alike” status, would all the patients be considered new patients, even though they were seen by the same practitioners in the same building within the last 3 years?

A11. Yes. The physician practice group is not a FQHC until it receives its designation from HRSA as a health center and its Medicare site certification for the specific permanent sites that are part of the HRSA scope of project. Once the physician’s practice group has met these conditions, it is considered a FQHC and a patient seen for the first time in the FQHC would be considered a new patient.

Q12. If a patient was seen in the FQHC and then goes to another FQHC that is part of the same organization as the first FQHC, would they be considered a new patient in the second FQHC? Does it make a difference if it is the main facility or another location? Does it make a difference if the locations bill different Medicare Administrative Contractors (MACs)?

A12. No. If a patient was seen in any location of the FQHC by any provider within the last 3 years, regardless of which MAC is billed, he/she would not be considered a new patient.

Q13. If an established patient sees a specialist in the FQHC for the first time, will the FQHC get the new patient adjustment?

A14. No. The new patient adjustment is only for Medicare patients that have not received any Medicare services from any practitioner in the FQHC organization within the last 3 years.

Q15. If a patient received only mental health services in the FQHC and then came in for primary care or preventive services, would they be considered a new patient?

A15. No. If the patient has received any Medicare-covered services at the FQHC from any practitioner in the FQHC, the patient is not new to the FQHC.

Per-diem Payment Exceptions

Q1. Are there any situations where a FQHC can bill for more than one visit per day for the same patient?

A1. Yes, there are two exceptions. The first exception is when a patient is seen in the FQHC for a medical visit, leaves the FQHC, and subsequently suffers an illness or injury that requires additional diagnosis or treatment on the same day. An example would be if a patient sees a FQHC practitioner in the morning for a medical condition and later in the day has a fall and returns to the FQHC for treatment of their injury.

Q2. Can the FQHC bill for two visits if one visit is medical and the other is mental health?

A2. Yes, this is the second exception. A FQHC can bill for two visits when a patient has a FQHC visit with a mental health practitioner (clinical psychologist or licensed clinical social worker) on the same day as a medical visit with a physician, nurse practitioner (NP), or physician assistant (PA).

Q3. If a patient has a medical visit with a physician, NP, or PA, and then sees a clinical psychologist for a medication adjustment on the same day, can both a medical and mental health visit be billed?

A3. No. Effective January 1, 2015, medication management does not qualify as a stand-alone visit in a FQHC. When medication management is furnished on the same date of service as a qualifying medical visit, the charges would go on the claim. If there is no qualifying visit associated with medication management, no claim is submitted and no payment is made.

Q4. If a medical visit, a mental health visit, and a subsequent illness/injury visit are reported on the same day, can we bill for 3 visits?

A4. Yes, although we would not expect that to be a common occurrence.

Q5. If a Diabetes Self-Management Training (DSMT) or /Medical Nutrition Therapy (MNT) visit occurs on the same day as a mental health visit, can two visits be billed?

A5. Yes, because DSMT/MNT is considered a medical visit and a FQHC can bill for 2 visits when a medical and mental health visit occur on the same day.

Q6. If a DSMT/MNT visit is furnished on the same day as another medical visit, can two visits be billed?

A6. No. If DSMT/MNT is furnished on the same day as another medical visit, only one visit can be billed.

Q7. If an IPPE or AWV occurs on the same day as another medical visit, can two visits be billed?

A7. No. However, the FQHC would receive an adjustment to their payment when an IPPE or AWV is furnished.

FQHC PPS Payment Codes

Q1. What are FQHC G codes?

A1. FQHC G codes (G0466 through G0470), are specific payment codes used for payment under the FQHC PPS. They represent a bundle of services that the individual FQHC typically furnishes to a Medicare patient. *See [FQHC PPS Specific Payment Codes](#).*

Q2. What services are included in each of the codes?

A2. Each FQHC determines which services to include in each G code, based on the services typically furnished by that FQHC to a Medicare patient.

Q3. Do we have to submit documentation to justify the services we are including?

A3. No. We expect that the services will reflect a typical bundle of services that your FQHC provides to Medicare patients.

Q4. How do I set my FQHC G code amounts?

A4. Once you have determined the typical bundle of services that your FQHC furnishes to Medicare patients during an encounter, total your normal charges for those services. The sum of the charges for the services included in the bundle of services is your G code amount.

Q5. Can I change the FQHC G code amount for each patient or visit?

A5. No. You can only change the total amount of your FQHC G code whenever you change the bundle of services that are included in that G code, or whenever you change the charges for the services included in your the bundle.

Q6. Do the charges in the G code have to be the same for each patient?

A6. Yes. The charges associated with a specific G code must be uniform for all patients. Also, the charges for all individual services included under the G code must be the same charges that are charged to all non-Medicare patients for those services.

Q7. Does the FQHC G code amount have to equal the charges on the claim?

A7. No. It is possible that the charges would equal the FQHC G code, but the FQHC G code reflects the typical bundle of services furnished to your Medicare patients, which may be different from the services furnished to the patient on that particular day.

Q8. Do we have to submit the list of services included in our FQHC G codes and their associated charges?

A8. No. A list of the services included in the bundle of services and their associated charges should be maintained by the FQHC and only provided upon request. If the bundle of services changes, or the charges for the services included in the bundle changes, this information, along with the dates of the changes, should be part of the FQHC's recordkeeping.

Q9. Is there a penalty if my FQHC G code amount is higher than my adjusted PPS rate?

A9. No. Your payment will be the lesser of your adjusted PPS rate or FQHC G code.

Q10. Do I need to use the FQHC G codes for non-Medicare patients?

A10. Other payers will determine what information is required for their payment systems.

Q11. What G code does the FQHC report with HCPCS code 99490 for chronic care management services?

A11. CCM or general BHI services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491 (30 minutes or more of CCM furnished by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

Q12. What G code does the FQHC report with the telehealth originating site facility fee (HCPCS code Q3014)?

A12. The telehealth originating site facility fee does not require a G code.

Q13. Can FQHCs bill for remote patient monitoring?

A14. Remote patient monitoring (RPM) is not a stand-alone billable visit. When it is furnished incident to an FQHC visit, payment for RPM services are included in the FQHC PPS rate.

Preventive Services

Q1. Can DSMT/MNT still be billed as a separate billable visit if they are the only services provided to a patient on a specific day?

A1. Yes. However, if DSMT/MNT is furnished on the same day as another medical visit, only one visit will be paid.

Q2. Can a pharmacist bill for DSMT/MNT?

A2. In FQHCs, only certified DSMT practitioners can bill for DSMT, and only qualified nutritional professionals can bill for MNT. If a pharmacist also happens to be a certified DSMT practitioner or a qualified nutritional professional, he/she could bill for a visit.

Q3. Should I submit a claim if influenza and pneumococcal vaccines were the only services provided?

A3. No. If influenza and pneumococcal vaccines were the only services provided, there is no claim and these services are reported only on the cost report. If they were provided as part of an encounter, they

should be reported on both the claim and the cost report.

Q4. Is a pap smear (Q0091) or a pelvic screening (G0101) a stand-alone billable visit if no other services are furnished on the same day?

A4. Yes. Please see [FQHC Specific Payment Codes](#) for a full list of services that qualify to be billed as a visit.

Billing and Claims Processing

Q1. Should I bill medical and mental health services on one claim if they occurred on the same day?

A1. Yes. All services furnished on the same day must be reported on one claim.

Q2. If I have to bill medical and mental health encounters on the same claim, which NPI do I put in form locator 76 (attending provider) on the UB-04?

A2. The National Billing Uniform Committee (NUBC) definition for attending NPI is: 'The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim'. The person who has overall responsibility will vary depending on which services are furnished on that day.

Q3. If a patient is seen at one site of a FQHC organization for a medical visit and is seen at different site of the same FQHC organization on the same day but at a different time of day or with a different provider, should both visits be reported on the same claim?

A3. Yes. All visits that occur within the FQHC organization on the same day to the same patient should be on the same claim, even if they occurred at different sites.

Q4. Do I have to report the FQHC G codes on Medicare MSP claims?

A4. Yes, the FQHC G codes and qualifying visit codes must be reported on all FQHC claims.

Q5. Should the FQHC report the G codes on both primary and secondary claims?

A5. Yes, the G codes should be reported on both primary and secondary claims. The G codes are part of the HCPCS code set and as a Health Insurance Portability and Accountability Act (HIPAA) standard; all payers must accept these codes. However, payers may choose to pay based on other services reported on the claim.

Q6. How will crossover claims be handled?

A6. There is no change to the crossover process. If Medicare is secondary, we would process Medicare's allowed amount and subtract the primary payment amount from the MSP covered amount in the MSP module.

Q7. Does the FQHC G code have to be the first line on the claim?

A7. No. The Medicare claims processing system will sort the lines as long as there is both a FQHC G code and a qualifying visit code.

Q8. How do I bill for procedures if no other service is furnished?

A8. Except for certain preventive services, procedures are not separately billable. If the procedure is furnished on the same date of service as a qualifying visit, the charges for the procedure would go on the claim with the payment code and qualifying visit code, and the FQHC would be paid the lesser of the total charges or the adjusted PPS rate. If there is no qualifying visit associated with the procedure, no claim is submitted and no payment is made.

Q9. If there is no qualifying visit associated with the procedure, can we give the patient an Advanced Beneficiary Notice (ABN) and bill them for the full amount?

A9. Yes, an ABN can be given in this situation.

Q10. How is the Medicare Advantage (MA) wrap-around payment made?

A10. FQHCs that have a written contract with a MA organization that furnishes care to beneficiaries covered by the MA plan are paid by the MA organization at the rate that is specified in their contract. If the MA contract rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary. The supplemental payment is only paid if the contracted rate is less than the adjusted PPS rate.

Q11. Are G codes required for the MA wrap around payment?

A11. Yes. The specific payment codes that correspond to the appropriate PPS rates and the detailed HCPCS coding required for all FQHC PPS claims, including MA payments.

Q12. What should we do if we think that we have been paid incorrectly or have questions about MSP payment?

A12. Contact your MAC if you have any questions regarding your payment.

Q13. Are we required to perform an evaluation and management (E&M) service with HCPCS codes 90833, 90836 or 90838?

A13. Yes, an E&M must be furnished on the same day with these codes because the codes are for both psychotherapy and an E/M visit.

Q14. Are HCPCS codes 90833, 90836 or 90838 stand-alone mental health visits if no other services are furnished on the same day?

A14. No, effective April 1, 2015 HCPCS codes 90833, 90836 and 90838 are no longer qualify as stand-alone mental health services in a FQHC.

Q5. Are Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) required to enroll as an Opioid Treatment Program (OTP) to provide OTP services?

A5: No. RHCs and FQHCs can already provide most services included in the OTP bundle. RHCs and FQHCs can bill for medically-necessary, face to face services, such as evaluation and management or psychotherapy visits, when furnished by an RHC or FQHC practitioner. They can also bill monthly for care management services, which include chronic care management, general behavioral health integration, and psychiatric collaborative care management, in addition to the billable visit.

Q6. Can RHCs and FQHCs bill separately for medication management or toxicology screening tests?

A6. Medication management is already included in the RHC or FQHC payment when an RHC or FQHC service is furnished and it is not separately billable. Laboratory services, including toxicology screening tests, are not part of the RHC or FQHC service and are billed separately.

Q7. Can RHCs and FQHCs furnish and bill for methadone?

A7. No, only facilities enrolled as OTP providers can furnish and bill for methadone.

¹ The FAQs in this document do not necessarily apply to grandfathered tribal FQHCs.

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