Federally Qualified Health Center (FQHC) Medicare Billing

BASIC 101 PLUS

IMPORTANT NOTICE

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- **The information provided in this manual was current as of December 2009. Any changes or new information superseding the information in this manual, provided in newsletters, MLN articles, listserv notices, Local Coverage Determinations (LCDs), or Centers for Medicare and Medicaid Services (CMS) Internet-Only Manuals with publication dates after December 2009, are available at:**

  http://www.trailblazerhealth.com/Medicare.aspx

Qualifying

Qualify as FQHC

- An FQHC seeking to enroll as a Medicare-participating supplier is subject to a filing procedure instead of State Agency (SA) certification or recertification. The FQHC must attest that it is in compliance with all applicable Medicare regulations. The SA does not conduct a survey to confirm the FQHC's compliance with Medicare's regulations.

CMS will enter into an agreement with an entity that qualifies to participate as an FQHC when:

- Applicant provides a copy of its Notice of Grant Award by the Health Resources and Services Administration (HRSA) that verifies the applicant qualifies as an FQHC; the applicant provides a copy of its FQHC Look-Alike Designation Memo from CMS; *or* the applicant is confirmed as a qualifying Tribal or Urban Indian organization outpatient healthcare facility.
- The applicant assures CMS through a self-attestation that it satisfies the regulatory requirements in 42 CFR 405, Subpart X and 42 CFR, Part 491, except for Section 491.3.

- The applicant submits a complete CMS-855A enrollment application (along with all supporting documentation) to its Medicare Administrative Contractor (MAC)/Fiscal Intermediary (FI), and the MAC/FI recommends approval of said application.

- The entity terminates other Medicare provider agreements it has, unless it assures CMS that it is not using the same space, staff, and resources simultaneously as a physician's office or other type of provider or supplier. For example, a Rural Health Clinic (RHC) cannot concurrently be approved for Medicare as both an RHC and FQHC.

Multiple Locations

- In accordance with 42 CFR, 491.5(a)(3)(iii), if an FQHC provides services in permanent units in more than one location, each such unit must be separately enrolled in the Medicare program. One FQHC permanent unit cannot be provider-based to another FQHC unit.

- However, mobile units operated by the FQHC do not require separate enrollment, but are considered part of the permanent FQHC unit that operates them.

MAC Jurisdiction

The Regional Office (RO) Survey and Certification staff are responsible for reviewing , approving, or denying requests for Medicare participation as an FQHC. The RO notifies the FQHC applicant and HRSA's Bureau of Primary Health Care or the Indian Health Service (IHS), as appropriate.

For approvals, the RO shall transmit the Tie-In Notice in accordance with the following instructions:

- A freestanding FQHC undergoing initial enrollment, except for a Tribal or Urban Indian FQHC, is to be assigned to the MAC or legacy FI that covers the state where the FQHC is located.
- *A Tribal or Urban Indian FQHC undergoing initial enrollment is to be assigned to the Jurisdiction 4 MAC.*

Jurisdiction and Enrollment

NGS -> Trailblazers

Pub. 100-04 Transmittal: 1707 Date: March 27, 2009 Change Request: 6207B. Policy:

1. FQHCs

- Most existing FQHCs and FQHC lookalikes are currently within the workload serviced by NGS Wisconsin, (workload # 00450.) *…tribal FQHCs will be assigned to the Jurisdiction 4 MAC.* As used in these business requirements, a "tribal FQHC" means *a Medicare FQHC operated by a Tribe or Tribal organization under the Indian Self-Determination Act (25 USCS 40(b)) or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (25 USCS 13).*
- A new, Tribal FQHC will submit its Form CMS-855A application to the Jurisdiction 4 MAC.
- Provider-based FQHCs will submit their Form CMS-855A applications to the MAC or FI that services the main provider.
- *Enrolled RHCs and FQHCs will remain in those workloads until CMS undertakes the process of moving them to their destination MACs.*

Preparing to Enroll as FQHC

ROs will provide potential applicants for enrollment as an FQHC a copy of the document, titled “Information on Medicare Participation for FQHCs (Exhibit 179).” This document includes information on:

- Obtaining a copy of CMS-855A enrollment application from the CMS Web site at http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf

- Attestation Statement for FQHCs (Exhibit 177)

855A and Attachments

To participate in the Medicare program, applicants seeking initial enrollment as an FQHC must submit to the MAC *Jurisdiction 4 (J4) contractor, in the case of all applicants that are operated by a tribe or tribal organization;* and to the MAC/FI having jurisdiction for the state where the facility is located in the case of all other applicants:

- A signed and completed application CMS-855A enrollment application.
- Two signed and dated copies of the attestation statement (Exhibit 177). Since FQHCs must sign an agreement stipulating that they will comply with Section 1861(aa)(4) of the Act and specific FQHC regulations, this statement serves as the Medicare FQHC agreement when signed by the RO.

- HRSA Notice of Grant Award or FQHC Look-Alike Designation Memo from CMS (HRSA provides the applicant notice of CMS approval). In the case of FQHCs receiving a Section 330 grant, a copy of the form that lists the service sites covered by its HRSA grant to verify the site covered by the 855A falls under the scope of the HRSA grant.
- CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement.
- Clinical Laboratory Improvement Amendments (CLIA) certificate.
- State license (if applicable).
- A copy of the National Provider Identifier (NPI) notification the applicant received from the National Plan and Provider Enumeration System (NPPES).

The MAC/FI will review the completed 855A and other documents submitted by the applicant to ensure that all required information and documentation has been provided. Upon completion of its review, the MAC/FI will either: (1) forward its recommendation for approval to the RO; or (2) deny the application (with a cc: to the RO on the denial letter). Upon receipt of a recommendation for approval, the RO verifies that the application package is complete and satisfies the requirements listed in 2826B.

•For outpatient health programs or facilities operated by a Tribe or Tribal organization or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act, the RO confirms the applicant's attestation by using the IHS lists of facilities or organizations provided by the Central Office (CO) or by contacting the CO or the IHS for applicants not on the list. Each RO should designate a survey and certification primary Point-of-Contact (POC) for coordination with HRSA, IHS, and CMS CO. If the RO determines that the FQHC application meets all requirements, the RO signs the applicant's Attestation Statement for Federally Qualified Health Centers (Exhibit 177). The RO will use the date on the MAC's/legacy FI's recommendation letter when signing the attestation, and this date is the effective date of the FQHC's agreement with CMS.

PECOS: Enrolling in Medicare Online

- The CMS has created a way for providers to enroll in Medicare online. The system for enrolling online is called the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). Internet-based PECOS is available to physicians, NPPs, and provider and supplier organizations in all States and the District of Columbia. Go to https://pecos.cms.hhs.gov/pecos/login.do

Definition of an Encounter
Noncovered and Covered Services

FQHC Encounter

- FQHCs are paid on the basis of an encounter. An encounter is defined as “a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit,” per Section 504 of CMS Pub. 27. The following exception is possible in rare circumstances: “…except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.”

As a result of Section 5114 of the Deficit Reduction Act of 2005, the FQHC definition of a face-to-face encounter is expanded to include encounters with qualified practitioners of outpatient Diabetes Self-Management Training (DSMT) services and Medical Nutrition Therapy (MNT) services when the FQHC meets all relevant program requirements for the provision of such services.

Outside the Office Setting

- Full-time and part-time *physicians* who are employees of an FQHC or who are compensated under agreement by the center for providing services furnished to the center's patients in a location other than at the clinic *may furnish services to clinic patients at the clinic or in other locations (e.g., in a patient's home*). These services are FQHC services and are payable only to the clinic. Center patients include individuals who receive services at the clinic facility or services provided elsewhere for which the costs are included in the costs of the FQHC. A physician who is an employee of an FQHC or who is compensated by the clinic for services in locations other than the clinic may not bill the Medicare Part B program on the CMS-1500 claim form for services furnished to Medicare beneficiaries who are center patients, regardless of place of service.

If the clinic does not compensate a physician for services furnished to center patients in a location other than at the FQHC location, the physician may bill for Medicare payment under Part B for a location away from the clinic.

Note: services rendered in hospital settings (inpatient, outpatient, and emergency room) are not considered FQHC.

Noncovered FQHC Services

An FQHC may provide other items or services that are covered under Part B but are not FQHC services as defined in the regulations. The items listed below are not billable to Part A. They must be billed to the Medicare Part B contractor for your state for fee-for-service payment.

Services not covered in an FQHC as clinic services, which may be covered under other Medicare benefits, include:

- Services provided in a hospital setting
- EKG/EEG/ECG services (technical portion)
- Durable Medical Equipment (DME) (whether rented or sold), including crutches, hospital beds used in the patient's home, wheelchairs, etc.
- Ambulance services

Noncovered FQHC Services continued…

- Prosthetic devices that replace all or part of an internal body organ (including colostomy bags), supplies directly related to colostomy care, and the replacement of such devices
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition
- Physical, speech, or occupational therapy with a therapist *not employed by the FQHC*
- Technical components of diagnostic tests
- Arranging for physical, speech, or occupational therapy with suppliers not employed by the FQHC

TC–Not Covered

The technical component of the following specific preventive services (the professional component is an FQHC service if performed by an FQHC physician or NPP):

- Screening Pap smears and screening pelvic exams
- Prostate cancer screening
- Colorectal cancer screening tests
- Screening mammography
- Bone mass measurements
- Glaucoma screening

FQHC Covered Services

The services offered in an FQHC are the types of services that patients receive in a doctor's office, outpatient clinic, or emergency room. Such services are physician's diagnostic, treatment, or consultation services. In an FQHC, a nurse practitioner, physician's assistant, certified nurse midwife, clinical psychologist, or clinical social worker may also provide the services.

Services are covered in an FQHC if the following apply:

•Medically reasonable and necessary.

•The service is provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical social worker, or clinical psychologist who is employed by or receives compensation from the clinic.

FQHC Covered Services continued…

•If not provided by a physician, the service is provided under the general supervision of the physician.

•The service is provided in accordance with the clinic's policies, protocols, standing orders, or any physician's medical orders for patient care and treatment.

•If not provided by a physician, state law permits the nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker to provide the service.

•Services not provided by a physician are covered if Medicare would cover the service when performed by a physician.

Incident To

SERVICES AND SUPPLIES 'INCIDENT TO' THE SERVICES

Services and supplies that are "incident to" the services of the physician, nurse practitioner, physician assistant, clinical psychologist, or clinical social worker are also covered in the FQHC. This would include services of other clinic employees, including registered nurses, licensed vocational nurses, technicians, or aides. This also includes supplies such as casts, bandages, and splints used for these services. Only drugs and biological products that cannot be self-administered are covered in the FQHC.

Physician Services

Physician services are the professional services performed by a physician for a patient including diagnosis, therapy, surgery, and consultation. A service may be considered a physician service if the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization is possible by means of X-rays, EKG and Electroencephalogram (EEG) tapes, tissue samples, etc.

- *Example: The interpretation by a physician of an actual EKG or EEG reading that has been transmitted via telephone (i.e., electronically rather than by means of verbal description) is a covered service.*

Professional Services

DETERMINING PROFESSIONAL SERVICES

In determining whether the professional services of a physician are FQHC services, the following general rules apply:

- The services of a physician performed at the clinic are FQHC services and are payable only to the clinic.
- Services by means of a telephone call between a physician and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are *not separately billable* but can be included as part of another billable visit by the FQHC practitioner (e.g., Revenue Code 0521).
- Visits for the sole purpose of obtaining or *renewing a prescription*, in which the need was previously determined (so that no examination of the patient is performed), are not covered services.
- Time used in completion of claim forms.
- Care plan oversight is not allowed by either Part A or Part B for FQHC providers.

Nurse Practitioner, Physician Assistant, and Nurse Midwife Services

Nurse practitioner or physician assistant services (including services furnished by nurse midwives) are covered as FQHC services.

The services are covered if they are:

- Furnished by a nurse practitioner, physician assistant, or certified nurse midwife who is employed by or receives compensation from an FQHC (mid-levels cannot be contracted workers; they can only be an employee of the clinic or clinic owner)

- Furnished under the general (or direct, if required by state law) medical supervision of a physician

NP, PA, NM continued…

•Furnished in accordance with center policies and any physician's medical orders for the care and treatment of a patient

•A service that the nurse practitioner, physician assistant or certified nurse midwife who furnished the service is legally permitted to perform by the state in which the service is furnished

•A service that would be covered under Medicare if furnished by a physician.

Clinical Psychologist Services

To qualify as a clinical psychologist, a practitioner must meet the following requirements:

- Holds a doctoral degree in psychology from a program in clinical psychology of an educational institution that is accredited by an organization recognized by the Council on Post-Secondary Accreditation
- Meets licensing or certification standards for psychologists in independent practice in the state in which he practices
- Has two years of supervised clinical experience, at least one of which is post-degree

Preventive Services

Preventive Services

Professional Components

- Professional components of preventive services are part of the overall encounter, and for TOB 73X, have always been billed with revenue code 052X. In addition to previous requirements for independent FQHCs exclusively, all FQHCs are required to report HCPCS codes for certain preventive services subject to frequency limits. (IPPE; AAA; DSMT; MNT)
- FQHCs do not receive any reimbursement on TOBs 73X for technical components of such services.

Preventive (Continued)

- *Note: for dates of services on or after April 1, 2010, TOB 77X will be used instead of TOB 73X when billing for FQHC services.*
- Although most preventive services have HCPCS codes that allow separate billing of professional and technical components, Prostate-Specific Antigen (PSA) and mammography services do not. However, FQHCs still must provide the professional component of these services since they are in the scope of the FQHC benefit. Such encounters are billed on line items using revenue code 052X and no HCPCS coding.

Preventive Services

- Preventive primary services must be furnished by or under the direct supervision of a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker. These services must be furnished by a member of the center's health care staff who is an employee of the center or by a physician under arrangements with the center.

- Preventive primary services include only drugs and biologicals that are usually self-administered, unless Section 1861(s) of the Social Security Act provides for coverage of the drug, regardless of whether it is self-administered.

Preventive Primary Services

The following preventive primary services may be covered and billed to the contractor when provided by FQHCs to Medicare beneficiaries:

- Medical social services
- Nutritional assessment and referral
- Preventive health education
- Children's eye and ear examinations
- Prenatal and postpartum care
- Prenatal services
- Well child care, including periodic screening
- Immunizations, including tetanus-diphtheria booster and influenza vaccine

Preventive Primary continued

- Voluntary family planning services
- Taking patient history
- Blood pressure measurement
- Physical examination targeted to risk
- Visual acuity screening
- Hearing screening
- Cholesterol screening
- Stool testing for occult blood
- Dipstick urinalysis
- Risk assessment and initial counseling regarding risks

Women’s Health

For women only:

- Clinical breast exam
- Referral for mammography
- Thyroid function test

Screening Pap Smears

- The professional component of a screening Pap smear furnished within an FQHC by a physician or nonphysician is considered an FQHC service. FQHCs bill the contractor under bill type 73X for the professional component along with revenue code 052X.
- *Note: For dates of services on or after April 1, 2010, TOB 77X will be used instead of TOB 73X when billing for FQHC services.*

Pap (Continued)

- The technical component of a screening Pap smear is outside the scope of the FQHC benefit. If the technical component of this service is furnished within a freestanding FQHC, the provider of that technical service bills the contractor on the CMS-1500.
- If the technical component of a screening Pap smear is furnished within a provider-based FQHC, the provider of that service bills the contractor under bill type 13X, 14X, 22X, 23X or 85X, as appropriate, using its outpatient CCN (not the FQHC's CCN, since these services are not covered as FQHC services).

Screening Pelvic Examination

- The professional component of a screening pelvic examination furnished within an FQHC by a physician or nonphysician is considered an FQHC service. FQHCs bill the contractor under bill type 73X for the professional component along with revenue code 052X.
- *Note: For dates of services on or after April 1, 2010, TOB 77X will be used instead of TOB 73X when billing for FQHC services.*

Pelvic Exam (Continued)

- The technical component of a screening pelvic examination is outside the scope of the FQHC benefit. If the technical component of this service is furnished within a freestanding FQHC, the provider of that technical service bills the contractor on the CMS-1500.
- If the technical component of a screening pelvic examination is furnished within a provider-based FQHC, the provider of that service bills the contractor under bill type 13X, 22X, 23X or 85X, as appropriate, using its outpatient CCN (not the FQHC's CCN since these services are not covered as FQHC services). The appropriate Revenue Code is 0770.

Vaccines

- Administration of influenza virus vaccine, *H1N1 (influenza A) vaccine and Pneumococcal Pneumonia Vaccine (PPV) does not count as a visit when the only service performed is the administration of PPV, H1N1 and/or influenza vaccine. If there was another reason for the visit, the FQHC should bill for the visit without adding the cost of the vaccine(s) to the charge for the visit on the bill.*
- Payment for the Hepatitis B virus vaccine is included in the all-inclusive rate. However, FQHCs do not bill for a visit when the only service involved is the administration of the Hepatitis B vaccine. As with other vaccines administered during an otherwise payable encounter, no line items specifically for this service are billed on the FQHC claims in addition to the encounter.

Influenza Vaccine, H1N1, and PPV Reimbursement

FQHCs are *not allowed* to bill for the cost and administration of PPV, H1N1 and other types of influenza virus vaccine *at the time of service*.

These services should not be billed to the contractor on the UB-04 or the CMS-1500. These charges are reimbursable only through the Medicare cost report.

Mental Health Services

Covered Mental Health Services

Clinical psychologist and services/supplies furnished incident to such services are covered in an FQHC. However, the clinical psychologist must be legally authorized to perform the services under applicable licensure laws of the state in which they are furnished.

To be covered incident to a clinical psychologist's service, the services and supplies must be:

•Mental health services that are commonly furnished in a clinical psychologist's office

•An integral, although incidental, part of professional services performed by the clinical psychologist

•Performed under the direct and personal supervision of a clinical psychologist (i.e., the clinical psychologist must be physically present and immediately available)

Mental Health (Continued)

- The services of clinical psychologists are not covered if they are otherwise excluded from Medicare coverage, even though a clinical psychologist is authorized by state law to perform them. Services at the FQHC or away from the FQHC are covered. See the previous discussion under Physician Services.

- The clinical psychologist must provide written notification to the patient's designated attending or primary care physician that services are being provided to the patient, or must consult directly with the physician to consider medical conditions that may be contributing to the patient's symptoms, unless the patient specifically requests that such notification or consultation not be made.

Psychiatric Payment Limitation

- All therapeutic psychiatric services furnished by qualified clinical psychologists in an FQHC are subject to the outpatient mental health services limitation (i.e., 62.5 percent of expenses for these services are considered incurred expenses for Medicare purposes). This limitation does not apply to diagnostic services.
- *CMS is phasing out the outpatient mental health treatment limitation over a 5-year period (2010–2014). Effective January 1, 2014, Medicare will pay outpatient mental health services at the same rate as other Part B services, which are paid at 80% of the Medicare Physician Fee Schedule (MPFS).*

Phase Out Psych Payment Limitation

Section 102 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that the current 62.5% outpatient mental health treatment limitation will be reduced as follows:

- *January 1, 2010–December 31, 2011: The limitation percentage is 68.75 % (Medicare pays 55% and the patient pays 45%).*

- *January 1, 2012–December 31, 2012: The limitation percentage is 75 % (Medicare pays 60% and the patient pays 40%).*

- *January 1, 2013–December 31, 2013: The limitation percentage is 81.25 % (Medicare pays 65% and the patient pays 35%).*

- *Beginning January 1, 2014: The limitation percentage is 100% (Medicare pays 80% and the patient pays 20%).*

Clinical Social Worker Services

FQHC services include the services provided by a clinical social worker. A clinical social worker is an individual who:

- Possesses a master's or doctor's degree in social work
- Has performed at least two years of supervised clinical social work, and is either licensed or certified as a clinical social worker by the state in which the services are performed
- In the case of an individual in a state that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post-master's degree clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting, such as a hospital, Skilled Nursing Facility (SNF), or clinic

LCSW Covered Services

Coverage is limited to the services a clinical social worker is legally authorized to perform in accordance with laws of the state in which such services are performed for the diagnosis and treatment of mental illnesses and services and supplies furnished incident to such services.

The services of a clinical social worker may be covered in an FQHC if they are:

•The type of services that are otherwise covered if furnished by a physician or incident to a physician's service.

•Performed by a person who meets the above definition of clinical social worker.

•Not otherwise excluded from coverage.

•Only the direct "hands on" services of a clinical social worker are covered. No coverage is available for services and supplies furnished incident to the professional services of a clinical social worker.

Diabetes Self-Management Training (DSMT)

Diabetes Self-Management Training

Certified FQHCs may bill the Medicare contractor for DSMT when the treating physician or treating qualified NPP managing the patient's diabetic condition certifies that such services are needed. These services are reimbursed on a per-visit basis for covered services. All relevant program requirements must be met for these services to be included under the FQHC benefits as billable visits.

- DSMT is a comprehensive training program intended to educate beneficiaries in the successful self-management of diabetes. The DSMT program includes:
- Instructions in self-monitoring blood glucose
- Education about diet and exercise
- Insulin plan treatment developed for the patient
- Motivation to use these skills for self-management

DSMT and Medical Nutrition Therapy (MNT)

DSMT Provider Eligibility

CONDITIONS FOR COVERAGE

- The order must be part of a plan of care. A physician or nonphysician treating the beneficiary's diabetes must order treatment. The order must also include a statement signed by the physician that the service is needed, as well as the following:
- The number of initial or follow-up hours ordered (physician can order less than 10 hours of training)
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas, such as nutrition or insulin training)
- A determination that the beneficiary should receive individual or group training

DSMT–Beneficiary Eligibility

- Eligible beneficiaries must be diagnosed with diabetes using any of the following criteria:
- Fasting blood sugar greater than or equal to 126 mg/dL on two different occasions
- A two-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes

DSMT Billing

DSMT services must be billed on TOB 73X with HCPCS code G0108 and the appropriate site of service revenue code in the 052X revenue code series.

Note: for dates of services on or after April 1, 2010, TOB 77X will be used instead of TOB 73X when billing for FQHC services.

MNT

MNT

MNT includes nutritional diagnostic therapy and counseling provided by a Registered Dietitian (RD) or licensed nutrition professional for the purpose of managing renal disease or diabetes. MNT is a more intensive (individualized) nutrition counseling and therapy regimen that relies heavily on follow-up and feedback to the beneficiary to change behavior over a period of time.

MNT is covered when provided by a qualifying registered dietitian or nutrition professional. The benefit includes:

- Initial visit for an assessment
- Follow-up visits for interventio.
- Reassessments as necessary during a 12-month period beginning with the initial assessment for compliance

MNT–Provider Eligibility

For Medicare coverage, the dietitian or nutritionist must be licensed or certified in a state as of December 21, 2000 (they are not required to meet any other requirements), or on or after December 22, 2000, must meet the following requirements:

- Bachelor's degree or higher by accredited college or university, with completion of academic requirements of a program in nutrition or dietetics.
- At least 900 hours of supervised dietetics.
- Licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide licensure or certification, the individual will be deemed to have met this requirement if they are recognized as a registered dietitian by the Commission on Dietetic Registration or its successor organization.

MNT–Covered Services

Benefit allowances include:

- A maximum of three hours for initial episode of care
- For subsequent years, two hours with physician referral
- Coverage limitations include:
  - Noncovered for beneficiaries receiving maintenance dialysis
  - The number of hours covered in an episode of care (12-month period) cannot be exceeded (without physician referral)
  - The initial and subsequent years are based on the calendar year; therefore, none of the hours in an episode of care can be carried over into the next calendar year

MNT Billing

- MNT services must be billed on TOB 73X with HCPCS code 97802, 97803, or G0270 and the appropriate site of service revenue code in the 052X revenue code series.
- *Note: for dates of services on or after April 1, 2010, TOB 77X will be used instead of TOB 73X when billing for FQHC services.*

CERTIFICATE

- Each clinic will need to submit the Education Recognition Program Certificate from the American Diabetes Association to provider enrollment.

Telemedicine

- Telecommunications systems may be used as a substitute for a face-to-face encounter for a *consultation, office visit, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, End Stage Renal Disease (ESRD)-related services, or individual MNT.* Originating sites must be located in either a non-Metropolitan Statistical Area (non-MSA) county or an FQHC Health Professional Shortage Area (HPSA). An interactive audio (e.g., a two-way radio) and video telecommunications system must be used, permitting real-time communication between the distant-site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

Telemedicine (Continued)

- For telehealth services, continue to use HCPCS Code Q3014 and the appropriate revenue code. For FQHCs, modifiers are not required.
- Revenue Code 0780 (telemedicine, general classification) is used to bill for the telehealth originating site facility fee. Telehealth originating site facility fees billed using Revenue Code 0780 are the only line items allowed on TOB 73X that are not part of the FQHC benefit.
- These are the only services billed on TOB 73X that will be subject to the Part B deductible.
- *Note: for dates of services on or after April 1, 2010, TOB 77X will be used instead of TOB 73X when billing for FQHC services.*

Deductibles
Coinsurance
Advantage Plans
Rates
Bill Type
Cost Report
Revenue Codes
HCPC/CPT Codes

Deductible and Coinsurance

Part B Deductible

- The Part B annual deductible is waived for FQHC services. However, the Medicare patient is required to pay the deductible (subject to a sliding fee) for non-FQHC Medicare covered services.

Coinsurance

- The Medicare patient is responsible for 20% of the allowable charge for services rendered. An FQHC must apply a sliding fee discount to the coinsurance, depending on the patient's ability to pay.

Medicare Advantage Plans

Supplemental Payments to FQHCs Under Contract With Medicare Advantage Plans

- Beginning January 1, 2006, FQHCs *participating* in a Medicare Advantage (MA) plan are entitled to receive supplemental payments to cover the difference between the payment received from treating MA enrollees and the payment an FQHC would be entitled to under the all-inclusive payment rate (Section 237 of the Medicare Modernization Act).

Copy of MA Plan

- The Medicare contractor will determine if the Medicare cost-based payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization. FQHCs seeking payment under Section 237 of the MMA *must submit to their contractor copies of their contracts under each MA plan*. If it is determined that the payment that the FQHC would be entitled to under the cost-based payments exceeds the payment received by the FQHC from the MA organization, the difference will be paid to the FQHC at least quarterly. In determining this supplemental payment, any financial incentives provided to the FQHC under its MA arrangements will be excluded from the calculation of supplemental payment.

Interim Rate

- FQHC providers must submit information to their contractor to identify the per-visit encounter rates (i.e., the actual contract with your MA plans or an estimate of the encounter rate per visit). If submitting an estimate, supporting documentation will be required on how this estimate was determined. The per-visit encounter rate information is reviewed and the interim per-visit rate is determined. This interim rate may be a blended per-visit amount if the FQHC has a contract with multiple MA plans. The contractor will notify the FQHC by mail of the MA encounter rate.

Payment Rate

REIMBURSEMENT

- FQHCs are reimbursed the lower of the national capped amount or the clinic-specific cost per encounter. The national capped amount is indexed for inflation and can increase each year. This amount is subject to regulatory change. FQHCs are reimbursed 80% of the all-inclusive reimbursement rate. The patient is responsible for a coinsurance amount equal to 20% of the billed amount.
- An FQHC with both rural and urban sites will have a blended rate based on the percentage of total visits at the rural and urban sites. The reimbursement rate caps are adjusted annually based on the Medical Economic Index applicable to primary health care practitioner services.

Year	Urban Payment	Rural Payment
2010	$125.72	$108.81
2009	$119.29	$102.58
2008	$117.41	$100.96

Change Bill Type and Revenue Codes

- Qualifying claims should be billed using Type of Bill (TOB) 73X for dates of service prior to April 1, 2010, with revenue code 0519 for the amount of the interim supplemental payment rate. *For dates of service on or after April 1, 2010, TOB 77X will be used when billing for FQHC services.*

- Do not submit revenue codes 0520 and/or 0900 on the same claim as revenue code 0519. HCPCS codes are not required.

Bill Type Changing 04/01/2010

All charges submitted by an FQHC will appear under TOB 73X for dates of service prior to April 1, 2010. *For dates of service on or after April 1, 2010, TOB 77X will be used when billing for FQHC services. The third digit of the TOB is the bill frequency. This digit shows the nature or intent of the bill submitted. Below is a listing of the possible third digits available to an FQHC:*

- Non-payment/zero claim 0
- Regular clinic visit 1
- Replacement of prior claim 7
- Void/cancel of prior claim 8

Impact to Cost Report

- Beginning January 1, 2006, eligible FQHCs must report actual MA revenue and visits on their cost reports. The contractor will use actual MA revenue and visit data, along with the FQHC's final all-inclusive payment rate, to determine the FQHC's final actual supplemental per-visit payment. This will serve as an interim rate. The contractor will review the cost report to ensure the information is appropriate and make a final settlement on the MA claims.

FQHC Revenue Codes

	0001	Total charges
•	0519	Clinic, other clinic supplemental payments (effective for dates of service on or after January 1, 2006
•	0520	Freestanding clinic visit
•	*0521*	*Clinic visit*
•	0522	Home visit
•	0524	Visit in a SNF covered Part A stay
•	0525	Visit in a SNF non-covered Part A stay
•	0527	Visiting nurse service in home health shortage area
•	0528	Visit to other non-FQHC site (Example: scene of accident)
•	0780	Telehealth originating site facility fee
•	090X	Psychiatric/psychological services

HCPC (CPT) Codes

- FQHCs do not have to report HCPCS codes for Evaluation and Management (E/M) services.
- *All charges associated with the patient's visit should be combined into a single dollar amount that is reflected under the appropriate encounter code.*
- The number of units associated with the encounter code is one per visit.
- *Note: Please refer to the Preventive Services section, since some preventive services require a HCPCS code.*

Additional Reimbursement

Additional Reimbursement for the Technical Component

- The technical component of a diagnostic procedure is reimbursed outside of the encounter rate. For a provider-based FQHC, this reimbursement is made to the mother entity. This billing occurs under the mother entity's TOB and CCN. For a freestanding FQHC, these charges are billed to the Medicare contractor on the CMS-1500.

Additional Reimbursement for Diagnostic Laboratory Services

- All diagnostic laboratory services, including the six waived tests, are reimbursed outside the encounter rate. For a provider-based FQHC, this reimbursement is made to the mother entity. Billing for diagnostic laboratory services is completed by the FQHC's mother facility. This bill will appear as TOB 141 and will use the mother facility's CCN and not the FQHC's CCN.

Technical Components

PROVIDER-BASED FQHC

- The technical component of a screening or diagnostic mammography for provider-based FQHCs is typically furnished by the base provider. The provider of that service bills the Medicare contractor under TOB 13X, 22X, 23X, or 85X, as appropriate, using its outpatient CCN (not the FQHC's CCN, since these services are not covered as FQHC services). Payment is based on the payment method for the base provider.

FREESTANDING FQHC

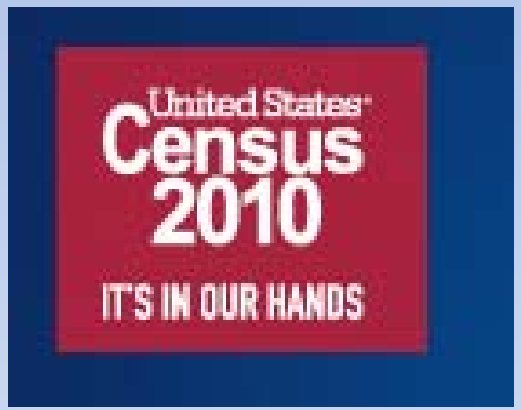
- The technical component of a screening or diagnostic mammography is outside the scope of the FQHC benefit. The practitioner who renders the technical service bills on the CMS-1500. Payment is based on the Medicare Physician Fee Schedule.

10 Questions in 10 Minutes

April 1st 2010

National Census Day

Use this day as a point of reference for sending your completed forms back in the mail



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