

Clinical Revenue Maximization

Operational Overview, Payment Structure, Coding & Billing
Guidelines

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Objectives

- Participants will understand the following:
 - General key requirements and policy support for FQHCs
 - Cost based reimbursement/encounter cost payment, co-insurance, deductibles
 - Benchmarking key indicators
 - Providers who may render services
 - Services that are cost based services versus fee for service
 - Coding and billing concepts relating to: Claim submission; E/M levels of service; "global" care; "bundling" of services; services performed away from the FQHC
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Tennessee Primary Care Association

- Mission – to strengthen community-based comprehensive primary health care in Tennessee
 - 34 Community Health Centers with 144 sites serving approximately 80% of the population who fall below 200% of the federal poverty level
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FQHC-The Regulations

- FQHC- Federally Qualified Health Center
 - **Criteria pertaining to FQHC**
 - Federal regulations CMS Publication 27 October, 1997 (New Publication 100)
 - Federal Register beginning with Part 491
 - Medicare Claims Processing Manual, Pub. 100-4, Chpt. 9
 - Medicare Benefit Policy Manual, Pub. 100-2, Chpt. 13
 - Reimbursement Manual, Chpt. 29 (T7) (Independent) Cost Report Information
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Intro to FQHCs

- FQHCs – Must be in a rural OR urban area where there is a population of underserved people, e.g. poor, migrant workers and families, homeless, public housing residents, etc.
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Type of FQHCs

- Provider based-certified as part of a provider, e.g., a hospital
 - Physically located in close proximity of the provider where it is based, and both facilities serve the same patient population
 - **Note: Only FQHCs or look-alikes that were provider based prior to 1995 may remain. No longer granting provider based status for FQHCs**
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Independent

- FQHC – Community based in underserved area
 - May not be for profit

 - Most FQHCs are Independent Clinics
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Key Certification Requirements for FQHCs

- Must be receiving a grant under Section 330 Public Health Service Act.
 - Must provide primary care for family practice, internal medicine, pediatrics, and OB/GYN patients as well as preventive medical care
 - Must provide comprehensive services in the clinic or through arrangement with other specialists/facilities
 - Must provide or arrange for dental care, mental health care, substance abuse, hospital and specialty care
 - Must have an ongoing quality assurance program
 - Must have governing board of directors with at least 51% clients of the FQHC
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Key Certification Requirements for FQHCs (cont.)

- Must have a sliding fee scale implemented after proof of income- --based on the National Poverty Guidelines
 - Must provide emergency medical services
 - Must provide pharmaceutical services where appropriate
 - Must provide laboratory and radiology services
 - Must provide patient case management services to assist with housing, transportation, education, and finance
 - Must provide interpreters where there are language barriers
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Reimbursement FQHC Services

- Payment based on actual cost to perform services
 - Cost divided by number of encounters to determine cost per encounter
 - Cost report is filed
 - Actual cost is compared to interim payment & adjustments are made
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Reimbursement FQHC Services

- FQHC services paid on the basis of the encounter
 - All services subject to the Medicare coinsurance
 - NO deductibles in FQHC and co-insurance may be waived if patient financially qualifies
 - *CMS Pub. 100-2 Sect. 20*
 - NOTE: Need data for financial income status
 - NOTE: Deductible does apply for applicable services billed to Part B (current deductible is \$155)
 - Physicians
 - Government expectation- 4,200 encounters per year
 - Mid-levels
 - Government expectation 2,100 encounters per year
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Reimbursement (cont.)

- Payment is 80% of the established encounter rate
 - Co-insurance=20% of billed FQHC charges
 - Co-insurance not applicable to lab (2001)
 - Deductibles not applicable to FQHC services (except services billed to Part B)
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Payment Limit Rates

- FQHCs – Upper payment limit 2010
 - Rural FQHCs - \$108.81 (2010) \$102.58 (2009) UP 1.6 % from \$100.96 in 2008
 - Urban FQHCs - \$125.72 (2010) \$119.29 (2009) UP 1.6% from \$117.41 in 2008

 - Note: Limits applicable to Medicare patients. TENNCare not imposing limits currently
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Encounter Definition

- Encounter
 - A face-to-face encounter (“visit”) between a physician or a mid-level during which a FQHC service is performed
 - Only one encounter allowed per day UNLESS subsequent to the first encounter the patient either suffers illness or injury requiring additional diagnosis or treatment (bill each separately and describe in FL 80 of UB) (check with your payer) OR has a medical visit and a mental health visit with a clinical psychologist or clinical social worker.

Medicare Claims Processing Manual , Chpt. 9, Section 40.4

Encounters with Ancillary Staff

- May attach services for up to 30 days (Medicare)
 - Bill with the date of the actual face-to-face encounter ("from" and "to" date may reflect total time period)
- On line equal with revenue, use the date of the actual encounter

Encounters-No Face-to-Face

- Interpretation of results of tests or procedures which do **NOT** require a face-to-face contact between a physician/provider & the patient are **NOT** considered a reimbursable encounter
 - Reading an EKG or x-ray is **NOT** an encounter
 - Drawing blood is **NOT** an encounter

Encounters Face-to-Face But Not Medically Necessary

- Even if have face-to-face with a provider to
 - Draw blood
 - Render injection
 - Change a dressing
 - AND it is not medically necessary for the NP, PA, or physician to see patient again for the condition, it may NOT be counted as encounter-MUST be INCIDENT TO service
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Encounter Example FQHC

- Total costs are \$275,000
 - If physician saw 4,200 pt cost would be $\$400,000 / 4,200 = \95.24 per patient (does not exceed cap and all cost would be allowed)
 - If physician saw 3,000 pts cost would be $\$400,000 / 3,000 = \133.34 (cap \$108.81 for the rural FQHC)
 - Payment would be limited to the cost if the provider had seen 4,200
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“Wrap Around” Payments

- Additional monies received from the traditional Medicare and Medicaid programs to make up the deficit of what managed care plans did not pay for the ALL INCLUSIVE RATE due the FQHC
 - Managed Care Medicaid
 - Filed quarterly to the STATE
 - Managed Care Medicare
 - Filed with Rev code 0519 claim by claim
Pub. 100-4, Chpt. 9, page 22 – check with your intermediary for specific instructions

Foundation for Clinic Viability

- Appropriate staffing – “OM wants to hire more staff”**

- Strong business staff “working harder than ever”**

Foundation for Clinic Viability (cont.)

- ❑ Entire staff understands FOHC concept – sliding fee scale, co-insurance and deductibles
 - ❑ Registration & scheduling personnel efficient in working with managed care plans
 - ❑ Provider preferences for patient flow understood
 - How to work with walk-ins
 - Time required for acute illnesses, EPSDT screens, well-woman exam, physicals, etc.
 - ❑ Dedication to the collection process
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Benchmark Your Clinic

- ❑ Search for Excellence a book by Tom Peters, he wrote:
 - “you cannot manage what you do not measure.”
 - ❑ Why benchmark
 - Gives the owner or manager constructive feedback regarding areas of operation that need improvement – need to benchmark against LIKE organizations
 - Provides an objective basis for discussing operations improvement
 - Helps to give a subjective rather than objective basis to thinking
 - Identifies specific improvement opportunities and prompts creative thinking when problems are identified
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Benchmarking Key Indicators

- ❑ **Staffing ratio**- number of FTE employees divided by FTE providers
 - ❑ **Expenses to charges** ratio-total operating expenses compared to total charges
 - ❑ **Visits per week** per provider – measures productivity (to meet government expectations, need 18 per day per 240 days generally worked per year)
 - ❑ **New patient visits** – may indicate need to begin recruiting
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Staffing Primary Care

- ❑ ***Cost Survey for Single-Specialty Practices: MGMA 2009 Report Based on 2008 Data*** support staff per 1 FTE physician not hospital owned - median:
 - **Family Practice- 3.76 FTE**
 - **Obstetrics & Gynecology – 4.47**
 - **Pediatrics – 4.46**
 - **Internal Medicine – 3.13 (Note: Data available is only for hospital owned practices)**
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Productivity of Physicians

- Physician productivity –
 - Government expectations for all inclusive cost-based reimbursement
 - 4,200 per physician
 - 2,100 per non-physician practitioner
 - Ambulatory encounters MGMA
 - Family Practice – 4,150 (no in-pt practice)
 - OB/GYN (General)– 2,726 + 88 in-pt
 - Pediatrics (General) – 4,284 + 210 in-pt
 - Internal Medicine – 3,649 (no in-pt practice)
 - *MGMA Physician Compensation and Production Survey: 2009 Report Based on 2008 Data*
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Provider Coding Accuracy

- Providers educated concerning assignment of evaluation & management (E/M) services
 - Medicare 2010 Based on 2008 codes Utilization Part B
 - 99212 = 5.18%
 - 99213 = 52.05%
 - 99213 = 35.82%
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Provider Coding Accuracy (cont.) Medicare

- Example of coding impact on revenue
 - 4,200 visits – 99214 – 36% utilization = 1,512 visits X \$120 (\$91.58 is fee schedule) X 20% = \$36,288
 - 4,200 visits – 99214 – 20% utilization and other 16% charged at a 99213 X \$80 (fee schedule is \$66.99) = 840 visits X \$120 X 20% = \$20,160 + 672 visits X \$80 X 20% = \$10,752 or \$30,912 **\$5,376** less than national average
 - Total charge for 1,512 X \$120 = \$181,440
 - Total charge for 840 X \$120 + 672 X \$80 = \$154,560
 - If all were self-pay or forgiven based on income loss would be \$26,880 in grant monies
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Provider Coding Accuracy TennCare

- 99214 @ 36% utilization = 1,512 X \$120 = \$181,440
 - Under utilization of 20% = 840 visits X \$120 = \$100,800
 - Under utilization other 16% charged at 99213 or \$80 = 672 visits X \$80 = \$53,760
 - \$100,800 + \$53,760 = \$154,560 or **\$26,800**
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Benchmarking Opportunities- Charges & Collections

- ❑ **Charges** – gross professional charges – IF too low, may indicate:
 - Fees are too low
 - Productivity is too low
 - Providers are not charging appropriately (undercoding)
 - ❑ **Collections** – Net collection % - in FOHC runs higher than other primary care clinics due to all inclusive rate-know problem if
 - Collection % is 98% or lower (non-FOHC/RHC rate)
 - Days gross charges in collections
 - % of AR 30, 60, 90, 120+days old
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Charge Capture

- ❑ **All charges captured**
 - In-house labs
 - Radiology services
 - Injections and serum
 - Breathing treatments & medications used
 - Procedures
 - Vaccines & administration
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Business Office Strength

- Days in Accounts Receivable – 40 or lower (MGMA Data showed Pediatrics with a median of 26 days in A/R)
 - Denials tracked with follow-up on denied claims
 - Fee schedule set appropriately
 - Services appropriately tracked and submitted for payment- managed care plan timely filing
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Benchmarking AR Ageing

- Total AR Family Practice
 - 0-30 days 58.71%
 - 31-60 days 13.09%
 - 61-90 days 7.21%
 - 91-120 days 4.83%
 - Over 121 days 15.91%
 - Note: Because of high managed care Medicaid, the numbers should not vary significantly from non-FQHC clinics
 - *Cost Survey for Single-Specialty Practices: MGMA 2009 Report Based on 2008 Data*
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FQHC Confusion

- FQHC – Applicable to MEDICARE & MEDICAID (traditional) only
 - Managed care contracts
 - Medicaid managed care
 - Medicare managed care
 - Private insurance managed care
 - Traditional Medicare and Medicaid
 - Provider enrollment into each
 - PCP providers for specific plans
 - Rules and regulations different for each
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Providers Who May Render Care for Reimbursement

Physicians, either M.D. or D.O.

- Mid-levels included are:
 - Nurse practitioner
 - Physician's assistant
 - Certified midwife
 - Clinical social worker
 - Clinical nurse specialist
 - Clinical psychologist
 - Certified Diabetic Self-Management Trainer
 - Certified Medical Nutrition Therapist
 - Visiting nurse (ONLY if so designated by CMS due to shortage)
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Place Of Service Covered

- Services **IN** the FQHC
 - Services performed away from the clinic such as nursing home rounds, home visits
IF
 - Physician is an employee of the clinic/center
 - Compensation for physician includes agreement to render these services
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Place Of Service Covered

- Covered services
 - Those rendered to the homeless
 - Those rendered to people in a shelter
 - May count these as encounters
 - May bill payers **IF** patient has coverage (if no coverage, may claim as visits – paid through annual payment rate and Public Health Service grant)
 - NON**-covered services
 - Services rendered to those who are incarcerated
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FQHC Services

- Medically necessary professional services rendered by a provider which are cost-base reimbursed
 - Surgical care
 - Interpreting x-rays or EKGs
 - Treatment of illness or injury including injections and fractures
 - Services provided “incident to” if the service would be covered when rendered by a physician
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“Incident to” Services & Supplies

- Covered if the service is:
 - An integral, although incidental, part of the physician’s plan of treatment
 - Of a type commonly furnished in a physician’s office
 - The ancillary personnel are employees of the physician (or both employees of the provider)
 - Furnished under DIRECT supervision of the ordering physician or mid-level
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Incident to (cont.)

- Claims are submitted under the FQHC provider number
- Mid-levels in a FQHC do not require direct supervision in order to see new patients and new conditions
 - Must be able to prove collaboration with a physician (document presence of physician at the FQHC at least once every two weeks)
 - Must follow scope of practice laws per state (If State law is more stringent, must abide by State law)

Benefit Policy Manual, Chpt. 13, Section 70.6

Covered FQHC Service for Preventive Care (per CMS)

- | | |
|--|--|
| <input type="checkbox"/> Medical Social Services | <input type="checkbox"/> TB testing for high risk |
| <input type="checkbox"/> Nutritional Assessment | <input type="checkbox"/> Dipstick UA |
| <input type="checkbox"/> Preventive health education | <input type="checkbox"/> Risk assessment and initial counseling regarding risks |
| <input type="checkbox"/> Immunizations including Td, flu and pneumonia | |
| <input type="checkbox"/> Voluntary family planning services | <input type="checkbox"/> For women only: |
| <input type="checkbox"/> BP, weight, measurement | <input type="checkbox"/> Prenatal services |
| <input type="checkbox"/> Visual and hearing screening | <input type="checkbox"/> Clinical breast exam |
| <input type="checkbox"/> Physical examinations targeted to risk | <input type="checkbox"/> Referral for mammography |
| | <input type="checkbox"/> Thyroid function test |
| | <input type="checkbox"/> ALL of the routinely covered preventive medicine services |
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Routinely Covered Services Preventive Primary Care

- G0402 Welcome to Medicare Physical
 - G0101 Well-woman exam with pap smear every 2 years & Q0091 for "screening" paps
 - (as of July 1, 2001-every 2 yrs.-HCFA Transmittal 1823)
 - G0102 Prostate screening rectal exam yearly
 - (not separately reportable with an E/M)
 - G0103 PSA yearly
 - 82270 Occult blood testing
 - Mammogram yearly
 - Bill to Medicare Part B if performed in the FQHC
 - NOTE: "G" codes are codes defined by Medicare. Most other payers do not recognize them, but, rather have the common CPT codes for reporting – CHECK with each of your payers
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Preventive Services Medicare

- Entire list of preventive services Medicare recognizes for payment
 - http://www.cms.hhs.gov/MLNProduct/s/downloads/MPS_QuickReferenceChart_1.pdf
-

Preventive Medicine Assessment

- IF during the preventive medicine exam a problem is encountered, but it does not need additional work-up, code the preventive medicine diagnosis first
- Code second the diagnosis to reflect the medical problem encountered
- Do NOT use 99201-99215 if the intent of the visit was for preventive care

Preventive Medicine and E/M

- IF a significant problem is encountered during a preventive medicine visit the hx, exam, and medical decision making concerning the problem must be included in the documentation
 - Code BOTH the preventive medicine code & the E/M service
 - Attach modifier -25 to the E/M service
 - (Some payers may not recognize)

Welcome to Medicare Physical Exam

- ❑ G0402-Medicare pays one initial physical performed within the first year of Medicare eligibility
 - ❑ EKG (G0403) no longer required as it once was
 - ❑ Must include G0402 in FL 44
 - ❑ If separate E/M services provided same day, bill claim separately (*Transmittal 477, CR 6338, April 24, 2009*)
 - ❑ Very strict concerning the documentation
 - ❑ <http://www.laoncologysociety.org/documents/clm104c12.pdf>
 - ❑ *Claims Processing Manual Chapter 12, Section 30.6.1.1 page 36*
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Components of the IPPE

- ❑ Initial Preventive Physical Examination components:
 - Review of medical and social hx including illnesses, hospital stays, operations, allergies, injuries, treatment, meds, fm hx
 - Review of individual's risk factors for depression. Must use an approved screening instrument
 - Examination, ht, wt, BP, visual acuity, hearing impairment, screen and other systems as appropriate
 - Activities of daily living, fall risks, home safety
 - Plan for preventive work up
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Preventive Well-Woman

- Medicare's descriptor is different:
 - G0101-Allowed once every 2 years *(July 1, 2001, allowed once every 2 years, Transmittal 1823)*
 - Must have 7 of these 11 components:
 - Inspection & palpation of breasts
 - Digital rectal exam including sphincter tone, presence of hemorrhoids, and rectal masses
 - Pelvic exam with or without collection of smears and cultures
 - External genitalia-general appearance, hair distribution, or lesions
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G0101 (cont.)

- Urethral-masses, tenderness, scaring
 - Bladder-fullness, masses, or tenderness
 - Vagina-general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele
 - Cervix-appearance, lesions or discharge
 - Uterus-size, contour, position, mobility, tenderness, consistency, descent, or support
 - Adnexa-masses, tenderness, organomegaly
 - Anus and perineum
 - Note: Breast exam now 1 of 11 components
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G0101 (cont.)

- V76.2-for screening for malignant neoplasm, cervix
 - V76.49-screening for malignant for patients who do not have a uterus or a cervix
 - <http://www.cms.hhs.gov/Transmittals/downloads/R1541CP.pdf>
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G0101 for High Risk

- May perform more than every 23 mo. IF**
 - Early onset of sexual activity (under 16 yrs)
 - Multiple sex partners (five or more)
 - Hx of sexually transmitted disease
 - Fewer than 3 negative pap smears within the previous 7 years
 - DES-exposed daughters of women who took diethylstilbestrol (DES)
 - Dx code-V15.89-personal Hx presenting hazards to health**
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Q0091 with G0101

- Q0091- collection and preparation of a pap specimen to the lab for MEDICARE only
 - Billable for SCREENING paps only
 - Has no technical component per Medicare Physician Fee Schedule (check with your payer for specific instructions on billing requirements)
 - Considered bundled for diagnostic paps and not separately billable
 - Note: Frequency limitations apply in FQHC unless meet exceptions – to bill the patient must get an ABN
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Prostate Preventive Care

- Paid by Medicare 1 time every 12 months
 - Digital rectal exam-G0102
 - Not payable if any other E/M service paid on the same day**
 - Payable if another non-payable service is performed, e.g. routine check-up**
 - Code V76.44**
 - PSA-G0103
 - Dx code V76.44**
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Occult Blood

- 82270-SCREENING for occult blood
 - Paid for once every year
 - Is one unit for 1-3 tests
 - DX code needs to be appropriate code – not defined by Medicare

 - Do NOT BILL until the test cards have been returned
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Preventive Immunizations

- Medicare covers:
 - Pneumovac
 - Influenza
 - AND the administration of each
 - G0008 for influenza
 - G0009 for pneumococcal
 - No order needed from a physician
 - Paid above & beyond per diem rate of pay
 - Never put these on a FOHC claim. They are roster billed at the end of the year and paid separate from the per diem
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Flu & Pneumonia Shots

- Log should include:
 - Beneficiary name
 - Beneficiary HIC#
 - Date of service
 - Type of injection received, e.g. influenza or pneumococcal
 - May not count as visit if encounter for shot only
 - May not include \$ value of shots in visit
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Other Preventive Immunizations

- Medicare will pay for Hepatitis B as part of the FQHC reimbursement IF
 - Patient is at high risk
 - Administration code G0010
 - Tetanus (part of the FQHC reimbursement)
 - Immunoglobulin, rabies, etc., covered under the all inclusive rate when injury or direct exposure has occurred-bill as part of the FQHC claim – cost reimbursement
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Immunizations (cont.)

- Zostavax- payable by Medicare Part D only and the administration is considered part of the Part D reimbursement (Do not include on a FQHC claim)
 - Commercial payer- dependent upon plan
 - Administration codes 90471 and 90472
 - REMEMBER-90472 cannot be billed without 90471
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Preventive Services TennCare

- TenderCare – covers EPSDT screens for children
 - complete physical exam / dental check-ups
 - lab tests if needed
 - immunizations or shots
 - vision and hearing tests
 - developmental and behavioral tests if needed
 - advice on how to keep the child healthy
 - NO co-pays applicable for child or adult wellness checks
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Preventive Services TennCare

- Check-ups for adults
- Pregnancy care and birth control
- Cholesterol
- Blood sugar
- Colon and rectal cancer
- Bone hardness (osteoporosis)
- Thyroid
- STDs (sexually transmitted diseases)
- HIV and AIDS
- Heart problems (EKG tests)
- TB (tuberculosis)
- Well-woman check-ups (pap smears and
- Mammogram every 1-3 years age 40+
- Vaccinations Tetanus, Hepatitis B, Pneumonia, Flu, Measles, Mumps (as medically indicated)

Telehealth Services

- Telehealth – Live, interactive audio and visual transmissions of physician-patient encounter from one site to another using telecommunications technology
- 0780 – Telehealth originating site facility fee is billed IN ADDITION to the 077X revenue code
- Must add Q3014 in FL 44 on the claim to indicate facility fee
- *Note-telehealth is NOT an FOHC service. Use the above to report originating site facility fee)
- Only service on Type of Bill 77X subject to deductible
 - *Medicare Claims Processing Manual, Chpt. 9, Section 100, A*

Telehealth Services

- ❑ **Community Health Network (CHN)**
 - ❑ A \$1.6 million state-funded grant to the Community Health Network (CHN) helped create the Tennessee TeleHealth Network (TTN) which connects specialists in urban areas with community health centers serving disadvantaged or isolated populations throughout the state. (*Tennessee Office of E-Health Initiatives*)
 - ❑ Many medical specialties are now available without driving any further than your regular doctor's appointment. Using specialized medical video equipment, the specialist you need to see may be as close as a visit to the local community health center (*CHN Telehealth Network: Bringing Medical Specialists Closer to Home*)
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Telehealth Services (Medicaid)

- ❑ TennCare covers Telehealth Services –follow the Center for Medicare and Medicaid Services guidelines
 - ❑ Bill managed care plans for site of service reimbursement in a FQHC with locator code "11" and Q3014
 - ❑ Specialists performing telehealth need appropriate CPT code with the GT modifier
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Mental Health

- **0900 Revenue code**
 - **Mental health limit applies (62.5% Medicare previous allowable)**
 - Use for all therapeutic psychiatric services such as counseling services (see next slide)
 - **Exceptions to use of 0900 and billed as a medical encounter (billed by psychiatrists or non psychiatric physicians)**
 - Psychiatric testing using testing instruments such as intelligence tests
 - Psychiatric consultations –evaluation made by a physician for purposes of preparing a report for the attending physician
 - Initial psychiatric visits – evaluation made by a physician who will test the patient
 - Monitoring or changing drugs-use 520 revenue code (FQHC Training Manual, page 20)
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Mental Health

- Limit for mental health for Medicare has been 62.5% since inception of Part B program. New limits 1/1/2010
 - Jan 1, 2010 - Dec 31-2011 68.75%
 - Jan 1, 2012 – Dec 31, 2012 75%
 - Jan 1, 2013 – Dec 31- 2013 81.25%
 - Jan 1, 2014 – forward 100%
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Behavioral Health

- ❑ Increase focus on alcohol and drug substance abuse-public health approach
 - ❑ SBIRT program – Screening, Brief Intervention and Referral to Treatment
 - Supported by TennCare and all MCOs
 - Supported by Medicare
 - Must be delivered in a FQHC or Primary Care setting
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Behavioral Health (cont.)

- ❑ SBIRT screening
 - Pre-screen – questions concerning use of alcohol and drugs – part of the E/M payment
 - Full-screen – positive pre-screen and primary care physician elects to personally provide intervention
 - ❑ Must use valid tool (AUDIT, DAST-10, ASSIST, CRAFFT)
 - ❑ May assign CPT codes 99408 or 99409
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Substance Abuse Services

- January 1, 2010, TennCare for adults 21 years and older will NO LONGER limit substance abuse services
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Screening Glaucoma Services

- FQHC covered service
 - Billed under the 520 or applicable site of service revenue code
 - No HCPCS code required
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Medical Nutrition Therapy (MNT)

- ❑ MNT in FQHCs are covered FQHC services and payment is made in addition to the all-inclusive encounter rate as of 2006 if meet all requirements (*Pub. 100-4, Chpt. 18, Section 120*)
 - ❑ Must be one-on-one face-to-face services (group sessions do not count as visits)
 - ❑ Must include revenue code as applicable for site of service
 - ❑ Must include MNT HCPCS codes 97802, 97803, or G0270
 - ❑ May not bill on same day that Diabetic Self Management Training is provided
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Diabetes Self Management Training (DSMT)

- ❑ DSMT is a covered FQHC encounter service as of January 1, 2006 if there is a one-on-one, face-to-face visit (group sessions may not be billed as visits)
 - ❑ Payment made for DSMT in addition to another qualifying visit payment
 - ❑ Must use applicable site of service revenue code 52X
 - ❑ Must include HCPCS code G0108 or G0109
 - ❑ *Pub. 100-4, Chpt. 9, Section 180*
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FQHC Services Outside the Clinic

- Services rendered to patients in their home
 - Services rendered to patients in skilled nursing facilities and nursing homes
 - If the physician is compensated for rendering services outside the FQHC
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NON-FQHC Services (Still Covered by Medicare)

- TC of x-rays/EKGs
 - All laboratory tests performed on-site
 - Screening mammography (bill to Part B)
 - DME (bill to regional DME carrier)
 - Ambulance services
 - Services provided in a hospital setting
 - Prosthetic devices
 - Leg, arm, back, and neck braces and artificial limbs/eyes
 - **MUST have all associated costs carved out of the cost report**
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Non-FQHC Services

Non-Covered Medicare Services

- Services not necessary or reasonable
- Routine foot care
- Hearing aids or eyeglasses
- Personal comfort items
- Cosmetic surgery
- Custodial care
- Preventive dental care including filling, removal or replacement of teeth (even though FQHC required to provide)

(generally covered by Medicaid)

Elements Needed For Filing Claims

- ICD-9 Diagnosis codes
 - CPT-4 Procedure codes
 - Documentation to support the E/M services and procedures performed
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Provider Education for Documentation of E/M Services

- Documentation to support history:
 - History of the presenting problem
 - Review of systems
 - Past medical, family, and social history
 - Documentation to support exam
 - Documentation to support medical decision making
 - Complexity and number of problems
 - Data ordered or reviewed
 - Risk of morbidity and mortality
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Provider Education for FQHC Procedures

- Lesion removal – size, type of lesion, submission to pathology, biopsy component, margin to margin excision, repair of skin deficit
 - Incision & Drainage – Simple or complex
 - Laceration repair – size, type of repair, addition of like lacerations, appropriate billing instructions for Dermabond, steri-strips (bundled) etc.
 - Trigger point and joint injections
 - Cerumen impaction removal
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National Correct Coding Initiatives (NCCI edits)

- ❑ National Correct Coding Initiatives (NCCI edits) define services considered to be a component of other services
 - ❑ Define code combinations that should be or should not be used together
 - ❑ “Bundling” – combining several codes into one code
 - ❑ “Unbundling” – billing components of one code individually
 - ❑ <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>
 - ❑ <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>
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Documentation to Support an Interpretation & Report

- ❑ Must be similar to that prepared by a specialist in the field
 - ❑ Must address findings, relevant clinical issues, and comparative data
 - ❑ Considered to be a “review of data” which is a component of the medical decision making E/M if statements such as “fx of tibia” or “EKG is normal” *Medicare Carrier’s Manual 15023*
 - ❑ Bill all appropriate charges rolled into the encounter revenue code 520
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Interpretation and Report X-ray

- Body of report should include:
 - Type of exam (A/P and lateral views of the chest)
 - Procedure and materials
 - Findings –precise anatomic and radiologic terminology
 - Clinical Issues
 - Comparative data
 - Impression
 - *American College of Radiology: ACR Standard for Communication: Diagnostic Radiology*
-

Interpretation and Report of an EKG

- EKGs should describe applicable components of these elements:
 - Rate and rhythm
 - Axis
 - Intervals
 - ST segment changes
 - Comparison to prior tracings
 - Summary of clinical condition
 - Example: EKG-NSR, no ST changes, unchanged from prior EKG with no evidence of ischemia.
 - Bill all services of the day under the 520 revenue code
-

Billing FQHC Claims

- Remember-the FQHC is only an FQHC in the eyes of Medicare and Medicaid
 - Bill Medicare FQHC services on a UB-04 claim form (each state defines Medicaid claim form)
 - Bill type 771 for FQHC
 - 7 means clinic
 - 7 means FQHC
 - 1 means admit through discharge date
-

Type of Bill

- FQHC bill type: 73X (prior to April 10, 2010- Use 77X after April 10, 2010)
 - *Reference: CR 6338, IOM Pub. 100-20, Transmittal*
 - 770 Non-payment/zero claim
 - 771 Regular clinic visit
 - 777 Replacement of prior claim
 - 778 Void/cancel of prior claim

 - *Medicare Claims Processing Manual, Chpt. 9, Section 100, A*
-

FQHC Claim

- Revenue codes applicable
 - 0519 FQHC Medicare supplemental payments (only for FQHCs)
 - 0520 FQHC free-standing clinic
 - 0522 Home visit by from FQHC practitioner
 - 0524 SNF Part A visit FQHC
 - 0525 SNF or NF or ICF visit patient not in a Part A stay
 - 0527 Visiting nurse service (must have been credentialed as a home health shortage area)
 - 0528 Visit by FQHC practitioner to another site (e.g. scene of accident)
 - 0780 Telehealth originating site visit
 - 0900 Mental health service
 - Per Publication 100, Rev. 820, Issued:02-01-06, Effective: 07-01-06, Implementation: 07-03-06*
-

E/M & Procedure

- Assure documentation is present to support the E/M and the procedure
 - Charge each service
 - Report one line entry on claim with revenue code 520 and the dollar value of the E/M and procedure OR procedure only (billing guidelines for Medicare applicable in FQHCs)
 - May charge E/M for same diagnosis as the procedure if all components documented & medically necessary
 - Check with payer to see if actual procedure code is required in FL 74
-

“Global” Services

- ❑ **FQHC**
 - No global services exist for Medicare
 - Bill each service for each day patient is seen
 - ❑ **Commercial insurance-global services must be tracked as encounters**
 - Suggest 99024 (services rendered during a global period)
 - ❑ **Medicaid – state specific-check with your payer**
 - ❑ **If surgery performed in HOSPITAL by FQHC physician**
 - Add modifier -54 on CMS-1500 claim for the surgery (not applicable to surgeries reported as surgery service only)
-

OB Services

- ❑ Medicare patients - bill E/M that represents the service at time of each encounter plus any additional lab/service
 - ❑ Bill the delivery performed in the hospital to Medicare Part B under the physician's own provider number
 - ❑ Medicaid managed care – generally follow commercial global guidelines (CHECK with them for specific instructions)
 - ❑ Commercial payers – global services are applicable for billing
-

Encounter + Lab

- For all FQHCs
 - As of January 1, 2001, bill **ALL** lab services performed in the FQHC to Medicare Part B on a CMS-1500 form for independent FQHCs
 - Must carve out associated costs for labs on the cost report
-

Injections

- May attach services for 30 days to the face-to-face encounter
 - Example
 - OV is on Wednesday (\$50)
 - Patient receives a Rocephin inj. (\$50) \$10 adm fee (as of 2005)
 - Patient gets another Rocephin injection on Thursday & Friday (\$100) + \$10 administration fee each day
 - Claim is filed for \$230 with "from & to" dates on claim to represent the time span
 - One unit because only one time face-to-face with provider (use date actually saw patient)
(incident to rules apply)
-

Treatment of Hospice Patients in the FQHC

- "A beneficiary who elects to enroll in the hospice program waives all rights to Medicare payments for all services related to the terminal illness. The only exceptions are for those services furnished by his or her non-hospice employed attending physician. A physician working for a FQHC has the option of continuing to follow his or her patient as an attending physician. In this case, the attending physician's services is provided and billed to the carrier under his or her provider number."
-

Hospice (cont)

- Non-physician for hospice care and condition is non-hospice condition, physician is not "attending physician"
 - May bill as FQHC claim
 - Condition code 07 is required
- IF non-hospice physician and condition IS related to hospice condition, BILL hospice
- IF non-hospice physician but designated as "attending physician" bill the carrier

Publication 100-04, chapter 11, section 50

Billing Non-Covered Services Patient Request

- Patient asks that a non-covered service be submitted to Medicare
 - FQHC – Bill type 770
 - Fill in FL 48 with total non-covered charges
 - Condition code 20 or 21
 - 20 patient requests to get a Medicare determination
 - 21 patient wants denial to submit to other insurance
 - Occurrence code 32
-

Remember

- The patient's healthcare is priority
 - The viability of the clinic is mandatory
 - The documentation to support everything that was billed is priority
 - Appropriate submission of the FQHC claim is mandatory
 - The success of the clinic depends on you!
-

References

- Current Procedural Terminology (CPT)
 - International Classification of Disease 9th Revision Clinical Modification (ICD-9-CM)
 - Health Care Financing Administration's Common Procedural Coding System (HCPCS)
-

References

- FQHC Manuals, Pub. 100-04, Pub. 100-2
 - TrailBlazer FQHC Manual, June, 2009
 - "Fact Sheet Federally Qualified Health Center" from the Medicare Learning Network, CMS
 - TENNCare Internet site
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Thank You!

Questions or Comments?

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