Navigating Medicare Billing in Federally Qualified Health Centers (FQHCs)

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HRSA Funding Acknowledgement

This webinar is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award to CHCANYS' New York State Primary Care Association (NYS-PCA) totaling $1,932,890. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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Introduction

About S4CH

Since 2007, Solutions 4 Community Health (S4CH) has focused on management solutions to meet the complex needs of our clients in response to the constant changing healthcare landscape. S4CH's expertise is in Strategic Consulting, Practice Transformation, Revenue Cycle Enhancement, Analytics, HEDIS and Risk Contracting Performance Improvements.

S4CH focuses its work primarily federally qualified health centers (FQHCs) and health care organizations that serve predominantly low-income, uninsured, and at risk populations.

S4CH Revenue Cycle Management

We optimize & maximize revenue, ensure accurate billing and coding, and streamline the financial processes within organizations. We utilize the use of automation to help optimize revenue cycle processes. We work hand in hand with our clients to ensure timely and efficient billing practices.

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CHCANYS Billing & Coding Webinar Series in Partnership with S4CH

1. ~~Basics of FQHC Billing 11/6/2024~~
2. ~~Mastering Medicaid Billing in FQHCs 12/4/2024~~
3. Navigating Medicare Billing in FQHCs 1/8/2025
4. Provider Coding and Documentation 2/5/2025
5. Effective Claim Denial Management 3/5/2025

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Outline-Navigating Medicare Billing in FQHCs

- ✓ Parts of Coverage
- ✓ Types of Reimbursement
- ✓ Prospective Payment System (PPS) Calculation
- ✓ Medicare Advantage (MA) Supplemental Payments
- ✓ Covered Services and Providers in FQHCs
- ✓ Credentialing
- ✓ Medicare Billing
- ✓ FQHC Payment Codes
- ✓ Telehealth Billing
- ✓ Initial Preventative Physical Examination (IPPE) and Annual Wellness Visit (AWV)
- ✓ Care Coordination Services
- ✓ Cost Report
- ✓ Useful Links

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Parts of Medicare Coverage

- A federal health insurance offered to individuals age 65 and older or people under 65 with certain disabilities or conditions.
- Part A helps cover inpatient care in hospitals, skilled nursing facility care, hospice care and other institutional billing. Most Medicare billing in the FQHC setting is billed under Medicare Part A.
- Part B covers outpatient care medical services; however, FQHC still bills the majority to Part A. Patients must have part b coverage. Only FQHC carveouts are billed to part b as well as non FQHC services.
- Part D helps cover the cost of prescription drugs (including many recommended shots or vaccines).
- Medicare Advantage Plans are a type of Medicare health plan that is offered by a private managed care organization (Part C).

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Medicare Jurisdictions

- **New York falls under National Government Services**
  - Medicare Wisconsin (J6)
  - Medicare Upstate NY (JK)

- **Regional Medicare jurisdiction is determined based on:**
  - Date that FQHC site was established and credentialed with Medicare.
  - Any recent site credentialed must bill Medicare Upstate.

- **Regional payer applies to straight Medicare and Medicare Supplemental**

Reimbursement Models

- Part A
  - Prospective Payment System (PPS) all inclusive rate
    - One payment per date of service. Exceptions to this include:
      - Carved out services billed to Medicare Part B
      - Behavioral Health and Medical on the same day can be combined for two PPS payments.
- Part B
  - Always Fee For Service (FFS) at the published Medicare fee schedule.

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Medicare Prospective Payment System (PPS)

- The FQHC Medicare PPS payment rate reflects a base rate that is the same for all FQHCs nationwide, a geographic adjustment based on the location where services are furnished, and other applicable adjustments;
- Factors determining PPS:
  - PPS base rate adjusted for each FQHC based on the location by the FQHC Geographic Adjustment Factor (FQHC GAF)
  - PPS payment is determined by the PPS base rate multiplied by the FQHC GAF
  - Since the FQHC GAF is based on where the services are provided, the FQHC PPS rate may differ among FQHC sites within the same organization.
  - FQHC GAFs are updated yearly.

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

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Medicare Prospective Payment System (PPS) cont.

- **New Patient Adjustment**
  - The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes care to a patient who is new to the FQHC.
  - A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

- **IPPE and AWV Adjustment**
  - The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes an IPPE or an AWV to a Medicare beneficiary.

PPS Calculation Example

Base FQHC PPS Rate 2025	GAF NYC	Established Patient Rate (Base Rate x GAF)	New Patient Adjustment (Est Patient Rate x 1.3416)	IPPE/AWV Adjustment (Est Patient Rate x 1.3416)
$ 202.65	1.073	$ 217.44	$ 291.72	$ 291.72

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Medicare Advantage Supplemental Payments

- Medicare pays for supplemental payments when the patient has a Medicare Advantage primary insurance. This is to ensure that payments made to the FQHC are close to if not equal to the Medicare PPS rate.
- The FQHC must be contracted with the Medicare Advantage plan.
- For each Medicare Advantage plan the FQHC is contracted with, they are required to submit an application to Medicare and a documented estimate of their average visit payment from the Medicare Advantage plan.
- The difference from the Medicare PPS rate and the average payment from the Medicare Advantage plan is used to calculate the supplemental payment.
- Claims are submitted to Medicare with the 0519 revenue code indicating it is a claim for supplemental payment.
- The supplemental rate is typically different for each plan.
- The respective G code is required on the supplemental claim to be paid.

Medicare Shared Savings Program (MSSP)

- The Shared Savings Program is a voluntary program that offers providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) an opportunity to create an Accountable Care Organization (ACO).
- FQHCs are eligible ACO providers that may participate in the Shared Savings Program.

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Accountable Care Organizations Realizing Equity, Access and Community Health (ACO REACH)

- Value-Based care initiative introduced by the Centers for Medicare and Medicaid Services (CMS).
- The program aims to improve outcomes for Medicare beneficiaries by incentivizing providers to focus on quality, cost efficiency, and addressing social determinants of health.
- The program supports better integration of services, emphasizing preventive care and stronger patient-provider relationships.
- Claims are typically reimbursed under capitation agreements.

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Medicare FQHC Covered Providers

- Physicians
- Physician Assistants (PAs)
- Nurse Practitioners (NPs)
- Certified Nurse Midwives (CNMs)
- Clinical Psychologists (CPs)
- Licensed Clinical Social Workers (LCSWs)
- Licensed Mental Health Counselors (LMHCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Nutrition (Medicare covers medical nutrition therapy (MNT) and diabetes self-management training (DSMT)

Medicare Federally Qualified Health Center Defined Services

- Physician Services
- Services and supplies furnished incident to a physician's services
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP),clinical social worker (CSW), marriage and family therapist (MFT), and mental health counselor (MHC) services;
- Services and supplies furnished incident to an NP, PA, CNM, CP, MFT or MHC services
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for beneficiaries with diabetes or renal disease
- Care Management Services
- Initial Patient Preventative Exam
- Annual Wellness Exam

Note: services must be identified as in scope with HRSA to be billed to Part A under PPS and Medicare Supplemental.

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Medicare Non-Covered FQHC Services

- Routine physical checkups
- Dental care
- Hearing tests
- Group therapy

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Typical Part B claims for an FQHC

- Hospital Admission, Discharge and Subsequent Care
- EKG
- Inhouse labs
- Radiology
- Any specialty/service outside HRSA scope of service

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Polling Question

Does your organization bill Medicare Supplemental claims?

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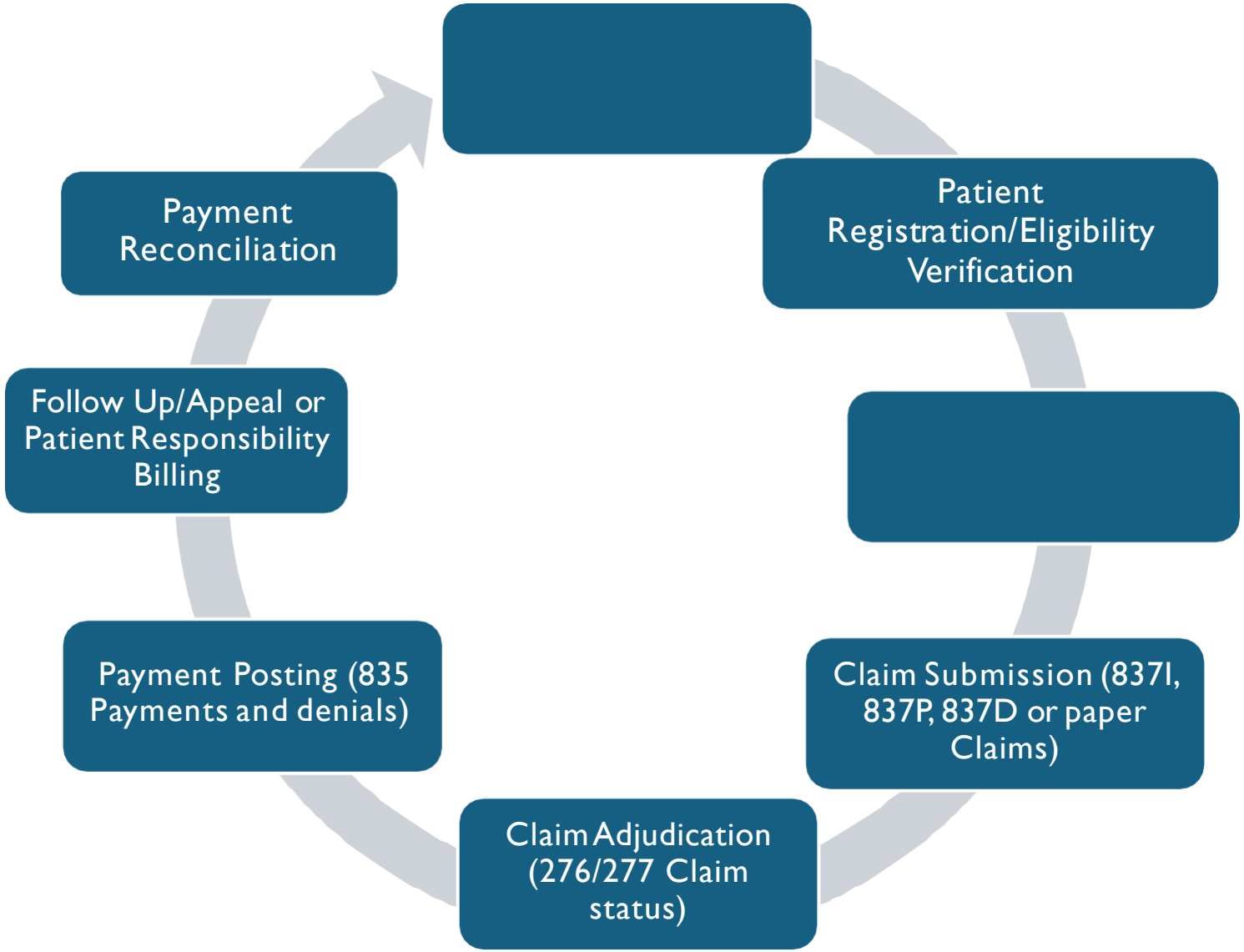
Medicare Billing Cycle



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Medicare Institutional Credentialing

Receive HRSA Grant Award

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Receive Article 28 Operating Certificate

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Complete Medicare 855I with Award Letter and Operating Certificate

↓

Medicare typically processes in 60 days and retro to date of completed application (received and approved).

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Medicare assigns a PTAN/CCN for billing.

↓

Providers need to be credentialed via PECOS for Part A and Part B reimbursement.

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General Medicare Billing in FQHCs

- **Medicare deductibles not applicable**
- **Under the FQHC PPS, co-insurance applies, generally 20 percent of the PPS rate**
- **Bill Type**
  - 771- Original Claim Submission
  - 777- Adjustment/Corrected Claim
  - 778- Cancel/Void
- **Revenue Codes**
  - 0521- Medical Visit
  - 0900- Mental Health Treatment Services
  - 0519- Supplemental Medicare Advantage Organization (MAO) Payment
- **HCPCS Codes for PPS Reimbursement**

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FQHC Payment Codes

FQHCs must include one or more of the FQHC payment codes listed below on claims to receive payment for services furnished:

G0466 - FQHC medical visit, new patient
G0467 - FQHC medical visit, established patient
G0468 - FQHC visit, IPPE or AWV
G0469 - FQHC visit, mental health, new patient
G0470 - FQHC visit, mental health, established patient

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Eligibility

- Integrated with Electronic Health Record (EHR) System
- Clearinghouse
- CONNEX Website

  https://www.ngsmedicare.com/NGS_LandingPage/

Note: eMedNY has valuable responses that sometimes include Medicare coverage.

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Claims Submission

- Electronic Health Record (EHR) System through Clearinghouse
- The Fiscal Intermediary Standard System (FISS) is the standard Medicare Part A claims processing system. Through its Direct Data Entry (DDE) system you may perform the following functions:
  - Enter, correct, adjust, or cancel claims
  - Inquire about the status of claims
  - Access various inquiry screens (e.g., revenue codes, diagnosis codes, reason codes, etc.)
- To connect to some of Medicare systems including Fiscal Intermediary Standard System (FISS), a VPN vendor must be contracted for additional cost.
  - Common Vendors:
    - Inovalon
    - Availity
    - Novitas

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Claim Adjudication

- **An Electronic Remittance Advice (ERA) reports the adjustment reasons using standard codes. For any claim or service-line level adjustment, Medicare may use three sets of codes:**
  - Claim Adjustment Group Code (Group Code)
  - Claim Adjustment Reason Code (CARC)
  - Remittance Advice Remark Code (RARC)
- **Accessing ERAs**
  - Clearinghouse
  - Connex

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Common Denial Codes

24-Enrolled in a Medicare Advantage Plan
26-Inactive Coverage Prior to Date of Service
27-Inactive Coverage After Date of Service
97-Two Visits on Same Day
16-Error or Lack of Information
29-Denied Timely
22-Cordination of Benefits
119-Maximum Benefit for Time Period Reached
18-Duplicate Claim
242-Services Not Provided By In-Network Provider

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Best Practices for Medicare Denial Management

- Insurance Aging
- Denial Management
- Monitor Credentialing
- Payment/Deposit Reconciliation
- Monitoring Data Capture, Registration Errors, Provider Coding etc.

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Telehealth

- **Effective January 1, 2022** a mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder

- **CPT**
  - Requires G2025 (only medical telehealth visits). The 2025 rate is $94.45.

- **Modifiers**
  - 95-(Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) in instances where the visit was furnished using audio-video communication technology
  - FQ-(Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System) in cases where the service was furnished using audio only communication.

- **Policy update:**
  - Medical Telehealth is extended until March 31, 2025.
  - Behavioral Health Telehealth in person requirements extended until April 1, 2025.

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Polling Question

Does your organization utilize Fiscal Intermediary Standard System (FISS)?

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Initial Preventative Physical Exam (IPPE) and Annual Wellness Visit (AWV)

- **Initial Preventative Physical Exam (IPPE)**
  - The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment.
  - Requires cpt G0402 and G0468 to be reimbursed

- **Annual Wellness Visit (AWV)**
  - The AWV is a face-to-face personalized prevention visit for beneficiaries who are not within the first 12 months of their coverage period and have not received an IPPE or AWV within the past 12 months. A Social Determinants of Health (SDOH) risk assessment and Advance Care Planning (ACP) can be furnished as a part of the AWV.
  - The beneficiary coinsurance and deductible are waived.
  - Requires codes G0438 or G0439 and G0468 to be reimbursed
  - If in an ACO, these are important for attribution and risk adjusting

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Care Coordination Services

- Starting January 1, 2025, care coordination services (previously care management services) provided in FQHCs has expanded.
- FQHCs will report the individual HCPCS base codes and add-on codes for each of the care coordination services which will replace HCPCS code G0511. These services will be paid at the national non-facility PFS payment rates. 2025 Rate for G0511 is $54.67.
- For those FQHCs that need additional time to update their billing systems, they may continue to bill G0511 until July 1, 2025. For those that are ready, you may bill the individual HCPCS codes starting January 1, 2025.
- You can bill for multiple care coordination services in the same month if time spent for each specific service doesn’t overlap with any other care coordination service provided.

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Care Coordination Services cont.

	CCM	PCM	CPM	BHI	RPM	RTM	CHI	PIN
	Chronic Care Management	**Principle Care Management**	**Chronic Pain Management**	**Behavioral Health Integration**	**Remote Patient Monitoring**	**Remote Therapeutic Monitoring**	**Community Health Integration**	**Principal Illness Navigation**
Billing Requirements	An initiating visit with a PCP, NP, PA or CNM is required before CCM services can be furnished. Minimum of 20 mins of CCM care provided per month.	Patient must have a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization and/or placed the patient at significant risk of death. Minimum of 30 mins of PCM services per month.	CPM services may be furnished to patients with multiple chronic conditions that involve chronic pain, and may include a person-centered plan of care, care coordination, medication management, and other aspects of pain care. Minimum of 30 minutes of CPM services per month	FQHCs are paid for general BHI services when a minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished to patients with one or more new or pre-existing behavioral health or psychiatric conditions being treated by the FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RFQHC primary care practitioner, warrants BHI services. An initial assessment and ongoing monitoring is required.	FQHCs are paid for RPM services when a minimum of 20 minutes of qualifying non-face-to-face RPM services are furnished during a calendar month. RPM services include the collection, analysis, and interpretation of digitally collected physiologic data, followed by the development of a treatment plan, and the managing of a patient under the treatment plan. FQHCs are also paid for the initial set-up and patient education on use of the equipment that stores the physiologic data for RPM services	FQHCs are paid for RTM services when a minimum of 20 minutes of qualifying non-face-to-face RTM services are furnished during a calendar month. RTM services include remote monitoring of respiratory system status, musculoskeletal status, therapy adherence, or therapy response. FQHCs are also paid for the initial set-up and patient education on use of the equipment that stores the physiologic data for RTM services.	FQHCs are paid for CHI services when a minimum of 60 minutes of qualifying non-face-to-face CHI services are furnished during a calendar month. CHI services include coordination of care, facilitation of access to services, and communication between settings to address the SDOH need(s) that may interfere with, or present a barrier to, the diagnosis or treatment of a patient.	FQHCs are paid for PIN services when a minimum of 60 minutes of qualifying non-face-to-face PIN services are furnished during a calendar month. PIN services include health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.
Medicare FQHC Billing Code	G0511	G0511	G3002/G3003	G0323	G0511	G0511	G0019/G0022	G0023/G0024

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Psychiatric Collaborative Care Model (CoCM)

- Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment.
- It includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving.
- The primary care team regularly reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care, as needed.
- A separately billable initiating visit with an FQHC primary care practitioner (physician, NP, PA, or CNM) is required before psychiatric CoCM services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services.
- Billing requires at least 70 minutes of documented time spent providing CoCM services for the first month and at least 60 minutes in subsequent calendar months.
- Bill HCPCS code G0512 for each month services are provided. 2025 rate is $139.41.

Cost Report

- FQHCs are required to file a cost report annually and are paid for the costs of:
  - Graduate Medical Education (GME)
  - Bad Debt
  - Influenza, Pneumococcal, and COVID-19 Vaccines
- Medicare cost reports covers a 12-month period and must be submitted within five months after the fiscal period.

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

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Medicare Bad Debt

- Medicare allows FQHCs to submit unpaid co-insurance from self pay or secondary as bad debt in the annual cost report.
  - There is no filing limit to file Medicare bad debt.
  - If after reasonable and customary attempts to collect a bill, the debt remains unpaid for more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.
  - Patients must be charged the lesser of the two for their coinsurance. i.e.: a patient whose sliding scale is under 100% of poverty and entitled to the nominal fee should be billed the nominal fee if less than the coinsurance.
  - The receivable that qualifies for bad debt should be financially adjusted before year end to be included in the following years cost report.
  - Methods must exist to exclude prior submission as well as to credit Medicare when a patient or secondary insurance pays after submission.
  - Medicare will reimburse 65% of qualifying bad debt and it is subject to audit.

Useful Links

Federally Qualified Health Center Medicare Learning Network Booklet
https://www.cms.gov/files/document/mln006397-federally-qualified-health-center.pdf

Centers for Medicare and Medicaid Services FQHC Center
https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center

CMS FQHC Payment Codes
https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf

NGSConnex
https://www.ngsmedicare.com/NGS_LandingPage/

NGS FISS DDE Provider Online Guide
https://www.ngsmedicare.com/ca/fiss-dde-provider-online-guide?lob=93617&state=97263&rgion=93623&selectedArticleId=203888

American Relief Act 2025 (Telemedicine Extension)
https://www.congress.gov/bill/118th-congress/house-bill/10545/text#toc-H61EDF9841E6C43E8AC9148C59C153CF6

Thank You

Questions

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