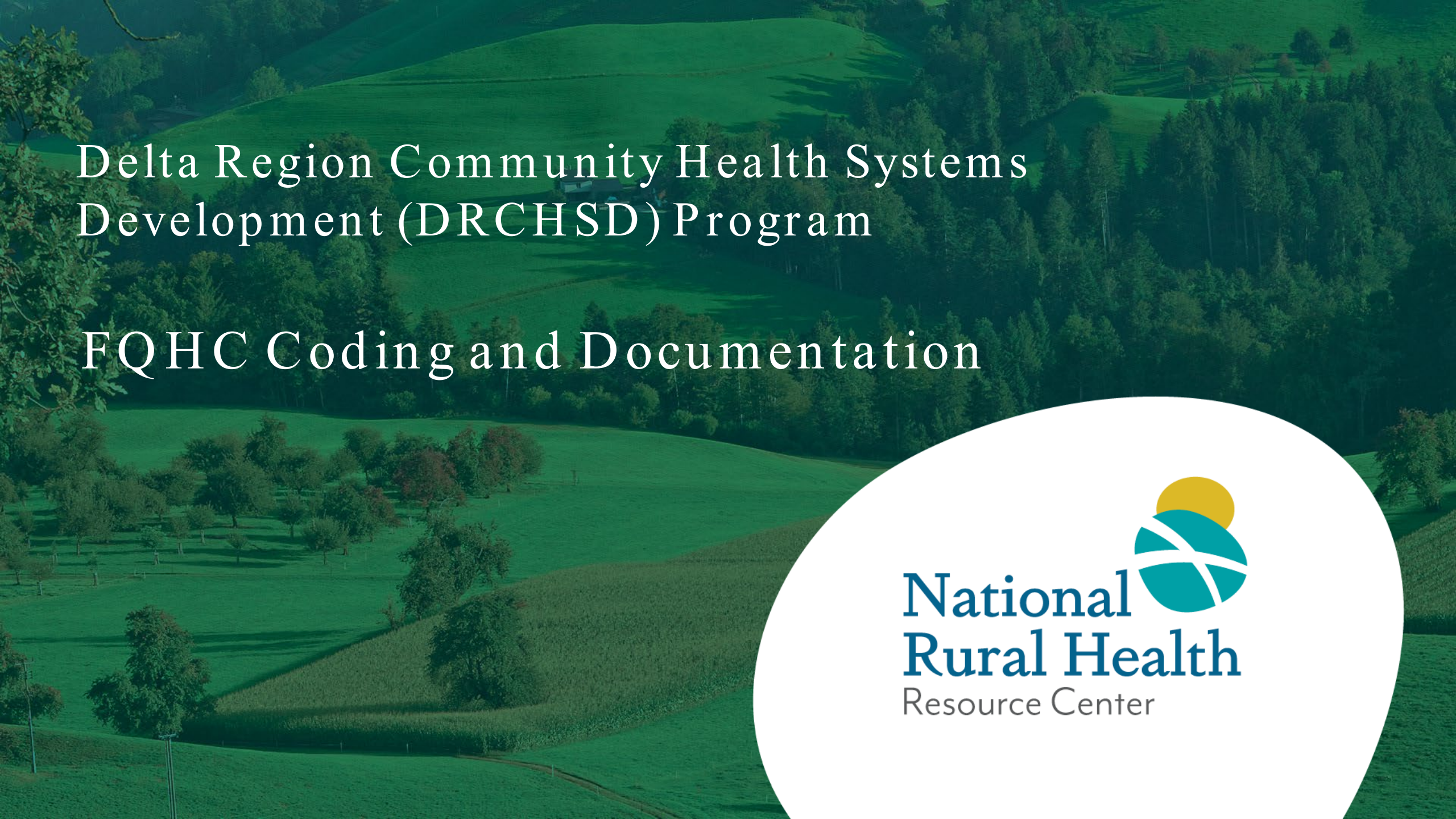
Delta Region Community Health Systems Development (DRCHSD) Program

FQHC Coding and Documentation



National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $10,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

ruralcenter.org

National Rural Health Resource Center

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

https://www.ruralcenter.org/about/dei

DRCHSD Upcoming Webinars

- **DRCHSD Webinar: HCC Risk Adjustment Update**
  - **August 24 from 11:00am- 12:00 pm CT**

- **DRCHSD Webinar: Telehealth Insights Post PHE**
  - **August 31 from 11:00am- 12:00 pm CT**

Pre-Polling Questions

1. I am ___ in my understanding of specific Federally Qualified Health Center (FQHC) billing guidelines related to encounter types, reimbursement mechanisms, and documentation requirements.

2. I am ___ in my understanding of how to optimize billing practices and ensure compliance for my healthcare organization.

Todays Speakers

Caroline Golmon-Hernandez, RHIA, CRCR

Senior Consultant

FORVIS

Stacey Gee, COC, CRCR, CPHT

Managing Consultant

FORVIS

FORVIS

FQHC Billing

August 17, 2023

Agenda

- Introductions
- What is FQHC
- Services Provided
- Claims & Billing
- Reimbursement
- Questions

Meet the Presenters

Caroline Golmon-Hernandez, RHIA, CRCR

Senior Consultant

Stacey Gee, COC, CRCR, CPHT

Managing Consultant

FORVIS

What is an FQHC?

- A Federally Qualified Health Center (FQHC), more commonly known as a Community Health Center (CHC), is a primary care center that is community-based and patient directed
- FQHCs provide preventive services to vulnerable populations that would otherwise not have access to healthcare services
- FQHCs provide services to all individuals, regardless of ability to pay, offering a Sliding Fee Discount Scale to eligible patients

FORVIS

FQHC Qualifications

- To qualify as an FQHC, an entity must meet one of these requirements:
- Get a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code [U.S.C.] § 254a) or is funded by the same grant contracted to the recipient
- **Not** getting a grant under Section 330 of the PHS Act but the Secretary of the Department of Health & Human Services (HHS) allows such a grant, which qualifies the entity as an "FQHC lookalike" based on a Health Resources and Services Administration (HRSA) recommendation
- Treated by the Secretary of HHS as a comprehensive Federally funded health center as of January 1, 1990, for purposes of Medicare Part B
- Operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act as of October 1991

FORVIS

FQHC certification requires the entity to meet all these requirements:

- Provide comprehensive services and have an ongoing quality assurance program including an annual review
- Meet all health and safety requirements
- Not concurrently approved as a Rural Health Clinic
- Meet **all** requirements in Section 330 of the PHA, including:
  - Serve a designated Medically-Underserved Area (MUA) or Medically-Underserved Population (MUP)
  - Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty guidelines
  - Governed by a board of directors, where the majority of members get care at the FQHC

FORVIS

Reference: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FQHC-Text-Only-Factsheet.pdf

FQHC Visits:

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC practitioner (physician, NP, PA, CNM, CP, or CSW), and the practitioner gives one or more qualified FQHC services
- In certain limited situations, include a registered nurse or a licensed practical nurse visit to a homebound patient
- Under certain conditions, a qualified practitioner gives outpatient DSMT or MNT services when the FQHC meets the relevant program requirements to provide these services

FORVIS

FQHC Eligible Providers

- Physicians (MD or DO)
- Nurse Practitioners
- Physician Assistants
- Clinical Psychologist
- Certified Nurse Midwives
- Clinical Social Worker

FORVIS

FQHC Eligible Providers, Continued

- The term ‘physician’ includes:
  - Doctor of medicine
  - Osteopathy
  - Dental surgery
  - Dental medical
  - Podiatry
  - Optometry
  - Chiropractic

FORVIS

FQHC Services

- Physicians' services
  - Services and supplies incident-to a physician's service
- Services of NPs, PAs, CNMs, CP, CSW
  - Services and supplies incident-to the services of NPs, Pas, CNMs, CPs, CSWs
- Visiting nurse services to confined patients at home
- Certain care management services
- Certain virtual communication services
- Initial Preventive Physician Exam (IPPE)
- Annual Wellness Visit (AWV)
- Outpatient DSTM and MNT

FORVIS

FQHC Visits May Take Place:

- In the FQHC
- At the patient's home
  - including an assisted living facility
- In a Medicare-covered Part A Skilled Nursing Facility (SNF)
- At the scene of an accident

FORVIS

FQHC Locations - NEVER

- FQHC visits cannot take place at:
  - An inpatient or outpatient hospital department, including a Critical Access Hospital
  - A facility with specific requirements that exclude FQHC visits

FORVIS

Qualifying Visits

- FQHCs report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the FQHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line
- A list of qualifying visits for FQHCs is located on the FQHC web page at https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf

FORVIS

FQHC G Codes

- G0466: New patient, medical visit
- G0467: Established patient, medical visit
- G0468: Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
- G0469: New patient, mental health visit
- G0470: Established patient, mental health visit

FORVIS

G0466 – FQHC visit, new patient

- A medically-necessary, face-to-face (one-on-one) encounter between a new patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services.
  - A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.
- To qualify as a FQHC visit, the encounter must include one of the services listed under "Qualifying Visits."
- If a new patient is also receiving a mental health visit on the same day, the patient is considered "new" for only one of these visits, and FQHCs should use G0466 to bill for the medical visit and G0470 to bill for the mental health visit.

FORVIS

G0467 – FQHC, established patient

- A medically-necessary, face-to-face (one-on-one) encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving medical services.
  - An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.
- To qualify as a FQHC visit, the encounter must include one of the services listed under "Qualifying Visits."
- If an established patient is also receiving a mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit.

FORVIS

G0468 – FQHC visit, IPPE or AWV

- A FQHC visit that includes an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) and includes the typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving an IPPE or AWV, including all services that would otherwise be billed as a FQHC visit under G0466 or G0467

FORVIS

G0469 – FQHC visit, mental health, new patient

- A medically-necessary, face-to-face (one-on-one) mental health encounter between a new patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving a mental health visit.
  - A new patient is one who has not received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within the past three years prior to the date of service.
- To qualify as a FQHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy. If a new patient is receiving both a medical and mental health visit on the same day, the patient is considered “new” for only one of these visits, and FQHCs should not use G0469 to bill for the mental health visit; instead, FQHCs should use G0466 to bill for the medical visit and G0470 to bill for the mental health visit.

FORVIS

G0470 – FQHC visit, mental health, established patient

- A medically-necessary, face-to-face (one-on-one) mental health encounter between an established patient and a qualified FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of services that would be furnished per diem to a Medicare beneficiary receiving a mental health visit.
  - An established patient is one who has received any professional medical or mental health services from any practitioner within the FQHC organization or from any sites within the FQHC organization within three years prior to the date of service.
- If an established patient is receiving both a medical and mental health visit on the same day, the FQHC can bill for 2 visits and should use G0467 to bill for the medical visit and G0470 to bill for the mental health visit.
- To qualify as a FQHC mental health visit, the encounter must include a qualified mental health service, such as a psychiatric diagnostic evaluation or psychotherapy.

FORVIS

Example of Qualifying Visit List

G0466 - FQHC visit, new patient

HCPCS	Qualifying Visits for G0466
92002	Eye exam new patient
92004	Eye exam new patient
97802	Medical nutrition indiv in
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min

FORVIS

FQHC Bill Types

- TOB = 077X
- 0770 = nonpayment/zero claim (all charges are noncovered)
- 0771 = admit through discharge – used for an original claim
- 0777 = claim adjustment
- 0778 = void/cancel claim
- DOS cannot overlap calendar years
- Split billing periods that overlap calendar year

Reference: CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 9, Section 100A

FORVIS

Applicable Revenue Codes

- 0521 All Clinic Visits and Professional Services by qualified FQHC provider
- 0522 Home visit by FQHC provider
- 0524 Visit by FQHC provider to a Part A SNF bed
- 0525 Visit by FQHC provider to a SNF (not in a covered Part A stay), NF or ICR or other residential facility
- 0527 Visiting Nurse service(s) to a member's home when in home health shortage area
- 0528 Visit by FQHC provider to other non-FQHC site (i.e., scene of an accident)
- 0250 Drugs (not requiring HCPC code assignment)
- 0900 Behavioral Health

FORVIS

New vs Established Patients

- New patient: has not received any professional medical or mental health services from any sites within the FQHC organization within the past 3 years
  - If a new patient is receiving mental health services and medical services on the same day, the patient is considered ‘new’ for only of these visits

FORVIS

Multiple Encounters – Same Day, Modifier 59

- Modifier-59 indicates that separate conditions on the same treated are unrelated. This is used only if a subsequent illness or injury on the same day as another visit
- Modifier-59 is only on the subsequent service line item UB-04 on a claim form

FORVIS

Modifier Example – Subsequent Visit

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45Offic Date of Service	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213	08/12/2021	1	$350.00
0521	Established patient, med visit	G0467	08/12/2021	1	$ .01
0521	Laceration Repair	12002 59	08/12/2012	1	$275.00
0001	Total Charge				$625.01

- ❑ Modifier 59 is NOT reported on the same service line together
- ❑ Assign modifier 59 to the subsequent service line to indicate the subsequent medically necessary visit

FORVIS

Mental Health & Medical Visit – Same Day

Revenue Code	CPT/HCPCS Code	Modifier	Date of Service
0521	G0468 FQHC Payment code	N/A	8/12/2021
0521	G0439 – AWV	N/A	8/12/2021
0900	G0470 – FQHC Payment code	N/A	8/12/2021
0900	90832 – Psy therapy, 30 mins	N/A	8/12/2021

- G0468 = FQHC payment code, medical visit
- G0439 = Annual wellness visit (AWV)
- G0470 = FQHC payment code, mental health, established patient
- 90832 = Psychotherapy, 30 minutes with patient

FORVIS

Behavioral Health Providers

- Eligible FQHC providers:
  - Clinical Psychologist (PhD)
  - Licensed Clinical Social Worker (LCSW)
  - Physician
  - Licensed Clinical Professional Counselor (LCPC) or Clinical Professional Counselor (CPC) is not payable by Medicare*
  - *Check with your own state to see if LCPC or CPC are eligible – in most states they are not

FORVIS

Mental Health Visits

- Medically necessary face-to-face encounter between an FQHC patient and an FQHC practitioner during which time one or more FQHC mental health services are provided
- Group mental health services do not meet the criteria for a one-to-one, face-to-face encounter

Behavioral Health Qualified Visits

G0469 – FQHC visit, mental health, new patient:

HCPCS/CPT	Short Description
90791	Psych Diagnostic Evaluation
90792	Psych Diagnostic Evaluation w/Medical Services
90832	Psytx PT/Family 30 minutes
90834	Psytx PT/Family 45 minutes
90837	Psytx PT/Family 60 minutes
90839	Psytx Crisis Initial 60 minutes
90845	Psychoanalysis

FORVIS

Behavioral Health Qualified Visits, continued

G0470 – FQHC visit, mental health, established patient:

HCPCS/CPT	Short Description
90791	Psych Diagnostic Evaluation
90792	Psych Diagnostic Evaluation w/Medical Services
90832	Psytx PT/Family 30 minutes
90834	Psytx PT/Family 45 minutes
90837	Psytx PT/Family 60 minutes
90839	Psytx Crisis Initial 60 minutes
90845	Psychoanalysis

Behavioral Health Services

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charge
0900	Psytx PT/Family 30 minutes	90832	08/12/2021	1	$120.00
0900	FQHC visit, mental health, est	G0470	08/12/2021	1	$ .01
0001	Total Charge				$120.01

- Behavioral Health Services performed by a qualified provider are billed using revenue code 0900

FORVIS

Importance of Correct Coding

- Integrity behind coding
  - Diagnosis coding needs to correlate to CPT/ HCPCS coding
- Coding needs to reflect the true health of the patient
- Payers reimburse differently, it is important to accurately code/report services to the most accurate and specific levels
- Your claim tells the story of the patient:
  - CPT/HCPCS codes tell what happened
  - Diagnosis codes tell why it happened

FORVIS

Reimbursement

- National rate $180.16
  - Geographic Adjustment Factor (GAF) based on locality is applied
  - IPPE and AWV = Medicare will pay the FQHC PPS G Code at a FQHC's billed charge or the annual PPS rate maximum, whichever is less
    - Coinsurance not applicable

Locality Number	State	Locality Name	2023 FQHC GAF
00	AL	ALABAMA	0.902
01	AK	ALASKA*	1.255
00	AZ	ARIZONA	0.941
13	AR	ARKANSAS	0.891
54	CA	BAKERSFIELD	1.008
55	CA	CHICO	1.005
71	CA	EL CENTRO	1.005
56	CA	FRESNO	1.005
57	CA	HANFORD-CORCORAN	1.005
18	CA	LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES CNTY)	1.065
26	CA	LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)	1.065
58	CA	MADERA	1.005
59	CA	MERCED	1.005
60	CA	MODESTO	1.005
51	CA	NAPA	1.104
07	CA	SAN FRANCISCO-OAKLAND-BERKELEY (ALAMEDA/CONTRA COSTA CNT	1.170
17	CA	OXNARD-THOUSAND OAKS-VENTURA	1.054
61	CA	REDDING	1.005
62	CA	RIVERSIDE-SAN BERNARDINO-ONTARIO	1.005
63	CA	SACRAMENTO-ROSEVILLE-FOLSOM	1.030
64	CA	SALINAS	1.051
72	CA	SAN DIEGO-CHULA VISTA-CARLSBAD	1.054

FORVIS

Incident-To Services

- Commonly rendered without charge or included in the FQHC bill;
  - Commonly furnished in a physician office or clinic
  - Furnished under the physician's direct supervision; and
  - Furnished by a member of the FQHC staff
  - Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal)
  - Bandages, gauze, oxygen, and other supplies; or
  - Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician
- Incident-to services are considered covered *and paid* under the FQHC
  - They must be bundled with the FQHC encounter. They are not separately billable or payable
  - Services that do not occur on the same date as the encounter can be bundled if they occur 30 days before or after
  - The effect on payment is an increase in the charge, and therefore in the co-insurance
  - The cost for these services are included in the cost report, but are not separately payable on claims

FORVIS

Examples of Non-Encounter – Does not warrant Medical Necessity

- Injections
- Suture Removal
- Dressing Changes
- Prescription Services
- Blood Pressure Monitoring

FORVIS

Influenza (G0008) and Pneumococcal and Vaccines (G009)

- Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report
- FQHCS may report these vaccines and their administration on an FQHC claim, the reporting of these codes are informational only
- Report these charges on the claim if furnished as part of an encounter
- The beneficiary coinsurance and deductible are waived

FORVIS

Reference: MCPM, Chapter 9

Hepatitis B

- The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit
- A visit cannot be billed if vaccine administration is the only service provided
- Hepatitis B should be reported on the claim and is included in the claim payment. These services will be carved out of the coinsurance calculation

FORVIS

Well Woman Exams

- Medicare does not pay well-woman exams (99381-99387). An annual or subsequent wellness visit (G0438, G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091)

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charge
0521	Subsq AWV	G0439	08/12/2021	1	$175.00
0521	Breast/pelvic	G0101	08/12/2021	1	$ 75.00
0521	Pap Smear	Q0091	08/12/2021	1	$ 50.00
0001	Total Charge				$300.00

All Preventive Services are listed to capture quality measure and to report utilization to Medicare for COB. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

FORVIS

Other Resources Available

- CMS FQHC Qualifying Visit List Link
  - https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf
- CMS Medicare Benefit Policy Manual
- CMS Medicare Claims Processing Manual
- CMS FQHC Reporting Requirements FAQs
- Medlearn MLN006762 Publication

FORVIS

Post-Polling Questions

1. I am ___ in my understanding of specific Federally Qualified Health Center (FQHC) billing guidelines related to encounter types, reimbursement mechanisms, and documentation requirements.

2. I am ___ in my understanding of how to optimize billing practices and ensure compliance for my healthcare organization.

3. I am ___ that I will apply the knowledge gained from this educational training to identify leading practices to mitigate risks and improve processes that enhance my organization's financial position.

Questions?

forvis.com

FORVIS

Assurance / Tax / Advisory

Thank you!

forvis.com

FORVIS

Assurance / Tax / Advisory