FQHC Medicare Wrap-Around Payment Process
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Topics

FQHC billing requirements
- Standard billing requirements
- PPS requirements

Medicare wrap-around payments
- Process
- Billing
- Q & A received from our providers

FQHC billing requirements

Standard billing requirements
- FQHC claims subject to timely filing
- FQHCs required to administer/update Medicare Secondary Payer questionnaire
- Type of bill (TOB) 77x
- Separate line items with revenue codes
  - For all FQHC covered services
- Line item date of service (LIDOS) required for each revenue code
- Charges for allowable costs
- Detailed HCPCS codes required for all services rendered during the encounter
- G-codes
  - New with PPS
FQHC PPS requirements

- FQHCs submit claims using the PPS requirements beginning with their first cost reporting period beginning on or after October 1, 2014
- All services rendered on the same day must be submitted on one claim
  - Or the claim will be rejected
- Multiple claims submitted with the same date of service will be rejected
  - Exceptions:
    - Subsequent illness or injury requiring additional diagnosis and treatment
    - Mental health visit occurring on the same day as another billable medical visit
      - Medication adjustment alone does not constitute a mental health visit

Types of FQHC Bills

<table>
<thead>
<tr>
<th>TOB</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>770</td>
<td>Non-payment/zero claim (a claim with only non-covered charges)</td>
</tr>
<tr>
<td>771</td>
<td>Admit through discharge (original claim)</td>
</tr>
<tr>
<td>777</td>
<td>Replacement of prior claim (adjustment)</td>
</tr>
<tr>
<td>778</td>
<td>Void/cancel prior claim (cancellation)</td>
</tr>
</tbody>
</table>
### Common FQHC Revenue codes:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0519</td>
<td>Supplemental payment for visit by a beneficiary in a contracted Medicare Advantage Plan</td>
</tr>
<tr>
<td>0521</td>
<td>Clinic visit by beneficiary to the FQHC</td>
</tr>
<tr>
<td>0522</td>
<td>Home visit by FQHC practitioner</td>
</tr>
<tr>
<td>0524</td>
<td>Visit by FQHC practitioner to a beneficiary in a covered Part A stay at a SNF</td>
</tr>
<tr>
<td>0525</td>
<td>Visit by FQHC practitioner to a beneficiary in a SNF (not in a covered Part A stay) or Nursing Facility (NF) or Intermediate Care Facility for Mental Retardation (ICF/MR) or other residential facility</td>
</tr>
<tr>
<td>0527</td>
<td>FQHC Visiting Nurse Service(s) to a beneficiary’s home when in a home health shortage area</td>
</tr>
<tr>
<td>0528</td>
<td>Visit by FQHC practitioner to other non FQHC site (e.g., scene of accident)</td>
</tr>
<tr>
<td>0780</td>
<td>Telemedicine, General Classification</td>
</tr>
<tr>
<td>0900</td>
<td>Behavioral Health Treatment Services</td>
</tr>
</tbody>
</table>
G-Codes for FQHCs Authorized to Bill under PPS

<table>
<thead>
<tr>
<th>G Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0466</td>
<td>FQHC visit, new patient</td>
</tr>
<tr>
<td>G0467</td>
<td>FQHC visit, established patient</td>
</tr>
<tr>
<td>G0468</td>
<td>FQHC visit, IPPE or AWV</td>
</tr>
<tr>
<td>G0469</td>
<td>FQHC visit, mental health, new patient</td>
</tr>
<tr>
<td>G0470</td>
<td>FQHC visit, mental health, established patient</td>
</tr>
</tbody>
</table>

- FQHC billing under the PPS
  - Required to use G codes (FQHC payment codes)
- FQHC sets own charges for services
  - FQHC determines which services are included in bundle of services associated with G code
    - FQHC should maintain records of services included in each G code and the associated charges
      - Charges must be uniform for all patients
- Each specific G code must be submitted with a qualifying visit on a separate line

Historical Payment of FQHC Claims

- FQHC claims paid an AIR per visit subject to a payment limit
  - Visit defined as a face to face encounter with FQHC practitioner
  - AIR determined by MAC using data collected from cost reports, number of visits per year and allowable adjustments
- Payment of FQHC claims includes:
  - Medicare pays 80% of the AIR
  - Beneficiary pays 20% of FQHC charges
    - AIR and totaled FQHC charges may or may not be the same dollar amount
- More than one FQHC encounter in a single day constitute a single visit, paid one AIR,
  - Whether or not visits are scheduled or unscheduled
  - Whether visits are with the same or a different FQHC practitioner
• Exceptions to single visit rule:
  ○ After an initial visit, the beneficiary suffers an illness or injury on the same day, requiring additional, unrelated diagnosis and treatment
  ○ The beneficiary has a medical visit and a visit with a clinical psychologist or clinical social worker (a mental health visit) on the same day
  ○ The beneficiary has a medical or mental health visit and the IPPE on the same day

Payment of FQHC Claims after the Implementation of FQHC PPS
• FQHCs transition to the FQHC PPS based on their cost reporting periods
  ○ FQHCs transition to FQHC PPS on the first day of their cost reporting period that begins on or after October 1, 2014
• Claims paid a per diem (PPS) rate per encounter
  ○ Base rate for 2015 = $158.85
  ○ PPS rate = Base rate x FQHC Geographic Adjustment Factor (GAF)
    ☆ GAF adjusts the base rate up or down, according to the cost of providing services in a particular geographic location
    ☆ FQHC GAF is based on where services are rendered
      ‣ Payment rates may differ among FQHC sites within the same organization
  ○ 34% increase in the PPS rate for
    ☆ New patients
    ☆ Patients receiving an IPPE
    ☆ Patients receiving an initial or subsequent AWV
• Medicare pays 80% of the lesser of the actual charge or the PPS rate
• Beneficiary pays 20% (coinsurance) of the lesser of the actual charge or the PPS rate
  ○ No coinsurance charged for preventive services for which coinsurance is waived
    ☆ Claims with both preventive and non-preventive services, coinsurance is 20% of the full payment after the dollar value of the preventive service charge is subtracted

Detailed Payment Examples

Detailed examples of Medicare payments can be found in the CMS, MLN Connects presentation entitled “New Medicare Prospective Payment System (PPS) for FQHCs: Operational Requirements” http://www.cms.gov/Outreach-and-Education/Outreach/NPC/
Medicare Wraparound Payments for Medicare Advantage (MA) Members

- FQHCs that have a written contract with a MA organization are paid by the MA organization at the rate that is specified in their contract.
- If contracted rate is less than Medicare PPS rate, Medicare will pay FQHC the difference, less any cost sharing amounts owed by beneficiary.
- PPS rate is subject to FQHC GAF, and may also be adjusted for a new patient visit or if a IPPE or AWV is furnished.
- Supplemental payment is only paid if the contracted rate is less than fully adjusted PPS rate.
- Billing Medicare for Supplemental Payment:
  - TOB 77x
  - Revenue code 0519
  - HCPCS codes are required
  - G code is required
  - Bill Medicare as primary

<table>
<thead>
<tr>
<th>FL 42 Rev Code</th>
<th>FL 43 Description</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0519</td>
<td>FQHC visit, estab pt</td>
<td>G0467</td>
<td>100114</td>
<td>1</td>
<td>$156.00</td>
</tr>
<tr>
<td>0519</td>
<td>Office/outpatient visit est</td>
<td>99212</td>
<td>100114</td>
<td>1</td>
<td>$100.00</td>
</tr>
<tr>
<td>0519</td>
<td>Hep b vacc adult 3 dose im</td>
<td>90746</td>
<td>100114</td>
<td>1</td>
<td>$60.00</td>
</tr>
<tr>
<td>0519</td>
<td>Admin hepatitis b vaccine</td>
<td>G0010</td>
<td>100114</td>
<td>1</td>
<td>$20.00</td>
</tr>
<tr>
<td>0001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$336.00</td>
</tr>
</tbody>
</table>
FQHC Wrap-Around Process Q & A

Q1. Can we get the difference between the MA contracted rate and the fully adjusted PPS rate at cost settlement instead of sending in MA wraparound payment claims?

A1. No. The only way to be paid the difference would be to send in your MA wraparound payment claims with the 0519 revenue code.

Q2. What address do we send our MA contracts to?

A2. Please see below.

<table>
<thead>
<tr>
<th>J5 Providers</th>
<th>J8 Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>WPS Medicare Part A</td>
<td>WPS Medicare Part A</td>
</tr>
<tr>
<td>Audit and Reimbursement</td>
<td>Audit and Reimbursement</td>
</tr>
<tr>
<td>P.O. Box 8310</td>
<td>P.O. Box 2430</td>
</tr>
<tr>
<td>Omaha, NE 68108-0310</td>
<td>Omaha, NE 68103-2430</td>
</tr>
</tbody>
</table>

Q3. When sending our Medicare Advantage contracts to Medicare to be set up for the wraparound payments, do we need to send a copy of the entire contract or do we send specific information?

A3. WPS Medicare will make extra payments to certain FQHCs that have written contracts with MA plans for rates below the national per visit limit. The FQHC must have a written contract with the MA plan that contains the terms specified by Title 42 of the Code of Federal Regulations (CFR) Section 422.527 ([http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/pdf/CFR-2007-title42-vol3-sec422-527.pdf](http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/pdf/CFR-2007-title42-vol3-sec422-527.pdf)). The contract must be signed by both the FQHC and the MA plan, and the FQHC must provide the MAC with a valid MA contractor number with each contract. The FQHC must provide the MAC with an average MA per-visit payment rate for each MA plan they are under contract with, and the MA rate must be accompanied by documentation of how the rate was calculated. The FQHC would send this information to the Audit Department for further review and payment calculation.

Q4. How will we know when the MAC receives the copies of our MA contracts?

A4. WPS Medicare’s Audit department will send a letter to the FQHC with the rate.
Q5. I was told by another FQHC that is assisting with our set up that we just need to bill Medicare secondary in order to get the wraparound amount. Obviously this is incorrect from what you stated during the presentation. Do we bill Medicare first and then Medicare will forward it to the MA plan for the patient? Also, we have everything set up with revenue code 0521 for FQHC, so I'm wondering if I have to go in and change the code just for these claims?

A5. Yes, unfortunately the information you were given was incorrect. If you have a contract with the MA plan, you will need to send that to our Audit department to get set up for us to accept your claims for the MA wraparound payment. Keep in mind, you’ll only receive this payment if your contracted amount with the MA plan is less than your fully adjusted Medicare payment rate. You will need to send in two separate claims: one to the MA plan, one to traditional Medicare. You will also need to change the revenue code for all lines on these claims to 0519.

References

General Information
- CMS Internet-Only Manual (IOM); Publication 100-02; Medicare Benefit Policy Manual; Chapter 13
- CMS IOM; Publication 100-04, Medicare Claims Processing Manual; Chapter 9
- CMS Federally Qualified Health Center Website
  - http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

FQHC PPS
- Transmittal 1383; Change Request 8743; Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)

Medicare Wraparound Payments for Medicare Advantage (MA) Members
- CMS Internet-Only Manual (IOM); Publication 100-04, Medicare Claims Processing Manual; Chapter 9; Section 110.2