Medicare FQHC PPS RATE SETTING

An Overview of Implementation

Disclaimer

These slides are created to assist Indian Health outpatient centers to develop internal polices and processes.

Highlights

- Background
- Basics
- G-Codes
- Base Rate * GAF
- The Bundle
- The Lesser Of
- Tips

The Affordable Care Act mandated the development of a prospective payment system (PPS) for Medicare payments to FQHCs beginning on October 1, 2014, and requires that Medicare payment under the FQHC PPS shall be 80 percent of the lesser of the actual charge or the PPS rate.

Basics are still the basics

A federally qualified health center (FQHC) visit is a medically-necessary, face-to-face (one-on-one) encounter between a FQHC patient and a FQHC practitioner during which time one or more FQHC services are rendered. A FQHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), or a clinical social worker (CSW), or a certified DSMT/MNT provider. An Initial Preventive Physical Examination (IPPE) and an Annual Wellness Visit (AWV) can also be considered a FQHC visit.

FQHC Visits

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A FQHC visit can also be a visit between a home-bound patient and a RN or LPN under certain conditions. Outpatient diabetes self-management training (DSMT), medical nutrition therapy (MNT), and transitional care management (TCM) services also may qualify as a FQHC visit when furnished by qualified practitioners and the FQHC meets the relevant program requirements for provision of these services. If these services are furnished on the same day as an otherwise billable visit, only one visit is payable.

Effective the 1st day of your cost report period following 10/01/2014

G-Codes

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

Calculating the Two Rates

Rate #1 The geographically adjusted PPS rate for your location (base*gaf)

Rate #2 Your bundle rates for the new billing G- Codes

Rate #1 Your PPS Rate = Base Rate * GAF

PPS Base Rate: $158.85 * GAF = your PPS rate

For example…$158.85 * 1.053 = **$167.27**

California Geographic Adjustment Factor's

FQHC GEOGRAPHIC ADJUSTMENT FACTORS (FQHC GAFs)
April 1, 2015 through December 31, 2015

Locality	Locality name	2015 FQHC GAFs
26	Anaheim/Santa Ana, CA	1.12
18	Los Angeles, CA	1.1
3	Marin/Napa/Solano, CA	1.165
7	Oakland/Berkeley, CA	1.154
5	San Francisco, CA	1.224
6	San Mateo, CA	1.122
9	Santa Clara, CA	1.209
17	Ventura, CA	1.1
99	Rest of California	1.053

Rate #2 The Typical Bundle

- Report the FQHC covered procedure codes you billed for the recent 3 year period for Medicare Patients (VGEN)
- If you use VGEN, be sure to clean out any codes that were not eligible for FQHC billing
- A choice for you: Most common E/M code or average the charges for the two categories (next slide)
- Other FQHC services performed more than 50% of the time (venipuncture)

Bundle Rate example for established patient visit

			Option 1	Option 2
VGEN Data			Most Common	Average
Estab. E/M	Times Used	Fee		
99211	13	$75.00		Total all E/M fees divided by times used $84,931/459) = $185.03
99212	79	$114.00		
99213	194	$190.00	$190.00	
99214	115	$280.00		
99215	58	$375.00		
36415	312	$5.00	$5.00	$5.00
			$195.00	$190.03

New Patient, IPPE/AWV Boost

The adjusted FQHC PPS rate is increased by 34.16 percent when a patient is new to the FQHC, or an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) is furnished. Only one adjustment per day can be applied.

Code	GAF adj Rate	Boost 1.3416	Final Rate
G0466 New patient	$280.20	34.16%	$375.92
G0468 IPPE/AWV	$450.00	34.16%	$448.66
G0469 New patient, mental health visit	$295.00	34.16%	$395.77

Now you have all the rates ****EXAMPLES ONLY***

- PPS Rate = $167.27

- G0466 New Patient = $375.92
- G0467 Established Patient= $348.77
- G0468 IPPE/AWV = $448.66
- G0469 Mental Health New Patient = $395.77
- G0470 Mental Health Est Patient = $215.00

BILLING

- Bill both the G-Code and the itemized services together on the same claim form
- All items are to have fees
- …yes, the A/R is now inflated

Include both new G-code & itemized codes

- Do not add totals on the claims like before
- Bill the new G-Code with your bundle rate (not default PPS rate)
- The actual codes with charges for the service date
  - E/M & qualifying Procedures
  - Flu & Pneumovax informational only (Medicare codes)

PAYMENT

80% OF THE LESSER OF:

The G-Code Rate $348.77 * 80% = $279.02

OR

Your PPS Rate $167.27 * 80% = $133.82

The Lesser of

- 80% of the lesser of the actual charge or the Medicare PPS rate
- Actual Charges = the regular rates for services that are charged to beneficiaries and other paying clients.

Preventive Care

Medicare waives coinsurance for certain preventive services. For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, MACs shall pay 100 percent of the lesser of the provider's charge for the FQHC payment code or the FQHC PPS rate, and no beneficiary coinsurance would be assessed.

Word to the wise

- Your G-Code rates can only be as good as your clinic fee schedule
- If your clinic fee schedule is low then your G-Code rates could be lower than your PPS rate
- Beware of the lesser of……

TIPS

Medical and Mental Health Same Day

- 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.

- These must be on the same claim form and therefore causes you to merge the claims and choose which provider you submit.

Mixed preventive and non-preventive service dates

For FQHC claims that include a mix of preventive and non-preventive services, contractors shall use the lesser of the provider's charge for the specific FQHC payment code or the corresponding FQHC PPS rate to determine the total payment amount.

To determine the amount of Medicare payment and the amount of coinsurance that should be waived, contractors shall use the FQHC's reported line-item charges and subtract the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount. (See Pub. 100-04, chapter 18, section 1.2, for a table of preventive services that are exempt from beneficiary coinsurance.)

Medicare Advantage

Section 1833(a)(3)(B)(i) of the Act requires that FQHCs that contract with Medicare Advantage (MA) organizations be paid at least the Medicare amount for FQHC services. 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, and the rate must reflect rates for similar services furnished outside of a FQHC setting. **If the contracted rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary**. The PPS rate is subject to the FQHC GAF, and may also be adjusted for a new patient visit or if a IPPE or AWV is furnished. The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate. To facilitate accurate payment, claims for MA supplemental payments under the FQHC PPS must include the specific payment codes that correspond to the appropriate PPS rates and the detailed HCPCS coding required for all FQHC PPS claims.

Revenue Codes

- No Changes

Re-evaluate

- Annually along with your regular fee schedule updates
- Check the GAF every 6 months

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

Discussion