CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1395	**Date: July 16, 2014**
	Change Request 8743

Transmittal 1383, dated May 9, 2014, is being rescinded and replaced by Transmittal 1395 dated July 16, 2014, to update the following business requirement: 8743.14 updated to add revenue code 0900; 8743.16 -8743.19, 8743.22 and 8743.23 updated to remove FISS from the responsibility column; 8743.21 and 8743.23.1 updated to add the IOCE flags; 8743.24 and 8743.25 updated to add additional input and output fields for the Pricer; 8743.26 and 8743.26.2 updated to change the field name to geographic adjustment factor (GAF); 8743.32 updated to add additional return codes for the Pricer; and 8743.42 and 8743.43 updated to remove the ANSI information. All other information remains the same.

SUBJECT: Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)

I. SUMMARY OF CHANGES: This change request implements the Federally Qualified Health Centers prospective payment system (PPS).

EFFECTIVE DATE: October 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

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SUBJECT: Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)

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I. GENERAL INFORMATION

A. Background: Medicare currently pays federally qualified health centers (FQHCs) 80 percent of their all-inclusive rate (AIR), which is determined annually based on total costs divided by the number of visits, subject to productivity adjustments and an upper payment limit. Contractors reconcile costs and visits at year-end through cost report settlement.

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. In developing the Medicare FQHC PPS, the Affordable Care Act requires that the PPS rate reflect total reasonable costs for FQHCs without the application of the productivity adjustment or the current payment limits, and allows for other adjustments. In subsequent years, rates must be adjusted by the Medicare Economic Index (MEI) or by a percentage increase in a market basket of FQHC goods and services.

B. Policy: Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added section 1834(o) of the Social Security Act to establish a new system of payment for the costs of FQHC services under Medicare Part B based on prospectively set rates. The statute requires implementation of the FQHC PPS for FQHCs with cost reporting periods beginning on or after October 1, 2014.

In compliance with the statutory requirements of the Affordable Care Act, CMS published a final rule with comment period to implement methodology and payment rates for a PPS for FQHCs under Medicare Part B beginning on October 1, 2014. CMS established a national, encounter-based prospective payment rate for all FQHCs, determined based on an average of the reasonable costs of all FQHCs. Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC (including any sites that are part of the FQHC organization) or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be

used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). The FQHC GAFs are adapted from the work and practice expense geographic practice cost indices (GPCIs) used to adjust payment under the physician fee schedule (PFS). The FQHC GAFs for October 1 through December 31, 2014, will be adapted from the CY 2014 PFS GPCIs applicable during that same period. Subsequent updates to the FQHC GAFs will be made in conjunction with updates to the PFS GPCIs for the same period. In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished.

For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site. CMS notes this is different from the current payment system where all FQHC delivery sites that are included in a consolidated cost report are paid the same amount per FQHC visit, regardless of the locality of the delivery site, based on the lower of the FQHC organization's all-inclusive rate or a single weighted payment limit calculated for the entire FQHC organization.

From October 1, 2014 through December 31, 2015, the FQHC PPS base payment rate is $158.85. In accordance with section 1834(o)(2)(B)(ii) of the Act, after the first year of implementation, the PPS payment rates must be increased by the percentage increase in the MEI. After the second year of implementation, PPS rates shall be increased by the percentage increase in a market basket of FQHC goods and services as established through regulations, or, if not available, the MEI that is published in the PFS final rule. Updates to the FQHC PPS base payment rates will be made available through program instruction.

The FQHC PPS rates will be calculated as follows:

Base payment rate x FQHC GAF = PPS rate

If the patient is new to the FQHC, or the FQHC is furnishing an IPPE, initial AWV, or subsequent AWV, the PPS rate will be adjusted by 1.3416. This is a composite adjustment factor and would only be applied once per day. If the patient is new to the FQHC, or the FQHC is furnishing an IPPE, initial AWV, or subsequent AWV, the PPS rate would be calculated as follows:

Base payment rate x FQHC GAF x 1.3416 = PPS rate

To qualify for an encounter-based payment, a FQHC visit must include a medically-necessary, face-to-face (one-on-one) encounter between a FQHC patient and a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), or a clinical social worker (CSW) during which time one or more FQHC services are rendered. An IPPE and an AWV can also be considered a FQHC visit.

A FQHC visit can also be a visit between a home-bound patient and a RN or LPN under certain conditions. If a home visit occurs on the same day as an otherwise billable visit, only one visit is payable. 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 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. Additional information on the coverage requirements for FQHC visits can be found in Pub 100-02, Chapter 13.

CMS is establishing five payment codes to be used by FQHCs submitting claims under the PPS based on the services furnished. (See attachment A for a description of these codes). FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary. CMS will also

continue to require FQHCs to report detailed HCPCS coding with the associated line item charges, with the line item charges reflecting the regular rate charged for the specific service described by each HCPCS code. The detailed HCPCS coding and associated charges will be used to list the visit that qualifies for an encounter payment; to support the application of adjustments for new patients, IPPE, and AWV; and to facilitate the waiving of coinsurance for preventive services.

The total payment amount for a FQHC visit shall be the lesser of the FQHC's reported charge for the FQHC payment code or the fully adjusted FQHC PPS rate for the specific payment code. CMS notes that the FQHC PPS rate used in this comparison is fully adjusted by the FQHC GAF and the composite adjustment for a new patient visit, IPPE, or AWV, as applicable. Contractors shall not apply the FQHC GAF or the composite adjustment to the FQHC's reported charges.

Under the FQHC PPS, contractors shall generally pay 80 percent of the lesser of the FQHC's charge for the FQHC payment code or the corresponding FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the FQHC PPS rate. For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, contractors 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.

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.)

The following explains the components of the FQHC PPS that Contractors will need to consider for implementation:

- FQHCs will be transitioned to the FQHC PPS based on their cost reporting periods. For FQHC claims with dates of service on or after October 1, 2014, contractors shall check the FQHC's cost reporting period beginning date and pay FQHCs using the new PPS system if the FQHC's cost reporting period begins on or after October 1, 2014.

- For FQHCs with cost reporting periods beginning before October 1, 2014, contractors shall pay FQHCs using the current all-inclusive rate system. Contractors will need to maintain both systems concurrently until all FQHCs are transitioned to the PPS.

- Payment for a FQHC encounter requires a medically necessary face-to-face visit. FQHCs shall submit claims with a specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these payment codes will correspond to the appropriate PPS rates. The specific payment codes and the HCPCS for face-to-face visits that qualify the encounter for Medicare payment are included as an attachment to this change request. FQHCs submitting claims for supplemental payments for covered FQHC services furnished to MA enrollees also must include a specific payment code and the HCPCS for the face-to-face visit that qualifies the encounter for Medicare payment.

- Under the FQHC PPS, contractors shall pay a single, encounter-based payment for all FQHC services furnished to the same beneficiary on the same day. Contractors shall allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as the medical visit.

- The total payment amount will be based on the lesser of the fully adjusted PPS rate or the FQHC's charge for the specific payment code.

- Contractors shall use the same base rate for all FQHCs under the PPS.

- Contractors shall apply the FQHC GAF based on the zip+4 of the FQHC's practice location, as determined by the Medicare CCN on the claim. Contractors shall define the geographic location associated with the FQHC GAFs using the Medicare PFS definitions of the GPCI localities. Contractors shall NOT apply the FQHC GAF to the FQHC's charge.

- Contractors shall adjust the base payment rate by **1.3416** when a FQHC furnishes care to a new patient or when a FQHC furnishes an IPPE, initial AWV, or subsequent AWV. This is a composite adjustment factor and would be applied once per beneficiary per day, without exception – e.g., if a patient is a new patient and receiving an AWV, the base payment rate would be adjusted once by 1.3416. Contractors shall NOT apply the composite adjustment factor to the FQHC's charge.

- If the HCPCS listed on the claim is for a "new patient," contractors shall adjust the PPS rate if the patient had not been seen by the FQHC, or any FQHC practice location associated with the same grantee, within the past three years, as calculated based on three years prior to the date of service. For each of these conditions, contractors shall increase the base payment rate by a factor of **1.3416.** Contractors shall check if the FQHC has submitted claims for the same beneficiary in the past three years. If the beneficiary had been seen in the past three years by the same FQHC, the FQHC will not receive the new patient adjustment and shall be required to resubmit the claim for an established patient. Contractors shall check if the FQHC billed for the FQHC visit using the specific payment codes: G0466 (FQHC visit, new patient) or G0469 (FQHC visit, mental health, new patient). Contractors shall check the line item HCPCS for procedure codes that describe visits furnished to new patients. (See Attachment A for relevant HCPCS codes for new patients visits that crosswalk to G0466 and G0469.)

- Contractors shall increase the base payment rate by a factor of **1.3416** when the FQHC furnishes an IPPE or AWV. Contractors shall check if the FQHC billed for the FQHC visit using the specific payment code G0468 (FQHC visit, IPPE or AWV).Contractors shall check the line item HCPCS for procedure codes that describe an IPPE or AWV. (See Attachment A for relevant HCPCS codes for IPPE and AWV that crosswalk to payment code G0468). Contractors shall apply appropriate frequency edits for IPPE and AWV. Contractors shall not apply the adjustment to claims listing an IPPE if the beneficiary had previously received an IPPE or AWV (coded as initial or subsequent) from any provider. Contractors shall not apply the adjustment for an initial AWV if the beneficiary had previously received an initial AWV or IPPE from any provider. Contractors shall not apply the adjustment for a subsequent AWV if the beneficiary had received an IPPE, initial AWV, or subsequent AWV in the past 12 months from any provider.

- For services that can be split into professional and technical components, FQHCs shall bill the professional component as part of the encounter, and separately bill the Part B MAC under different identification for the technical portion of the service on a Part B practitioner claim (for example, Form CMS-1500).

- Payment to a FQHC for laboratory tests is not included in the encounter rate. Routine venipuncture (36415) is included in the FQHC PPS encounter rate. HCPCS codes for all other clinical lab fee schedule (CLFS) services listed on a FQHC institutional claim shall be considered informational only. Contractors shall exclude line item charges for these lab tests when calculating Medicare payment and assessing coinsurance.

- In general, contractors shall pay 80 percent of the lesser of the FQHC's charge for the specific payment code or the fully adjusted PPS rate. Contractors shall determine the amount of beneficiary coinsurance based on the related balance of the FQHC's charge for the specific payment code or the

PPS rate, which would be 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate.

- For FQHC claims that only include preventive services for which coinsurance is waived (which for purposes of this document will be referred to as "preventive services"), contractors shall pay the FQHC 100 percent of the lesser of the FQHC's charge for the specific payment code or the fully adjusted PPS rate, and the beneficiary will not be responsible for any coinsurance.

- For FQHC claims that include a mix of preventive services and other services for which coinsurance is not waived, contractors shall use the FQHC's reported line-item charges to determine the amount of coinsurance to waive, whether payment is based on the FQHC's charge for the payment code or the PPS rate. Contractors shall pay the FQHC 100 percent of the dollar value of the FQHC's reported line-item charge for the preventive service, up to the total payment amount. If the reported line-item charge for the preventive service equals or exceeds the full payment amount, contractors shall pay 100 percent of the full payment amount, and the beneficiary would not be responsible for any coinsurance. If the reported line-item charge for the preventive service is less than the full payment amount, to determine the amount of cost-sharing, contractors shall subtract the dollar value of the FQHC's reported line-item charge for the preventive service from the full payment amount, pay the FQHC 80 percent of the remainder of the full payment amount (in addition to 100 percent of the reported line-item charge for the preventive service), and determine beneficiary coinsurance based on 20 percent of the remainder of the full payment amount.

- Total payment to the FQHC, including Medicare and beneficiary liability, shall not exceed the FQHC's charge for the payment code or the fully adjusted PPS rate.

- Contractors shall continue to pay for the influenza and pneumococcal vaccines at 100% of reasonable costs through the cost report, and continue to pay for the hepatitis B vaccine as part of the FQHC encounter. HCPCS codes for influenza and pneumococcal vaccines and their administration that are listed on a FQHC claim shall be considered informational only. Contractors shall exclude line item charges for these services when calculating Medicare payment and assessing coinsurance.

- Contractors shall reject FQHC claims that list HCPCS codes for hospital-based care (e.g., 99217-99239, 99281-99292, 99460-99480).

- Contractors shall disallow line item charges for group services (e.g., 97804, G0271).

- Contractors shall disallow line item charges for non-face-to-face services (e.g., 99441-99444). Note that qualified TCM services, even if furnished without a face-to-face visit, are allowable.

- Contractors shall reject a claim that lists both DSMT and MNT. Contractors shall apply the frequency edits for DSMT and MNT and disallow line item charges for DSMT or MNT that exceed these frequency edits (as described in Pub 100-04, Chapter 18). For claims where DSMT or MNT represents the medically necessary face-to-face visit that qualifies the FQHC encounter and these services exceed the frequency edits, contractors shall reject the claim.

Medicare Advantage Claims

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.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8743.1	The contractor shall load the new FQHC PPS PRICER.					X				
8743.2	Contractors shall process claims based on the FQHC PPS for FQHCs whose cost reporting periods begin on or after October 1, 2014.	X				X				IOCE
8743.2.1	Contractors shall update the PPS effective date field on the provider file (MAP1101) for each FQHC. The date entered should be the fiscal year start date for the FQHC, beginning with cost reporting periods that begin on or after October 1, 2014.	X								
8743.3	Contractors shall ensure a condition code 65 (non PPS claim) is moved to all non-PPS FQHC claims with dates of service on or after October 1, 2014 to identify claims that are not subject to the FQHC PPS. **NOTE**: Condition code 65 should be passed to the IOCE and CWF. Condition code 65 should not be passed to the Benefit Coordinator and Recovery Center (BCRC).					X				IOCE
8743.4	Contractors shall not apply the subsequent BRs to FQHC claims submitted by FQHCs whose cost reporting periods begin prior to October 1, 2014 for fiscal year 2014. **NOTE:** This applies to all FQHC claims.	X				X				IOCE
8743.5	Contractors shall accept HCPCS code G0466 *FQHC visit, new patient* for FQHC claims only. This specific payment code will identify the encounter/visit when reported with revenue code 0519 or 052X.	X								
8743.6	Contractors shall accept HCPCS code G0467,	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	FQHC visit, established patient for FQHC claims only. This specific payment code will identify the encounter/visit when reported with revenue code 0519 or 052X.									
8743.7	Contractors shall accept HCPCS code G0468, *FQHC visit, IPPE or AWV* for FQHC claims only. This specific payment code will identify the encounter/visit when reported with revenue code 0519 or 052X.	X								
8743.8	Contractors shall accept HCPCS code G0469, *FQHC visit, mental health, new patient* for FQHC claims only. This specific payment code will identify the encounter/visit when reported with revenue code 0900 or 0519.	X								
8743.9	Contractors shall accept HCPCS code G0470, *FQHC visit, mental health, established patient* for FQHC claims only. This specific payment code will identify the encounter/visit when reported with revenue code 0900 or 0519.	X								
8743.9.1	Contractors shall update the HCPCS TOB Table (Selection 6G, MAP1I51) to only allow G0466, G0467, G0468, G0469, and G0470 to be submitted on FQHC claims (77X TOB), effective October 1, 2014.	X								
8743.10	Contractors shall ***continue*** to pass the following fields to the IOCE input buffer for 77X TOBs: Condition code (65) Revenue code CPT/HCPCS code Modifiers					X				IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	LIDOS Units Total Charges Line item action flag									
8743.10.1	Contractors shall send a '5' in the line action flag to the IOCE for any service line(s) that contain non-covered charges.					X				IOCE
8743.11	Contractors shall ***continue*** to accept all of the IOCE flags for FQHC claims.					X				IOCE
8743.12	The IOCE shall assign an edit when G0466, G0467, G0468, G0469 or G0470 is not present on a FQHC claim. **NOTE:** The edit will be bypassed when the type of bill is 770.					X				IOCE
8743.12.1	Contractors shall return the claim to the FQHC.	X								
8743.13	The IOCE shall assign an edit when the HCPCS code for the qualifying visit (listed in Attachment A) is not reported on the same day with appropriate G-code from requirements 8743.5-8743.9.					X				IOCE
8743.13.1	The Contractor shall make this edit overrideable.					X				
8743.13.1.1	Contractors shall return the claim to the FQHC.	X								
8743.14	The IOCE shall assign an edit when G0466, G0467, G0468, G0469 or G0470 is reported with a revenue code other than 0519, 052X or 0900.					X				IOCE
8743.14.1	Contractors shall return the claim to the FQHC.	X								
8743.15	The IOCE shall assign an edit to reject service lines containing DME (revenue code 029X), Lab (excluding 36415), Ambulance (revenue code 054X), Hospital-Based Care (99217-99239, 99281-99292, and 99460-99480), Group (97804, G0271) and non-Face-to-Face (99441-99444) services.	X				X				IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code CO - Contractual obligation CARC 8 - The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N95 - This provider type/provider specialty may not bill this service. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.									
8743.16	The IOCE shall identify the encounter/visit line with the specific payment code that will receive the per diem payment and return a payment flag to the FISS.									IOCE
8743.17	The IOCE shall identify and allow an additional per diem payment for a date of service that has both a medical visit (revenue code 052x or 0519 with G0466, G0467 or G0468) and a mental health visit (revenue code 0900 or 0519 with G0469 or G0470) and return a payment flag to the FISS.									IOCE
8743.18	The IOCE shall identify and allow an additional per diem payment for modifier 59 with revenue code 0519, 052X or 0900 with G0467 or G0470. A payment flag shall be returned to FISS.									IOCE
8743.19	The IOCE shall return a flag to FISS to identify all service lines that are bundled and not eligible for a separate per diem payment.									IOCE
8743.20	The IOCE shall send a flag to FISS to identify Telehealth services, revenue code 078X with Q3014. **NOTE:** FISS shall continue to pay Telehealth services based on the Fee Schedule amount.					X				IOCE
8743.21	The contractor shall ensure all services lines identified as packaged are shown as covered					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	services with the following ANSI information: Group code CO- Contractual obligation CARC 97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column. **NOTE**: These services will receive a packaging flag of '6' from the IOCE.									
8743.22	The IOCE shall return a flag to FISS to identify all approved preventive services (excluding Flu and PPV and their administration).									IOCE
8743.23	The IOCE shall return a separate flag to FISS to identify Flu and PPV vaccines and their administration codes. **NOTE:** These services are informational only, the Pricer will ignore these lines.									IOCE
8743.23.1	The Contractor shall ensure Flu and PPV vaccines and their administration codes are shown as informational only services. Assign the following ANSI information: Group code CO- Contractual obligation CARC 246- This non-payable code is for required reporting only. MSN 16.34 - You should not be billed for this					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column. **NOTE**: These services will receive a payment indicator flag of '11'from the IOCE.									
8743.24	The contractor shall pass the following fields to the FQHC PRICER for the input buffer: From the Claim level: • Provider Number • Carrier/locality number (taken from the Provider file) • MA Plan amount (taken from the Provider File Supplemental Payment Rate screen • Service From and Thru date • Service line count From the service line: • IOCE Flags • Revenue Code • CPT/HCPCS code • Modifier • Service Date • Total Unit • Covered Unit • Covered Charges					X				FQHC Pricer
8743.25	Contractors shall accept the following fields from the FQHC PRICER for the output buffer: At the Claim level:					X				FQHC Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Provider number • Carrier/locality number • MA Plan amount • Service From and Thru date • Service line count At the service line: • IOCE Flags • Revenue Code • CPT/HCPCS code • Modifier • Service Date • Total Unit • Covered Unit • Covered Charges The following output is calculated from the Pricer: • PRICER payment amount (line level) • PRICER return codes (line level) • Coinsurance amount (line level) • Claim total payment amount (claim level) • Claim total coinsurance amount (claim level) • Geographic Adjustment Factor - GAF (claim level) • Add on payment amount (line level)									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8743.26	The contractor shall display the PRICER output fields: (Pricer payment amount, Pricer return codes, coinsurance, add on payment amount) at the service line and (total coinsurance (value code A2), total payment amount, geographic adjustment factor (GAF)) at the claim level.					X				FQHC Pricer
8743.26.1	The Contractor shall create a line level field to house the new patient/initial Medicare visit Add on Payment Amount. This field should be passed to CWF. CWF shall ensure the new field is passed to the downstream systems.					X			X	FPS, IDR, NCH, PS&R
8743.26.2	The Contractor shall create a claim level field to house the Geographic Adjustment Factor (GAF). This field should be passed to CWF. CWF shall ensure the new field is passed to the downstream systems.					X			X	FPS, IDR, NCH, PS&R
8743.27	FQHC PRICER shall utilize the IOCE flags to apply payment.									FQHC Pricer
8743.28	FQHC PRICER shall ignore non-covered identified by the IOCE with a line item action flag of '5'.									FQHC Pricer, IOCE
8743.29	FQHC PRICER shall adjust the PPS rate by 1.3416 for G0466, G0468 or G0469. **NOTE**: This is for a new patient or initial Medicare visit adjustment. Only one adjustment may be applied per day. The adjustment is contingent on frequency edits.									FQHC Pricer
8743.30	The PRICER shall compare the FQHC PPS rate to the total submitted covered charges for the specific payment codes, G0466, G0467, G0468, G0469 and G0470. If the total submitted covered charges for the specific payment codes are less than the FQHC PPS rate, pay as follows: (FQHC's charge for specific payment codes – charges for approved preventive services) * 80% + (charges for approved preventive services) =									FQHC Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Payment (FQHC's charge for specific payment codes – charges for approved preventive services) * 20% = Coinsurance **NOTE:** If the charges for approved preventive services are greater than the FQHC's charge for the specific payment codes, payment will be 100% of the FQHC's charge for the specific payment code, and the beneficiary would not be responsible for any coinsurance.									
8743.30.1	When the FQHC PPS rate is less than the total submitted covered charges for the specific payment codes, pay as follows: (PPS rate – charges for approved preventive services) * 80% + (approved preventive services) = Payment (PPS rate – charges for approved preventive services) * 20% = Coinsurance **NOTE:** If the preventive charges are greater than the PPS rate, payment will be 100% of the PPS rate, and the beneficiary would not be responsible for any coinsurance.									FQHC Pricer
8743.30.1.1	When the claim only contains approved preventive services, the PRICER shall compare and pay 100% of the lesser of the FQHC PPS rate or the total submitted covered charges for the specific payment codes. Coinsurance is waived.									FQHC Pricer
8743.31	For claims with revenue code 0519, the FQHC PPS will calculate the difference between the PPS rate and the MA contract rate. **NOTE:** Apply the new patient and initial visit adjustments to the PPS rate before calculating the difference between the PPS rate and the MA contract rate.									FQHC Pricer
8743.32	Contractors shall accept the following return codes from the FQHC PRICER:					X				FQHC Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	<u>Claim Level</u>: 01 Claim Processed 02 Service From Date not numeric or less than the FQHC PPS start date **<u>Line level:</u>** *Line Processed Successfully* 01- Line Processed-Payment based on PPS rate 02- Line Processed-Payment based on provider submitted charges 03- Line Processed-payment based on PPS rate, preventive service present 04- Line Processed-payment based on provider submitted charges, preventive service present 05- Line Processed-Payment based on PPS rate with adjustment factor 06- Line Processed-Supplemental MA payment applied 07- Line Processed-Supplemental MA payment not applied 08- Line Processed- Informational only 09- Line Processed- payment not applied. Payment applied to another line *Line Not Processed because of IOCE Flag Value* 10- Payment Method invalid for FQHC Pricer, line Processing Discontinued 11- Payment Indicator invalid for FQHC Pricer, line processing discontinued 12- Composite adjustment invalid for FQHC Pricer, line processing discontinued									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	13- Packaging Flag invalid for FQHC Pricer, line processing discontinued 14- Line Item Denial/Reject Flag-Line Item Action Flag combination invalid for FQHC Pricer, line processing discontinued 15- Line Item Action Flag equal to '5', line processing discontinued *Line Not Processed because of FISS values* 17- MA Plan amount equal to zero *Line Not Processed because of Pricer values* 18- No Effective Base Rate, line processing discontinued 19- No Effective GAF, line processing discontinued 20- No Effective Add-on Rate, line processing discontinued									
8743.32.1	Contractors shall reserve return codes 21 - 28 for future use.					X				FQHC Pricer
8743.33	Contractors shall reject an FQHC claim with a LIDOS that matches another LIDOS on a previously submitted FQHC claim for the same FQHC. Assign the following ANSI information: Group code CO – Contractual obligation CARC 97- The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC –M80 Not covered when performed during the same session/date as a previously processed service for the patient.	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.									
8743.34	Contractors shall return the claim to the FQHC when PPS and non-PPS dates of service are submitted on the same claim.	X				X				
8743.35	Contractors shall reject the claim if both DSMT and MNT are reported on the same day. **NOTE:** This applies to PPS and non-PPS claims. Group Code CO - Contractual obligation CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.	X				X				
8743.36	Contractors shall return to the FQHC all MA claims (77X TOBs with revenue code 0519) that do not contain a valid HCPCS codes.	X				X				
8743.37	The contractor shall create the FQHC Supplemental Payment Rate Screen as outlined during the analysis period.					X				
8743.38	Contractors shall update the FQHC Supplemental Payment Rate Screen with MA contract rates for FQHCs.	X								
8743.39	The contractor shall ensure supplemental claims					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(TOB 77X with revenue code 0519) are passed back to the FQHC Pricer after edit U5261 is received from CWF with the HMO –ID. The MA Plan rate should be pulled from the newly created FQHC Supplemental Rate Screen (8743.38) and passed to the FQHC Pricer in the MA Plan field for pricing.									
8743.40	The contractor shall store the MA plan amount under payer only value code Q9. Value code Q9 should not be passed to BCRC.					X				FPS, IDR, NCH, PS&R
8743.41	Contractors shall create an edit to assign when a FQHC claim (TOB 77X) is received and condition code 65 is not present and a specific payment code for a new patient visit (G0466 or G0469) is reported and a prior claim exist within a 36 month period by the same FQHC for type of bill 77X. The line should be rejected. Group code CO – Contractual obligation CARC 119 - Benefit maximum for this time period or occurrence has been reached. RARC N130- Consult plan benefit documents/guidelines for information about restrictions for this service. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.	X				X			X	
8743.42	Contractors shall ensure G0468 is returned in Trailer 43 when G0402, G0438 or G0439 is also rejected based on current frequency edits. **NOTE**: When processing the CWF trailer for G0468, FISS should take the same action that is currently being used for the frequency edits.	X				X			X	
8743.43	Contractors shall ensure G0466 or G0467 is returned in CWF Trailer 43 when 97802, 97803,	X				X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	G0108 or G0270 is also rejected based on current frequency edits. **NOTE**: When processing the CWF trailer with G0466 and G0467, FISS should take the same action that is currently being used for the frequency edits.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8743.44	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Esther Markowitz, 410-786-4595 or Esther.Markowitz@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

In accordance with Section 1834(o)(1)(A) and 1834(o)(2)(C), we are establishing specific payment codes to be used under the FQHC PPS. When submitting a claim for FQHC services for payment under the FQHC PPS, FQHCs must use these specific payment codes. We also continue to require FQHCs to report detailed HCPCS coding with the associated line item charges to list both the visit that qualifies the service for an encounter-based payment and all other FQHC services (e.g., ancillary services) furnished during the encounter.

FQHC Visits

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.

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.

To qualify for Medicare payment, all the coverage requirements for a FQHC visit must be met. A FQHC visit must be furnished in accordance with the applicable regulations at 42 CFR Part 405 Subpart X, including 42 CFR 405.2463 that describes what constitutes a visit. Additional information on the coverage requirements for FQHC visits can be found in CMS Pub 100-02, Chapter 13.

Specific Payment Codes

Following are the specific payment codes and the appropriate descriptions of services that correspond to these payment codes. FQHCs must use these codes when submitting claims to Medicare under the FQHC PPS:

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 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 following: an evaluation and management medical visit; transitional care management (TCM) services; outpatient diabetes self-management training (DSMT); or medical nutrition therapy (MNT).

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.

G0467 – FQHC visit, 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 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 following: an evaluation and management medical visit; transitional care management (TCM) services; outpatient diabetes self-management training (DSMT); or medical nutrition therapy (MNT).

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.

G0468 – FQHC visit, IPPE or AWV
A FQHC visit that includes an IPPE or 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.

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 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 visit, such as a psychiatric diagnostic evaluation, psychotherapy, or pharmacologic management. 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.

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 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 visit, such as a psychiatric diagnostic evaluation, psychotherapy, or pharmacologic management.

Qualifying Visits

Each specific payment code must be submitted with a qualifying visit on a separate line. The use of these specific payment codes, and the crosswalk to the corresponding line item HCPCS code, may be subject to the following conditions, which are flagged by number in the following tables:

1) A new patient is one who has not received any professional medical or mental health services from any sites within the FQHC organization within the past three years. The qualifying visit does not specify whether the service was furnished to a new or established patient. Use G0466 only if the beneficiary is new to the FQHC or any of its sites for any professional services. Otherwise, use G0467.

2) A new patient is one who has not received any professional medical or mental health services from any sites within the FQHC organization within the past three years. The qualifying visit does not specify whether the service was furnished to a new or established patient. Use G0469 only if the beneficiary is new to the FQHC or any of its sites for any professional services. Otherwise, use G0470.

3) A FQHC that furnishes an IPPE or AWV would include all medical services in G0468. FQHCs would not bill G0466 or G0467 on the same day, unless there was a subsequent illness or injury that would qualify for additional payment which the FQHC would attest to by submitting the claim with modifier 59.

4) The related evaluation and management service must be listed as a line item but is not billable as a separate FQHC visit.

5) Preventive primary services, as defined in 42 CFR 405.2448, are statutorily authorized for FQHCs and not excluded by the provisions of section 1862(a) of the Act. If the service furnished meets the definition of a preventive primary service under 42 CFR 405.2448 and is covered under the FQHC benefit, this code could qualify the visit for Medicare payment. Note that the services described by this code are not covered in other Medicare settings.

The qualifying visits that correspond to the specific payment codes are as follows:

G0466 - FQHC visit, new patient

HCPCS	Qualifying Visits for G0466	Conditions
92002	Eye exam new patient	
92004	Eye exam new patient	
97802	Medical nutrition indiv in	1
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	
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	
99381	Init pm e/m new pat infant	5
99382	Init pm e/m new pat 1-4 yrs	5
99383	Prev visit new age 5-11	5
99384	Prev visit new age 12-17	5
99385	Prev visit new age 18-39	5
99386	Prev visit new age 40-64	5
99387	Init pm e/m new pat 65+ yrs	5
G0108	Diab manage trn per indiv	1

G0467 – FQHC visit, established patient:

HCPCS	Qualifying Visits for G0467	Conditions
92012	Eye exam establish patient	
92014	Eye exam&tx estab pt 1/>vst	
97802	Medical nutrition indiv in	
97803	Med nutrition indiv subseq	
99211	Office/outpatient visit est	
99212	Office/outpatient visit est	
99213	Office/outpatient visit est	
99214	Office/outpatient visit est	
99215	Office/outpatient visit est	
99304	Nursing facility care init	
99305	Nursing facility care init	
99306	Nursing facility care init	
99307	Nursing fac care subseq	
99308	Nursing fac care subseq	
99309	Nursing fac care subseq	

HCPCS	Qualifying Visits for G0467	Conditions
99310	Nursing fac care subseq	
99315	Nursing fac discharge day	
99316	Nursing fac discharge day	
99318	Annual nursing fac assessmnt	
99334	Domicil/r-home visit est pat	
99335	Domicil/r-home visit est pat	
99336	Domicil/r-home visit est pat	
99337	Domicil/r-home visit est pat	
99347	Home visit est patient	
99348	Home visit est patient	
99349	Home visit est patient	
99350	Home visit est patient	
99391	Per pm reeval est pat infant	5
99392	Prev visit est age 1-4	5
99393	Prev visit est age 5-11	5
99394	Prev visit est age 12-17	5
99395	Prev visit est age 18-39	5
99396	Prev visit est age 40-64	5
99397	Per pm reeval est pat 65+ yr	5
99495	Trans care mgmt 14 day disch	
99496	Trans care mgmt 7 day disch	
G0108	Diab manage trn per indiv	
G0270	Mnt subs tx for change dx	

G0468 – FQHC visit, IPPE or AWV:

HCPCS	Qualifying Visits for G0468	Conditions
G0402	Initial preventive exam	3
G0438	Ppps, initial visit	3
G0439	Ppps, subseq visit	3

G0469 – FQHC visit, mental health, new patient:

HCPCS	Qualifying Visits for G0469	Conditions
90791	Psych diagnostic evaluation	2
90792	Psych diag eval w/med srvcs	2
90832	Psytx pt&/family 30 minutes	2
90833	Psytx pt&/fam w/e&m 30 min	2, 4
90834	Psytx pt&/family 45 minutes	2
90836	Psytx pt&/fam w/e&m 45 min	2, 4
90837	Psytx pt&/family 60 minutes	2
90838	Psytx pt&/fam w/e&m 60 min	2, 4
90839	Psytx crisis initial 60 min	2
90845	Psychoanalysis	2

G0470 – FQHC visit, mental health, established patient:

HCPCS	Qualifying Visits for G0470	Conditions
90791	Psych diagnostic evaluation	
90792	Psych diag eval w/med srvcs	
90832	Psytx pt&/family 30 minutes	
90833	Psytx pt&/fam w/e&m 30 min	4
90834	Psytx pt&/family 45 minutes	
90836	Psytx pt&/fam w/e&m 45 min	4
90837	Psytx pt&/family 60 minutes	
90838	Psytx pt&/fam w/e&m 60 min	4
90839	Psytx crisis initial 60 min	
90845	Psychoanalysis	
M0064	Visit for drug monitoring	