MEDICARE PPS & G CODES

REVENUE CYCLE . CHC EXPERTISE
PEACE OF MIND

Agenda

- Intro
- The Final Rule
- What is the Same and What is Different?
- The G codes
- Speed Bumps and Potholes
- Calculating Liability
- G Code Charge Setting
- Summary

FQHC…Medicare Encounter Rate Pre October 1, 2014

- Unique Medicare Benefits
  - Deductible…waived (EXCEPT Part B)
  - Preventive Visits
    - Annual Well Visit (AWV) Initial Visit G0438
    - Annual Well Visit (AWV) Subsequent Visit G0439
    - Initial Preventive Physical Examination (IPPE) G0402
- Encounter Rate (Typically 80% of rate below)
  - Rural: $112.56; Urban: $130.05
  - Co-pay based on FFS charges
    - 99212 = $45…co-pay is $9, NOT 20% of encounter rate
    - Coinsurance waived on some preventive services
- Additional Encounter Rate Scenarios
  - Nursing Facilities & Homebound patient

What Did Not Change?

- 77X type of bill
- HCPCS for all services
- Standard, national coding guidelines
- Timely filing guidelines
- Revenue codes

Revenue Codes

- 519 - Supplemental payment for visit by a beneficiary in a contracted Medicare Advantage Plan
- 0521 - Clinic visit by beneficiary to the FQHC
- 0522 - Home visit by the FQHC practitioner
- 0524 - Visit by the FQHC practitioner to a beneficiary in a covered Part A stay at the Skilled Nursing Facility (SNF)
- 0525 - 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 Individuals with Mental Retardation (ICF/MR)or other residential facility
- 0527 - FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
- 0528 - Visit by a FQHC practitioner to other non FQHC site (e.g., scene of accident)
- 0900 - Behavioral Health Treatment

Affordable Care Act
Medicare FQHC PPS

- FQHC preventive services updated 11-Jan 2011
  - Include expanded list of preventives services

- New PPS payment methodology, Oct-2014 or after

CMS/Federal Timeline

- March 23, 2010 – ACA signed into law

- Requires development & implementation of FQHC PPS
  - 1-Jan 2011: CR7038, Descriptive HCPCS on 837-I
  - 23-Sep 2013: Proposed rule for Medicare PPS
  - 2-May 2014: Final rule for Medicare PPS
  - 1-Oct 2014: Gradual transition to new Medicare PPS
  - 31-Dec 2015: All FQHCs expected to be transitioned
  - 2016 and forward… fully transitioned

Medicare PPS Provisions

- FQHC encounter-based payment
  - **2019: $169.77**
  - 2018: $160.60
- Geographic Adjustment Factor (GAF)
  - Puerto Rico: .80
  - Alaska: 1.307
  - SC: .959
- New/Initial Patient Adjustment: **1.3416 ($227.76)**

BIG financial opportunity…. Gotta do it right.

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

GAF Ranges (1 of 2)

Zip Code	State	GAF
10112	ALABAMA	0.948
02102	ALASKA	1.321
03102	ARIZONA	0.986
07102	ARKANSAS	0.940
01112	BAKERSFIELD, CA	1.045
01112	CHICO, CA	1.045
01182	EL CENTRO, CA	1.045
01112	FRESNO, CA	1.045
01112	HANFORD-CORCORAN, CA	1.046
01182	LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES CNTY), CA	1.107
01182	LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY), CA	1.107
01112	MADERA, CA	1.045
01112	MERCED, CA	1.045
01112	MODESTO, CA	1.045
01112	NAPA, CA	1.149
01182	OXNARD-THOUSAND OAKS-VENTURA, CA	1.095
01112	REDDING, CA	1.045
01112	RIVERSIDE-SAN BERNARDINO-ONTARIO, CA	1.046
01112	SACRAMENTO--ROSEVILLE--ARDEN-ARCADE, CA	1.057
01112	SALINAS, CA	1.061
01182	SAN DIEGO-CARLSBAD, CA	1.067

Certain locations omitted.

GAF Ranges (2 of 2)

Zip Code	State	GAF
11502	NORTH CAROLINA	0.968
03302	NORTH DAKOTA	1.000
15202	OHIO	0.961
04312	OKLAHOMA	0.949
02302	PORTLAND, OR	1.031
12502	METROPOLITAN PHILADELPHIA, PA	1.046
12502	REST OF PENNSYLVANIA	0.970
09202	PUERTO RICO	1.003
14412	RHODE ISLAND	1.038
11202	SOUTH CAROLINA	0.959
03402	SOUTH DAKOTA	1.000
10312	TENNESSEE	0.954
04412	AUSTIN, TX	1.010
04412	REST OF TEXAS	0.971
03502	UTAH	0.966
14512	VERMONT	1.007
11302	VIRGINIA	0.993
09302	VIRGIN ISLANDS	1.003
02402	SEATTLE (KING CNTY), WA	1.083

Certain locations omitted.

Carolina Calculation

North Carolina GAF = .968
South Carolina GAF = .959

NC PPS Rate = $169.77 x .968 = $164.34
SC PPS Rate = $169.77 x .959 = $162.81

NC New Patient = $164.34 x 1.3416 = $220.48
SC New Patient = $162.81 x 1.3416 = $218.43

Multiple Visits on the Same Day

- Proposed: Multiple visits, same DOS, paid once
- Final Rule Allows for additional:
  - Subsequent illness and/or behavioral health visit

  NOTE: MNT or DSMT: No longer allowed as second

- All services on same DOS on single claim form
- Multiple claims, same DOS, rejected

SOURCE: http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-06-25-FQHC.pdf

“Lesser than” Clause

PPS payment = 80% of lesser of…

Actual charge vs. PPS payment amount

The G Codes for FQHC Visit

- G0466: General medical, new patient
- G0467: General medical, established patient
- G0468: IPPE or AWV
- G0469: Mental health, new patient
- G0470: Mental health, established, patient

Billing Example

Description	HCPCS	Charge
FQHC visit	G0467	$150.00
Office visit	99213	$105.00
Routine Venipuncture	36415	$ 15.00
	Total:	**$270.00**

PPS rate is $169.77 so Medicare will pay 80% of $150.00 not the $169.77!!

Optimal G Code pricing is essential!!

CMS New Patient Definition

A New patient is someone who has not received ***any professional*** medical or mental health services from any site or from any practitioner within the FQHC organization within the past 3 years from the date of service

"The 3-year rule"

Yet NOT CPT Rule…

Source: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-06-25-FQHC.pdf; Slide 10

New or Established Patient, FAQs

#1 Within past 3 years, Medicare patient saw dentist?

New…because dental not CMS covered.

#2 Newly hired physician sees patient from previous private practice?

*New…because they are new to your FQHC**

** Inconsistent with historic/traditional guidelines but CMS says "OK."*

Source: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf

G Codes FQHC Medical Visit

G0466 = New Patient
G0467 = Established Patient

BOTH REQUIRE:

- Medically necessary face-to-face, patient & core provider
- Includes "typical bundle of Medicare covered services"

NOTE: ≥1 FQHC service rendered, bill both
****ONLY CONSIDERED NEW FOR ONE!****

EXPECT DENIALS… Fight via appeal.
Get MAC to update systems.

G0467
FQHC Visit, Established Patient

42 Rev Code	43 DESCRIPTION	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges
0521	FQHC visit, estab pt	G0467	10/01	1	$150.00
0521	Office/outpatient visit est	99213	10/01	1	$135.00
0300	Routine venipuncture	36415	10/01	1	$15.00
0001	*	*	*	*	$300.00

SOURCE: http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-06-25-FQHC.pdf

New or Established Patient, FAQs

#1 Patient seen by specialist & same DOS by LCSW?

Specialist new but MHSA, established

#2 Patient seen by DPM, next DOS seen by Family Practice?

DPM = core provider so next DOS, established patient

#3 Initial DOS, only LCSW. Now Family Practice?

LCSW is Medicare "core provider" so next DOS, established.

NOTE: Some behavioral health providers non-covered by CMS

SOURCE: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf

G Codes for FQHC Mental Health

G0469 = New Patient (3 year rule)

G0470 = Established Patient (All others)

BOTH REQUIRE:

- Medically necessary face to face encounter, patient & core provider
- Includes "typical bundle of Medicare covered services"

HCPCS Code List for PPS G Codes

CMS FQHC PPS Document*:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

*NOTE: Updated 6-Dec 2017

AND… What's Missing???

- Procedure Codes
- Preventive Codes (99381-99397)… Never again

Qualifying Visits for G0468

G0468 = IPPE or AWV

- G0402 Initial preventive exam (IPPE)
- G0438 Annual Wellness Visit (AWV) PPPS, initial
- G0439 AWV, PPPS, subsequent

  * *Note: Other "G" code options (e.g., glaucoma screening) but one of the above must be linked to G0468.*

PPPS = Personalized Prevention Plan of Service

Requirements for 837-I Revenue Codes

- TOB: 77X
- FQHC G codes correspond to visit type
- G0466-G0468 reported with revenue code 052X or 0519

  * *NOTE: 0519 is only used for Medicare Advantage (MA)*

- G0469 & G0470 reported via revenue code 0900 or 0519

Reporting on the claim…
All Three Required

1. Revenue Code
2. HCPCS (e.g., CPT) code (CR7038)
3. FQHC G code(s)

All lines must have associated charges!

Speed Bumps and Potholes

- Linking qualifying visits to PPS “G” codes
- New vs. established
- Overstated A/R & adjustments
- Secondary Claims (MSP) & G codes
- EHR code calculation/determination
- Billing function vs. clinician selection
- Auto posting… functional?
- 2 PPS “G” codes, single DOS... Fight denials

Calculating Patient Liability

- Rule #1… Read the EOMB/EOB
- Medicare payment:
  Lesser of fee for “G” code or adjusted PPS rate
- If “G” code < adjusted PPS rate, EOB conveys $
- Due to complexity… read EOB before patient billing

Fee Schedule/ Charge Master

HRSA Requirements

- Charges MUST be….
  - Consistent with local prevailing (market) rates
  - Designed to cover reasonable costs
  - Posted
  - *Board approved with "regular" review/update*
- Make "all" reasonable efforts for 3rd party payments

Considerations for Setting the Rate for G Codes

PPS is designed to reflect the **cost for all the services associated with a comprehensive primary care visit, even if not all the services occur on the same day**.

Considerations for Setting the Rate for G Codes

- Fee includes typical bundle of covered, per diem Medicare services
- ***CMS: NO MANDATORY REQUIREMENTS/PROCESSES***
- G codes determinations must be defensible/explainable
- Consider:
  - What are Medicare covered services?
  - What should be reviewed?
  - New vs. established patients vs. mental health
  - Total dollars for each visit across your Medicare population
  - Historical analysis; i.e., 1, 2, or 3 years?
  - Evaluate complexity based on diagnosis/pros and cons

Setting the Rate - Option 1

Total Charges ÷ Total Visits

- Data over defined (optimal) span
- E.g., new charge schedule… Recent 6 months?
- Include just Part A or both A&B?
  - Part A charges only ÷ Total Visits
  - Part A charges + Part B charges ÷ Total Visits
  - Part A + Part B + Expenses ÷ Total Visits

Setting the Rate - Option 2 (1 of 2)

The Resource-Based Relative Value Scale

Determine G code Rates with RVUs							
HCPCS Code	Fee Schedule	Work RVU	Practice Expense RVU	Malpractice RVU	Total RVU	Frequency	Total Non-Facility RVUs
99201	$ 110	0.48	0.71	0.04	1.23	3458	4253.34
99202	$ 188	0.93	1.10	0.07	2.10	8261	17348.1
99203	$ 273	1.42	1.48	0.15	3.05	31475	95998.75
99204	$ 415	2.43	1.99	0.22	4.64	16745	77696.8
99205	$ 521	3.17	1.31	0.29	4.77	9451	45081.27
99211	$ 50	0.18	0.37	0.01	0.56	976	546.56
99212	$ 110	0.48	0.20	0.04	0.72	10148	7306.56
99213	$ 182	0.97	1.01	0.06	2.04	29862	60918.48
99214	$ 271	1.50	1.43	0.10	3.03	21423	64911.69
99215	$ 366	2.11	1.82	0.16	4.09	10974	44883.66
					TOTALS:	142773	418945.21
NOTE: Include other services representative of "typical bundle of services"							

Setting the Rate - Option 2 (2 of 2)

HCPCS Code	Charge	Total Non Facility RVUs	Total Units	Total RVUs
99201	$ 110.00	1.23	3,458	4,253.34
99202	$ 188.00	2.10	8,261	17,348.10
99203	$ 273.00	3.05	31,475	95,998.75
99204	$ 415.00	4.64	16,745	77,696.80
99205	$ 521.00	4.77	9,351	44,604.27
		Totals:	**69,290**	**239,901**

NOTE: Typical bundle of services… include more than above.

Total RVUs = 239,901
Total Frequency = 69,290
Average RVU/Visit = 3.4641
Medicare CF = 35.80
3.46 X 35.7547 = **$124.02**

Setting the Rate - Option 3 (1 of 2)

Average Charge ÷ Average RVU

Determine G code Rates with RVUs								
HCPCS Code	Fee Schedule	Work RVU	Practice Expense RVU	Malpractice RVU	Total RVU	Frequency	Total Non-Facility RVUs	Total Charges
99201	$ 110	0.48	0.71	0.04	1.23	3458	4253.34	$ 380,207.10
99202	$ 188	0.93	1.10	0.07	2.10	8261	17348.1	$ 1,550,589.70
99203	$ 273	1.42	1.48	0.15	3.05	31475	95998.75	$ 8,580,871.88
99204	$ 415	2.43	1.99	0.22	4.64	16745	77696.8	$ 6,944,988.75
99205	$ 521	3.17	1.31	0.29	4.77	9451	45081.27	$ 4,925,152.38
99211	$ 50	0.18	0.37	0.01	0.56	976	546.56	$ 48,848.80
99212	$ 110	0.48	0.20	0.04	0.72	10148	7306.56	$ 1,115,772.60
99213	$ 182	0.97	1.01	0.06	2.04	29862	60918.48	$ 5,445,335.70
99214	$ 271	1.50	1.43	0.10	3.03	21423	64911.69	$ 5,802,419.55
99215	$ 366	2.11	1.82	0.16	4.09	10974	44883.66	$ 4,012,094.40
					TOTALS:	142773	418945.21	$ 38,806,280.85
NOTE: Include other services representative of "typical bundle of services"								

Setting the Rate - Option 3 (2 of 2)

Step 1: Total Charges ÷ Total Visits = Average Charge/Visit

Step 2: Total RVUs ÷ Total Visits = Average RVU

Step 3: Average Charge ÷ Average RVU = G code $

***Example only! A typical bundle of services would include more than the codes above.*

Average Charge	= $322.55
Average RVU	= 3.464
Charge per RVU	= **$93.11**

Setting the Rate - Option 4

- Step 1: Identify trigger codes for each G code
  - E.g., 99201 – 99205 for new patient
- Step 2: Determine total Medicare charges for all
- Step 3: Total charges ÷ Total visits = G code $

Roadblocks

- Categorizing the trigger codes… very hard
- BH codes neither new nor established
- What about procedure only visits?
- What about nurse visits?

Unknown Immediate Challenges

CMS/MAC: Limited to no answers for most billing questions

- FAQs posted
- As beginning to generally address “how to bill”
  - E.g., 2 NPIs for medical & mental health, same DOS
- Expect updates… many
- Read Medicare correspondence
  - Appoint Medicare watch dog, on all things PPS
- Submit questions… have perseverance & patience

MACs may not have even considered raised issue…

Summary & Action Plan

- Update PM tables
- Establish G code pricing
- Interact with MACs
- Train staff
- Expect unexpected & delays
- Assure vendors (PM) can handle PPS requirements

Questions