Medicare FQHC Prospective Payment System (PPS)

Background

The Affordable Care Act (ACA) of 2010 modified how payment is made for Medicare services furnished at FQHCs. Beginning on October 1, 2014, FQHCs began transitioning to a prospective payment system (PPS) in which Medicare payment is made based on a predetermined, fixed amount and geographic adjustment. All FQHCs are expected to be transitioned to PPS by December 31, 2015.

Beginning with dates of service on or after January 1, 2011, when billing Medicare, FQHCs must report all pertinent services provided and list the appropriate HCPCS code for each line item along with revenue code(s) for each FQHC visit. The additional line item(s) and HCPCS reporting are for informational and data gathering purposes only. This information was used to develop the new FQHC payment system.

Also, beginning with dates of service on or after January 1, 2011, ACA revised the list of preventive services paid for in the FQHC setting. Effective January 1, 2011 the professional component of the following preventive services will be covered FQHC services when provided by an FQHC:

- Initial preventive physical examination (IPPE);
- The following professional services of screening and preventive services:
  - Pneumococcal, influenza, and hepatitis B vaccine and administration.
  - Screening mammography.
  - Screening pap smear and screening pelvic exam.
  - Prostate cancer screening tests.
  - Colorectal cancer screening tests.
  - Diabetes self-management training services.
  - Bone mass measurement.
  - Screening for glaucoma.
  - Medical nutrition therapy services.
  - Cardiovascular screening blood tests.
  - Diabetes screening tests.
  - Ultrasound screening for abdominal aortic aneurysm.

The FQHC payment is determined by the yearly PPS national base rate multiplied by the Geographical Adjustment Factor (GAF) (based on where the FQHC is located). Payment will be 80% of the lesser of the actual charge or the PPS rate. Payment will be made based on a “G” code. Very Important: If you bill less than the PPS rate (G-Code), you will receive payment based on your billed charge. 20% coinsurance will be applied, except for preventive services that are allowed at 100%.
The PPS national base rate for October 1, 2014, through December 31, 2015, is $158.85.

The PPS base rate is adjusted by the FQHC Geographic Adjustment Factor (GAF). For example, in Montana the GAF for CY 2014 is 0.974 and for CY 2015 will be 0.977.

- For 2014 the FQHC PPS rate for Montana is $154.72 ($158.85 x 0.974)
- For 2015 the FQHC PPS rate for Montana is $155.20 ($158.85 x 0.977)

CMS has posted the GAF state adjustments on their CMS FQHC webpage, under Downloads: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html)

There will be a 1.3416 (34%) increase in the PPS rate for:

- New patients. 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
- Patients receiving an Initial Preventive Physical Examination (IPPE).
- Patients receiving an Annual Wellness Visit (AWV) (initial or subsequent).

**Payment Example**

FQHCs transitioning to the PPS will be required to use new payment codes (G-codes) when billing for an FQHC visit. Each payment “G-code” line must have a corresponding service line with a HCPCS code that describes the qualifying visit.

New patient clinic visit - G0466 (FQHC “G” code)

<table>
<thead>
<tr>
<th>42. EX.CD.</th>
<th>43. DESCRIPTION</th>
<th>44. HCPCS/SEQ</th>
<th>45. SERV. DATE</th>
<th>46. SERV. UNITS</th>
<th>47. TOTAL CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
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<td>99202</td>
<td>MNDDYY</td>
<td>1</td>
<td>200.00</td>
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</tbody>
</table>

Using Montana PPS rate: $154.72 x 1.3416 (new patient adjustment) = $207.57

Medicare payment = 80% x $200.00 = $160.00

Coinsurance - 20% x $200.00 = $40.00

**REMINDER:** Medicare will pay 80% of the lesser of the billed amount (of payment “G” code) or the PPS rate (i.e. Montana $154.72). In above example, the payment was made based on the billed amount since it was the lesser amount.
FQHC Payment Codes

- **G0466** – Medical encounter, new patient
  Report with revenue code 052X or 0519
- **G0467** – Medical encounter, established patient
  Report with revenue code 052X or 0519
- **G0468** – IPPE or AWV
  Report with revenue code 0521 or 0519
- **G0469** – Mental health encounter, new patient
  Report with revenue code 0900 or 0519
- **G0470** – Mental health encounter, established patient
  Report with revenue code 0900 or 0519

FQHCs are required to set a charge amount for each payment code:

- Identify typical bundle of services furnished during an encounter.
- Determine what normal charges are for those services.
- The sum of the normal charge will be the facilities charge for the payment code.
- Payment code charges can be updated as charges for services change; however, the charges must be uniform for all patients.

Additional billing requirements:

- FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on the FQHC claim when provided the same day as a covered clinic visit. Payment will be made on the cost report.
- Durable Medical Equipment (DME), laboratory services (excluding 36415), ambulance services, hospital-based services, group services, and non-face-to-face services will be rejected when submitted on the FQHC claims.
- Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services are subject to frequency edits and should not be reported together on the same day.

FQHC services are for the professional component of a service rendered. The Non-FQHC services listed below, can be submitted on the CMS-1500 if the FQHC has enrolled with Medicare Part B and has an active PTAN. Non-FQHC services include:

- Laboratory services (except 36415).
- EKG or Electroencephalogram (EEG) services (technical portion) (e.g., 93005).
- Durable Medical Equipment (DME). Enrolled with DME MAC.
- Ambulance services.
- Technical components of a diagnostic test.
  - Example: 71010 with TC modifier.
FQHCs use the following revenue codes to indicate a covered encounter:

- 0519 Clinic visit (MA plan)
- 0521 Clinic visit
- 0522 Home visit (Physician or NPP)
- 0524 Visit in a SNF/SB/NF covered Part A stay
- 0525 Visit in a SNF/SB/NF non-covered Part A stay
- 0527 Visiting nurse service in home health shortage area
- 0528 Visit to other non-FQHC site (scene of accident)
- 0780 Telehealth originating site facility fee
- 0900 Psychiatric/psychological services

**Qualifying Visits**

CMS has established FQHC PPS payment codes ( "G" code) and their qualifying CPT/HCPCS codes.

Each specific payment code must be submitted with a qualifying visit on a separate line.

CMS may periodically update the FQHC PPS codes; therefore it is important to make sure you are using the most current document when billing.

The following link is to the CMS FQHC payment codes and their qualifying CPT/HCPCS codes:

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

**Medical Necessity and Documentation**

CMS is required by the Social Security Act to ensure payment is made only for those medical services that are reasonable and necessary.

Medical necessity is defined as services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare program.

Medical necessity is documented on the claim by the use of diagnosis codes.

**General Principals of Documentation**

The principles of documentation listed below are applicable to all types of medical and surgical services, in all settings.

- Medical records should be complete, legible and include:
  - Patient demographics.
• Financial information (i.e. employment and insurance).
• Consent and authorization forms (i.e. HIPAA).
• Treatment history.

• Documentation of each patient encounter should include:
  ◦ The date of encounter.
  ◦ Reason for encounter and relevant history, findings and prior diagnostic test results.
  ◦ Assessment, clinical impression or diagnosis.
  ◦ Plan of care.
  ◦ Past and present diagnoses.
  ◦ Health risks factors identified.
  ◦ Patient’s progress, response to and changes in treatment, any revision to diagnosis and any patient non-compliance should be documented.
  ◦ Thought processes and medical decision-making.
  ◦ Information in records must clearly support all diagnoses/procedures to be reported on claim.

Follow the SOAP note process:

**S is for Subjective**
Subjective notes pertain to the patient’s ideas and feelings about how they see the state of their health or treatment plan. The information should be documented based on the patient’s responses to questions regarding treatment plans or current illnesses.
• Past medical history
• History of present illness
• Review of symptoms
• Social history
• Family history

**O is for Objective**
Objective notes pertain to the patient’s vital signs, all components of the physical examination and results of labs, x-rays and other tests performed during the patient visit.
• Temperature, blood pressure, pulse and respiration
• General appearance
• Internal organs, extremities and musculoskeletal conditions
• Neurologic and psychiatric conditions
• Other information based on specialty
A is for Assessment
Assessment notes consolidates subjective and objective information together that results in the patient’s health status, lifestyle or diagnosis. The assessment includes an overview of the patient’s progress since the last visit from the clinician’s perspective.

- Main symptoms and diagnosis
- Patient’s progress
- Differential diagnosis
- Basic description of the patient and condition presented

P is for Plan
Plan notes pertains to the course of action as a result of the assessment notes. The plan notes includes whatever the physician plans to do or instruct the patient to do in order to treat the patient or address their concerns. This would include documentation of the physician’s orders for a variety of services provided to the patient.

- Lab testing
- Radiology services
- Procedures
- Referral information
- Prescriptions or OTC medications
- Patient Education
- Other testing
FQHC PPS Claim Examples

Clinic Visit

Established patient seen for diabetic check-up. Labs drawn.

<table>
<thead>
<tr>
<th>Description</th>
<th>HCPCS/ICD Code</th>
<th>Service Date</th>
<th>Units</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521 Clinic visit - established</td>
<td>0467</td>
<td>MMDDYY</td>
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<td>$300</td>
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<td>0521 Clinic visit - established</td>
<td>9212</td>
<td>MMDDYY</td>
<td>1</td>
<td>$300</td>
</tr>
<tr>
<td>0300 Venipuncture</td>
<td>36415</td>
<td>MMDDYY</td>
<td>1</td>
<td>$300</td>
</tr>
</tbody>
</table>

Patient seen in morning for diabetic check-up. Returned in afternoon requiring stitches to thumb on right hand after accident working outside.

<table>
<thead>
<tr>
<th>Description</th>
<th>HCPCS/ICD Code</th>
<th>Service Date</th>
<th>Units</th>
<th>Charges</th>
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<tr>
<td>0521 Clinic visit - established</td>
<td>0467</td>
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<td>0521 Clinic visit - established</td>
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<td>MMDDYY</td>
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<td>0521 Clinic visit - established</td>
<td>0467 59</td>
<td>MMDDYY</td>
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<td>0521 Clinic visit - established</td>
<td>9213</td>
<td>MMDDYY</td>
<td>1</td>
<td>$300</td>
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</tbody>
</table>

Use the 59 modifier to indicate separate patient encounter. There should be two unrelated diagnosis codes and a comment in FL 80 explaining the second visit. Condition code G0 (distinct medical visit) can be used.

Diabetic patient seen for podiatry visit. Physician performed nail debridement on left foot, T1, T2 and T3.

<table>
<thead>
<tr>
<th>Description</th>
<th>HCPCS/ICD Code</th>
<th>Service Date</th>
<th>Units</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521 Clinic visit - established</td>
<td>0467</td>
<td>MMDDYY</td>
<td>1</td>
<td>$300</td>
</tr>
<tr>
<td>0521 Clinic visit - established</td>
<td>9212</td>
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<td>1</td>
<td>$300</td>
</tr>
<tr>
<td>0521 Debride nail 15</td>
<td>11720</td>
<td>MMDDYY</td>
<td>1</td>
<td>$300</td>
</tr>
</tbody>
</table>
Patient seen for diabetic check-up; received influenza vaccination.

If the only service rendered was the influenza vaccination, then do not submit a claim. Payment will be made on cost report (whether billed on claim or through cost report). Condition Code A6 is required, along with diagnosis V0481 and the appropriate HCPCS for the influenza drug. A separate diagnosis for the clinic visit.

Patient seen for Annual Wellness Visit.

The FQHC AWV payment “G” code is G0468. The AWV HCPCS codes are:

- G0438 - AWV, initial
- G0439 - AWV, subsequent
Visiting Nurse Services

Visiting nurse services are covered as FQHC services if:

- FQHC has special certification from CMS to provide visiting nurse services because the FQHC is located in an area where there is a shortage of home health agencies (as determined by CMS).

- A homebound patient is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from an FQHC.

The services are furnished under a written plan of treatment established by a physician or NPP and reviewed at least every 60-days. The treatment plan must be signed by the physician or NPP. The treatment plan should follow the CMS HHA plan of care format.

Nurses should report all services provided to the patient during each visit. Clinical notes should document:

- History and physical exam pertinent to the day’s visit;
- Skilled services applied;
- Patient response to services provided;
- Plan for the next visit based on results;
- Rational for continued care;
- Complexity of the service to be performed;
- Pertinent characteristics of the patient or home.

The revenue code for visiting nurse services is 0527. The FQHC payment “G” code will be either G0466 (new) or G0467 (established).

<table>
<thead>
<tr>
<th>REI. CO.</th>
<th>DESCRIPTION</th>
<th>HCPCS CODE</th>
<th>46 SERVICE DATE</th>
<th>47 TOTAL CHARGES</th>
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<tr>
<td>0527</td>
<td>Visiting Nurse - established patient</td>
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<td>MMDDYY</td>
<td>$$$</td>
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<tr>
<td>0527</td>
<td>Visiting Nurse - established patient</td>
<td>G9347</td>
<td>MMDDYY</td>
<td>$$$</td>
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</table>

Visiting Nurse Resources:

CMS IOM, Benefit Policy Manual, Chapter 13, Section 180

Diabetic Services

Diabetic Foot Exam

If a beneficiary has diabetes-related nerve damage (documented diagnosis of diabetic sensory neuropathy and LOPS) in either of their feet, Medicare will cover 1 foot exam every 6 months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past 6 months.

HCPCS codes G0245, G0246 and G0247 have been developed for reporting these physician services under this coverage.

**G0245** Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in LOPS, which must include:

- The diagnosis of LOPS.
- A patient history.
- A physical examination consisting of findings regarding at least the following elements:
  - Visual inspection of the forefoot, hindfoot and toe web spaces.
  - Evaluation of protective sensation.
  - Evaluation of foot structure and biomechanics.
  - Evaluation of vascular status and skin integrity.
  - Evaluation and recommendation of footwear.
  - Patient education.

**G0246** Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in LOPS to include at least the following:

- A patient history.
- A physical examination consisting of findings that includes:
  - Visual inspection of the forefoot, hindfoot and toe web spaces.
  - Evaluation of protective sensation.
  - Evaluation of foot structure and biomechanics.
  - Evaluation of vascular status and skin integrity.
  - Evaluation and recommendation of footwear.
  - Patient education.

**G0247** Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in LOPS to include if present, at least the following:

- Local care of superficial wounds.
- Debridement of corns and calluses.
- Trimming and debridement of nails.

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTION</th>
<th>HCPCS RATE</th>
<th>HCPCS CODE</th>
<th>HCPCS DATE</th>
<th>HCPCS UNITS</th>
<th>HCPCS TOTAL CHARGES</th>
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<tbody>
<tr>
<td>G0245</td>
<td>Clinic visit - Diabetic foot exam</td>
<td>G0245</td>
<td>MMDDYY</td>
<td>1</td>
<td>$350.00</td>
<td></td>
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<tr>
<td>G0246</td>
<td>Clinic visit - Diabetic foot exam</td>
<td>G0246</td>
<td>MMDDYY</td>
<td>1</td>
<td>$350.00</td>
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</tbody>
</table>
Medical Nutrition Therapy (MNT)

MNT services require a referral from the physician that is treating the patient’s diabetes or renal disease. NPP’s cannot make the referral.

Registered dietitians or nutrition professionals are only providers eligible to provide MNT services.

Medicare covers three hours of MNT during the calendar year. Hours cannot be rolled over to the next year. Two hours of reassessment can be allowed during the year; with another referral from physician. Patient is eligible for two hours of MNT in the following year (with referral). Only face-to-face MNT services are billable for an FQHC. Group sessions not allowed.

97802© Medical nutrition, indiv, in (initial visit)

Note: Use this CPT code only for the initial visit.

97803© Med nutrition, indiv, subseq

G0270 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.

MNT and DSMT are allowed for diabetes, however not on the same day.

Diabetes Self-Management Training (DSMT)

DSMT is an accredited program. The Medicare contractor must have a copy of the DSMT certification before payment can be made. CMS recognizes national certification from the American Diabetes Association and the American Association of Diabetic Educators.

Medicare may cover diabetes self-management training services only if the treating physician or treating qualified non-physician practitioner managing the beneficiary’s diabetic condition certifies that such services are needed.

Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes. Beneficiaries are eligible to receive follow-up training (2 hours) each calendar year.
DSMT qualifies as an FQHC visit when provided one-on-one in a face-to-face encounter. Group sessions cannot be billed as a visit.

DSMT cannot be billed in addition to MNT on the same day.

**G0108** Diabetes outpatient self-management training service, individual, per 30 minutes.

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### Diabetic Lab Tests

Medicare covers the following diabetic lab tests. These are non-FQHC services that can be submitted to Medicare Part B on the CMS-1500 claim form.

### Diabetic Screening

Covered twice a year for pre-diabetes or once a year for patients not diagnosed with pre-diabetes or who have never been tested.

<table>
<thead>
<tr>
<th>HCPCS/CPT Codes</th>
<th>Code Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>82947</td>
<td>Glucose; quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82950</td>
<td>Glucose; post glucose dose (includes glucose)</td>
</tr>
<tr>
<td>82951</td>
<td>Glucose; Tolerance Test (GTT), three specimens (includes glucose)</td>
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</table>

### Hemoglobin A1c

It is not considered reasonable and necessary to perform glycated hemoglobin test more often than every 3 months on a controlled diabetic patient to determine whether the patient's metabolic control has been on average within the target range. Testing for uncontrolled type one or two diabetes mellitus may require testing more than four times a year.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>82985</td>
<td>Glycated protein</td>
</tr>
<tr>
<td>83036</td>
<td>Hemoglobin; glycated</td>
</tr>
</tbody>
</table>
Glaucoma Screening

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma;
- African-Americans age 50 and older; and
- Hispanic-Americans age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure measurement; and
- A direct ophthalmoscopy examination, or a slit-lamp bio microscopic examination.

Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed.

FQHCs can report:

- G0117 Glaucoma screening for high-risk patient, furnished by optometrist or ophthalmologist
- G0118 Glaucoma screening for high-risk patient, furnished under the direct supervision of an optometrist or ophthalmologist.

The diagnosis for the glaucoma screening is V80.1

“Welcome to Medicare” Exam

The Initial Preventive Physical Examination (IPPE) is also known as the “Welcome to Medicare Preventive Visit.” The goals of the IPPE are health promotion and disease prevention and detection.

Either a physician (a doctor of medicine or osteopathy) or a qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist) must furnish the IPPE.

A beneficiary, who has not yet had an IPPE is eligible for an IPPE as long as it is done within 12 months of the beneficiary’s Medicare Part B enrollment effective date.

All elements of the IPPE must be performed and documented.
IPPE HCPCS code: G0402
FQHC PPS “G” code: G0468

<table>
<thead>
<tr>
<th>42 REV. CD</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS/PPS CODE</th>
<th>45 SERV. DATE</th>
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<td>$$$; $5</td>
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<tr>
<td>0521</td>
<td>IPPE</td>
<td>G0402</td>
<td>MEEDYYYY</td>
<td>1</td>
<td>$$$; $5</td>
</tr>
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</table>

**Annual Wellness Visit (AWV)**

Medicare covers the AWV for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months.

Either a physician (a doctor of medicine or osteopathy) or a qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist) must furnish the AWV. All elements of the AWV must be performed and documented.

- G0438 AWF, includes a PPPS, initial visit.
  - NOTE: G0438 is only allowed once per lifetime.
- G0439 AWF, includes a PPPS, subsequent.
  - NOTE: G0439 is allowed every 12 months after either an IPPE or initial AWV.

G0438 and G0439 are not allowed within 12 months of the patient’s initial enrollment into Medicare.

<table>
<thead>
<tr>
<th>42 REV. CD</th>
<th>43 DESCRIPTION</th>
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**Preventive and Diabetic Services Resources:**

CMS IOM, Claims Processing Manual, Chapter 18, Preventive and Screening Services


CMS Preventive Services Webpage


Foot Care

The following foot care services are generally excluded from Medicare coverage:

- Treatment of flat foot.
- Routine foot care – including cutting or removal of corns and calluses; trimming, cutting, clipping or debriding of nails; and other hygienic and preventive maintenance care. There are exceptions to routine foot care.
- Supportive devices for feet (except when furnished to diabetics.)

Exceptions

1. Necessary and integral part of otherwise covered services. Example: diagnosis and treatment of ulcers, wounds or infection.
2. Presence of systemic condition such as metabolic, neurologic or peripheral vascular disease.

Routine foot care codes include:

- G0127  Trimming of dystrophic nails, any number.
- 11055  Trim skin lesion
- 11056  Trim skin lesions, 2-4
- 11057  Trim skin lesions, more than 4
- 11719  Trim nails, any number
- 11720  Debridement of nails, 1-5
- 11721  Debridement of nails, 6 or more

Foot Care Resources:

**CMS** Internet Only Manual (IOM), National Coverage Determination, Chapter 1, Part 1, section 70.2.1 – Diabetic foot exam.

CMS IOM, Benefit Policy Manual, Chapter 15, Section 290 – Foot Care

Noridian Medicare – Local Coverage Determinations (LCD)
Routine Foot Care (L24356) – Retired policy as of 3/1/14, but contains coverage and documentation guidelines that follow CMS NCD policy.
Symptomatic, Pathological Nail and It's Treatment (L24366) – Retired policy as of 3/1/14, but contains coverage and documentation guidelines that follow CMS NCD policy.

http://coverage.cms.fu.com/mcd_archive/overview.asp

Novitas-Solutions - LCD
Routine Foot Care (L32269)
Mycotic Nail Debridement (L32634)
Nail Avulsion (L32637)
www.novitas-solutions.com

NGS Medicare - LCD
Routine Foot Care and Nail Debridement (L26426)
www.ngsmedicare.com

Physical Therapy
Physical Therapy (PT) and Occupational Therapy (OT) may be provided in the FQHC directly by a physician, NP, or PA, if included in the practitioner’s scope of practice.
PT and OT services furnished by a PT or OT therapist who is employed by the FQHC and furnished incident to a visit with a FQHC practitioner are not billable visits, but the charges are included in the charges for an otherwise billable visit if all of the following occur:

- The PT or OT is furnished by a qualified therapist incident to a professional service as part of an otherwise billable visit,
- The service furnished is within the scope of practice of the therapist, and
- The therapist is employed by or has an employment agreement with the FQHC.
If the services are furnished on a day when no otherwise billable visit has occurred, the PT or OT service provided incident to the visit would become part of the cost of operating the FQHC. The cost would be included in the costs claimed on the cost report and there would be no billable visit.

Outpatient therapy requirements:

- Patient must be under the care of a physician or NPP, require therapy and an order has been written.
- Evaluation and plan of care.
- Obtain certification (and recertification) of the plan.
- Must be reasonable and necessary.

**Order** - An order (or referral) for therapy service, if documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.

**Plan of Care** - The POC must contain at least a diagnosis, long-term treatment (POC) goals and the type, amount, duration and frequency of therapy services. The plan must be signed (with identification) and dated by person who established the plan.

**Certification** - Initial certification should be obtained as soon as possible after the POC has been established. Certification requires a dated signature on the POC or some other document that indicates approval of the POC.

**Recertification** - Every 30 days the POC must be reviewed, dated and signed by a physician/NPP.

**Treatment Notes** - The purpose of the treatment note is not to document medical necessity, but to create a record of all encounters and skilled intervention. Documentation is required for every treatment day and every therapy service.

**Progress Report** - The progress report provides justification for the medical necessity of treatment. A clinician must complete a progress report at least once every 10 treatment days or at least once during each certification interval, whichever is less.

**Functional Reporting**

Effective with dates of service on or after January 1, 2013, CMS developed and implemented the collection system known as “Functional Reporting.”

Medicare has assigned categories for primary functional reporting and the provider will determine which category the patient’s limitation best describes. If the patient fits into more than one category, the provider must select the one that will show most improvement.

Functional reporting, G-codes and severity/complex modifiers, will be required on all outpatient therapy claims.
Medicare has assigned categories for primary functional reporting and the provider will determine which category the patient’s limitation best describes. Each of the primary functional categories has three status G-codes assigned. These G-codes are different for each category, however they refer to the same status indicators:

- **Projected Goal Status** – Assigned at evaluation and re-evaluation for the primary functional limitation.
- **Current Status** – Assigned during the reporting period to indicate progress towards projected goal. The reporting period begins with the first reporting of the primary functional code, and then reported at every 10th treatment day.
- **Discharge Status** – Assigned to report end of episode treatment. Only reported if the patient shows up for therapy on the discharge date.

**Each required therapy claim will have two functional reporting G-codes reported.** The initial and subsequent claims will show a G-code for current status and projected goal status. The final therapy session will include the projected goal status and discharge status.

**Each functional reporting G-code reported will have a severity/complex modifier** that reflects the patient’s percentage level or status of functional impairment as determined by the provider. This determination can be made by the use of functional assessment tools along with the provider’s clinical judgment. The G-codes, severity modifiers, their rational for use and the pertinent tests provided need to be documented in the medical record. There are seven severity modifiers, each with different percentage levels. **In addition** to the severity/complex modifier, the G-code will also report the **type of therapy (GP, GO GN) modifier.**

Clinic visit and physical therapy on the same day.

| Occurrence code 35 is used to report when therapy began. |
| Occurrence code 29 is used to report date the PT plan was established or last reviewed. |
| Occurrence code 11 is used to report onset of symptoms. |

### Therapy Resources:
CMS IOM, Benefit Policy Manual, chapter 15, section 220, Therapy services:

**Noridian** - Medicare Coverage Article (MCA)
Medical Necessity of Therapy Services
Therapy Evaluation and Assessment
Wound Care and Debridement Provided by Therapist
[www.noridianmedicare.com](http://www.noridianmedicare.com)

**Novitas-Solutions** - (LCD)
Therapy Services (L32710)
[www.novitas-solutions.com](http://www.novitas-solutions.com)
Mental Health Visits

Medicare covers mental health services in an FQHC when they are provided by a Clinical Psychologist and/or a Clinical Social Worker (CSW).

- Clinical psychologist and licensed clinical social worker services are covered in an FQHC when performed under applicable state licensure laws and providers meet the Medicare qualification guidelines.
- Mental health services are not covered if they are otherwise excluded from Medicare coverage, even though a qualified provider is authorized to perform them.

For Medicare coverage of therapy:

- Only individual therapy is covered as an encounter service.
- Group therapy is not covered. May be performed but it is captured as an allowable cost and not billed on a claim form.

Medicare will allow a clinic visit and a mental health visit on the same day.

Mental health services are billed under revenue code 0900, except for the annual depression screening (G0444), which is reported under revenue code 0521.

Claim Examples

Established patient seeing NP for hypertension; follow-up on new medication progress. Patient also seeing clinical social worker who is helping her cope with the loss of a job where she had been employed for 20 years.
FQHC established patient being seen by Clinical Psychologist after family members noticed a change in behavior. Family noticed depression and agitation after patient was fired from job.

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**Mental Health Resources:**

**Novitas-Solutions - LCD**
Psychiatric Codes (L32766)
www.novitas-solutions.com

**FQHC Resources:**
CMS FQHC PPS Website:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html

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

CMS Internet Only Manual (IOM), Benefits Policy 100-02, Chapter 13:
http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

CMS IOM, Claims Processing 100-04, Chapter 9: