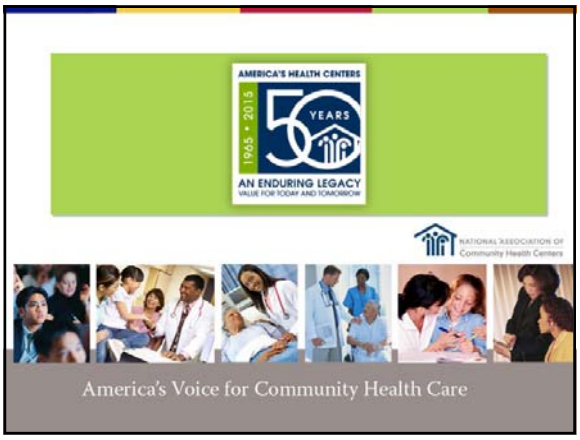


NATIONAL ASSOCIATION OF Community Health Centers

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) represents Community and Migrant Health Centers, as well as Health Care for the Homeless and Public Housing Primary Care Programs and other community-based health centers.

Founded in 1971, NACHC is a nonprofit advocacy organization providing education, training and technical assistance to health centers in support of their mission to provide quality health care to medically underserved populations.

NATIONAL ASSOCIATION OF Community Health Centers

The NACHC Mission

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

NATIONAL ASSOCIATION OF Community Health Centers

For further information about NACHC and America's Health Centers

Visit us at www.nachc.com

Agenda

- Introduction
- FQHC Overview
- Medicare Reporting
  - Part A Encounter Rate Services
  - Part B Services
- EOB Examples
  - Payment posting & Calculations
- Summary

FQHC …. What makes a CHC Unique

- Encounter Rate… Face-to-face with core provider
- Fixed Rate of Reimbursement vs. FFS
  - So why is coding important?
    - Appropriate capture of breadth & scope of service
    - Compliance
    - Commercial FFS maximization
    - Managed Medicaid with Encounter Rate secondary
    - Data collection for PPS change for Medicare in 2014 –
      - data is being collected as of 1/1/11
  - PPS – Prospective Payment System

Core Provider-Encounter Rate

- Medicare's definition of a visit or billable encounter is:
  A one-on-one face-to-face encounter in an outpatient setting between a patient and a FQHC Core Practitioner.
  - Medical Doctor (MD, DO)
  - Optometrist
  - Podiatrist
  - Chiropractor
  - Physician's Assistant (PA)
  - Certified Midwife (CNM)
  - Nurse Practitioner (NP)
  - Clinical Psychologist (CP)
  - Licensed Clinical Social Worker (LCSW)
  - Certified Diabetic Educator

Note: Some Medicaid programs also include Registered Nurses as Core Providers

Physician Services

- Professional services that include:
  - Diagnosis
  - Therapy
  - Surgery
  - Consultation

NP, CNM, and PA Services

- Services are covered if:
  - Furnished by employee of clinic or is compensated as individual from clinic
  - General (or direct, if state law requires) medical supervision of physician
  - Clinic policies must be in place and followed and any physician medical order for care and treatment of patient must be followed

Clinical Psychologist

- Clinical psychologist must:
  - Have doctoral degree in psychology from program in clinical psychology of educational institution accredited by organization recognized by Council on Post-Secondary Accreditation
  - Meet licensing or certification standards for psychologists in independent practice in state in which he/she practices
  - Possess two years of supervised clinical experience, with one done post-degree

License Clinical Social Worker

- LCSW
  - Possesses master or doctoral degree in social work
  - Performed at least two years of supervised CSW
  - Licensed or certified as CSW by state where services are performed, or
  - Where state does not provide licensure or certification, CSW has completed two years or 3,000 hours of post-master degree supervised clinical social work practice under supervision of master's level social worker in hospital, SNF, or clinic

FQHC Medicare Encounter Rate

- Flat Cost-based Encounter Rate (Core Provider = threshold)
- Unique Medicare Benefits
  - Deductible… waived (Part B….yes)
  - Preventive Visits (e.g., 99387/99397) covered
    - Expanded to include Annual Well Visit (AWV)
- Encounter Rate (Typically 80% of rate below)
  - 2015: $158.85; 2016: $160.60
  - Co-pay based on calculated rate or charge for G code which ever is less
  - No Co-pay for AWV and certain preventive services
- Additional Encounter Rate Scenarios
  - Nursing Facilities & Homebound patients

Annual Exams & Medicare

According to the Medicare Benefits Policy Manual Chapter 13 Section 40.1, the following preventive primary

- Medical social services;
- Nutritional assessment and referral;
- Preventive health education;
- Children's eye and ear examinations;
- Prenatal and post-partum care;
- Prenatal services;
- Well child care, including periodic screening;
- Immunizations, including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- For women only:
  - Clinical breast exam;
  - Referral for mammography; and
  - Thyroid function test.
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;
- Stool testing for occult blood;
- Dipstick urinalysis;
- Risk assessment and initial counseling regarding risks;

Physical Exam Targeted to Risk

- **This is NOT the Welcome to Medicare Exam (IPPE) not the Annual Wellness Visit (AWV). This is the annual exam as described by 99381-99397.**
  - Medicare Fiscal Intermediaries (FIs) are denying many 993XX services as non-covered service.
  - FIs are recommending a code change to IPPE and AWV. Not the same!!
  - FIs have interpreted "targeted to risk" to mean that the patient has diagnosed risk factors.
  - Claims with 99397 and V70.0 are denying in most instances.
  - Claims with 99397 and V70.00 AND a problem diagnosis code (401.9 or 250.00 etc.) are paying
  - Re-train providers to list all conditions addressed at the visit in addition to the V70.00
  - Re-train billers to link all diagnosis codes to the 993XX code; ensuring V70.00 is

FQHC Encounter Rate

- Encounter Rate Ineligible… CODE WHAT YOU DID
  - Billing/Charge Entry… must know what is billable
    - Nurse Visits, INR, BP Checks, etc.
- Carve Outs
  - Immunizations (Cost Report)
  - Labs (Billable to Part B)
- Medicare Wrap Around
  - Medicare Advantage "balance billing"
  - Medicare As Secondary Payer (ASP) when using "incident to" billing option
- Encounter Rate Logic… professional "core provider"
  - Diagnostics… -TC Only (not professional (-26))

Medicare Claims Destination

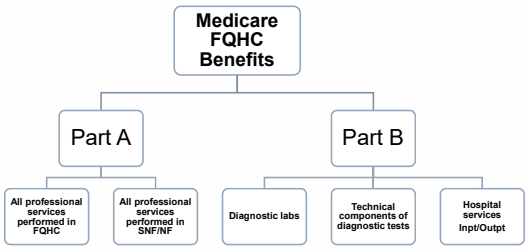
- Historically, Part A: UGS/NGS for ANSI 837I
  - New sites going forward: Part A – MAC
- Part A Submission (EDI) … must have
  - EDI Enrollment Form (Trading Partner Agreement)
  - Submitter Action Request form (obtain a submitter ID or links to clearinghouse submitter ID
    - Indicate desire for ERA on this form!!
- Part B… always goes to carrier MAC
  - ALL FORMS LISTED ABOVE
  - 855R for EACH provider
- Direct Deposit (EFT) for Parts A&B: CMS-588
- Recommend clearinghouse vs. direct submission

Medicare Claim Formats

- **Medicare Part A Intermediary/FI**
- UB-04 (ANSI 837I)
  - Medical: 521 Revenue Code
  - Behavioral Health: 900 code
- Three Encounter Types
1. Medical
   a. 80% of Encounter Rate
2. Behavioral Health
   a. Individual face-to-face
   b. Encounter Rate Reduction
3. Medical Nutrition Therapy (MNT) or Diabetes Self Management Training (DSMT)

- **Medicare Part B Carrier/MAC**
- CMS 1500 (ANSI 837P)
- Four Typical Options
1. Office Based Diagnostic Lab
   a. 81002: Urine Dip
2. X-Ray
   a. 76010-TC: Chest x-ray
3. Machine Testing
   a. 93005: EKG (TC Only)
4. Hospital Billing
   a. 99221: Initial Hospital Care
   b. Inpatient Surgery

Part A vs. Part B



Medicare Reporting
UB-04

FQHC Revenue codes must be on first line of claim

- 0521 – Medical Visit
- 0900 – Behavioral Health Visit subject to Medicare treatment limitation
- 0780 – Telehealth – bill with HCPCS Q3014
- 0521 – DSMT with HCPCS code G0108
- 0521 – MNT with HCPSC code 97802, 97803, G0270
- Other FQHC revenue codes:
  - 0522, 0524, 0525, 0527, 0528, 0519

52X Revenue Codes
UB-04

- 0521 = Clinic visit by member to RHC/FQHC
- 0522 = Home visit by RHC/FQHC practitioner
- 0524 = Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
- 0525 = Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility;
- 0527 = RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
- 0528 = Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)
- 0519 = Clinic, Other Clinic (only for the FQHC supplemental payment)

Other Revenue Codes
UB-04

- For dates of service *on or after January 1, 2011*, all except the following revenue codes may be used when billing for services provided in a FQHC:
- 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x.
- **NOTE: This information is being captured for data collection and gathering purposes only.**

Medicare Provisions

- FQHC encounter-based payment
  - 2015 $158.85
  - 2016 $160.60
- Geographic Adjustment Factor (GAF)
  - Puerto Rico .80
  - Oklahoma .91
  - NYC 1.108
  - Alaska 1.307
- New/Initial Patient Adjustment: **1.3416**

Looking at the "G" codes

What exactly is a G code?

Understand: Medicare PPS G codes vs. Medicare Temp Codes

- Medicare Temp Codes
  - G0008: Flu shot administration
  - G0101: Breast and Pelvic Exam
  - G0402: IPPE
- Created to meet Medicare requirements.
- May not be recognized by other payers.
- Medicare PPS Payment Codes G0466, G0467, G0468, G0469, G0470

G0466: FGHC visit, new patient

- A medically necessary face to face encounter between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving an FQHC 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.
- 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

HCPCS Qualifying Visits for G0466

- 92002 Eye exam new patient
- 92004 Eye exam new patient
- 97802 Medical nutrition indiv in
- 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
- G0101 Ca screen; pelvic/breast exam
- G0102 Prostate ca screening; dre
- G0108 Diab manage trn per indiv
- G0117 Glaucoma scrn hgh risk direc
- G0118 Glaucoma scrn hgh risk direc
- G0436 Tobacco-use counsel 3-10 min
- G0437 Tobacco-use counsel >10
- G0442 Annual alcohol screen 15 min
- G0443 Brief alcohol misuse counsel
- G0444 Depression screen annual
- G0445 High inten beh couns std 30 min
- G0446 Intens behave ther cardio dx
- G0447 Behavior counsel obesity 15 min
- Q0091 Obtaining screen pap smear

G0467 FQHC visit, established patient

- A medically necessary face to face encounter between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving an FQHC visit.

Qualifying Visits for G0467

- 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
- 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
- 99495 Trans care mgmt 14 day disch
- 99496 Trans care mgmt 7 day disch
- G0101 Ca screen; pelvic/breast exam
- G0102 Prostate ca screening; dre
- G0108 Diab manage trn per indiv
- G0117 Glaucoma scrn hgh risk direc
- G0118 Glaucoma scrn hgh risk direc
- G0270 Mnt subs tx for change dx
- G0436 Tobacco-use counsel 3-10 min
- G0437 Tobacco-use counsel >10
- G0442 Annual alcohol screen 15 min
- G0443 Brief alcohol misuse counsel
- G0444 Depression screen annual
- G0445 High inten beh couns std 30 min
- G0446 Intens behave ther cardio dx
- G0447 Behavior counsel obesity 15 min
- Q0091 Obtaining screen pap smear

G0468: FQHC visit: IPPE or AWV

- An FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
- 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.
- The related evaluation and management service must be listed as a line item but is not billable as a separate FQHC visit.

Qualifying Visits for G0468

- G0402 Initial preventive exam
- G0438 Ppps, initial visit
- G0439 Ppps, subseq visit

- Note: You may have additional "G" codes to list such as glaucoma screening or other G code screening items, but one of the three listed above must be linked to G0468.

G0469: FQHC visit, Mental Health, new patient

- A medically necessary face to face mental health encounter between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving an 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.
- 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.

Qualifying Visits for G0469

- 90791 Psych diagnostic evaluation
- 90792 Psych diag eval w/med srvcs
- 90832 Psytx pt &/family 30 minutes
- 90834 Psytx pt &/family 45 minutes
- 90837 Psytx pt &/family 60 minutes
- 90839 Psytx crisis initial 60 min
- 90845 Psychoanalysis

G0470: FQHC, Mental Health visit, established patient

- A medically necessary face to face mental health encounter between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving an mental health visit.

Qualifying Visits for G0470

- 90791 Psych diagnostic evaluation
- 90792 Psych diag eval w/med srvcs
- 90832 Psytx pt &/family 30 minutes
- 90834 Psytx pt &/family 45 minutes
- 90837 Psytx pt &/family 60 minutes
- 90839 Psytx crisis initial 60 min
- 90845 Psychoanalysis

Codes that are new or established

- 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.

Considerations for Setting the Rate for G Codes

- The regulations state that the fee includes a typical bundle of Medicare covered services that would be furnished per diem
- Here is the only guidance from Medicare: FAQ
- First consideration is to determine that "**typical bundle of MEDICARE covered services.**"
- Consider:
  - What are Medicare covered services?
  - What should be reviewed? new patient vs established patients vs mental health
  - Total dollars for each visit across your Medicare population
  - How far back to look—1 or 2 or 3 years?
  - Looking at complexity based on diagnosis/pros and cons
  - Once you can make that determination:
    - will you use the mean, median or average of these charges
- Then determine if your current fees are appropriate or in need of review.
- Medicare isn't asking for or dictating the method of the calculation, but the regs suggest that the methodology be kept available in case a request is made to show the calculations.
- G codes will need to make sense across the spectrum of all your services

FQHC Covered Services billable to Part B (1 of 2)

- Hospital inpatient services
  - Billing Part B work… carve out salary portion for core providers
- Labs for "diagnostic" purpose
- The technical component of these preventive services
  - Screening mammography
  - Screening pap smear and screening pelvic exam
  - Prostate cancer screening tests
  - Colorectal cancer screening tests
  - Bone mass measurement
  - Screening for glaucoma

FQHC Covered Services billable to Part B (2 of 2)

- Technical component of diagnostic tests
  - ECG – 93005;
  - Chest X-ray - 71020 - TC
  - Note: X-ray (reading) or EKG interpretation alone… no "encounter rate"
- DME – crutches, wheelchairs
- Ambulance Services
- Prosthetics and Orthotic braces

Sample Claim

Performed	Coded	Amount
OV	99213	$100
I&D	10060	$75
EKG	93000	$50
UA	81000	$20
Flu Shot	G0008	$15
Flu Vaccine	Q2035	$18

UB-04 & CMS-1500

Part A	Amount	Comment
0521 - 99213	$195.00	Sum of 99213, 10060, 93010
G0467	205.00	
0499 – 10060	$ 75.00	Rolled up
0730 – 93010	$ 20.00	Professional Component of EKG
0771 – G0008	$ 15.00	Cost Report
0636 – Q2035	$ 18.00	Cost Report
Part B	**Amount**	**Comment**
93005	$30.00	Technical component of EKG
81000	$20.00	Diagnostic Lab

FQHC Behavioral Health Services (1 of 2)

- Behavioral Health (ICD Range: 290-319)
  - Initial… 90801: Diagnostic or 90802: Interactive
  - ONLY individual (e.g., 90804), No group (e.g., 90853)
- Exceptions to Reduction of Encounter Rate
  - Initial Evaluation (90801 & 90802)
  - Pharmacologic Management (90862)
  - Mental Health or Substance Abuse (MHSA) managed by medical provider as co-morbidity versus stand alone service
    - i.e., Rank non MHSA service ICD ahead of MHSA & avoid use of a 900 (vs. 521) revenue code

FQHC Behavioral Health Services (2 of 2)

- Behavioral Health Reduction (Phase Out by 2014)
  - Historic Example:

    62.5% of Charge… 20% co-pay of this plus difference
    - $100 charge; Eligible amount is $62.50
    - 20% co-pay is $12.50
    - Patient owes $12.50 + $37.50 balance or total of $50
- Planned Phase Out**
  - Jan 2010 thru Dec 2011: Limitation percentage = 68.75%
  - Jan 2012 thru Dec 2012: Limitation percentage = 75%
  - Jan 2013 thru Dec 2013: Limitation percentage = 81.25%
  - Jan 2014 and onward: Limitation percentage = Medical

**Source: MCPM IOM 100-04 Chapter 9, Section 60

Tele-health Services

- Telecommunications system may substitute for:
  - Face-to-Face
  - Hands on Encounter
  - System include tools such as two-way radios/Skype
    - Permits real time communication

Tele-health Services

- Tele-health services include:
  - Consultation
  - Office Visits
  - Individual Psychotherapy
  - Psychiatric Diagnostic Interview Exam
  - Pharmacological Management
  - Neurobehavioral Status exam
  - Individual MNT
  - Individual health behavior and assessment and intervention

Tele-health Services Sites

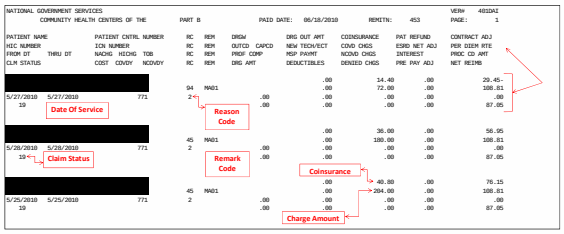
- Originating site
  - Location of eligible Medicare beneficiary at the time service furnished via telecommunications system
- Distant site
  - Site where physician or practitioner providing professional service is located at the time service is provided via telecommunications system

Tele-health Service Fee

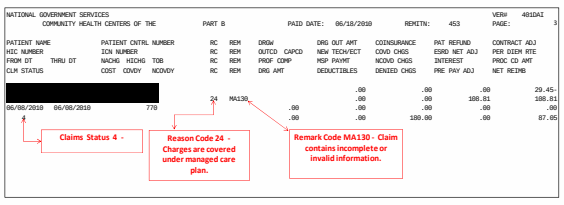
- Originating site facility fee
  - Claims for facility fees should be submitted to FI
  - Be sure to include HCPCS code Q3014 on claim
- Distant site fee
  - Services provided by the distant site practitioner is reimbursed under the Medicare Part B carrier system

Reading The Eobs

Part A Remit Sample Paid



Part A Remit Sample Paid



Calculations- Part A

A. Charge Amount:
$72.00
B. Coinsurance (20% of charge):
$14.40
C. Encounter Rate (per diem):
$108.81
D. Payment Amount (20% of encounter rate): $87.05
E. Adjustment Amount:
-$29.45

– Adjustment Amount = (Charge Amount * 80%)-Payment Amount
– Adjustment Amount = ($72.00 *0.80) - $87.05
– Adjustment Amount = -$29.45

– Adjustments can be posted as positive or negative

Calculations- Part A

A. Charge Amount:
$180.00
B. Coinsurance (20% of charge):
$36.00
C. Encounter Rate (per diem):
$108.81
D. Payment Amount (20% of encounter rate): $87.05
E. Adjustment Amount:
$56.95

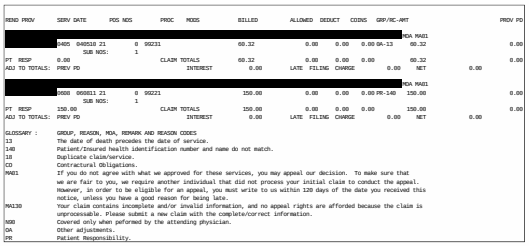
– Adjustment Amount = (Charge Amount * 80%)-Payment Amount
– Adjustment Amount = ($180.00 *0.80) - $87.05
– Adjustment Amount = $56.95

– Adjustments can be posted as positive or negative

Part B Remit Sample Paid

REND PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]									ASG Y	MOA MA01 MA18
[redacted]	0924 092410	22	1	99221	157.25	113.15	0.00	22.63	CO-45	44.10 90.52
PT RESP	22.63			CLAIM TOTALS	157.25	113.15	0.00	22.63		44.10 90.52
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE			0.00	NET 90.52
CLAIM INFORMATION FORWARDED TO: BCBS OF MASSACHUSETTS INC.										
[redacted]									ASG Y	MOA MA01 MA18
[redacted]	0826 082410	11	1	93005	25.00	10.55	0.00	2.11	CO-45	14.45 8.44
PT RESP	26.43			CLAIM TOTALS	25.0	10.55	0.00	2.11		14.45 8.44
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE			0.00	NET 8.44
CLAIM INFORMATION FORWARDED TO: BCBS OF MASSACHUSETTS INC.										
[redacted]									ASG Y	MOA MA01 MA18
[redacted]	0923 092310	22	1	99231	64.71	46.19	0.00	9.24	CO-45	18.52 36.95
PT RESP	9.24			CLAIM TOTALS	64.71	46.19	0.00	9.24		18.52 36.95
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE			0.00	NET 36.95
CLAIM INFORMATION FORWARDED TO: BCBS OF MASSACHUSETTS INC.										

Part B Remit Sample Denied



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REND PROV      SERV DATE      POS NOS      PROC   MODS          BILLED        ALLOWED  DEDUCT   COINS   GRP/RC-AMT                    PROV PD
[redacted]                                                                                                          MOA MA01
[redacted]0405  040818 21      0  99231                       60.32            0.00     0.00    0.00 OA-13     60.32                    0.00
                       SUB NOS:    1
PT  RESP        0.00                        CLAIM TOTALS      60.32            0.00     0.00    0.00           60.32                    0.00
ADJ TO TOTALS:  PREV PD                        INTEREST         0.00        LATE  FILING  CHARGE            0.00    NET          0.00
[redacted]                                                                                                          MOA MA01
[redacted]0600  060811 21      0  99221                      150.00            0.00     0.00    0.00 PR-140   150.00                    0.00
                       SUB NOS:    1
PT  RESP      150.00                        CLAIM TOTALS     150.00            0.00     0.00    0.00          150.00                    0.00
ADJ TO TOTALS:  PREV PD                        INTEREST         0.00        LATE  FILING  CHARGE            0.00    NET          0.00

GLOSSARY :      GROUP, REASON, MOA, REMARK AND REASON CODES
13              The date of death precedes the date of service.
140             Patient/Insured health identification number and name do not match.
18              Duplicate claim/service.
CO              Contractural Obligations.
MA01            If you do not agree with what we approved for these services, you may appeal our decision.  To make sure that
                we are fair to you, we require another individual that did not process your initial claim to conduct the appeal.
                However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this
                notice, unless you have a good reason for being late.
MA130           Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is
                unprocessable. Please submit a new claim with the complete/correct information.
N00             Covered only when performed by the attending physician.
OA              Other adjustments.
PR              Patient Responsibility.
```

Calculations Part B

A. Charge Amount:
   $157.23
B. Allowed Amount:
   $113.75
C. Coinsurance (20% of charge):
   $22.63
D. Payment Amount (80% of Allowed): $90.52
E. Adjustment Amount (Charge-Allowed): $44.10

Never a negative adjustment on fee-for-service (FFS).

Never paid more than charge.

FQHC Resources

- 2015 Updates from CMS
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8981.pdf

- CMS FQHC / RHC Manual (IOM 100-2 Chpt.13)
  http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf

Summary

- Claims Processing Manual
- Benefit Policy Manual
- Educate all billing staff
- Stay up to date on all changes
- Watch payments and denials
- Commit to Educate (Top down

Questions

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