CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2034	**Date: August 24, 2010**
	Change Request 7038

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 16, 2010. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

NOTE: Transmittal 2013, dated July 30, 2010 is being rescinded and replaced by Transmittal 2034 dated August 24, 2010 to indicate the new waiver of coinsurance and deductible for Preventive Services as enacted by 4104 of the Affordable Care Act. Business Requirement 7038.11 and the Claims Processing Manual, Pub. 100-04, Chapter 9, sections 120 and 150 have been updated to reflect the above policy changes. All other material remains the same.

"This policy is discussed in the CY 2011 physician fee schedule proposed rule published on July 13, 2010 and may change based on analysis of public comments. This advance notice is provided so contractors can begin making the necessary systems changes for the policy to go in effect January 1, 2011."

SUBJECT: Affordable Care Act (ACA) Mandated Collection of Federally Qualified Health Center (FQHC) Data and Updates to Preventive Services Provided by FQHCs

I. SUMMARY OF CHANGES: The ACA provides the statutory framework for development and implementation of a prospective payment system (PPS) for Medicare FQHCs in 2014. The ACA grants the Secretary of HHS the authority to require FQHCs to submit such information as may be required in order to develop and implement a PPS for Medicare FQHCs. The ACA mandates the collection of the data begins no later than January 1, 2011. ACA also expands the definition of FQHC preventive services. **NOTE:** The original section 110.1 is being deleted from Chapter 9. Sections 110.2 and 110.3 have been re-numbered to 110.1 and 110.2.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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
R	9/Table of Contents
R	9/100/General Billing Requirements
R	9/110/FQHC Affordable Care Act (ACA) Requirements
R	9/110.1/Reporting of Specific HCPCS Codes for Hospital-Based FQHCs
R	9/110.2/Billing for Supplemental Payments to FQHCs Under Contract with Medicare Advantage (MA) Plans
R	9/120/General Billing Requirements for Preventive Services
R	9/150/Initial Preventive Physical Examination (IPPE)
R	9/160/Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
R	9/181/Diabetes Self-Management Training (DSMT) Services Provided by RHCs and FQHCs
R	9/182/Medical Nutrition Therapy (MNT) Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2034	Date: August 24, 2010	Change Request: 7038

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SUBJECT: Affordable Care Act (ACA) Mandated Collection of Federally Qualified Health Center (FQHC) Data and Updates to Preventive Services Provided by FQHCs

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background:

Section 10501(i)(3)(A) of ACA amended section 1834 of the Social Security Act (the Act) by adding a new subsection (o), *Development and Implementation of Prospective Payment System*. This subsection provides the statutory framework for development and implementation of a prospective payment system for Medicare FQHCs. Section 1834(o)(1)(B), as amended by the ACA, addresses collection of data necessary to develop and implement the new Medicare FQHC prospective payment system. Specifically, the ACA grants the Secretary of Health and Human Services the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC prospective payment system, including the reporting of services using Healthcare Common Procedure Coding System (HCPCS) codes. The ACA requires that the Secretary impose this data collection submission requirement no later than January 1, 2011.

Section 10501(i)(2) of the ACA amended the definition of FQHC services as defined in section 1861(aa)(3)(A) of the Act by removing the specific references to services provided under section 1861(qq) and (vv) and by adding preventive services as defined in section 1861(ddd)(3), as amended by the ACA. The ACA establishes a new Medicare FQHC preventive services definition by referencing preventive services as defined in section 1861(ddd)(3) of the Act, as amended by the ACA. In accordance with 1833 (a)(3) of the Act, preventive services listed in 1861(ddd)(3) are paid in the manner as all other Medicare FQHC services (with the exception of 1861(s)(10) services, i.e., pneumococcal and influenza vaccines and administration which are paid at 100%).

B. Policy:

This policy is subject to change based on analysis of public comments of the final rule to Payment Policies under the Physician Fee Schedule for Calendar Year (CY) 2011. Any changes will be reflected in the implementation of this Change Request before issuance.

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 code reporting are for informational and data gathering purposes only, and will not be utilized to determine current Medicare payment to FQHCs. Until the FQHC prospective payment system is implemented in 2014, the Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.

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: (1) Initial preventive physical examination (IPPE); (2) The following screening and other preventive services: (A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10); (B) Screening mammography as defined in 1861(jj); (C) Screening pap smear and screening pelvic exam as defined in 1861 (nn).; (D) Prostate cancer screening tests as defined in 1861(oo); (E) Colorectal cancer screening tests as defined in 1861 (pp); (F) Diabetes outpatient self-management training services as defined in 1861 (qq)(1); (G) Bone mass measurement as defined in 1861 (rr); (H) Screening for glaucoma as defined in 1861 (uu); (I) Medical nutrition therapy services as defined in 1861 (vv); (J) Cardiovascular screening blood tests as defined in 1861 (xx)(1); (K) Diabetes screening tests as defined in 1861(yy); (L) Ultrasound screening for abdominal aortic aneurysm as defined in 1861(bbb); (M) Additional preventive services (as defined in 1861 (ddd)(1); (3) The personalized prevention plan services as defined in Section 1861(hhh)(1) of the Act.

This CR does not impact claims for supplemental payments to FQHCs under contact with Medicare Advantage Plans.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7038.1	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall require all service lines contain a valid HCPCS code except for revenue codes that do not permit HCPCS code reporting, i.e. revenue code 025x.						X				
7038.1.1	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall return to provider all FQHC claims that	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	contain service line (s) without a valid HCPCS code(s).										
7038.2	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall accept all service lines with valid revenue codes except for the following revenue codes: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.						X				
7038.2.1	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall return to provider all service lines with any of the following revenue codes: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.	X		X			X				
7038.3	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall make one payment at 80% of the all-inclusive rate for each date of service which contains one of the following revenue codes 0521, 0522, 0524, 0525, 0527 or 0528 and a valid HCPCS code. Medicare systems shall make an additional payment at 80% of the all-inclusive rate for the same DOS when the service line information meets the criteria in BR 7038.4 or BR 7038.5.	X		X			X				
7038.4	Medicare systems shall make a second payment at 80% of the all-inclusive rate for a second visit on the same DOS when the service line contains one of the revenue codes in the following series: 0521, 0522, 0524 0525, 0527 or 0528 with a valid HCPCS code and modifier 59.	X		X			X				
7038.5	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall make one payment at 80% of the all-inclusive rate for each DOS which contains one of the following revenue codes 0521, 0522, 0524, 0525, or 0527 and HCPCS code G0108 for an individual diabetes self management training (DSMT) session or HCPCS codes 97802, 97803 or G0270 for an individual Medical	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Nutrition therapy (MNT) session. Medicare systems shall not make payment for both DSMT and MNT sessions on the same DOS.										
7038.6	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall make payment subject to the outpatient mental health treatment limitation for each DOS which contains revenue code 0900 and a valid HCPCS code.	X		X			X				
7038.7	For all Medicare fee-for-service claims on TOB 77x with dates of service on or after 01/01/2011, Medicare systems shall make payment at 80% of the lesser of the charge or the applicable originating site facility fee for each date of service which contains revenue code 0780 and HCPCS code Q3014.	X		X			X				
7038.8	For all service lines on TOB 77x that meet the requirement in BR 7038.1 but do not meet the criteria in any one of the following BRs: 7038.3, 7038.4, 7038.5, 7038.6 or 7038.7 Medicare systems shall not make payment. Medicare systems shall use group code CO and reason code 97-"Payment adjusted because the benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated".	X		X			X				
7038.9	For all service lines that do not receive payment, Medicare systems shall ensure that the MSN reflects the following message: 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				
7038.10	Medicare systems shall not apply the Medicare deductible to payments for FQHC services. Medicare systems shall apply the Medicare deductible to the telehealth originating site facility fee in BR 7038.7. (The telehealth originating site facility fee is not an FQHC service.)	X		X			X				
7038.11	Medicare systems shall apply the Medicare FQHC co-	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	insurance of 20% of charges to all FQHC services. Note: This does not apply to Preventive Services, as coinsurance is waived for these services as outlined in CR7012.										
7038.12	Medicare systems shall apply the standard Medicare co-insurance of 20 % to the telehealth originating site facility fee in BR 7038.7. (The telehealth originating site facility fee is not an FQHC service.)	X		X			X				
7038.13	Medicare systems shall ensure FQHC claims submitted with dates of service on or after 01/01/2011 with preventive services HCPCS code are posted to the appropriate auxiliary file as a professional component.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7038.14	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site 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 your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey (claims processing) 410-786-5736 or Randy Ricktor (policy) 410-786-4632

Post-Implementation Contact(s): Appropriate RO

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

Table of Contents
(Rev.2034, Issued: 08-24-10)

100 - General Billing Requirements

(Rev.2034, Issued: 08-24-10, Effective: 01-01-11, Implementation: 01-03-11)

***NOTE**: For dates of service prior to April 1, 2010 all FQHC services must be submitted on a 73X bill type. For dates of service on or after April 1, 2010 all FQHC services must be submitted on a 77X type of bill.*

General information on basic Medicare claims processing can be found in this manual in:

- Chapter 1, "General Billing Requirements," (http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf) for general claims processing information;

- Chapter 2, "Admission and Registration Requirements," (http://www.cms.hhs.gov/manuals/downloads/clm104c02.pdf) for general filing requirements applicable to all providers.

For Medicare institutional claims:

- See Chapter 25 "Completing and Processing the CMS-1450 Data Set" (http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf) for general requirements for completing the institutional claim data set (paper and HIPAA Version (837)).

NOTE: Chapter 25 lists all revenue codes available; however RHCs and FQHCs are limited to the revenue codes listed in B-Service Level Information, below.

- See the Medicare Claims Processing Manual on the CMS Web site for general Medicare institutional claims processing requirements, such as for timely filing and payment, admission processing, Medicare Summary Notices, and required claim data elements that are applicable to RHCs and FQHCs.

- See §10.3 in this chapter for claims processing jurisdiction for RHC and FQHC claims

- Contact your fiscal intermediary (FI) for basic training and orientation material if needed.

The focus of this chapter is RHCs and FQHCs, meaning only institutional claims using TOBs 71x and 73x/77x, not any other provider or claim types. Professional claims completed by physicians and non-institutional practitioners are sent to Medicare carriers in the ASC 837P ANSI X-12 format for professional claims or on Form CMS-1500.

The RHC and FQHC benefits provide specific primary or professional medical services, to Medicare beneficiaries in underserved or specially designated areas. These benefits are equivalent to certain physician or practitioner services. Provision of these services in underserved or specially designated areas may qualify the provider to receive specific types of grants or funding. Limited services are provided under the RHC and FQHC benefits. Generally, only those services that are included in the RHC and FQHC benefits are billed on these claims.

- The RHC and FQHC benefits are defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf.)

The core services of the benefits are professional, meaning the hands-on delivery of care by medical professionals. Some preventive services, however, are also encompassed in primary care under the benefits, and these services may have a technical component, such as a laboratory service or use of diagnostic testing equipment. For FQHCs only: Certain mandated preventive services include a laboratory test that is included in the FQHC visit rate. (See CFR 42 405.2446 (b)(9) and 405.2448 (b) and the RHC/FQHC specific billing instructions in A and B, below.) In general, if NOT part of the RHC or FQHC benefits, technical services, (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims. All services in the RHC and FQHC benefits are reimbursed through the all-inclusive rate paid for each patient encounter or visit.

The visit rate includes: covered services provided by an RHC or FQHC physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker or, in very limited situations, visiting nurse; and related services and supplies. The rate does not include services that are not defined as RHC or FQHC services.

The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker or in very limited situations, visiting nurse, during which an RHC or FQHC service is rendered. These services are reimbursed by the Medicare Part B trust fund. RHC services are subject to the Medicare coinsurance and deductible rules. FQHC services are subject to the Medicare coinsurance rules but are exempt from the Medicare deductible rules.

A. Claim-Level Information

The RHCs and FQHCs bill FIs on institutional claims, either on the ASC 837I ANSI X-12 format for institutional claims or the UB-04/Form CMS-1450, using type of bill (TOB) 71x for RHCs, and 73x/*77x* for FQHCs.

The following rules apply specifically to all RHC and FQHC claims:

- Bill types 71x and 73x/*77x* MUST be used on institutional claims for RHC and FQHC benefit services for BOTH independent and provider-based facilities.

- The third digit of TOBs 71x and 73x/*77x* provides additional information regarding the individual claim. When the third digits, called frequency codes, are used on RHC or FQHC claims the TOBs are:

    - 710 or 730/*770* = non-payment/zero claim (a claim with only noncovered charges)

    - 711 or 731/*771* = Admit through discharge (original claim)

    - 717 or 737/*777* = Replacement of prior claim (adjustment)

    - 718 or 738/*778* =Void/cancel prior claim (cancellation)

NOTE: "x" represents a digit that can vary.

- RHC and FQHC claims cannot overlap calendar years. Therefore, the statement dates, or from and through dates of the claim, must always be in the same calendar year, and periods of billing ranging over 2 calendar years must be split into 2 separate claims for the 2 different calendar years.

- RHC TOB 71x claims and FQHC TOB 73x/*77*x claims are defined as outpatient institutional claims under HIPAA and should follow the guidelines below:

B. Service-Level Information

The types of services billed on TOBs 71x:

- Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s)using revenue code 052x;

- Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); and

- Telehealth originating site facility fees are billed under revenue code 0780.

The only types of services payable on TOBs 73x/77x:

- *Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052x;*

- *An additional payment maybe received for professional and primary services furnished on the same day at different times. These services should be billed using revenue code 052x and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon;*

- *Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900;*

- *Telehealth originating site facility fees are billed under revenue code 0780 and HCPCS code Q3014;*

- *Diabetes Self Management Training (DSMT) billed under revenue code 052x and HCPCS code G0108 and Medical Nutrition Therapy (MNT) billed under revenue code 052x and HCPCS code 97802, 97803, or G0270; and*

- *FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.*

***NOTE**: All other services will be included in the Provider's all inclusive rate.*

- For dates of service prior to July 1, 2006, the values for all four digits of revenue code 052x are:

  - 0520 = Free-Standing Clinic – to be used by all FQHCs;

  - 0521 = Rural Health Clinic – to be used by RHCs; and

  - 0522 = Rural Health Home – to be used by RHCs in home settings.

- For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment (FQHCs only):

  - 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; and

- 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)*

- *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.*

Revenue code 0900 ("Behavioral Health Treatments/Services, General Classification") is used for services subject to the Medicare outpatient mental health treatment limitation on claims with dates of service on or after October 16, 2003, that are received on and after October 1, 2004; for claims received before October 1, 2004, and for all claims with dates of service before October 16, 2003, use revenue code 0910 ("Behavioral Health Treatments/Services-Extension of 0900, Reserved for National Use", formerly "Psychiatric/ Psychological Services, General Classification") instead.

Telehealth is not an RHC or FQHC service. As appropriate, however, the telehealth originating site facility fee is billed by the RHC or FQHC using revenue code 0780, in addition to the appropriate visit billed in revenue code 052x or 0900. For information on billing for the FQHC supplemental payment see section 110.3 of this chapter.

Revenue code 0780 ('Telemedicine, General Classification") is used to bill for the telehealth originating site facility fee. Telehealth originating site facilities' fees billed using revenue code 0780 are the only line items allowed on TOBs 71x that are NOT part of the RHC.

- These line items require use of HCPCS code Q3014 in addition to the revenue code (0780) to indicate the facility fee is being billed.

- These are the only services billed on TOB 73x/*77x* that will be subject to the Part B deductible.

- See chapter 15, §270 of Pub. 100-02, Medicare Benefit Policy Manual, (http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf) for coverage requirements and the definition of telehealth services.

- See chapter 1, §60 (http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf) of this manual for information on billing noncovered charges or claims to FIs;

- Line items on outpatient claims under HIPAA require reporting of a line-item service date for each iteration of each revenue code. A single date should be reported on a line item for the date the service was provided, not a range of dates. Most if not all RHC and FQHC services are provided on a single day.

    - For services that do not qualify as a billable visit, the usual charges for the services are added to those of the appropriate (generally previous) visit. RHCs/FQHCs use the date of the visit as the single date on the line item.

- Units are reported based on visits, which are paid based on the all-inclusive rate no matter how many services are delivered. Only one visit is billed per day unless the patient leaves and later returns with a different illness or impairment suffered later on the same day (and medical records should support these cases). Units for visits are to be reported under revenue codes 052x or 0900 (0910 depending on the date), as applicable.

- No type of technical services, such as a laboratory service, or technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x/*77x*. Technical services specifically included in these benefits or expressly applicable to the 71x or 73x/*77x* TOBs in other instructions are bundled into the visit rate. Consequently they are not separately identified on the claim.

If technical services/components not part of either the RHC or FQHC benefits are performed in association with professional services or components of services billed on 71x or 73x/*77x* claims, how the technical services/components are billed depends on whether the RHC or FQHC is independent or provider-based:

- Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers in the designated claim format (837P or Form CMS-1500.) See chapters 12 (http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf) and 26 (http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf) of this manual for billing instructions.

- Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI; see the applicable chapter of this manual based on the base-provider type, such as (http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf) for outpatient hospital services, chapter 6 (http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf) for inpatient SNF services chapter 7 for Outpatient SNF services, etc.

The following three sections describe other billing rules applicable to RHC and FQHC claims and services.

110 - FQHC Affordable Care Act (ACA) Requirements

(Rev2034, Issued: 08-24-10, Effective: 01-01-11, Implementation: 01-03-11.)

Section 1834 (o)(1)(B) of the Afforable Care Act (ACA) requires the collection of data necessary to develop and implement the Medicare FQHC prospective payment system which is scheduled to be implemented in 2014. Beginning with dates of service on or after January 1, 2011, when billing services on a 77X type of bill, all services provided should be listed with the appropriate revenue code and HCPCS code for each line.

This data reporting will be as follows:

- *For each billable visit, FQHCs must submit the appropriate revenue code as explained in section 100, and a valid HCPCS code for all claims with DOS on or after January 1, 2011.*

- *In addition, FQHCs must submit separate service lines with revenue codes and HCPCS codes to reflect any cost associated with all FQHC covered services provided by the FQHC but not reflected on the service line submitted for the billable visit. For example, for Part B covered injectable drugs administered in an FQHC during a billable visit, the FQHC should report a separate line item with the appropriate revenue code and HCPCS codes to reflect the charge for the drug and its administration which is covered as an incident to service.*

- *Pneumococcal, influenza and hepatitis B vaccine and their administration should be reported separately with the appropriate HCPCS code and revenue codes.*

110.1 - *Reporting of Specific HCPCS Codes for Hospital-based FQHCs*

(Rev. 2034, Issued: 08-24-10, Effective: 01-01-11, Implementation: 01-03-11)

A. Claims With Dates of Service on or After April 1, 2005

Effective April 1, 2005, hospital-based FQHCs are no longer required to report any specific HCPCS codes when billing for FQHC services.

B. Claims with Dates of Service on or After January 1, 2011

Effective January 1, 2011, FQHCs are required to report specific HCPCS codes when billing for FQHC services. FQHC claims submitted with revenue lines that do not contain a valid HCPCS code will be returned to the provider.

110.2 – *Billing for Supplemental Payments to FQHCs Under Contract with Medicare Advantage (MA) Plans*

(Rev. 2034, Issued: 08-24-10, Effective: 01-01-11, Implementation: 01-03-11)

This section provides basic instructions on calculating and billing for the supplemental payments to FQHCs under contract with MA Plans.

Title II of the Medicare Modernization Act (MMA) established the MA program. The MA program replaces the Medicare + Choice (M+C) program established under Part C of the Act. Effective for services furnished on or after January 1, 2006, during contract years beginning on or after such date, Section 237 of the MMA requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

This new supplemental payment for covered FQHC services furnished to MA enrollees augments the direct payments made by the MA organization to FQHCs for all covered FQHC services. The Medicare all-inclusive payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare program, is based on the FQHC's unique cost-per-visit as calculated by the Medicare Fiscal Intermediary (FI) based on the Medicare cost report. FQHC's seeking payment under Section 237 of the MMA must submit to their FI copies of their contracts under each MA plan.

In order to implement this new supplemental payment provision, the FI must determine if the Medicare cost-based payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC at least quarterly. In determining the supplemental payment, the statute also excludes in the calculation of the supplemental payments any financial incentives provided to FQHCs under their MA arrangements, such as risk pool payments, bonuses, or withholds.

The FQHC supplemental payment shall be based on a per visit calculation subject to an annual reconciliation. The supplemental payments, as required by the MMA, for FQHC covered services rendered to beneficiaries enrolled in MA plans will be calculated by determining the difference between 100 percent of the FQHC's all-inclusive cost-based per visit rate and the average per visit rate received by the FQHC from the MA organization for payment under that MA plan, less the amount the FQHC may charge to MA enrollees permitted under Federal law i.e., any beneficiary cost sharing allowed under the MA enrollee's plan.

Each eligible FQHC seeking the supplemental payment is required to submit (for the first two rate years) to the FI an estimate of the average MA payments (per visit basis) for covered FQHC services. Every eligible FQHC seeking the supplemental payment is required to submit a documented estimate of their average per visit payment for their MA enrollees, for each MA plan they contract with, and any other information as may be required to enable the FI to accurately establish an interim supplemental payment.

Expected payments from the MA organization would only be used until actual MA revenue and visits collected on the FQHC's cost report can be used to establish the amount of the supplemental payment.

Effective January 1, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the FI shall use actual MA revenue and visit data along with the FQHC's final all-inclusive payment rate, to determine the FQHC's final actual supplemental per visit payment. Once this amount (per visit basis) is determined it will serve as the interim rate for the next full rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment thereon will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the FI. Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the FI on type of bill (TOB) 73x/*77x* with revenue code 0519 for the amount of the interim supplemental payment rate (FQHC interim all-inclusive rate – estimated average payment from the MA plan plus any beneficiary cost sharing = billed amount > 0). Do not submit revenue codes 0520 and/or 0900 on the same claim as revenue code 0519.

For services of plan years beginning on and after January 1, 2006 and before an interim supplemental rate can be determined by the FI based on cost report data, FIs shall calculate an interim supplemental payment for each MA plan the FQHC has contracted with using the documented estimate provided by the FQHC of their average MA payment (per visit basis) under each MA plan they contract with. Once an interim supplemental rate is determined for a previous plan year based on cost report data, use that interim rate until the FI receives information that changes in service patterns that will result in a different interim rate. FIs shall calculate an interim supplemental payment rate for each MA plan the FQHC has contracted with. Reconcile all interim payments at cost settlement.

Do not apply the Medicare deductible in calculating the FQHC interim supplemental payment. Do not apply the original Medicare co-insurance (20%) to the FQHC all

inclusive rate when calculating the FQHC interim supplemental payment. Any beneficiary cost sharing under the MA plan is included in the calculation of the FQHC interim supplemental payment rate.

FIs shall submit all claims to CWF for approval. CWF will verify each beneficiary's enrollment in an MA plan for the line item date of service (LIDOS) on the claim. CWF shall reject all claims for the FQHC interim supplemental payment for beneficiaries who are not MA enrollees on the same date as the LIDOS on the claim. FIs shall RTP such claims to the FQHCs. FIs shall not make payments to an FQHC for the interim supplemental payment and the all-inclusive rate for claims with the same LIDOS for the same beneficiary. The beneficiary is never liable for any part of the supplemental payment amount owed the FQHC. FIs shall accept TOB 73x/*77x* with revenue code 0519 and pay the interim supplemental payment rate for each qualified visit billed.

FIs shall at cost settlement determine the FQHC's final supplemental payment.

120 – General Billing Requirements for Preventive Services

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Professional components of preventive services are part of the overall encounter, and for TOBs 71x or 73x/*77x*, have always been billed on lines with the appropriate site of service revenue code in the 052x series. In addition to previous requirements for independent FQHCs exclusively, all RHCs/FQHCs had been required to report HCPCS codes for certain preventive services subject to frequency limits. As of April 1, 2005, RHCs and FQHCs do not have to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71x *or* 73x/*77x* absent a few exceptions. The number of preventive services requiring HCPCS coding has expanded as described in the sections below.

RHCs/FQHCs do not receive any reimbursement on TOBs 71x *or* 73x/*77x* for technical components of services provided by clinics/centers. This is because the technical components of services are not within the scope of Medicare-covered RHC/FQHC services. The associated technical components of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

Though most preventive services have HCPCS codes that allow separate billing of professional and technical components, mammography and prostate PSA do not. However, RHCs/FQHCs still may provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using the appropriate site of service revenue code in the 052x series.

For vaccines, RHCs/FQHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x *or* 73x/*77x* claims. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. Neither co-insurance nor deductible apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. No line items specifically for this service are billed on RHC/FQHC claims. The charges of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. Both co-insurance and deductible apply for Hepatitis B vaccines in RHCs. Coinsurance applies to Hepatitis B vaccines provided in FQHCs. Deductible does not apply for services provided in the FQHC. An encounter can not be billed if vaccine administration is the only service the RHC/FQHC provides.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are being waived for all Preventive Services as enacted in section 4104 of the Affordable Care Act.

Additional information on vaccines can be found in Chapter 1, section 10 of this manual. Additional coverage requirements for pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in Publication 100-02, the Medicare Benefit Policy Manual, Chapter 15.

150 – Initial Preventive Physical Examination (IPPE)

(Rev. 2034, Issued: 08-24-10, Effective: 01-01-11, Implementation: 01-03-11)

Effective for services furnished on or after January 1, 2005, Section 611 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B of one initial preventive physical examination (IPPE) for new beneficiaries only, subject to certain eligibility and other limitations. For RHCs the Part B deductible for IPPE is waived for services provided on or after January 1, 2009. FQHC services are always exempt from the Part B deductible. Coinsurance is applicable. *For RHCs and FQHCs coinsurance is waived for services provided on or after January 1, 2011.*

Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location generally constitute a single visit. However, in rare circumstances an RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the IPPE when they are performed on the same day.

RHCs and FQHCs must HCPCS code for IPPE for the following reasons:

- To avoid application of deductible (on RHC claims);
- To assure payment for this service in addition to another encounter on the same day if they are both separate, unrelated, and appropriate; and
- To update the CWF record to track this once in a lifetime benefit.

Beginning with dates of service on or after January 1, 2009 if an IPPE is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or Part A MAC using TOBs 71X and 73X/*77X*, respectively, and the appropriate site of service revenue code in the 052X revenue code series, and must include HCPCS *code* G0402. Additional information on IPPE can be found in Chapter 18, section 80 of this manual.

NOTE: The technical component of an EKG performed at a clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the independent RHC/FQHC. Rather, it is billed to Medicare carriers or Part B MACs on professional claims (Form CMS-1500 or 837P) under the practitioner's ID following instructions for submitting practitioner claims. Likewise, the technical component of the EKG performed at a provider-based clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the provider-based RHC\FQHC. Instead, it is billed on the applicable TOB and submitted to the FI or Part A MAC using the base provider's ID following instructions for submitting claims to the FI/Part A MAC from the base provider. For the professional component of the EKG, there is no separate payment and no separate billing of it. The IPPE is the only HCPCS *code* for which the deductible is waived under this benefit. For more information on billing for a screening EKG see chapter 18 section 80 of this manual.

160 – Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

(Rev. 2034, Issued: 08-24-10, Effective: 01-01-11, Implementation: 01-03-11)

Section 5112 of the Deficit Reduction Act of 2005 amended the Social Security Act to provide coverage under Part B of the Medicare program for a one-time ultrasound screening for abdominal aortic aneurysms (AAA). Payment for the professional services that meet all of the program requirements will be made under the all-inclusive rate. For RHCs the Part B deductible for screening AAA is waived for dates of service on or after January 1, 2007. FQHC services are always exempt from the Part B deductible. Coinsurance is applicable. Additional information on AAA can be found in Chapter 18, section 110 of this manual.

If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or Part A MAC using TOBs 71X and 73X/*77X*, respectively, and the appropriate site of service revenue code in the 052X revenue code series and must include HCPCS *code* G0389.

If the AAA screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier or Part B MAC under the practitioner's ID following instructions for submitting practitioner claims.

If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI or Part A MAC under the base provider's ID, following instructions for submitting claims to the FI/Part A MAC from the base provider.

181 - Diabetes Self-Management Training (DSMT) Services Provided by RHCs and FQHCs

(Rev. 2034, Issued: 08-24-10, Effective: 01-01-11, Implementation: 01-03-11)

A - FQHCs

Previously, DSMT type services rendered by qualified registered dietitians or nutrition professionals were considered incident to services under the FQHC benefit, if all relevant program requirements were met. Therefore, separate all-inclusive encounter rate payment could not be made for the provision of DSMT services. With passage of DRA, effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these services provided they meet all program requirements. See Pub. 100-04, chapter 18, section 120. Payment is made at the all-inclusive encounter rate to the FQHC. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying DSMT services.

For FQHCs to qualify for a separate visit payment for DSMT services, the services must be a one-on-one face-to-face encounter. Group sessions don't constitute a billable visit for any FQHC services. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate. To receive separate payment for DSMT services, the DSMT services must be billed on TOB 73x/*77x* with HCPCS code G0108 and the appropriate site of service revenue code in the 052X revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service that the beneficiary received qualifying DSMT services as long as the claim for DSMT services contains the appropriate coding specified above. Additional information on DSMT can be found in Chapter 18, section 120 of this manual.

NOTE: DSMT is not a qualifying visit on the same day that MNT is provided.

Group services (G0109) do not meet the criteria for a separate qualifying encounter. All line items billed on TOBs 73x/*77x* with HCPCS codes for DSMT services will be denied.

B - RHCs

Separate payment to RHCs for these practitioners/services continues to be precluded as these services are not within the scope of Medicare-covered RHC benefits. Note that the provision of the services by registered dietitians or nutritional professionals, might be considered incident to services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.

182 – Medical Nutrition Therapy (MNT) Services

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A - FQHCs

Previously, MNT type services were considered incident to services under the FQHC benefit, if all relevant program requirements were met. Therefore, separate all-inclusive encounter rate payment could not be made for the provision of MNT services. With passage of DRA, effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these services provided they meet all program requirements. Payment is made at the all-inclusive encounter rate to the FQHC. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying MNT services.

For FQHCs to qualify for a separate visit payment for MNT services, the services must be a one-on-one face-to-face encounter. Group sessions don't constitute a billable visit for any FQHC services. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate. To receive payment for MNT services, the MNT services must be billed on TOB 73/x*77x* with the appropriate individual MNT HCPCS code (97802, 97803, or G0270) and with the appropriate site of service revenue code in the 052X revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying MNT services as long as the claim for MNT services contain the appropriate coding specified above.

NOTE: MNT is not a qualifying visit on the same day that DSMT is provided.

Additional information on MNT can be found in Chapter 4, section 300 of this manual. Group services (HCPCS *code* 97804 or G0271) do not meet the criteria for a separate qualifying encounter. All line items billed on TOB 73x/*77x* with HCPCS code 97804 or G0271 will be denied.

B - RHCs

Separate payment to RHCs for these practitioners/services continues to be precluded as these services are not within the scope of Medicare-covered RHC benefits. All line items billed on TOB 71x with HCPCS codes for MNT services will be denied.