CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 477	**Date: APRIL 24, 2009**
	Change Request 6338

Subject: Change Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73x to 77x

I. SUMMARY OF CHANGES: On August 5, 2008, the National Uniform Billing Committee (NUBC) voted to change the TOB that is used to identify FQHCs from 73x to 77x effective April 1, 2010. Medicare fee for service payer and provider systems will need to change in order to accommodate this change of bill type in the Health Insurance Portability and Accountability Act (HIPAA)-approved institutional code set. All CMS Internet Only Manuals containing reference to TOB 73x will be updated once the transition is complete.

EFFECTIVE DATE: April 1, 2010
IMPLEMENTATION DATES: October 5, 2009 **All entities other than FISS**
October 5, 2009 **FISS Implementation:** Phase 1
January 4, 2010 **FISS Implementation:** Phase 2

For this Change Request, the implementation dates precede the effective date to allow for shared-system and/or business process updates before new claims processing policies take effect.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
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):
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:

One-Time Notification

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

Attachment – One-Time Notification

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IMPLEMENTATION DATES: October 5, 2009 **All entities other than FISS**
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For this Change Request, the implementation date precedes the effective date to allow for shared-system and/or business process updates before new claims processing policies take effect.

I. GENERAL INFORMATION

A. Background: On August 5, 2008, the National Uniform Billing Committee (NUBC) voted to change the TOB that is used to identify FQHCs from 73x to 77x effective April 1, 2010. The NUBC created the new TOB for FQHCs because TOB 73x, which has historically been used for FQHCs, is technically designed to apply to free-standing clinics of any kind. An FQHC TOB distinct from the TOB used by free-standing clinics will allow all payers to identify FQHCs separately from free-standing clinics allowing for consistent and appropriate adjudication. Most Medicare fee for service payer and provider systems will need to change in order to accommodate this change of bill type in the Health Insurance Portability and Accountability Act (HIPAA)-approved institutional code set. Under the new Medicare Administrative Contractor (MAC) environment, all MACs will eventually be processing FQHC claims, so plan accordingly.

TOB 77x will be used for both free-standing and provider-based FQHCs. All CMS Internet Only Manuals containing references to TOB 73x will be updated once the transition period is complete. For dates of service (DOS) on or after April 1, 2010, TOB 73x will continue to be a valid bill type for certain non-Medicare claims. See NUBC requirements for further details.

B. **Policy:** To implement this NUBC mandated change, all Medicare fee for service system owners and users (FIs, A/B MACs, shared system maintainers along with all downstream systems) shall change the allowed TOB for FQHCs from 73x to 77x effective for all claims with DOS on or after April 1, 2010. Contractors shall Return to Provider (RTP) all Medicare FQHC 73X TOBs for DOS on or after April 1, 2010.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

NUMBER	REQUIREMENT	RESPONSIBILITY									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6338.1	Effective October 5, 2009, all contractors shall	X		X			X	X		X	All down

NUMBER	REQUIREMENT	RESPONSIBILITY									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	implement the TOB change for FQHCs from 73x to 77x for all claims with DOS on or after April 1, 2010. NOTE: FISS will implement Phase 1. Phase 2 will be implemented January 4, 2010.										stream systems *
6338.1.1	Contractors shall update all affected edit/reason codes and update all files containing this TOB element.	X		X			X	X		X	All down stream systems *
6338.1.2	Contractors shall allow for OSCAR logic changes that include changes to the National Provider Identifier 1 to many combination.	X		X			X	X		X	All down stream systems *
6338.1.3	Contractors shall modify LCDs to allow for this TOB change allowing for various DOS parameters.	X		X							
6338.2	Contractors shall RTP all Medicare FQHC 73X TOBs for DOS on or after April 1, 2010 with group code CO, adjustment reason code 5, and MSN message 16.13.	X		X							

* All Downstream Systems:

National Claims History (NCH)
Medicare Quality Assurance (MQA)
Integrated Outpatient Code Editor (IOCE)
Healthcare Integrated General Ledger Accounting System (HIGLAS)
Provider Statistical & Reimbursement (PS&R)
System Tracking for Audit & Reimbursement (STAR)
Coordination of Benefits Contractor (COBC)
Next Generation Desktop (NGD)
Medicare Beneficiary Database (MBD)
Risk Adjustment System (RAS)/Risk Adjustment Processing System (RAPS)
Automated Reporting and Tracking System (ARTS)
Medicare Provider Analysis & Review System
Medicare Integrated Data Repository (IDR)
Regional Data Exchange System (RDES)
National Medicare Utilization Data Base (NMUD)
Data Extract System (DESY)
Quality Improvement Organization (QIO)
Online Survey Certification and Reporting System (OSCAR)
Medicare Coverage Database (MCD)
Systematic MSP Automated Recovery Tracking (SMART) System
Expert Claim Process System (ECPS)

III. PROVIDER EDUCATION TABLE

NUMBER	REQUIREMENT	RESPONSIBILITY									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6338.3	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 administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

X-REF REQUIREMENT NUMBER	RECOMMENDATIONS OR OTHER SUPPORTING INFORMATION
N/A	

Section B: All other recommendations and supporting information:

CR 6246 Analysis of System Changes Needed to Change TOB for FQHCs from 73x to 77x, transmittal R388OTN, dated 10/24/2008.

V. CONTACTS

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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.