CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 820

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 1, 2006

Change Request 4210

SUBJECT: Sites of Service Revenue Codes for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

I. SUMMARY OF CHANGES: This CR changes the revenue codes both RHCs and FQHCs use when billing for RHC/FQHC services.

NEW/REVISED MATERIAL
EFFECTIVE DATE: July 1, 2006
IMPLEMENTATION DATE: July 3, 2006

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	9/100/General Billing Requirements

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 820	Date: February 1, 2006	Change Request 4210

SUBJECT: Sites of Service Revenue Codes for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

I. GENERAL INFORMATION

A. Background: Currently**,** FQHCs bill most FQHC services, except for those subject to the Medicare outpatient mental health treatment limitation, under one revenue code, 0520. RHCs bill most RHC services, except for those subject to the Medicare outpatient mental health treatment limitation, under revenue code 0521. Occasionally, RHCs use revenue code 0522 to bill when RHC services are provided in the beneficiary's home.

CMS requested a redefinition of revenue codes 0521 and 0522 to include FQHC services as well as RHC services. CMS also requested the addition of revenue codes 0524, 0525, 0527 and 0528 to provide the Agency with information needed to improve administration of the RHC and FQHC programs. These revenue code changes will allow for the identification of various types of claims which will be useful in gathering the data necessary for evaluating any expansion of the RHC/FQHC programs and will allow for various reviews to ensure the integrity of the program. The National Uniform Billing Committee approved our request on December 14, 2005.

B. Policy:

For all claims for RHC and FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the telehealth originating site facility fee or for the FQHC supplement payment (FQHCs only), with line item dates of service on or after July 1, 2006, providers shall use the following revenue codes:

Revenue Code	Requested Change
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)

NOTE: For claims with line item dates of service (LIDOS) on or after July 1, 2006, fiscal intermediaries (FIs) shall continue to accept revenue code 0519 from FQHCs when billing for the FQHC supplemental payment. FIs shall also continue to accept revenue code 0900 from both RHCs and FQHCs when billing for services subject to the Medicare outpatient mental health treatment limitation and revenue code 0780 when billing for the telehealth originating site facility fee.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	**Requirements**	**Responsibility ("X" indicates the columns that apply)**								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4210.1	Medicare contractors shall accept revenue codes 0521, 0522, 0524, 0525, 0527 & 0528 on claims for FQHC and RHC services for LIDOS on or after July 1, 2006. These revenue codes are defined as follows**:** o 0521 = Clinic visit by member to RHC/FQHC; o 0522 = Home visit by RHC/FQHC practitioner; o 0524 = Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF; o 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;	X				X			X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	o 0527 = RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area; and o 0528 = Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident).									
4210.2	FIs shall educate RHCs and FQHCs that claims previously billed with revenue codes 0520, 0521 and 0522 are to be billed using the revenue codes in 4210.1 to reflect the location in which the service is rendered when the LIDOS is on or after July 1, 2006.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4210.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 1 week of the availability of the provider	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: Approval of coding changes by the NUBC

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2006 **Implementation Date:** July 3, 2006 **Pre-Implementation Contact(s):**	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

Gertrude Saunders, 410-786-5888 gertrude.saunders@cms.hhs.gov & Cindy Murphy, 410-786-5733 cindy.murphy@cms.hhs.gov **Post-Implementation Contact(s):** Your local regional office	

*__Unless otherwise specified, the effective date is the date of service.__

100 - General Billing Requirements

(Rev.820, Issued: 02-01-06, Effective: 07-01-06, Implementation: 07-03-06)

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 UB-92 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*; h*owever RHC*s and* FQHC*s are limited* to the revenue codes listed in B-Service Level Information, below.

- *See the Medicare Claims Processing Manual on the CMS website 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, 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 benefit*s 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 benefit*s* are professional, meaning the hands-on delivery of care by medical professionals. *S*ome preventive services, however, *are* also encompassed in primary care under the benefit*s*, 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 benefit*s*, 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* benefit*s* are reimbursed through a single 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

RHCs *and* FQHCs bill FIs on institutional claims, either on the *ASC* 837I *ANSI X-12 format for institutional claims* or the UB-92/Form CMS-1450, using type of bill (TOB) 71x for RHC*s*, and 73x for FQHC*s*.

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

- Bill types 71x and 73x 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 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 = non-payment/zero claim (a claim with only noncovered charges)
    - 711 or 731 = Admit through discharge (original claim)
    - 717 or 737 = Replacement of prior claim (adjustment)
    - 718 or 738 =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 claims are defined as outpatient institutional claims under HIPAA and should follow *the* guidelines *below:*

B. Service-Level Information

Only *four* types of services are billed on TOBs 71x and 73x:

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

All charges are entered in the following revenue code lines:

- 052x – Free-Standing Clinic; or
- 0900 – Behavioral Health Treatment/Services, General Classification *(previously 0910)* ;
- 0780 –Telemedicine, General Classification*; and/or*
- *0519 - Clinic, Other Clinic (only for the FQHC supplemental payment)*

NOTE: 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 052x, "Free-Standing Clinic", is used to bill for all professional services under the RHC *and* FQHC benefit*s, other than those services subject to the Medicare outpatient mental health treatment limitation (0900) or for the FQHC supplement payment (0519) (FQHCs only).*

- *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)*

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.

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/73x that are NOT part of the RHC *and* FQHC benefits.

- 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 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.

For dates of service from January 1, 2002, through March 31, 2005, HCPCS codes were required for selected screening and preventive services *with statutory frequency limitations*. For details, see *section 120 of this chapter* and chapter 18 of this manual (http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf). Additionally, Independent FQHC services were billed using one of five HCPCS codes, and hospital-based FQHC services were billed with one of a series of HCPCS codes. The hospital-based HCPCS codes were 99201-99205 and 99211-99215 *respectively*. Effective with dates of service on and after April 1, 2005, RHCs *and* FQHCs are no longer required to use HCPCS codes when billing for RHC *or* FQHC services. Charges *for each visit* are *combined and* entered on *one* revenue code line.

- 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. Technical services specifically included in th*ese* benefit*s* or expressly applicable to the 71x/73x 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* benefit*s* are performed in association with professional services or components of services billed on 71x/73x 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.