

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3434	Date: December 31, 2015
	Change Request 9397

SUBJECT: Reorganization of Chapter 9

I. SUMMARY OF CHANGES: Chapter 9 of the Claims Processing Manual has been reorganized and updated.

EFFECTIVE DATE: March 31, 2016

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

IMPLEMENTATION DATE: March 31, 2016

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	Table of Contents
R	9/Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Services

III. FUNDING:

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**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3434	Date: December 31, 2015	Change Request: 9397
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SUBJECT: Reorganization of Chapter 9

EFFECTIVE DATE: March 31, 2016

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I. GENERAL INFORMATION

A. Background: Chapter 9 of the Medicare Claims Processing Manual, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), is being revised to include more comprehensive billing information.

B. Policy: There are no new policies contained in the manual.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
9397.1	Contractors shall be aware of the updated content of Pub. 100-04, Chapter 9.	X									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
9397.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are	X				

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

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:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): TRACEY mackey, 410-786-5736 or tracey.mackey@cms.hhs.gov , JASON KERR, 410-786-2123 or JASON.KERR@CMS.HHS.GOV

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

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

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(Rev. 3434)

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10 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) General Information

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

10.1 - RHC General Information

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs are facilities that provide services that are typically furnished in an outpatient clinic setting. The statutory requirements that RHCs must meet to qualify for the Medicare benefit are in §1861(aa) (2) of the Social Security Act (the Act).

A RHC visit is defined as a medically-necessary, face-to-face (one-on-one) medical or mental health visit, or a qualified preventive health visit, with a RHC practitioner during which time one or more RHC services are rendered. A RHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW). A Transitional Care Management (TCM) service can also be a RHC visit. A RHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions.

RHCs can be either independent or provider-based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (MAC). They are assigned a CMS Certification Number (CCN) in the range of XX3800-XX3974 or XX8900-XX8999. Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH), skilled nursing facility (SNF), or a home health agency (HHA)).

Information on RHC covered services, visits, payment policies, and other information can be found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 13, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>.

Information on certification requirements can be found in Pub. 100-07, Medicare State Operations Manual, Chapter 2, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf>.

10.2 - FQHC General Information

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs are facilities that provide services that are typically furnished in an outpatient clinic setting. FQHC services consist of services that are similar to those furnished in RHCs. The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in §1861(aa)(4) of the Act. An entity that qualifies as a FQHC is assigned a CCN in the range of XX1000-XX1199 or XX1800-XX1989.

NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to tribal or urban Indian FQHCs or grandfathered tribal (GFT) FQHCs.

20 - RHC and FQHC All-Inclusive Rate (AIR) Payment System

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

20.1 – Per Visit Payment and Exceptions under the AIR

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs and FQHCs are paid an AIR per visit, except for FQHCs that have transitioned to the Medicare Prospective Payment System (PPS). For RHCs and FQHCs billing under the AIR, more than one

medically-necessary face-to-face visit with a RHC or FQHC practitioner on the same day is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC/FQHC);*
- The patient has a medical visit and a mental health visit on the same day;*
- The patient has an Initial Preventive Physical Examination (IPPE) and a separate qualified medical and/or mental health visit on the same day;*
- The patient has a Diabetes Self-Management Training (DSMT) or Medical Nutrition Therapy (MNT) visit on the same day as an otherwise payable medical visit. DSMT and MNT apply to FQHCs only.*

20.2 – Payment Limit under the AIR

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

For RHCs and FQHCs that bill under the AIR, Medicare pays 80 percent of the RHC or FQHC's AIR, subject to a payment limit, except for RHCs that have an exception to the payment limit. An interim rate for newly certified RHCs, and for FQHCs certified prior to October 1, 2014, is established based on the RHC's or FQHC's anticipated average cost for direct and supporting services. At the end of the cost reporting period, the MAC determines the total payment due and reconciles payments made during the period with the total payments due.

For FQHCs paid under the AIR, there is a payment limit for FQHCs located in an urban area and a payment limit for FQHCs located in a rural area. Urban FQHCs are those located within a Metropolitan Statistical Area (MSA). Rural FQHCs cannot be reclassified into an urban area (as determined by the Bureau of Census) for FQHC payment limit purposes. If the FQHC organization includes both urban and rural sites and the FQHC organization files a consolidated cost report, the FQHC is paid the lower of the FQHC organization's AIR or a single weighted payment limit calculated for the entire FQHC organization. The payment limit is weighted by the percentage of urban and rural visits as a percentage of total visits for the entire FQHC organization.

RHCs and FQHCs paid under the AIR are required to file a cost report annually in order to determine their payment rate. If a RHC or FQHC is in its initial reporting period, the MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

For information on cost reporting requirements, see the Medicare Provider Reimbursement Manual (PRM), at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>

30 – FQHC PPS Payment System

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

30.1 – Per-Diem Payment and Exceptions under the PPS

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added section 1834(o) of the Social Security Act to establish a Medicare PPS for FQHC services. FQHCs transition to the Medicare PPS beginning on October 1, 2014, based on their cost-reporting period. All FQHCs are expected to be transitioned to the PPS by December 31, 2015.

For FQHCs paid under the PPS, Medicare payment is based on the lesser of the FQHC's actual charge or the PPS rate, as determined by the MAC. The FQHC PPS rate will be updated annually beginning January 1, 2016.

For FQHCs billing under the PPS, more than one medically-necessary face-to-face visit with a FQHC practitioner on the same day is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the FQHC),*
- The patient has a medical visit and a mental health visit on the same day.*

Separate payment is not made to FQHCs under the PPS for an IPPE or DSMT/MNT visit that is furnished on the same day as another FQHC medical visit.

30.2 – Adjustments under the PPS

((Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

The FQHC PPS rate will be adjusted to account for geographic differences in costs by the FQHC geographic adjustment factor (FQHC GAF). In calculating the PPS rate, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

The FQHC PPS rate for a covered visit will be calculated as follows:

$$\text{Base payment rate} \times \text{FQHC GAF} = \text{PPS rate}$$

Updates to the FQHC GAFs will be made in conjunction with updates to the Physician Fee Schedule Geographic Practice Cost Indices for the same period and will be posted on CMS's FQHC PPS webpage at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html>.

The PPS per-diem rate will be adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC (has not been a patient at any site that is part of the FQHC organization within the previous 3 years) or to a beneficiary receiving an IPPE or an annual wellness visit (AWV). This is a composite adjustment factor and only one adjustment per day can be applied.

If the patient is new to the FQHC, or the FQHC furnishes an Initial Preventive Physical Examination (IPPE) or Annual Wellness Visit (AWV), the FQHC PPS rate for a covered visit will be calculated as follows:

$$\text{Base payment rate} \times \text{FQHC GAF} \times 1.3416 = \text{PPS rate}$$

For more information on the FQHC PPS, please see the FQHC PPS Final Rule located at: <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

40 - Deductible and Coinsurance

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

40.1 - Part B Deductible

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHC services are subject to an annual deductible of twenty percent of charges for covered services. Effective for dates of service on or after January 1, 2011, the deductible is not applicable for certain preventive services. Please see section 80 for more information on how to bill for preventive services.

RHCs collect the patient's deductible or the portion of the patient's deductible that has not already been met. Once RHCs have billed the MAC for services, they do not collect or accept any additional money from the patient for their deductible until the MAC notifies the RHC of how much of the deductible has been met.

The Part B deductible does not apply to FQHC services.

40.2 - Part B Coinsurance

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

After any applicable deductibles have been satisfied, RHCs and FQHCs paid under the AIR system will be paid 80 percent of their AIR. The patient is responsible for a coinsurance amount of 20 percent of the charges after deduction of the deductible, where applicable.

Effective for dates of service on or after January 1, 2011, coinsurance is not applicable for certain preventive services. See section 80 of this manual for information on how to bill for preventive services on a RHC and FQHC claims.

FQHCs paid under the PPS will be paid 80 percent of the lesser of the FQHC's actual charge for the specific payment code or the adjusted PPS rate. The patient is responsible for a coinsurance amount of 20 percent of the lesser of the FQHC's actual charge for the specific payment code or the adjusted PPS rate. See section 60.2 for more information on the FQHC specific payment codes.

50 - General Requirements for RHC and FQHC Claims

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 for coverage requirements for RHCs and FQHCs. This section addresses requirements for claim submission only.

Section §1862 (a)(22) of the Act requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic format required for billing RHC and FQHC services is the ASC X12 837 institutional claim transaction. Instructions relative to the data element names on the Form CMS-1450 hardcopy form are described below. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names is found in Chapter 25.

Not all data elements are required or utilized by all payers. Detailed information is given only for items required for Medicare RHC and FQHC claims. Only the items listed below are required for RHCs and FQHCs.

Provider Name, Address, and Telephone Number, Form Locator (FL) 01

The RHC/FQHC enters this information for their agency.

Type of Bill, FL 4

This four-digit alphanumeric code gives three specific pieces of information. The first digit is a leading zero. CMS ignores the first digit. The second digit identifies the type of facility. The third classifies the

type of care. The fourth indicates the sequence of this bill in this particular benefit period. It is referred to as a “frequency” code.

Code Structure

<i>1st Digit – Leading Zero</i>
<i>CMS ignores the first digit</i>

<i>2nd Digit - Type of Facility</i>
<i>7 - Special facility (Clinic)</i>

<i>3rd Digit - Classification (Special Facility Only)</i>
<i>1 – Rural Health Clinic</i>
<i>7 – Federally Qualified Health Centers</i>

<i>4th Digit – Frequency</i>	<i>Definition</i>
<i>0 - Nonpayment/Zero Claims</i>	<i>Used when no payment from Medicare is anticipated.</i>
<i>1 - Admit Through Discharge Claim</i>	<i>This code is used for a billing for a confined treatment.</i>
<i>7 - Replacement of Prior Claim</i>	<i>This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or “new” bill.</i> <i>For additional information on replacement bills see Chapter 3.</i>
<i>8 - Void/Cancel of a Prior Claim</i>	<i>This code is used to cancel a previously processed claim.</i> <i>For additional information on void/cancel bills see Chapter 3.</i>

Statement Covers Period (From-Through), FL 06

The RHC/FQHC shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY).

Patient Name/Identifier, FL 08

The RHC/FQHC enters the beneficiary’s name exactly as it appears on the Medicare card.

Patient Address, FL 09

The RHC/FQHC enters the mailing address of the patient. Enter the complete mailing address.

Patient Birth date, FL10

The RHC/FQHC enters the date of birth of the patient.

Patient Sex, FL 11

The RHC/FQHC enters the sex of the patient as recorded at the start of care.

Priority (Type) of Admission or Visit, FL14

The RHC/FQHC enters the most appropriate NUBC approved code indicating the priority of the visit.

Point of Origin for Admission or Visit, FL 15

The RHC/FQHC enters the most appropriate NUBC approved code indicating the point of origin for this admission or visit.

Patient Discharge Status, FL 16

The RHC/FQHC enters the most appropriate NUBC approved code indicating the patient's status as of the "Through" date of the billing period.

Condition Codes, FL 18-28

The RHC/FQHC enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing.

Value Codes and Amounts, FL 39-41

The RHC/FQHC enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing.

Revenue Codes, FL42

The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge.

For FQHC claims with dates of service on or after January 1, 2010, FQHCs may report additional revenue codes when describing services rendered during an encounter. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in the following table:

<i>Code</i>	<i>Description</i>
<i>0521</i>	<i>Clinic visit by member to RHC/FQHC</i>
<i>0522</i>	<i>Home visit by RHC/FQHC practitioner</i>
<i>0524</i>	<i>Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF</i>
<i>0525</i>	<i>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</i>
<i>0527</i>	<i>RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area</i>
<i>0528</i>	<i>Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)</i>
<i>0519</i>	<i>Clinic, Other Clinic (only for the FQHC supplemental payment)</i>

Code	Description
0900	Mental Health Treatment/Services

When billing for additional services rendered during the FQHCs encounter, any valid revenue codes may be used with a HCPCS code. However, the following revenue codes are not allowed on FQHC claims: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x.

HCPCS/Accommodation Rates/HIPPS Rate Codes, FL 44

For all services provided in a FQHC on or after January 1, 2010 and for approved preventive services provided in a RHC, HCPCS codes are required to be reported on the service lines.

The following HCPCS codes must be reported on FQHC PPS claims:

HCPCS Code	Definition
G0466	<i>FQHC visit, new patient A medically-necessary, face-to-face encounter (one-on-one) 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 a FQHC visit.</i>
G0467	<i>FQHC visit, established patient A medically-necessary, face-to-face encounter (one-on-one) 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 a FQHC visit.</i>
G0468	<i>FQHC visit, IPPE or AWW A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.</i>
G0469	<i>FQHC visit, mental health, new patient A medically-necessary, face-to-face mental health encounter (one-on-one) 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 a mental health visit.</i>
G0470	<i>FQHC visit, mental health, established patient A medically-necessary, face-to-face mental health encounter (one-on-one) 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 a mental health visit.</i>

Modifiers, FL 44

The FQHC reports modifier 59 when billing for a subsequent injury or illness. This is not to be used when a patient sees more than one practitioner on the same day, or has multiple encounters with the same practitioner on the same day, unless the patient, subsequent to the first visit, leaves the FQHC and then suffers an illness or injury that requires additional diagnosis or treatment on the same day.

Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left

the FQHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit).

For claims subject to the FQHC PPS, modifier 59 is only valid with FQHC Payment Code G0467. Please see section 60.2 of this manual for more information on the FQHC Payment Codes.

Service Date, FL 45

Medicare requires a line item dates of service for all outpatient claims. Medicare classifies RHC/FQHC claims as outpatient claims. Non-payment service revenue codes – report dates as described in the table above under Revenue Codes.

Line items on outpatient claims under HIPAA require reporting of a line-item service date for each iteration of revenue code. A single date must be reported on a line item for the date the service was provided, not a range of dates.

For services that do not qualify as a billable visit, the usual charges for the services are added to those of the qualified visit. RHCs/FQHCs use the date of the visit as the single date on the line item. If there is no billable visit associated with the services, then no claim is filed.

Service Units, FL 46

The RHC/FQHC enters the number of units for each type of service. Units represent visits, which are paid based on the AIR or the FQHC PPS, 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 injury suffered later on the same day.

Total Charges, FL 47

The RHC/FQHC enters the total charge for the service described on each revenue code line.

Payer Name, FL 50

The RHC/FQHC identifies the appropriate payer(s) for the claim.

National Provider Identifier (NPI) – Billing Provider, FL 56

The RHC/FQHC enters its own NPI. When more than one encounter/visits is reported on the same claim i.e., medical and mental health visits, please choose the NPI of the provider that furnished the majority of the services.

Principal Diagnosis Code, FL 67

The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

Other Diagnosis Codes, FL 67A-Q

The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

Attending Provider Name and Identifiers, FL 76

The RHC/FQHC enters the NPI and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care.

Other Provider Name and Identifiers, FL78-79

The RHC/FQHC enters the NPI and name

NOTE: *For electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.*

60 - Billing Requirements for RHCs and FQHCs

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs and FQHCs are institutional claims and are submitted to the MAC on TOB 71x and 77x. 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>.)

All professional services in the RHC and FQHC benefit are paid through the AIR system or the FQHC PPS payment for each patient encounter or visit. Technical services (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims.

For FQHCs with cost reporting periods beginning on or after October 1, 2014, all services are paid according to the FQHC PPS methodology. The visit rate includes: covered services provided by a FQHC practitioner and services and supplies furnished incident to the visit. For additional information on FQHC services, see the Medicare Policy Manual, Chapter 13.

60.1 – Billing Guidelines for RHCs and FQHC Claims under the AIR System (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

When billing Medicare, FQHCs must report all services provided during the encounter/visit by listing the appropriate HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes. RHCs are only required to report the appropriate revenue code for medical and mental health services.

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. For FQHCs, payment is applied to the service line with revenue code 052X and a valid evaluation and management (E&M) HCPCS code for medical visits and revenue code 0900 for mental health visits. Since RHCs are not required to report detailed HCPCS codes, the payment is applied to the service line with revenue code 052X for medical and revenue code 0900 for mental health visits. However, an additional AIR payment may be made for IPPE, DSMT or MNT (FQHCs only), and a subsequent illness and injuries billed with modifier 59 (FQHCs only).

When reporting multiple services on FQHC claims, the 052X revenue line with the E&M HCPCS code must include the total charges for all of the services provided during the encounter, minus any charges for approved preventive services.

For approved preventive services with a grade of A or B from the United States Preventive Services Task Force (USPSTF), the charges for these services must be deducted from the E&M HCPCS code for the purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is \$350.00, and \$50.00 of that is for a qualified preventive service, the beneficiary coinsurance is based on \$300.00 of the total charge.

For Example:

Rev Code	HCPCS code	Modifier	Date of Service	Charges
0521	E&M code*		01/01	300.00
0771	Preventive Service code		01/01	50.00

* RHCs are not required to report a HCPCS code.

Medicare will make an additional AIR payment for IPPE, when billed on the same day with a qualified encounter/visit. When reporting an additional encounter/visit for IPPE, the FQHC or RHC reports the appropriate HCPCS code for the service. The revenue lines should be reflected as follows:

For Example:

Rev Code	HCPCS code	Modifier	Date of Service	Charges
0521	Office Visit		01/01	75.00
0419	Breathing Treatment		01/01	75.00
0521	IPPE		01/01	150.00

For FQHCs, Medicare will make an additional AIR payment for a subsequent illness or injury that occurs on the same day. This is reported on the claim with an additional service line with revenue code 052X, a valid HCPCS code and modifier 59. Please see section 50 for more information on reporting modifier 59.

For Example:

Rev Code	HCPCS code	Modifier	Date of service	Charges
0521	Office Visit		01/01	150.00
0479	Removal of Wax From Ear		01/01	50.00
0521	Office Visit	59	01/01	135.00
0271	Wound Cleaning		01/01	25.00
0279	Bone Setting With Casting		01/01	95.00

Medicare will make an additional AIR payment to FQHCs when DSMT or MNT is reported on the same day with a qualified encounter/visit. When reporting an additional encounter/visit for DSMT or MNT Report the appropriate HCPCS code for the service. The revenue lines should be reflected as follows:

For Example:

Rev Code	HCPCS code	Modifier	Date of Service	Charges
0521	Office Visit		01/01	75.00
0419	Breathing Treatment		01/01	75.00
0521	DSMT or MNT		01/01	150.00

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, the reporting of these codes are informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines and their administration through the cost report.

60.2 – Billing for FQHC Claims Paid under the PPS (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs transitioning to the PPS must submit separate claims for services subject to the PPS and services paid under the AIR.

CMS established five FQHC payment specific codes to be used by FQHCs submitting claims under the PPS. When reporting an encounter/visit for payment, the FQHC must bill on the claim (77X TOB) a FQHC specific payment code.

FQHC Specific Payment Codes

G0466 – FQHC visit, new patient

A medically-necessary, face-to-face encounter (one-on-one) 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 a FQHC visit.

G0467 – FQHC visit, established patient

A medically-necessary, face-to-face encounter (one-on-one) 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 a FQHC visit.

G0468 – FQHC visit, IPPE or AWW

A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.

G0469– FQHC visit, mental health, new patient

A medically-necessary, face-to-face mental health encounter (one-on-one) 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 a mental health visit.

G0470 – FQHC visit, mental health, established patient

A medically-necessary, face-to-face mental health encounter (one-on-one) 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 a mental health visit.

FQHCs must use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052X or 0519.

NOTE: *Revenue code 0519 is used for Medicare Advantage (MA) Supplemental claims only.*

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must report HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges. The additional services reported on the claim that are part of the FQHC encounter, will not be paid. The payment for these services is included in the payment under the FQHC payment code.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit. The link below contains the list of the qualifying visits for each payment specific code:

For example:

<i>Revenue Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0467 – FQHC Payment code		10/01
0521	99213 – Qualifying visit		10/01

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

For example:

<i>Revenue Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0468 – FQHC Payment code		10/01
0521	G0439 – Qualifying visit		10/01
0900	G0470 – FQHC Payment code		10/01
0900	90832 -Qualifying visit		10/01

When submitting a claim for a subsequent illness or injury, the FQHCs reports G0467 for a medical visit), with modifier 59. A qualifying visit is still required when reporting modifier 59 with G0467.

<i>Revenue Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Service Date</i>
0521	G0468 – FQHC Payment code		10/01
0521	G0439 – Qualifying visit		10/01
0521	G0467 – FQHC Payment code	59	10/01
0900	99211 -Qualifying visit		10/01

FQHCs must report all services that occurred on the same day on one claim. FQHC may submit claims that span multiple days of service. However, for FQHCs transitioning to the PPS, a separate claim must be submitted for services subject to the PPS and services paid based on the AIR. MACs will reject claims with multiple dates of service that include both PPS and non-PPS dates, as determined based on the individual FQHC’s cost reporting period.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

60.3-Payments for FQHC PPS Claims

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Payment for FQHC PPS claims is made by comparing the adjusted FQHC PPS rate to the total submitted covered charges reported for the specific payment codes G0466, G0467, G0468, G0469, and G0470.

To calculate payment, follow the steps below:

Step 1: Determine the lesser of the provider's submitted charges for the specific payment code(s) and the fully-adjusted PPS rate.

Step 2: Determine if preventive services for which the coinsurance is waived are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.

(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: *If no preventive services are present, use the lesser of the providers charge for the specific payment code(s) or the PPS rate as the Step 3 total.*

Step 4: Multiply the total from Step 3 by 80%.

Step 3 total * 80% = Step 4 total

Note: *If no preventive services are present, contractors will pay this amount and skip step 5.*

Step 5: Add the charges for the approved preventive services to the total from step 4.

Contractors will pay this amount.

Step 4 total + preventive services charges = Medicare Payment

Note: *If the charges for the approved preventive services are greater than the total payment amount identified in Step 1 (i.e., the lesser of the charges for the specific payment code or the PPS rate), pay 100% of the total payment amount determined in Step 1 and do not apply coinsurance. (Please see example 3)*

To calculate coinsurance, follow the steps below:

Step 1: Determine the lesser of the submitted charges for the G-code (s) and the PPS rate.

Step 2: Determine if approved preventive services (i.e., preventive services for which coinsurance is waived) are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.

(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: *If no approved preventive services are present, use the lesser the provider's charge for the specific payment code(s) or the PPS rate as the Step 3 total.*

Step 4: Multiply the total from Step 3 by 20%.

Step 3 total * 20% = Coinsurance

- **Example: Payment based on the charges**

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0467 = \$150

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0467		10/01	150.00	150.00
0521	99213		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0001				310.00	310.00

The comparison is between the PPS rate and the provider's \$150 actual charge for the specific payment code, G0467. In this case, the sum of the line items exceeds the provider's actual charge for the payment code.

Payment based on the provider's charge of 150.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Coinsurance
0521	G0467		10/01	150.00	150.00	120.00	30.00
0521	99213		10/01	135.00	135.00	CO 97*	0
0300	36415		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = 150.00 (charges) * 80%

Coinsurance = 150.00 (charges) * 20%

For service lines that do not receive payment, group code CO- contractual obligation and the appropriate claim adjustment reason code (CARC) will be used.

* CARC 97 – the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

• **Example: Payment based on the charges with approved preventive service**

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = \$150

Preventive Service = 135.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	150.00	150.00
0521	G0439 PS**		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0001				310.00	310.00

Payment based on the provider's actual charge of 150.00 for the specific payment code, G0468.

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	150.00	150.00	147.00	3.00
0521	G0439 PS		10/01	135.00	135.00	CO 97*	0
0300	36415		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 135.00 (preventive service G0439)) * 80% + 135.00 preventive service

Coinsurance = (150.00 (charges) – 135.00 (preventive service G0439)) * 20%

- ** PS – Preventive Service -These are approved preventive services where the coinsurance is waived based on the USPSTF recommendation.

Example: Payment based on the charges when preventive service is greater than G-code

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = \$150 Preventive Service = 155.00

REV CODE	HCPC	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	150.00	150.00
0521	G0439 PS		10/01	155.00	155.00
0300	36415		10/01	25.00	25.00
0001				330.00	330.00

Payment based on charges of 150.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	150.00	150.00	150.00	0
0521	G0439 PS		10/01	155.00	155.00	CO 97*	0
0300	36415		10/01	25.00	25.00	CO 97	0
0001				330.00	330.00		

Payment = (150.00 (charges) * 100% = 150.00

Since the charges for the preventive service, G0439 are greater than the provider's actual charge for the specific payment code G0468, Medicare pays 100% of the provider's actual charge for the specific payment code, G0468.

Reporting Multiple G-codes

When a FQHC reports multiple specific payment codes (G-codes) on the same day, the total payment amount will be determined by comparing the sum of the charges for all the G-codes reported to the PPS rate. When a qualified mental health visit occurs on the same day as a qualified medical visit, the G-codes will be totaled separately (see example 8).

Listed below is the order in which payment will be applied when multiple G-codes are reported on the same day:

Medical visits:

- G0468-IPPE or AWW
- G0466-Medical, new patient
- G0467-Established patient

Mental health visits:

- G0469-Mental health, new patient
- G0470- Mental health, established patient

When G0466 (Medical, new patient) and G0468 (IPPE or AWW) are reported together, the add-on payment will be applied to G0468.

• **Example: Payment based on PPS rate with multiple G-codes and preventive services**

Because this scenario does not qualify for an exception to a per diem payment, the system will calculate and apply a PPS rate to only one of the specific payment codes. However, the FQHC may list its actual charges for both specific payment codes, and the comparison would be between the PPS rate and the total of the provider's charges for the specific payment codes. Payment would be based on the lesser amount.

PPS RATE, reflecting a 1.3416 adjustment for new patients or a visit including an IPPE or AWW = 215.00

Total of provider charges for the specific payment codes (170.00 + 65.00) = 235.00

Provider's charge for the Preventive Service = 135.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	170.00	170.00
0521	G0438 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0466		10/01	65.00	65.00
0521	92004		10/01	45.00	45.00
0001				440.00	440.00

Payment based on adjusted PPS rate of 215.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Coinsurance
0521	G0468		10/01	170.00	170.00	199.00	16.00
0521	G0438 PS		10/01	135.00	135.00	CO 97	0

0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0466		10/01	65.00	65.00	CO 97	0
0521	92004		10/01	45.00	45.00	CO 97	0
0001				440.00	440.00		

*Payment = (215.00 (PPS rate) – 135.00 (preventive service G0438) * 80% + 135.00 preventive service
 Coinsurance = (215.00 (PPS rate) – 135.00 (preventive service G0438)) * 20%*

Reporting Multiple Preventive Services

When multiple preventive services are reported on the same day, the coinsurance will be determined by carving out the total preventive services charges.

- Example: Payment based on PPS rate with multiple G-codes and multiple preventive services***

PPS RATE = 225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00

Total Preventive Services (135.00 + 60.00) = 195.00

<i>REV CODE</i>	<i>HCPC CODE</i>	<i>MODS</i>	<i>SERV DATE</i>	<i>TOTAL CHARGE</i>	<i>COV CHARGE</i>
0521	G0468		10/01	140.00	140.00
0521	G0439 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0467		10/01	75.00	75.00
0521	97802 PS		10/01	60.00	60.00
0521	G0466		10/01	55.00	55.00
0521	92004		10/01	45.00	45.00
0001				535.00	535.00

Payment based on PPS rate of 225.00

<i>REV CODE</i>	<i>HCPC CODE</i>	<i>MODS</i>	<i>SERV DATE</i>	<i>TOTAL CHARGE</i>	<i>COV CHARGE</i>	<i>Payment</i>	<i>Co-insurance</i>
0521	G0468		10/01	140.00	140.00	219.00	6.00
0521	G0439 PS		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0467		10/01	75.00	75.00	CO 97	0
0521	97802 PS		10/01	60.00	60.00	CO 97	0

0521	G0466		10/01	55.00	55.00	CO 97	0
0521	92004		10/01	45.00	45.00	CO 97	0
0001				535.00	535.00		

$Payment = (225.00 - (135.00 + 60.00)) * 80\% + 135.00 + 60.00$

$Coinsurance = (225.00 (PPS rate) - (135.00 + 60.00)) * 20\%$

Influenza and Pneumococcal Pneumonia Vaccination (PPV)

Flu and PPV vaccines and their administration will continue to be paid through the cost report. However, these services should be reported on the claim for information purposes only. Flu and PPV vaccines and their administration codes will not be carved out of the coinsurance calculation.

- **Example: Payment based on charges with Flu and Flu administration code services**

PPS rate = 160.00

Preventive Service = 135.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	150.00	150.00
0521	G0438 PS		10/01	135.00	135.00
0636	90655		10/01	15.00	15.00
771	G0008		10/01	5.00	5.00
0001				305.00	305.00

Payment based on charges of 150.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	150.00	150.00	150.00	0
0521	G0438 PS		10/01	135.00	135.00	CO 97	0
0636	90655 ****		10/01	15.00	15.00	CO 246***	0
0771	G0008 ****		10/01	5.00	5.00	CO 246	0
0001				305.00	305.00		

Because flu and PPV are reported on the claim for information purposes only, G0438 remains as the only service payable on this claim. Because the claim consists solely of preventive services for which

coinsurance is waived, the contractor will pay 100% of the provider's actual charge for the specific payment code, G0468.

*** CARC 246- This non-payable code is for required reporting only.

**** Flu/PPV are reported on the claim for information purposes only, the payment and coinsurance are not impacted by the charges associated with the Flu/PPV vaccine and their administration code.

Hepatitis B

Hepatitis B should be reported on the claim and is included in the claim payment. These services will be carved out of the coinsurance calculation.

- **Example: Payment based on charges with Hepatitis B**

PPS rate= 160.00

Preventive Services = 20.00 (15.00 +5.00)

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0467		10/01	150.00	150.00
0521	99213		10/01	135.00	135.00
0300	36415		10/01	5.00	5.00
0636	90746 PS		10/01	15.00	15.00
771	G0010 PS		10/01	5.00	5.00
0001				310.00	310.00

Payment based on charges of 150.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0467		10/01	150.00	150.00	124.00	26.00
0521	99213		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	5.00	5.00	CO 97	0
0636	90746 PS		10/01	15.00	15.00	CO 97	0
0771	G0010 PS		10/01	5.00	5.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 80% + 20.00 preventive

Coinsurance = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 20%

Mental Health Services

Qualified mental health visits billed under revenue code 0900 receive an additional payment when billed on the same day as a medical visit.

- **Example: Mental Health Services**

PPS RATE for G0468: \$225.00

PPS rate for G0470: \$160

Total of provider's actual charges for the specific payment codes representing medical visits (140.00 + 75.00 + 55.00) = 270.00- This does not include charges for G0470

Provider's charge for the specific payment code representing mental health services = 159.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	140.00	140.00
0521	G0439 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0467		10/01	75.00	75.00
0521	97802 PS		10/01	60.00	60.00
0521	G0466		10/01	55.00	55.00
0521	92004		10/01	45.00	45.00
0900	G0470		10/01	159.00	159.00
0900	90832		10/01	139.00	139.00
0636	J3490		10/01	15.00	15.00
0001				848.00	848.00

Payment based on PPS rate of 225.00 for the specific payment codes describing the medical visits and based on the provider's actual charges for the specific payment code describing the mental health visit.

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	140.00	140.00	219.00	6.00
0521	G0439 PS		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0467		10/01	75.00	75.00	CO 97	0
0521	97802 PS		10/01	60.00	60.00	CO 97	0
0521	G0466		10/01	55.00	55.00	CO 97	0

0521	92004		10/01	45.00	45.00	CO 97	0
0900	G0470		10/01	159.00	159.00	127.20	31.80
0900	90832		10/01	139.00	139.00	CO 97	0
0636	J3490		10/01	15.00	15.00	CO 97	0
0001				848.00	848.00		

For Medical visit with revenue code 052X

*Payment = (225.00 – (135.00 + 60.00)) * 80% + 135.00 + 60.00*

*Coinsurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%*

For Mental Health visit with revenue code 0900

*Payment = 159.00 * 80% = 127.20*

*Coinsurance = 159.00 * 20% = 31.80*

Modifier 59

Medicare allows for an additional payment when an illness or injury occurs subsequent to the initial visit, and the FQHC bills these visits with the specific payment codes and modifier 59. Services billed with a modifier 59 will be paid an additional per diem rate.

- **Example: Modifier 59**

PPS rate for G0468 = 225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00 – This does not include charges for G0470 and G-code charges for modifier 59

Total mental Health Services = 159.00

PPS rate for G0467 (billed with Modifier 59) = 160.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	140.00	140.00
0521	G0438 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0467		10/01	75.00	75.00
0521	97802 PS		10/01	60.00	60.00
0521	G0466		10/01	55.00	55.00
0521	92004		10/01	45.00	45.00
0900	G0470		10/01	159.00	159.00
0900	90832		10/01	139.00	139.00
0636	J3490		10/01	15.00	15.00

0521	G0467	59	10/01	165.00	165.00
0521	99211		10/01	105.00	105.00
0001				1118.00	1118.00

Payment based on PPS rate of 225.00 for the G-codes, based on the charges for the mental health visit and based on the PPS rate for G0467 billed with modifier 59.

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Coinsurance
0521	G0468		10/01	140.00	140.00	219.00	6.00
0521	G0438 PS		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0467		10/01	75.00	75.00	CO 97	0
0521	97802 PS		10/01	60.00	60.00	CO 97	0
0521	G0466		10/01	55.00	55.00	CO 97	0
0521	92004		10/01	45.00	45.00	CO 97	0
0900	G0470		10/01	159.00	159.00	127.20	31.80
0900	90832		10/01	139.00	139.00	CO 97	0
0636	J3490		10/01	15.00	15.00	CO 97	0
0521	G0467	59	10/01	165.00	165.00	128.00	32.00
0521	99211		10/01	105.00	105.00	CO 97	0
0001				1118.00	1118.00		

For Medical visit with revenue code 052X

$$\text{Payment} = (225.00 - (135.00 + 60.00)) * 80\% + 135.00 + 60.00$$

$$\text{Coinsurance} = (225.00 \text{ (PPS rate)} - (135.00 + 60.00)) * 20\%$$

For Mental Health visit with revenue code 0900

$$\text{Payment} = 159.00 * 80\% = 127.20$$

$$\text{Coinsurance} = 159.00 * 20\% = 31.80$$

For G0467 billed with modifier 59

$$\text{Payment} = 160.00 * 80\% = 128.00$$

$$\text{Coinsurance} = 160.00 * 20\% = 32.00$$

60.4 – Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Section 237 of the Medicare Modernization Act (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 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 per diem 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 MAC. The MAC determines if the Medicare 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.

FQHCs seeking the supplemental payment are required to submit (for the first two rate years) to the MAC an estimate of the average MA payments (per visit basis) for covered FQHC services. They are 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 MAC 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 MAC 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 MAC.

Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the MAC on type of bill (TOB) 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 052X 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 MAC based on cost report data, MACs 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 MAC receives information that changes in service patterns that will result in a different interim rate. MACs 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 when 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.

MACs 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. MACs shall RTP such claims to the FQHCs. MACs shall accept TOB 77x with revenue code 0519 and pay the interim supplemental payment rate for each qualified visit billed.

Billing for Supplemental Payments under the AIR

When billing for supplemental payment to the MAC, the encounter is reported on type of bill (TOB) 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. HCPCS coding is not required.

For Example:

<i>Rev Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Date of Service</i>	<i>Charges</i>
<i>0519</i>	<i>blank</i>		<i>01/01</i>	<i>150.00</i>

Billing for Supplemental Payments under the PPS

When billing for supplemental payment to the MAC under the PPS, a FQHC payment specific code and a qualifying visit must be reported under revenue code 0519.

For example:

<i>Revenue Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Service Date</i>
<i>0519</i>	<i>G0467 – FQHC Payment code</i>		<i>10/01</i>
<i>0519</i>	<i>99213 – Qualifying visit</i>		<i>10/01</i>

60.5 – PPS Payments to FQHCs under Contract with MA Plans (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

For claims with the 0519 revenue code, the wraparound payment is based on the PPS rate without comparison to the provider’s charge. The rate is also NOT adjusted for coinsurance or preventive services as the MA plan would have already assessed any applicable coinsurance and related waivers of coinsurance.

Medicare will compare the PPS rate with the MA contract rate for a FQHC visit.

When the MA contract rate is lower than the applicable PPS rate that would otherwise have been paid by traditional Medicare had the beneficiary not been covered by the MA plan, the contractor will pay the difference as a supplemental wraparound payment.

The FQHC does not qualify for a supplemental wraparound payment when the MA contract rate is higher than the applicable PPS rate that would otherwise have been paid by traditional Medicare had the beneficiary not be covered by the MA plan.

- Example: MA Claim that Qualifies for a Supplemental Wraparound Payment**

PPS Rate = \$225

<i>Rev</i>	<i>HCPC</i>	<i>MODS</i>	<i>SERV DATE</i>	<i>TOTAL CHARGE</i>	<i>COV CHARGE</i>
0519	G0468		10/01	170.00	170.00
0519	G0439 PS		10/01	150.00	150.00
0001				320.00	320.00

If the MA contract rate is lower than the applicable PPS rate – e.g., \$200:

Wraparound payment = PPS rate – MA contract rate = \$225 - \$200 = \$25

Note that the charge of \$170 would reflect the FQHC’s typical charge for G0468, but would not be used to calculate the supplemental payment.

- Example : MA Claim that Does Not Qualify for a Supplemental Wraparound Payment**

PPS Rate = \$225

<i>Rev</i>	<i>HCPC</i>	<i>MODS</i>	<i>SERV DATE</i>	<i>TOTAL CHARGE</i>	<i>COV CHARGE</i>
0519	G0468		10/01	170.00	170.00
0519	G0439 PS		10/01	150.00	150.00
0001				320.00	320.00

If the MA contract rate was higher than the applicable PPS rate – e.g., the MA contract rate was \$250- no wraparound payment is due to the FQHC.

70 – General Billing Requirements for Preventive Services

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Professional components of preventive services are covered under the RHC and FQHC benefit. The payment for most preventive services is included with a qualified visit as part of the overall encounter/visit. To ensure coinsurance and deductible (deductible applies to RHC claims only) are applied correctly, detailed HCPCS coding is required for approved preventive services recommended by the USPSTF with a grade of A or B for TOBs 71x or 77x. Additionally, RHCs/FQHCs are required to report HCPCS codes for certain preventive services subject to frequency limits.

70.1 - RHCs Billing Approved Preventive Services

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service HCPCS code and the associated charges. For example, if the total charge for the visit is \$150.00, and \$50.00 of that is a qualified preventive service, the service lines should be coded as follows:

<i>Revenue Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Service Date</i>	<i>Charges</i>
0521	<i>Encounter = Blank or valid HCPCS code</i>		10/01	100.00
0521	<i>Preventive Service Code</i>		10/01	50.00

In the example above, the encounter service line will receive the AIR payment. The charges reported on this line should not include the charges for the approved preventive service. Coinsurance and deductible will be accessed based on the charges reported on this service line. The qualified preventive service reported on the additional service line will not receive payment, as payment is made under the AIR for the services reported under the encounter service line. Coinsurance and deductible are accessed based on the charges reported on the preventive services line.

70.2 - FQHCs Billing Approved Preventive Services under the AIR (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Detailed HCPCS codes are required for all service lines. When reporting the encounter/visit, revenue code 052X for medical and revenue code 0900 for mental health visits must be used. For additional services, the most appropriate revenue code for the service rendered should be used.

<i>Revenue Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Service Date</i>	<i>Charges</i>
0521	<i>Encounter = E&M HCPCS code</i>		10/01	100.00
0771	<i>Preventive Service Code</i>		10/01	50.00

In the example above, the services reported under the encounter/visit service line will receive the AIR payment. The charges reported on this line should not include the charges for the approved preventive service. Since deductible does not apply to FQHC claims, only coinsurance will be applied to the charges reported on the encounter service line. The qualified preventive service reported on the second revenue line will not receive payment. Coinsurance and deductible are not accessed to the services reported under the preventive services line.

70.3 - FQHC Billing Approved Preventive Services under the PPS (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

*An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service HCPCS code and the associated charges. For example, if the total charge for the visit is \$150.00, report the total charges for the encounter. **NOTE:** Do not carve out the charges for the approved preventive services. The service lines should be coded as follows:*

<i>Revenue Code</i>	<i>HCPCS code</i>	<i>Modifier</i>	<i>Service Date</i>	<i>Charges</i>
0521	<i>Encounter = FQHC Payment Code (G-code) code</i>		10/01	150.00
0771	<i>Preventive Service code</i>		10/01	75.00

*In the example above, the services reported under the encounter/visit service line will receive the PPS payment. The charges reported on this line **should** include the charges for the approved preventive service. The coinsurance will be applied to the charges reported on the encounter service line. Coinsurance will not be applied to the charges reported for the approved preventive service. The qualified preventive service reported on the second revenue line will not receive payment. **NOTE:** A qualified HCPCS code visit must be reported if the preventive service is not a qualified visit.*

70.4 - Vaccines

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x claim. However, FQHCs must report these services with their charges on the 77x claim for informational and data collection purposes only.

The costs for the influenza virus or pneumococcal pneumonia vaccines for RHCs and FQHCs are included in the cost report. Neither coinsurance nor deductible apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. An encounter cannot be billed if vaccine administration is the only service the RHC/FQHC provides.

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 13.

70.5 – Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs billing under the AIR system

Payment is made at the all-inclusive encounter rate to the FQHC for DSMT or MNT. This payment can be in addition to payment for another 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 or MNT services, the services must be a one-on-one face-to-face encounter. Group sessions do not constitute a billable visit for any FQHC services. To receive separate payment for DSMT or MNT services, the services must be billed on TOB 77x with HCPCS code G0108 (DSMT) or HCPCS code 97802, 97803, or G0270 (MNT) 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/MNT services as long as the claim for DSMT/MNT services contains the appropriate coding specified above. Additional information on DSMT can be found in Chapter 18, section 120 of Pub. 100-04.

Additional information on MNT can be found in Chapter 4, section 300 of Pub. 100-04.

Group services (G0109, 97804 and G0271) do not meet the criteria for a separate qualifying encounter. All line items billed on TOBs 77x with group services will be denied.

DSMT and MNT services are subject to the frequency edits described in Pub. 100-04, Chapter 18, and should not be reported on the same day.

FQHCs billing under the PPS

DSMT and MNT are qualifying visits when billed under G0466 or G0467. For additional information on the payment specific codes and qualifying visits, see section 60.2 of this manual. Under the FQHC PPS, DSMT and MNT do not qualify for a separate payment when billed on the same day with another qualified visit.

RHCs

RHCs are not paid separately for DSMT and MNT services. All line items billed on TOB 71x with HCPCS codes for DSMT and MNT services will be denied.

70.6 - Initial Preventive Physical Examination (IPPE)

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs and RHCs billing under the AIR system

Medicare provides for coverage for one IPPE for new beneficiaries only, subject to certain eligibility and other limitations.

Payment for the professional services will be made under the AIR. However, RHCs/FQHCs can receive a separate payment for an encounter in addition to the payment for the IPPE when they are performed on the same day.

When IPPE is provided in an RHC or FQHC, the professional portion of the service is billed on TOBs 71X and 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 Pub. 100-04.

EKGs

The professional component is included in the AIR or FQHC PPS and is not separately billable.

The technical component of an EKG performed at a RHC/FQHC billed to Medicare on professional claims (Form CMS-1500 or 837P) under the practitioner's ID following instructions for submitting practitioner claims for independent/freestanding clinics. Practitioners at provider-based clinics bill the applicable TOB to the A/B MAC using the base provider's ID.

FQHCs billing under the PPS:

IPPE is qualifying visits when billed under G0468, for additional information on the payment specific codes and qualifying visits, please refer to section 60.2 of this manual. Under the FQHC PPS, IPPE does not qualify for a separate payment when billed on the same day with another encounter/visit.

80 -Telehealth Services

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs and FQHCs may bill the Telehealth originating site facility fee on a RHC or FQHC claim under revenue code 0780 and HCPCS code Q3014. Telehealth services are the only services billed on FQHC claims that are subject to the Part B deductible. Additionally, a FQHC payment code and qualifying visit HCPCS code are not required when the only service reported on the claim is for Telehealth services. RHCs and FQHCs are not authorized to serve as distant practitioners for Telehealth services.

*For more information on Telehealth services please see Pub 100-04, chapter 12, section 190:
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>*

90- Services non-Covered on RHC and FQHC Claims

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Technical Services

RHCs/FQHCs do not bill using TOBs 71x or 77x for technical components of services because they are not within the scope of Medicare-covered RHC/FQHC services. The associated technical components of services furnished by the RHC/FQHC are billed on other types of claims that are subject to applicable frequency limits edits.

For services that can be split into professional and technical components, RHCs and FQHCs bill for the professional component as part of the AIR or the FQHC PPS payment and bill the MAC separately for the technical component. See Chapter 17, section 30.1.1, for more information on how RHCs and FQHCs can bill the MAC for laboratory services. See Chapter 13 for more information on how to bill the MAC for technical components of diagnostic services.

- *Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are submitted to the MAC 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 submitted by the base-provider on the appropriate TOB to the MAC in the designated claim format (837I or the UB-04 claim form); 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.*

Laboratory Services

RHCs must furnish the following lab services to be approved as an RHC. However, these and other lab services that may be furnished are not included in the encounter rate and must be billed separately.

- *Chemical examinations of urine by stick or tablet method or both;*

- *Hemoglobin or hematocrit;*

- *Blood sugar;*

- *Examination of stool specimens for occult blood;*

- *Pregnancy tests; and*

- *Primary culturing for transmittal to a certified laboratory (No CPT code available).*

RHCs/FQHCs bill all laboratory services to their MAC under the host provider's bill type and payment is made under the fee schedule. HCPCS codes are required for lab services.

Venipuncture is included in the AIR and the PPS per diem payment and is not separately billable.

Refer to Chapter 16 for general billing instructions.

Durable Medical Equipment (DME), ambulance services, hospital-based services, group services, and non-face-to-face services are also non-covered and are billed separately.

*When billing these services on FQHC PPS claims, a FQHC payment code and qualifying visit HCPCS code is **not** required.*

100- Frequency of Billing and Same Day Billing

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

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.

RHCs and FQHCs billing under the FQHC PPS may submit claims that span multiple days of service.

FQHCs billing under the PPS must submit all services that are rendered on the same day on one claim. 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 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, and Medicare Summary Notices.*
- *Contact your MAC for basic training and orientation material if needed.*