| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 3000** | **Date: July 25, 2014** |
| | **Change Request 8670** |

**SUBJECT: Update to Pub. 100-04, Chapter 09 to Provide Language-Only Changes for Updating ASC X12**

**I. SUMMARY OF CHANGES:** This Change Request contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter [09]. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

**EFFECTIVE DATE: January 1, 2012**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: August 25, 2014**

***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:**
**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 obliged 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: 3000 | Date: July 25, 2014 | Change Request: 8670 |
|---|---|---|---|

**SUBJECT: Update to Pub. 100-04, Chapter 09 to Provide Language-Only Changes for Updating ASC X12**

**EFFECTIVE DATE: January 1, 2012**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: August 25, 2014**

## I. GENERAL INFORMATION

**A. Background:** This Change Request contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 09.

**B. Policy:** There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 8670.1 | A/B MACs shall be aware of the updated language for ASC X12 in Pub. 100 - 04, Chapter 09. | X | X | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"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):** Not Applicable

**Post-Implementation Contact(s):** Not Applicable

## 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

### 100 - General Billing Requirements
***(Rev. 3000; Issued: 07/25/14; Effective: 01-01-12; Implementation: 08-25-14)***

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

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

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

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

For Medicare institutional claims:

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

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

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

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

- Contact your *A/B MAC (A)* for basic training and orientation material if needed.

The focus of this chapter is RHCs and FQHCs, meaning only institutional claims using TOBs 71x and 73x/77x, not any other provider or claim types. Professional claims completed by physicians and non-institutional practitioners are sent to Medicare *A/B MACs (B)* in the ASC *X12* 837 *professional claim* format or, *if permissible*, on Form CMS-1500.

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

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

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

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

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

**A. Claim-Level Information**

The RHCs and FQHCs bill *A/B MACs (A)* on institutional claims *using* the ASC X12 *837 institutional claim* format *or, if permissible,* Form CMS-1450, using type of bill (TOB) 71x for RHCs, and 73x/77x for FQHCs.

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

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

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

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

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

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

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

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

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

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

**B. Service-Level Information**

The types of services billed on TOBs 71x:

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

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

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

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

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

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

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

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

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

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

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

- For dates of service prior to July 1, 2006, the values for all four digits of revenue code 052x are:
  - 0520 = Free-Standing Clinic – to be used by all FQHCs;
  - 0521 = Rural Health Clinic – to be used by RHCs; and
  - 0522 = Rural Health Home – to be used by RHCs in home settings.
- For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment (FQHCs only):
  - 0521 = Clinic visit by member to RHC/FQHC;
  - 0522 = Home visit by RHC/FQHC practitioner;
  - 0524 = Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF;

- 0525 = Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility;

- 0527 = RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area; and

- 0528 = Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)

- 0519 = Clinic, Other Clinic (only for the FQHC supplemental payment)

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

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

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

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

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

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

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

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

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

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

- Units are reported based on visits, which are paid based on the all-inclusive rate no matter how many services are delivered. Only one visit is billed per day unless the patient leaves and later returns with a different illness or impairment suffered later on the same day (and medical records should support

these cases). Units for visits are to be reported under revenue codes 052x or 0900 (0910 depending on the date), as applicable.

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

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

- Technical services/components associated with professional services/ components performed by independent RHCs or FQHCs are billed to Medicare *A/B MACs (B)* 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 *A/B MAC (A)*; 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.