CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3415	**Date: November 23, 2015**
	Change Request 9267

Transmittal 3313, dated August 6, 2015, is being rescinded and replaced by Transmittal 3415, dated November 23, 2015, to add a provider education requirement and updated references to the Physician Fee Schedule Proposed and Final Rules. This Transmittal is no longer sensitive/controversial, and may be posted to the Internet. All other information remains the same.

SUBJECT: Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) that were Provider-Based Clinics on or Before April 7, 2000

I. SUMMARY OF CHANGES: This CR provides instructions to the Medicare Administrative Contractors (MACs) for payment to grandfathered tribal federally qualified health centers (FQHCs) that were provider-based clinics on or before April 7, 2000.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 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	1/190/Payer Only Codes Utilized by Medicare

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: 3415	Date: November 23, 2015	Change Request: 9267

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I. GENERAL INFORMATION

A. Background: In 1976, the Indian Health Care Improvement Act (IHCIA, P.L. 94-437) amended the statute to permit payment by Medicare and Medicaid for services provided to American Indians and Alaskan Natives (AI/ANs) in Indian Health Service (IHS) and tribal health care facilities that meet the applicable requirements.

In 1978, CMS agreed to use a Medicare all-inclusive payment rate for IHS hospitals and IHS hospital-based clinics. Payment rates for inpatient and outpatient medical care furnished by the IHS and tribal facilities is set annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service (PHS) Act (42 U.S.C. 248 and 249(b)), Public Law 83–568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1601 et seq.), based on the previous year's cost reports from federal and tribal hospitals. The Medicare outpatient rate is only applicable for those IHS or tribal facilities that meet the definition of a provider-based department as described at 42 CFR 413.65(a), or a "grandfathered" facility as described at 42 CFR 413.65(m).

In the CY 2001 Hospital Outpatient Prospective Payment System (PPS) final rule with comment period (65 FR 18507), we adopted regulations at §413.65 that established criteria for facilities to be considered provider-based to a hospital for Medicare payment purposes. We also recognized the special relationship between tribes and the United States government, and did not apply the general provider-based criteria to IHS and tribally-operated facilities. The regulations currently include a "grandfathering" provision at §413.65(m) for IHS and tribal facilities that were provider-based to a hospital on or prior to April 7, 2000.

Under the authority of the Indian Self Determination Education Assistance Act (ISDEAA), a tribe may assume control of an IHS hospital and the provider-based clinics affiliated with the hospital, or may only assume responsibility of the provider-based clinic.

On August 11, 2003, CMS issued a letter to Trailblazer Health Enterprises, LLC, stating that changes in the status of a hospital or facility from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital, would not affect the facility's grandfathered status if the resulting configuration is one which would have qualified for grandfathering under section 413.65(m) if it had been in effect on April 7, 2000.

The Medicare Conditions of Participation (CoPs) for Medicare-participating hospitals at 42 CFR 482.12 require administrative and clinical integration between a hospital and its clinics, departments, and provider-based entities. A tribal clinic billing under an IHS hospital's CMS Certification Number (CCN), without any additional administrative or clinical relationship with the IHS hospital, could put that hospital at risk for

non-compliance with the CoPs.

In order to maintain access to care for AI/AN populations served by these hospitals and clinics, while also ensuring that these facilities are in compliance with health and safety rules, a different structure is warranted. In the CY 2016 PFS proposed rule (80 FR 41799), we proposed that IHS and tribal facilities that were provider-based to a hospital that meet certain qualifications may seek to become certified as grandfathered tribal FQHCs and proposed a payment methodology for grandfathered tribal FQHCs. We finalized the payment requirements and methodology for grandfathered tribal FQHCs in the CY 2016 PFS final rule with comment period (80 FR 71089).

B. Policy: Effective for dates of service on or after January 1, 2016. IHS and tribal facilities and organizations that met the conditions of section 413.65(m) on or before April 7, 2000, and have a change in their status on or after April 7, 2000 from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the CoPs, may seek to become certified as grandfathered tribal FQHCs. These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements.

The FQHC PPS adjustment for grandfathered tribal clinics would not apply to a currently certified tribal FQHC, a tribal clinic that was not provider-based as of April 7, 2000, or an IHS-operated clinic that is no longer provider-based to a tribally-operated hospital. This provision would also not apply in those instances where both the hospital and its provider-based clinic(s) are operated by the tribe or tribal organization.

Grandfathered tribal FQHCs will be paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

From January 1, 2015 through December 31, 2015, the grandfathered tribal FQHC PPS rate is $307. The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS Geographic Adjustment Factor (GAF) or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an IPPE or an AWV. The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the Medicare Economic Index (MEI) or a FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the grandfathered tribal FQHC PPS rate.

Grandfathered tribal FQHCs will be paid for services included in the FQHC benefit, even if those services are not included in the IHS Medicare outpatient all-inclusive rate. Services that are included in the IHS outpatient all-inclusive rate but not in the FQHC benefit will not be paid.

Grandfathered tribal FQHCs are subject to the payment requirements under the FQHC PPS. The five FQHC payment G-codes shall be used by grandfathered tribal FQHCs when submitting claims under the PPS based on the services furnished. Grandfathered tribal FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment. Each grandfathered tribal FQHC shall report a charge for the visit code that would reflect the sum of regular rates charged to both beneficiaries and other patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary. Additional information on the coverage and payment requirements for FQHC visits can be found in Pub 100-02, Chapter 13. Additional information regarding the services that are qualifying visits can be found on the FQHC PPS center page web site (http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html).

Contractors shall generally pay 80 percent of the lesser of the grandfathered tribal FQHC's charge for the FQHC payment code or the grandfathered tribal FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the grandfathered tribal FQHC PPS rate. For claims that consist solely of preventive services that are exempt from beneficiary coinsurance, contractors shall pay 100 percent of the lesser of the actual charge or the grandfathered tribal FQHC PPS rate, and no beneficiary coinsurance would

be assessed.

For claims that include a mix of preventive and non-preventive services, contractors shall use the current methodology established under the FQHC PPS to calculate coinsurance. Contractors shall suppress the Medicare Summary Notice for Grandfathered Tribal FQHC claims. Additional information on claims processing requirements can be found in Pub. 100-04, chapter 18.

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	
9267.1	Contractors shall create a user controlled indicator to identify Grandfathered Tribal FQHCs. The valid values should be 'Y' , 'N' or blank.					X				
9267.2	Contractors shall update the indicator with a ‘Y’ using the CMS supplied listing of Grandfathered Tribal FQHCs.	X								
9267.2.1	Contractors shall ensure the IHS/ASC Cert indicator contains a ‘Y’ or ‘X’ when the Grandfathered Tribal FQHC field created in business requirement 9267.1 is populated with a ‘Y’.	X				X				
9267.3	Contractors shall assign payer only condition code 'MG' to all FQHCs claim with a ‘Y’ in the Grandfathered Tribal FQHC field created in requirement 9267.1.					X				IOCE
9267.3.1	Contractors shall pass payer only condition code 'MG' to the IOCE.					X				
9267.3.2	Contractors shall ensure payer only condition code 'MG' is not be passed to the Benefit Coordinator and Recovery Center (BCRC).					X				
9267.4	The IOCE shall assign payment indicator (PI) of 14 to Grandfathered Tribal FQHC claims with payer only condition code 'MG' when identifying payment lines.									IOCE
9267.5	Contractors shall accept the following return codes from the FQHC PRICER for Grandfathered Tribal FQHC claims.					X				FQHC Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	21- Line Processed-Payment based on Grandfathered Tribal FQHC payment 22-Line Processed- Payment based on Grandfathered Tribal FQHC submitted charges									
9267.6	Contractors shall suppress the Medicare Summary Notice for Grandfathered Tribal FQHC claims with condition code 'MG'.	X				X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9267.7	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 free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

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): Simone Dennis, 410-786-8409 or Simone.Dennis@cms.hhs.gov , Tracey Mackey, 410-786-5736 or Tracey.Mackey@hhs.cms.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

190 – Payer Only Codes Utilized by Medicare

(Rev.3415, Issued, Effective: 01-01-16, Implementation: 01-04-16)

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes

12-14 - Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

60 – Operating Cost Day Outlier.

61 – Operating Cost Outlier.

62 – PIP Bill.

63 – Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

M0 – All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 – Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.

M3 – M9 Not used by Medicare.

MA – GI Bleed.

MB – Pneumonia.

MC – Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH-MZ – Not currently used by Medicare.

UU – Not currently used by Medicare.

Occurrence Codes

23 - Date of Cancellation of Hospice Election period.

48-49 – Not currently used by Medicare.

Occurrence Span Codes

79 - Verified non-covered stay dates for which the provider is liable.

Value Codes

17- Operating Outlier Amount – The A/B MAC (A) reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The A/B MAC (A) REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 - Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

63 –HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The A/B MAC (A) reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 – Low volume hospital payment amount

75- Prior covered days for an interrupted stay.

76 – Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 – Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 – Accountable Care Organization reduction.

Q1 - Q9 – Not used by Medicare.