CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 371 **Date: NOVEMBER 19, 2004**

CHANGE REQUEST 3487

SUBJECT: Updated Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

I. SUMMARY OF CHANGES: The general billing instructions in chapters 9, 18 and 32 of Pub. 100-04, Medicare Claims Processing Manual are being updated to: (1) provide more detailed instructions overall; (2) eliminate the HCPCS coding for FQHCs; (3) eliminate the additional line item reporting for certain preventive services when billed on TOBs 71x and 73x and (4) except for the telehealth originating site facility fees reported using revenue code 0780, requires all charges to only be reported on the revenue code line for the encounter, 052x or 0900/0910.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	9/Table of Contents
R	9/100/General Billing Requirements
R	9/110/Special FQHC Requirements
N	9/110.1/Reporting of Preventive Services in the FQHC Benefit by Independent FQHCs
N	9/110.2/Reporting of Specific HCPCS Codes for Hospital-based FQHCs
R	9/120/General Billing Requirements for Preventive Services
R	18/10.2.2/Bills Submitted to FIs
R	18/10.2.2.2/Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs)
R	18/10.3.2/Claims Submitted to Intermediaries for Mass Immunizations of Influenza and PPV

R	18/20.3.2.2/Payment for Computer Add-on Diagnostic and Screening Mammograms for FIs and Carriers
R	18/20.4.1.1/RHC/FQHC Claims with Dates of Service Prior to January 1, 2002
R	18/20.4.1.2/RHC/FQHC Claims with Dates of Service on or After January 1, 2002
R	18/30.5/HCPCS Codes for Billing
R	18/70.1.1.1/Additional Coding Applicable to Claims Submitted to FIs
R	18/70.1.1.2/Special Billing Instructions for RHCs and FQHCs
R	32/11.1/Electrical Stimulation
R	32/11.2/Electromagnetic Therapy

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 371	Date: November 19, 2004	Change Request 3487

SUBJECT: Updated Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

I. GENERAL INFORMATION

A. Background: The general billing instructions in chapters 9, 18 and 32 of Pub.100-04, Medicare Claims Processing Manual are being updated to provide more detailed instructions overall. In addition we are eliminating the HCPCS coding for independent FQHCs and hospital-based FQHCs. Independent FQHCs are currently required to report one of five designated HCPCS codes on each line item billed. Hospital-based FQHCs are currently required to report HCPCS codes for each encounter. Also, we are eliminating the additional line item reporting for preventive services (RHCs/FQHCs only). Currently, RHCs and FQHCs are required to report a second line item when certain preventive services are billed. Currently, the second revenue code line for reporting preventive services may contain charges. Except for the telehealth originating site facility fee reported using revenue code 0780, all charges must now be reported on the revenue code line for the encounter, 052x or 0900/0910.

B. Policy: RHCs and FQHCs will no longer report additional line items when billing for preventive services on TOBs 71X and 73X. In addition, independent FQHCs will no longer be required to report one of five designated HCPCS codes for each line item on the bill. Hospital-based FQHCs will no longer be required to report HCPCS codes for each FQHC service line item on the bill. Also, except for the telehealth originating site facility fee reported using revenue code 0780, all charges must now be reported on the revenue code line for the encounter, 052x or 0900/0910 or the claim will be returned to the provider.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3487.1	FIs, FISS and CWF shall eliminate the requirement for HCPCS coding for all FQHC services billed on TOB 73X for claims with dates of service on or after April 1, 2005.	X				X			X	
3487.2	FIs, FISS and CWF shall eliminate the requirement for additional line item coding when billing for Medicare preventive services on TOBs 71X and 73X for claims with dates of service on or after April 1, 2005.	X				X			X	
3487.3	CWF shall eliminate all frequency edits from CWF for TOBs 71X and 73X.								X	
3487.4	FIs shall only allow revenue codes 052x, 0780, 0900 and 0910 on TOBs 71X and 73X. FIs shall RTP any claims that do not meet this requirement.	X								
3487.5	FIs shall educate providers of these changes.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Gertrude Saunders, 410-786-5888 or Cindy Murphy, 410-786-5733 **Post-Implementation Contact(s):** Gertrude Saunders, 410-786-5888 or Cindy Murphy, 410-786-5733	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

Medicare Claims Processing Manual

Chapter 9 - Rural Health Clinics / Federally Qualified Health Centers

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Table of Contents

(Rev. 371, Issued: 11-19-04)

Crosswalk to Source Material

100 - General Billing Requirements

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

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/104_claims/clm104c01.pdf) for general claims processing information;*

- Chapter 2, *"Admission and Registration Requirements,"* (*http://www.cms.hhs.gov/manuals/104_claims/clm104c02.pdf)* for general filing requirements applicable to all providers.

For Medicare institutional claims:

- *See Chapter 25 "Completing and Processing UB-92 Data Set" (http://www.cms.hhs.gov/manuals/104_claims/clm104c25.pdf) for general requirements for completing the institutional claim data set (paper, flat file, and HIPAA Version (837)).*

NOTE: *Chapter 25 lists all revenue codes available. However, RHC/FQHC is limited to the revenue codes listed in B-Service Level Information, below.*

Additionally, see §10.3 *in this chapter* for jurisdiction *of RHC/FQHC* claims.

- General *Medicare institutional claims processing* requirements, such as for timely filing and payment, admission processing, Medicare Summary Notices, and *required claim* data elements are applicable to RHCs and FQHCs.

- *Any institutional provider, including RHCs/FQHCs, should contact their fiscal intermediary (FI) for basic training and orientation material if needed.*

The focus of this chapter is RHCs/FQHCs, meaning only institutional claims using TOBs 71x and 73x, not any other provider or claim types. Professional claims, completed by physicians and non-institutional practitioners, are sent to Medicare carriers on Form CMS-1500 or 837 HIPAA professional claim.

Generally, it is only services that are part of the RHC or FQHC benefit that are billed on these claims, and there are limited services provided under this benefit. The RHC/FQHC benefit provides specific primary or professional medical services, equivalent to certain physician or practitioner services, to Medicare beneficiaries in underserved or specially designated areas receiving specific types of grants or funding.

- *The RHC/FQHC benefit is defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (http://www.cms.hhs.gov/manuals/102_policy/bp102c13.pdf.)*

The core services of the benefit are professional, meaning the hands-on delivery of care by medical professionals. However, some preventive services are also encompassed in primary care under the benefit, 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 encounter 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/FQHC benefit, technical services, or technical components of services with both professional and technical components, are not billed on RHC/FQHC claims****.*

All services in the benefit are reimbursed through a single all-inclusive rate paid for each patient encounter or visit. The encounter rate includes covered services provided by an RHC/FQHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies. The rate does not include services that are not defined as RHC/FQHC services.

The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/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 not subject to the Medicare deductible rules.

A. Claim-Level Information

RHCs or FQHCs bill to FIs on institutional claims, either on the UB-92/Form CMS-1450, or the 837 institutional claim, using type of bill (TOB) 71x for RHC, and 73x for FQHC.

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

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

- *The third digit of TOBs 71x and 73x provides additional information regarding the individual claim. When the third digits, called frequency codes are used on RHC/FQHC claims the TOBs are:*
    - *710 or 730 = non-payment/zero claim (a claim with only noncovered charges, beneficiary liable)*
    - *711 or 731 = Admit through discharge (original claim)*
    - *717 or 737 = Replacement of prior claim (adjustment)*
    - *718 or 738 =Void/cancel prior claim (cancellation)*

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

- *RHC/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/FQHC TOB 71x/73x claims are defined as outpatient institutional claims under HIPAA and should follow those guidelines.*

B. Service-Level Information

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

- *Professional or primary services not subject to the psychiatric limit bundled into line item(s)using revenue code 052x;*

- *Services subject to the psychiatric limit under revenue code 0900*; and*

- *Telehealth originating site facility fees under revenue code 0780.*

All charges are entered in the following revenue code lines:

- *052x – FreeStanding Clinic; or*

- *0900* – Behavioral Health Treatment/Services, General Classification; and/or*

- *0780 –Telemedicine, General Classification.*

***NOTE:** Telehealth is not an RHC/FQHC service. As such, the originating site facility fee is billed in addition to the appropriate encounter billed in revenue code 052x or 0900.*

Revenue code 052x, "Freestanding Clinic", is used to bill all professional services, not subject to the psychiatric limit, under the RHC/FQHC benefit, in the encounter bundle.

- *Values for the fourth digit of revenue code 052x are:*

  - *0520 = Freestanding Clinic – to be used by all FQHCs;*

  - *0521 = Rural Health Clinic – to be used by RHCs clinics; and*

  - *0522 = Rural Health Home – to be used by RHCs in home settings.*

Revenue code 0900 ("Behavioral Health Treatments/Services, General Classification") is used for services subject to the psychiatric limit *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.

- *All fourth digits for this revenue code may be valid on RHC/FQHC claims; the value that best represents the service should be used.*

- *All revenue codes are listed in Chapter 25, mentioned above (http://www.cms.hhs.gov/manuals/104_claims/clm104c25.pdf).*

Revenue code 0780 ('Telemedicine, General Classification") is used to bill for the telehealth originating site facility fee. Telehealth originating site facilities' fees billed using revenue code 0780 are the only line items allowed on TOBs 71x/73x that are NOT part of the RHC/FQHC benefit.

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

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

- *See chapter 15, §270 of Pub. 100-02, Medicare Benefit Policy Manual, (http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf) for definition of telehealth services.*

For dates of service from January 1, 2002 through March 31, 2005, HCPCS codes were required for selected screening and preventive services. For details, see chapter 18 of this manual (http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf). Additionally, Independent FQHC services were billed using one of five HCPCS codes, and hospital-based FQHC services were billed with one of a series of HCPCS codes. Those HCPCS codes are 99201-99205 and 99211-99215. Effective with dates of service on and after April 1, 2005 FQHCs/RHCs are no longer required to use HCPCS codes when billing for RHC/FQHC services. Charges are only entered on the revenue code line.

- *See chapter 1, §60 (http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf) of this manual for information on* billing noncovered charges or claims to FIs;

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

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

- Units are reported based on encounters, *which are paid the all-inclusive rate no matter how many services are delivered.* Only one encounter 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 encounters are to be reported under revenue codes *0900 (0910 depending on the date) or 052x*, as applicable.

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

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

- *Technical services/components associated with professional services/components performed by **independent RHCs/FQHCs** are billed to Medicare carriers on professional claims (Form CMS-1500 or 837P.) See chapters 12 (http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf) and 26 (http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf) of this manual for billing instructions.*

- *Technical services/components associated with professional services/components performed by **provider-based RHCs/FQHCs** are billed by the base-provider on the applicable TOB and submitted to the FI; see the applicable chapter of this manual based on the base-provider type, such as chapter 3 (*http://www.cms.hhs.gov/manuals/104_claims/clm104c03.pdf*) for inpatient hospital claims, chapter 4 (*http://www.cms.hhs.gov/manuals/104_claims/clm104c04.pdf*) for outpatient hospital, chapter 6 (*http://www.cms.hhs.gov/manuals/104_claims/clm104c06.pdf*) for inpatient SNF, chapter 7 for Outpatient SNF, etc.*

The following *three* sections describe other billing rules applicable to RHC and FQHC claims *or services*.

110 - Special FQHC Requirements

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

***Effective April 1, 2005 FQHCs need not report HCPCS codes for FQHC services.** For earlier dates some requirements to report HCPCS codes apply. For details on these requirements, see the following two subsections.*

110.1 - Reporting of Preventive Services in the FQHC Benefit by Independent FQHCs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Claims with Dates of Service on or After April 1, 2005

Preventive services that are part of the FQHC benefit no longer require HCPCS codes. These services are included in the encounter bundle billed under revenue code 0520.

> ***NOTE:*** *However, though HCPCS code 90749 is no longer required, a visit is not billed if an immunization is the only service the FQHC provides. See instructions in §100B - Service Level Information, above.*

B. Claims with Dates of Service Before April 1, 2005

For claims submitted by independent FQHCs with dates of service before April 1, 2005, Medicare instructions to FIs required HCPCS code reporting for specific preventive services that are part of the FQHC benefit as follows:

a - Preventive Medicine Evaluation and Service Management

Covers services related to a physical exam, history, and interventional counseling. Independent FQHCs should continue to follow their FI's instructions for HCPCS coding of service. No replacement code.

b - FQHC Preventive Laboratory Procedure

Cholesterol screening, stool testing, dipstick urinalysis, and thyroid function test (HCPCS code 89399 until December 31, 2003).

NOTE: *HCPCS code 89399 is reported only if the FQHC actually performs the laboratory test. When the FQHC draws the specimen but orders the test to be done in an independent lab, this code should not be reported. In addition, you must use this code only when done in conjunction with a face-to-face encounter during the same visit. This code is discontinued after December 31, 2003.*

c - FQHC Preventive Medicine Intervention

Counseling and risk identification without the physical exam; additional counseling. Independent FQHCs should continue to follow their FI's instructions for HCPCS coding of service. No replacement code.

d - FQHC Acute Care Visit

No preventive services rendered (HCPCS code 99212).

e - Immunizations

(HCPCS code 90749).

See sections 120 and 130 below for information on billing preventive or lab services, applicable to RHCs/FQHCs as specified therein.

Billing requirements claim forms/formats do not allow for more than one HCPCS code to be reported per line item. Therefore, in situations where an independent FQHC provides more than one preventive service during the course of a visit, and these services are billed under different HCPCS codes listed above, the independent FQHC must report separate lines for the clinic visit revenue code (0520) for each preventive service provided to show each HCPCS code. All but the first line item for that date is billed with a 0 in the units and total charges field. The first line item for the visit is billed with units equaling 1, representing the single encounter that day, and usual total charges are reported for the encounter on that line. The FQHC must report only 1 unit per visit regardless of the number of preventive services provided during a visit.

In addition, in situations where the independent FQHC provides more than one of the preventive services in a specific grouping under a single HCPCS during the course of a visit, the independent FQHC must report the appropriate HCPCS code for that group only once. For example, if the independent FQHC provides a dipstick urinalysis and a thyroid function test during the same visit, AND those are the only services provided in the encounter, a single line item would be billed with only 1 unit.

When independent FQHCs provide immunizations, they report HCPCS code 90749 only when the immunization(s) is given in conjunction with another service during a particular visit. If the sole purpose of the visit is to obtain an immunization, HCPCS code 90749 is not reported since a visit is not billed if this is the only service the FQHC provides.

Where an independent FQHC does not provide any preventive service during the course of a visit, the FQHC must report HCPCS code 99212 (no preventive service rendered). Therefore, every claim from an independent FQHC must contain at least one of the HCPCS codes described above.

110.2 - Reporting of Specific HCPCS Codes for Hospital-based FQHCs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Claims with Dates of Service on or After April 1, 2005

Effective April 1, 2005, hospital-based FQHCs are no longer required to report any specific HCPCS codes when billing for FQHC services.

B. Claims with Dates of Service Before April 1, 2005

For claims submitted by hospital-based FQHCs with dates of service before April 1, 2005, Medicare instructions for billing to FIs required HCPCS code reporting for specific services in the following HCPCS ranges:

99201-99205, 99211-99215, as appropriate.

Similar requirements were never developed for other types of provider-based FQHCs.

120 – General Billing Requirements for Preventive Services

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Professional components of preventive services are part of the overall encounter, and for TOBs 71x/73x, have always been billed on lines with revenue code 052x. In addition to previous requirements for independent FQHCs exclusively, all RHCs/FQHCs had been required to report HCPCS codes for certain preventive services subject to frequency limits.

*Detailed billing instructions for preventive benefits and vaccines are found in chapter 18 of this manual (*http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf*).*

Physician or base-provider claims would reflect these services under specific HCPCS codes.

RHCs/FQHCs do not receive any reimbursement on TOBs 71x/73x for technical components of such services. The associated technical components are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits. Therefore, CMS concluded that the enforcement of the frequency limits was accomplished for RHCs/FQHCs via the technical components of the services they do not bill themselves, and no specific data had to be provided on TOBs 71x and 73x to further enforce these statutory limits. Therefore, as of April 1, 2005, RHCs and FQHCs do not have to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71x/73x.

Though most preventive services have HCPCS codes that allow separate billing of professional and technical components, mammography and prostate PSA do not. However, RHCs/FQHCs still must provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using revenue code 052x and no HCPCS coding (dates of service April 1, 2005 and after).

For vaccines, RHCs/FQHCs do not separately report for influenza virus or pneumococcal pneumonia *vaccines on the 71x/73x claims.* Costs for the influenza virus or pneumococcal pneumonia *vaccines are* included in the cost report and *no line items billed are billed in addition to the encounter. Hepatitis vaccine is also reimbursed through the cost report, though it is not paid at the same 100% rate as the other 2 vaccines. Therefore, no line items specifically for this service are billed on RHC/FQHC claims in addition to the encounter. An encounter can not be billed if the vaccine administration is the only service the FQHC provides.*

10.2.2 - Bills Submitted to FIs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

The applicable types of bills acceptable when billing for influenza and PPV are 13X, 22X, 23X, 34X, 72X, 75X, and 85X.

The following revenue codes are used for reporting vaccines and administration of the vaccines for all providers except RHCs and FQHCs. Independent and *Provider Based* RHCs and FQHCs follow §10.2.2.2 *below when billing for* influenza, PPV and hepatitis B *vaccines.*

Units and HCPCS codes are required with revenue code 0636:

Revenue Code	Description
0636	*Pharmacy, Drugs requiring detailed coding (a)*
0771	*Preventive Care Services, Vaccine Administration*

In addition, for the influenza virus vaccine, providers report condition code M1 in Form Locator (FLs) 24-30 when roster billing. See roster billing instructions in §10.3 of this chapter.

When vaccines are provided to inpatients of a hospital or SNF, they are covered under the vaccine benefit. However, the hospital bills the FI on bill type 13X using the discharge date of the hospital stay to avoid editing in the Common Working File (CWF) as a result of hospital bundling rules. A SNF submits type of bill 22X for its Part A inpatients.

10.2.2.2 - Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs)

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Independent and provider-based RHCs and FQHCs do not include charges for influenza and PPV on Form CMS-1450. *Administration of these vaccines* does not count as a visit when the only service involved is the administration of influenza and*/or* PPV *vaccine(s)*. If there was another reason for the visit, the RHC/FQHC should bill for the visit without adding the cost of the influenza and PPV to the charge for the visit on the bill. FIs pay at the time of cost settlement and adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.

Payment for the hepatitis B vaccine is included in the all-inclusive rate. However, RHCs/FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine. *As with other vaccines administered during an otherwise payable encounter, no line items specifically for this service are billed on the RHC/FQHC claims in addition to the encounter.*

10.3.2 - Claims Submitted to Intermediaries for Mass Immunizations of Influenza and PPV

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Some potential "mass immunizers," such as hospital outpatient departments and HHAs, have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations simplified (roster) billing procedures are available to mass immunizers. The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the influenza virus vaccine or PPV to a group of beneficiaries, e.g., at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date are required. (See §10.3.2.2 for an exception to this requirement for inpatient hospitals.)

The simplified (roster) claims filing procedure applies to providers other than RHCs and FQHCs that conduct mass immunizations. Since independent and *provider based* RHCs and FQHCs do not submit individual Form CMS-1450s for the influenza virus vaccine, they do not utilize the simplified billing process. Instead, payment is made for the vaccine at the time of cost settlement.

The simplified process involves use of the provider billing form (Form CMS-1450) with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form CMS-1450 that contains the variable claims information regarding the service provider and individual beneficiaries.

Qualifying individuals and entities must attach a roster, which contains the variable claims information regarding the supplier of the service and individual beneficiaries.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file."

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature for all institutional providers that roster bill from an inpatient or outpatient department provided the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, they are not required to obtain the patient signature on the roster. However, the provider has the option of reporting "signature on file" in lieu of obtaining the patient's actual *signature on the roster.*

The PPV roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering PPV.

Warning: Beneficiaries must be asked if they have been vaccinated with PPV.

- Rely on the patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine,
- If patients are certain that they have been vaccinated within the past 5 years, **do not revaccinate**.

For providers using the simplified billing procedure, the modified Form CMS-1450 shows the following preprinted information in the specific form locators (FLs):

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code) (See NOTE below);
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with the appropriate "G" HCPCS code in FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number); and
- Diagnosis code V03.82 for PPV or V04.8 for Influenza Virus vaccine in FL 67 (Principal Diagnosis Code). **For influenza virus vaccine claims with dates of service October 1, 2003 and later, use diagnosis code V04.81.**
- Influenza virus vaccines require the UPIN SLF000 in FL 82.

Providers conducting mass immunizations are required to complete the following FLs on the preprinted Form CMS-1450:

- FL 4 (Type of Bill);
- FL 47 (Total Charges);
- FL 85 (Provider Representative); and
- FL 86 (Date).

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed. First claim development alerts from CWF are not generated for PPV and influenza virus vaccines.

Intermediaries use the beneficiary roster list to generate Form CMS-1450s to process PPV claims by mass immunizers indicating condition code M1 in FLs 24-30 to avoid MSP editing. Standard System Maintainers must develop the necessary software to generate Form CMS-1450 records that will process through their system.

Providers that do not mass immunize must continue to bill for PPV and influenza virus vaccines using the normal billing method, e.g., submission of a Form CMS-1450 or electronic billing for each beneficiary.

20.3.2.2 - Payment for Computer Add-On Diagnostic and Screening Mammograms for FIs and Carriers

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Payment for computer add-on diagnostic mammogram HCPCS code G0236 or 76082 when billed with CPT code 76090, 76091, G0204, or G0206 is as follows:

Place/Provider of Service	**Payment**
Physician	Medicare physicians' fee schedule
Outpatient Hospital	Outpatient Prospective Payment System (OPPS)
Critical Access Hospital (CAH)	Reasonable Cost
SNF	Medicare physicians' fee schedule – *technical component*
Independent RHC	All-inclusive rate for professional component (*codes 76090 and 76091*)*
Freestanding FQHC	All-inclusive rate for professional component *(codes76090 and 76091*)*

** Only for dates of service prior to April 1, 2005.*

Code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography," for CAD has been established as an add on code that can be billed in conjunction with primary service code G0204 or G0206, as well as existing codes 76090 or 76091. The Part B deductible and coinsurance apply. HCPCS code G0236 is deleted as of December 31, 2003.

Effective for claims with dates of service January 1, 2004 and later, add-on HCPCS code 76082, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with primary service codes G0204 or G0206 as well as codes 76090 or 76091. The Part B deductible and coinsurance apply.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes G0236 or 76082 with an explanation that payment for code G0236 or 76082 cannot be made when billed alone.

Carriers deny the claim using remark code N122, "Mammography add-on code can not be billed by itself" (effective September 12, 2002).

Payment for computer add-on screening mammogram HCPCS code 76085 or 76083 when billed with CPT code 76092 or G0202 is as follows:

Place/Provider of Service	**Payment**
Physician	Medicare physicians' fee schedule
Outpatient Hospital	Medicare physicians' fee schedule
Critical Access Hospital (CAH)	Reasonable Cost
SNF	Medicare physicians' fee schedule – *technical component*
Independent RHC	All-inclusive rate for professional component (code 76092*)
Freestanding FQHC	All-inclusive rate for professional component (code 76092*)

** Only for dates of service prior to April 1, 2005.*

Code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography," for CAD has been established as an add on code that can be billed in conjunction with primary service code G0202 as well as 76092. HCPCS code 76085 is deleted as of December 31, 2003. The Part B Deductible does not apply. However, coinsurance is applicable. FIs use the benefit pricing file provided by CMS to pay the above codes where payment is based on the *technical component of the* Medicare physician fee schedule.

Effective for claims with dates of service January 1, 2004 and later, HCPCS code 76083, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service code G0202 as well as code 76092. There is no Part B deductible but coinsurance applies.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes 76085 or 76083 with an explanation that payment for code 76085 or 76083 cannot be made when billed alone. Carriers deny the claim using remark code N122 "Mammography add-on code cannot be billed by itself" (effective September 12, 2002).

20.4.1.1 - RHC/FQHC Claims With Dates of Service Prior to January 1, 2002

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A - Provider-Based RHC and FQHC

For claims with dates of service prior to January 1, 2002, provider-based RHCs and FQHCs bill the FI for the technical component and their carrier for the professional component of the screening and diagnostic mammography. Provider-based RHCs and FQHCs use the *base* provider number and bill type (13X, 22X, 23X or 85X as appropriate) when billing the FI for this service. Payment is based on the payment method for the *base* provider - the limitation.

B - Independent RHCs and Freestanding FQHCs

Independent RHCs and freestanding FQHCs bill their carrier for both the technical and professional components. Payment is made based on the limitation.

20.4.1.2 - RHC/FQHC Claims With Dates of Service on or After January 1, 2002

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A - Provider-Based RHC & FQHC - Technical Component

The technical component of a screening or diagnostic mammography for provider-based RHCs/FQHCs is typically furnished by the *base* provider. The provider of that service bills the FI under bill type 13X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code for a screening mammography is 0403, and the appropriate HCPCS codes are 76085 and 76092. Payment is based on the payment method for the *base* provider.

The appropriate revenue code for a diagnostic mammography is 0401, and the appropriate HCPCS codes are 76090, 76091 and G0236*.

*G0236 is a deleted code after December 31, 2003. Use 76082 for claims with dates of service January 1, 2004 and later.

B - Independent RHCs and Freestanding FQHCs - Technical Component

The technical component of a screening or diagnostic mammography is outside the scope of the RHC/FQHC benefit. The *practitioner that renders* the technical service bills their carrier on Form CMS-1500. Payment is based on the MPFS.

C - Provider-Based RHC & FQHC, Independent RHCs and Freestanding FQHCs - Professional Component

For claims with dates of service on or after January 1, 2002 *but before April 1, 2005*, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 0403 and HCPCS code 76085* or 76092. Payment is made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

*76085 is a deleted code after December 31, 2003. Use 76083 for claims with dates of service on or after January 1, 2004 *but before April 1, 2005.*

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography along with revenue code 0401 and HCPCS codes 76090 or 76091.

Payment should not be made for a screening or diagnostic mammography unless the claim contains a related visit code. FIs should assure payment is not made for revenue code 0403 (screening mammography) or 0401(diagnostic mammography). The claim *must* also contain a visit revenue code 0520 or 0521. *Payment is made for the professional component under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0403.*

For claims with dates of service on or after April 1, 2005, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component. Payment is made for the professional component under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the professional component. Use revenue code 0520 or 0521 as appropriate.

For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography. Use revenue code 0520 or 0521 as appropriate. No HCPCS coding is required for the diagnostic mammography.

30.5 - HCPCS Codes for Billing

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

The following HCPCS codes can be used for screening Pap smear:

A - Codes Billed to the Carrier and Paid Under the Physician Fee Schedule

The following HCPCS codes are submitted only to the carrier by those entities that submit claims to carriers. These codes are not billed on FI claims except code Q0091 may be submitted to an FI.

- Q0091 - Screening Papanicolaou (Pap) smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.

- P3001 - Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician;

- G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician; and

- G0141 - Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual re-screening, requiring interpretation by physician.

B - Codes Paid Under the Clinical Lab Fee Schedule by FI and Carriers

The following codes are billed to FIs by providers they serve, or billed to carriers by the physicians/suppliers they service. Deductible and coinsurance do not apply except for code Q0091. For this code, deductible is not applicable but coinsurance applies.

- P3000 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision;

- G0123 - Screening cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid; automated thin layer preparation, screening by cytotechnologist under physician supervision;

- G0143 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and re-screening, by cytotechnologist under physician supervision;

- G0144 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision;

- G0145 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual re-screening under physician supervision;

- G0147 - Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision; and

- G0148 - Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

- Q0091 - Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.

Payment for code Q0091 in a hospital outpatient department is under OPPS. A SNF is paid *using the technical component of* the MPFS. For a CAH, payment is on a reasonable cost basis. For RHC/FQHCs payment is *made under* the all inclusive rate for *the* professional component. Deductible is not applicable, however, coinsurance applies.

The technical component of a screening pap smear is outside the RHC/FQHC benefit. If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their base provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). For independent RHCs/FQHCs the practitioner bills the technical component to the carrier on Form CMS-1500 or 837 P.

C - Billing to the Carrier

Effective for services on or after April 1, 1999, a covered evaluation and management visit and code Q0091 may be reported by the same physician for the same date of service if the evaluation and management visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the evaluation and management service and the medical records must clearly document the evaluation and management service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

70.1.1.1 - Additional Coding Applicable to Claims Submitted to FIs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A - Type of Bill

The applicable FI claim bill types for screening glaucoma services are 13X, 22X, 23X, 71X, 73X, 75X, and 85X. (See instructions below for rural health clinics (RHCs) and federally qualified health centers (FQHCs).)

B - Revenue Coding

The following revenue codes should be reported when billing for screening glaucoma services: Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), and skilled nursing facilities (SNFs) bill for this service under revenue code 0770. CAHs electing the optional method of payment for outpatient services *als*o report this service under revenue codes 096X, 097X, or 098X. Hospital outpatient departments bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 0770. *(See instructions below for RHCs and FQHCs.)*

70.1.1.2 - Special Billing Instructions for RHCs and FQHCs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Screening glaucoma services are considered RHC/FQHC services. *For claims with dates of service before April 1, 2005,* RHCs and FQHCs bill the FI under bill type 71X or 73X along with revenue code 0770 and HCPCS codes G0117 or G0118 and RHC/FQHC revenue code 0520 or 0521 to report the related visit. Reporting of revenue code 0770 and HCPCS codes G0117 and G0118 in addition to revenue code 0520 or 0521 is required for this service in order for CWF to perform frequency editing. Payment should not be made for a screening glaucoma service unless the claim also contains a visit code for the service. FIs must edit to assure payment is not made for revenue code 0770. *The claim must* also contain a visit revenue code (0520 or 0521). *Payment is made for the screening glaucoma service under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0770.*

Screening glaucoma services furnished within an RHC/FQHC by a physician or nonphysician are considered RHC/FQHC services. For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the service. Payment is made under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the service. Use revenue code 0520 or 0521, as appropriate.

11.1 - Electrical Stimulation

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A - Coding Applicable to Carriers & Fiscal Intermediaries (FIs)

Effective April 1, 2003, a National Coverage Decision was made to allow for Medicare coverage of Electrical Stimulation for the treatment of certain types of wounds. The type of wounds covered are chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers. All other uses of electrical stimulation for the treatment of wounds are not covered by Medicare. Electrical stimulation will not be covered as an initial treatment modality.

The use of electrical stimulation will only be covered after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electrical stimulation is being used, wounds must be evaluated periodically by the treating physician but no less than every 30 days by a physician. Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electrical stimulation must be discontinued when the wound demonstrates a 100% epithelialzed wound bed.

Coverage policy can be found in Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 270.1
(http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp)

The applicable Healthcare Common Procedure Coding System (HCPCS) code for Electrical Stimulation and the covered effective date is as follows:

HCPCS	Definition	Effective Date
G0281	Electrical Stimulation, (unattended), to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.	04/01/2003

Medicare will not cover the device used for the electrical stimulation for the treatment of wounds. However, Medicare will cover the service. Unsupervised home use of electrical stimulation will not be covered.

B - FI Billing Instructions

The applicable types of bills acceptable when billing for electrical stimulation services are 12X, 13X, 22X, 23X, 71X, 73X, 74X, 75X, and 85X. Chapter 25 of this manual

provides general billing instructions that must be followed for bills submitted to FIs. FIs pay for electrical stimulation services under the Medicare Physician Fee Schedule for *a* hospital, Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehabilitation Facility (ORF), Outpatient Physical Therapy (OPT) and Skilled Nursing Facility (SNF).

Payment methodology for independent Rural Health Clinic (RHC), provider-based RHCs, free-standing Federally Qualified Health Center (FQHC) and provider based FQHCs is made under the all-inclusive rate for the visit furnished to the RHC/FQHC patient to obtain the therapy service. Only one payment will be made for the visit furnished to the RHC/FQHC patient to obtain the therapy service. *As of April 1, 2005, RHCs/FQHCs are no longer required to report HCPCS codes when billing for these therapy services.*

Payment Methodology for a Critical Access Hospital (CAH) is on a reasonable cost basis unless the CAH has elected the Optional Method and *then the FI pays*115% of the MPFS amount for *the professional component of* the HCPCS code *in addition to the technical component.*

In addition, the following revenues code must be used in conjunction with the HCPCS code identified:

Revenue Code	Description
420	Physical Therapy
430	Occupational Therapy
520	Federal Qualified Health Center *
521	Rural Health Center *
977, 978	Critical Access Hospital- method II CAH professional services only

**** NOTE:*** *As of April 1, 2005, RHCs/FQHCs are no longer required to report HCPCS codes when billing for these therapy services.*

C - Carrier Claims

Carriers pay for Electrical Stimulation services billed with HCPCS codes G0281 based on the MPFS. Claims for Electrical Stimulation services must be billed on Form CMS-1500 or the electronic equivalent following instructions in chapter 12 of this manual (http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf).

D - Coinsurance and Deductible

The Medicare contractor shall apply coinsurance and deductible to payments for *these* therapy services except for services billed to the FI by FQHCs. For FQHCs, only co-insurance applies.

11.2 - Electromagnetic Therapy

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A - HCPCS Coding Applicable to Carriers & Fiscal Intermediaries (FIs)

Effective July 1, 2004, a National Coverage Decision was made to allow for Medicare coverage of electromagnetic therapy for the treatment of certain types of wounds. The type of wounds covered are chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers. All other uses of electromagnetic therapy for the treatment of wounds are not covered by Medicare. Electromagnetic therapy will not be covered as an initial treatment modality.

The use of electromagnetic therapy will only be covered after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electromagnetic therapy is being used, wounds must be evaluated periodically by the treating physician but no less than every 30 days by a physician. Continued treatment with electromagnetic therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electromagnetic therapy must be discontinued when the wound demonstrates a 100% epithelialzed wound bed.

Coverage policy can be found in Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 270.1. (www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp)

The applicable Healthcare Common Procedure Coding System (HCPCS) code for Electrical Stimulation and the covered effective date is as follows:

HCPCS	Definition	Effective Date
G0329	ElectromagneticTherapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.	07/01/2004

Medicare will not cover the device used for the electromagnetic therapy for the treatment of wounds. However, Medicare will cover the service. Unsupervised home use of electromagnetic therapy will not be covered.

B - FI Billing Instructions

The applicable types of bills acceptable when billing for electromagnetic therapy services are 12X, 13X, 22X, 23X, 71X, 73X, 74X, 75X, and 85X. Chapter 25 of this manual

provides general billing instructions that must be followed for bills submitted to FIs. FIs pay for electromagnetic therapy services under the Medicare Physician Fee Schedule for *a* hospital, CORF, ORF, and SNF.

Payment methodology for independent (RHC), provider-based RHCs, free-standing FQHC and provider based FQHCs is made under the all-inclusive rate for the visit furnished to the RHC/FQHC patient to obtain the therapy service. Only one payment will be made for the visit furnished to the RHC/FQHC patient to obtain the therapy service. *As of April 1, 2005, RHCs/FQHCs are no longer required to report HCPCS codes when billing for the therapy service.*

Payment Methodology for a CAH is payment on a reasonable cost basis unless the CAH has elected the Optional Method and *then the FI pays* pay 115% of the MPFS amount for *the professional component of* the HCPCS code *in addition to the technical component.*

In addition, the following revenues code must be used in conjunction with the HCPCS code identified:

Revenue Code	Description
420	Physical Therapy
430	Occupational Therapy
520	Federal Qualified Health Center *
521	Rural Health Center *
977, 978	Critical Access Hospital- method II CAH professional services only

*** NOTE:** *As of April 1, 2005, RHCs/FQHCs are no longer required to report HCPCS codes when billing for the therapy service.*

C - Carrier Claims

Carriers pay for Electromagnetic Therapy services billed with HCPCS codes G0329 based on the MPFS. Claims for electromagnetic therapy services must be billed on Form CMS-1500 or the electronic equivalent following instructions in chapter 12 of this manual (www.cms.hhs.gov/manuals/104_claims/clm104index.asp).

Payment information for HCPCS code G0329 will be added to the July 2004 update of the Medicare Physician Fee Schedule Database (MPFSD).

D - Coinsurance and Deductible

The Medicare contractor shall apply coinsurance and deductible to payments for electromagnetic therapy services except for services billed to the FI by FQHCs. For FQHCs only co-insurance applies.