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As a result of the Affordable Care Act, claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6960.pdf on the Centers for Medicare & Medicaid Services website.

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Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Guide

Note: At the time this article was first published in 2010, the information reflected Medicare policy correctly at that time. Since then, more current information is available and new articles have been released. This article was updated on June 5, 2014, to refer to some of the key new articles.

Provider Types Affected

This article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

This Special Edition article is based on Change Request (CR) 7038, CR 7208, and CR 8743; and it provides a billing guide for FQHCs and RHCs. It describes the information FQHCs are required to submit in order for the Centers for Medicare & Medicaid Services (CMS) to develop and implement a Prospective Payment System (PPS) for Medicare FQHCs. It also explains how RHCs should bill for certain preventive services under the Affordable Care Act. Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the Initial Preventive Physical Examination (IPPE) provided by RHCs. However, to ensure coinsurance and deductible are not applied, detailed Healthcare Common Procedure Coding System (HCPCS)

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coding must be provided for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. The Affordable Care Act also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

Background

Historically, RHCs and FQHCs billing instructions have been the same. However, effective January 1, 2011, the billing requirements will be different for each of these facilities' types.

As outlined in CR 7208, transmittal 2122, RHCs are only required to submit detailed HCPCS codes for preventive services with a United States Preventive Services Task Force (USPSTF) grade of A or B in order to waive coinsurance and deductible. As outlined in CR 7038 (see the related MLN Matters® article, MM7038 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7038.pdf** on the CMS website), FQHCs are required to submit detailed HCPCS code(s) for all services rendered during the encounter. As outlined in CR 8743 (see the related MLN Matters® article, MM8743 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8743.pdf** on the CMS website) and effective for cost reporting periods beginning on or after October 1, 2014, FQHCs are required to implement a prospective payment system (PPS). FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting period beginning on or after October 1, 2014. Listed below is a summary of the billing requirements for each facility that you need to know when submitting claims for either RHCs or FQHCs.

RHCs (71X Types of Bills (TOBs):

The professional components of preventive services are part of the overall encounter, and for TOB 71x, these services have always been billed on revenue lines with the appropriate site of service revenue code in the 052x series. In previous requirements, HCPCS codes have only been required to report certain preventive services subject to frequency limits.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are waived for the IPPE, the annual wellness visit, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. Lab and technical components should continue to be billed as non RHC services.

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Basic RHC Billing for Preventive Services:

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance and deductible. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on $100 of the total charge.

To ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052X series with the approved preventive service HCPCS code and the associated charges. For example, the service lines should be reported as follows:

Line	Revenue Code	HCPCS code	Date of Service	Charges
1	052X		01/01/2011	100.00
2	052X	Preventive Service Code	01/01/2011	50.00

The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate, and the coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable to the service line with the preventive service.

Exceptions:

If the only service provided is a preventive service (such as the IPPE or Annual Wellness Visit (AWV)) , report only one line with the appropriate site of service revenue code (052X) and the preventive service HCPCS code. The services will be paid based on the all inclusive rate. Coinsurance and deductible are not applicable.

> **NOTE:** An additional visit may be paid for IPPE when billed with another qualified encounter/visit, as outlined with CR6445 (see the related MLN Matters® article, MM6445, at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6445.pdf** on the CMS website).

RHCs are not required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines on the 71x claims as the cost for these services are not included in the encounter. Costs for the influenza virus or pneumococcal pneumonia

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vaccines are included in the cost report and no line items are billed. Coinsurance and deductible do not apply to either of these vaccines.

The hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration shall be carved out of the office visit and reported on a separate line as outlined in the above example. An encounter cannot be billed if vaccine administration is the only service the RHC provides. For additional information on incident to services, please see the "Medicare Benefit Policy Manual" (Chapter 13, Section 60) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf** on the CMS website.

RHCs do not receive any reimbursement on TOBs 71x for the technical component of services provided by clinics. This is because the technical component of services are not within the scope of Medicare-covered RHC services. The associated technical component of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

FQHCs (77X TOBs):

The Affordable Care Act (Section 10501(i)(3)(A) amended the Social Security Act (Section 1834; see **http://www.ssa.gov/OP_Home/ssact/title18/1834.htm**) by adding a new subsection (o) titled "Development and Implementation of Prospective Payment System."

This subsection provides the statutory framework for development and implementation of a Prospective Payment System (PPS) for Medicare FQHCs. The Social Security Act (Section 1834(o)(1)(B)) as amended by the Affordable Care Act, addresses collection of data necessary to develop and implement the new Medicare FQHC PPS. Specifically, the Affordable Care Act grants the Secretary of Health and Human Services the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC PPS, including the reporting of services using HCPCS codes. The Affordable Care Act requires that the Secretary impose this data collection submission requirement no later than January 1, 2011.

Beginning with dates of service on or after January 1, 2011, when billing Medicare, FQHCs must report all services provided during the encounter/visit by listing the appropriate HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes in order to develop the FQHC PPS set to be implemented in 2014. The additional data will not be utilized to determine current Medicare payment to FQHCs. The Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.

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Basic FQHC Billing Requirements:

For dates of service on or after January 1, 2011, all valid UB04 revenue codes **except** the following may be used to report the additional services that are needed for data collection and analysis purposes only:

- 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.

Medicare will make one payment at the all-inclusive rate for each date of service that contains a valid HCPCS code for professional services when one of the following revenue codes is present:

Revenue Code	Definition
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 a Skilled Nursing Facility (SNF)
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC/FQHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)

Payments for Encounter/Visits:

Medicare will make an additional encounter payment at the all-inclusive rate on the same claim when:

- Effective January 1, 2011, two services lines are submitted with a 052X revenue code and one line contains modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the

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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;
- Diabetes Self Management Training (DSMT) is billed under revenue code 052x and HCPCS code G0108 and Medical Nutrition Therapy (MNT) is billed under revenue code 052x and HCPCS code 97802, 97803, or G0270; and
- The Initial Preventive Physical Examination (IPPE) billed under revenue code 052X and HCPCS code G0402. This is a once in a lifetime benefit. HCPCS coding is required.

Note: Modifier 59 is **not required** for DSMT, MNT, or IPPE in order to receive an additional encounter payment.

When reporting multiple services on FQHC claims, the 052X revenue line should include the total charges for all of the services provided during the encounter. For preventive services with a grade of A or B from the USPSTF, the charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is $350.00, and $50.00 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on $300.00 of the total charge.

Example A:

Line	Rev Code	HCPCS code	Date of Service	Charges
1	0521	Office Visit	01/01	300.00
2	0636	Penicillin Injection	01/01	125.00
3	0271	Wound Cleaning	01/01	125.00
4	0771	Preventive Service Code	01/01	50.00

When reporting multiple services on the same day that are unrelated, modifier 59 must be used to report these services, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.

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Example B:

Line	Rev Code	HCPCS code	Modifier	Date of Service	Charges
1	0521	Office Visit		01/01	150.00
2	0479	Removal of Wax From Ear		01/01	100.00
3	0521	Office Visit	59	01/01	450.00
4	0271	Wound Cleaning		01/01	150.00
5	0279	Bone Setting With Casting		01/01	300.00

When reporting an additional encounter for IPPE, the revenue lines should be reflected as follows:

Example C:

Line	Rev Code	HCPCS code	Date of Service	Charges
1	0521	Office Visit	01/01	75.00
2	0419	Breathing Treatment	01/01	75.00
3	0521	IPPE (G0402)	01/01	150.00

As of January 01, 2011, for data collection and analysis for the PPS, FQHCs are required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines (PPV) on the 77x claims. The charges of these vaccines and the administration shall be carved out of the office visit and reported on a separate line as outlined in example A. The cost for these services will continue to be reimbursed through cost reporting. Coinsurance and deductible do not apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges for the vaccine and its administration will be carved out of the office visit and reported on a separate line as outlined in example A. An encounter cannot be billed if vaccine administration is the only service the FQHC provides. For additional information on incident to services, please see Chapter 13, Section 60 of the "Medicare Benefit Policy Manual" at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf** on the CMS website.

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Laboratory and technical components should continue to be billed as non FQHC services.

Summary of Differences

The chart below displays a list of elements and notes the differences between RHCs and FQHCs:

Element	RHCs	FQHCs
Revenue Codes	052X series	All except: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x
HCPCS code	Required for Preventive Services only excluding Flu and PPV	Required for **all** services rendered during encounter/visit
Modifier 59	Not applicable at this time	Should be used to report two distinct unrelated visits on the same day
DSMT and MNT	Not separately payable	All inclusive payment rate

November 2013 Manual Updates

In November 2013, CR8504 updated Chapter 13 of the "Medicare Benefit Policy Manual" to reflect numerous updates that were effective on January 1, 2014. The MLN Matters® article MM8504, which relates to CR8504 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8504.pdf** on the CMS website.

The FQHC PPS

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall

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continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

Complete details of the FQHC PPS are available in MLN Matters® article MM8743, which is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8743.pdf** on the CMS website.

Additional Information

Additional information on vaccines can be found in the "Medicare Claims Processing Manual" (Chapter 1, section 10) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf** on the CMS website, and additional coverage requirements for the pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in the "Medicare Benefit Policy Manual" (Chapter 15) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf** on the CMS website.

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