



News Flash – The Medicare Learning Network® has released a new educational tool titled “5010: Taking Electronic Billing and Electronic Data Interchange (EDI) to the Next Level”. This educational tool is designed to provide education on the upcoming implementation of Versions 5010 and D.0, which will replace the current version that covered entities must use when conducting electronic HIPAA transactions. It includes a timeline and list of resources related to the implementation. This product is suggested for all Medicare Fee-For-Service Providers and is available in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM7038

Related Change Request (CR) #: 7038

Related CR Release Date: August 24, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2034CP

Implementation Date: January 3, 2011

Affordable Care Act Mandated Collection of Federally Qualified Health Center (FQHC) Data and Updates to Preventive Services Provided by FQHCs

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7038 which 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. The Affordable Care Act mandates the collection of the data begin no later than January 1, 2011. The Affordable Care Act also expands the definition of FQHC preventive services. Be sure that your billing staff is aware of these changes.

Background

Section 10501(i)(3)(A) of The Affordable Care Act amended section 1834 of The Social Security Act by adding a new subsection (o), which provides the statutory

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framework for development and implementation of a PPS for Medicare FQHCs. 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 Healthcare Common Procedure Coding System (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 pertinent services provided and list the appropriate HCPCS code for each line item along with revenue code(s) for each FQHC visit. The additional line item(s) and HCPCS reporting are for informational and data gathering purposes only, and will not be utilized to determine current Medicare payment to FQHCs. Until the FQHC PPS is implemented in 2014, the Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.

Section 10501(i)(2) of The Affordable Care Act amended the definition of FQHC services as defined in section 1861(aa)(3)(A) of The Social Security Act by removing the specific references to services provided under section 1861(qq) and (vv) and by adding preventive services as defined in section 1861(ddd)(3), as amended by The Affordable Care Act. The Affordable Care Act establishes a new Medicare FQHC preventive services definition by referencing preventive services as defined in section 1861(ddd)(3) of The Social Security Act, as amended by The Affordable Care Act. In accordance with 1833 (a)(3) of The Social Security Act, preventive services listed in 1861(ddd)(3) are paid in the same manner as all other Medicare FQHC services (with the exception of 1861(s)(10) services, i.e., pneumococcal and influenza vaccines and administration which are paid at 100%).

Thus, beginning with dates of service on or after January 1, 2011, The Affordable Care Act revised the list of preventive services paid for in the FQHC setting. Effective January 1, 2011, the professional component of the following preventive services will be covered FQHC services when provided by an FQHC:

- Initial Preventive Physical Examination (IPPE);
- The following screening and other preventive services:
 - Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10);
 - Screening mammography as defined in 1861(jj); Screening pap smear and screening pelvic exam as defined in 1861 (nn);

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- Prostate cancer screening tests as defined in 1861(oo); (E) Colorectal cancer screening tests as defined in 1861 (pp);
- Diabetes outpatient self-management training services as defined in 1861 (qq)(1);
- Bone mass measurement as defined in 1861 (rr);
- Screening for glaucoma as defined in 1861 (uu);
- Medical nutrition therapy services as defined in 1861 (vv);
- Cardiovascular screening blood tests as defined in 1861 (xx)(1);
- Diabetes screening tests as defined in 1861 (yy);
- Ultrasound screening for abdominal aortic aneurysm as defined in 1861 (bbb);
- Additional preventive services (as defined in 1861 (ddd)(1).
- The personalized prevention plan services as defined in Section 1861 (hhh)(1) of The Social Security Act.

CR7038 does not impact claims for supplemental payments to FQHCs under contract with Medicare Advantage Plans.

Key Points of CR7038

For all Medicare FQHC Fee-For-Service claims on Type of Bill (TOB) 77x with dates of service on or after January 1, 2011:

- If all the service lines do not contain valid HCPCS code(s) the claim will be returned to the provider, except for those revenue codes that do not permit HCPCS code reporting, i.e., revenue code 025x.
- All claims with any service lines with any of the following revenue codes will be returned to the provider: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.
- Medicare will make one payment at 80 percent of the all-inclusive rate for each date of service which contains a valid HCPCS code and one of the following revenue codes: 0521, 0522, 0524, 0525, or 0527 or 0528. Medicare will make a second payment at 80 percent of the all-inclusive rate for a second visit on the same Date of Service (DOS) when the service line contains revenue codes 0521, 0522, 0524, 0525, 0527, or 0528 with a valid HCPCS code with modifier 59, which denotes the conditions being treated are totally unrelated and services are provided at separate times of the day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon. Medicare systems will also make one payment at 80 percent of the all-inclusive rate for each DOS which contains one of the following revenue codes 0521, 0522, 0524, 0525, or 0527 and HCPCS code G0108 for an individual Diabetes Self Management Training (DSMT) session or HCPCS codes 97802, 97803 or G0270 for an individual Medical Nutrition Therapy

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(MNT) session. Note, however, that Medicare will not make payment for both DSMT and MNT sessions on the same DOS.

- Note: Service lines containing revenue code 0520 will not receive the all-inclusive rate. The specific site of service revenue code 0521, 0522, 0524, 0525, 0527 or 0528 should be used to report an encounter/visit.
- Medicare will make payment subject to the outpatient mental health treatment limitation for each DOS which contains revenue code 0900 and a valid HCPCS code.
- Medicare will make payment at 80 percent of the lesser of the charge or the applicable originating site facility fee for each DOS which contains revenue code 0780 and HCPCS Q3014.
- When claims service lines contain a valid HCPCS code, but do not contain a revenue code identified in the above bullet points as payable on a TOB 77x, Medicare will not make payment on those service lines and will show this action by returning Group Code CO (Contractual Obligation) and Claim Adjustment Reason Code 97 (Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.).
- Medicare will not apply the Medicare deductible to payments for FQHC services. Medicare will apply the Medicare deductible to the Telehealth originating site facility fee. (The Telehealth originating site facility fee is not an FQHC service.)
- Medicare will apply the Medicare FQHC co-insurance of 20 percent of charges to all FQHC services, except effective for dates of service on or after January 1, 2011, coinsurance and deductible are being waived for all Preventive Services as enacted in section 4104 of the Affordable Care Act.
- Medicare will apply the standard Medicare co-insurance of 20 percent to the telehealth originating site facility fee. (The telehealth originating site facility fee is not an FQHC service.)

Additional Information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR7038) issued to your Medicare A/B MAC and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R2034CP.pdf> on the CMS website.

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