

★ ★ **IMPORTANT** ★ ★

The information provided in this manual was current as of July 2004. Any changes or new information superseding the information in this manual are provided in the Medicare Part A newsletters with publication dates after July 2004. Medicare Part A newsletters are available at:

www.trailblazerhealth.com/pubs.asp

© CPT codes, descriptions, and other data only are copyright 2003 American Medical Association. All rights reserved. Applicable FARS/DFARS clauses apply.



★ ★ **IMPORTANT** ★ ★

Rural Health Clinic (RHC) Manual

Table of Contents

Rural Health Clinic (RHC) History	1
Creation and Scope of the Program	1
Certification	2
Certification Criteria	2
CMS Policy Statement.....	4
Health Care Professionals and Coverage.....	6
Covered Services	6
Health Care Professionals.....	9
Physician	9
Services and Supplies	11
Nurse Practitioner, Physician Assistant, and Nurse Midwife.....	13
Services and Coverage Issues.....	13
Visiting Nurse Services.....	15
Clinical Psychologist Services	16
Clinical Social Worker Services.....	18
Rural Health Clinic (RHC) Rules	20
Provider Number Components	20
Type of Bill	20
Part B Deductible.....	20
Coinsurance.....	21
Split Billing	21
Unique Physician Identification Number (UPIN).....	21
RHC Encounters.....	22
RHC Revenue Coding	23
Technical Component (TC)	24
Diagnostic Laboratory.....	24
Skilled Nursing Facility (SNF).....	25
Influenza Virus Vaccine and Pneumococcal Pneumonia Vaccine (PPV)	26
Worksheet B-1 Examples of PPV and Influenza Reimbursement Calculations.....	27
Non-RHC Services	26
Balanced Budget Act of 1997.....	27
RHC Services (Section 4205).....	27
UB-92 Claim Requirements for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).....	28
UB-92 Form Locators	28
Billing Examples	33

**Contact TrailBlazer Health Enterprises, LLC at:
(888) 763-9836 and at www.trailblazerhealth.com**

Rural Health Clinic (RHC) History

Creation and Scope of the Program

Creation of the Program

The Rural Health Clinic (RHC) Services Act (PL95-210) is a federal law passed in 1977 to help meet the primary and emergency health needs of the rural communities. The interest in rural health services grew in the 1980s for several reasons:

- Many rural hospitals closed due to increased financial pressures.
- In 1987, Congress passed laws improving RHC reimbursement.
- Rural physicians found Medicare and Medicaid reimbursement inadequate, causing limited access to rural medical services.
- An increased demand for primary care services for Medicaid beneficiaries due to expansions in Medicaid benefits.
- Reductions in the National Health Services Corps that caused the number of physicians in the under-served rural areas to drop dramatically.

There are currently over 3,000 RHCs throughout the nation certified by the Centers for Medicare & Medicaid Services (CMS) U.S. Department of Health and Human Services.

Scope of the Program

Roughly 20 percent of the nation's population lives in areas where education, economic, transportation and health services are sparse to nonexistent. Because of the scarcity of physicians, rural health services in the clinics may be provided by independent RHCs that are owned and operated by a physician, nurse practitioner, physician's assistant and/or certified nurse midwife CNM or the RHC may be owned and operated by a Medicare participating provider (hospital, Skilled Nursing Facility (SNF) and Home Health Agency (HHA)). The RHC may be housed in a permanent or mobile structure.

Certification

Certification Criteria

**Certification
Criteria**

Following are the Rural Health Clinic (RHC) certification criteria:

- An RHC must be in compliance with federal, state and local laws, which include the Federal Americans With Disabilities Act, the state medical and nursing practices acts and the pharmacy laws, as well as local fire, sanitation and building codes.
- The clinic may be in a permanent location or a mobile unit with a fixed schedule of locations.
- An RHC must have a physician on staff who provides medical supervision for the clinic's staff. The physician must be present at the clinic at least every two weeks for medical direction, consultation and supervision and be available by telecommunication at all times for assistance with medical emergencies and patient referrals.
- The clinic must employ at least one nurse practitioner, physician assistant or certified nurse midwife who is on duty at least 50 percent of the time the clinic is open and who is under the general direction of the physician. One of these professionals must be present to provide service whenever the clinic is open.
- Other required staff members include:
 - Clinic nurse/aide.
 - Front desk receptionist.
 - Clinic administrator.
 - Billing personnel.
 - Medical records librarian.

Note: Several of the above positions may be filled by one person but each position must be listed on the Medicare survey.

Continued on next page

Certification Criteria, Continued

Certification Criteria (continued)

The RHC must:

- Provide routine diagnostic and laboratory services such as, chemical examination of urine, hemoglobin/hematocrit, blood sugar, occult blood, pregnancy and primary cultures for transmittal to a certified lab.
 - Have written policies and procedures.
 - Establish arrangements with providers and suppliers participating in the Medicare and/or Medicaid program to furnish medically necessary services not available at the clinic, such as inpatient hospital care, physician services, and additional or specialized laboratory services.
 - Be able to provide first-response emergency care including necessary drugs.
 - Assure the maintenance and security of patient records.
 - Must maintain appropriate health and safety standards, complying with local, state and federal laws.
 - Have a mechanism for an annual evaluation of the clinic's program.
 - Have policies and procedures in place for transferring patients in need of acute care.
- To become Medicare certified as an RHC, a provider must submit an application to their local Department of Health. If a hospital provides RHC services at more than one site, each site is considered a clinic. The location of the site, rather than the location of the provider hospital, will determine the eligibility of the RHC.

Note: Once the provider's state has certified its clinic, CMS will assign a provider number.

CMS Policy Statement

Request For Provider-Based Status

For clinics seeking status as provider-based, the provider will need to furnish documentation to support its claim of provider-based status to the State Survey Agency. See the requirements listed below from Program Memorandum 60A 96-7, dated August 1996. (These requirements also apply to a change of ownership request.)

CMS Policy Statement

CMS policy states that the following applicable requirements must be met before an entity can be designated as part of a provider for payment purposes:

1. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (e.g., from the same service or catchment area).
2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the state separately licenses the provider-based entity).
3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body) and the accrediting body recognizes the entity as part of the provider.
4. The entity is operated under common ownership and control (i.e., common governance) by the provider where it is based as evidenced by the following:
 - The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based.
 - The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity.
 - The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment and service personnel on a daily basis.
5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:
 - The director or individual responsible for day-to-day operations at the entity maintains daily reporting and is accountable to the chief executive officer of the provider and reports (through that individual) to the governing body of the provider where the entity is based.
 - Administrative functions of the entity, e.g., records, billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.

Continued on next page

CMS Policy Statement, Continued

CMS Policy Statement,
continued

6. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:
 - Professional staff of the provider-based entity has clinical privileges in the provider's facility where it is based.
 - The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the chief medical officer or other similar officials of the provider where it is based.
 - All medical staff committees or other professional committees, at the provider's facility where the entity is based, are responsible for all medical activities in the provider-based entity.
 - Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based.
 - Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services.
 - Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.
7. The entity is held out to the public as part of the provider where it is based (e.g., patients know they are entering the provider and will be billed accordingly).
8. The entity and the provider, where it is based, are financially integrated as evidenced by the following:
 - The entity and the provider where it is based have an agreement for the sharing of income and expenses.
 - The entity reports its cost in the cost report of the provider where it is based using the same accounting system for the same cost-reporting period as the provider where it is based.

For any questions concerning certification, please contact your state survey and certification department.

Health Care Professionals and Coverage

Covered Services

Description	The services offered in a Rural Health Clinic (RHC) are the type of services that patients receive in a doctor's office, an outpatient clinic or emergency room. Such services are physician's diagnostic, treatment or consultation services. In an RHC, the services may also be provided by a nurse practitioner, physician's assistant, certified nurse midwife, clinical psychologist or clinical social worker.
RHC Covered Services	<p>Services are covered in an RHC if the following apply:</p> <ul style="list-style-type: none"> • Medically reasonable and necessary. • The service is provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical social worker or clinical psychologist who is employed by or receives compensation from the clinic. • If not provided by a physician, the service is provided under the general supervision of the physician. • The service is provided in accordance with the clinic's policies, protocols, standing orders or any physician's medical orders for patient care and treatment. • If not provided by a physician, the service is permitted by state law for the nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist or clinical social worker to provide the service. • If not provided by a physician, the service would be covered by Medicare if performed by a physician.
Services and Supplies "Incident To" the Services	Services and supplies which are "incident to" the services of the physician, nurse practitioner, physician assistant, clinical psychologist or clinical social worker are also covered in the RHC. This would include services of other clinic employees including registered nurses, licensed vocational nurses, technicians, or aides. This also includes supplies such as casts, bandages, splints, etc., used for these services. Only drugs and biologicals, which cannot be self-administered, are covered in the RHC. Clinical laboratory test, furnished in the RHC laboratory, are also covered as RHC services.

Continued on next page

Covered Services, Continued

**RHC Services
not Covered**

Services not covered in an RHC as clinic services but may be covered under other Medicare benefits include:

- Durable Medical Equipment (DME) (whether rented or sold) including iron lungs, hospital beds used in the patient's home, wheelchairs, etc.
- Ambulance services.
- Prosthetic devices, which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care, and the replacement of such devices.
- Leg, arm, back and neck braces and artificial legs, arms, and eyes, including replacements if required, because of a change in the patient's physical condition.
- Physical, speech or occupational therapy with a therapist not employed by the RHC.
- Screening mammography.
- Technical components of diagnostic tests.

Contracted non-physician diagnostic or therapeutic services are also excluded from RHC coverage.

Example: If an RHC has an agreement to obtain specialized laboratory or therapy services from an outside agency or individual not employed by the RHC. The service must be billed by the outside agency or individual to its own carrier or intermediary. The service cannot be billed through the RHC.

Note: Services related to the terminal illness of a hospice patient cannot be billed as RHC services. If the RHC physician is the hospice patient's attending physician, these hospice-related services can be reimbursed by the hospice service to the physician. RHC physicians and practitioners can bill, as an RHC, only the services that are not related to the terminal condition of a hospice patient.

Continued on next page

Covered Services, Continued

General Exclusions from Medicare Coverage

No payment can be made under Medicare Part A or Part B for items and services with the following characteristics:

- Not reasonable and necessary.
 - No legal obligation to pay for or provide.
 - Furnished or paid for by government instrumentalities.
 - Not provided within the United States.
 - Personal comfort.
 - Routine services and appliances.
 - Supportive devices for feet.
 - Custodial care.
 - Cosmetic surgery.
 - Charges by immediate relatives or members of household.
 - Dental services.
 - Paid or expected to be paid under a Medicare Secondary Payer (MSP) provision.
- Or,
- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital.
-

Health Care Professionals

Physician

Description

Physician services are the professional services performed by a physician for a patient including diagnosis, therapy, surgery and consultation. A service may be considered to be a physician service if the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization is possible by means of X-rays, electrocardiogram (EKG) and electroencephalogram tapes, tissue samples, etc.

Example: The interpretation by a physician of an actual EKG or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of verbal description) is a covered service.

Determining Professional Services

In determining whether the professional services of a physician are RHC services, the following general rules apply:

- The services of a physician performed at the clinic are RHC services and are payable only to the clinic.
- Services by means of a telephone call between a physician and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are not separately billable but can be included as part of another billable visit by the RHC practitioner (e.g., revenue code 521).
- Visits for the sole purpose of obtaining or renewing a prescription, in which the need was previously determined (so that no examination of the patient is performed), are not covered services.
- Time used in completion of claim forms.
- Care-plan oversight is not allowed by either Part A or Part B for RHC providers.

Full-time and part-time physicians who are employees of an RHC or who are compensated under agreement by the clinic for providing services furnished to the clinic's patients in a location other than at the clinic, may furnish services to clinic's patients at the clinic or in other locations (e.g., in a patient's home). These services are RHC services and are payable only to the clinic. Clinic patients include individuals who receive services at the clinic facility or services provided elsewhere for which the costs are included in the costs of the RHC. A physician who is an employee of an RHC or who is compensated by the clinic for services in locations other than the clinic, may not bill the Medicare Part B program through the carrier for services furnished to Medicare beneficiaries at locations away from the clinic.

Continued on next page

Physician, Continued

**Determining
Professional
Services,**
continued

If the clinic does not compensate a physician for services furnished to clinic patients in a location other than at the RHC location, the physician may bill for Medicare payment under Part B for a location away from the clinic.

Note: Services rendered in hospital settings, (inpatient, outpatient, emergency room and swing beds) are *not considered RHC services*. These services must be billed to the carrier on the 1500 claim form.

Services and Supplies

Services and Supplies Furnished Incident to the Professional Services of the RHC Practitioner

Services and supplies incident to an RHC practitioner's (physician, physician's assistant, nurse practitioner, nurse midwife and clinical psychologist) professional services are covered as RHC services as long as the services are supplies are:

- Furnished as an incidental, although integral, part of an RHC Practitioner's services.
- A type commonly furnished either without charge or included in the RHC's bill.
- A type commonly furnished in a physician's office.
- Services provided by *clinic employees* that are furnished under the direct and personal supervision of an RHC practitioner.
- Furnished by a member of the clinic or staff who is an *employee* of the clinic.

The service or supply must be an integral, although incidental, part of the RHC practitioner's personal professional services in the course of diagnosis or treatment of an injury or illness. In other words, there must be a practitioner's personal service furnished in which the clinical staff member's service (or the supply) is an incidental, although integral part. However, this does not mean that each occasion of service by a clinical staff member (or the furnishing of a supply) need to also always be the occasion of the actual furnishing of a personal professional service by the RHC practitioner. This requirement is also met for clinic staff services furnished during a course of treatment in which the practitioner performs an initial and subsequent service with a frequency that reflects his active participation in, and management of, the course of treatment. However, the direct and personal supervision requirement must still be met with respect to every clinical staff member's service for it to be covered as an incidental to service.

Commonly furnished services and supplies are those customarily incident to a physician's personal services in the office or in physician-directed clinic settings. The requirement is not met when supplies are clearly types of materials that a physician is not expected to have on hand in his office or where services are a type that are not medically appropriate in the office setting.

Continued on next page

Services and Supplies, Continued

Services and Supplies Furnished Incident to the Professional Services of the RHC Practitioner,
continued

Example: The performance of an appendectomy is not a service that is commonly furnished in a physician's office.

Coverage is limited to situations where there is direct supervision of the clinic staff performing the service. Direct and personal supervision does not mean that the RHC practitioner must be present in the same room. However, the practitioner must be on the premises and immediately available to provide assistance and direction throughout the time the clinical staff is performing services. In other words, if no mid-level or physician is on the premises; auxiliary staff may not provide any medical services.

To be "incident to", the services must be provided by a member of the clinic's health-care staff who is a clinic employee. Services provided by auxiliary personnel *not employed by* the clinic, even if provided on the physician's order or included in the clinic bill (e.g., services of an independently practicing therapist who forwards his bill to the clinic for inclusion in the entity's statement of services), are not covered as incident to an RHC practitioner's service. Thus, non-physician diagnostic and therapeutic services that a clinic obtains (i.e., from an independent laboratory or a hospital outpatient department) *are not covered* as RHC services and cannot be billed to Medicare by the RHC.

As with the physician's personal professional service, the services (or supplies) must be furnished without charge or be included in the clinic bill. The patient's financial liability for the incidental services (or supplies) is to the clinic. Therefore, the incidental services (or supplies) must represent an expense incurred by the RHC.

Example: If a patient purchases a drug and the physician administers it, the drug is not covered as an RHC service.

Services and supplies covered under this provision include such items as bandages, gauze, assistance by a nurse to a practitioner performing a covered nurse practitioner or physician's assistant's service, etc. Only drugs and biologicals that cannot be self-administered or are specifically covered by Medicare law (e.g., antigens prepared by a physician for a particular patient) are covered under this provision.

Nurse Practitioner, Physician Assistant, and Nurse Midwife Services and Coverage Issues

Services and Coverage Issues Nurse practitioner or physician assistant services (including services furnished by nurse midwives) are covered as RHC services. The services are covered if they are:

- Furnished by a nurse practitioner, physician assistant, or certified-nurse midwife who is employed by or receives compensation from an RHC (Mid-levels cannot be contracted workers, they can only be an employee of the clinic or clinic owner).
- Furnished under the general (or direct, if required by state law) medical supervision of a physician.
- Furnished in accordance with clinic policies and any physician's medical orders for the care and treatment of a patient.
- A type which the nurse practitioner, physician assistant, or certified nurse midwife who furnished the service is legally permitted to perform services by the state in which the service is furnished.
- A type which would be covered under Medicare if furnished by a physician.

Nurse practitioner and physician assistant (including certified nurse midwife) services are professional services performed by a nurse practitioner, physician assistant, or certified-nurse midwife for a patient. Services include diagnosis, treatment, therapy, and consultation. The service must be rendered directly by the practitioner (i.e., the practitioner must either examine the patient in person or be able to visualize some aspect of the patient's condition without the interposition of a third person's judgment). Direct visualization is possible by means of X-rays, EKG and electroencephalogram tapes, tissue samples, etc.

In general, Medicare covers services provided by a nurse practitioner, physician assistant, and certified-nurse midwife, which would be considered covered physician services under Medicare, and are permitted by state laws and clinic policies to be furnished by a nurse practitioner or physician assistant, or a certified-nurse midwife. As with physician services under Medicare, a service will not be covered if it is not reasonable and necessary for the treatment of a patient's illness or condition, or to improve the functioning of a malformed body member.

Continued on next page

Services and Coverage Issues, Continued

Services and Coverage Issues, continued

To determine whether the professional services of a nurse practitioner, physician assistant, or certified-nurse midwife are RHC services, the following general rules apply:

- The services of a nurse practitioner or physician assistant (including services furnished by certified-nurse midwives) performed at the clinic are RHC services and are payable only to the clinic.
- Services by means of a telephone call between a physician and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are not separately billable but can be included as part of another billable visit by the RHC practitioner (e.g., revenue code 521).
- Visits for the sole purpose of obtaining or renewing a prescription, the need for which was previously determined (so that no examination of the patient is performed) are not covered services.
- Time used in completion of claim forms.
- Care-plan oversight is not allowed either by Part A or Part B for RHC providers.

Full-time and part-time nurse practitioners, physician assistants (including nurse midwives) who are employees of an RHC or who are compensated by the clinic for providing services furnished to the clinic's patients in locations other than at the clinic, may furnish services to clinic patients at the clinic or in other locations, such as the patient's home. These services are RHC services and are reimbursable only to the clinic. Clinic patients include individuals who receive services at the clinic facility or services provided elsewhere. These costs are included in the costs of the RHC.

A nurse practitioner, physician assistant (including nurse midwives) who is an employee of an RHC, or who is compensated by the clinic for services in locations other than the clinic, may not bill Medicare Part B for services furnished to Medicare beneficiaries at locations away from the clinic. If the clinic does not compensate a physician for services furnished to the clinic's patients in a location other than at the RHC location, the physician may bill for Medicare payment under Part B for "location away from the clinic."

Note: Services rendered in a hospital setting (inpatient, outpatient, emergency room, and swing beds) are not considered RHC services. These can be charged to the carrier on the 1500 claim form.

Continued on next page

Services and Coverage Issues, Continued

Services and Coverage Issues, continued

Note: Under Medicare Part B, non-RHC services of physician assistants are covered in any setting in rural health professional shortage areas and non-RHC services of nurse practitioners are covered in any non-medical service administration rural setting. Such services are billed to the Part B carrier, and payment may be made directly to the nurse practitioner or the employer of the physician's assistant or nurse practitioner. Certified-nurse midwives can provide services in any area. Part B carrier payment can be paid directly to the nurse midwife or to the employer of the nurse midwife.

State laws concerning services of physician assistant, nurse practitioners and certified nurse midwives vary from state to state. Please contact the carrier in your state for additional information regarding Part B coverage and billing.

Visiting Nurse Services

Coverage Issues Visiting nurse services are covered as RHC services if:

- The RHC has received special certification from CMS to provide visiting nurse services because the RHC is located in an area in which CMS has determined there is a shortage of home health agencies (contact your state Department of Health).
 - The services are rendered to patients who are homebound.
 - The patient is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse that is employed by or receives compensation for the services from the RHC.
 - The services are furnished under a written plan of treatment.
-

Clinical Psychologist Services

- Requirements** To qualify as a clinical psychologist a practitioner must meet the following requirements:
- Hold a doctoral degree in psychology from a program in clinical psychology of an educational institution that is accredited by an organization recognized by the Council on Post-Secondary Accreditation.
 - Meet licensing or certification standards for psychologists in independent practice in the state in which he practices.
 - Have two years of supervised clinical experience, at least one of which is post-degree.

Clinical Psychologist Services

Effective July 1, 1990, the diagnostic and therapeutic services of a clinical psychologist and services/supplies furnished incident to such services are covered in an RHC. However, the clinical psychologist must be legally authorized to perform the service under applicable licensure laws of the state in which they are furnished.

To be covered incident to a clinical psychologist's service, the following services and supplies must be:

- Mental health services that are commonly furnished in a clinical psychologist's office.
- An integral, although incidental, part of professional services performed by the clinical psychologist.
- Performed under the direct and personal supervision of a clinical psychologist (i.e., the clinical psychologist must be physically present and immediately available).

The services of clinical psychologists are not covered if they are otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by state law to perform them. Services at the RHC or away from the RHC are covered. See the previous discussion in the "Physician" section.

The clinical psychologist must provide written notification to the patient's designated attending or primary care physician that services are being provided to the patient, or must consult directly with the physician to consider medical conditions that may be contributing to the patient's symptoms, unless the patient specifically requests that such notification or consultation not be made.

Continued on next page

Clinical Psychologist Services, Continued

**Psychiatric
Limitations**

All covered therapeutic services furnished by qualified clinical psychologists in a RHC are subject to the outpatient mental health services limitation (i.e., 62.5 percent of expenses for these services are considered incurred expenses for Medicare purposes). For examples of payment calculations please refer to section 419 (F) of the CMS Publication 27 Rural Health Clinic and Federally Qualified Health Center manual. This limitation does not apply to diagnostic services.

Clinical Social Worker Services

Requirements

RHC services include the services provided by a clinical social worker. A clinical social worker is an individual who:

- . Possesses a master or doctor's degree in social work.
 - . Has performed at least two years of supervised clinical social work; and, is either licensed or certified as a clinical social worker by the state in which the services are performed.
 - Or,
 - In the case of an individual in a state that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, Skilled Nursing Facility (SNF) or clinic.
-

Clinical Social Worker Covered Services

Coverage is limited to the services a clinical social worker is legally authorized to perform in accordance with state law (or state regulatory mechanism established by state law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses and services and supplies furnished incident to such services.

The services of a clinical social worker may be covered in an RHC if they are:

- The type of services that are otherwise covered if furnished by a physician, or incident to a physician's service.
- Performed by a person who meets the above definition of clinical social worker.
- Not otherwise excluded from coverage.

Note: Services of a clinical social worker are not covered when furnished to inpatients of a hospital or to inpatients of a SNF if the services furnished in the SNF are those that the SNF is required to furnish as a condition of participation to Medicare. Services at the RHC or away from the RHC are covered. See the previous information in the "Physician" section.

Note: Only the direct "hands on" services of a clinical social worker are covered. No coverage is available for services and supplies furnished incident to the professional services of a clinical social worker.

Continued on next page

Clinical Social Worker Services, Continued

**Psychiatric
Limitations**

All covered therapeutic services furnished by qualified clinical social workers in an RHC are subject to the outpatient mental health services limitation (i.e., 62.5 percent of expenses for these services are considered incurred expenses for Medicare purposes). For examples of payment calculations please refer to section 419 (F) of the CMS Publication 27 Rural Health Clinic and Federally Qualified Health Center manual. This limitation does not apply to diagnostic services.

Rural Health Clinic (RHC) Rules

Provider Number Components

Provider Number Components

All providers will be issued a provider number by the Centers for Medicare & Medicaid Services (CMS) after they complete their state survey. This number will contain the following components, state codes and provider specialty ranges. The freestanding state code and ranges are listed below:

State Codes (XX)				Freestanding RHC Ranges (0000)	Provider-based RHC Ranges (0000)
Arkansas	04	Oklahoma	37	3800 - 3974	3400-3499
Colorado	06	South Dakota	43	8900 - 8999	3975-3999
Louisiana	19	Texas	45		8500-8899
Montana	27	Texas	67		
New Mexico	32	Utah	46		
North Dakota	35	Wyoming	53		

Type of Bill

Type of Bill

All charges submitted by an RHC will appear under Type of Bill (TOB) 71X. The third digit of the TOB is the bill frequency. This digit shows the nature or intent of the bill submitted. Below is a listing of the possible third digits available to an RHC.

- Non-payment/Zero Claim - 0
- Admit through Discharge Claim - 1
- Replacement of Prior Claim - 7
- Void/Cancel of Prior Claim - 8

TOB 715 (late charge) is no longer allowed for any RHC use.

Part B Deductible

Part B Deductible

The Part B annual deductible applies to services covered under the RHC benefit.

Coinsurance

Part B Coinsurance

If the item or service is covered as an RHC service, the clinic may not charge the beneficiary more than 20 percent of the charges plus the deductible. The clinic may charge the beneficiary for items and services that are not Medicare covered services.

Split Billing

Split Billing

All Part B providers must split their outpatient bills for both:

- Calendar year end.
- Fiscal year end.

This will assist in proper cost reporting information and the correct calculations of Part B deductible amounts on the patient's statements.

Unique Physician Identification Number (UPIN)

Unique Physician Identification Number (UPIN)

Effective for services on or after Jan. 1, 1992, all RHC bills submitted require the Unique Physician's Identification Number (UPIN).

The UPIN is six characters in length. The first three characters of the UPIN may be numbers or letters. However, the last three characters of the UPIN must be numeric.

Reporting the Name and UPIN

On the UB-92 claim form, in Form Locator (FL) 82 (attending/admitting/supervising physician ID), enter the UPIN, physician's last name and initial of the first name. Providers should report the UPIN of the supervising physician or physician director.

RHC Encounters

RHC Reimbursement

RHCs are paid on the basis of an encounter.

An encounter is defined as “a face to face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an RHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit” **per section 504 of the CMS publication 27. It is possible in rare circumstances in** “except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.”

RHCs are reimbursed the lower of the national capped amount or the clinic specific cost per encounter. The national capped amount is indexed for inflation and can increase each year.

RHC payment is subject to the Part B cash deductible. This amount is subject to regulatory change.

After the deductible has been satisfied, RHCs are reimbursed 80 percent of the all-inclusive reimbursement rate. The patient is responsible for a coinsurance amount equal to 20 percent of the billed amount.

RHCs

For newly certified RHCs, the reimbursement rate will be automatically established at 75 percent of the national capped amount. This rate will remain in effect until the provider submits financial data or until the cost report is submitted. A copy of the CMS-222 cost reporting form will be sent with the rate notification letter for providing additional updated information. The cost report can be completed containing, at a minimum, three months of actual data or the Fiscal Intermediary (FI) will also accept budget data. Beginning Jan. 1, 2001, pneumococcal and influenza vaccines are payable through the cost report for both provider based and freestanding RHCs and cannot be billed.

Payment	Limit Adjustment	Period
\$61.85	2.4 percent	01/01/00 - 12/31/00
\$63.14	2.1 percent	01/01/01 - 12/31/01
\$64.78	2.6 percent	01/01/02 - 12/31/02
\$66.46	2.6 percent	01/01/03 - 02/28/03
\$66.72	3.0 percent	03/01/03 - 12/31/03
\$68.65	2.9 percent	01/01/04 - 12/31/04
<i>CMS Pub. 100-20 Trans. 49 (CR 3075) dated Jan. 30, 2004</i>		

RHC Revenue Coding

Revenue Codes Freestanding clinics are not required to provide Healthcare Common Procedure Coding System (HCPCS) codes for the following applicable revenue code. Provider-based clinics are required to HCPCS codes for the following applicable revenue codes. All charges associated with the patient's visit should be combined into a single dollar amount that is reflected under the appropriate encounter code. The number of units associated with the encounter code is one per visit.

Applicable Revenue Codes

- 0001 - Total Charges
- 0510 - Tele-medicine
- 0521 - Rural health - Clinic Visit
- 0522 - Rural health - Off-site Visit
- 0770 - Glaucoma Screening
- 091X - Psychiatric/psychological services (until Oct.15, 2003)
- 090X - Psychiatric/Psychological Services (Oct.16, 2003, and after)*
- 0940 - Peripheral Neuropathy

Charges for the RHC services, furnished during an encounter, are reported under 52X revenue code. It is not appropriate for RHCs to fragment the visit/encounter into unique components, e.g., separate charges for pharmacy, supplies, surgeries, etc. For RHCs all these services should be combined into one encounter (revenue code 52X or 91X). Charges for the interpretation of diagnostic tests performed by RHC staff (physician or midlevel) are included with the charges for the encounter under revenue code 52X.

*CMS Pub. 100-04 Trans. 167 (CR 3194) dated April 30, 2004

*CMS Pub. 100-20 Trans. 98 (CR 3343) dated July 23, 2004

Technical Component (TC)

Additional Reimbursement for the Technical Component (TC)

The Technical Component (TC) of a diagnostic procedure is reimbursed outside of the encounter rate. For a provider-based RHC, this reimbursement is made to the mother entity. This billing occurs under the mother entity's type of bill and provider number. For a freestanding RHC, these charges are billed to the carrier on the 1500 claim form.

Diagnostic Laboratory

Additional Reimbursement For Diagnostic Laboratory Services

All diagnostic laboratories, including the six waived tests are reimbursed outside of the encounter rate. For a provider-based RHC, this reimbursement is made to the mother entity. Billing for diagnostic laboratory services will be completed by the RHCs mother facility. This bill will appear as a 141 type of bill and appear using the mother facilities provider number and not the RHCs provider number. For a freestanding RHC these charges are billed to the carrier on the 1500 claim form.

Skilled Nursing Facility (SNF)

**Additional
Reimbursement
For Skilled
Nursing
Facility (SNF)
Services**

Reimbursement for RHC services provided in a Skilled Nursing Facility (SNF) is as follows:

- When RHC services are provided to a SNF resident in a covered Part A stay, the services by law are subject to the SNF consolidated billing provision and may not be billed by the RHC. Reimbursement is made to the RHC by the SNF.
 - When RHC services are provided during the RHC's regular business hours to a SNF resident not in a covered Part A stay, the RHC bills the services under revenue code 0522 to the FI on the UB-92 claim form.
 - When RHC services are provided outside of the RHC's regular business hours to a SNF resident in a covered Part A stay, the RHC bills the services to the carrier on the 1500 claim form.
 - When RHC services are provided outside of the RHC's regular business hours to a SNF resident not in a covered Part A stay, the RHC bills the services to the carrier on the 1500 claim form.
-

Influenza Virus Vaccine and Pneumococcal Pneumonia Vaccine (PPV)

Influenza Virus Vaccine and Pneumococcal Pneumonia Vaccine (PPV) Interim Reimbursement

RHCs are not allowed to bill for the cost and administration of influenza virus and Pneumococcal Pneumonia Vaccinations (PPVs) at the time of service. These services should not be billed to the FI on the UB-92 claim form or to the Medicare Part B (carrier) on the 1500 claim form. These charges are reimbursable only through the Medicare cost report. This became effective for provider-based RHCs on Jan. 1, 2001. This has always been the process for freestanding RHC.

Data elements:

- The total cost of pneumococcal vaccine.
- The total cost of the influenza vaccine.
- The number of pneumococcal injections administered.
- The number of influenza injections.
- The number of Medicare beneficiaries who received the pneumococcal vaccine.
- The number of Medicare beneficiaries who received the influenza vaccine.

The individual who collected the data must sign the reimbursement form. It must also include the telephone number and date. The completed form is returned to Provider Audit and Reimbursement for calculations.

Worksheet B-1 Examples of PPV and Influenza Reimbursement Calculations

W/S B-1

Pneumococcal Injections

Facility Health Care Staff Costs		\$210,000	d	
Staff Hours Spent in Pneumococcal Injections	210.67			
Total Staff Hours	/	<u>6,390.00</u>		
Ratio of Staff Time Spent in Pneumococcal Injections	x	<u>0.032969</u>		
Total Pneumococcal Vaccine Staff Cost		\$6,923		
Medical Supplies Cost - Pneumococcal Vaccines	+	<u>\$1,050</u>		
Total Direct Cost of Pneumococcal Vaccines		\$7,973	\$7,973	
Total Direct Cost of the Allowable RHC		/	<u>\$244,000</u>	a
Ratio of Pneumococcal Vaccines Direct Cost to Total Direct Cost		0.032678		
Total Facility Overhead	x	<u>\$235,000</u>	c	
Overhead Cost - Pneumococcal Vaccines			\$7,679	
Total Cost - Pneumococcal Vaccines			<u>\$15,653</u>	f
Total Pneumococcal Injections			/	<u>450</u>
Cost per Pneumococcal Injection			\$34.78	
Medicare Pneumococcal Injections			x	<u>200</u>
Total Medicare Cost - Pneumococcal Vaccines				<u><u>\$6,957</u></u>

Continued on next page

Worksheet B-1 Examples of PPV and Influenza Reimbursement Calculations, Continued

Total Medicare Cost - Pneumococcal Vaccines (*repeated from prior page*) \$6,957

Influenza Injections

Facility Health Care Staff Costs	\$210,000		d	
Staff Hours Spent in Influenza Injections	200.00			
Total Staff Hours	/ 6,390.00			
Ratio of Staff Time Spent in Influenza Injections	x 0.031299			
Total Influenza Vaccine Staff Cost	\$6,573			
Medical Supplies Cost - Influenza Vaccines	+ \$950			
Total Direct Cost of Influenza Vaccines	\$7,523	\$7,523		
Total Direct Cost of the Allowable RHC	/ \$244,000	a		
Ratio of Influenza Vaccines Direct Cost to Total Direct Cost	0.030831			
Total Facility Overhead	x \$235,000	c		
Overhead Cost - Influenza Vaccines		\$7,245		
Total Cost - Influenza Vaccines		\$14,768	g	
Total Influenza Injections		/ 350		
Cost per Influenza Injection		\$42.19		
Medicare Influenza Injections		x 145		
Total Medicare Cost - Influenza Vaccines			\$6,118	
Total Medicare Cost - Pneumococcal and Influenza Vaccines			<u>\$13,075</u>	j

Non-RHC Services

**Services
Outside of The
Scope of The
RHC Benefit**

Following are the services outside of the scope of the RHC benefit:

- Durable Medical Equipment (DME) (whether rented or sold) including iron lungs, hospital beds used in the patient's home, wheelchairs, etc.
- Ambulance services.
- Prosthetic devices that replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care, and the replacement of such devices.
- Leg, arm, back and neck braces and artificial legs, arms and eyes, including replacements if required, because of a change in the patient's physical condition.
- Physical speech or occupational therapy with a therapist not employed by the RHC.
- Screening mammography.
- Telemedicine.
- Hospital visits.

Services outside the RHC benefits should be billed to the appropriate Part B carrier on the 1500 claim form using a provider number that is recognized by the carrier. The Part B carrier does not recognize RHC provider numbers. Providers should contact the Part B carrier for further information on billing of these services.

Balanced Budget Act of 1997

RHC Services (Section 4205)

**Per-Visit
Payment Limits
for Provider-
Based RHCs**

The provision extends the current per visit payments limits applicable to independent RHCs to provider-based clinics (other than clinics based in small rural hospitals with less than 50 beds).

**Assurance of
Quality
Services**

The provision requires RHCs to have a quality assurance and performance program as specified by the secretary.

**Waiver of
Staffing
Requirements
Limited to
Clinics in
Program**

The provision limits the current authority for the secretary to waive the requirement that a clinic have a mid-level professional available at least 50 percent of the time. The waiver will be applicable only to clinics already providing services under Medicare, and not to entities seeking Medicare certification.

**Refinement of
Shortage Area
Requirements**

The provision refines the requirement concerning the area in which an RHC is located. RHCs must be in shortage areas that have been reviewed within the last three years. The secretary has to find that there are insufficient numbers of needed health care practitioners in the clinic's area (not just primary care physicians). Clinics that no longer meet the shortage area requirements will be permitted to retain their designation only if the secretary determines that they are essential to the delivery of primary care services that would otherwise be unavailable in the area.

**Direct
Payments to
Physician
Assistants in
Decertified
RHCs**

The secretary shall allow physician assistants to receive direct Medicare payments for their services if they were previously the owner of an RHC that lost its RHC designation. Direct payment will be allowed for services provided before Jan. 1, 2003.

UB-92 Claim Requirements for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

UB-92 Form Locators

UB-92 Form Locators Following are the UB-92 form locator requirements for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs):

Form Locator	Description
1	Hospital name, address and telephone number (required)
2	Unlabeled (not used)
3	Patient Control Number (not required/but recommended) (This number will appear on the remittance advice.)
4	Type of bill required
5	Federal Tax Identification Number (not required)
6	Statement covers period (required) (The beginning and ending service dates of the period included on this bill.)
7	Covered days (not required for RHC billing) (The total number of covered days as applicable to cost reporting)
8	Non-covered days (not required for RHC billing) (Enter the number of days within the from and through date that are not to be billed as patient days on the cost report.)
9	Coinsurance days (not required for RHC billing)
10	Lifetime Reserve Days (not required for RHC billing)
11	Unlabeled (not used)
12	Patient name (required) Last name, first name and middle initial of the patient
13	Patient address (required) (Full mailing address where beneficiary resides)
14	Patient birth date (required) (Enter the month, day, century and year)
15	Patient sex (required)
16	Patient marital status (not required for RHC billing)
17	Admission/start of care date (not required for RHC billing)
18	Admission hour (not required for RHC billing)
19	Type of admission (not required for RHC billing)
20	Source of admission (not required for RHC billing)
21	Discharge hour (not required for RHC billing)
22	Patient status (not required for RHC billing)
23	Medical record number (required)
24-30	Condition code (required if applicable)
31	Not labeled (not required)

Continued on next page

UB-92 Form Locators, Continued

UB-92 Form Locators (continued)

Form Locator	Description
32-35	Occurrence code and dates (required if applicable)
36	Occurrence span code and date (required if applicable)
37	Internal Control Number/Document Control Number (Required for all bill types when requesting an adjustment or cancel. This number is on the remittance advice.)
38	Responsible party name and address (not required)
39-41	Value codes and amounts (required if applicable)
42	Revenue code (required) (A code that identifies a specific accommodation, ancillary service or billing calculation.)
43	Revenue description (not required)
44	Healthcare Common Procedure Coding System (HCPCS)/Rates (required for provider-based only) (HCPCS applicable to ancillary services, outpatient bills, or the accommodation rate for inpatient bills.)
45	Service date (required) (Effective July 1, 2004, report Line Item Date of Service (LIDOS) for all revenue code lines except 0001. MMDDYY format is effective Oct. 1, 2004. When more than one encounter is billed per claim each revenue code will need its own LIDOS.) <i>CMS Pub. 100-04 Trans. 199 (CR 3337) dated June 10, 2004</i>
46	Units of service (required)
47	Total charges (required)
48	Non-covered charges (required if applicable)
49	Unlabeled (not used)
50 (A-C)	Payer Identification (required) (This field is used to report the primary payer.)
51 (A-C)	Provider number (required) (This field is used to indicate the number assigned to the provider by the payer indicated in form locator 50 (A-C).)
52 (A-C)	Release of information certification indicator (required) (This field is used to indicate whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.)

Continued on next page

UB-92 Form Locators, Continued

UB-92 Form Locators (continued)

Form Locator	Description
53 (A-C)	Assignment of benefits certification indicator (not required)
54 (A-C)	Prior payment, payers and patients (not required for RHC billing) (This field is used to indicate the amount received from the patient or patient representative only.) Note: This field should not be used when Medicare is secondary payer. Please use the appropriate value codes.
55 (A-C)	Estimated amount due (not required)
56	Unlabeled (not used)
57	Unlabeled (not used)
58 (A-C)	Insured's name (required) (This field should indicate the name of the individual in whose name the insurance is carried. For Medicare purposes list the last name first, then the first name and middle initial, as it appears on their Medicare card.)
59 (A-C)	Patient's relationship to insured (required) (This field should be used when reporting the relationship of the patient to the identified insured when Medicare is secondary.)
60 (A-C)	Certificate/Social Security Number/Health Insurance Claim Number (HICN) (required) (This field is used to report the patient's HICN, or if Medicare is the secondary payer the identification number the benefits are paid under.)
61 (A-C)	Insured group name (required if applicable) (This field is used to report the name of the group or plan through which the insurance is provided to the insured when Medicare is secondary payer.)
62 (A-C)	Insurance group number (required if applicable) (This field is used to report the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered when Medicare is secondary payer.)

Continued on next page

UB-92 Form Locators, Continued

UB-92 Form Locators (continued)

Form Locator	Description
63 (A-C)	Treatment authorization code (not required for RHC billing) (This field is used to report the authorization number whenever Quality Improvement Group (QIO) review has been performed on a pre-admission or pre-procedure basis. The authorization number is required for all approval admissions or services.)
64 (A-C)	Employment status code of the insured (required if applicable) (This field is used to indicate the employment status of the insured individual identified in form locator 58. Report only when Medicare is secondary payer.)
65	Employer name of the insured (required if applicable) (This field is used to indicate the name of the employer that might or does provide health care coverage for the insured individual identified in form locator 58. Report only when Medicare is secondary payer.)
66	Employer location of the insured (required if applicable) (This field is used to indicate the specific location of the employer of the insured individual identified in form locator 58. Report only when Medicare is secondary payer.)
67	Principal diagnosis code (required) (This field is used to indicate the full ICD-9 code for the condition established after examination to be chiefly responsible for causing services to be rendered.)
68-75	Other diagnosis codes (not required for RHC billing) (This field is used to indicate the full ICD-9 code for reporting additional conditions that also exist at the time services are rendered.)
76	Admitting diagnosis (not required for RHC billing) (This field is used to indicate the full ICD-9 diagnosis code provided at the time of admission.)
77	External cause of injury (E-code) (not-required) Note: Report all E-codes in form locator 68-75.
78	Unlabeled (not used)
79	Procedure coding method used (not required)

Continued on next page

UB-92 Form Locators, Continued

UB-92 Form Locators (continued)

Form Locator	Description
80	Principal procedure code and date (not required for RHC billing) (This field is used to report the principal procedure performed during an inpatient or outpatient stay.)
81 (A-E)	Other procedure codes and dates (not required for RHC billing) (This field is used to report all other significant procedures other than the principal procedure.)
82	Attending physician ID (required) (This field is used to report the name and Unique Physician Identification Number (UPIN) of the licensed physician who would normally be expected to certify the medical necessity of the service rendered or who has primary responsibility for the patient's medical care.)
83 (A-B)	Other physician ID (required if applicable) (This field is used to indicate the name and UPIN of the attending physician who perform principal procedure.)
84	Remarks (required if applicable) (This field can be used to document additional information necessary to justify the claim.)
85	Provider representative signature (required)
86	Date bill submitted (required)

Billing Examples

Free-Standing On-Site Billing Example

1 Facility Name Facility Street Facility City, State and Zip Code	2		3 PATIENT CONTROL NO. Recommended							4 TYPE OF BILL 711										
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM MMDDYY THROUGH MMDDYY		7 COV.D.	8 N-C.D.	9 C-I.D.	10 L-R.D.		11											
12 PATIENT NAME Beneficiary Last, First & Middle Initial				13 PATIENT ADDRESS Beneficiary Street, City, State & Zip Code																
14 BIRTHDATE MMDDCCYY	15 SEX X	16 MS	17 DATE MMDDYY	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO. 123	24	25	26	27	28	29	30	31			
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE CODE	39 OCCURRENCE DATE	40 OCCURRENCE CODE	41 OCCURRENCE DATE	42 OCCURRENCE CODE	43 OCCURRENCE DATE	44 OCCURRENCE CODE	45 OCCURRENCE DATE	46 OCCURRENCE CODE	47 OCCURRENCE DATE	48 OCCURRENCE CODE	49 OCCURRENCE DATE	50 OCCURRENCE CODE	51 OCCURRENCE DATE	
39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE MMDDYY	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49										
1 0521	1 0001	1	1	1	1	1	1	1	1	1										
2	2	2	2	2	2	2	2	2	2	2										
3	3	3	3	3	3	3	3	3	3	3										
4	4	4	4	4	4	4	4	4	4	4										
5	5	5	5	5	5	5	5	5	5	5										
6	6	6	6	6	6	6	6	6	6	6										
7	7	7	7	7	7	7	7	7	7	7										
8	8	8	8	8	8	8	8	8	8	8										
9	9	9	9	9	9	9	9	9	9	9										
10	10	10	10	10	10	10	10	10	10	10										
11	11	11	11	11	11	11	11	11	11	11										
12	12	12	12	12	12	12	12	12	12	12										
13	13	13	13	13	13	13	13	13	13	13										
14	14	14	14	14	14	14	14	14	14	14										
15	15	15	15	15	15	15	15	15	15	15										
16	16	16	16	16	16	16	16	16	16	16										
17	17	17	17	17	17	17	17	17	17	17										
18	18	18	18	18	18	18	18	18	18	18										
19	19	19	19	19	19	19	19	19	19	19										
20	20	20	20	20	20	20	20	20	20	20										
21	21	21	21	21	21	21	21	21	21	21										
22	22	22	22	22	22	22	22	22	22	22										
23	23	23	23	23	23	23	23	23	23	23										
50 PAYER A Medicare	51 PROVIDER NO. B XXXXXX	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	57	58	59	60										
58 INSURED'S NAME A Beneficiary Last, First Name	59 P.REL B XX	60 CERT.-SSN - HIC - ID NO. C XXXXXXXXXXXX	61 GROUP NAME	62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67 PRIN. DIAG. CD. A XXXX	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	82 ATTENDING PHYS. ID UPIN #	83 OTHER PHYS. ID	84 REMARKS	85 PROVIDER REPRESENTATIVE X	86 DATE	87	88	89	90	91	92	93	94	95	96	97	98	99

Service Date: Use format MMDD from 07/01/04 to 09/30/04 and MMDDYY 10/01/04 and after.

Free-Standing Off-Site Billing Example

1 Facility Name Facility Street Facility City, State and Zip Code	2		3 PATIENT CONTROL NO. Recommended							4 TYPE OF BILL 711												
5 FED. TAX NO.			6 STATEMENT COVERS PERIOD FROM MMDDYY THROUGH MMDDYY		7 COV.D.	8 N-C.D.	9 C-I.D.	10 L-R.D.		11												
12 PATIENT NAME Beneficiary Last, First & Middle Initial				13 PATIENT ADDRESS Beneficiary Street, City, State & Zip Code																		
14 BIRTHDATE MMDDCCYY	15 SEX X	16 MS	17 DATE MMDDYY		18 ISS	19 TYPE	20 SRC		21 D HR	22 STAT	23 MEDICAL RECORD NO. 123	24	25	26	27	28	29	30	31			
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE CODE	39 OCCURRENCE DATE	40 OCCURRENCE CODE	41 OCCURRENCE DATE	42 OCCURRENCE CODE	43 OCCURRENCE DATE	44 OCCURRENCE CODE	45 OCCURRENCE DATE	46 OCCURRENCE CODE	47 OCCURRENCE DATE	48 OCCURRENCE CODE	49 OCCURRENCE DATE	50 OCCURRENCE CODE	51 OCCURRENCE DATE	52 OCCURRENCE CODE	53 OCCURRENCE DATE	
38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE MMDDYY	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64
1	0522		MMDDYY	1	120:00		1															
2	0001				120:00		2															
3							3															
4							4															
5							5															
6							6															
7							7															
8							8															
9							9															
10							10															
11							11															
12							12															
13							13															
14							14															
15							15															
16							16															
17							17															
18							18															
19							19															
20							20															
21							21															
22							22															
23							23															
50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72
A Medicare	XXXXXX						DUE FROM PATIENT >															
58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
A Beneficiary Last, First Name	XX	XXXXXXXXXXA																				
63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85
A																						
B																						
C																						
67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78	79	80	81	82	83	84	85	86	87	88	89
XXXXX																						
79 P.C.	80 PRINCIPAL PROCEDURE CODE	81 OTHER PROCEDURE CODE	82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE	87	88	89	90	91	92	93	94	95	96	97	98	99	100	
			UPIN #			X																
			Physician Last Name, First Name & Middle Initial																			

Free-Standing Two Visits Billing Example

1 Facility Name Facility Street Facility City, State and Zip Code	2		3 PATIENT CONTROL NO. Recommended							4 TYPE OF BILL 711									
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM MMDDYY THROUGH MMDDYY		7 COV.D.	8 N.C.D.	9 C.I.D.	10 L.R.D.	11												
12 PATIENT NAME Beneficiary Last, First & Middle Initial				13 PATIENT ADDRESS Beneficiary Street, City, State & Zip Code															
14 BIRTHDATE MMDDCCYY	15 SEX X	16 MS	17 DATE MMDDYY	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO. 123	24	25	26	27	28	29	30	31		
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE CODE	39 OCCURRENCE DATE	40 OCCURRENCE CODE	41 OCCURRENCE DATE	42 OCCURRENCE CODE	43 OCCURRENCE DATE	44 OCCURRENCE CODE	45 OCCURRENCE DATE	46 OCCURRENCE CODE	47 OCCURRENCE DATE	48 OCCURRENCE CODE	49 OCCURRENCE DATE		
a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r		
38	39 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	42 VALUE CODES AMOUNT	43 VALUE CODES CODE	44 VALUE CODES AMOUNT	45 VALUE CODES CODE	46 VALUE CODES AMOUNT	47 VALUE CODES CODE	48 VALUE CODES AMOUNT	49 VALUE CODES CODE	50 VALUE CODES AMOUNT	51 VALUE CODES CODE	52 VALUE CODES AMOUNT	53 VALUE CODES CODE	54 VALUE CODES AMOUNT	55 VALUE CODES CODE	56 VALUE CODES AMOUNT	
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE MMDDYY	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	50	51	52	53	54	55	56	57	58	59	60	
1	0521		MMDDYY	1	100:00		1												
2	0521		MMDDYY	1	110:00		2												
3	0001				210:00		3												
4							4												
5							5												
6							6												
7							7												
8							8												
9							9												
10							10												
11							11												
12							12												
13							13												
14							14												
15							15												
16							16												
17							17												
18							18												
19							19												
20							20												
21							21												
22							22												
23							23												
50 PAYER A Medicare	51 PROVIDER NO. XXXXXX	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	57	58	59	60	61	62	63	64	65	66	67	68	
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	
58 INSURED'S NAME Beneficiary Last, First Name	59 P.REL XX	60 CERT. - SSN - HIC - ID NO. XXXXXXXXXXA	61 GROUP NAME	62 INSURANCE GROUP NO.	63	64	65	66	67	68	69	70	71	72	73	74	75	76	
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	
63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	
67 PRIN. DIAG. CD. XXXX	68 CODE XXXXX	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78	79	80	81	82	83	84	85	
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	82 OTHER PROCEDURE CODE DATE	83 OTHER PROCEDURE CODE DATE	84 OTHER PROCEDURE CODE DATE	85 OTHER PROCEDURE CODE DATE	86 ATTENDING PHYS. ID UPIN #	87 PHYSICIAN LAST NAME, FIRST NAME & MIDDLE INITIAL	88 OTHER PHYS. ID	89 OTHER PHYS. ID	90 OTHER PHYS. ID	91 OTHER PHYS. ID	92 OTHER PHYS. ID	93 OTHER PHYS. ID	94 OTHER PHYS. ID	95 OTHER PHYS. ID	96 OTHER PHYS. ID	97 OTHER PHYS. ID	98 OTHER PHYS. ID
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	
84 REMARKS a First dx was for (define condition). Second dx was for (define condition). b Two visits, same day, not related. c d	85 PROVIDER REPRESENTATIVE X	86 DATE	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	

Provider-Based Off-Site Billing Example

1 Facility Name Facility Street Facility City, State and Zip Code	2		3 PATIENT CONTROL NO. Recommended							4 TYPE OF BILL 711																				
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM MMDDYY THROUGH MMDDYY		7 COV D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11																						
12 PATIENT NAME Beneficiary Last, First & Middle Initial				13 PATIENT ADDRESS Beneficiary Street, City, State & Zip Code																										
14 BIRTH DATE MMDDCCYY	15 SEX X	16 MS	17 DATE MMDDYY	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO. 123	24	25	26	27	28	29	30	31													
32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE	36 OCCURRENCE CODE DATE	37 OCCURRENCE SPAN FROM THROUGH	A	B	C	A	B	C																			
38	a	b	c	d	39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT	a	b	c	d																			
42 REV. CD. 0522 0001	43 DESCRIPTION	44 HCPCS / RATES 9921X	45 SERV. DATE MMDDYY	46 SERV. UNITS 1	47 TOTAL CHARGES 120.00 120.00	48 NON-COVERED CHARGES	49	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
50 PAYER A Medicare	51 PROVIDER NO. XXXXXX	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	57	A	B	C																				
58 INSURED'S NAME A Beneficiary Last, First Name	59 P-REL XX	60 CERT. - SSN - HIC - ID NO. XXXXXXXXXXA	61 GROUP NAME	62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67 PRIN. DIAG. CD. XXXXXX	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78										
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	82 ATTENDING PHYS. ID UPIN #	83 OTHER PHYS. ID	84 REMARKS	85 PROVIDER REPRESENTATIVE X	86 DATE	a	b	a	b	a	b																	

