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Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

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PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11019 informs MACs about the updates to Chapter 13 of the Medicare Benefit Policy Manual to clarify RHC and FQHC payment and other policy information. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The 2019 update of the Medicare Benefit Policy Manual, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act.

Chapter 13 of the Medicare Benefit Policy Manual has been revised to include payment policy for Care Management and Virtual Communication Services in RHCs and FQHCs as finalized in the CY 2019 Physician Fee Schedule (PFS) Final Rule. All other revisions serve to clarify existing policy.

Payment for General Care Management Services

Care management services are RHC and FQHC services and include Transitional Care Management (TCM), Chronic Care Management (CCM), general Behavioral Health Integration (BHI), and psychiatric Collaborative Care Model (CoCM) services. The RHC and FQHC face-

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to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.)

Except for TCM services, care management services are paid separately from the RHC All Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS) payment methodology. RHCs and FQHCs may not bill for care management services for a beneficiary if another practitioner or facility has already billed for care management services for the same beneficiary during the same time period. RHCs and FQHCs may not bill for care management and TCM services, or another program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment), for the same beneficiary during the same time period.

Medicare pays for CCM services furnished between January 1, 2016, and December 31, 2017, based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim.

Medicare pays for CCM or general BHI services furnished between January 1, 2018, and December 31, 2018, at the average of the national non-facility PFS payment rate for CPT codes 99490 (30 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM or general BHI services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491(30 minutes or more of CCM furnished by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

Coinsurance for care management services is 20 percent of the lesser of submitted charges or the payment rate for G0511. Care management costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate. G0511 can be billed once per month per beneficiary when at least 20 minutes of CCM services or at least 20 minutes of general BHI services have been furnished and all other requirements have been met.

Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 20 minutes that is required to bill for general care management services and does not include administrative activities such as transcription or translation services.

Virtual Communications Services

Virtual communication services are RHC and FQHC services and include communications-based technology and remote evaluation services. The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient.

Effective January 1, 2019, RHCs and FQHCs receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR or the FQHC PPS payment when the requirements for these services are met. Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

RHCs and FQHCs must meet the following requirements to bill for virtual communication services:

- The RHC or FQHC must furnish at least 5 minutes of communications-based technology or remote evaluation services by an RHC or FQHC practitioner to a patient that has had a billable visit in the RHC or FQHC within the previous year.
- The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC or FQHC service within the next 24 hours or at the soonest available appointment.

If the discussion between the patient and the RHC or FQHC practitioner is related to a billable visit furnished by the RHC or FQHC within the previous 7 days or within the next 24 hours or at the soonest available appointment, the cost of the RHC or FQHC practitioner's time would be included in the RHC AIR or the FQHC PPS payment and is not separately billable.

Virtual communication services furnished by RHCs and FQHCs on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services), when the virtual communication HCPCS code, G0071, is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0071 is updated annually based on the PFS amounts for these codes.

ADDITIONAL INFORMATION

The official instruction, CR11019, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R252BP.pdf. The updated Chapter of the Medicare Benefit Policy Manual is attached to CR11019.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
December 10, 2018	Initial article released.