CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1719	**Date: April 24, 2009**
	Change Request 6445

SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Updates

I. SUMMARY OF CHANGES: This transmittal provides updates and clarifications to RHC/FQHC preventive billing instructions on Initial Preventive Physical Exam (IPPE), Abdominal Aortic Aneurism (AAA) screening, Diabetes Self Management Training (DSMT), Medical Nutrition Therapy (MNT), and Vaccines.

New / Revised Material
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	4/Table of Contents
N	4/300.5.1/RHCs/FQHCs Special Billing Instructions
R	9/Table of Contents
R	9/120/General Billing Requirements for Preventive Services
N	9/150/Initial Preventive Physical Exam (IPPE)
N	9/160/Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)
R	9/181/Diabetes Self-Management Training (DSMT) Services
N	9/182/Medical Nutrition Therapy (MNT) Services
R	18/Table of Contents
R	18/80.3.1/RHCs/FQHCs Special Billing Instructions
N	18/110.3.4/RHCs/FQHCs Special Billing Instructions
N	18/120.2.3/RHCs/FQHCs Special Billing Instructions

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1719	Date: April 24, 2009	Change Request: 6445

SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Updates

Effective Date: October 1, 2009

Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background:

The professional component of certain preventive services provided in a RHC or FQHC is part of the overall encounter, and for TOBs 71x/73x, has always been billed on lines with the appropriate site of service revenue code in the 052x series. As of April 1, 2005 RHCs/FQHCs were only required to report HCPCS codes for a few services. The number of RHC/FQHC services requiring HCPCS coding is increasing for the following reasons:

1) the number of new benefits subject to frequency limits has increased;
2) for certain preventive benefits, no deductible is applicable on RHC services. (All FQHC services are already exempt from application of the deductible.); and
3) the number of circumstances when a provider is eligible to receive payments in addition to the all-inclusive daily encounter rate has increased.

Important detailed information on the rules/requirements for preventive benefits and vaccines can be found in chapter 18 of this manual (http://www.cms.hhs.gov/manuals/104_claims/clm104c18.pdf). Billing instructions for certain preventive benefits in the RHC/FQHC setting is detailed in this CR and in the associated manual instructions.

B. Policy:

Initial Preventive Physical Examinations (IPPE)

Payment for IPPE professional services that meets all of the program requirements is made under the all-inclusive rate. This is a once in a lifetime benefit. HCPCS coding is required to: adhere to the statutory limit; to allow for the deductible to be waived when computing payment to RHCs for dates of service (DOS) on or after January 1, 2009; and in rare circumstances depending on the clinical appropriateness of a separate visit, to allow RHCs/FQHCs to receive separate payment for an encounter in addition to the payment for IPPE encounter when they are performed on the same day. When the IPPE is provided, detailed HCPCS coding is required. For RHCs, the Part B deductible for IPPE is waived for DOS on or after January 1, 2009. FQHC services are already exempt from the Part B deductible. Coinsurance is applicable.

NOTE: For the professional component of the EKG, there is no separate payment and no separate billing of it.

Abdominal Aortic Aneurysm (AAA) Ultrasound Screening

Section 5112 of the Deficit Reduction Act of 2005 (DRA) amended the Social Security Act to provide coverage under Part B of the Medicare program for a one-time ultrasound screening for AAA. Payment for the professional services that meet all of the program requirements are made under the all-inclusive rate. This CR is

to clarify that for RHCs the Part B deductible for screening AAA is waived for DOS on or after January 1, 2007 and to add a section on ultrasound screening for AAA to Publication 100-04, Chapter 9. FQHC services are already exempt from the Part B deductible. Coinsurance is applicable.

Diabetes Self Management Training (DSMT) and Medical Nutrition Therapy (MNT)

With the passage of DRA, effective January 1, 2006, FQHCs are eligible for separate payment under Part B for DSMT and MNT in addition to any other qualifying visit on the same DOS, provided they meet all of the program requirements and the required HCPCS coding is reported on the claim. This CR is to: clarify that group services for DSMT and MNT provided by an FQHC are not eligible for payment of the all-inclusive rate; and to add a section on MNT to Pub. 100-04, Chapter 9. DSMT and MNT services may be provided in a group setting, but do not meet the criteria for a separate qualifying encounter and, therefore, can not be billed as an encounter. DSMT and MNT services provided in an RHC are not eligible for payment as an encounter.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6445.1	Effective for DOS 1/1/09, FISS shall ensure that when RHCs and FQHCs submit a second encounter for the same DOS for the IPPE benefit, the HCPCS code G0402 is present.						X				
6445.2	Effective for DOS 1/1/09, FISS shall ensure that the Part B deductible is not applied when RHCs and FQHCs submit HCPCS code G0402 for IPPE. NOTE: All FQHC services are exempt from the Part B deductible.						X			X	
6445.3	Effective for DOS 1/1/07, FISS shall ensure that the Part B deductible is not applied when RHCs and FQHCs submit HCPCS code G0389 for a ultrasound screening for AAA. NOTE: All FQHC services are exempt from the Part B deductible.						X			X	
6445.4	Effective for DOS 1/1/06, for DSMT, FISS must edit to ensure that FQHCs do not submit HCPCS codes for group services (G0109) to meet the criteria for a separate qualifying encounter.						X				
6445.4.1	Contractors shall use group code CO when denying claims for group DSMT services.	X		X							
6445.4.2	Contractors shall use claim adjustment reason code B5 (Program coverage guidelines were not met or exceeded) when denying claims for group DSMT services.	X		X							
6445.4.3	Contractors shall use MSN message 16.2 (This service cannot be paid when provided in this location/facility)	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	when denying claims for group DSMT services.										
6445.5	Effective for DOS 1/1/06, for MNT, FISS must edit to ensure that FQHCs do not submit HCPCS codes for group services (97804 or G0271) to meet the criteria for a separate qualifying encounter.						X				
6445.5.1	Contractors shall use group code CO when denying claims for group MNTservices.	X		X							
6445.5.2	Contractors shall use claim adjustment reason code B5 (Program coverage guidelines were not met or exceeded) when denying claims for group MNT services.	X		X							
6445.5.3	Contractors shall use MSN message 16.2 (This service cannot be paid when provided in this location/facility) when denying claims for group MNT services.	X		X							
6445.6	Contractors shall not search for claims but should adjust claims brought to their attention.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6445.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: CR 6223, Transmittal 1615, dated October 17, 2008, Update to the Initial IPPE Benefit. CR 4385, Transmittal 49, dated March 31, 2006, Payment of FQHCs for DSMT and MNT services.

V. CONTACTS

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Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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300.5.1 - RHCs/FQHCs Special Billing Instructions

Detailed billing instructions for Medical Nutrition Therapy (MNT) services provided in RHCs and FQHCs can be found in Chapter 9, section 182 of this manual.

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

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120 – General Billing Requirements for Preventive Services
(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

Professional components of preventive services are part of the overall encounter, and for TOBs 71x/73x, have always been billed on lines with *the appropriate site of service* revenue code *in the* 052x *series.* In addition to previous requirements for independent FQHCs exclusively, all RHCs/FQHCs had been required to report HCPCS codes for certain preventive services subject to frequency limits. As of April 1, 2005, RHCs and FQHCs do not have to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71x/73x *absent a few exceptions. The number of preventive services requiring HCPCS coding has expanded as described in the sections below.*

RHCs/FQHCs do not receive any reimbursement on TOBs 71x/73x for technical components of services *provided by clinics/centers. This is because the technical components of services are not within the scope of Medicare-covered RHC/FQHC services.* The associated technical components 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.

Though most preventive services have HCPCS codes that allow separate billing of professional and technical components, mammography and prostate PSA do not. However, RHCs/FQHCs still may provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using the *appropriate site of service* revenue code *in the* 052x *series.*

For vaccines, RHCs/FQHCs do not report *charges* for influenza virus or pneumococcal pneumonia vaccines on the 71x/73x claims. Costs for the influenza virus or

pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. *Neither co-insurance nor deductible apply to either of these vaccines.*

Hepatitis B vaccine is included in the encounter rate. No line items specifically for this service are billed on RHC/FQHC claims. *The charges of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. Both co-insurance and deductible apply for Hepatitis B vaccines in RHCs. Coinsurance applies to Hepatitis B vaccines provided in FQHCs. Deductible does not apply for services provided in the FQHC*. An encounter can not be billed if vaccine administration is the only service the RHC/FQHC provides.

Additional information on vaccines can be found in Chapter 1, section 10 of this manual. Additional coverage requirements for pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in Publication 100-02, the Medicare Benefit Policy Manual, Chapter 15.

150 – Initial Preventive Physical Examination (IPPE)

(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

Effective for services furnished on or after January 1, 2005, Section 611 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B of one initial preventive physical examination (IPPE) for new beneficiaries only, subject to certain eligibility and other limitations. For RHCs the Part B deductible for IPPE is waived for services provided on or after January 1, 2009. FQHC services are always exempt from the Part B deductible. Coinsurance is applicable.

Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location generally constitute a single visit. However, in rare circumstances an RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the IPPE when they are performed on the same day.

RHCs and FQHCs must HCPCS code for IPPE for the following reasons:

- *To avoid application of deductible (on RHC claims);*
- *To assure payment for this service in addition to another encounter on the same day if they are both separate, unrelated, and appropriate; and*
- *To update the CWF record to track this once in a lifetime benefit.*

Beginning with dates of service on or after January 1, 2009 if an IPPE is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or Part A MAC using TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series, and must include HCPCS G0402. Additional information on IPPE can be found in Chapter 18, section 80 of this manual.

NOTE: The technical component of an EKG performed at a clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the independent RHC/FQHC. Rather, it is billed to Medicare carriers or Part B MACs on professional claims (Form CMS-1500 or 837P) under the practitioner's ID following instructions for submitting practitioner claims. Likewise, the technical component of the EKG performed at a provider-based clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the provider-based RHC\FQHC. Instead, it is billed on the applicable TOB and submitted to the FI or Part A MAC using the base provider's ID following instructions for submitting claims to the FI/Part A MAC from the base provider. For the professional component of the EKG, there is no separate payment and no separate billing of it. The IPPE is the only HCPCS for which the deductible is waived under this benefit. For more information on billing for a screening EKG see chapter 18 section 80 of this manual.

160 – Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

Section 5112 of the Deficit Reduction Act of 2005 amended the Social Security Act to provide coverage under Part B of the Medicare program for a one-time ultrasound screening for abdominal aortic aneurysms (AAA). Payment for the professional services that meet all of the program requirements will be made under the all-inclusive rate. For RHCs the Part B deductible for screening AAA is waived for dates of service on or after January 1, 2007. FQHC services are always exempt from the Part B deductible. Coinsurance is applicable. Additional information on AAA can be found in Chapter 18, section 110 of this manual.

If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or Part A MAC using TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series and must include HCPCS G0389.

If the AAA screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier or Part B MAC under the practitioner's ID following instructions for submitting practitioner claims.

If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI or Part A MAC under the base provider's ID, following instructions for submitting claims to the FI/Part A MAC from the base provider.

181 – Diabetes Self-Management Training (DSMT) Services

(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

A - FQHCs

Previously, DSMT type services rendered by qualified registered dietitians or nutrition professionals were considered incident to services under the FQHC benefit, if all relevant program requirements were met. Therefore, separate all-inclusive encounter rate payment could not be made for the provision of DSMT services. With passage of DRA, effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these services provided they meet all program requirements. See Pub. 100-04, chapter 18, section 120. Payment is made at the all-inclusive encounter rate to the FQHC. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying DSMT services.

For FQHCs to qualify for a separate visit payment for DSMT services, the services must be a one-on-one face-to-face encounter. Group sessions don't constitute a billable visit for any FQHC services. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate. To receive separate payment for DSMT services, the DSMT services must be billed on TOB 73X with HCPCS code G0108 and the appropriate site of service revenue code in the 052X revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service that the beneficiary received qualifying DSMT services as long as the claim for DSMT services contains the appropriate coding specified above. Additional information on DSMT can be found in Chapter 18, section 120 of this manual.

NOTE: DSMT is not a qualifying visit on the same day that MNT is provided.

Group services (G0109) do not meet the criteria for a separate qualifying encounter. All line items billed on TOBs 73x with HCPCS codes for DSMT services will be denied.

B - RHCs

Separate payment to RHCs for these practitioners/services continues to be precluded as these services are not within the scope of Medicare-covered RHC benefits. Note that the provision of the services by registered dietitians or nutritional professionals, might be considered incident to services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.

182 – Medical Nutrition Therapy (MNT) Services

(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

A - FQHCs

Previously, MNT type services were considered incident to services under the FQHC benefit, if all relevant program requirements were met. Therefore, separate all-inclusive encounter rate payment could not be made for the provision of MNT services. With passage of DRA, effective January 1, 2006, FQHCs are eligible for a separate payment under Part B for these services provided they meet all program requirements. Payment is made at the all-inclusive encounter rate to the FQHC. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying MNT services.

For FQHCs to qualify for a separate visit payment for MNT services, the services must be a one-on-one face-to-face encounter. Group sessions don't constitute a billable visit for any FQHC services. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate. To receive payment for MNT services, the MNT services must be billed on TOB 73X with the appropriate individual MNT HCPCS code (codes 97802, 97803, or G0270) and with the appropriate site of service revenue code in the 052X revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying MNT services as long as the claim for MNT services contain the appropriate coding specified above.

NOTE: MNT is not a qualifying visit on the same day that DSMT is provided.

Additional information on MNT can be found in Chapter 4, section 300 of this manual. Group services (HCPCS 97804 or G0271) do not meet the criteria for a separate qualifying encounter. All line items billed on TOB 73x with HCPCS code 97804 or G0271 will be denied.

B - RHCs

Separate payment to RHCs for these practitioners/services continues to be precluded as these services are not within the scope of Medicare-covered RHC benefits. All line items billed on TOB 71x with HCPCS codes for MNT services will be denied.

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Chapter 18 - Preventive and Screening Services

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(Rev. 1719, 04-24-09)

80.3.1 – RHCs/FQHCs Special Billing Instructions

(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

*There are Initial Preventive Physical Examination (**IPPE**) instructions that are unique to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Please refer to Publication 100-4, Chapter 9, section 150 of this manual for a description of these instructions.*

110.3.4 - RHCs/FQHCs Special Billing Instructions

(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

Detailed billing instructions for ultrasound screening for Abdominal Aortic Aneurism (AAA) screenings provided in RHCs and FQHCs can be found in Chapter 9, section 160 of this manual.

120.2.3 - RHCs/FQHCs Special Billing Instructions

(Rev.1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

Detailed billing instructions for Diabetes Self Management Training (DSMT) services provided in RHCs and FQHCs can be found in Chapter 9, section 181 of this manual.