DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

NEW products from the Medicare Learning Network® (MLN)

- "Vaccine Payments Under Medicare Part D", Fact Sheet, ICN 908764, downloadable

MLN Matters® Number: MM8504	Related Change Request (CR) #: CR 8504
Related CR Release Date: November 22, 2013	Effective Date: January 1, 2014
Related CR Transmittal #: R173BP	Implementation Date: January 6, 2014

Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13

Provider Types 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 to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8504, which advises MACs of updates to Chapter 13 of the "Medicare Benefit Policy Manual." These updates include new information on Transitional Care Management and Hospice payment exceptions, and RHC employment, and provides clarification of existing information. Make sure that your billing staffs are aware of these updates.

Background

Some of the key revisions/updates of the "Medicare Benefit Policy Manual," Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, are as follows:

- RHCs are not paid for services furnished by contracted individuals other than physicians (CFR 42 405.2468(b)(1)). Therefore, nonphysician practitioners must be employed by the RHC, as evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100

percent ownership of the RHC, the W-2 form can be from that entity as long as all the non-physician practitioners in the RHC receive their W-2 from this owner.

- Transitional Care Management (TCM) services can also be considered a RHC or FQHC visit. TCM services can be billed as a visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.
- Effective January 1, 2013, RHCs and FQHCs can bill for qualified TCM services furnished by a RHC or FQHC practitioner. TCM services must be furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or Community Mental Health Center (CMHC). Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT code 99495), or within 7 days of discharge for high complexity decision making (CPT code 99496). The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-discharge period. The TCM visit is subject to applicable copayments and deductibles. If the TCM visit occurs on the same day as another billable visit, only one visit may be billed.
- Services furnished incident to an RHC or FQHC professional service are included in the per-visit payment and are not billed as a separate visit. The costs of covered services provided incident to a billable visit may be included on the RHC or FQHC cost report. Auxiliary services are included as administrative and general costs on the cost report.
- Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see section 1861(aa)(2)(G) of the Act), and for FQHCs see section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.
- RHCs and FQHCs can treat hospice beneficiaries for medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from a RHC or FQHC related to his/her terminal illness, the RHC or FQHC cannot be reimbursed for the visit, even if it is a medically necessary, face-to-face visit with a RHC or FQHC provider, since that would result in duplicate payment for services, except under either of the following circumstances:
    - The RHC or FQHC has a contract with the hospice provider to furnish core hospice services related to the patient's terminal illness and related conditions when extraordinary circumstances exist within the hospice. Extraordinary circumstances are described as "unanticipated periods of high patient loads; staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside the hospice's service area" (42CFR 418.64);

- The RHC or FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are provided by the hospice so infrequently that it would be impractical and prohibitively expensive for the hospice to employ a practitioner to provide these services. For example, a hospice may infrequently have a pediatric patient, and in those situations, contract with a RHC or FQHC that has a pediatric nurse on staff to furnish hospice services to the patient.

Additional Information

The official instruction, CR 8504, issued to your MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R173BP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- HealthMap Vaccine Finder - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

The CDC website for Free Resources, including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.