

MLN Matters® Number: MM6445 **Revised** Related Change Request (CR) #: 6445

Related CR Release Date: April 24, 2009 Effective Date: October 1, 2009

Related CR Transmittal #: R1719CP Implementation Date: October 5, 2009

Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Coverage and Billing Updates

Important Note: Medicare will only pay claims for DME if the ordering physician and DME supplier are actively enrolled in Medicare on the date of service. Physicians and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If you are not enrolled on the date the prescription is filled or re-filled, Medicare will not pay the submitted claims. It is also important to tell the Medicare beneficiary if you are not participating in Medicare before you order DME. If you do not have an active record, please see the following fact sheet containing information on how to **enroll, revalidate your enrollment and/or make a change:** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf on the CMS website.

Note: The article was revised on December 21, 2015, to include the "Important Note" above. All other information remains unchanged.

Provider Types Affected

All RHCs and FQHCs submitting claims and cost reports to Medicare contractors (Fiscal Intermediaries (FSI), and Medicare Administrative Contractors (MACs)) for services and supplies provided to Medicare beneficiaries.

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Provider Action Needed

This article describes change request (CR) 6445, which updates billing and cost reporting for the following preventive benefits and vaccines provided by RHCs and FQHCs with various effective dates:

- Initial preventive physician examination (IPPE);
- Ultrasound screening for abdominal aortic aneurysm (AAA);
- Individual services for diabetes self-management training (DSMT) services;
- Individual services for medical nutrition therapy services (MNT); and
- Certain vaccines.

Ensure that your billing and cost reporting staffs are aware of these updates.

Background

For RHCs and FQHCs, professional components of preventive services are part of the overall encounter, and, for types of bill (TOBs) 71x and 73x, have always been billed on lines with the appropriate site of service revenue code in the 052x series. As of April 1, 2005, RHCs and FQHCs were only required to report Healthcare Common Procedure Coding System (HCPCS) codes for a few services. The number of RHC and FQHC services requiring HCPCS coding is increasing for the following reasons: the number of new benefits subject to frequency limits is increasing; for certain preventive benefits, no deductible is applicable on RHC services (all FQHC services are already exempt from application of the deductible.); and the number of circumstances when a provider is eligible to receive payments in addition to the all-inclusive daily encounter rate has increased.

Payment for professional services that meet all of the program requirements is made under the all-inclusive rate. The IPPE and the ultrasound screening for AAA are once in a lifetime benefits. Therefore, HCPCS coding is required to adhere to the statutory limit; to allow for the deductible to be waived when computing payment to RHCs for DOS on or after the effective dates (Note: Deductible is never applied for FQHC services); and, in rare circumstances, depending on the clinical appropriateness of a separate visit, to allow RHCs and FQHCs to receive separate payment for an encounter, in addition to the payment for IPPE or AAA encounter, when they are performed on the same day.

Medicare contractors will not search for and adjust claims already processed, but will adjust claims that you bring to their attention.

Policy Clarifications for IPPEs

Effective for dates of service (DOS) on or after January 1, 2009, RHCs and FQHCs may bill for the professional portion of an IPPE in addition to a daily encounter by using

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TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series, and must include HCPCS G0402.

For RHCs, the Part B deductible for the 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: The technical component of an electrocardiogram (EKG) performed at a clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the independent RHC or FQHC. Rather, it is billed to Medicare carriers or Part B MACs on professional claims (Form CMS 1500 or 837P) under the practitioner's national provider identifier (NPI) following instructions for submitting practitioner claims. 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 or FQHC. Instead, it is billed on the applicable TOB and submitted to the FI or Part A MAC using the base provider's NPI following instructions for submitting claims to the FI/PART A MAC from the base provider.

Policy Clarifications for Ultrasound Screening for AAA

Effective for DOS on or after January 1, 2007, RHCs and FQHCs need not apply the Part B deductible when billing for ultrasound screening for AAA using the HCPCS code G0389. 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. FQHC services are already exempt from the Part B deductible. Coinsurance is applicable.

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 NPI following instructions for submitting practitioner claims.

If the screening is provided in a provider-based RHC or 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 NPI, following instructions for submitting claims to the FI/PART A MAC from the base provider.

Policy Clarifications for DSMT and MNT Services

Effective for DOS on or after January 1, 2006, FQHCs may not bill for group services for DSMT or MNT services as a separate qualifying encounter. Group services do not meet the criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. DSMT and MNT services may be provided in a group setting, but do not meet the criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate. Claims for DSMT group services with HCPCS code G0109

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and MNT group services with HCPCS codes 97804 or G0271 will be denied using group code CO and claim adjustment reason code B5 (Program coverage guidelines were not met or exceeded).

FQHCs may bill for DSMT and MNT services when they are provided in a one-on-one face-to-face encounter and billed using the appropriate HCPCS and site of service revenue codes.

- To receive 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.
- To receive payment for MNT services, the MNT services must be billed on TOB 73X and with the appropriate site of service revenue code in the 052X revenue code series and the appropriate HCPCS code (97802, 97803, or G0270). 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 contains the appropriate coding specified above.

Separate payment to RHCs for these practitioners and services continues to be precluded. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note that the provision of these 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.

Policy Clarifications for Vaccines

RHCs and 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. CR 6445 clarifies that neither co-insurance nor deductible apply to either of these vaccines.

Hepatitis vaccine is included in the encounter rate. No line items specifically for this service are billed on RHC or FQHC claims. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. Both co-insurance and deductible apply to this benefit. An encounter cannot be billed if vaccine administration is the only service the RHC or FQHC provides.

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Additional Information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website. The official instruction (CR6445) issued to your Medicare MAC and/or FI is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1719CP.pdf> on the CMS website. The revised portions of the Medicare Claims Processing Manual are included in CR 6445.

You may also want to review MM7038, which is available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7038.pdf>, that alerts FQHCs to the new increased coverage of preventive services in the FQHC setting enacted as a part of the Affordable Care Act.

In addition, MM6338 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6338.pdf> discusses a new Type of Bill code for FQHCs effective April 1, 2010.

Document History

Date	Description
December 21, 2015	The article was revised on December 21, 2015, to include the "Important Note" near the top of page 1.
November 1, 2012	This article was updated to reflect current Web addresses..
October 25, 2012	This article MM6445 was revised to add a reference to MLN Matters® Article, MM6338, which announced a new Type of Bill code for FQHCs, effective April 1, 2010.

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