CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1637	**Date: March 23, 2016**
	Change Request 9269

Transmittal 1596, dated January 26, 2016 is being rescinded and replaced by Transmittal 1637 to add FISS to business requirement 9269.1. All other information remains the same.

SUBJECT: Required Billing Updates for Rural Health Clinics

I. SUMMARY OF CHANGES: This change request (CR) provides instructions to the Medicare Administrative Contractors (MACs) to accept Healthcare Common Procedure Coding System (HCPCS) coding on Rural Health Clinic (RHC) claims.

EFFECTIVE DATE: April 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2016

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
N/A	N/A

III. FUNDING:
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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1637	Date: March 23, 2016	Change Request: 9269

Transmittal 1596, dated January 26, 2016 is being rescinded and replaced by Transmittal 1637 to add FISS to business requirement 9269.1. All other information remains the same.

SUBJECT: Required Billing Updates for Rural Health Clinics

EFFECTIVE DATE: April 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2016

I. GENERAL INFORMATION

A. Background: For dates of service on or after April 1, 2005 through December 31, 2010, Rural Health Clinics (RHCs) billing under the all-inclusive rate (AIR) were not required to report HCPCS coding when billing for RHC services, absent a few exceptions. Generally, it has not been necessary to require reporting of HCPCS since the AIR system was designed to provide payment for all of the costs associated with an encounter for a single day.

Provisions of the Affordable Care Act of 2010 further modified the billing requirements for RHCs. Effective January 1, 2011, Section 4104 of the Affordable Care Act, waived the coinsurance and deductible for the initial preventive physical examination (IPPE), the annual wellness visit (AWV), and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. In accordance with policy, RHCs have been required to report HCPCS codes when furnishing certain preventive services since January 1, 2011.

CMS regulations require covered entities to report standard medical code sets for electronic health care transactions, although CMS program instructions have directed RHCs to submit HCPCS codes only for preventive services. Such standard medical code sets are defined as level I and level II of the HCPCS. In the CY 2016 PFS proposed rule (80 FR 41943), CMS proposed that all RHCs, including RHCs exempt from electronic reporting under §424.32(d)(3), are required to submit HCPCS and other codes as required on claims for services furnished. The requirements for RHCs to submit HCPCS codes were finalized in the CY 2016 PFS final rule with comment period (80 FR 71088).

B. Policy: Effective for dates of service on or after April 1, 2016, RHCs, including RHCs exempt from electronic reporting under §424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other codes as required.

Payment for RHC services will continue to be made under the AIR when all of the program requirements are met. There is no change in the AIR system and payment methodology including the "carve out" methodology for coinsurance calculation due to this reporting requirement.

<u>Basic Guidelines on RHC Visits and Billing for 71X Types of Bills (TOBs):</u>

An RHC visit is defined as a medically necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and an RHC practitioner during which time one or more RHC services are furnished. A Transitional Care Management (TCM) service can also be an RHC visit. Qualified preventive health services include the initial preventive physical examination (IPPE), the annual wellness visit (AWV), and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Additional information on what constitutes a RHC visit can be found in the Medicare Benefit Policy

manual, Pub 100-02, Chapter 13.

Beginning with dates of service on or after April 1, 2016, when billing Medicare, RHCs are required to report the appropriate HCPCS code for each line item along with revenue code.

RHC qualifying visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. See Attachment A for a list of HCPCS codes that are defined as qualifying visits, which corresponds with the following guidance on service level information.

Service Level Information:

- The professional component of qualified medical services are reported on a line item using revenue 052X (free-standing clinic).

- When an approved preventive health service is furnished, report it on an additional 052X service line.

- Mental health services are reported on a line item using revenue code 0900 (mental health treatment services).

RHCs shall report one service line per encounter/visit with revenue code 052X and a medical service qualifying visit from Attachment A. Payment will be applied to the service line with revenue code 052X and a valid medical service qualifying visit, and coinsurance and/or deductible will be applied to this line. When a preventive health service is reported on an additional 052X line it is not eligible for a separate per diem payment, except for the initial preventive physical exam (IPPE).

When a preventive health service is the only qualifying visit reported for the encounter, payment will be applied to this service line with revenue code 052X. For approved preventive services, frequency edits apply and coinsurance and/or deductible will be waived for the line.

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a mental health service qualifying visit from Attachment A.

Billing for Exceptions to the Same Day Policy:

Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit. Except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC). The subsequent medical service should be billed using a valid HCPCS code, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day.

- The patient has a medical visit and a mental health visit on the same day.

- The patient has an IPPE and a separate medical and/or mental health visit on the same day. IPPE is a once in a lifetime benefit and should be billed using HCPCS code G0402 and revenue code 052X. For IPPE, the beneficiary coinsurance and deductible are waived.

Please refer to Attachment A for a list of HCPCS codes that are defined as qualifying visits.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9269.1	Contractors shall allow RHCs to report all valid revenue codes except the following: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x	X				X				
9269.2	Contractors shall require all service lines reported on RHC claims (TOB 71X) to contain a valid HCPCS code except for revenue codes that do not require HCPCS code reporting, i.e. revenue code 025x.	X								
9269.2.1	Contractors shall return to the provider all RHC claims with service lines that do not contain a valid HCPCS code except for revenue codes that do not require HCPCS code reporting, i.e. revenue code 025x.	X								
9269.3	Contractors shall only allow RHCs to report one service line per day with revenue code 052X and a qualifying visit HCPCS code (attachment A) for medical services. This does not apply to approved preventive health services listed in attachment A and services reported with modifier 59.					X				
9269.3.1	Contractors shall only allow RHCs to report one service line per day with revenue code 0900 and a qualifying visit HCPCS code (attachment A) for mental health services.					X				
9269.3.2	Contractors shall return to the provider all RHC claims that contain more than one qualifying visit HCPCS code from attachment A billed under revenue code 052X for medical service lines (excluding approved preventive services and modifier 59) and mental health services billed under revenue code 0900.	X								
9269.4	Contractors shall make an AIR payment for each of the following on RHC claims per day: • Medical services with revenue code 052X and a qualifying visit HCPCS code from Attachment A (this applies to non-preventive and preventive services);					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Mental health services with revenue code 0900 and a qualifying visit HCPCS code from Attachment A; • IPPE, HCPCS code G0402 with revenue code 052X (*subject to CWF frequency edits*); • Medical services with revenue code 052X, a qualifying visit HCPCS code from Attachment A and modifier 59. **NOTE**: When a qualifying visit HCPCS code for a medical service is reported on the same day with a qualifying visit HCPCS code for preventive health, pay the medical service visit at the AIR, (excluding IPPE, G0402) and package/bundle the preventive health service line (9269.6). When a qualifying visit HCPCS code for an approved preventive service (from attachment A) is billed on the same day with a qualifying visit HCPCS code for a mental health service, both services should be paid based on AIR.									
9269.4.1	Contractors shall apply coinsurance and deductible based on submitted charges to service lines paid at the AIR. **NOTE**: This does not apply to approved preventive services where coinsurance and/or deductible is waived.					X				
9269.5	Contractors shall continue to pay for Telehealth services with revenue code 0780 and HCPCS code Q3014 based on the lesser of the actual charges or the fee amount. Telehealth services do not have to be reported with an encounter/visit. **NOTE:** Deductible and coinsurance apply.					X				
9269.6	Contractors shall ensure any service lines not receiving the AIR payment on RHC claims are shown as covered with the following ANSI information: Group code CO- Contractual obligation CARC 97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.									
9269.7	Contractors shall ensure RHC claims with preventive service HCPCS codes are posted to the appropriate auxiliary files as a professional component.								X	
9269.8	Contractors shall apply the appropriate frequency edits to RHC claims for preventive services.								X	
9269.9	The IOCE shall assign edit 91 to reject service lines containing DME (revenue code 029X), Lab (excluding 36415), Ambulance (revenue code 054X), Hospital-Based Care (99217-99239, 99281-99292, and 99460-99480), Group (97804, G0271) and non-Face-to-Face (99441-99444) services on RHC claims.					X				IOCE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9269.10	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next	X				

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or tracey.mackey@cms.hhs.gov , Simone Dennis, 410-786-8409 or Simone.Dennis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 1

Attachment A-
RHC Qualifying Visits

Medical Services

HCPCS Code	Short Descriptor
92002	Eye exam new patient
92004	Eye exam new patient
92012	Eye exam establish patient
92014	Eye exam&tx estab pt 1/>vst
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessmnt
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min

Approved Preventive Health Services

HCPCS Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0102*	Prostate ca screening; dre
G0117*	Glaucoma scrn hgh risk direc
G0118*	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

****Coinsurance and deductible are not waived***

Mental Health Services

HCPCS Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

Effective January 1, 2016 CPT code 99490 (chronic care management) is paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC claim.