CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10357	**Date: September 18, 2020**
	Change Request 11961

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 9, Section 70.7 and 70.8.

I. SUMMARY OF CHANGES: This Change Request (CR) makes updates to chapter 9 of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: October 19, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 19, 2020

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	09/70/70.7/Virtual Communication Services
N	09/70/70.8/General Care Management Services - Chronic Care and Psychiatric Collaborative Care Model (CoCM) Services

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10357	Date: September 18, 2020	Change Request: 11961

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) constitutes additions to Pub. 100-04, Chapter 9 of the Medicare Claims Processing manual, sections 70.7 - Virtual Communication Services and 70.8 - General Care Management Services – Chronic Care and Psychiatric Collaborative Care Model (CoCM) Services.

B. Policy: There are no policy changes.

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	
11961.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 9, Sections 70.7 and 70.8.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

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

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(Rev. 10357, Issued: 09-18 -2020)

Transmittals for Chapter 9

70.7 – Virtual Communication Services
70.8 – General Care Management Services – Chronic Care and Psychiatric Collaborative Care Model (CoCM) Services

70.7 - Virtual Communication Services

(Rev. 10357, Issued: 09-18-2020, Effective: 10-19-2020, Implementation: 10-19-2020)

In the CY 2019 PFS final rule, CMS finalized a policy for payment to RHCs and FQHCs for communication technology-based services ("virtual check-in") or remote evaluation services, effective January 1, 2019. CMS created a new Virtual Communications G Code, G0071 for use by RHCs and FQHCs only, with the payment rate set at the average of the PFS non-facility payment rate for communication technology-based services and remote evaluation services.

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 can bill HCPCS code G0071 alone or with other payable services on an RHC or FQHC claim. The services should be billed with a revenue code 052x and should not be billed with modifier CG for payment on RHC claims. HCPCS codes G0071 are paid based on the lesser of the charges or the rate from the Medicare Physician Fee Schedule (MPFS).

70.8- General Care Management Services – Chronic Care or Psychiatric Collaborative Care Model (CoCM) Services

(Rev. 10357, Issued: 09-18-2020, Effective: 10-19-2020, Implementation: 10-19-2020)

Effective for services furnished on or after January 1, 2018, RHCs and FQHCs are paid for General Care Management or Psychiatric CoCM services when G0511 or G0512 is billed alone or with other payable services on an RHC or FQHC claim. HCPCS code G0511 or G0512 can only be billed once per month per beneficiary, and cannot be billed if other care management services are billed for the same time period.

HCPCS codes G0511 and G0512 are subject to coinsurance and deductibles on RHC claims. Only coinsurance applies on FQHC claims. Coinsurance is 20 percent of the lesser of the RHC or FQHC's charge for HCPCS codes G0511 and G0512, or the corresponding rate.

The allowable revenue code is 052X. These HCPCS codes of G0511 or G0512 should not be billed with modifier CG for payment on RHC claims.