

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 252	Date: December 7, 2018
	Change Request 11019

SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

I. SUMMARY OF CHANGES: Chapter 13 has been updated to clarify payment and other policy information.

EFFECTIVE DATE: January 1, 2019

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

IMPLEMENTATION DATE: January 2, 2019

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	13/Table of Contents
R	13/40.1/Location
R	13/50.1/RHC Services
R	13/70/RHC and FQHC Payment
R	13/80.1/RHC and FQHC Cost Report Requirements
R	13/90/RHC and FQHC Charges, Coinsurance, Deductible, and Waivers
R	13/110/Physician Services
R	13/120.1/Provision of Incident to Services and Supplies
R	13/130/Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services
R	13/150/Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services
R	13/160/Services and Supplies Incident to CP and CSW Services
R	13/190.2/Requirements for Furnishing Visiting Nursing Services
R	13/190.5/Treatment Plans for Visiting Nursing Services
R	13/230/Care Management Services
R	13/230.1/Transitional Care Management Services
R	13/230.2/General Care Management Services
R	13/230.3/Psychiatric Collaborative Care Model (CoCM) Services
N	13/240/Virtual Communication 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. 100-02	Transmittal: 252	Date: December 7, 2018	Change Request: 11019
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SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

EFFECTIVE DATE: January 1, 2019

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

IMPLEMENTATION DATE: January 2, 2019

I. GENERAL INFORMATION

A. Background: The 2019 update of the Medicare Benefit Policy Manual, Chapter 13 - RHC and FQHC Services provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act.

B. Policy: Chapter 13 of the Medicare Benefit Policy Manual has been revised to include payment policy for Care Management in RHCs and FQHCs as finalized in the CY 2019 Physician Fee Schedule Final Rule. All other revisions serve to clarify existing policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
11019.1	Contractors shall be aware of the updates to the Medicare Benefit Policy Manual - Chapter 13.	X									
11019.2	Contractors shall be aware of the new guidelines mandated in Section 240, Virtual Communication Services, of the Medicare Benefit Policy Manual - Chapter 13; effective January 1, 2019.	X									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E M A C	C M E D I C I A N	C O N S U M E R	P R O V I D E R
		A	B	H H H				
11019.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects	X						

Number	Requirement	Responsibility			
		A/B MAC			D M E D I C A C
		A	B	H H H	
	information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.				

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): Glenn McGuirk, 410-786-5723 or Glenn.McGuirk@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

Medicare Benefit Policy Manual

Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Table of Contents
(Rev. 252, Issued 12-7-18)

Transmittals for Chapter 13

Index of Acronyms

190.2 - Requirements for Furnishing Visiting Nursing Services

190.5 – Treatment Plans for Visiting Nursing Services

240 – Virtual Communication Services

40.1 – Location

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHC or FQHC visits may take place in:

- the RHC or FQHC,
- the patient’s residence (including an assisted living facility),
- a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
- the scene of an accident.

RHC and FQHC visits may not take place in:

- an inpatient or outpatient department of a hospital, including a CAH, or
- a facility which has specific requirements that preclude RHC or FQHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).

Qualified services provided to a RHC or FQHC patient are considered RHC or FQHC services if:

- the practitioner is compensated by the RHC or FQHC for the services provided;
- the cost of the service is included in the RHC or FQHC cost report; and;
- other requirements for furnishing services are met.

This applies to full and part time practitioners, and it applies regardless of whether the practitioner is an employee of the RHC or FQHC, working under contract to the RHC or FQHC, or is compensated by the RHC or FQHC under another type of arrangement. RHCs and FQHCs should have clear policies regarding the provision of services in other locations and include this in a practitioner’s employment agreement or contract. RHCs and FQHCs providing RHC or FQHC services in locations other than the RHC or FQHC facility must continue to meet all certification and cost reporting requirements. Services in other locations may be subject to review by the A/B MAC. RHC or FQHC services furnished *by an RHC or FQHC practitioner* may not be billed separately by the RHC or FQHC practitioner, or by *another practitioner or* an entity other than the RHC or FQHC, *even if the service is not a stand-alone billable visit*. Services furnished to patients in any type of hospital setting (inpatient, outpatient, or emergency department) are statutorily excluded from the RHC/FQHC benefit and may not be billed by the RHC or FQHC.

50.1 - RHC Services

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHC services include:

- Physicians' services, as described in section 110;
- Services and supplies incident to a physician’s services, as described in section 120;
- Services of NPs, PAs, and CNMs, as described in section 130;
- Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 140;
- CP and CSW services, as described in section 150;
- Services and supplies incident to the services of CPs, as described in section 160; and
- Visiting nurse services to patients confined to the home, as described in section 190.
- Certain care management services, as described in section 230.
- *Certain virtual communication services, as described in section 240.*

RHC services also include certain preventive services when specified in statute or when established through the National Coverage Determination (NCD) process and not specifically excluded (see section 220 – Preventive Health Services). These services include:

- Influenza, Pneumococcal, Hepatitis B vaccinations;

- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.

Influenza and pneumococcal vaccines and their administration are paid through the cost report, and payment for the hepatitis B vaccine and its administration is included in an otherwise billable visit. The professional component of the IPPE, AWV, and other qualified preventive services is paid based on the AIR.

70 - RHC and FQHC Payment

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHCs and FQHCs must submit claims for RHC or FQHC services under the RHC or FQHC payment methodologies and are not authorized to submit claims under the *Physician Fee Schedule* (PFS) for RHC or FQHC services. Newly certified RHCs or FQHCs should work with their A/B MAC to ensure that all claims filed for RHC or FQHC services are paid as RHC or FQHC claims as of the date of their certification.

80.1 - RHC and FQHC Cost Report Requirements

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHCs are required to file a cost report annually in order to determine their payment rate and reconcile interim payments, including adjustments for GME payments, bad debt, and influenza and pneumococcal vaccines and their administration. If in its initial reporting period, the RHC submits a budget that estimates the allowable costs and number of visits expected during the reporting period. The A/B MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

FQHCs are required to file a cost report annually and are paid for the costs of GME, bad debt, and influenza and pneumococcal vaccines and their administration through the cost report. *All FQHCs, including an FQHC that does not have GME costs, bad, debt, or costs associated with influenza and pneumococcal vaccines and their administration, must file a cost report.*

RHCs and FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors.

RHCs and FQHCs are allowed to claim bad debts in accordance with [42 CFR 413.89](#). RHCs may claim unpaid coinsurance and deductible, and FQHCs may claim unpaid coinsurance. RHCs and FQHCs that claim bad debt must establish that reasonable efforts were made to collect these amounts. Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed.

90 - RHC and FQHC Charges, Coinsurance, Deductible, and Waivers

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

Except for certain preventive services for which the coinsurance is statutorily waived, the beneficiary in an RHC must pay the deductible and coinsurance amount, and the beneficiary in an FQHC must pay the coinsurance amount (there is no Part B deductible in FQHCs for FQHC-covered services). For RHCs, the coinsurance is 20 percent of the total charges. For FQHCs, the coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate. For claims with a mix of waived and non-

waived services, applicable coinsurance and deductibles are assessed only on the non-waived services. For both RHCs and FQHCs, coinsurance for care management *and virtual communication* services is 20 percent of *the lesser of* submitted charges *or the payment rate*.

110 - Physician Services

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

The term “physician” includes a doctor of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractic who is licensed and practicing within the licensee’s scope of practice, and meets other requirements as specified.

Physician services are professional services furnished by a physician to an RHC or FQHC patient and include diagnosis, therapy, surgery, and consultation. The physician must either examine the patient in person or be able to visualize directly some aspect of the patient’s condition without the interposition of a third person’s judgment. Direct visualization includes review of the patient’s X-rays, EKGs, tissue samples, etc.

Except for services that meet the criteria for authorized care management *or virtual communications* services, telephone or electronic communication between a physician and a patient, or between a physician and someone on behalf of a patient, are considered physicians’ services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Qualified services furnished at an RHC or FQHC *or other authorized site* by an RHC or FQHC physician are payable only to the RHC or FQHC. RHC and FQHC physicians are paid according to their employment agreement or contract (where applicable).

120.1 - Provision of Incident to Services and Supplies

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physician’s visit must result from the patient’s encounter with the physician and be furnished in a medically appropriate timeframe. More than one incident to service or supply can be provided as a result of a single physician visit.

Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC or FQHC to provide services. Services or supplies provided by individuals who are not employed by or under direct contract with the RHC or FQHC, even if provided on the physician’s order or included in the RHC or FQHC’s bill, are not covered as incident to a physician’s service. Services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the RHC or FQHC for inclusion in the entity’s statement of services, services provided by an independent laboratory or a hospital outpatient department, *services furnished by a nurse, medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the RHC or FQHC*, etc.

Services and supplies furnished incident to physician’s services are limited to situations in which there is direct physician supervision of the person performing the service, except for authorized care management services (as described in section 230) which may be furnished under general supervision. Direct supervision does not require the physician to be present in the same room. However, the physician must be in the RHC

or FQHC and immediately available to provide assistance and direction throughout the time the incident to service or supply is being furnished.

When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or FQHCs.

130 - Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services *(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)*

Professional services furnished by an NP, PA, or CNM to an RHC or FQHC patient are services that would be considered covered physician services under Medicare (see section 110), and which are permitted by state laws and RHC or FQHC policies. Services may include diagnosis, treatment, and consultation. The NP, PA, or CNM must directly examine the patient, or directly review the patient's medical information such as X-rays, EKGs and electroencephalograms, tissue samples, etc. Except for services that meet the criteria for authorized care management *or virtual communication* services, telephone or electronic communication between an NP, PA, or CNM and a patient, or between such practitioner and someone on behalf of a patient, are considered NP, PA, or CNM services, and are included in an otherwise billable visit. They do not constitute a separately billable visit.

150 - Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services *(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)*

A CP is an individual who:

- Holds a doctoral degree in psychology, and
- Is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

A CSW is an individual who:

- Possesses a master's or doctor's degree in social work;
- After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the state in which the services are performed; or, in the case of an individual in a state that does not provide for licensure or certification, meets the requirements listed in 410.73(a)(3)(i) and (ii).

Services may include diagnosis, treatment, and consultation. The CP or CSW must directly examine the patient, or directly review the patient's medical information. Except for services that meet the criteria for authorized care management *or virtual communication* services, telephone or electronic communication between a CP or CSW and a patient, or between such practitioner and someone on behalf of a patient, are considered CP or CSW services and are included in an otherwise billable visit. They do not constitute a separately billable visit. CSWs are statutorily authorized (1861(hh)(2) of the Act) to furnish services for the diagnosis and treatment of mental illnesses only.

Services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service. Services that a hospital or SNF is required to provide to an inpatient or outpatient as a requirement for participation are not included.

Services performed by CPs and CSWs must be:

- Furnished in accordance with RHC or FQHC policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the CP or CSW who furnished the service is legally permitted to furnish by the state in which the service is rendered; and
- Furnished in accordance with state restrictions as to setting and supervision, including any physician supervision requirements.

160 - Services and Supplies Incident to CP and CSW Services

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

Services and supplies that are integral, though incident to a CP *or CSW* service are:

- Commonly rendered without charge or included in the RHC or FQHC payment;
- Commonly furnished in an outpatient clinic setting;
- Furnished under the direct supervision of the CP *or CSW*, except for authorized care management services which may be furnished under general supervision; and
- Furnished by a member of the RHC or FQHC staff.

NOTE: The direct supervision requirement is met in the case of a CP or *CSW* who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC. Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of a CP *or CSW*.

190.2 - Requirements for *Furnishing* Visiting Nursing Services

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHCs and FQHCs are paid for visiting nursing services when G0490 is on an RHC or FQHC claim and all of the following requirements are met:

- The patient is considered confined to the home as defined in section 1835(a) of the Act and the Medicare Benefit Policy Manual, Chapter 7 (see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>);
- The RHC or FQHC is located in an area that has a shortage of home health agencies;
- The services and supplies are provided under a written plan of treatment;
- Nursing services are furnished on a part-time or intermittent basis only; and
- Drugs and biological products are not provided.

190.5 - Treatment Plans *for Visiting Nursing Services*

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

For services and supplies that require a treatment plan, the treatment plan must be written and reviewed by a supervising physician, NP, PA, CNM, or CP, as appropriate, at least once every 60 days; and meet other documentation requirements. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated for the purpose of Medicare coverage unless:

- The supervising physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient, or

- Nursing visits are required at intervals less frequently than once every 60 days, but the intervals are predictable (e.g., it is predictable that a visit is required only every 90 days for the purpose of changing a silicone catheter, etc.).

Home nursing visits furnished before the plan is put into writing are covered if authorized in writing by the supervising physician.

230 – Care Management Services

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

Care management services are RHC and FQHC service and *include transitional care management (TCM), chronic care management (CCM), general behavioral health integration (BHI), and psychiatric collaborative care model (CoCM) services. The RHC and FQHC face-to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.)* Except for TCM services, care management services are paid separately from the RHC AIR or FQHC PPS payment methodology. *RHCs and FQHCs may not bill for care management services for a beneficiary if another practitioner or facility has already billed for care management services for the same beneficiary during the same time period. RHCs and FQHCs may not bill for care management and TCM services, or another program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment), for the same beneficiary during the same time period.* Coinsurance and deductibles are applied as applicable to RHC claims, and coinsurance is applied as applicable to FQHC claims.

230.1 - Transitional Care Management Services

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

Effective January 1, 2013, RHCs and FQHCs are paid for TCM services furnished by an RHC or FQHC practitioner when all TCM requirements are met. 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.

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.

TCM services are billed by adding CPT code 99495 or CPT code 99496 to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit *is paid*.

230.2 – General Care Management Services

(Rev. 252, Issued: 12- 7-18, Effective: 01-01-19, Implementation: 01- 02-19)

General Care Management Services includes CCM and BHI services. A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before care

management services can be furnished. This visit can be an E/M, AWW, or IPPE visit, and must occur no more than one-year prior to commencing care management services. *Care management services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for CCM and BHI services as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of care management services.* Beneficiary consent to receive care management services may be written or verbal and must be documented in the patient's medical record before CCM or BHI services are furnished. *The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:*

- There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
- Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
- They can stop care management services at any time, effective at the end of the calendar month.

Beneficiary consent remains in effect unless the beneficiary opts out of receiving care management services. If the beneficiary chooses to resume care management services after opting out, beneficiary consent is required before care management services can resume. If the beneficiary has not opted out of care management services but there has been a period where no care management services were furnished, a new beneficiary consent is not required.

CCM

Effective January 1, 2016, RHCs and FQHCs are paid for CCM services when a minimum of 20 minutes of qualifying CCM services during a calendar month is furnished. CCM services may be furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CCM service requirements include:

- Structured recording of patient health information using Certified EHR Technology including demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care;
- 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications;
- Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
- Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver;
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after

discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;

- Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record; and
- Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

General BHI

BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions. Effective January 1, 2018, RHCs and FQHCs are paid for general BHI services when a minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished to patients with one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services. General BHI service requirements include:

- An initial assessment and ongoing monitoring using validated clinical rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Payment for General Care Management Services

CCM services furnished between January 1, 2016, and December 31, 2017, are paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim.

CCM or general BHI services furnished between January 1, 2018, and December 31, 2018, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490 (30 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM or general BHI services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491 (30 minutes or more of CCM furnished by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes. Coinsurance for care management services is 20 percent of lesser of submitted charges or the payment rate for G0511. Care management costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate. G0511 can be billed once per month per beneficiary when at least 20 minutes of CCM services or at least 20 minutes of general BHI services have been furnished and all other requirements have been met. Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the

minimum 20 minutes that is required to bill for general care management services and does not include administrative activities such as transcription or translation services.

230.3 – Psychiatric Collaborative Care Model (CoCM) Services *(Rev. 252, Issued: 12-7-18, Effective: 01-01-19, Implementation: 01-02-19)*

Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment. It includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving. The primary care team regularly reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care, as needed. Patients with mental health, behavioral health, or psychiatric conditions, including substance use disorders, who are being treated by an RHC or FQHC practitioner may be eligible for psychiatric CoCM services, as determined by the RHC or FQHC *primary care* practitioner. A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before psychiatric CoCM services can be furnished. This visit can be an E/M, AWW, or IPPE visit, and must occur no more than one-year prior to commencing care management services.

Psychiatric CoCM services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for psychiatric CoCM as for CCM and BHI services, as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of psychiatric CoCM services.

Beneficiary consent to receive care management services may be written or verbal and must be documented in the patient's medical record before *psychiatric* CoCM services are furnished. The medical record should document that the beneficiary has *been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:*

- There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
- Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
- They can stop care management services at any time, effective at the end of the calendar month.

Beneficiary consent remains in effect unless the beneficiary opts out of receiving care management services. If the beneficiary chooses to resume care management services after opting out, beneficiary consent is required before care management services can resume. If the beneficiary has not opted out of care management services but there has been a period where no care management services were furnished, a new beneficiary consent is not required.

RHC or FQHC Practitioner Requirements

The RHC or FQHC practitioner is a primary care physician, NP, PA, or CNM who:

- Directs the behavioral health care manager and any other clinical staff;
- Oversees the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and
- Remains involved through ongoing oversight, management, collaboration and reassessment.

Behavioral Health Care Manager Requirements

The behavioral health care manager is a designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs. The behavioral health care manager furnishes both face-to-face and non-face-to-face services under the general supervision of the RHC or FQHC practitioner and may be employed by or working under contract to the RHC or FQHC. The behavioral health care manager:

- Provides assessment and care management services, including the administration of validated rating scales;
- Provides behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Provides brief psychosocial interventions;
- Maintains ongoing collaboration with the RHC or FQHC practitioner;
- Maintains a registry that tracks patient follow-up and progress;
- Acts in consultation with the psychiatric consultant;
- Is available to provide services face-to-face with the beneficiary; and
- Has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.

Psychiatric Consultant Requirements

The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant is not required to be on site or to have direct contact with the patient and does not prescribe medications or furnish treatment to the beneficiary directly. The psychiatric consultant:

- Participates in regular reviews of the clinical status of patients receiving psychiatric CoCM services;
- Advises the RHC or FQHC practitioner regarding diagnosis and options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments; and
- Facilitates referral for direct provision of psychiatric care when clinically indicated.

Payment for Psychiatric CoCM

Psychiatric CoCM services *furnished on or after January 1, 2019*, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when psychiatric CoCM HCPCS code, G0512, is on an RHC or FQHC claim, either alone or with other payable services. This rate is updated annually based on the PFS amounts *for these codes*.

At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service.

Coinsurance for psychiatric CoCM services is 20 percent of the lesser of submitted charges or the payment rate for G0512. Psychiatric CoCM costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate. G0512 can be billed once per month per beneficiary when all requirements have been met.

Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes that is required to bill for psychiatric

CoCM services and does not include administrative activities such as transcription or translation services.

240 – Virtual Communication Services

(Rev. 252, Issued: 12-7-18, Effective: 01-01-19, Implementation: 01-02-19)

Virtual communication services are RHC and FQHC services and include communications-based technology and remote evaluation services. The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient.

Effective January 1, 2019, 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.

Requirements

The following requirements must be met for RHCs and FQHCs to bill for virtual communication services:

- At least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient that has had a billable visit in the RHC or FQHC within the previous year; and*
- The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC or FQHC service within the next 24 hours or at the soonest available appointment.*

If the discussion between the patient and the RHC or FQHC practitioner is related to a billable visit furnished by the RHC or FQHC within the previous 7 days or within the next 24 hours or at the soonest available appointment, the cost of the RHC or FQHC practitioner's time would be included in the RHC AIR or the FQHC PPS payment and is not separately billable.

Payment for Virtual Communication Services

Virtual communication services furnished by RHCs and FQHCs on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services), when the virtual communication HCPCS code, G0071, is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0071 is updated annually based on the PFS amounts for these codes.