DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: SE1611 | **Related Change Request (CR) #: N/A**

Related CR Release Date: N/A | **Effective Date: October 1, 2016**

Related CR Transmittal #: N/A | **Implementation Date: October 3, 2016**

Rural Health Clinics (RHCs) Healthcare Common Procedure Coding System (HCPCS) Reporting Requirement and Billing Updates

Note: We revised this article on June 6, 2019, to update the web links. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for Rural Health Clinics (RHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article provides information to assist RHCs in meeting the requirements to report the HCPCS code for each service furnished along with the revenue code on claims to Medicare effective for dates of service on or after April 1, 2016. Make sure your billing staff is aware of these instructions.

Background

From April 1, 2016, through September 30, 2016, all charges for a visit will continue to be reported on the service line with the qualifying visit HCPCS code, minus any charges for preventive services, using revenue code 052x for medical services and/or revenue code 0900 for mental health services. This guidance is available in MLN Matters Article MM9269 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf. The RHC Qualifying Visit List (QVL) can be accessed on the RHC Center Page located at https://www.cms.gov/center/provider-type/rural-health-clinics-center.html.

In April 2016, CMS instructed RHCs to hold claims only for a billable visit shown in red on the RHC QVL until October 1, 2016. Upon billing these claims and/or for claim adjustments beginning on October 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible. The subsequent paragraph explains modifier CG further.

Beginning on October 1, 2016, the MACs will accept modifier CG on RHC claims and claim adjustments. RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line per day, which includes all charges subject to coinsurance and deductible for the visit. For RHCs, the coinsurance is 20 percent of the charges. Therefore, coinsurance and deductible will be based on the charges reported on the revenue code 052x and/or 0900 service line with modifier CG. RHCs will continue to be paid an all-inclusive rate (AIR) per visit.

Coinsurance and deductible are waived for the approved preventive health services in Table 1. When a preventive health service is the primary service for the visit, RHCs should report modifier CG on the revenue code 052x service line with the preventive health service. Medicare will pay 100% of the AIR for the preventive health service.

Table 1: Approved Preventive Health Services with Coinsurance and Deductible Waived

HCPCS/CPT Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
99406	Tobacco-use counsel 3-10 min
99407	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

Note: HCPCS code G0436 and G0437 will be discontinued effective 10/1/2016. CPT codes 99406 and 99407 are the remaining codes for tobacco cessation counseling. The beneficiary copayment is waived for CPT codes 99406 and 99407.

Each additional service furnished during the visit should be reported with the most appropriate revenue code and charges greater to or equal to $0.01. The additional service

lines are for informational purposes only. MACs will continue to package/bundle the additional service lines, which do not receive the AIR.

When the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, the subsequent medical service should be billed using revenue code 052x and modifier 59. Beginning on October 1, 2016, RHCs can also report modifier 25 to indicate the subsequent visit was distinct or independent from an earlier visit furnished on the same day. When modifier 59 or modifier 25 is reported, RHCs will receive the AIR for an additional visit. This is the only circumstance in which modifier 59 or modifier 25 should be used.

Finally, note that the HCPCS reporting requirements have no impact in the way that telehealth or chronic care management services are reimbursed.

Additional Information

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
June 6, 2019	We revised this article to update the web links. All other information is unchanged.
August 2, 2016	This article was revised to show in Table 1 that codes G0436 and G0437 are replaced by 99406 and 99407, respectively, on October 1, 2016.
May 9, 2016	Initial article released.