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Federally Qualified Health Center

Module 4
Appendices of Source Authority

Version 01/2023
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Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter G - Standards and Certification

Part 491 - Certification of Certain Health Facilities

Subpart A - Rural Health Clinics: Conditions for Certification; and FQHCs Conditions for Coverage

Authority: 42 U.S.C. 263a and 1302.

§ 491.12 Emergency preparedness.

The Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) must comply with all applicable Federal, State, and local emergency preparedness requirements. The RHC/FQHC must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

- (a) **Emergency plan.** The RHC or FQHC must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do all of the following:
 - (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
 - (2) Include strategies for addressing emergency events identified by the risk assessment.
 - (3) Address patient population, including, but not limited to, the type of services the RHC/FQHC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
 - (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.
- (b) **Policies and procedures.** The RHC or FQHC must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:
 - (1) Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.
 - (2) A means to shelter in place for patients, staff, and volunteers who remain in the facility.
 - (3) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

- (4) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.
- (c) **Communication plan.** The RHC or FQHC must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:
- (1) Names and contact information for the following:
 - (i) Staff.
 - (ii) Entities providing services under arrangement.
 - (iii) Patients' physicians.
 - (iv) Other RHCs/FQHCs.
 - (v) Volunteers.
 - (2) Contact information for the following:
 - (i) Federal, State, tribal, regional, and local emergency preparedness staff.
 - (ii) Other sources of assistance.
 - (3) Primary and alternate means for communicating with the following:
 - (i) RHC/FQHC's staff.
 - (ii) Federal, State, tribal, regional, and local emergency management agencies.
 - (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).
 - (5) A means of providing information about the RHC/FQHC's needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.
- (d) **Training and testing.** The RHC or FQHC must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.
- (1) **Training program.** The RHC/FQHC must do all of the following:
 - (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles,
 - (ii) Provide emergency preparedness training at least every 2 years.
 - (iii) Maintain documentation of the training.
 - (iv) Demonstrate staff knowledge of emergency procedures.
 - (v) If the emergency preparedness policies and procedures are significantly updated, the RHC/FQHC must conduct training on the updated policies and procedures.

- (2) **Testing.** The RHC or FQHC must conduct exercises to test the emergency plan at least annually. The RHC or FQHC must do the following:
- (i) Participate in a full-scale exercise that is community-based every 2 years; or
 - (A) When a community-based exercise is not accessible, an individual, facility-based functional exercise every 2 years; or.
 - (B) If the RHC or FQHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the RHC or FQHC is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
 - (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to following:
 - (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
 - (B) A mock disaster drill; or
 - (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
 - (iii) Analyze the RHC or FQHC's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the RHC or FQHC's emergency plan, as needed.
- (e) **Integrated healthcare systems.** If a RHC/FQHC is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the RHC/FQHC may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:
- (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
 - (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.
 - (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.
 - (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:
 - (i) A documented community-based risk assessment, utilizing an all-hazards approach.
 - (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

- (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

[81 FR 64041, Sept. 16, 2016, as amended by 84 FR 51832, Sept. 30, 2019]

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Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 405 - Federal Health Insurance for the Aged and Disabled

Subpart X - Rural Health Clinic and Federally Qualified Health Center Services

Source: 57 FR 24976, 24977, June 12, 1992, unless otherwise noted.

Source: 57 FR 24978, June 12, 1992, unless otherwise noted.

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Source: 43 FR 8261, Mar. 1, 1978, unless otherwise noted.

Authority: 42 U.S.C. 263a, 405(a), 1302, 1320b-12, 1395x, 1395y(a), 1395ff, 1395hh, 1395kk, 1395rr, and 1395ww(k).

§ 405.2401 Scope and definitions.

(a) **Scope.** This subpart establishes the requirements for coverage and reimbursement of rural health clinic and Federally qualified health center services under Medicare.

(b) **Definitions.** As used in this subpart, unless the context indicates otherwise:

Allowable costs means costs that are incurred by a RHC or FQHC that is authorized to bill based on reasonable costs and are reasonable in amount and proper and necessary for the efficient delivery of RHC and FQHC services.

Beneficiary means an individual enrolled in the Supplementary Medical Insurance program for the Aged and Disabled (part of title XVIII of the Act).

Certified nurse midwife (CNM) means an individual who meets the applicable education, training, and other requirements of § 410.77(a) of this chapter.

Clinical psychologist (CP) means an individual who meets the applicable education, training, and other requirements of § 410.71(d) of this chapter.

Clinical social worker (CSW) means an individual who meets the applicable education, training, and other requirements of § 410.73(a) of this chapter.

CMS stands for Centers for Medicare & Medicaid Services.

Coinsurance means that portion of the RHC's charge for covered services or that portion of the FQHC's charge or PPS rate for covered services for which the beneficiary is liable (in addition to the deductible, where applicable).

Covered services means items or services for which the beneficiary is entitled to have payment made on his or her behalf under this subpart.

Deductible means the amount incurred by the beneficiary during a calendar year as specified in § 410.160 and § 410.161 of this chapter.

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Payment for Rural Health Clinic and Federally Qualified Health Center Services Payment for...

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Authority: 42 U.S.C. 263a, 405(a), 1302, 1320b-12, 1395x, 1395y(a), 1395ff, 1395hh, 1395kk, 1395rr, and 1395ww(k).

§ 405.2462 Payment for RHC and FQHC services.

(a) *Payment to independent RHCs that are authorized to bill under the reasonable cost system.*

- (1) RHCs that are authorized to bill under the reasonable cost system are paid on the basis of an all-inclusive rate, subject to a payment limit per visit determined in paragraph (b) of this section, for each beneficiary visit for covered services. This rate is determined by the Medicare Administration Contractor (MAC), in accordance with this subpart and general instructions issued by CMS.
- (2) The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(b) *RHC payment limit per visit.*

- (1) In establishing limits on payment for rural health clinic services provided by rural health clinics the limit for services provided prior to April 1, 2021:
 - (i) In 1988, after March 31, at \$46 per visit; and
 - (ii) In a subsequent year (before April 1, 2021), at the limit established for the previous year increased by the percentage increase in the Medicare Economic Index (MEI) (as defined in section 1842(i)(3) of the Act) applicable to primary care services (as defined in section 1842(i)(4) of the Act) furnished as of the first day of that year.
- (2) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by rural health clinics or any rural health clinic that is enrolled on or after January 1, 2021 under section 1866(j) of the Act, the limit for services provided:
 - (i) In 2021, after March 31, at \$100 per visit;
 - (ii) In 2022, at \$113 per visit;
 - (iii) In 2023, at \$126 per visit;
 - (iv) In 2024, at \$139 per visit;
 - (v) In 2025, at \$152 per visit;
 - (vi) In 2026, at \$165 per visit;

- (vii) In 2027, at \$178 per visit; and
 - (viii) In 2028, at \$190 per visit.
 - (ix) In a subsequent year, at the limit established for the previous year increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such year.
- (3) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by provider-based rural health clinics as described in section (c)(4) of this part, the limit for services provided:
- (i) In 2021, after March 31, at an amount equal to the greater of:
 - (A) For rural health clinics that had an all-inclusive rate established for services furnished in 2020 -
 - (1) The all-inclusive rate applicable to the rural health clinic for services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021, or
 - (2) The payment limit per visit applicable in paragraph (b)(2) of this section.
 - (B) For rural health clinics that did not have an all-inclusive rate established for services furnished in 2020 -
 - (1) The all-inclusive rate applicable to the rural health clinic for services furnished in 2021, or
 - (2) The payment limit per visit applicable in paragraph (b)(2) of this section.
 - (ii) In a subsequent year, at an amount equal to the greater of:
 - (A) The amount established under paragraph (b)(3)(i)(A) or (B) of this section, as applicable for the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such subsequent year, or
 - (B) The payment limit per visit applicable under paragraph (b)(2) of this section for such subsequent year.
- (c) **Payment to provider-based RHCs that are authorized to bill under the reasonable cost system.**
- (1) An RHC that is authorized to bill under the reasonable cost system is paid in accordance with parts 405 and 413 of this subchapter, as applicable, if the RHC is -
 - (i) An integral and subordinate part of a hospital, skilled nursing facility or home health agency participating in Medicare (that is, a provider of services); and
 - (ii) Operated with other departments of the provider under common licensure, governance and professional supervision.
 - (2) An RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate, subject to a payment limit per visit, described in paragraphs (b)(1) and (2) of this section, for each beneficiary visit for covered services when in a hospital with greater than 50 beds as determined in § 412.105(b) of this subchapter. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

- (3) Prior to April 1, 2021, an RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate and is not subject to a payment limit per visit described in paragraphs (b)(1) and (2) of this section for each beneficiary visit for covered services when in a hospital with less than 50 beds as determined in § 412.105(b) of this subchapter. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.
 - (4) On or after April 1, 2021, an RHC, described in paragraph (c)(1) of this section, is paid on the basis of an all-inclusive rate, subject to a payment limit per visit, described in paragraph (b)(3) of this section, for each beneficiary visit for covered services when it meets the specified qualifications in paragraph (d) of this section. This all-inclusive rate is determined by the MAC, in accordance with this subpart and general instructions issued by CMS. The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.
- (d) **Specified qualifications.** A provider-based rural health clinic must meet the following qualifications to have a payment limit per visit established in accordance with paragraph (b)(3) of this section.
- (1) As of December 31, 2020, was in a hospital with less than 50 beds (as determined in § 412.105(b) of this subchapter) and after December 31, 2020, in a hospital that continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the COVID-19 Public Health Emergency (PHE)); and one of the following circumstances:
 - (i) As of December 31, 2020, was enrolled under section 1866(j) of the Act (including temporary enrollment during the COVID-19 PHE); or
 - (ii) Submitted an application for enrollment under section 1866(j) of the Act (or a request for temporary enrollment during the COVID-19 PHE) that was received not later than December 31, 2020.
 - (2) [Reserved]
- (e) **Payment to FQHCs that are authorized to bill under the PPS.** A FQHC that is authorized to bill under the PPS is paid a single, per diem rate based on the prospectively set rate for each beneficiary visit for covered services. Except as noted in paragraph (f) of this section, this rate is adjusted for the following:
- (1) Geographic differences in cost based on the Geographic Practice Cost Indices (GPCIs) in accordance with section 1848(e) of the Act and 42 CFR 414.2 and 414.26 are used to adjust payment under the physician fee schedule during the same period, limited to only the work and practice expense GPCIs.
 - (2) Furnishing of care to a beneficiary that is a new patient with respect to the FQHC, including all sites that are part of the FQHC. A new patient is one that has not been treated by the FQHC's organization within the previous 3 years.
 - (3) Furnishing of care to a beneficiary receiving a comprehensive initial Medicare visit (that is an initial preventive physical examination or an initial annual wellness visit) or a subsequent annual wellness visit.
- (f) **Payment to grandfathered tribal FQHCs.**
- (1) A "grandfathered tribal FQHC" is a FQHC that:
 - (i) Is operated by a tribe or tribal organization under the Indian Self-Determination Education and Assistance Act (ISDEAA);

- (ii) Was billing as if it were provider-based to an IHS hospital on or before April 7, 2000; and
 - (iii) Is not operating as a provider-based department of an IHS hospital.
 - (2) A grandfathered tribal FQHC is paid at the Medicare outpatient per visit rate as set annually by the IHS.
 - (3) The payment rate is not adjusted:
 - (i) By the FQHC Geographic Adjustment Factor;
 - (ii) For new patients, annual wellness visits, or initial preventive physical examinations; or
 - (iii) Annually by the Medicare Economic Index or a FQHC PPS market basket.
 - (4) The payment rate is adjusted annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Pub. L. 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).
- (g)
- (1) Except for preventive services for which Medicare pays 100 percent under § 410.152(l) of this chapter, Medicare pays -
 - (i) Eighty (80) percent of the lesser of the FQHC's actual charge or the PPS encounter rate for FQHCs authorized to bill under the PPS; or
 - (ii) Eighty (80) percent of the lesser of a grandfathered tribal FQHC's actual charge, or the outpatient rate for Medicare as set annually by the IHS for grandfathered tribal FQHCs that are authorized to bill at this rate.
 - (2) No deductible is applicable to FQHC services.
- (h) For RHCs visits, payment is made in accordance with one of the following:
- (1) If the deductible has been fully met by the beneficiary prior to the RHC visit, Medicare pays 80 percent of the all-inclusive rate.
 - (2) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is less than the all-inclusive rate, the amount applied to the deductible is subtracted from the all-inclusive rate and 80 percent of the remainder, if any, is paid to the RHC.
 - (3) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is equal to or exceeds the all-inclusive rate, no payment is made to the RHC.
- (i) To receive payment, the RHC or FQHC must do all of the following:
- (1) Furnish services in accordance with the requirements of subpart X of part 405 of this chapter and subpart A of part 491 of this chapter.
 - (2) File a request for payment on the form and manner prescribed by CMS.
 - (3) **HCPCS coding.** FQHCs and RHCs are required to submit HCPCS and other codes as required in reporting services furnished.

[79 FR 25477, May 2, 2014, as amended at 80 FR 71371, Nov. 16, 2015; 83 FR 60073, Nov. 23, 2018; 86 FR 65660, Nov. 19, 2021]

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§ 405.2463 What constitutes a visit.

(a) *Visit - General.*

(1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter (or, for mental health disorders only, an encounter that meets the requirements under paragraph (b)(3) of this section) between an RHC patient and one of the following:

- (A) Physician.
- (B) Physician assistant.
- (C) Nurse practitioner.
- (D) Certified nurse midwife.
- (E) Visiting registered professional or licensed practical nurse.
- (G) Clinical psychologist.
- (H) Clinical social worker.

(ii) Qualified transitional care management service.

(2) For FQHCs, a visit is either of the following:

(i) A visit as described in paragraph (a)(1)(i) or (ii) of this section.

(ii) A face-to-face encounter between a patient and either of the following:

- (A) A qualified provider of medical nutrition therapy services as defined in part 410, subpart G, of this chapter.
- (B) A qualified provider of outpatient diabetes self-management training services as defined in part 410, subpart H, of this chapter.

(b) *Visit - Medical.*

(1) A medical visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:

- (i) Physician.
- (ii) Physician assistant.
- (iii) Nurse practitioner.
- (iv) Certified nurse midwife.
- (v) Visiting registered professional or licensed practical nurse.

(2) A medical visit for a FQHC patient may be either of the following:

- (i) Medical nutrition therapy visit.
- (ii) Diabetes outpatient self-management training visit.

(3) **Visit - Mental health.** A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder, including an in-person mental health service, beginning 152 days after the end of the COVID-19 public health emergency, furnished within 6 months prior to the furnishing of the telecommunications service and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record, between an RHC or FQHC patient and one of the following:

- (i) Clinical psychologist.
- (ii) Clinical social worker.
- (iii) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

(c) **Visit - Multiple.**

(1) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the patient -

- (i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day;
- (ii) Has a medical visit and a mental health visit on the same day; or
- (iii) Has an initial preventive physical exam visit and a separate medical or mental health visit on the same day.

(2) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, Medicare pays RHCs and FQHCs for more than 1 visit per day when the conditions in paragraph (c)(1) of this section are met.

- (3) For FQHCs that are authorized to bill under the reasonable cost system, Medicare pays for more than 1 visit per day when a DSMT or MNT visit is furnished on the same day as a visit described in paragraph (c)(1) of this section are met.
- (4) For FQHCs billing under the PPS, and grandfathered tribal FQHCs that are authorized to bill as a FQHC at the outpatient per visit rate for Medicare as set annually by the Indian Health Service -
 - (i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day; or
 - (ii) Has a medical visit and a mental health visit on the same day.

[79 FR 68001, Nov. 13, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 86 FR 65661, Nov. 19, 2021; 87 FR 70222, Nov. 18, 2022]

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Medicare Benefit Policy Manual

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

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Index of Acronyms
(Rev. 10729, 04-26-21)

AIR – all inclusive rate
AWV – annual wellness visit
BHI – behavioral health integration
CCM – chronic care management
CCN – CMS certification number
CNM – certified nurse midwife
CoCM – collaborative care model
CP – clinical psychologist
CSW – clinical social worker
DSMT – diabetes self-management training
EKG – electrocardiogram
E/M – evaluation and management
FQHC – Federally qualified health center
FTE – full time equivalent
GAF – geographic adjustment factor
GME – graduate medical education
HCPCS – Healthcare Common Procedure Coding System
HHA – home health agency
HHS – Health and Human Services
HPSA – Health Professional Shortage Area
HRSA – Health Resources and Services Administration
IPPE – initial preventive physical exam
LDTC – low dose computed tomography
LPN – licensed practical nurse
MAC – Medicare Administrative Contractor
MEI – Medicare Economic Index
MNT – medical nutrition therapy
MSA – metropolitan statistical area
MUA – Medically-Underserved Area
MUP – Medically-Underserved Population

NCD – national coverage determination
NECMA – New England County Metropolitan Area
NP – nurse practitioner
OBRA - Omnibus Budget Reconciliation Act
PA – physician assistant
PCE - Primary Care Exception
PCM – Principal Care Management
PFS – physician fee schedule
PPS – prospective payment system
PHS – Public Health Service
RHC – rural health clinic
RN – registered nurse
RO – regional office
RUCA – Rural Urban Commuting Area
SLP – speech language therapy
TCM – transitional care management
UA – urbanized area
USPSTF – U.S. Preventive Services Task Force

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10 - RHC and FQHC General Information

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

10.1 - RHC General Information

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Rural Health Clinics (RHCs) were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas. RHCs have been eligible to participate in the Medicare program since March 1, 1978, and are paid an all-inclusive rate (AIR) for medically-necessary primary health services, and qualified preventive health services, furnished by an RHC practitioner.

RHCs are defined in section 1861(aa)(2) of the Social Security Act (the Act) as facilities that are engaged primarily in providing services that are typically furnished in an outpatient clinic. RHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services; and
- Services and supplies furnished incident to an NP, PA, CNM, or CP services.

RHC services may also include nursing visits to patients confined to the home that are furnished by a registered professional nurse (RN) or a licensed professional nurse (LPN) when certain conditions are met. (See section 190 of this manual)

To be eligible for certification as an RHC, a clinic must be located in a non-urbanized area, as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary, Health and Human Services (HHS), in any one of the four types of shortage area designations that are accepted for RHC certification. (See section 20 of this manual)

In addition to the location requirements, an RHC must:

- Employ an NP or PA;

- Have an NP, PA, or CNM working at the clinic at least 50 percent of the time the clinic is operating as an RHC;
- Directly furnish routine diagnostic and laboratory services;
- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC;
- Have available drugs and biologicals necessary for the treatment of emergencies;
- Meet all health and safety requirements;
- Not be a rehabilitation agency or a facility that is primarily for mental health treatment;
- Furnish onsite all of the following six laboratory tests:
 - Chemical examination of urine by stick or tablet method or both;
 - Hemoglobin or hematocrit;
 - Blood sugar;
 - Examination of stool specimens for occult blood;
 - Pregnancy tests; and
 - Primary culturing for transmittal to a certified laboratory.
- Not be concurrently approved as an FQHC, and
- Meet other applicable State and Federal requirements.

RHCs can be either independent or provider-based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (A/B MAC). They are assigned a CMS Certification Number (CCN) in the range 3800-3974 or 8900-8999. Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH)), skilled nursing facility (SNF), or a home health agency (HHA). They are assigned a CCN in the range 3400-3499, 3975-3999, or 8500-8899. (**NOTE:** A provider-based CCN is not an indication that the RHC has a provider-based determination for purposes of an exception to the payment limit.)

The statutory requirements for RHCs are found in section 1861(aa) of the Act. Many of the regulations pertaining to RHCs can be found at 42 CFR 405.2400 Subpart X and following, and 42 CFR 491 Subpart A and following.

For information on claims processing, see Pub. 100-04, Medicare Claims Processing Manual, chapter 9, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf>.

For information on certification requirements, see Pub. 100-07, Medicare State Operations Manual, Chapter 2, and Appendix G, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

10.2 - FQHC General Information

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

 Federally Qualified Health Centers (FQHCs) were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and were effective beginning on October 1, 1991. As with RHCs, they are also facilities that are primarily engaged in providing services that are typically furnished in an outpatient clinic. FQHCs were paid an AIR for primary health services and qualified preventive health services until October 1, 2014, when they began to transition to the FQHC prospective payment system (PPS). Beginning on January 1, 2016, all FQHC are paid under the provisions of the FQHC PPS, as required by Section 10501(i)(3)(B) of the Affordable Care Act.

FQHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies furnished incident to an NP, PA, CNM, or CP services; and
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for beneficiaries with diabetes or renal disease.

The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in section 1861(aa)(4) of the Act. No Part B deductible is applied to expenses for

services that are payable under the FQHC benefit. An entity that qualifies as an FQHC is assigned a CCN in the range 1800-1989 and 1000-1199.

FQHC services also include certain preventive primary health services. The law defines Medicare-covered preventive services provided by an FQHC as the preventive primary health services that an FQHC is required to provide under section 330 of the Public Health Service (PHS) Act. Medicare may not cover some of the preventive services that FQHCs provide, such as dental services, which are specifically excluded under Medicare law.

There are 3 types of organizations that are eligible to enroll in Medicare as FQHCs:

- Health Center Program Grantees: Organizations receiving grants under section 330 of the PHS Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers;
- Health Center Program Look-Alikes: Organizations that have been identified by HRSA as meeting the definition of “Health Center” under section 330 of the PHS Act, but not receiving grant funding under section 330; and
- Outpatient health programs/facilities operated by a tribe or tribal organization (under the Indian Self-Determination Act) or by an urban Indian organization (under Title V of the Indian Health Care Improvement Act).

NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to tribal or urban Indian FQHCs or grandfathered tribal FQHCs.

An FQHC must:

- Provide comprehensive services and have an ongoing quality assurance program;
- Meet other health and safety requirements;
- Not be concurrently approved as an RHC; and

- Meet all requirements contained in section 330 of the Public Health Service Act, including:
 - Serve a designated Medically-Underserved Area (MUA) or Medically-Underserved Population (MUP);
 - Offer a sliding fee scale to persons with incomes below 200 percent of the federal poverty level; and
 - Be governed by a board of directors, of whom a majority of the members receive their care at the FQHC.

Additional information on these and other section 330 requirements can be found at <http://bphc.hrsa.gov/>.

Per 42 CFR 413.65(n), only FQHCs that were operating as provider-based clinics prior to 1995 and either a) received funds under section 330 of the PHS Act or b) were determined by CMS to meet the criteria to be a look-alike clinic, are eligible to be certified as provider-based FQHCs. Clinics that do not already have provider-based status as an FQHC are no longer permitted to receive the designation.

For information on claims processing, see to Pub. 100-04, Medicare Claims Processing Manual, chapter 9, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf>, and Pub. 100-07, State Operations Manual chapter 2, sections 2825 and 2826, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf>.

20 - RHC and FQHC Location Requirements

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

To be eligible for certification as an RHC, a clinic must be located in 1) a non-urbanized area, as determined by the U.S. Census Bureau, and 2) an area designated or certified within the previous 4 years by the Secretary, HHS, in any one of the four types of shortage area designations that are accepted for RHC certification as listed in section 20.2.

A clinic applying to become a Medicare-certified RHC must meet both the rural and underserved location requirements. Mobile clinics must have a fixed schedule that specifies the date and location for services, and each location must meet the location requirements.

Existing RHCs are not currently required to continue to meet the location requirements. RHCs that plan to relocate or expand should contact their Regional Office (RO) to determine their location requirements.

FQHCs may be located in rural or urban areas. FQHCs that are Health Center Program Grantees or Look-Alikes must be located in or serve people from a HRSA-designated MUA or MUP.

20.1 - Non-Urbanized Area Requirement for RHCs

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

The U.S. Census Bureau determines if an area is an urbanized area (UA). Any area that is not in a UA is considered a non-urbanized area. A clinic located in an area that is not a UA would meet the RHC requirement for being in a non-urbanized area. Information on whether an area is in an urbanized area can be found at <http://factfinder.census.gov>; or <http://www.raconline.org>; or by contacting the appropriate CMS RO at <http://www.cms.gov/RegionalOffices/>.

20.2 - Designated Shortage Area Requirement for RHCs

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

The HRSA designates areas as MUAs/MUPs and/or Health Professional Shortage Areas (HPSAs). To be eligible for RHC certification, a clinic must be located in an area that has one of the following types of shortage area designations:

- Geographic Primary Care HPSA;
- Population-group Primary Care HPSA;
- MUA (this does not include the population group MUP designation); or
- Governor-Designated and Secretary-Certified Shortage Area (this does not include a Governor's Medically Underserved Population designation).

No other type of shortage area designation is accepted for purposes of RHC certification. The designation cannot be more than 4 years old in order to meet the requirement of being in a currently designated area. For RHC purposes, the age of the designation is calculated as the last day of the year 4 years from the date of the original designation, or the date the area was last designated. For example, a clinic that is located in an area that was most recently designated or updated on June 1, 2010, would be considered as meeting this location requirement through December 31, 2014.

Areas that are listed as "proposed for withdrawal" are considered designated. The designation date is the date that the area was last updated, not when the area was proposed for withdrawal. To determine the designation date of an area that is listed as "proposed for withdrawal", contact HRSA's Shortage Designation Branch at sdb@hrsa.gov or call 1-888-275-4772.

30 - RHC and FQHC Staffing Requirements

(Rev. 166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

30.1 - RHC Staffing Requirements

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

In addition to the location requirements, an RHC must:

- Employ an NP or PA; and
- Have an NP, PA, or CNM working at the clinic at least 50 percent of the time the clinic is operating as an RHC.

The employment may be full or part time, and is evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100 percent ownership of the RHC, the W-2 form can be from that entity as long as all the non-physician practitioners employed in the RHC receive their W-2 from this owner.

The following are examples of situations that would NOT satisfy the employment requirement:

- An NP or PA who is employed by a hospital that has an ownership interest in the RHC but is not physically present and working in the RHC;
- A CNM who is employed by the RHC;
- An Advanced Practice Registered Nurse who is not an NP or PA; or
- An NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician.

An RHC practitioner is a physician, NP, PA, CNM, CP, or CSW. At least one of these practitioners must be present in the RHC and available to furnish patient care at all times the RHC is in operation. A clinic that is open solely to address administrative matters or to provide shelter from inclement weather is not considered to be in operation during this period and is not subject to the staffing requirements.

An NP, PA, or CNM must be available to furnish patient care at least 50 percent of the time that the RHC is open to provide patient care. This requirement can be fulfilled through any combination of NPs, PAs, or CNMs as long as the total is at least 50 percent of the time the RHC is open to provide patient care. Only the time that an NP, PA, or CNM spends in the RHC, or the time spent directly furnishing patient care in another location as an RHC practitioner, is counted towards the 50 percent time. It does not include travel time to another location, or time spent not furnishing patient care when in another location outside the RHC (e.g. home, SNF, etc.).

A clinic located on an island that otherwise meets the requirements for RHC certification is not required to employ an NP or PA, although it is still required to have an NP or PA at least 50 percent of the time that the RHC is in operation (OBRA '89, Sec 4024). An island is a body of land completely surrounded by water, regardless of size and accessibility (e.g., bridges).

As of July 1, 2014, RHCs may contract with non-physician practitioners (PAs, NPs, CNM, CPs or CSWs) if at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at section 1861(aa)(7) of the Act).

It is the responsibility of the RHC to assure that all staffing requirements are met and that RHC practitioners provide services in accordance with state and federal laws and regulations.

See section 80.4 of this chapter for information on productivity standards for RHCs.

30.2 - RHC Temporary Staffing Waivers **(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)**

An existing RHC may request a temporary staffing waiver if the RHC met the staffing requirements before seeking the waiver, and either or both of the following occur:

- An NP or PA is not currently employed by the RHC.
- An NP, PA, or CNM is not furnishing patient care at least 50 percent of the time the RHC operates.

To receive a temporary staffing waiver, an RHC must demonstrate that it has made a good faith effort to recruit and retain the required practitioner(s) in the 90 day period prior to the waiver request. Recruitment activities should begin as soon as the RHC becomes aware that they will no longer be in compliance with this requirement. Good faith efforts can include activities such as advertising in an appropriate newspaper or professional journal, conducting outreach to an NP, PA, or CNM school, or other activities.

Staffing waivers are for a period not to exceed 1 year. The waiver cannot be extended beyond 1 year, and another waiver cannot be granted until a minimum of 6 months have elapsed since the prior waiver expired. RHCs should continue their recruitment activities during the waiver period to avoid termination when the waiver period ends.

An RHC will be terminated if any of the following occur:

- The RHC does not meet the staffing requirements and does not request a temporary staffing waiver;
- The RHC requests a temporary staffing waiver and the request is denied due to a lack of good faith effort to meet the requirements;
- The RHC does not meet the staffing requirements and is not eligible for a temporary staffing waiver because less than 6 months have passed since the expiration of the previous waiver;
- The RHC reaches the expiration date of the temporary staffing waiver and has not come into compliance; or
- Other non-compliance issue.

30.3 - FQHC Staffing Requirements

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHCs must have a core staff of appropriately trained primary care practitioners and meet other clinical requirements. It is the responsibility of the FQHC to assure that all staffing requirements are met and that FQHC practitioners provide services in accordance with State and Federal laws and regulations. Additional information on FQHC staffing requirements can be found at: <http://bphc.hrsa.gov/about/requirements/index.html>.

40 - RHC and FQHC Visits

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)



An RHC or FQHC visit is 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 a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits.

An RHC or FQHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions. See section 190 of this chapter for information on visiting nursing services to home-bound patients.

Under certain conditions, an FQHC visit also may be provided by qualified practitioners of outpatient DSMT and MNT when the FQHC meets the relevant program requirements for provision of these services.

RHC and FQHC visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. A list of qualifying visits for FQHCs is located on the FQHC web page at <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>.

40.1 – Location

(Rev. 252, Issued: 12- 07-18, 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.

40.2 - Hours of Operation

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs are required to post their hours of operations at or near the entrance in a manner that clearly states the days of the week and the hours that RHC or FQHC services are furnished, and days of the week and the hours that the building is open solely for administrative or other purposes, if applicable. This information should be easily readable, including by people with vision problems and people who are in wheel chairs. Qualified services provided to an RHC or FQHC patient other than during the posted hours of operation are considered RHC or FQHC services when the practitioner is compensated by the RHC or FQHC for the services provided, and when the cost of the service is included in the RHC's cost report.

Services furnished at times other than the RHC or FQHC posted hours of operation to Medicare beneficiaries who are RHC or FQHC patients may not be billed to Medicare Part B if the practitioner's compensation for these services is included in the RHC/FQHC cost report. (See Section 100 on Commingling).

This applies to full and part time practitioners, practitioners who are employees, practitioners working under contract to the RHC or FQHC, and practitioners who are compensated by the RHC or FQHC under another type of arrangement. RHCs and FQHCs should have clear policies regarding the provision of services at other times, and include this in a practitioner's employment agreement or contract.

40.3 - Multiple Visits on Same Day

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where an RHC or FQHC patient has a medically-necessary face-to-face visit with an RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

Exceptions are for the following circumstances only:

- 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 or FQHC). In this situation only, the FQHC would use modifier 59 on the claim and the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits;
- The patient has a qualified medical visit and a qualified mental health visit on the same day (2 billable visits); or
- For RHCs only, the patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits).

NOTE: These exceptions do not apply to grandfathered tribal FQHCs.

40.4 - Global Billing

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, the charges for the procedure go on the claim with the visit. Payment is included in the AIR when the procedure is furnished in an RHC, and payment is included in the PPS methodology when furnished in an FQHC. The Medicare global billing requirements do not apply to RHCs and FQHCs, and global billing codes are not accepted for RHC or FQHC billing or payment.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If an RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.

Services not included in the global surgical package are listed in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 40.1.B, and include, but are not limited to: initial consultation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed (unless the visit occurs due to complications of the surgery); treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery; etc.

For additional information on global billing, see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>

40.5 - 3-Day Payment Window

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare's 3-day payment window applies to outpatient services furnished by a hospital (or an entity that is wholly owned or wholly operated by the hospital). The statute requires that hospitals' bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with section 1886 of the Act.

RHCs and FQHC services are not subject to the Medicare 3- day payment window requirements.

For additional information on the 3 day payment window, see <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7502.pdf>

50 - RHC and FQHC Services

(Rev. 166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

50.1 - RHC Services

(Rev. 252, Issued: 12- 07-18, 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.

50.2 - FQHC Services



(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHC services include all of the RHC services listed in section 50.1 of this chapter. While the following services may also be furnished in an RHC, the statute specifically lists certain services as FQHC services, including but not limited to:

- Screening mammography;
- Screening pap smear and screening pelvic exam;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- DSMT services;
- Diabetes screening tests;
- MNT services;
- Bone mass measurement;
- Screening for glaucoma;

- Cardiovascular screening blood tests; and
- Ultrasound screening for abdominal aortic aneurysm.

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 lesser of the FQHC's charge or the PPS rate for the specific payment code, with an adjustment for IPPE and AWV (see section 70.4 – FQHC Payment Codes).

50.3 - Emergency Services

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs provide outpatient services that are typically furnished in a physician's office or outpatient clinic and generally provide only limited emergency care. Neither independent nor hospital-based RHCs are subject to Emergency Medical Treatment and Active Labor Act regulations. However, RHC practitioners are required to provide medical emergency procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. The definition of a "first response" is a service that is commonly provided in a physician's office.

If a patient presents at the RHC with an emergency when the RHC is not open for patient care because a physician, NP, PA, CNM, CP, or CSW is not present, other staff may attend to the patient until care of the individual can be transferred. Any care provided in this situation must be within the individual's ability, training, and scope of practice, and in accordance with state laws, and would not be considered an RHC service.

During their regular hours of operations, FQHC practitioners are required to provide medical procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. After their operating hours, FQHCs must provide telephone access to an individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open.

Additional information on emergency preparedness requirements for RHCs and FQHCs can be found 42 CFR 491.12.

60 - Non RHC/FQHC Services

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit,

such as laboratory services or the technical component of an RHC or FQHC service. If these services are authorized to be furnished by the RHC or FQHC and are covered under a separate Medicare benefit category, the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service. RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.

60.1 - Description of Non RHC/FQHC Services

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)



Certain services are not considered RHC or FQHC services either because they 1) are not included in the RHC or FQHC benefit, or 2) are not a Medicare benefit. Non-RHC/FQHC services include, but are not limited to:

Medicare excluded services - Includes routine physical checkups, dental care, hearing tests, routine eye exams, etc. For additional information, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf>

Technical component of an RHC or FQHC service - Includes diagnostic tests such as x-rays, electrocardiograms (EKGs), and other tests authorized by Medicare statute or the NCD process. These services may be billed separately to the A/B MAC by the facility). (The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner or furnished incident to an RHC or FQHC visit).

Laboratory services - Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see section 1861(aa)(2)(G) of the Act, and for FQHCs see section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the AIR when furnished in an RHC by an RHC practitioner or furnished incident to an RHC service, and it is included in the per-diem payment when furnished in an FQHC by an FQHC practitioner or furnished incident to an FQHC service.

Durable medical equipment - Includes crutches, hospital beds, and wheelchairs used in the patient's place of residence, whether rented or purchased.

Ambulance services - The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat the patient's condition, and any other methods of transportation are contraindicated. See <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf> for additional information on covered ambulance services.

Prosthetic devices - Prosthetic devices are included in the definition of “medical and other health services” in section 1861(s)(8) of the Act and are defined as devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. Other examples of prosthetic devices include cardiac pacemakers, cochlear implants, electrical continence aids, electrical nerve stimulators, and tracheostomy speaking valves.

Body Braces – Includes leg, arm, back, and neck braces and their replacements.

Practitioner services at certain other Medicare facility – Includes services furnished to inpatients or outpatients in a hospital (including CAHs), ambulatory surgical center, Medicare Comprehensive Outpatient Rehabilitation Facility, etc., or other facility whose requirements preclude RHC or FQHC services. (**NOTE:** Covered services provided to a Medicare beneficiary by an RHC or FQHC practitioner in a SNF may be an RHC or FQHC service.)

Telehealth distant-site services - See section 200 of this chapter for additional information on telehealth services in RHCs and FQHCs.

Hospice Services – See section 210 of this chapter for additional information on hospice services in RHCs and FQHCs.

Group Services – Includes group or mass information programs, health education classes, group therapy, or group education activities, including media productions and publications.

70 - RHC and FQHC Payment

(Rev. 252, Issued: 12-07-18, 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.

70.1 - RHC Payment

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare pays 80 percent of the RHC AIR, subject to a payment limit, for medically-necessary medical, and qualified preventive, face-to-face (one-on-one) visits with an RHC practitioner (as defined in section 30) for RHC services (as defined in section 50.1), unless otherwise noted. The rate is subject to a payment limit, except for RHCs that have an exception to the payment limit (see section 70.2). An interim rate for newly certified RHCs is established based on the RHC’s anticipated average cost for direct and supporting services. At the end of the reporting period, the A/B MAC determines the

total payment due and reconciles payments made during the period with the total payments due.

In general, the AIR for an RHC is calculated by the A/B MAC by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation. Allowable costs must be reasonable and necessary and include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services.

Services furnished incident to an RHC professional service are included in the AIR and are not billed as a separate visit. The professional component of a procedure is usually a covered service, but is not a stand-alone billable visit. The costs of covered services provided incident to a billable visit may be included on the RHC cost report. To receive payment for qualified services, HCPCS coding is required on all claims.

70.2 - RHC Payment Limit and Exceptions

(Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)

The RHC payment limit was set by Congress in 1988 and is adjusted annually based on the Medicare Economic Index (MEI). The payment limit is released annually via Recurring Update Notifications.

A provider-based RHC that is an integral and subordinate part of a hospital (including a CAH), as described in regulations at 42 CFR 413.65, can receive an exception to the per-visit payment limit if:

- the hospital has fewer than 50 beds as determined at 42 CFR 412.105(b); or
- the hospital's average daily patient census count of those beds described in 42 CFR 412.105(b) does not exceed 40 and the hospital meets both of the following conditions:
 - it is a sole community hospital as determined in accordance with 42 CFR 412.92 or an essential access community hospital as determined in accordance with 42 CFR 412.109(a), and
 - it is located in a level 9 or level 10 Rural-Urban Commuting Area (RUCA). (For additional information on RUCAs, see <http://depts.washington.edu/uwruca/>).

The exception to the payment limit applies only during the time that the RHC meets the requirements for the exception.

70.3 - FQHC PPS Payment Rate and Adjustments

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare pays 80 percent of the lesser of the FQHC's charge or the FQHC PPS payment rate for the specific payment code, unless otherwise noted. Except for grandfathered tribal FQHCs, the FQHC PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment based on the location where services are furnished, and other applicable adjustments as described below. The 2015 and 2016 FQHC PPS base rates were updated by the MEI. Beginning in 2017, the FQHC PPS rate is updated annually by the FQHC market basket. To receive payment for qualified services, HCPCS coding is required on all claims.

Geographic Adjustment: The PPS base rate is adjusted for each FQHC based on its location by the FQHC Geographic Adjustment Factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished. Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs are updated periodically and can be found at: <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>.

New Patient Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

IPPE and AWW Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes an IPPE or an AWW to a Medicare beneficiary.

NOTE: These adjustments do not apply to grandfathered tribal FQHCs.

70.4 - FQHC Payment Codes

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G code based on a typical bundle of services that they would furnish per diem to a Medicare beneficiary. The FQHC should maintain records of the services included in each FQHC G code and the charges associated with the service at the time the service was furnished. Each FQHC decides what documentation is appropriate to record the services included in each G-code pursuant to its own determination. Charges must be reasonable and uniform for all patients, regardless of insurance status. G code services and charges can be changed by the FQHC, but must be the same for all patients and cannot be changed retrospectively.

FQHCs must include one or more of the FQHC payment codes listed below on claims to receive payment for services furnished:

1. G0466 – FQHC visit, new patient: A medically-necessary medical, or a qualified preventive health, face-to-face encounter (one-on-one) between a new patient (as defined

in section 70.3), and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an FQHC visit.

2. G0467 – FQHC visit, established patient: A medically-necessary medical, or a qualifying preventive health, face-to-face encounter (one-on-one) between an established patient and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an FQHC visit.

3. G0468 – FQHC visit, IPPE or AWV: An FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

4. G0469– FQHC visit, mental health, new patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient (as defined in section 70.3), and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

5. G0470 – FQHC visit, mental health, established patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

80 - RHC and FQHC Cost Reports

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

80.1 - RHC and FQHC Cost Report Requirements

(Rev. 252, Issued: 12- 07-18, 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.

80.2 - RHC and FQHC Consolidated Cost Reports

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs with more than one site may file consolidated cost reports if approved by the A/B MAC in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC or FQHC may not revert to individual reporting without the prior approval of the A/B MAC.

80.3 – RHC and FQHC Cost Report Forms

(Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)

RHCs and FQHCs use one of the following cost report forms:

Independent RHCs and Freestanding FQHCs:

RHCs: Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report.

FQHCs: Form CMS-224-14, Federally Qualified Health Center Cost Report.

Provider-based RHCs and FQHCs:

Hospital-based: Worksheet M of Form CMS-2552-10, Hospital and Hospital Care Complex Cost Report.

Skilled Nursing Facility based: Worksheet I series of form CMS-2540-10, “Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report”.

Home Health Agency based: Worksheet RF series of Form CMS-1728-94, “Home Health Agency Cost Report”.

Information on these cost report forms is found in Chapters 29, 44, 32, 40, and 41 and 32, respectively, of the “Provider Reimbursement Manual - Part 2” (Publication 15-2), which can be located on the CMS Website at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>.

80.4 – RHC Productivity Standards

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. The current productivity standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent non-physician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined. The FTE on the cost report for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time.

The A/B MAC has the discretion to make an exception to the productivity standards based on individual circumstances. All visits (Medicare, Medicaid, Managed Care, etc.) are included in determining the productivity standards for the cost report.

At the end of the cost reporting year, the A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator). In this example, this would have the effect of lowering the AIR.

Physician services that are provided on a short term or irregular basis under agreements are not subject to the productivity standards. Instead of the productivity limitation, purchased physician services are subject to a limitation on what Medicare would otherwise pay for the services under the Physician Fee Schedule (PFS), in accordance with 42 CFR 405.2468(d)(2)(v). Practitioners working on a regular, ongoing basis are subject to the productivity standards, regardless of whether they are paid as an employee or independent contractor.

FQHCs are not subject to the productivity standards.

90 - RHC and FQHC Charges, Coinsurance, Deductible, and Waivers **(Rev. 252, Issued: 12-07-18, 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.

90.1 - Charges and Waivers

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

Charges for services furnished to Medicare beneficiaries must be the same as the charges for non-Medicare beneficiaries. FQHCs may waive collection of all or part of the copayment, depending on the beneficiary's ability to pay. RHCs may waive the copayment and deductible after a good faith determination has been made that the patient is in financial need, provided the waivers are not routine and not advertised. (See 42 U.S.C. 1320a-7a(6)(A))

90.2 - Sliding Fee Scale

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs may establish a sliding fee scale if it is uniformly applied to all patients. An RHC that chooses to offer a sliding fee scale must post the policy so that all patients are aware of the policy. If the payment policy is based on an individual's income, the RHC must document that income information from the patient was obtained in order to determine that the patient qualified. Copies of their wage statement or income tax return are not required, and self-attestations are acceptable.

FQHCs that are approved by HRSA are required to establish a sliding fee scale in accordance with statutory and HRSA requirements.

100 – Commingling

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC or FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- Selectively choosing a higher or lower reimbursement rate for the services.

RHC and FQHC practitioners may not furnish or separately bill for RHC or FQHC-covered professional services as a Part B provider in the RHC or FQHC, or in an area

outside of the certified RHC or FQHC space such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation.

If an RHC or FQHC practitioner furnishes an RHC or FQHC service at the RHC or FQHC during RHC or FQHC hours, the service must be billed as an RHC or FQHC service. The service cannot be carved out of the cost report and billed to Part B.

If an RHC or FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC or FQHC space must be clearly defined. If the RHC or FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

RHCs and FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC or FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC or FQHC and non-RHC or non-FQHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit an RHC practitioner from providing on-call services for an emergency room, as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the practitioner with the hospital emergency department would not be a common occurrence.

The A/B MAC has the authority to determine acceptable accounting methods for allocation of costs between the RHC or FQHC and another entity. In some situations, the practitioner's employment agreement will provide a useful tool to help determine appropriate accounting.

110 - Physician Services

(Rev. 252, Issued: 12-07-18, 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).

110.1 - Dental, Podiatry, Optometry, and Chiropractic Services (Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare statute, and qualified services furnished by physicians are billable visits in an RHC or FQHC. These practitioners can provide RHC or FQHC services that are within their scope of practice and not excluded from coverage (e.g., Medicare coverage of chiropractic services is limited to manual manipulation of the spine for a demonstrated subluxation).

An RHC or FQHC can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is a qualifying visit for RHCs or FQHCs and all other requirements are met. All services furnished must be within the state scope of practice for the practitioner, and all HCPCS codes must reflect the actual services that were furnished.

RHCs and FQHCs are required to primarily provide primary health care. Since dentists, podiatrists, optometrists, and chiropractors are not considered primary care physicians, they do not meet the requirements to be either i) a physician medical director or ii) the physician or non-physician practitioner (NP, PA, or CNM) that must be available at all times the clinic is open. Therefore, a dentist, podiatrist, optometrist, or chiropractor can provide a medically necessary, face-to-face visit with an RHC or FQHC patient only when the statutory and regulatory staffing requirements are otherwise met.

For additional information on these services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 on Covered Medical and Other Health Service at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.



110.2 - Treatment Plans or Home Care Plans (Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Except for comprehensive care plans that are a component of authorized care management services (see section 230), treatment plans and home care oversight provided by RHC or FQHC physicians to RHC or FQHC patients are considered part of the RHC or FQHC visit and are not a separately billable service.

110.3 - Graduate Medical Education

(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)

Freestanding RHCs and FQHCs may receive direct graduate medical education (GME) payment for residents if the RHC or FQHC incurs the salaries and fringe benefits (including travel and lodging expenses where applicable) of residents training at the RHC or FQHC. Allowable costs incurred by the RHC or FQHC for GME are paid on a reasonable cost basis and are not subject to the payment limit. RHCs and FQHCs may claim allowable costs only while residents are on their RHC or FQHC rotation.

RHCs and FQHCs that are receiving GME payment may not separately bill for an RHC or FQHC visit provided by a resident, as the cost of these practitioners is included in the GME payment. A medically-necessary medical, or a qualifying preventive health, face-to-face encounter with a teaching physician who is an RHC or FQHC practitioner may be a billable visit if applicable teaching physician supervision and documentation requirements are met.

Under Pub. 100-04, Chapter 12, section 100.1.1.C., the Primary Care Exception (PCE) only applies in an outpatient department or an ambulatory setting where a hospital is claiming on the cost report the residents for indirect medical education and direct GME purposes. Therefore, in the instance where the RHC or FQHC is incurring the cost of the resident(s), the PCE would not apply.

For additional information see [42 CFR 405.2468 \(f\)](#) and [42 CFR 413.75\(b\)](#).

120 - Services and Supplies Furnished “Incident to” Physician’s Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

“Incident to” refers to services and supplies that are an integral, though incidental, part of the physician’s professional service and are:

- Commonly rendered without charge and included in the RHC or FQHC payment;
- Commonly furnished in an outpatient clinic setting;
- Furnished under the physician’s direct supervision; except for authorized care management services which may be furnished under general supervision; and



- Furnished by RHC or FQHC auxiliary personnel.

Incident to services and supplies include:

- Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal);
- Venipuncture;
- Bandages, gauze, oxygen, and other supplies; or
- Services furnished by auxiliary personnel such as a nurse, medical assistant, or other clinical personnel acting under the supervision of the physician.

Supplies and drugs that must be billed to the DME MAC or to Part D are not included.

NOTE: Payment for Medicare-covered Part B drugs that are not usually self-administered and are furnished by an RHC or FQHC practitioner to a Medicare patient are included in the RHC AIR or the FQHC's PPS per diem payment. However, Section 1861(s)(2)(G) of the Act provides an exception for RHCs when a physician prepares a specific formulation of an antigen for a patient if the antigen is "forwarded to another qualified person (including a rural health clinic) for administration to such patient..., by or under the supervision of another such physician." An RHC practitioner (physician, NP, PA, or CNM) acting within their scope of practice may administer the drug and the cost of the administration may be included on the RHC's cost report as an allowable expense. The cost of the antigen prepared by a physician outside of the RHC is not included in the RHC AIR. Physicians who prepare an antigen that is forwarded to an RHC should submit a claim for the antigen in accordance with instructions from the contractor that processes their Part B claims and applicable CMS requirements.

120.1 - Provision of Incident to Services and Supplies (Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)



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, including services provided by a third party under contract, 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.

120.2 - Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC (Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Except for authorized care management services, services furnished incident to a physician's visit by RHC or FQHC auxiliary personnel in the patient's home or location other than the RHC or FQHC must have direct supervision by the physician. For example, if an RHC or FQHC nurse accompanies the physician to a patient's home and administers an injection, the nurse's services would be considered incident to the physician's visit. If the same nurse makes the call alone and administers an injection, the services are not incident to services since the physician is not providing direct supervision. The availability of the physician by telephone and the presence of the physician somewhere in the building does not constitute direct supervision. (This rule applies only to the incident to provision. It does not apply to visiting nursing services described in section 190.) For additional information on supervision requirements for Part B services incident to physician services see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 60.1.

120.3 - Payment for Incident to Services and Supplies

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with an RHC or FQHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.

Incidental services or supplies must represent an expense incurred by the RHC or FQHC. For example, if a patient purchases a drug and the physician administers it, the cost of the drug is not covered and cannot be included on the cost report.

If a Medicare-covered Part B drug is furnished by an RHC or FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the RHC's AIR or the FQHC's PPS payment. RHCs and FQHCs cannot bill separately for Part B drugs or other incident to services or supplies.

130 - Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services

(Rev. 252, Issued: 12-07-18, 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.

130.1 - NP, PA, and CNM Requirements

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

Services performed by NPs, PAs, and CNMs must be:

- Furnished under the general (or direct, if required by state law) medical supervision of a physician;

- 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 NP, PA, or CNM who furnished the service is legally permitted to furnish by the state in which the service is rendered;
- Furnished in accordance with state restrictions as to setting and supervision;
- Furnished in accordance with written RHC or FQHC policies that specify what services these practitioners may furnish to patients; and
- A type of service which would be covered under Medicare if furnished by a physician.

130.2 - Physician Supervision

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

RHCs and FQHCs which are not physician-directed must have an arrangement with a physician that provides for the supervision and guidance of NPs, PAs, and CNMs. The arrangement must be consistent with state law.

130.3 - Payment to Physician Assistants

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Section 1842(b)(6)(C) of the Act prohibits PAs from enrolling in and being paid directly for Part B services. The only exception to this is found in Section 4205(d)(3)(B) of the Balanced Budget Act (BBA), which amended Section 1842(b)(6)(C) of the Act to allow Medicare to directly pay a PA when the PA was the owner of an RHC for a continuous period beginning before the date of the enactment of the BBA, and ending on the date the Secretary determines the RHC no longer meets the requirements of Section 1861(aa)(2) of the Act.

140 - Services and Supplies Furnished Incident to NP, PA, and CNM Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Services and supplies that are integral, though incident to an NP, PA, or CNM 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 an NP, PA, or CNM, 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 an NP, PA, or CNM 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 an NP, PA, or CNM.

150 - Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services

(Rev. 252, Issued: 12- 07-18, 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: 12-07-18, 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.

170 - Mental Health Visits



(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

A mental health visit is a medically-necessary face-to-face encounter between an RHC or FQHC patient and an RHC or FQHC practitioner during which time one or more RHC or FQHC mental health services are rendered. Mental health services that qualify as stand-alone billable visits in an FQHC are listed on the FQHC center website, <http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>. Services furnished must be within the practitioner's state scope of practice.

Medicare-covered mental health services furnished incident to an RHC or FQHC visit are included in the payment for a medically necessary mental health visit when an RHC or

FQHC practitioner furnishes a mental health visit. Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in an FQHC or RHC.

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and for FQHCs, an appropriate FQHC mental health payment code. For detailed information on reporting mental health services and claims processing, see Pub. 100-04, Medicare Claims Processing Manual, chapter 9, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf>

Medication management, or a psychotherapy “add on” service, is not a separately billable service in an RHC or FQHC and is included in the payment of an RHC or FQHC medical visit. For example, when a medically-necessary medical visit with an RHC or FQHC practitioner is furnished, and on the same day medication management or a psychotherapy add on service is also furnished by the same or a different RHC or FQHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code. For FQHCs, an FQHC mental health payment code is not required for reporting medication management or a psychotherapy add on service furnished on the same day as a medical service.

180 - Physical Therapy, Occupational Therapy, and Speech Language Pathology Services

(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)

Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) services may be provided in the RHC or FQHC directly by a physician, NP, or PA, if included in the practitioner’s scope of practice. A physician, NP, or PA may also supervise the provision of PT, OT, and SLP services provided incident to their professional services in the RHC or FQHC by a PT, OT, or SLP therapist. PT, OT, and SLP therapists who provide services incident to a physician, NP, or PA visit may be an employee of the RHC or FQHC or contracted to the RHC or FQHC. PT, OT, and SLP services furnished by an RHC or FQHC practitioner or furnished incident to a visit with an RHC or FQHC practitioner are not billable visits.

If the services are furnished on a day when no otherwise billable visit has occurred, the PT, OT, or SLP service provided incident to the visit would become part of the cost of operating the RHC or FQHC. The cost would be included in the costs claimed on the cost report and there would be no billable visit.

190 - Visiting Nursing Services

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

190.1 - Description of Visiting Nursing Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

A visiting nurse provides skilled nursing services. The determination of whether a service requires the skills of a nurse is based on the complexity of the service (e.g., intravenous and intramuscular injections or insertion of catheters), the condition of the

patient (e.g., a non-skilled service that, because of the patient's condition, can only be safely and effectively provided by a nurse), and accepted standards of medical and nursing practice. All services must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition.

A service that can be safely and effectively self-administered or performed by a nonmedical person without the direct supervision of a nurse, is not considered a skilled nursing service, even if provided by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. If a patient needs skilled nursing care and there is no one trained or able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

The determination of whether visiting nurse services are reasonable and necessary is made by the physician based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

190.2 - Requirements for Furnishing Visiting Nursing Service (Rev. 252, Issued: 12- 07-18, 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.

190.3 - Home Health Agency Shortage Area (Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

A shortage of HHAs exists if an RHC or FQHC is currently located in a county, parish or similar geographic area in which the Secretary has determined that:

- There is no participating HHA under Medicare, or adequate home health services are not available to RHC or FQHC patients even though a participating HHA is in the area; or
- There are patients whose homes are not within the area serviced by a participating HHA; or considering the area's climate and terrain, whose homes are not within a reasonable traveling distance to a participating HHA.

190.4 - Authorization for Visiting Nursing Services

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

RHCs or FQHCs that are located in an area that has not been determined to have a current HHA shortage and are seeking to provide visiting nurse services must make a written request to the CMS RO along with written justification that the area it serves meets the required conditions.

190.5 - Treatment Plans for Visiting Nursing Services

(Rev. 252, Issued: 12-07-18, 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.

200 - Telehealth Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. RHCs and FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

Although FQHC services are not subject to the Medicare deductible, the deductible must be applied when an FQHC bills for the telehealth originating site facility fee, since this is not considered an FQHC service.

RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by an RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract. For more information on Medicare telehealth services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, and Pub. 100-04, Medicare Claims Processing Manual, chapter 12.

210 - Hospice Services

(Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)

210.1 - Hospice Attending Practitioner

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare beneficiaries who elect the Medicare hospice benefit may choose either an individual physician or NP to serve as their attending practitioner (Section 1861(dd) of the Act). RHCs and FQHCs are not physicians or NPs and are not authorized under the statute to serve in this role. However, a physician or NP who works for an RHC or FQHC may provide hospice attending services during a time when he/she is not working for the RHC or FQHC (unless prohibited by their RHC or FQHC contract or employment agreement). These services would not be considered RHC or FQHC services, since they are not being provided by an RHC or FQHC practitioner during RHC or FQHC hours. The physician or NP would bill for services under regular Part B rules using his/her own provider number. Any service provided to a hospice beneficiary by an RHC or FQHC practitioner must comply with Medicare prohibitions on commingling. (See section 100 of this chapter).

210.2 - Provision of Services to Hospice Patients in an RHC or FQHC

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs can treat hospice beneficiaries for medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from an RHC or FQHC related to his/her terminal illness, the RHC or FQHC cannot be reimbursed for the visit, even if it is a medically necessary, face-to-face visit with an RHC or FQHC practitioner, since that would result in duplicate payment for services, except under either of the following circumstances:

- The RHC or FQHC has a contract with the hospice provider to furnish core hospice services related to the patient's terminal illness and related conditions when extraordinary circumstances exist within the hospice. Extraordinary circumstances are described as "unanticipated periods of high patient loads; staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside the hospice's service area" (42CFR 418.64);

- The RHC or FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are provided by the hospice so infrequently that it would be impractical and prohibitively expensive for the hospice to employ a practitioner to provide these services. For example, a hospice may infrequently have a pediatric patient, and in those situations, contract with an RHC or FQHC that has a pediatric nurse on staff to furnish hospice services to the patient.

In these situations, all costs associated with the provision of hospice services must be carved out of the RHC or FQHC cost report, and the RHC or FQHC would be reimbursed by the hospice. (42 CFR 418.64(b)(3)).

Any service provided to a hospice beneficiary by an RHC or FQHC practitioner must comply with Medicare prohibitions on commingling. (See section 100 of this chapter).

220 - Preventive Health Services

(Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)

RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits (where applicable) have not been exceeded. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWW, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B.

220.1 - Preventive Health Services in RHCs

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Influenza (G0008) and Pneumococcal Vaccines (G0009)

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. No visit is billed, and these costs should not be included on the claim. The beneficiary coinsurance and deductible are waived.

Hepatitis B Vaccine (G0010)

Hepatitis B vaccine and its administration is included in the RHC visit and is not separately billable. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the RHC provides. The beneficiary coinsurance and deductible are waived.

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If an IPPE

visit is furnished on the same day as another billable visit, two visits may be billed. The beneficiary coinsurance and deductible are waived.

Annual Wellness Visit (G0438 and G0439)

The AWW is a face-to-face personalized prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWW within the past 12 months. The AWW can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If the AWW is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)

Diabetes self-management training or medical nutrition therapy provided by a registered dietician or nutritional professional at an RHC may be considered incident to a visit with an RHC practitioner provided all applicable conditions are met. DSMT and MNT are not billable visits in an RHC, although the cost may be allowable on the cost report. RHCs cannot bill a visit for services furnished by registered dietitians or nutritional professionals. 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 AIR. The beneficiary coinsurance and deductible apply.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

NOTE: Hepatitis C Screening (GO472) is a technical service only and therefore it is not paid as part of the RHC visit.

220.2 - Copayment and Deductible for RHC Preventive Health Services (Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

When one or more qualified preventive service is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment and deductible. For example, if the total charge for the visit is \$150, and \$50 of that is for a qualified preventive service, the beneficiary copayment and deductible is based on \$100 of the total charge, and Medicare would pay 80 percent of the \$100, and 100 percent of the \$50 (minus any deductible). If no other RHC service took place along with the preventive service, there would be no copayment or deductible applied, and Medicare would pay 100 percent of the payment amount.

220.3 - Preventive Health Services in FQHCs

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHCs must provide preventive health services on site or by arrangement with another provider. These services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW. Section 330(b)(1)(A)(i)(III) of the Public Health Service (PHS) Act required preventive health services can be found at <http://bphc.hrsa.gov/policiesregulations/legislation/index.html>, and include:

- prenatal and perinatal services;
- appropriate cancer screening;
- well-child services;
- immunizations against vaccine-preventable diseases;
- screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- voluntary family planning services; and
- preventive dental services.

NOTE: The cost of providing these services may be included in the FQHC cost report but they do not necessarily qualify as FQHC billable visits or for the waiver of the beneficiary coinsurance.

Influenza (G0008) and Pneumococcal Vaccines (G0009)

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The cost is included in the cost report and no visit is billed. FQHCs must include these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance is waived.

Hepatitis B Vaccine (G0010)

Hepatitis B vaccine and its administration is included in the FQHC visit and is not separately billable. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the FQHC provides. The beneficiary coinsurance is waived.

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a personalized face-to-face prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)

DSMT and MNT furnished by certified DSMT and MNT providers are billable visits in FQHCs when they are provided in a one-on-one, face-to-face encounter and all program requirements are met. Other diabetes counseling or medical nutrition services provided by a registered dietician at the FQHC may be considered incident to a visit with an FQHC

provider. The beneficiary coinsurance is waived for MNT services and is applicable for DSMT.

DSMT must be furnished by a certified DSMT practitioner, and MNT must be furnished by a registered dietitian or nutrition professional. Program requirements for DSMT services are set forth in 42 CFR 410 Subpart H for DSMT and in Part 410, Subpart G for MNT services, and additional guidance can be found at Pub. 100-02, chapter 15, section 300.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

NOTE: Hepatitis C Screening (GO472) is a technical service only and therefore not paid as part of the FQHC visit.

220.4 - Copayment for FQHC Preventive Health Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Under the FQHC PPS, coinsurance will generally be 20 percent of the lesser of the FQHC's charge or the PPS rate. When one or more qualified preventive services are provided as part of an FQHC visit, the A/B MAC will use the lesser of the FQHC's charge for the specific FQHC payment code or the PPS rate to determine the total payment amount. To determine the amount of Medicare payment and the amount of coinsurance that should be waived, the A/B MAC will use the FQHC's reported line-item charges and subtract the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount.

For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, Medicare pays 100 percent of the lesser of the FQHC's charge or the FQHC PPS rate, and no beneficiary coinsurance is assessed.

230 – Care Management Services

(Rev. 10729, Issued: 04-26-21: Effective: 01-01-21, Implementation: 05-26-21)

Care management services are RHC and FQHC service and include transitional care management (TCM), chronic care management (CCM), *principal care management (PCM)*, 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: 12-07-18, 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 – Chronic Care

(Rev. 10729, Issued: 04-26-21; Effective: 01-01-21, Implementation: 05-26-21)

General Care Management Services includes CCM, *PCM* 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, AWV, 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 must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, 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.



PCM

Effective January 1, 2021, RHCs and FQHCs are paid for PCM services when a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month. PCM services may be furnished to patients with a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death.

PCM service requirements include:

- A single complex chronic condition lasting at least 3 months, which is the focus of the care plan;
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
- The condition requires development or revision of disease-specific care plan;
- The condition requires frequent adjustments in the medication regimen; and
- The condition is unusually complex due to comorbidities.

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.

CCM, PCM or general BHI services furnished on or after January 1, 2021 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491, and HCPCS codes G2064 (30 minutes or more of PCM services furnished by physicians or non-physician practitioners (NPPs)) and G2065 (30 minutes or more of PCM services furnished by clinical staff under the direct supervision of a physician or NPP), 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, *at least 30 minutes of PCM 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 *CCM and general BHI services and the minimum 30 minutes that is required to bill for PCM services*, and does not include administrative activities such as transcription or translation services.

230.3 – Psychiatric Collaborative Care Model (CoCM) Services (Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)



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, AWV, 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 must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, 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: 12-07-18, 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.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R10729BP</u>	04/26/2021	Updates to Medicare Benefit Policy Manual for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (Manual Updates Only)	05/26/2021	12252
	12/20/2019	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	01/23/2020	11575
<u>R252BP</u>	12/07/2018	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	01/02/2019	11019
<u>R239BP</u>	01/09/2018	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	01/22/2018	10350
<u>R238BP</u>	11/17/2017	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	02/15/2018	10350
<u>R230BP</u>	12/09/2016	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Updates	03/09/2016	9864
<u>R220BP</u>	01/15/2016	Rural Health Clinic and Federally Qualified Health Center - Medicare Benefit Policy Manual Update	02/01/2016	9442
<u>R217BP</u>	12/31/2015	Rural Health Clinic and Federally Qualified Health Center - Medicare Benefit Policy Manual Update – Rescinded and replaced by Transmittal 220	02/01/2016	9442
<u>R201BP</u>	12/12/2014	Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13	01/05/2015	8981
<u>R173BP</u>	11/22/2013	Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13	01/06/2014	8504

<u>R166BP</u>	01/31/2013	Reorganization of Chapter 13	03/01/2013	7824
<u>R114BP</u>	10/30/2009	Outpatient Mental Health Treatment Limitation	01/04/2010	6686
<u>R49BP</u>	03/31/2006	Payment of Federally Qualified Health Centers (FQHCs) for Diabetes Self-Management Training Services (DSMT) and Medical Nutrition Therapy (MNT) Services	06/29/2006	4385
<u>R40BP</u>	11/18/2005	Skilled Nursing Facility Prospective Payment System	02/16/2006	4079
<u>R1BP</u>	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

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Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

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10 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) General Information

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

10.1 - RHC General Information

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs are facilities that provide services that are typically furnished in an outpatient clinic setting. The statutory requirements that RHCs must meet to qualify for the Medicare benefit are in §1861(aa) (2) of the Social Security Act (the Act).

A RHC visit is defined as a medically-necessary, face-to-face (one-on-one) medical or mental health visit, or a qualified preventive health visit, with a RHC practitioner during which time one or more RHC services are rendered. A RHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW). A Transitional Care Management (TCM) service can also be a RHC visit. A RHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions.

RHCs can be either independent or provider-based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (MAC). They are assigned a CMS Certification Number (CCN) in the range of XX3800-XX3974 or XX8900-XX8999. Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH), skilled nursing facility (SNF), or a home health agency (HHA)).

Information on RHC covered services, visits, payment policies, and other information can be found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 13, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>.

Information on certification requirements can be found in Pub. 100-07, Medicare State Operations Manual, Chapter 2, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf>.

10.2 - FQHC General Information

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs are facilities that provide services that are typically furnished in an outpatient clinic setting. FQHC services consist of services that are similar to those furnished in RHCs. The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in §1861(aa)(4) of the Act. An entity that qualifies as a FQHC is assigned a CCN in the range of XX1000-XX1199 or XX1800-XX1989.

NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to tribal or urban Indian FQHCs or grandfathered tribal (GFT) FQHCs.

20 - RHC and FQHC All-Inclusive Rate (AIR) Payment System (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

20.1 - Per Visit Payment and Exceptions under the AIR (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs and FQHCs are paid an AIR per visit, except for FQHCs that have transitioned to the Medicare Prospective Payment System (PPS). For RHCs and FQHCs billing under the AIR, more than one medically-necessary face-to-face visit with a RHC or FQHC practitioner on the same day 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/FQHC);
- The patient has a medical visit and a mental health visit on the same day;
- The patient has an Initial Preventive Physical Examination (IPPE) and a separate qualified medical and/or mental health visit on the same day;
- The patient has a Diabetes Self-Management Training (DSMT) or Medical Nutrition Therapy (MNT) visit on the same day as an otherwise payable medical visit. DSMT and MNT apply to FQHCs only.

20.2 - Payment Limit under the AIR (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

For RHCs and FQHCs that bill under the AIR, Medicare pays 80 percent of the RHC or FQHC's AIR, subject to a payment limit, except for RHCs that have an exception to the payment limit. An interim rate for newly certified RHCs, and for FQHCs certified prior to October, 1, 2014, is established based on the RHC's or FQHC's anticipated average cost for direct and supporting services. At the end of the cost reporting period, the MAC determines the total payment due and reconciles payments made during the period with the total payments due.

For FQHCs paid under the AIR, there is a payment limit for FQHCs located in an urban area and a payment limit for FQHCs located in a rural area. Urban FQHCs are those located within a Metropolitan Statistical Area (MSA). Rural FQHCs cannot be reclassified into an urban area (as determined by the Bureau of Census) for FQHC payment limit purposes. If the FQHC organization includes both urban and rural sites

and the FQHC organization files a consolidated cost report, the FQHC is paid the lower of the FQHC organization's AIR or a single weighted payment limit calculated for the entire FQHC organization. The payment limit is weighted by the percentage of urban and rural visits as a percentage of total visits for the entire FQHC organization.

RHCs and FQHCs paid under the AIR are required to file a cost report annually in order to determine their payment rate. If a RHC or FQHC is in its initial reporting period, the MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

For information on cost reporting requirements, see the Medicare Provider Reimbursement Manual (PRM), at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>

30 - FQHC PPS Payment System

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

30.1 - Per-Diem Payment and Exceptions under the PPS

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added section 1834(o) of the Social Security Act to establish a Medicare PPS for FQHC services. FQHCs transition to the Medicare PPS beginning on October 1, 2014, based on their cost-reporting period. All FQHCs are expected to be transitioned to the PPS by December 31, 2015.

For FQHCs paid under the PPS, Medicare payment is based on the lesser of the FQHC's actual charge or the PPS rate, as determined by the MAC. The FQHC PPS rate will be updated annually beginning January 1, 2016.



For FQHCs billing under the PPS, more than one medically-necessary face-to-face visit with a FQHC practitioner on the same day 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 FQHC),

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

Separate payment is not made to FQHCs under the PPS for an IPPE or DSMT/MNT visit that is furnished on the same day as another FQHC medical visit.

30.2 - Adjustments under the PPS

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

The FQHC PPS rate will be adjusted to account for geographic differences in costs by the FQHC geographic adjustment factor (FQHC GAF). In calculating the PPS rate, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

The FQHC PPS rate for a covered visit will be calculated as follows:

$$\text{Base payment rate} \times \text{FQHC GAF} = \text{PPS rate}$$

Updates to the FQHC GAFs will be made in conjunction with updates to the Physician Fee Schedule Geographic Practice Cost Indices for the same period and will be posted on CMS's FQHC PPS webpage at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html>.

The PPS per-diem rate will be adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC (has not been a patient at any site that is part of the FQHC organization within the previous 3 years) or to a beneficiary receiving an IPPE or an annual wellness visit (AWV). This is a composite adjustment factor and only one adjustment per day can be applied.

If the patient is new to the FQHC, or the FQHC furnishes an Initial Preventive Physical Examination (IPPE) or Annual Wellness Visit (AWV), the FQHC PPS rate for a covered visit will be calculated as follows:

$$\text{Base payment rate} \times \text{FQHC GAF} \times 1.3416 = \text{PPS rate}$$

For more information on the FQHC PPS, please see the FQHC PPS Final Rule located at: <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

40 - Deductible and Coinsurance

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

40.1 - Part B Deductible

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHC services are subject to an annual deductible of twenty percent of charges for covered services. Effective for dates of service on or after January 1, 2011, the deductible is not applicable for certain preventive services. Please see section 80 for more information on how to bill for preventive services.

RHCs collect the patient's deductible or the portion of the patient's deductible that has not already been met. Once RHCs have billed the MAC for services, they do not collect

or accept any additional money from the patient for their deductible until the MAC notifies the RHC of how much of the deductible has been met.

The Part B deductible does not apply to FQHC services.

40.2 - Part B Coinsurance

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

After any applicable deductibles have been satisfied, RHCs and FQHCs paid under the AIR system will be paid 80 percent of their AIR. The patient is responsible for a coinsurance amount of 20 percent of the charges after deduction of the deductible, where applicable.

Effective for dates of service on or after January 1, 2011, coinsurance is not applicable for certain preventive services. See section 80 of this manual for information on how to bill for preventive services on a RHC and FQHC claims.

FQHCs paid under the PPS will be paid 80 percent of the lesser of the FQHC's actual charge for the specific payment code or the adjusted PPS rate. The patient is responsible for a coinsurance amount of 20 percent of the lesser of the FQHC's actual charge for the specific payment code or the adjusted PPS rate. See section 60.2 for more information on the FQHC specific payment codes.

50 - General Requirements for RHC and FQHC Claims

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 for coverage requirements for RHCs and FQHCs. This section addresses requirements for claim submission only.



Section §1862 (a)(22) of the Act requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic format required for billing RHC and FQHC services is the ASC X12 837 institutional claim transaction. Instructions relative to the data element names on the Form CMS-1450 hardcopy form are described below. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names is found in Chapter 25.

Not all data elements are required or utilized by all payers. Detailed information is given only for items required for Medicare RHC and FQHC claims. Only the items listed below are required for RHCs and FQHCs.

Provider Name, Address, and Telephone Number, Form Locator (FL) 01

The RHC/FQHC enters this information for their agency.

Type of Bill, FL 4

This four-digit alphanumeric code gives three specific pieces of information. The first digit is a leading zero. CMS ignores the first digit. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular benefit period. It is referred to as a “frequency” code.

Code Structure

1st Digit – Leading Zero
CMS ignores the first digit

2nd Digit - Type of Facility
7 - Special facility (Clinic)

3rdDigit - Classification (Special Facility Only)
1 – Rural Health Clinic
7 – Federally Qualified Health Centers

4th Digit – Frequency	Definition
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
1 - Admit Through Discharge Claim	This code is used for a billing for a confined treatment.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or “new” bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

Statement Covers Period (From-Through), FL 06

The RHC/FQHC shows the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY).

Patient Name/Identifier, FL 08

The RHC/FQHC enters the beneficiary’s name exactly as it appears on the Medicare card.

Patient Address, FL 09

The RHC/FQHC enters the mailing address of the patient. Enter the complete mailing address.

Patient Birth date, FL10

The RHC/FQHC enters the date of birth of the patient.

Patient Sex, FL 11

The RHC/FQHC enters the sex of the patient as recorded at the start of care.

Priority (Type) of Admission or Visit, FL14

The RHC/FQHC enters the most appropriate NUBC approved code indicating the priority of the visit.

Point of Origin for Admission or Visit, FL 15

The RHC/FQHC enters the most appropriate NUBC approved code indicating the point of origin for this admission or visit.

Patient Discharge Status, FL 16

The RHC/FQHC enters the most appropriate NUBC approved code indicating the patient's status as of the "Through" date of the billing period.

Condition Codes, FL 18-28

The RHC/FQHC enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing.

Value Codes and Amounts, FL 39-41

The RHC/FQHC enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing.

Revenue Codes, FL42

The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge.

For FQHC claims with dates of service on or after January 1, 2010, FQHCs may report additional revenue codes when describing services rendered during an encounter. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in the following table:

Code	Description
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a

Code	Description
	covered Part A stay at the SNF
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)
0519	Clinic, Other Clinic (only for the FQHC supplemental payment)
0900	Mental Health Treatment/Services

When billing for additional services rendered during the FQHC's encounter, any valid revenue codes may be used with a HCPCS code. However, the following revenue codes are not allowed on FQHC claims:

002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x.

HCPCS/Accommodation Rates/HIPPS Rate Codes, FL 44

For all services provided in a FQHC on or after January 1, 2010 and for approved preventive services provided in a RHC, HCPCS codes are required to be reported on the service lines.

The following HCPCS codes must be reported on FQHC PPS claims:

HCPCS Code	Definition
G0466	FQHC visit, new patient A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
G0467	FQHC visit, established patient A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
G0468	FQHC visit, IPPE or AWV

	A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.
G0469	FQHC visit, mental health, new patient A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
G0470	FQHC visit, mental health, established patient A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

Modifiers, FL 44

The FQHC reports modifier 59 when billing for a subsequent injury or illness. This is not to be used when a patient sees more than one practitioner on the same day, or has multiple encounters with the same practitioner on the same day, unless the patient, subsequent to the first visit, leaves the FQHC and then suffers an illness or injury that requires additional diagnosis or treatment on the same day.



Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left the FQHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit).

For claims subject to the FQHC PPS, modifier 59 is only valid with FQHC Payment Code G0467. Please see section 60.2 of this manual for more information on the FQHC Payment Codes.

Service Date, FL 45

Medicare requires a line item dates of service for all outpatient claims. Medicare classifies RHC/FQHC claims as outpatient claims. Non-payment service revenue codes – report dates as described in the table above under Revenue Codes.

Line items on outpatient claims under HIPAA require reporting of a line-item service date for each iteration of revenue code. A single date must be reported on a line item for the date the service was provided, not a range of dates.

For services that do not qualify as a billable visit, the usual charges for the services are added to those of the qualified visit. RHCs/FQHCs use the date of the visit as the single date on the line item. If there is no billable visit associated with the services, then no claim is filed.

Service Units, FL 46

The RHC/FQHC enters the number of units for each type of service. Units represent visits, which are paid based on the AIR or the FQHC PPS, no matter how many services are delivered. Only one visit is billed per day unless the patient leaves and later returns with a different illness or injury suffered later on the same day.

Total Charges, FL 47

The RHC/FQHC enters the total charge for the service described on each revenue code line.

Payer Name, FL 50

The RHC/FQHC identifies the appropriate payer(s) for the claim.

National Provider Identifier (NPI) – Billing Provider, FL 56

The RHC/FQHC enters its own NPI. When more than one encounter/visits is reported on the same claim i.e., medical and mental health visits, please choose the NPI of the provider that furnished the majority of the services.

Principal Diagnosis Code, FL 67

The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

Other Diagnosis Codes, FL 67A-Q

The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

Attending Provider Name and Identifiers, FL 76

The RHC/FQHC enters the NPI and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care.

Other Provider Name and Identifiers, FL78-79

The RHC/FQHC enters the NPI and name

NOTE: For electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

60 - Billing Requirements for RHCs and FQHCs

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs and FQHCs are institutional claims and are submitted to the MAC on TOB 71x and 77x. Generally, only those services that are included in the RHC and FQHC benefits are billed on these claims.

- The RHC and FQHC benefits are defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13
(<http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf>.)

All professional services in the RHC and FQHC benefit are paid through the AIR system or the FQHC PPS payment for each patient encounter or visit. Technical services (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims.

For FQHCs with cost reporting periods beginning on or after October 1, 2014, all services are paid according to the FQHC PPS methodology. The visit rate includes: covered services provided by a FQHC practitioner and services and supplies furnished incident to the visit. For additional information on FQHC services, see the Medicare Policy Manual, Chapter 13.

60.1 - Billing Guidelines for RHCs and FQHC Claims under the AIR System

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

When billing Medicare, FQHCs must report all services provided during the encounter/visit by listing the appropriate HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes. RHCs are only required to report the appropriate revenue code for medical and mental health services.

Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location generally constitute a single visit. For FQHCs, payment is applied to the service line with revenue code 052X and a valid evaluation and management (E&M) HCPCS code for medical visits and revenue code 0900 for mental health visits. Since RHCs are not required to report detailed HCPCS codes, the payment is applied to the service line with revenue code 052X for medical and revenue code 0900 for mental health visits. However, an additional AIR payment may be made for IPPE, DSMT or MNT (FQHCs only), and a subsequent illness and injuries billed with modifier 59 (FQHCs only).

When reporting multiple services on FQHC claims, the 052X revenue line with the E&M HCPCS code must include the total charges for all of the services provided during the encounter, minus any charges for approved preventive services.

For approved preventive services with a grade of A or B from the United States Preventive Services Task Force (USPSTF), the charges for these services must be deducted from the E&M HCPCS code for the purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is \$350.00, and

\$50.00 of that is for a qualified preventive service, the beneficiary coinsurance is based on \$300.00 of the total charge.

For Example:

Rev Code	HCPCS code	Modifier	Date of Service	Charges
0521	E&M code*		01/01	300.00
0771	Preventive Service code		01/01	50.00

* RHCs are not required to report a HCPCS code.

Medicare will make an additional AIR payment for IPPE, when billed on the same day with a qualified encounter/visit. When reporting an additional encounter/visit for IPPE, the FQHC or RHC reports the appropriate HCPCS code for the service. The revenue lines should be reflected as follows:

For Example:

Rev Code	HCPCS code	Modifier	Date of Service	Charges
0521	Office Visit		01/01	75.00
0419	Breathing Treatment		01/01	75.00
0521	IPPE		01/01	150.00

For FQHCs, Medicare will make an additional AIR payment for a subsequent illness or injury that occurs on the same day. This is reported on the claim with an additional service line with revenue code 052X, a valid HCPCS code and modifier 59. Please see section 50 for more information on reporting modifier 59.

For Example:

Rev Code	HCPCS code	Modifier	Date of service	Charges
0521	Office Visit		01/01	150.00
0479	Removal of Wax From Ear		01/01	50.00
0521	Office Visit	59	01/01	135.00
0271	Wound Cleaning		01/01	25.00
0279	Bone Setting With Casting		01/01	95.00

Medicare will make an additional AIR payment to FQHCs when DSMT or MNT is reported on the same day with a qualified encounter/visit. When reporting an additional encounter/visit for DSMT or MNT Report the appropriate HCPCS code for the service. The revenue lines should be reflected as follows:

For Example:

Rev Code	HCPCS code	Modifier	Date of Service	Charges
0521	Office Visit		01/01	75.00
0419	Breathing Treatment		01/01	75.00
0521	DSMT or MNT		01/01	150.00

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, the reporting of these codes are informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines and their administration through the cost report.

60.2 - Billing for FQHC Claims Paid under the PPS (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs transitioning to the PPS must submit separate claims for services subject to the PPS and services paid under the AIR.

CMS established five FQHC payment specific codes to be used by FQHCs submitting claims under the PPS. When reporting an encounter/visit for payment, the FQHC must bill on the claim (77X TOB) a FQHC specific payment code.



FQHC Specific Payment Codes

G0466 – FQHC visit, new patient

A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

G0467 – FQHC visit, established patient

A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

G0468 – FQHC visit, IPPE or AWW

A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.

G0469– FQHC visit, mental health, new patient

A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

G0470 – FQHC visit, mental health, established patient

A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

FQHCs must use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052X or 0519.

NOTE: Revenue code 0519 is used for Medicare Advantage (MA) Supplemental claims only.

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must report HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges. The additional services reported on the claim that are part of the FQHC encounter, will not be paid. The payment for these services is included in the payment under the FQHC payment code.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit. The link below contains the list of the qualifying visits for each payment specific code:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf>

For example:

Revenue Code	HCPCS code	Modifier	Service Date
0521	G0467 – FQHC Payment code		10/01
0521	99213 – Qualifying visit		10/01

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

For example:

Revenue Code	HCPCS code	Modifier	Service Date
0521	G0468 – FQHC Payment code		10/01
0521	G0439 – Qualifying visit		10/01
0900	G0470 – FQHC Payment code		10/01
0900	90832 -Qualifying visit		10/01

When submitting a claim for a subsequent illness or injury, the FQHCs reports G0467 for a medical visit), with modifier 59. A qualifying visit is still required when reporting modifier 59 with G0467.

Revenue Code	HCPCS code	Modifier	Service Date
0521	G0468 – FQHC Payment code		10/01
0521	G0439 – Qualifying visit		10/01
0521	G0467 – FQHC Payment code	59	10/01
0900	99211 -Qualifying visit		10/01

FQHCs must report all services that occurred on the same day on one claim. FQHC may submit claims that span multiple days of service. However, for FQHCs transitioning to the PPS, a separate claim must be submitted for services subject to the PPS and services paid based on the AIR. MACs will reject claims with multiple dates of service that include both PPS and non-PPS dates, as determined based on the individual FQHC's cost reporting period.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

60.3 - Payments for FQHC PPS Claims

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Payment for FQHC PPS claims is made by comparing the adjusted FQHC PPS rate to the total submitted covered charges reported for the specific payment codes G0466, G0467, G0468, G0469, and G0470.

To calculate payment, follow the steps below:

Step 1: Determine the lesser of the provider's submitted charges for the specific payment code(s) and the fully-adjusted PPS rate.

Step 2: Determine if preventive services for which the coinsurance is waived are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.

(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: If no preventive services are present, use the lesser of the providers charge for the specific payment code(s) or the PPS rate as the Step 3 total.

Step 4: Multiply the total from Step 3 by 80%.

Step 3 total * 80% = Step 4 total

Note: If no preventive services are present, contractors will pay this amount and skip step 5.

Step 5: Add the charges for the approved preventive services to the total from step 4. Contractors will pay this amount.

Step 4 total + preventive services charges = Medicare Payment

Note: If the charges for the approved preventive services are greater than the total payment amount identified in Step 1 (i.e., the lesser of the charges for the specific payment code or the PPS rate), pay 100% of the total payment amount determined in Step 1 and do not apply coinsurance. (Please see example 3)

To calculate coinsurance, follow the steps below:

Step 1: Determine the lesser of the submitted charges for the G-code (s) and the PPS rate.

Step 2: Determine if approved preventive services (i.e., preventive services for which coinsurance is waived) are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.

(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: If no approved preventive services are present, use the lesser the provider's charge for the specific payment code(s) or the PPS rate as the Step 3 total.

Step 4: Multiply the total from Step 3 by 20%.

Step 3 total * 20% = Coinsurance

- Example: Payment based on the charges**

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0467 = \$150

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0467		10/01	150.00	150.00
0521	99213		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0001				310.00	310.00

The comparison is between the PPS rate and the provider's \$150 actual charge for the specific payment code, G0467. In this case, the sum of the line items exceeds the provider's actual charge for the payment code.

Payment based on the provider's charge of 150.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Coinsurance
0521	G0467		10/01	150.00	150.00	120.00	30.00
0521	99213		10/01	135.00	135.00	CO 97*	0
0300	36415		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = 150.00 (charges) * 80%

Coinsurance = 150.00 (charges) * 20%

For service lines that do not receive payment, group code CO- contractual obligation and the appropriate claim adjustment reason code (CARC) will be used.

* CARC 97 – the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- Example: Payment based on the charges with approved preventive service**

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = \$150

Preventive Service = 135.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	150.00	150.00
0521	G0439 PS**		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0001				310.00	310.00

Payment based on the provider's actual charge of 150.00 for the specific payment code, G0468.

REV CODE	HCPC CODE	MOD S	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	150.00	150.00	147.00	3.00
0521	G0439 PS		10/01	135.00	135.00	CO 97*	0
0300	36415		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 135.00 (preventive service G0439)) * 80% + 135.00 preventive service

Coinurance = (150.00 (charges) – 135.00 (preventive service G0439)) * 20%

- ** PS – Preventive Service -These are approved preventive services where the coinsurance is waived based on the USPSTF recommendation.

Example: Payment based on the charges when preventive service is greater than G-code

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = \$150 Preventive Service = 155.00

REV CODE	HCPC	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	150.00	150.00
0521	G0439 PS		10/01	155.00	155.00
0300	36415		10/01	25.00	25.00
0001				330.00	330.00

Payment based on charges of 150.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	150.00	150.00	150.00	0
0521	G0439 PS		10/01	155.00	155.00	CO 97*	0
0300	36415		10/01	25.00	25.00	CO 97	0
0001				330.00	330.00		

Payment = (150.00 (charges) * 100% = 150.00

Since the charges for the preventive service, G0439 are greater than the provider's actual charge for the specific payment code G0468, Medicare pays 100% of the provider's actual charge for the specific payment code, G0468.

Reporting Multiple G-codes

When a FQHC reports multiple specific payment codes (G-codes) on the same day, the total payment amount will be determined by comparing the sum of the charges for all the G-codes reported to the PPS rate. When a qualified mental health visit occurs on the same day as a qualified medical visit, the G-codes will be totaled separately (see example 8).

Listed below is the order in which payment will be applied when multiple G-codes are reported on the same day:

Medical visits:

- G0468-IPPE or AWW
- G0466-Medical, new patient
- G0467-Established patient

Mental health visits:

- G0469-Mental health, new patient
- G0470- Mental health, established patient

When G0466 (Medical, new patient) and G0468 (IPPE or AWW) are reported together, the add-on payment will be applied to G0468.

- **Example: Payment based on PPS rate with multiple G-codes and preventive services**

Because this scenario does not qualify for an exception to a per diem payment, the system will calculate and apply a PPS rate to only one of the specific payment codes. However, the FQHC may list its actual charges for both specific payment codes, and the comparison would be between the PPS rate and the total of the provider's charges for the specific payment codes. Payment would be based on the lesser amount.

PPS RATE, reflecting a 1.3416 adjustment for new patients or a visit including an IPPE or AWW = 215.00

Total of provider charges for the specific payment codes (170.00 + 65.00) = 235.00

Provider's charge for the Preventive Service = 135.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	170.00	170.00
0521	G0438 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0466		10/01	65.00	65.00
0521	92004		10/01	45.00	45.00
0001				440.00	440.00

Payment based on adjusted PPS rate of 215.00

REV CODE	HCPC CODE	MOD S	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Coinsurance
0521	G0468		10/01	170.00	170.00	199.00	16.00
0521	G0438 PS		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0466		10/01	65.00	65.00	CO 97	0
0521	92004		10/01	45.00	45.00	CO 97	0
0001				440.00	440.00		

Payment = (215.00 (PPS rate) – 135.00 (preventive service G0438)) * 80% + 135.00 preventive service

Coinsurance = (215.00 (PPS rate) – 135.00 (preventive service G0438)) * 20%

Reporting Multiple Preventive Services

When multiple preventive services are reported on the same day, the coinsurance will be determined by carving out the total preventive services charges.

- **Example: Payment based on PPS rate with multiple G-codes and multiple preventive services**

PPS RATE = 225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00

Total Preventive Services (135.00 + 60.00) = 195.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	140.00	140.00
0521	G0439 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0467		10/01	75.00	75.00
0521	97802 PS		10/01	60.00	60.00
0521	G0466		10/01	55.00	55.00
0521	92004		10/01	45.00	45.00
0001				535.00	535.00

Payment based on PPS rate of 225.00

REV CODE	HCPC CODE	MOD S	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	140.00	140.00	219.00	6.00
0521	G0439 PS		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0467		10/01	75.00	75.00	CO 97	0

0521	97802 PS		10/01	60.00	60.00	CO 97	0
0521	G0466		10/01	55.00	55.00	CO 97	0
0521	92004		10/01	45.00	45.00	CO 97	0
0001				535.00	535.00		

$$\text{Payment} = (225.00 - (135.00 + 60.00)) * 80\% + 135.00 + 60.00$$

$$\text{Coinsurance} = (225.00 (\text{PPS rate}) - (135.00 + 60.00)) * 20\%$$

Influenza and Pneumococcal Pneumonia Vaccination (PPV)

Flu and PPV vaccines and their administration will continue to be paid through the cost report. However, these services should be reported on the claim for information purposes only. Flu and PPV vaccines and their administration codes will not be carved out of the coinsurance calculation.

- **Example: Payment based on charges with Flu and Flu administration code services**

$$\text{PPS rate} = 160.00$$

$$\text{Preventive Service} = 135.00$$

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	150.00	150.00
0521	G0438 PS		10/01	135.00	135.00
0636	90655		10/01	15.00	15.00
771	G0008		10/01	5.00	5.00
0001				305.00	305.00

Payment based on charges of 150.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	150.00	150.00	150.00	0
0521	G0438 PS		10/01	135.00	135.00	CO 97	0
0636	90655 ****		10/01	15.00	15.00	CO 246***	0
0771	G0008 ****		10/01	5.00	5.00	CO 246	0
0001				305.00	305.00		

Because flu and PPV are reported on the claim for information purposes only, G0438 remains as the only service payable on this claim. Because the claim consists solely of preventive services for which coinsurance is waived, the contractor will pay 100% of the provider's actual charge for the specific payment code, G0468.

*** CARC 246- This non-payable code is for required reporting only.

**** Flu/PPV are reported on the claim for information purposes only, the payment and coinsurance are not impacted by the charges associated with the Flu/PPV vaccine and their administration code.

Hepatitis B

Hepatitis B should be reported on the claim and is included in the claim payment. These services will be carved out of the coinsurance calculation.

- **Example: Payment based on charges with Hepatitis B**

PPS rate= 160.00

Preventive Services = 20.00 (15.00 +5.00)

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0467		10/01	150.00	150.00
0521	99213		10/01	135.00	135.00
0300	36415		10/01	5.00	5.00
0636	90746 PS		10/01	15.00	15.00
771	G0010 PS		10/01	5.00	5.00
0001				310.00	310.00

Payment based on charges of 150.00

REV CODE	HCPC CODE	MOD S	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0467		10/01	150.00	150.00	124.00	26.00
0521	99213		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	5.00	5.00	CO 97	0
0636	90746 PS		10/01	15.00	15.00	CO 97	0
0771	G0010 PS		10/01	5.00	5.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 80% + 20.00 preventive

Coinsurance = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 20%

Mental Health Services

Qualified mental health visits billed under revenue code 0900 receive an additional payment when billed on the same day as a medical visit.

- **Example: Mental Health Services**

PPS RATE for G0468: \$225.00

PPS rate for G0470: \$160

Total of provider's actual charges for the specific payment codes representing medical visits (140.00 + 75.00 + 55.00) = 270.00- This does not include charges for G0470

Provider's charge for the specific payment code representing mental health services = 159.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	140.00	140.00
0521	G0439 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0467		10/01	75.00	75.00
0521	97802 PS		10/01	60.00	60.00
0521	G0466		10/01	55.00	55.00
0521	92004		10/01	45.00	45.00
0900	G0470		10/01	159.00	159.00
0900	90832		10/01	139.00	139.00
0636	J3490		10/01	15.00	15.00
0001				848.00	848.00

Payment based on PPS rate of 225.00 for the specific payment codes describing the medical visits and based on the provider's actual charges for the specific payment code describing the mental health visit.

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Co-insurance
0521	G0468		10/01	140.00	140.00	219.00	6.00
0521	G0439 PS		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0467		10/01	75.00	75.00	CO 97	0
0521	97802 PS		10/01	60.00	60.00	CO 97	0
0521	G0466		10/01	55.00	55.00	CO 97	0
0521	92004		10/01	45.00	45.00	CO 97	0
0900	G0470		10/01	159.00	159.00	127.20	31.80
0900	90832		10/01	139.00	139.00	CO 97	0
0636	J3490		10/01	15.00	15.00	CO 97	0
0001				848.00	848.00		

For Medical visit with revenue code 052X

Payment = (225.00 – (135.00 + 60.00)) * 80% + 135.00 + 60.00

Coinurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%

For Mental Health visit with revenue code 0900

Payment = 159.00 * 80% = 127.20

Coinsurance = 159.00 * 20% = 31.80

Modifier 59

Medicare allows for an additional payment when an illness or injury occurs subsequent to the initial visit, and the FQHC bills these visits with the specific payment codes and modifier 59. Services billed with a modifier 59 will be paid an additional per diem rate

- **Example: Modifier 59**

PPS rate for G0468 = 225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00 – This does not include charges for G0470 and G-code charges for modifier 59

Total mental Health Services = 159.00

PPS rate for G0467 (billed with Modifier 59) = 160.00

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0521	G0468		10/01	140.00	140.00
0521	G0438 PS		10/01	135.00	135.00
0300	36415		10/01	25.00	25.00
0521	G0467		10/01	75.00	75.00
0521	97802 PS		10/01	60.00	60.00
0521	G0466		10/01	55.00	55.00
0521	92004		10/01	45.00	45.00
0900	G0470		10/01	159.00	159.00
0900	90832		10/01	139.00	139.00
0636	J3490		10/01	15.00	15.00
0521	G0467	59	10/01	165.00	165.00
0521	99211		10/01	105.00	105.00
0001				1118.00	1118.00

Payment based on PPS rate of 225.00 for the G-codes, based on the charges for the mental health visit and based on the PPS rate for G0467 billed with modifier 59.

REV CODE	HCPC CODE	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE	Payment	Coinsurance
0521	G0468		10/01	140.00	140.00	219.00	6.00
0521	G0438 PS		10/01	135.00	135.00	CO 97	0
0300	36415		10/01	25.00	25.00	CO 97	0
0521	G0467		10/01	75.00	75.00	CO 97	0
0521	97802 PS		10/01	60.00	60.00	CO 97	0
0521	G0466		10/01	55.00	55.00	CO 97	0
0521	92004		10/01	45.00	45.00	CO 97	0

0900	G0470		10/01	159.00	159.00	127.20	31.80
0900	90832		10/01	139.00	139.00	CO 97	0
0636	J3490		10/01	15.00	15.00	CO 97	0
0521	G0467	59	10/01	165.00	165.00	128.00	32.00
0521	99211		10/01	105.00	105.00	CO 97	0
0001				1118.00	1118.00		

For Medical visit with revenue code 052X

Payment = $(225.00 - (135.00 + 60.00)) * 80\% + 135.00 + 60.00$

Coinsurance = $(225.00 \text{ (PPS rate)} - (135.00 + 60.00)) * 20\%$

For Mental Health visit with revenue code 0900

Payment = $159.00 * 80\% = 127.20$

Coinsurance = $159.00 * 20\% = 31.80$

For G0467 billed with modifier 59

Payment = $160.00 * 80\% = 128.00$

Coinsurance = $160.00 * 20\% = 32.00$

60.4 - Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Section 237 of the Medicare Modernization Act (MMA) requires CMS to provide supplemental payments to FQHCs that contract with MA organizations to cover the difference, if any, between the payment received by the FQHC for treating MA enrollees and the payment to which the FQHC would be entitled to receive under the cost-based all-inclusive payment rate as set forth in 42 CFR, Part 405, Subpart X.

This supplemental payment for covered FQHC services furnished to MA enrollees augments the direct payments made by the MA organization to FQHCs for all covered FQHC services. The Medicare per diem payment, which continues to be made for all covered FQHC services furnished to Medicare beneficiaries participating in the original Medicare program, is based on the FQHC's unique cost-per-visit as calculated by the MAC. The MAC determines if the Medicare payments that the FQHC would be entitled to exceed the amount of payments received by the FQHC from the MA organization and, if so, pay the difference to the FQHC.

FQHCs seeking the supplemental payment are required to submit (for the first two rate years) to the MAC an estimate of the average MA payments (per visit basis) for covered FQHC services. They are required to submit a documented estimate of their average per visit payment for their MA enrollees, for each MA plan they contract with, and any other information as may be required to enable the MAC to accurately establish an interim supplemental payment.

Expected payments from the MA organization would only be used until actual MA revenue and visits collected on the FQHC's cost report can be used to establish the amount of the supplemental payment.

Effective January 1, 2006, eligible FQHCs will report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the MAC shall use actual MA revenue and visit data along with the FQHC's final all-inclusive payment rate, to determine the FQHC's final actual supplemental per visit payment. Once this amount (per visit basis) is determined it will serve as the interim rate for the next full rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment thereon will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

An FQHC is only eligible to receive this supplemental payment when FQHC services are provided during a face-to-face encounter between an MA enrollee and one or more of the following FQHC covered core practitioners: physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, or clinical social workers. The supplemental payment is made directly to each qualified FQHC through the MAC.

Each FQHC seeking the supplemental payment is responsible for submitting a claim for each qualifying visit to the MAC on type of bill (TOB) 77x with revenue code 0519 for the amount of the interim supplemental payment rate (FQHC interim all-inclusive rate – estimated average payment from the MA plan plus any beneficiary cost sharing = billed amount > 0). Do not submit revenue codes 052X and/or 0900 on the same claim as revenue code 0519.

For services of plan years beginning on and after January 1, 2006 and before, an interim supplemental rate can be determined by the MAC based on cost report data, MACs shall calculate an interim supplemental payment for each MA plan the FQHC has contracted with using the documented estimate provided by the FQHC of their average MA payment (per visit basis) under each MA plan they contract with. Once an interim supplemental rate is determined for a previous plan year based on cost report data, use that interim rate until the MAC receives information that changes in service patterns that will result in a different interim rate. MACs shall calculate an interim supplemental payment rate for each MA plan the FQHC has contracted with. Reconcile all interim payments at cost settlement.

Do not apply the Medicare deductible when calculating the FQHC interim supplemental payment. Do not apply the original Medicare co-insurance (20%) to the FQHC all inclusive rate when calculating the FQHC interim supplemental payment. Any beneficiary cost sharing under the MA plan is included in the calculation of the FQHC interim supplemental payment rate.

MACs shall submit all claims to CWF for approval. CWF will verify each beneficiary's enrollment in an MA plan for the line item date of service (LIDOS) on the claim. CWF

shall reject all claims for the FQHC interim supplemental payment for beneficiaries who are not MA enrollees on the same date as the LIDOS on the claim. MACs shall RTP such claims to the FQHCs. MACs shall accept TOB 77x with revenue code 0519 and pay the interim supplemental payment rate for each qualified visit billed.

Billing for Supplemental Payments under the AIR

When billing for supplemental payment to the MAC, the encounter is reported on type of bill (TOB) 77x with revenue code 0519 for the amount of the interim supplemental payment rate (FQHC interim all-inclusive rate – estimated average payment from the MA plan plus any beneficiary cost sharing = billed amount > 0). Do not submit revenue codes 0520 and/or 0900 on the same claim as revenue code 0519. HCPCS coding is not required.

For Example:

Rev Code	HCPCS code	Modifier	Date of Service	Charges
0519	blank		01/01	150.00

Billing for Supplemental Payments under the PPS

When billing for supplemental payment to the MAC under the PPS, a FQHC payment specific code and a qualifying visit must be reported under revenue code 0519.

For example:

Revenue Code	HCPCS code	Modifier	Service Date
0519	G0467 – FQHC Payment code		10/01
0519	99213 – Qualifying visit		10/01

60.5 - PPS Payments to FQHCs under Contract with MA Plans (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

For claims with the 0519 revenue code, the wraparound payment is based on the PPS rate without comparison to the provider's charge. The rate is also NOT adjusted for coinsurance or preventive services as the MA plan would have already assessed any applicable coinsurance and related waivers of coinsurance.

Medicare will compare the PPS rate with the MA contract rate for a FQHC visit.

When the MA contract rate is lower than the applicable PPS rate that would otherwise have been paid by traditional Medicare had the beneficiary not been covered by the MA plan, the contractor will pay the difference as a supplemental wraparound payment.

The FQHC does not qualify for a supplemental wraparound payment when the MA contract rate is higher than the applicable PPS rate that would otherwise have been paid by traditional Medicare had the beneficiary not be covered by the MA plan.

- **Example: MA Claim that Qualifies for a Supplemental Wraparound Payment**

PPS Rate = \$225

Rev	HCPC	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0519	G0468		10/01	170.00	170.00
0519	G0439 PS		10/01	150.00	150.00
0001				320.00	320.00

If the MA contract rate is lower than the applicable PPS rate – e.g., \$200:

Wraparound payment = PPS rate – MA contract rate = \$225 - \$200 = \$25

Note that the charge of \$170 would reflect the FQHC's typical charge for G0468, but would not be used to calculate the supplemental payment.

- **Example : MA Claim that Does Not Qualify for a Supplemental Wraparound Payment**

PPS Rate = \$225

Rev	HCPC	MODS	SERV DATE	TOTAL CHARGE	COV CHARGE
0519	G0468		10/01	170.00	170.00
0519	G0439 PS		10/01	150.00	150.00
0001				320.00	320.00

If the MA contract rate was higher than the applicable PPS rate – e.g., the MA contract rate was \$250- no wraparound payment is due to the FQHC.

60.6 - RHCs and FQHCs for billing Hospice Attending Physician Services (Rev. 11200, Issued :01-12-22, Effective: 01-01-22, Implementation: 01-03-22)

Effective for services furnished on or after January 1, 2022, RHCs or FQHCs can bill and receive payment under the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS), when a designated attending physician employed by or working under contract with the RHC or FQHC furnishes hospice attending physician services during a patient's hospice election.

RHCs must report a GV modifier on the claim line for payment (that is, along with the CG modifier) each day a hospice attending physician service is furnished.

FQHCs must report a GV modifier on the claim line with the payment code (G0466 – G0470) each day a hospice attending physician service is furnished.

The hospice attending physician services are subject to coinsurance and deductibles on RHC claims and only coinsurance on FQHC claims.

70 - General Billing Requirements for Preventive Services

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Professional components of preventive services are covered under the RHC and FQHC benefit. The payment for most preventive services is included with a qualified visit as part of the overall encounter/visit. To ensure coinsurance and deductible (deductible applies to RHC claims only) are applied correctly, detailed HCPCS coding is required for approved preventive services recommended by the USPSTF with a grade of A or B for TOBs 71x or 77x. Additionally, RHCs/FQHCs are required to report HCPCS codes for certain preventive services subject to frequency limits.

70.1 - RHCs Billing Approved Preventive Services

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service HCPCS code and the associated charges. For example, if the total charge for the visit is \$150.00, and \$50.00 of that is a qualified preventive service, the service lines should be coded as follows:

Revenue Code	HCPCS code	Modifier	Service Date	Charges
0521	Encounter = Blank or valid HCPCS code		10/01	100.00
0521	Preventive Service Code		10/01	50.00

In the example above, the encounter service line will receive the AIR payment. The charges reported on this line should not include the charges for the approved preventive service. Coinsurance and deductible will be accessed based on the charges reported on this service line. The qualified preventive service reported on the additional service line will not receive payment, as payment is made under the AIR for the services reported under the encounter service line. Coinsurance and deductible are accessed based on the charges reported on the preventive services line.

70.2 - FQHCs Billing Approved Preventive Services under the AIR

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Detailed HCPCS codes are required for all service lines. When reporting the encounter/visit, revenue code 052X for medical and revenue code 0900 for mental health visits must be used. For additional services, the most appropriate revenue code for the service rendered should be used.

Revenue Code	HCPCS code	Modifier	Service Date	Charges
0521	Encounter = E&M HCPCS code		10/01	100.00
0771	Preventive Service Code		10/01	50.00

In the example above, the services reported under the encounter/visit service line will receive the AIR payment. The charges reported on this line should not include the charges for the approved preventive service. Since deductible does not apply to FQHC claims, only coinsurance will be applied to the charges reported on the encounter service line. The qualified preventive service reported on the second revenue line will not receive payment. Coinsurance and deductible are not accessed to the services reported under the preventive services line.

70.3 - FQHC Billing Approved Preventive Services under the PPS (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service HCPCS code and the associated charges. For example, if the total charge for the visit is \$150.00, report the total charges for the encounter. **NOTE:** Do not carve out the charges for the approved preventive services. The service lines should be coded as follows:

Revenue Code	HCPCS code	Modifier	Service Date	Charges
0521	Encounter = FQHC Payment Code (G-code) code		10/01	150.00
0771	Preventive Service code		10/01	75.00

In the example above, the services reported under the encounter/visit service line will receive the PPS payment. The charges reported on this line **should** include the charges for the approved preventive service. The coinsurance will be applied to the charges reported on the encounter service line. Coinsurance will not be applied to the charges reported for the approved preventive service. The qualified preventive service reported on the second revenue line will not receive payment. **NOTE:** A qualified HCPCS code visit must be reported if the preventive service is not a qualified visit.

70.4 - Vaccines

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x claim. However, FQHCs must report these services with their charges on the 77x claim for informational and data collection purposes only.

The costs for the influenza virus or pneumococcal pneumonia vaccines for RHCs and FQHCs are included in the cost report. Neither coinsurance nor deductible apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. An encounter cannot be billed if vaccine administration is the only service the RHC/FQHC provides.

Additional information on vaccines can be found in Chapter 1, section 10 of this manual. Additional coverage requirements for pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in Publication 100-02, the Medicare Benefit Policy Manual, Chapter 13.

70.5 - Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs billing under the AIR system

Payment is made at the all-inclusive encounter rate to the FQHC for DSMT or MNT. This payment can be in addition to payment for another qualifying visit on the same date of service as the beneficiary received qualifying DSMT services.

For FQHCs to qualify for a separate visit payment for DSMT or MNT services, the services must be a one-on-one face-to-face encounter. Group sessions do not constitute a billable visit for any FQHC services. To receive separate payment for DSMT or MNT services, the services must be billed on TOB 77x with HCPCS code G0108 (DSMT) or HCPCS code 97802, 97803, or G0270 (MNT) 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 /MNT services as long as the claim for DSMT/MNT services contains the appropriate coding specified above. Additional information on DSMT can be found in Chapter 18, section 120 of Pub. 100-04.

Additional information on MNT can be found in Chapter 4, section 300 of Pub. 100-04.

Group services (G0109, 97804 and G0271) do not meet the criteria for a separate qualifying encounter. All line items billed on TOBs 77x with group services will be denied.

DSMT and MNT services are subject to the frequency edits described in Pub. 100-04, Chapter 18, and should not be reported on the same day.

FQHCs billing under the PPS

DSMT and MNT are qualifying visits when billed under G0466 or G0467. For additional information on the payment specific codes and qualifying visits, see section 60.2 of this manual. Under the FQHC PPS, DSMT and MNT do not qualify for a separate payment when billed on the same day with another qualified visit.

RHCs

RHCs are not paid separately for DSMT and MNT services. All line items billed on TOB 71x with HCPCS codes for DSMT and MNT services will be denied.

70.6 - Initial Preventive Physical Examination (IPPE) (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

FQHCs and RHCs billing under the AIR system

Medicare provides for coverage for one IPPE for new beneficiaries only, subject to certain eligibility and other limitations.

Payment for the professional services will be made under the AIR. However, RHCs/FQHCs can receive a separate payment for an encounter in addition to the payment for the IPPE when they are performed on the same day.

When IPPE is provided in an RHC or FQHC, the professional portion of the service is billed on TOBs 71X and 77X, respectively, and the appropriate site of service revenue code in the 052X revenue code series, and must include HCPCS code G0402. Additional information on IPPE can be found in Chapter 18, section 80 of Pub. 100-04.

EKGs

The professional component is included in the AIR or FQHC PPS and is not separately billable.

The technical component of an EKG performed at a RHC/FQHC billed to Medicare on professional claims (Form CMS-1500 or 837P) under the practitioner's ID following instructions for submitting practitioner claims for independent/freestanding clinics. Practitioners at provider-based clinics bill the applicable TOB to the A/B MAC using the base provider's ID.

FQHCs billing under the PPS:

IPPE is qualifying visits when billed under G0468, for additional information on the payment specific codes and qualifying visits, please refer to section 60.2 of this manual. Under the FQHC PPS, IPPE does not qualify for a separate payment when billed on the same day with another encounter/visit.

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.

80 - Telehealth Services

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs and FQHCs may bill the Telehealth originating site facility fee on a RHC or FQHC claim under revenue code 0780 and HCPCS code Q3014. Telehealth services are the only services billed on FQHC claims that are subject to the Part B deductible. Additionally, a FQHC payment code and qualifying visit HCPCS code are not required when the only service reported on the claim is for Telehealth services. RHCs and FQHCs are not authorized to serve as distant practitioners for Telehealth services.

For more information on Telehealth services please see Pub 100-04, chapter 12, section 190: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

90 - Services non-Covered on RHC and FQHC Claims (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Technical Services

RHCs/FQHCs do not bill using TOBs 71x or 77x for technical components of services because they are not within the scope of Medicare-covered RHC/FQHC services. The associated technical components of services furnished by the RHC/FQHC are billed on other types of claims that are subject to applicable frequency limits edits.

For services that can be split into professional and technical components, RHCs and FQHCs bill for the professional component as part of the AIR or the FQHC PPS payment and bill the MAC separately for the technical component. See Chapter 17, section 30.1.1, for more information on how RHCs and FQHCs can bill the MAC for laboratory services. See Chapter 13 for more information on how to bill the MAC for technical components of diagnostic services.

- Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are submitted to the MAC in the designated claim format (837P or Form CMS-1500.) See chapters 12 (<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>) and 26 (<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>) of this manual for billing instructions.
- Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are submitted by the base-provider on the appropriate TOB to the MAC in the designated claim format (837I or the UB-04 claim form); see the applicable chapter of this manual based on the base-provider type, such as (<http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>) for outpatient hospital services, chapter 6 (<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>) for inpatient SNF services chapter 7 for Outpatient SNF services, etc.

Laboratory Services

RHCs must furnish the following lab services to be approved as an RHC. However, these and other lab services that may be furnished are not included in the encounter rate and must be billed separately.

- Chemical examinations of urine by stick or tablet method or both;
- Hemoglobin or hematocrit;
- Blood sugar;
- Examination of stool specimens for occult blood;
- Pregnancy tests; and
- Primary culturing for transmittal to a certified laboratory (No CPT code available).

RHCs/FQHCs bill all laboratory services to their MAC under the host provider's bill type and payment is made under the fee schedule. HCPCS codes are required for lab services.

Venipuncture is included in the AIR and the PPS per diem payment and is not separately billable.

Refer to Chapter 16 for general billing instructions.

Durable Medical Equipment (DME), ambulance services, hospital-based services, group services, and non-face-to-face services are also non-covered and are billed separately.

When billing these services on FQHC PPS claims, a FQHC payment code and qualifying visit HCPCS code is **not** required.

100 - Frequency of Billing and Same Day Billing

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHC and FQHC claims cannot overlap calendar years. Therefore, the statement dates, or from and through dates of the claim, must always be in the same calendar year.

RHCs and FQHCs billing under the FQHC PPS may submit claims that span multiple days of service.

FQHCs billing under the PPS must submit all services that are rendered on the same day on one claim.

General information on basic Medicare claims processing can be found in this manual in:

Chapter 1, “General Billing Requirements,”
(<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>) for general claims processing information;

Chapter 2, “Admission and Registration Requirements,”
(<http://www.cms.hhs.gov/manuals/downloads/clm104c02.pdf>) for general filing requirements applicable to all providers.

For Medicare institutional claims:

See the Medicare Claims Processing Manual on the CMS website for general Medicare institutional claims processing requirements, such as for timely filing and payment, admission processing, and Medicare Summary Notices.

Contact your MAC for basic training and orientation material if needed.

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Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R11200CP</u>	01/12/2022	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services	01/03/2022	12357
<u>R11095CP</u>	10/29/2021	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services - Rescinded and replaced by Transmittal 11200	01/03/2022	12357
<u>R11029CP</u>	09/29/2021	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services - Rescinded and replaced by Transmittal 11095	01/03/2022	12357
<u>R10907CP</u>	08/10/2021	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services - Rescinded and replaced by Transmittal 11029	01/03/2022	12357
<u>R10357CP</u>	09/18/2020	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 9, Section 70.7 and 70.8.	10/19/2020	11961
<u>R3434CP</u>	12/31/2015	Reorganization of Chapter 9	03/31/2016	9397
<u>R3000CP</u>	07/25/2014	Update to Pub. 100-04, Chapter 09 to Provide Language-Only Changes for Updating ASC X12	08/25/2014	8670
<u>R2186CP</u>	03/28/2011	Waiver of Coinsurance and Deductible for Preventive Services in Rural Health Clinics (RHCs), Section 4104 of Affordable Care Act (ACA)	04/04/2011	7208
<u>R2122CP</u>	12/21/2010	Waiver of Coinsurance and Deductible for	04/04/2011	7208

Preventive Services in Rural Health Clinics (RHCs), Section 4104 of Affordable Care Act (ACA) – Rescinded and replaced by Transmittal 2186

<u>R2093CP</u>	11/12/2010	Waiver of Coinsurance and Deductible for Preventive Services in Rural Health Clinics (RHCs), Section 4104 of Affordable Care Act (ACA) – Rescinded and replaced by Transmittal 2122	04/04/2011	7208
<u>R2034CP</u>	08/24/2010	Affordable Care Act (ACA) Mandated Collection of Federally Qualified Health Center (FQHC) Data and Updates to Preventive Services Provided by FQHCs	01/03/2011	7038
<u>R2013CP</u>	07/30/2010	Affordable Care Act (ACA) Mandated Collection of Federally Qualified Health Center (FQHC) Data and Updates to Preventive Services Provided by FQHCs - Rescinded and replaced by Transmittal 2034	01/03/2011	7038
<u>R1843CP</u>	10/30/2009	Outpatient Mental Health Treatment Limitation	01/04/2010	6686
<u>R1719CP</u>	04/24/2009	Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Updates	10/05/2009	6445
<u>R1707CP</u>	03/27/2009	Assignment of Initial Enrollment FQHC'S, ESRD Facilities, and RHC'S	04/27/2009	6207
<u>R1472CP</u>	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
<u>R1426CP</u>	02/01/2008	Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases	02/12/2008	5896
<u>R1421CP</u>	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
<u>R1255CP</u>	05/25/2007	Guidelines for Payment of Diabetes Self-Management Training DSMT)	07/02/2007	5433
<u>R1158CP</u>	01/19/2007	Guidelines for Payment of Diabetes Self-Management Training DSMT) – Replaced	07/02/2007	5433

by Transmittal 1255

<u>R820CP</u>	02/01/2006	Sites of Service Revenue Codes for Rural Health Clinics and Federally Qualified Health Centers	07/03/2006	4210
<u>R794CP</u>	12/29/2005	Announcement of Medicare Supplemental Payments to Federally Qualified Health Centers Under Contract with Medicare Advantage Plan	04/03/2006	3886
<u>R773CP</u>	12/02/2005	Announcement of the Medicare Federally Qualified Health Center Supplemental Payment	04/03/2006	3886
<u>R771CP</u>	12/02/2005	Revisions to Pub. 100-04, Medicare Claims in Preparation for the National Provider Identifier (NPI)	01/03/2006	4181
<u>R371CP</u>	11/19/2004	Updated Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	04/04/2005	3487
<u>R167CP</u>	04/30/2004	Discontinued Use of Revenue Code 0910	10/04/2004	3194
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA

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Consolidated Health Centers Act
Section 330 of the Public Health Service Act
Statutory Language

As of February 10, 2018

(includes revisions resulting from Bipartisan Budget Act of 2018)

(a) “Health center” defined

(1) In general

For purposes of this section, the term “health center” means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, ***either through the staff and supporting resources of the center or through contracts or cooperative arrangements—***

- (A)** required primary health services (as defined in subsection (b)(1) of this section); and
- (B)** as may be appropriate for particular centers, additional health services (as defined in subsection (b)(2) of this section) necessary for the adequate support of the primary health services required under subparagraph (A); for all residents of the area served by the center (hereafter referred to in this section as the “catchment area”).

(2) Limitation

The requirement in paragraph (1) to provide services for all residents within a catchment area shall not apply in the case of a health center receiving a grant only under subsection (g), (h), or (i) of this section.

(b) Definitions: For purposes of this section:

(1) Required primary health services

(A) In general

The term “required primary health services” means—

- (i)** basic health services which, for purposes of this section, shall consist of—
 - (I)** health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
 - (II)** diagnostic laboratory and radiologic services;
 - (III)** preventive health services, including—
 - (aa)** prenatal and perinatal services;
 - (bb)** appropriate cancer screening;
 - (cc)** well-child services;
 - (dd)** immunizations against vaccine-preventable diseases;

- (ee) screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- (ff) pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- (gg) voluntary family planning services; and
- (hh) preventive dental services;
- (IV) emergency medical services; and
- (V) pharmaceutical services as may be appropriate for particular centers;
- (ii) referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance use disorder and mental health services);
- (iii) patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services;
- (iv) services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and
- (v) education of patients and the general population served by the health center regarding the availability and proper use of health services.

(B) Exception

With respect to a health center that receives a grant only under subsection (g) of this section, the Secretary, upon a showing of good cause, shall—

- (i) waive the requirement that the center provide all required primary health services under this paragraph; and
- (ii) approve, as appropriate, the provision of certain required primary health services only during certain periods of the year.

(2) Additional health services

The term “additional health services” means services that are not included as required primary health services and that are appropriate to meet the health needs of the population served by the health center involved. Such term may include—

- (A) behavioral and mental health and substance use disorder services;
- (B) recuperative care services;
- (C) environmental health services, including—
 - (i) the detection and alleviation of unhealthful conditions associated with—
 - (I) water supply;
 - (II) chemical and pesticide exposures;
 - (III) air quality; or
 - (IV) exposure to lead;
 - (ii) sewage treatment;

- (iii) solid waste disposal;
 - (iv) rodent and parasitic infestation;
 - (v) field sanitation;
 - (vi) housing; and
 - (vii) other environmental factors related to health; and
- (D) in the case of health centers receiving grants under subsection (g) of this section, special occupation-related health services for migratory and seasonal agricultural workers, including—
- (i) screening for and control of infectious diseases, including parasitic diseases; and
 - (ii) injury prevention programs, including prevention of exposure to unsafe levels of agricultural chemicals including pesticides.

(3) Medically underserved populations

(A) In general

The term “medically underserved population” means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

(B) Criteria

In carrying out subparagraph (A), the Secretary shall prescribe criteria for determining the specific shortages of personal health services of an area or population group. Such criteria shall—

- (i) take into account comments received by the Secretary from the chief executive officer of a State and local officials in a State; and
- (ii) include factors indicative of the health status of a population group or residents of an area, the ability of the residents of an area or of a population group to pay for health services and their accessibility to them, and the availability of health professionals to residents of an area or to a population group.

(C) Limitation

The Secretary may not designate a medically underserved population in a State or terminate the designation of such a population unless, prior to such designation or termination, the Secretary provides reasonable notice and opportunity for comment and consults with—

- (i) the chief executive officer of such State;
- (ii) local officials in such State; and
- (iii) the organization, if any, which represents a majority of health centers in such State.

(D) Permissible designation

The Secretary may designate a medically underserved population that does not meet the criteria established under subparagraph (B) if the chief executive officer of the State in which such population is located and local officials of such State recommend the designation of such population based on unusual local

conditions which are a barrier to access to or the availability of personal health services.

(c) Planning grants

(1) Centers. – The Secretary may make grants to public and nonprofit private entities for projects to plan and develop health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition and lease of buildings and equipment (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

- (A)** an assessment of the need that the population proposed to be served by the health center for which the project is undertaken has for required primary health services and additional health services;
- (B)** the design of a health center program for such population based on such assessment;
- (C)** efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project;
- (D)** initiation and encouragement of continuing community involvement in the development and operation of the project; and
- (E)** proposed linkages between the center and other appropriate provider entities, such as health departments, local hospitals, and rural health clinics, to provide better coordinated, higher quality, and more cost-effective health care services.

(d) Improving Quality of Care.—

(1) SUPPLEMENTAL AWARDS.—The Secretary may award supplemental grant funds to health centers funded under this section to implement evidence-based models for increasing access to high-quality primary care services, which may include models related to—

- (A)** improving the delivery of care for individuals with multiple chronic conditions;
- (B)** workforce configuration;
- (C)** reducing the cost of care;
- (D)** enhancing care coordination;
- (E)** expanding the use of telehealth and technology enabled collaborative learning and capacity building models;
- (F)** care integration, including integration of behavioral health, mental health, or substance use disorder services; and
- (G)** addressing emerging public health or substance use disorder issues to meet the health needs of the population served by the health center.

(2) SUSTAINABILITY.—In making supplemental awards under this subsection, the Secretary may consider whether the health center involved has submitted a plan for continuing the activities funded under this subsection after supplemental funding is expended.

(3) SPECIAL CONSIDERATION.— The Secretary may give special consideration to applications for supplemental funding under this subsection that seek to address significant barriers to access to care in areas with a greater shortage of health care providers and health services relative to the national average.

(e) Operating grants

(1) Authority

(A) In general: The Secretary may make grants for the costs of the operation of public and nonprofit private health centers that provide health services to medically underserved populations.

(B) Entities that fail to meet certain requirements: The Secretary may make grants, for a period of not to exceed 1 year, for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required by subsection (k)(3) of this section. The Secretary shall not make a grant under this paragraph unless the applicant provides assurances to the Secretary that within 120 days of receiving grant funding for the operation of the health center, the applicant will submit, for approval by the Secretary, an implementation plan to meet the requirements of subsection (k)(3). The Secretary may extend such 120-day period for achieving compliance upon a demonstration of good cause by the health center.

(C) Operation of networks The Secretary may make grants to health centers that receive assistance under this section, or at the request of the health centers, directly to a network of this section)¹ that is at least majority controlled and, as applicable, at least majority owned by such health centers receiving assistance under this section, for the costs associated with the operation of such network including

- (i) the purchase or lease of equipment, which may include data and information systems (including the costs of amortizing the principal of, and paying the interest on, loans for equipment);
- (ii) the provision of training and technical assistance; and
- (iii) other activities that—
 - (I) reduce costs associated with the provision of health services;

¹ The words “of this section” should have been deleted, but due to an apparent drafting error in the BBA of 2018 they were not.

- (II) improve access to, and availability of, health services provided to individuals served by the centers;
- (III) enhance the quality and coordination of health services; or
- (IV) improve the health status of communities.

(2) Use of funds

The costs for which a grant may be made under subparagraph (A) or (B) of paragraph (1) may include the costs of acquiring and leasing buildings and equipment (including the costs of amortizing the principal of, and paying interest on, loans), and the costs of providing training related to the provision of required primary health services and additional health services and to the management of health center programs.

(3) Construction

The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings or constructing new buildings (including the costs of amortizing the principal of, and paying the interest on, loans) for projects approved prior to October 1, 1996.

(4) Limitation

Not more than two grants may be made under subparagraph (B) of paragraph (1) for the same entity.

(5) Amount**(A) In general**

The amount of any grant made in any fiscal year under subparagraphs (A) and (B) of paragraph (1) to a health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of—

- (i) State, local, and other operational funding provided to the center; and
- (ii) the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year.

(B) Networks

The total amount of grant funds made available for any fiscal year under paragraph (1)(C) to a health center or to a network shall be determined by the Secretary, but may not exceed 2 percent of the total amount appropriated under this section for such fiscal year.

(C) Payments

Payments under grants under subparagraph (A) or (B) of paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments.

(D) Use of nongrant funds

Nongrant funds described in clauses (i) and (ii) of subparagraph (A), including any such funds in excess of those originally expected, shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project.

(6) New Access Points and Expanded Services.—

(A) APPROVAL OF NEW ACCESS POINTS.—

- (i) **IN GENERAL.**—The Secretary may approve applications for grants under subparagraph (A) or (B) of subsection (1) to establish new delivery sites.
- (ii) **SPECIAL CONSIDERATION.** -- In carrying out clause (i), the Secretary may give special consideration to applicants that have demonstrated the new delivery site will be located within a sparsely populated area, or an area which has a level of unmet need that is higher relative to other applicants.
- (iii) **CONSIDERATION OF APPLICATIONS.**—In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by the applicants is not less than two to three or greater than three to two.
- (iv) **SERVICE AREA OVERLAP.**—If in carrying out clause (i) the applicant proposes to serve an area that is currently served by another health center funded under this section, the Secretary may consider whether the award of funding to an additional health center in the area can be justified based on the unmet need for additional services within the catchment area.

(B) APPROVAL OF EXPANDED SERVICE APPLICATIONS.—

- (i) **IN GENERAL.**—The Secretary may approve applications for grants to health centers under subparagraph (A) or (B) of paragraph (1) to expand the capacity of the health center to provide required primary health services described in subsection (b)(1) or additional health services described in subsection (b)(2).
- (ii) **PRIORITY EXPANSION PROJECTS.**—In carrying out clause (i), the Secretary may give special consideration to expanded service applications that seek to address emerging public health or behavioral health, mental health, or substance abuse issues through increasing the availability additional health services in subsection (b)(2) in an area in which

there are significant barriers to accessing care.

- (iii) **CONSIDERATION OF APPLICATIONS.**—In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by the applicants is not less than two to three or greater than three to two.

(f) Infant mortality grants

(1) In general

The Secretary may make grants to health centers for the purpose of assisting such centers in—

(A) providing comprehensive health care and support services for the reduction of—

(i) the incidence of infant mortality; and

(ii) morbidity among children who are less than 3 years of age; and

(B) developing and coordinating service and referral arrangements between health centers and other entities for the health management of pregnant women and children described in subparagraph (A).

(2) Priority

In making grants under this subsection the Secretary shall give priority to health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality.

(3) Requirements

The Secretary may make a grant under this subsection only if the health center involved agrees that—

(A) the center will coordinate the provision of services under the grant to each of the recipients of the services;

(B) such services will be continuous for each such recipient;

(C) the center will provide follow-up services for individuals who are referred by the center for services described in paragraph (1);

(D) the grant will be expended to supplement, and not supplant, the expenditures of the center for primary health services (including prenatal care) with respect to the purpose described in this subsection; and

(E) the center will coordinate the provision of services with other maternal and child health providers operating in the catchment area.

(g) Migratory and seasonal agricultural workers

(1) In general: The Secretary may award grants for the purposes described in subsections (c), (e), and (f) of this section for the planning and delivery of services to a special medically underserved population comprised of—

- (A) migratory agricultural workers, seasonal agricultural workers, and members of the families of such migratory and seasonal agricultural workers who are within a designated catchment area; and
- (B) individuals who have previously been migratory agricultural workers but who no longer meet the requirements of subparagraph (A) of paragraph (3) because of age or disability and members of the families of such individuals who are within such catchment area.

(2) Environmental concerns

The Secretary may enter into grants or contracts under this subsection with public and private entities to—

- (A) assist the States in the implementation and enforcement of acceptable environmental health standards, including enforcement of standards for sanitation in migratory agricultural worker and seasonal agricultural worker labor camps, and applicable Federal and State pesticide control standards; and
- (B) conduct projects and studies to assist the several States and entities which have received grants or contracts under this section in the assessment of problems related to camp and field sanitation, exposure to unsafe levels of agricultural chemicals including pesticides, and other environmental health hazards to which migratory agricultural workers and seasonal agricultural workers, and members of their families, are exposed.

(3) Definitions: For purposes of this subsection:

(A) Migratory agricultural worker

The term “migratory agricultural worker” means an individual whose principal employment is in agriculture, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode.

(B) Seasonal agricultural worker

The term “seasonal agricultural worker” means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

(C) Agriculture

The term “agriculture” means farming in all its branches, including—

- (i) cultivation and tillage of the soil;
- (ii) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land; and
- (iii) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in clause (ii).

(h) Homeless population

(1) In general The Secretary may award grants for the purposes described in subsections (c), (e), and (f) of this section for the planning and delivery of services to

a special medically underserved population comprised of homeless individuals, including grants for innovative programs that provide outreach and comprehensive primary health services to homeless children and youth, children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness

(2) Required services In addition to required primary health services (as defined in subsection (b)(1) of this section), an entity that receives a grant under this subsection shall be required to provide substance abuse services as a condition of such grant.

(3) Supplement not supplant requirement A grant awarded under this subsection shall be expended to supplement, and not supplant, the expenditures of the health center and the value of in kind contributions for the delivery of services to the population described in paragraph (1).

(4) Temporary continued provision of services to certain former homeless individuals: If any grantee under this subsection has provided services described in this section under the grant to a homeless individual, such grantee may, notwithstanding that the individual is no longer homeless as a result of becoming a resident in permanent housing, expend the grant to continue to provide such services to the individual for not more than 12 months.

(5) Definitions: For purposes of this section:

(A) Homeless individual

The term “homeless individual” means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

(B) Substance use disorder services

The term “substance abuse services” includes detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals.

(i) Residents of public housing

(1) In general The Secretary may award grants for the purposes described in subsections (c), (e), and (f) of this section for the planning and delivery of services to a special medically underserved population comprised of residents of public housing (such term, for purposes of this subsection, shall have the same meaning given such term in section 1437a (b)(1) of this title) and individuals living in areas immediately accessible to such public housing.

(2) Supplement not supplant A grant awarded under this subsection shall be expended to supplement, and not supplant, the expenditures of the health center and the value of in kind contributions for the delivery of services to the population described in paragraph (1).

(3) Consultation with residents: The Secretary may not make a grant under paragraph (1) unless, with respect to the residents of the public housing involved, the applicant for the grant—

(A) has consulted with the residents in the preparation of the application for the grant; and

(B) agrees to provide for ongoing consultation with the residents regarding the planning and administration of the program carried out with the grant.

(j) Access grants

(1) In general

The Secretary may award grants to eligible health centers with a substantial number of clients with limited English speaking proficiency to provide translation, interpretation, and other such services for such clients with limited English speaking proficiency.

(2) Eligible health center

In this subsection, the term “eligible health center” means an entity that—

(A) is a health center as defined under subsection (a) of this section;

(B) provides health care services for clients for whom English is a second language; and

(C) has exceptional needs with respect to linguistic access or faces exceptional challenges with respect to linguistic access.

(3) Grant amount

The amount of a grant awarded to a center under this subsection shall be determined by the Administrator. Such determination of such amount shall be based on the number of clients for whom English is a second language that is served by such center, and larger grant amounts shall be awarded to centers serving larger numbers of such clients.

(4) Use of funds An eligible health center that receives a grant under this subsection may use funds received through such grant to—

(A) provide translation, interpretation, and other such services for clients for whom English is a second language, including hiring professional translation and interpretation services; and

(B) compensate bilingual or multilingual staff for language assistance services provided by the staff for such clients.

(5) Application An eligible health center desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including—

(A) an estimate of the number of clients that the center serves for whom English is a second language;

(B) the ratio of the number of clients for whom English is a second language to the total number of clients served by the center;

(C) a description of any language assistance services that the center proposes to provide to aid clients for whom English is a second language; and

(D) a description of the exceptional needs of such center with respect to linguistic access or a description of the exceptional challenges faced by such center with respect to linguistic access.

(6) Authorization of appropriations

There are authorized to be appropriated to carry out this subsection, in addition to any funds authorized to be appropriated or appropriated for health centers under any other subsection of this section, such sums as may be necessary for each of fiscal years 2002 through 2006.

(k) Applications

- (1) Submission:** No grant may be made under this section unless an application therefore is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe.
- (2) Description of unmet need:** An application for a grant under subparagraph (A) or (B) of subsection (e)(1) or subsection (e)(6) of this section for a health center shall include—
- (A)** a description of the unmet need for health services in the catchment area of the center;
 - (B)** a demonstration by the applicant that the area or the population group to be served by the applicant has a shortage of personal health services;
 - (C)** a demonstration that the center will be located so that it will provide services to the greatest number of individuals residing in the catchment area or included in such population group. Such a demonstration shall be made on the basis of the criteria prescribed by the Secretary under subsection (b)(3) of this section or on any other criteria which the Secretary may prescribe to determine if the area or population group to be served by the applicant has a shortage of personal health services. In considering an application for a grant under subparagraph (A) or (B) of subsection (e)(1) of this section, the Secretary may require as a condition to the approval of such application an assurance that the applicant will provide any health service defined under paragraphs (1) and (2) of subsection (b) of this section that the Secretary finds is needed to meet specific health needs of the area to be served by the applicant. Such a finding shall be made in writing and a copy shall be provided to the applicant
 - (D)** in the case of an application for a grant pursuant to subsection (e)(6), a demonstration that the applicant has consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site.
- (3) Requirements:** Except as provided in subsection (e)(1)(B) or subsection (e)(6) of this section, the Secretary may not approve an application for a grant under subparagraph (A) or (B) of subsection (e)(1) of this section unless the Secretary determines that the entity for which the application is submitted is a health center (within the meaning of subsection (a) of this section) and that—
- (A)** the required primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity;

- (B)** the center has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers“, including other health care providers that provide care within the catchment area, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments;
- (C)** the center will have an ongoing quality improvement system that includes clinical services and management, and that maintains the confidentiality of patient records;
- (D)** the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;
- (E)** the center—
- (i)**
 - (I)** has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for the payment of all or a part of the center’s costs in providing health services to persons who are eligible for medical assistance under such a State plan; and
 - (II)** has or will have a contractual or other arrangement with the State agency administering the program under title XXI of such Act (42 U.S.C. 1397aa et seq.) with respect to individuals who are State children’s health insurance program beneficiaries; or
 - (ii)** has made or will make every reasonable effort to enter into arrangements described in subclauses (I) and (II) of clause (i);
- (F)** the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], to medical assistance under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], or to assistance for medical expenses under any other public assistance program or private health insurance program;
- (G)** the center—
- (i)** has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient’s ability to pay;
 - (ii)** has made and will continue to make every reasonable effort—
 - (I)** to secure from patients payment for services in accordance with such schedules; and

(II) to collect reimbursement for health services to persons described in subparagraph (F) on the basis of the full amount of fees and payments for such services without application of any discount;

(iii)

(I) will assure that no patient will be denied health care services due to an individual's inability to pay for such services; and

(II) will assure that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill the assurance described in subclause (I); and

(iv) has submitted to the Secretary such reports as the Secretary may require to determine compliance with this subparagraph;

(H) the center has established a governing board which except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act [25 U.S.C. 450f et seq.] or an urban Indian organization under the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.)—

(i) is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center;

(ii) meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center who shall be directly employed by the center, and, except in the case of a governing board of a public center (as defined in the second sentence of this paragraph), establishes general policies for the center; and

(iii) in the case of an application for a second or subsequent grant for a public center, has approved the application or if the governing body has not approved the application, the failure of the governing body to approve the application was unreasonable;

except that, upon a showing of good cause the Secretary shall waive, for the length of the project period, all or part of the requirements of this subparagraph in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p) of this section;

(I) the center has developed—

(i) an overall plan and budget that meets the requirements of the Secretary; and

(ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to—

(I) the costs of its operations;

(II) the patterns of use of its services;

(III) the availability, accessibility, and acceptability of its services; and

(IV) such other matters relating to operations of the applicant as the Secretary may require;

(J) the center will review periodically its catchment area to—

- (i) ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;
 - (ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and
 - (iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation;
- (K)** in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has—
- (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals; and
 - (ii) identified an individual on its staff who is fluent in both that language and in English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences;
- (L)** the center, has developed an ongoing referral relationship with one or more hospitals;
- (M)** the center encourages persons receiving or seeking health services from the center to participate in any public or private (including employer-offered) health programs or plans for which the persons are eligible, so long as the center, in complying with this subparagraph, does not violate the requirements of subparagraph (G)(iii)(I).
- For purposes of subparagraph (H), the term “public center” means a health center funded (or to be funded) through a grant under this section to a public agency; and
- (N)** the center has written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.

(I) Technical assistance

The Secretary shall establish a program through which the Secretary shall provide (either through the Department of Health and Human Services or by grant or contract) technical and other assistance to eligible entities to assist such entities to meet the requirements of subsection (k)(3) of this section. Services provided through the program may include necessary technical and nonfinancial assistance, including fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the entities of the variety of resources available under this subchapter and how those resources can be best used to meet the health needs of the communities served by the entities. Funds expended to carry out activities under this subsection and operational support activities

under subsection (m) shall not exceed 3 percent of the amount appropriated for this section for the fiscal year involved.

(m) Memorandum of agreement

In carrying out this section, the Secretary may enter into a memorandum of agreement with a State. Such memorandum may include, where appropriate, provisions permitting such State to—

- (1) analyze the need for primary health services for medically underserved populations within such State;
- (2) assist in the planning and development of new health centers;
- (3) review and comment upon annual program plans and budgets of health centers, including comments upon allocations of health care resources in the State;
- (4) assist health centers in the development of clinical practices and fiscal and administrative systems through a technical assistance plan which is responsive to the requests of health centers; and
- (5) share information and data relevant to the operation of new and existing health centers.

(n) Records

(1) In general

Each entity which receives a grant under subsection (e) of this section shall establish and maintain such records as the Secretary shall require.

(2) Availability

Each entity which is required to establish and maintain records under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying or mechanical reproduction on or off the premises of such entity upon a reasonable request therefore. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.

(o) Delegation of authority

The Secretary may delegate the authority to administer the programs authorized by this section to any office, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts may be delegated only within the central office of the Health Resources and Services Administration.

(p) Special consideration

In making grants under this section, the Secretary shall give special consideration to the unique needs of sparsely populated rural areas, including giving priority in the awarding of grants for new health centers under subsections (c) and (e) of this section, and the granting of waivers as appropriate and permitted under subsections (b)(1)(B)(i) and (k)(3)(G) of this section.

(q) Audits

(1) In general Each entity which receives a grant under this section shall provide for an independent annual financial audit of any books, accounts, financial records, files, and other papers and property which relate to the disposition or use of the funds received under such grant and such other funds received by or allocated to the project for which such grant was made. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with generally accepted accounting principles. Each audit shall evaluate—

- (A)** the entity's implementation of the guidelines established by the Secretary respecting cost accounting,
- (B)** the processes used by the entity to meet the financial and program reporting requirements of the Secretary, and
- (C)** the billing and collection procedures of the entity and the relation of the procedures to its fee schedule and schedule of discounts and to the availability of health insurance and public programs to pay for the health services it provides.

A report of each such audit shall be filed with the Secretary at such time and in such manner as the Secretary may require.

- (2) Records:** Each entity which receives a grant under this section shall establish and maintain such records as the Secretary shall by regulation require to facilitate the audit required by paragraph (1). The Secretary may specify by regulation the form and manner in which such records shall be established and maintained.
- (3) Availability of records** Each entity which is required to establish and maintain records or to provide for and ^[2] audit under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying or mechanical reproduction on or off the premises of such entity upon a reasonable request therefore. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.
- (4) Waiver** The Secretary may, under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an entity. A waiver provided by the Secretary under this paragraph may not remain in effect for more than 1 year and may not be extended after such period. An entity may not receive more than one waiver under this paragraph in consecutive years.

(r) Authorization of appropriations**(1) In general**

For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d) of this section, there are authorized to be

appropriated \$1,340,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006.

(2) Special provisions

(A) Public centers

The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (k)(3) of this section) the governing boards of which (as described in subsection (k)(3)(H) of this section) do not establish general policies for such centers, an amount which exceeds 5 percent of the amounts appropriated under this section for that fiscal year. For purposes of applying the preceding sentence, the term “public centers” shall not include health centers that receive grants pursuant to subsection (h) or (i) of this section.

(B) Distribution of grants

For fiscal year 2002 and each of the following fiscal years, the Secretary, in awarding grants under this section, shall ensure that the proportion of the amount made available under each of subsections (g), (h), and (i) of this section, relative to the total amount appropriated to carry out this section for that fiscal year, is equal to the proportion of the amount made available under that subsection for fiscal year 2001, relative to the total amount appropriated to carry out this section for fiscal year 2001.

(3) Funding report

The Secretary shall annually prepare and submit to the Committee on Health, Education, Labor, and Pensions Committee of the Senate, and the Committee on Energy and Commerce of the House of Representatives, a report including, at a minimum—

- (A) the distribution of funds for carrying out this section that are provided to meet the health care needs of medically underserved populations, including the homeless, residents of public housing, and migratory and seasonal agricultural workers, and the appropriateness of the delivery systems involved in responding to the needs of the particular populations;
- (B) an assessment of the relative health care access needs of the targeted populations ;
- (C) the distribution of awards and funding for new or expanded services in each of rural areas and urban areas;
- (D) the distribution of awards and funding for establishing new access points, and the number of new access points created;
- (E) the amount of unexpended funding for loan guarantees and loan guarantee authority under Title XVI;
- (F) the rationale for any substantial changes in the distribution of funds;

- (G) the rate of closures for health centers and access points;
- (H) the number and reason for any grants awarded pursuant to subsection (e)(1)(B); and
- (I) the number and reason for any waivers provided pursuant to subsection (q)(4).

(5) ²FUNDING FOR PARTICIPATION OF HEALTH CENTERS IN ALL OF US RESEARCH PROGRAM.—In addition to any amounts made available pursuant to paragraph (1) of this subsection, section 402A of this Act, or section 10503 of the Patient Protection and Affordable Care Act, there is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Secretary \$25,000,000 for fiscal year 2018 to support the participation of health centers in the All of Us Research Program under the Precision Medicine Initiative under section 498E of this Act.

Version 01/17/2018
Check for Updates

² Due to an apparent drafting error in the Bipartisan Budget Act of 2018, there is no subsection (r)(4).



Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs) 4-132

MLN Matters Number: MM10175 **Revised** Related Change Request (CR) Number: 10175

Related CR Release Date: August 11, 2017 Effective Date: January 1, 2018

Related CR Transmittal Number: R1899OTN Implementation Date: January 2, 2018

Note: This article was revised on November 13, 2017, to correct statements on page 2 (**in bold**). All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10175 provides instructions for payment to Rural Health Clinics (RHCs) billing under the all-inclusive rate (AIR), and Federally Qualified Health Centers (FQHCs) billing under the prospective payment system (PPS), for care coordination services for dates of service on or after January 1, 2018.

BACKGROUND

As authorized by §1861(aa) of the Social Security Act, RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. Care coordination services are RHC and FQHC services, but payment for the additional costs associated with certain care coordination services are not included in the RHC AIR or the FQHC PPS rate. In the CY 2016 Medicare Physician Fee Schedule (PFS) final rule (80 FR 71080), Centers for Medicare & Medicaid Services (CMS) finalized requirements and a payment methodology for Chronic Care Management (CCM) services furnished by RHCs and FQHCs. Effective January 1, 2016, CCM payment to RHCs and FQHCs is based on the Medicare PFS national non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate is updated annually and there is no geographic adjustment. Revisions to the CCM requirements for

RHCs and FQHCs were in the CY 2017 PFS final rule (81 FR 80256) for services furnished on or after January 1, 2017.

In the CY 2017 PFS final rule (81 FR 80225), CMS established separate payment, beginning January 1, 2017, for practitioners billing under the PFS, for complex CCM services, General Behavioral Health Integration (BHI) services, and a psychiatric collaborative care model (CoCM). To allow payment to RHCs and FQHCs for these new services, CMS finalized in the CY 2018 Physician Fee Schedule Final Rule to revise payment for care coordination services in RHCs and FQHCs by establishing 2 new G codes for use by RHCs and FQHCs, effective January 1, 2018. **The first new G code will be a General Care Management code for RHCs and FQHCs with the payment amount set at the average of the 3 national non-facility PFS payment rates for the CCM and general BHI codes. The second new G code for RHCs and FQHCs will be a Psychiatric CoCM code with the payment amount set at the average of the 2 national non-facility PFS payment rates for psychiatric CoCM services.** RHC or FQHC claims submitted using CPT 99490 for dates of service on or after January 1, 2018, will be denied.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for General Care Management services when G0511 is billed alone or with other payable services on a RHC or FQHC claim. Payment for G0511 is set at the average of the 3 national non-facility PFS payment rates for the CCM (CPT code 99490 and CPT code 99487) and general BHI (CPT code 99484). The rate is updated annually based on the PFS amounts and coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for Psychiatric CoCM services when G0512 is billed alone or with other payable services on an RHC or FQHC claim. Payment for G0512 is set at the average of the 2 national non-facility PFS payment rates for CoCM (CPT code 99492 and CPT code 99493). The rate is updated annually based on the PFS amounts and coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

General Care Management (G0511) Requirements: RHCs and FQHCs can bill the new General Care Management G code when the following requirements are met:

1. **Initiating Visit:** An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services. This would be billed as an RHC or FQHC visit.
2. **Beneficiary Consent:** Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff;

can be written or verbal, must be documented in the medical record and includes information:

- On the availability of care coordination services and applicable cost-sharing
- That only one practitioner can furnish and be paid for care coordination services during a calendar month
- On the right to stop care coordination services at any time (effective at the end of the calendar month)
- Permission to consult with relevant specialists.

3. Billing Requirements: At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the RHC or FQHC physician, NP, PA, or CNM, and b) by an RHC or FQHC practitioner, or by clinical personnel under general supervision.

4. Patient Eligibility: Patient must have:

- Option A: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, OR
- Option B: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

5. Requirement Service Elements

For patients meeting the eligibility requirements of Option A, the RHC or FQHC must meet all of the following requirements:

- Structured recording of patient health information using Certified EHR Technology and includes 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
- 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.

For patients meeting the eligibility requirements of Option B, the RHC or FQHC must meet all of the following requirements:

- Initial assessment or follow-up monitoring, including the use of applicable validated 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)
- Continuity of care with a designated member of the care team.

Psychiatric CoCM (G0512) Requirements: RHCs and FQHCs can bill the Psychiatric CoCM G code when the following requirements are met:

1. Initiating Visit: An E/M, AWV, or IPPE visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric CoCM services. This would be billed as an RHC or FQHC visit.

2. Beneficiary Consent: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:

- Information on the availability of care coordination services and applicable cost-sharing
- That only one practitioner can furnish and be paid for care coordination services during a calendar month
- That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month)
- The patient is giving permission to consult with relevant specialists

3. Billing Requirements: At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services, furnished a) under the direction of the RHC or FQHC practitioner, and b) by an RHC or FQHC practitioner or Behavioral Health Care Manager under general supervision.

4. Patient Eligibility: Patient must have a behavioral health or psychiatric condition that is being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants psychiatric CoCM services.

5. Requirement Service Elements: Psychiatric CoCM requires a team that includes the following:

RHC or FQHC Practitioner (physician, NP, PA, or CNM) who:

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

Behavioral Health Care Manager who:

- Provides assessment and care management services, including the administration of validated 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; provision of brief psychosocial interventions; ongoing collaboration with the RHC or FQHC practitioner; maintenance of the registry;

acting in consultation with the psychiatric consultant

- Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team
- Is available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager's duties

Psychiatric Consultant who:

- Participates in regular reviews of the clinical status of patients receiving CoCM services;
- Advises the RHC or FQHC practitioner regarding diagnosis, 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
- Facilitate referral for direct provision of psychiatric care when clinically indicated

MACs will apply coinsurance and deductible to HCPCS codes G0511 and G0512 on FQHC claims.

ADDITIONAL INFORMATION

The official instruction, CR 10175, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1899OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

DOCUMENT HISTORY

Date of Change	Description
November 13, 2017	The article was revised to correct statements on page 2 (in bold).
November 8, 2017	Initial article released

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Medicare FFS Response to the PHE on COVID-19

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Note: We revised this Article to add more information about the SNF waivers. You'll find substantive content updates in dark red font on page 13. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is for physicians, providers and suppliers who bill Medicare Fee-for-Service (FFS).

Provider Information Available

The Secretary of the HHS declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020, HHS authorized waivers and modifications under [Section 1135 of the Social Security Act](#) (the Act), retroactive to March 1, 2020.

CMS is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for patients affected by the emergency. You don't need to apply for an individual waiver if a blanket waiver is issued.

For more Information, refer to:

- [Coronavirus Waivers and Flexibilities](#) webpage
- [Instructions](#) to ask for an individual waiver if no blanket waiver exists

Background

Section 1135 and Section 1812(f) Waivers

As a result of this PHE, apply the following to claims for which Medicare payment is based on a "formal waiver" including, but not limited to, [Section 1135](#) or [Section 1812\(f\)](#) of the Act:

1. The "DR" (disaster related) condition code for institutional billing, that is, claims you submit using the ASC X12 837 institutional claims format or paper Form CMS-1450.

2. The “CR” (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, that is, claims you submit using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

Clarification for Using the “CR” Modifier and “DR” Condition Code

When HHS declares a PHE and invokes Section 1135 authority, we have the authority to take proactive steps through 1135 waivers as well as, where applicable, authority granted under Section 1812(f) of the Act, to approve blanket waivers of certain Social Security Act requirements. These waivers help prevent gaps in access to care for patients affected by the emergency. In prior emergencies, we issued waivers for the Medicare Fee-for-Service program. To allow us to assess the impact of prior emergencies, we needed modifier “CR” and condition code “DR” for all services provided in a facility operating per CMS waivers that typically were in place, for limited geographical locations and durations of time.

For the COVID-19 PHE, we added many blanket waivers, flexibilities, and modifications to existing deadlines and timetables that apply to the whole country. See the [full list](#) of waivers and flexibilities. Due to the large volume and scope of these new blanket waivers and flexibilities, we are clarifying which need the usage of modifier “CR” or condition code “DR” when submitting claims to Medicare. The chart below identifies those blanket waivers and flexibilities for which CMS requires the modifier or condition code. Submission of the modifier or condition code isn’t needed for any waivers or flexibilities not included in this chart.

Please note that we wouldn’t deny claims due to the presence of the “CR” modifier or “DR” condition code for services or items related to a COVID-19 waiver that aren’t on this list, or for services or items that aren’t related to a COVID-19 waiver. There may be potential claims implications, like claims denials, for claims that don’t contain the modifier or condition code as identified in the below chart, but providers don’t need to resubmit or adjust previously processed claims to conform to the requirements below, unless claims payment was affected.

Waiver/Flexibility	Summary	CR	DR
Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient psychiatric units to move inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit as a result of a disaster or emergency.		X
Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units	Allows acute care hospitals to house acute care inpatients in excluded distinct part units, like excluded distinct part unit IRFs or IPFs, where the distinct part unit’s beds are appropriate for acute care inpatients.		X

Waiver/Flexibility	Summary	CR	DR
Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient rehabilitation units to move inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit as a result of this PHE.		X
Supporting Care for Patients in Long Term Care Acute Hospitals (LTCHs)	We decided to issue a blanket waiver to long-term care hospitals (LTCHs) where an LTCH admits or discharges patients to meet the demands of the emergency from the 25-day average length of stay requirement at § 412.23(e)(2), which allows these hospitals to take part in the LTCH PPS. Also, during the applicable waiver period, we decided to issue a blanket waiver to hospitals not yet classified as LTCHs, but seeking classification as an LTCH, to exclude patient stays where the hospital admits or discharges patients to meet the demands of the emergency from the 25-day average length of stay requirement, which must be met in order for these hospitals to be eligible to take part in the LTCH PPS.		X
Care for Patients in Extended Neoplastic Disease Care Hospital	Allows extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which allows these facilities to be excluded from the hospital inpatient prospective payment system and paid an adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based payment rules.		X
Skilled Nursing Facilities (SNFs)	Using the authority under Section 1812(f) of the Act, we are waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. Also, for certain patients who exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those patients who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their up-to-date benefit period and renewing their SNF benefits that would have occurred under normal circumstances).		X

Waiver/Flexibility	Summary	CR	DR
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise unusable, allow the DME MACs to have the flexibility to waive replacements requirements so the face-to-face requirement, a new physician's order, and new medical necessity documentation aren't needed. Suppliers must still include a narrative description on the claim explaining the reason why they are replacing equipment and we remind them to keep documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise unusable or unavailable as a result of the emergency.	X	
Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)	Modifies the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency, plus an added period of no more than 60 continuous days after the PHE expires. On the 61st day after the PHE ends (or earlier), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least 1 day to reset the 60-day clock. Physicians and eligible physical therapists must continue to use the Q5 or Q6 modifier (as applicable) and don't need to begin including the CR modifier until the 61st continuous day.	X	
Critical Access Hospitals	Waives the requirements that Critical Access Hospitals limit the number of inpatient beds to 25, and that the length of stay, on an average annual basis, be limited to 96 hours.		X
Replacement Prescription Fills	We allow Medicare payment for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise unusable by damage due to the disaster or emergency.	X	
Hospitals Classified as Sole Community Hospitals (SCHs)	Waives certain eligibility requirements for hospitals classified as SCHs before the PHE, specifically the distance requirements and the "market share" and bed requirements (as applicable).		X

Waiver/Flexibility	Summary	CR	DR
Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)	For hospitals classified as MDHs before the PHE, waives the eligibility requirements that the hospital has 100 or fewer beds during the cost reporting period and that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods.		X
IRF 60 Percent Rule	Allows an IRF to exclude patients from its inpatient population for purposes of calculating the applicable thresholds associated with the requirements to get payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency. Also, during the applicable waiver period, we would also apply the exception to facilities not yet classified as IRFs, but that are trying to obtain classification as an IRF.		X
Waivers of certain hospital and Community Mental Health Center (CMHC) Conditions of Participation and provider-based rules	Allows a hospital or Community Mental Health Center (CMHC) to consider temporary expansion locations, including the patient's home, to be a provider-based department of the hospital or extension of the CMHC, which allows institutional billing for certain outpatient services provided in temporary expansion locations. If the entire claim falls under the waiver, the provider would only use the DR condition code. If some claim lines fall under this waiver and others don't, then the provider would only append the CR modifier to the particular line(s) that falls under the waiver.	X	X
Billing Procedures for ESRD services when the patient is in a SNF/NF	To keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily provide renal dialysis services to ESRD patients in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who got staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition.	X	X

Waiver/Flexibility	Summary	CR	DR
Clinical Indications for Certain Respiratory, Home Anticoagulation Management, Infusion Pump and Therapeutic Continuous Glucose Monitor national and local coverage determinations	In the interim final rule with comment period (CMS-1744-IFC and CMS-5531-IFC) we state that clinical indications of certain national and local coverage determinations wouldn't be enforced during the COVID-19 PHE. We wouldn't enforce clinical indications for respiratory, oxygen, infusion pump and continuous glucose monitor national coverage determinations and local coverage determinations.	X	
Face-to-face and In-person Requirements for national and local coverage determinations	In the interim final rule with comment period (CMS-1744-IFC) we state that to the extent a national or local coverage determination would otherwise need a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements wouldn't apply during the COVID-19 PHE.	X	
Requirement for DMEPOS Prior Authorization	We paused the requirement to send a prior authorization request for certain DMEPOS items and services. Suppliers were given the choice to voluntarily continue to send prior authorization requests or to skip prior authorization and have the claim reviewed through post payment review at a later date. Claims that would normally need prior authorization, but were submitted without going through the process should be submitted with a CR modifier.	X	
Signature requirements for proof of delivery	We waived the signature requirement for Part B drugs and certain Durable Medical Equipment (DME) that need a proof of delivery and or a patient signature. You should use a CR modifier on the claim and document in the medical record the right delivery date and that a signature couldn't be obtained because of COVID-19.	X	
Part B Prescription Drug Refills	MACs may exercise flexibilities about the payment of Medicare Part B claims for drug quantities that exceed usual supply limits, and to allow payment for larger quantities of drugs, if necessary. MACs may require the CR modifier in these cases.	X	

Waiver/Flexibility	Summary	CR	DR
Services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient.	During the COVID-19 PHE, hospitals may send clinical staff services in the patient's home as a provider-based outpatient department and bill and be paid for these services as Hospital Outpatient Department (HOPD) services when the patient is registered as a hospital outpatient. Hospitals should bill as if they provided the services in the hospital, including appending the PO modifier for excepted items and services and the PN modifier for non-excepted services. The DR condition code should also be appended to these claims.		X
Ground Ambulance Services: Treatment in Place	CMS waived the requirements that an ambulance service include the transport of an individual to the extent necessary to allow payment for ground ambulance services furnished in response to a 911 call (or the equivalent in areas without a 911 call system) in cases in which an individual would have been transported to a destination permitted under Medicare regulations but such transport did not occur as a result of community-wide emergency medical service (EMS) protocols due to the COVID-19 PHE.	X	

Medicare FFS, FAQs available on the [Waivers and Flexibilities webpage](#) apply to items and services for Medicare patients in the current emergency. We display these FAQs in these files:

- [COVID-19 FAQs](#)
- FAQs that apply [without any Section 1135](#) or other formal waiver.
- FAQs apply only [with a Section 1135](#) waiver or, when applicable, a Section 1812(f) waiver.

Blanket Waivers Issued by CMS

View the [complete list](#) of COVID-19 blanket waivers.

Counseling and COVID-19 Testing

To prevent further spread of COVID-19, a key strategy includes quarantine and isolation while patients wait for test results or after they get positive test results – regardless of showing symptoms.

Health care providers who counsel patients during their medical visits have an opportunity to decrease the time between patient-testing and quarantine or isolation, especially when this counseling happens concurrent with COVID-19 testing. Working in partnership with public health personnel, you could speed the counseling, testing, and referrals for case tracing

initiation to reduce potential exposures and added cases of COVID-19. By having patients isolated 1-2 days earlier, you can reduce the spread of COVID-19 significantly. Modeling shows early isolation can reduce transmission by up to 86 percent.

Through counseling, you can discuss with patients:

- The signs and symptoms of COVID-19
- The immediate need to separate from others by isolation or quarantine, particularly while awaiting test results
- The importance of informing close contacts of the person being tested (for example, family members) to separate from the patient awaiting test results
- If the patient tests positive, the patient will be contacted by the public health department to learn the names of the patient's close contacts. The patient should be encouraged to speak with the health department
- The services that may be available to help the patient in successfully isolating or quarantining at home

This early intervention of counseling steps and isolation can reduce spread of COVID-19.

How to Bill for Counseling Services

Medicare covers these counseling services. Health care providers providing counseling services to people with Original Medicare should use existing and applicable coding and payment policies to report services, including [evaluation and management](#) visits.

When providing these services during 2020, when you spend more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) providing counseling or coordination of care, you may use that time to select the level of visit reported.

Please review the following provider resources:

- [Provider Counseling Q&A](#)
- [Provider Counseling Talking Points](#)
- [Provider Counseling Check List](#)
- [Handout for Patients to Take Home](#)

Please also review the following information from CDC:

- [Overall COVID-19 Information](#)
- [Testing](#)
- [Symptoms](#)
- [Self-Care](#)
- [Care at Home](#)

Contact Tracing:

- [Contact Tracing webpage](#)
- [Principles Contact Tracing Booklet](#)
- [Investigation Contact Tracing](#)

Billing for Professional Telehealth Distant Site Services During the PHE

We are expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

View a [complete list](#) of services payable under the Medicare Physician Fee Schedule when provided via telehealth.

When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the PHE, bill with:

- Place of Service (POS) equal to what it would have been had the service been provided in-person
- Modifier 95, indicating that you provided the service via telehealth

As a reminder, we aren't requiring the CR modifier on telehealth services. But, consistent with current rules for telehealth services, 2 scenarios where modifiers are needed on Medicare telehealth professional claims are:

- Provided as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Provided for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims. Critical access hospital method II claims should continue to bill with modifier GT.

CMS released a video providing answers to common questions about the Medicare telehealth services benefit.

[Video](#)

Teaching Physicians and Residents: Expansion of CPT Codes that You May Bill with the GE Modifier

Teaching physicians and residents: Expansion of CPT codes that you may bill with the GE modifier under [42 CFR 415.174](#) on and after March 1, 2020, for the duration of the PHE:

- Residents providing services at primary care centers may provide an expanded set of services to patients, including levels 4-5 of an office/outpatient Evaluation and

Management (E/M) visit, telephone E/M, care management, and some communication technology-based services

- This expanded set of services are CPT codes 99204-99205, 99214-99215, 99495-99496, 99421-99423, 99452, and 99441-99443 and HCPCS codes G2010 and G2012
- Teaching physicians may send claims for these services provided by residents in the absence of a teaching physician using the GE modifier

MACs automatically reprocessed claims billed with the GE modifier on or after March 1, 2020, that were denied. You don't need to do anything.

Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Added COVID-19 Related Services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients who got COVID-19 testing-related services. These services are medical visits under the HCPCS E/M categories described below when outpatient providers, physicians, or other providers and suppliers who bill Medicare for Part B services order or administer COVID-19 lab tests regardless of the HCPCS codes they use to report the tests.

Cost-sharing doesn't apply for COVID-19 testing-related services, which are medical visits that: are provided between March 18, 2020 and the end of the PHE that result in an order for or administration of a COVID-19 test; are related to providing or administering such a test or to the evaluation of an individual for purposes of determining the need for a test; and are in any of the following categories of HCPCS E/M codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital E/M services

 Cost-sharing doesn't apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- RHCs
- FQHCs

 We provided the CS modifier for the gulf oil spill in 2010, but we recently repurposed the CS modifier for COVID-19 purposes. Now, for services provided on March 18, 2020, and through the end of the PHE, you should use the CS modifier on applicable claim lines to show the service is subject to the cost-sharing waiver for COVID-19 testing-related services. Don't charge Medicare patients any co-insurance and deductible amounts for those services.

Use these HCPCS codes for billing:

- [Health care practitioners](#)
- [Outpatient Prospective Payment System \(OPPS\)](#)
- [RHCs and FQHCs](#)
- CAHs: use OPPS codes
- Method II CAHs: use the OPPS list or the health care practitioner list, as appropriate

COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers

During the COVID-19 PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where you provide services. On an interim basis, we're expanding the list of destinations that may include but aren't limited to:

- Any location that is an alternative site determined to be part of a hospital, CAH, or SNF
- CMHCs
- FQHCs
- RHCs
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location providing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility isn't available
- Patient's home

We expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - CMHC, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location providing dialysis services and not affiliated with ESRD facility
- Modifier E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the patient's home
- Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N - Alternative care site for SNF
- Modifier P - Physician's office
- Modifier R - Patient's home

For the complete list of ambulance origin and destination claim modifiers see [Medicare Claims Processing Manual Chapter 15](#), Section 30 A.

New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

To identify and pay for specimen collection for COVID-19 testing, we provide 2 Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a home health agency, any specimen source

Note that G2024 applies to patients in a non-covered stay in a SNF and not to those residents in Medicare-covered stays (whose bundled lab tests would be covered instead under Part A's SNF benefit at Section 1861(h) of the Act).

These codes are billable by clinical diagnostic laboratories.

Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients

We instructed MACs and notified Medicare Advantage plans to cover COVID-19 laboratory tests for nursing home residents and patients. This instruction follows the CDC recent update of COVID-19 [testing guidelines for nursing homes](#) that give recommendations for testing of nursing home residents and patients with symptoms consistent with COVID-19 as well as for asymptomatic residents and patients who have been exposed to COVID like in an outbreak. Starting on July 6, 2020, and for the duration of the PHE, consistent with sections listed in the CDC guidelines titled, "Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel," original Medicare and Medicare Advantage plans cover diagnostic COVID-19 lab tests:

Diagnostic Testing

- Testing residents with signs or symptoms of COVID-19
- Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2, including close and expanded contacts (for example, an outbreak in the facility)
- Initial (baseline) testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 is part of the recommended reopening process
- Testing to determine resolution of infection

Original Medicare and Medicare Advantage Plans don't cover non-diagnostic tests.

SNF Qualifying Hospital Stay (QHS) and Benefit Period Waivers - Provider Information

CMS recognizes that disruptions arising from a PHE can affect coverage under the SNF benefit:

- Prevent a patient from having the 3-day inpatient QHS

- Disrupt the process of ending the patient's current benefit period and renewing their benefits

The emergency SNF QHS and benefit period requirements under [Section 1812\(f\)](#) of the Social Security Act help restore SNF coverage that patients affected by the emergency would be entitled to under normal circumstances. **By contrast, these emergency measures don't waive or change any other existing requirements for SNF coverage under Part A such as the SNF level of care criteria, which remain in effect under the emergency.**

Using the authority under Section 1812(f) of the Social Security Act, CMS doesn't require a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services (including SNF-level swing-bed services in rural hospitals and CAHs) without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19. **At the same time, we're monitoring for any SNF admissions under Section 1812(f) that don't meet the SNF level of care criteria (which, as noted above, remain in effect during the emergency), and we'll take appropriate administrative action in any instances that we find. See [SNF Billing Reference](#) for more information on SNF eligibility and coverage requirements.**

Also, for certain patients who recently exhausted their SNF benefits, the waiver authorizes a one-time renewal of benefits for an added 100 days of Part A SNF coverage without first having to start a new benefit period (this waiver will apply only for those patients who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

For the QHS waiver:

- All patients qualify, regardless of whether they've SNF benefit days remaining
- The patient's status of being "affected by the emergency" exists nationwide under the current PHE. (You don't need to verify individual cases.)

In contrast, for the Benefit Period Waiver:

- Patients who exhaust their SNF benefits can get a renewal of SNF benefits under the waiver *except* in one particular scenario: that is, those patients who are receiving ongoing skilled care in a SNF that is unrelated to the emergency, as discussed below. To qualify for the benefit period waiver, a patient's continued receipt of skilled care in the SNF must in some way be related to the PHE. One example would be when a patient who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube. We would also note that patients who don't themselves have a COVID-19 diagnosis may nevertheless be affected by the PHE (for example, when disruptions from the PHE cause delays in obtaining treatment for another condition).
- Wouldn't apply to those patients who are receiving ongoing skilled care in the SNF that is *unrelated to the emergency* - a scenario that would have the effect of prolonging the current benefit period and precluding a benefit period renewal even under normal circumstances. For example, if the patient has a continued skilled care need (such as a

feeding tube) that is unrelated to the COVID-19 emergency, then the patient can't renew his or her SNF benefits under the Section 1812(f) waiver as it's this continued skilled care in the SNF rather than the emergency that is preventing the patient from beginning the 60 day "wellness period."

- In making determinations, a SNF resident's ongoing skilled care is considered to be emergency-related unless it is altogether unaffected by the COVID-19 emergency itself (that is, the patient is receiving the very same course of treatment as if the emergency had never occurred). This determination basically involves comparing the course of treatment that the patient has actually gotten to what would have been provided *absent* the emergency. Unless the two are exactly the same, the provider would determine that the treatment has been affected by and related to the emergency.
- **Providers should use the above criteria in determining when to document on the claim that the patient meets the requirement for the waiver.**

In this situation, we would also ask those providers to work with their respective MACs to provide any documentation needed to prove that the COVID-19 emergency applies for the benefit period waiver under §1812(f) for each benefit period waiver claim. We also recognize that during the COVID-19 PHE, some SNF providers may haven't yet submitted the PPS assessments for the benefit period waiver. In these limited circumstances, providers may use the Health Insurance Prospective Payment System (HIPPS) code that was being billed when the patient reached the end of their SNF benefit period.

Billing Instructions

The following guidance provides specific instructions for using the QHS and benefit period waivers, as well as how this affects claims processing and SNF patient assessments.

To bill for the QHS waiver, include the DR condition code.

To bill for the benefit period waiver:

- Submit a final discharge claim on day 101 with patient status 01, discharge to home
- Readmit the patient to start the benefit period waiver

For ALL admissions under the benefit period waiver (within the same spell of illness)

- Complete a 5-day PPS Assessment. (The interrupted stay policy doesn't apply.)
- Follow all SNF Patient Driven Payment Model (PDPM) assessment rules
- Include the HIPPS code derived from the new 5-day assessment on the claim
- The variable per diem schedule begins from Day 1

For ALL SNF benefit period waiver claims, include the following (within the same spell of illness):

- Condition code DR - identifies the claims as related to the PHE
- Condition code 57 (readmission) - this will bypass edits related to the 3-day stay being within 30 days

- COVID100 in the remarks - this identifies the claim as a benefit period waiver request

Note: Providers may use the added 100 SNF benefit days at any time within the same spell of illness. Claims must contain the above coding for ALL benefit period waiver claims.

Example: If a benefit waiver claim was paid using 70 of the added SNF benefit days and the patient either was discharged or fell below a skilled level of care for 20 days, the patient may subsequently use the remaining 30 added SNF benefit days as long as the resumption of SNF care occurs within 60 days (that is, within the same spell of illness).

If you submitted a claim for a one-time benefit period waiver that rejected for exhausted benefits, take either of the following actions:

1. If you billed the discharge and readmission correctly:
 - Cancel the rejected claim to remove it from claims history. DON'T send an adjustment to the rejected claim
 - Once the cancel has completed, resubmit the first claim
 - If you send a claim without COVID100 in the remarks, we can't process it for an added 100 benefit days
2. If you didn't send a bill for a discharge on the last covered day to start a new admission with the benefit period waiver days:
 - Cancel the paid claim that includes the last covered coinsurance benefit day
 - Once the cancel is processed, resubmit as a final bill with patient status equal to 01
 - Cancel the first benefit period waiver claim that rejected for exhausted benefits. You can send this concurrently with the cancel of the paid claim
 - Once the rejected claim is cancelled, send the first bill for the benefit period waiver following the same instructions as #1 above

CAH Swing-bed providers don't have to follow 1 and 2 since they aren't paid according to the SNF PPS. They must submit separate claims for the one-time benefit period waiver claims with the DR condition code. These claims shouldn't contain both benefit period waiver days and non-benefit period waiver days.

Please note, as previously stated, ongoing skilled care in the SNF that is **unrelated** to the PHE doesn't qualify for the benefit period waiver. You must decide if the waiver applies following the criteria set forth above. If so:

- Fully document in medical records that care meets the waiver requirements. This may be subject to post payment review.
- Track benefit days used in the benefit period waiver spell and only send claims with covered days 101 – 200.

- Once the added 100 days have been exhausted, follow existing processes to continue to bill Medicare no-pay claims until you discharge the patient.
- Identify no-pay claims as relating to the benefit period waiver by using condition code DR and including “BENEFITS EXHAUST” in the remarks field. This remark is only necessary when the full extra 100 days have been exhausted.

MACs must manually process claims to pay the benefit period waiver but will make every effort to make sure of timely payment. Please allow enough time before inquiring about claims in process.

Note: You must abide by all other SNF billing guidelines. CAH Swing bed providers aren't subject to PPS and so aren't required to send assessments.

Beneficiary Notice Delivery Guidance in Light of COVID-19

If you're treating a patient with suspected or confirmed COVID-19, we encourage you to be diligent and safe while issuing the following beneficiary notices to patients receiving institutional care:

- Important Message from Medicare (IM)_CMS-10065
- Detailed Notices of Discharge (DND)_CMS-10066
- Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
- Detailed Explanation of Non-Coverage (DENC)_CMS-10124
- Medicare Outpatient Observation Notice (MOON)_CMS-10611
- Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
- Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)_CMS-10055
- Hospital Issued Notices of Non-Coverage (HINN)

Due to concerns related to COVID-19, current notice delivery instructions give flexibilities for delivering notices to patients in isolation. These procedures include:

- Hard copies of notices may be dropped off with a patient by any hospital worker able to enter a room safely. A contact phone number should be provided for a patient to ask questions about the notice, if the individual delivering the notice is unable to do so. If you can't drop off a hard copy of the notice, you can deliver notices to patients by email if the patient has access in the isolation room. Annotate the notices with the circumstances of the delivery, including the person delivering the notice, and when and where you sent the email.
- Notice delivery may be made via telephone or secure email to patient representatives who are offsite. Annotate the notices with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where you sent the email.

We encourage you to review all of the specifics of notice delivery, as in [Chapter 30 of the Medicare Claims Processing Manual](#).

More Information

See the complete list of [COVID-19 blanket waivers](#).

For more information, review the [current emergencies webpage](#).

Providers may also want to view the [Survey and Certification FAQs](#).

For more information, contact your [MAC](#).

Document History

Date of Change	Description
September 8, 2021	We revised this Article to add more information about the SNF waivers. You'll find substantive content updates in dark red font on page 13. All other information remains the same.
May 12, 2021	We revised the article to add waiver information about ground ambulance services at the end of the table on page 7. All other information remains the same.
November 9, 2020	We revised the article to clarify the billing instructions in the SNF Benefit Period Waiver - Provider Information section. All other information remains the same.
October 16, 2020	We revised the article to clarify the HCPCS codes that Critical Access Hospitals (CAHs) should use in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. Also, we clarified the Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information section to show the SNF waiver applies to swing-bed services in rural hospitals and CAHs. All other information remains the same.
August 26, 2020	We revised the article to add information about the HCPCS codes for OPPS, RHC, FQHC, and CAH billers in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. All other information remains the same.
August 20, 2020	We revised the article to add information about the HCPCS codes in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. All other information remains the same.
July 30, 2020	We revised the article to add the section, "Counseling and COVID-19 Testing." All other information remains the same.

Date of Change	Description
July 24, 2020	We revised the article to add clarifying language to the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section to show it applies to lab tests regardless of the HCPCS codes used to report those tests. All other information remains the same.
July 17, 2020	We revised the article to: - Update information on CDC nursing home patients or /residents testing - Add clarifying language to the SNF Benefit Period Waiver - Provider Information section All other information remains the same.
July 8, 2020	We revised the article to add a row at the end of the Waiver/Flexibility table (page 7) to discuss services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient. Also, we added the section on Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier. All other information remains the same.
July 1, 2020	We revised the billing instructions on page 12 of this article. Changes include instructions to readmit the patient on day 101 to start the SNF benefit period waiver. All other information remains the same.
June 26, 2020	We revised the article to add the section, "Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information" and related billing instructions. All other information remains the same.
June 19, 2020	We revised the article to add the section, "Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients." All other information remains the same.
June 1, 2020	We revised the article to add a section on Clarification for Using the "CR" Modifier and "DR" Condition Code. All other information remains the same.
April 10, 2020	Note: We revised this article to: <ul style="list-style-type: none"> • Link to all the blanket waivers related to COVID-19 • Provide place of service coding guidance for telehealth claims • Link to the Telehealth Video for COVID-19 • Add information on the waiver of coinsurance and deductibles for certain testing and related services • Add information on the expanded use of ambulance origin/destination modifiers • Provide new specimen collection codes for clinical diagnostic laboratories billing • Add guidance about delivering notices to patients. All other information is the same.

Date of Change	Description
March 20, 2020	We revised the article to add a note in the Telehealth section to cover _ modifiers on telehealth claims and to explain the DR condition code isn't needed on telehealth claims under the waiver. All other information is the same.
March 19, 2020	We corrected a typo in the article. One of the e-visit codes was incorrectly stated as 99431 and we corrected it to show 99421.
March 18, 2020	We revised this article to include information about the Telehealth waiver. All other information remains the same.
March 16, 2020	Initial article released.

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New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers during the COVID-19 PHE

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Note: We revised this article to add the 2023 payment rate for distant site telehealth services. You'll find substantive content updates in dark red (pages 2, 3, 5, and 6). All other information is the same.

Provider Types Affected

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services they provide to Medicare patients.

What You Need To Know

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and CMS have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE. We'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view the [COVID-19 FAQs on Medicare Fee-for-Service \(FFS\) Billing](#).

Background

New Payment for Telehealth Services

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). [Section 3704 of the CARES Act](#) authorizes RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Medicare telehealth services generally involves 2-way, interactive, audio and video technology that permits communication between the practitioner and patient. If you have this capability, you can now provide and get paid for telehealth services to Medicare patients for the duration of the COVID-19 PHE.

Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site [telehealth services](#) (approved by Medicare as a distant site telehealth service under the Physician Fee Schedule (PFS)) from any location, including their home, during the time that they're working for you.



The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that we develop payment rates similar to the national average payment rates for comparable telehealth services under the PFS. You must use HCPCS code G2025 (the new RHC- and FQHC-specific G code for distant site telehealth services) to bill services provided via telehealth starting on January 27, 2020, the date the [COVID-19 PHE](#) became effective.

Note that the changes in eligible originating site locations, including the patient's home, during the COVID-19 PHE are effective starting March 6, 2020.

Effective January 1, 2023, the payment rate for distant site telehealth services is \$95.88. From January 1, 2022 – December 31, 2022, the payment rate for distant site telehealth services was \$97.24. From January 1 – December 31, 2021, the payment rate for distant site telehealth services was \$99.45. For services between January 27 – December 31, 2020, your rate was set at \$92.03. These rates are the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS during the given timeframes. Because we made these changes in policy on an emergency basis, we made changes to claims processing systems in several stages.

Claims Requirements for RHCs

For telehealth distant site services provided between January 27 – June 30, 2020, report HCPCS code G2025 on your claims with the CG modifier. You may also append modifier “95” (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System), but this isn't required. We paid these claims at the RHC's all-inclusive rate (AIR), and the Medicare Administrative Contractor (MAC) automatically reprocessed these claims starting on July 1, 2020, at the \$92.03 rate. You didn't need to resubmit these claims for the payment adjustment.

Starting July 1, 2020, don't put the CG modifier on claims with HCPCS code G2025.

Table 1. RHC Claims for Telehealth Services from January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required), 95 (optional)

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Claims Requirements for FQHCs

For telehealth distant site services you provided between January 27 – June 30, 2020, that are also FQHC qualifying visits, report 3 HCPCS/CPT codes:

- The FQHC Prospective Payment System (PPS) specific payment code (G0466, G0467, G0468, G0469, or G0470)
- The HCPCS/CPT code that describes the services provided via telehealth with modifier 95

- G2025 with modifier 95

We paid these claims at the FQHC PPS rate until June 30, 2020, and the MAC automatically reprocessed these claims starting on July 1, 2020, at the \$92.03 rate. You didn't need to resubmit these claims for the payment adjustment.

When providing services via telehealth that aren't FQHC qualifying visits, you should have held these claims until July 1, 2020, and then billed them with HCPCS code G2025. You may append modifier 95, but it isn't required. (See [FQHC PPS specific payment codes](#)). Starting July 1, 2020, only submit G2025. You may append modifier 95, but it isn't required.

Table 3. Example of FQHC Claims for Telehealth Services January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G0467 (or other appropriate FQHC Specific Payment Code)	N/A
052X	99214 (or other FQHC PPS Qualifying Payment Code)	95
052X	G2025	95

Table 4. FQHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Payment Rate for 2023

Effective January 1, 2023, the payment rate for distant site telehealth services is set at \$95.88. From January 1 – December 31, 2022, your payment for distant site telehealth services was set at \$97.24.

Medicare only authorizes payment for distant site telehealth services to RHCs and FQHCs provided during the COVID-19 PHE. If the COVID-19 PHE is in effect after December 31, 2023, we'll update this rate based on the CY 2024 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

Cost Reporting

We won't use costs for providing distant site telehealth services to decide the RHC AIR or the FQHC PPS rate, but you must report these costs on the proper cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services." FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled "Other FQHC Services."

Medicare Advantage Wrap-Around

Since telehealth distant site services aren't paid under the RHC AIR or the FQHC PPS, the Medicare Advantage (MA) wrap-around payment doesn't apply to these services. MA plans will adjust wrap-around payment for distant site telehealth services.

Cost-Sharing Related to COVID-19 Testing

For services provided between March 18, 2020, and the duration of the COVID-19 PHE, we'll pay all of the reasonable costs for specified categories of evaluation and management (E/M) services if they result in an order for or administration of a COVID-19 test and relate to the supply or administration of such test or to the evaluation of an individual for purposes of deciding the need for such test. This would include applicable telehealth services. (See MLN Matters Article [SE20011](#) for more information.) For the specified E/M services related to COVID-19 testing, including when provided via telehealth, you must waive the collection of coinsurance from patients. For services in which Medicare waives the coinsurance, you must put the "CS" modifier on the service line. **We paid your claims with the "CS" modifier with the coinsurance applied, and the MAC automatically reprocessed these claims starting on July 1, 2020. Don't collect coinsurance from patients if the coinsurance is waived.**

Claims Examples

Table 5. RHC Claims for Telehealth Services from January 27 – June 30, 2020, when we waive cost sharing

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG, CS (required) 95 (optional)

Table 6. RHC Claims for Telehealth Services when we waive cost sharing starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CS (required), 95 (optional)

Table 7. FQHC Claims for Telehealth Services January 27 – June 30, 2020, when we waive cost sharing

Revenue Code	HCPCS Code	Modifiers
052X	G0467 (or other appropriate FQHC Specific Payment Code)	N/A
052X	G0446 (or other FQHC PPS Qualifying Payment Code)	CS, 95 (required)
052X	G2025	CS, 95 (required)

Table 8. FQHC Claims for Telehealth Services starting July 1, 2020, when we waive cost sharing

Revenue Code	HCPCS Code	Modifiers
052X	G205	CS (required), 95 (optional)

Other Telehealth Flexibilities

During the COVID-19 PHE, you can provide any [Medicare-approved telehealth service](#) under the PFS. Also, effective March 1, 2020, these services include CPT codes 99441, 99442, and 99443, which are audio-only telephone E/M services. You can provide and bill for these services using HCPCS code G205. To bill for these services, a physician or Medicare provider who may report E/M services must provide at least 5 minutes of telephone E/M service to an established patient, parent, or guardian. You can't bill for these services if they start from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Telehealth Services with Cost Sharing

For the CPT and HCPCS codes included in the list of telehealth codes at the link above, we'll adjust the coinsurance and payment calculation for distant site telehealth services you provided to reflect the method used to calculate coinsurance and payment under the PFS. The coinsurance for these services will be 20% of the lesser of the allowed amount (\$92.03 for 2020 claims, \$99.45 for 2021, \$97.24 for 2022 or \$95.88 for 2023 claims based on date of service) or actual charges. The payment will be 80% of the lesser of the allowed amount (\$92.03 for 2020 claims, \$99.45 for 2021 claims, \$97.24 for 2022 or \$95.88 for 2023 claims based on date of service) or the actual charges.

Before the adjustment, the coinsurance for distant site services you provided was 20% of the actual charges and the payment was the allowed amount (\$92.03 for 2020 claims, \$99.45 for 2021 claims, \$97.24 for 2022 or \$95.88 for 2023 claims based on date of service) minus the coinsurance.

MACs will automatically reprocess any claims with HCPCS code G205 for services you provided on or after January 27 – November 16, 2020, that we paid before we updated the claims processing system to pay HCPCS code G205 based on the “lesser of” methodology, as described above.

Telehealth Services with Cost Sharing Waived

The list of telehealth codes at the link above includes several CPT and HCPCS codes that describe preventive services that have waived cost sharing. As stated earlier in this Article, bill telehealth services on this list using HCPCS code G205. To distinguish those telehealth services that don't have cost sharing waived from those that do, like some preventive services, also report modifier CS. We've modified the descriptor of the CS modifier to account for this

additional use as follows:

CS – Cost sharing waived for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services provided via telehealth in RHCs and FQHCs during the COVID-19 PHE.

For preventive services provided via telehealth that have cost sharing waived, RHCs must report G2025 on claims with the CG and CS modifiers, and FQHCs must report G2025 with the CS modifier on or after July 1, 2020.

See the above-referenced claim examples for Cost-Sharing Related to COVID-19 Testing. These examples will also apply to preventive services that have cost sharing waived.

Expansion of Virtual Communication Services

Payment for virtual communication services now includes online digital E/M services. Online digital E/M services are non-face-to-face, patient-initiated, digital communications using a secure patient portal. The online digital E/M codes that are billable during the COVID-19 PHE are CPT codes:

- 99421 (5-10 minutes over a 7-day period)
- 99422 (11-20 minutes over a 7-day period)
- 99423 (21 minutes or more over a 7-day period)

To get payment for the new online digital E/M (CPT codes 99421, 99422, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), you must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for these 5 codes. We'll pay \$24.76 for claims submitted with G0071 on or after March 1 – December 31, 2020.

From January 1 – December 31, 2022, we'll pay \$23.88 for claims submitted with G0071. **Effective January 1 – December 31, 2023, we'll pay the new rate of \$23.14 for claims submitted with G0071.**

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

You can bill for visiting nursing services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to homebound individuals under a written treatment plan in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, we've found that the area typically served by the RHC, and the area included in the FQHC service area plan, have a shortage of HHAs, and this finding doesn't require a request. Check the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) before providing visiting nurse services to make sure that the patient isn't already under a home health plan of care.

Consent for Care Management and Virtual Communication Services

Medicare requires patient consent for all services, including non-face-to-face services. During the COVID-19 PHE, you may get patient consent at the same time you initially provide the services. This means that someone working under your general supervision can get patient consent. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services. The person getting consent can be an employee, independent contractor, or leased employee of the billing practitioner. (See [CMS-1744-IFC](#)).

Revision of Bed Count Methodology for Determining Provider-Based RHCs Exemption to the RHC Payment Limit

Note: [Section 132 of the Consolidated Appropriations Act, 2021](#), restructures the payment limits for all independent and provider-based RHCs starting April 1, 2021. See [CR 12185](#) and [CR 12489](#) for more information on establishing certain provider-based RHC payment limits.

Before April 1, 2021, if you're an RHC provider based to a hospital with fewer than 50 beds, you're exempt from the national per-visit payment limit for RHCs. Due to the COVID-19 PHE, some hospitals have been or are planning to increase inpatient bed capacity to address the increased need for inpatient care. If you're currently exempt from the national per-visit payment, we're working to prevent you from losing your exemption due to the COVID-19 PHE and to encourage hospitals to increase bed capacity if needed. We'll use the number of beds from the cost reporting period before the start of the COVID-19 PHE as the official hospital bed count for deciding exemption to the payment limit.

Exception to the Productivity Standards for RHCs

We use productivity standards to help decide the average cost per patient for your Medicare reimbursement. Physicians, nurse practitioners, physician assistants, and certified nurse midwives are held to a minimum number of visits per Full-Time Employee (FTE) that they're expected to provide in the RHC. Failure to meet this minimum may show that they're operating at an excessive staffing level, thus, generating excessive cost.

Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID-19 PHE. As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, your MAC may grant exceptions to the productivity standard during the COVID-19 PHE. Your MAC will provide further direction.

More Information

View the [complete list](#) of coronavirus waivers.

Review information on the [current emergencies](#) webpage.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
November 22, 2022	We revised this article to add the 2023 payment rate for distant site telehealth services. You'll find substantive content updates in dark red (pages 2,3, 5, and 6). All other information is the same.
January 13, 2022	We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6, and 7). All other information is the same.
February 23, 2021	We revised this article to provide the updated rate effective January 1, 2021, for G2025. You'll find substantive content updates in dark red font (see pages 2, 3, and 5). We also updated the rate for G0071 on page 6.
December 3, 2020	We revised this article to provide additional guidance on telehealth services that have cost-sharing and cost-sharing waived. You'll find substantive content updates (see pages 5-6). We also made other language changes for clarity, but these changes didn't change the substance of the article.
July 6, 2020	We revised this article to provide: <ul style="list-style-type: none"> - Additional guidance on telehealth services that have cost sharing waived and additional claim examples - An additional section on the RHC Productivity Standards All other information remains the same.
April 30, 2020	We revised this article to provide: <ul style="list-style-type: none"> - Additional claims submission and processing instructions - Information on cost-sharing related to COVID-19 testing - Additional information on telehealth flexibilities - Information on provider-based RHCs exemption to the RHC payment limit All other information remains the same.
April 17, 2020	Initial article released.

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Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

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Note: We revised this Article to show a delay in certain in-person visit requirements. This change is in dark red font on page 2. All other information is the same.

Provider Types Affected

This MLN Matters Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about these changes:

- Regulatory changes for mental health visits in RHCs & FQHCs
- Billing information for mental health visits done via telecommunications

Coding Requirements

CMS finalized regulatory language for mental health visits in RHCs and FQHCs in the [CY 2022 Physician Fee Schedule \(PFS\) final rule](#). Effective January 1, 2022, you may provide mental health visits using interactive, real-time telecommunications technology.

RHCs and FQHCs can provide telecommunications for mental health visits using audio-video technology and audio-only technology. You may use audio-only technology in situations when your patient can't access or doesn't consent to use audio-video technology. You can report and get paid in the same way as in-person visits.

Audio-video visits: Use modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System).

Audio-only visits: Use new service-level modifier FQ.

These visits are different from telehealth services provided during the COVID-19 Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See [MLN Matters Article SE20016](#) for information on billing G2025 for professional telehealth distant site services other than mental health visits during the COVID-19 PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

FQHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	G0470 (or other appropriate FQHC Specific Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only)
0900	90834 (or other FQHC PPS Qualifying Mental Health Visit Payment Code)	N/A

In-Person Mental Health Visit Requirements

These in-person visit requirements apply only to a patient getting mental health visits via telecommunications at home:

- There must be an in-person mental health visit 6 months before the telecommunications visit
- In general, there must be an in-person mental health visit at least every 12 months while the patient is getting services from you via telecommunications to diagnose, evaluate, or treat mental health disorders

NOTE: [Section 304 of the Consolidated Appropriations Act \(CAA\), 2022](#), delayed the in-person visit requirements under Medicare for mental health visits that RHCs and FQHCs provide via telecommunications technology. For RHCs and FQHCs, in-person visits won't be required until the 152nd day after the end of the COVID-19 PHE.

Exceptions

We'll allow for limited exceptions to the requirement for an in-person visit every 12 months based on patient circumstances in which the risks and burdens of an in-person visit may outweigh the benefit. These include, but aren't limited to, when:

- An in-person visit is likely to cause disruption in service delivery or has the potential to worsen the patient's condition
- The patient getting services is in partial or full remission and only needs maintenance level care
- The clinician's professional judgment says that the patient is clinically stable and that an in-person visit has the risk of worsening the patient's condition, creating undue hardship on self or family
- The patient is at risk of withdrawing from care that's been effective in managing the illness

With proper documentation, the in-person visit requirement isn't applicable for that 12-month period. You must document the circumstance in the patient's medical record.

More Information

Read [Rural Health Clinic](#) and [Federally Qualified Health Center](#) booklets.

Visit [RHC Center](#) and [FQHC Center](#) webpages.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
June 6, 2022	We revised this Article to show a delay in certain in-person visit requirements. This change is in dark red font on page 2. All other information is the same.
May 5, 2022	We revised this Article to show that RHCs must include modifier CG on claims for mental health visits via telecommunications. This change is in dark red font on page 2. All other information is the same.
March 30, 2022	Initial article released.

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Health Center Program Compliance Manual

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Chapter 9: Sliding Fee Discount Program

Note: This chapter contains revisions based on a technical correction. [View the revisions.](#)

Authority

Section 330(k)(3)(G) of the PHS Act; 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u)

Requirements

- The health center must operate in a manner such that no patient shall be denied service due to an individual's inability to pay.¹
- The health center must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)] to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.
- The health center must establish systems for [sliding fee] eligibility determination.
- The health center's schedule of discounts must provide for:
 - A full discount to individuals and families with annual incomes at or below those set forth in the most recent [Federal Poverty Guidelines \(FPG\)](#) [100 percent of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
 - No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200 percent of the FPG].

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

¹ See Chapter 16: [Billing and Collections](#) for more information on waiving or reducing charges due to a patient's inability to pay.

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- a. The health center has a sliding fee discount program² that applies to all [required](#) and [additional health services](#)³ within the HRSA-approved [scope of project](#) for which there are distinct fees.⁴
- b. The health center has board-approved policy(ies) for its sliding fee discount program that apply uniformly to all patients and address the following areas:
 - Definitions of income⁵ and family;
 - Assessment of all patients for sliding fee discount eligibility based only on income and family size, including methods for making such assessments;
 - The manner in which the health center’s sliding fee discount schedule(s) (SFDS(s)) will be structured in order to ensure that patient charges are adjusted based on ability to pay; and
 - *Only applicable to health centers that choose to have a nominal charge for patients at or below 100 percent of the FPG:* The setting of a flat nominal charge(s) at a level that would be nominal from the perspective of the patient (for example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes) and would not reflect the actual cost of the service being provided.⁶
- c. For services provided directly by the health center ([Form 5A: Services Provided](#), Column I), the health center’s SFDS(s) is structured consistent with its policy and provides discounts as follows:
 - A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
 - Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and

² A health center’s sliding fee discount program consists of the schedule of discounts that is applied to the fee schedule and adjusts fees based on the patient’s ability to pay. A health center’s sliding fee discount program also includes the related policies and procedures for determining sliding fee eligibility and applying sliding fee discounts.

³ See Chapter 4: [Required and Additional Health Services](#) for more information on requirements for services within the scope of the project.

⁴ A distinct fee is a fee for a specific service or set of services, which is typically billed for separately within the local health care market.

⁵ Income is defined as earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings.

⁶ Nominal charges are not “minimum fees,” “minimum charges,” or “co-pays.”

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those discounts adjust based on gradations in income levels and include at least three discount pay classes.⁷

- No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.⁸
- d. For health centers that choose to have more than one SFDS, these SFDSs would be based on services (for example, having separate SFDSs for broad service types, such as medical and dental, or distinct subcategories of service types, such as preventive dental and additional dental services) and/or on service delivery methods (for example, having separate SFDSs for services provided directly by the health center and for in-scope services provided via formal written [contract](#)) and no other factors.
 - e. The health center's SFDS(s) has incorporated the most recent FPG.
 - f. The health center has operating procedures for assessing/re-assessing all patients for income and family size consistent with board-approved sliding fee discount program policies.
 - g. The health center has records of assessing/re-assessing patient income and family size except in situations where a patient has declined or refused to provide such information.
 - h. The health center has mechanisms for informing patients of the availability of sliding fee discounts (for example, distributing materials in language(s) and literacy levels appropriate for the patient population, including information in the intake process, publishing information on the health center's website).
 - i. For in-scope services provided via contracts (Form 5A: Services Provided, Column II, Formal Written Contract/Agreement), the health center ensures that fees for such services are discounted as follows:
 - A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
 - Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.

⁷ For example, a SFDS with discount pay classes of 101 percent to 125 percent of the FPG, 126 percent to 150 percent of the FPG, 151 percent to 175 percent of the FPG, 176 percent to 200 percent of the FPG, and over 200 percent of the FPG would have four discount pay classes between 101 percent and 200 percent of the FPG.

⁸ See Chapter 16: [Billing and Collections](#), if the health center has access to other grants or subsidies that support patient care.

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- No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.
- j. For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center ensures that fees for such services are either discounted as described in element “c.” above or discounted in a manner such that:
- Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if the health center’s SFDS were applied to the referral provider’s fee schedule; and
 - Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.
- k. Health center patients who are eligible for sliding fee discounts and have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class.⁹ Such discounts are subject to potential legal and contractual restrictions.¹⁰
- l. The health center evaluates, at least once every three years, its sliding fee discount program. At a minimum, the health center:
- Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100 percent of the FPG, are accessing health center services;
 - Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
 - Identifies and implements changes as needed.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

⁹ For example, an insured patient receives a health center service for which the health center has established a fee of \$80, per its fee schedule. Based on the patient’s insurance plan, the co-pay would be \$60 for this service. The health center also has determined, through an assessment of income and family size, that the patient’s income is 150 percent of the FPG and thus qualifies for the health center’s SFDS. Under the SFDS, a patient with an income at 150 percent of the FPG would receive a 50 percent discount of the \$80 fee, resulting in a charge of \$40 for this service. Rather than the \$60 co-pay, the health center would charge the patient no more than \$40 out-of-pocket, consistent with its SFDS, as long as this is not precluded or prohibited by the applicable insurance contract.

¹⁰ Such limitations may be specified by applicable Federal or state programs, or private payor contracts.

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- The health center determines whether to establish a nominal charge for individuals and families at or below 100 percent of the FPG.
- The health center determines how to document income and family size in health center records.
- The health center determines whether to take into consideration the characteristics of its patient population when developing definitions for income and family size and procedures for assessing patient eligibility for SFDS. For example, the health center may consider the availability of income documentation for [individuals experiencing homelessness](#), build in cost of living considerations when calculating income, permit self-declaration of income and family size.
- The health center determines how and with what frequency to re-assess patient eligibility for the SFDS.
- The health center determines whether to identify individuals who refuse to provide information on income and family size as ineligible for SFDS.
- The health center determines how to make patients aware of sliding fee discounts (for example, signage, registration process).
- The health center determines:
 - Whether to establish more than three discount pay classes above 100 percent of the FPG and up to and including 200 percent of the FPG;
 - What income range to establish for each discount pay class above 100 percent of the FPG and up to and including 200 percent of the FPG;
 - What method to use for discounting fees above 100 percent of the FPG and up to and including 200 percent of the FPG (for example, percentage of fee, fixed/flat fee per discount pay class); and
 - Whether to establish multiple SFDSs (for example, separate SFDSs for medical services and dental services) including, if appropriate, different nominal charges for each SFDS.

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