



Medicare Critical Access Hospital Astria Health Custom Version

KEY CONCEPTS OUTLINE Module 12: General Billing Requirements for Rural Health Clinic Services

I. General Billing Guidelines

A. Qualifying Visit in an RHC

1. A qualifying visit is a medically necessary face-to-face medical or mental health visit, or a covered preventive health visit between the patient and a qualified RHC practitioner, such as a physician, NP, PA, CNM, CP or a CSW during which one or more RHC services are rendered. <42 C.F.R. 405.2463; see *Medicare Benefit Policy Manual*, Chapter 13 § 40; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.1, 20.1>
 - a. In certain circumstances, other “incident to” services may be provided that do not require a face-to-face visit with a practitioner (discussed later in this module).
 - b. In certain circumstances, multiple medically necessary visits with an RHC practitioner on the same day may be billed separately (discussed later in this module).
 - c. Certain preventive services may be provided in an RHC. However, if the preventive service has a technical component, it must be billed separately (discussed later in this module).
 - d. In most cases, telephone or electronic communication between the RHC practitioner and the patient or someone acting on behalf of the patient are covered services that are considered to be part of a face-to-face qualifying visit and may not be billed separately. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 110, 130, 150>
 - e. Treatment plans and home care oversight are considered to be part of a face-to-face qualifying visit and may not be billed separately. <See *Medicare Benefit Policy Manual*, Chapter 13 § 110.2>

- f. A qualifying mental health visit is typically a psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis between the patient and a clinic practitioner such as a CP or CSW. Beginning January 1, 2022, the face-to-face encounter furnished via interactive, real-time audio and video telecommunications technology to diagnosis, evaluation, and treatment of a mental health disorder. <See *Medicare Benefit Policy Manual*, Chapter 13 § 170; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.1, 20.1>
- i. If the patient does not have the capability or does not consent to the use of two-way interactive audio-video technology, audio-only technology may be used.
- ii. Medication management or a psychotherapy add-on service is not a separately billable service in an RHC when provided during a qualifying visit. The payment for these services is included in the qualifying visit.
- ii. When a medical visit with an RHC practitioner is furnished on the same day that medication management or a psychotherapy add-on service is furnished by the same or a different practitioner, only one payment is made for the qualifying visit reported with revenue code 052X.

Group mental health services do not meet the criteria for a face-to-face visit in an RHC.

2. Exceptions for billable non-face-to-face services

- a. Care management services encompass structured ongoing coordination of care between an RHC practitioner, staff, the patient, and their caregivers. These services are discussed in detail later in this module.
 - i. Transitional Care Management (TCM) services include direct contact, telephone communication, or electronic communication with the patient or caregiver. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.1>
 - ii. General Care Management (GCM) (e.g., Chronic Care Management (CCM), Principal Care Management (PCM), Chronic Pain Management (CPM), and General Behavioral Health Integration (BHI)) services include care coordination for patients with multiple chronic conditions, a long-term single high-risk condition, or a mental/behavioral health condition using certified EHR or other electronic technology. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2>

- iii. Psychiatric Collaborative Care Model (CoCM) services include primary healthcare services with care management team support for patients receiving behavioral health treatment. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
- iv. Virtual communication services include certain RHC communications-based technology and remote evaluation services. Face-to-face requirements are waived when these services are furnished in an RHC. <See *Medicare Benefit Policy Manual*, Chapter 13 § 240>

B. Qualifying Visit in a Non-RHC Location

1. A qualifying visit with a practitioner may take place in locations other than in the RHC, including:
 - a. A Medicare-covered SNF;
 - b. The scene of an accident;
 - c. The patient's residence, including an assisted living facility; or
 - d. The patient's location during a Hospice election, including a patient's residence or a Medicare certified facility. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.1>

Under certain circumstances, a qualifying visit may include a visit by a registered nurse (RN) or licensed practical nurse (LPN) to a patient confined to home (discussed later in this module).

2. Services provided to a patient in a location other than in the RHC are covered services, if the practitioner is compensated by the RHC for the services and the cost is included on the clinic's cost report. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.1>

Services provided in locations other than the clinic may be subject to review by the MAC.

3. A qualifying visit may not take place in:
 - a. Any type of hospital setting (inpatient, outpatient, or emergency department);

- b. A facility that has specific requirements that preclude RHC visits such as Medicare comprehensive outpatient rehabilitation facility or a hospice facility. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.1>

(ii) Hospice facility exception

- (a) Services may be considered a qualifying visit when the RHC is furnishing hospice attending services during a hospice election.

II. Overview of the UB-04 Claim Form

General billing and claims processing information can be found in the Medicare Claims Processing Manual, Chapter 1. General admission and registration requirements for all claims can be found in the Medicare Claims Processing Manual, Chapter 2.

- A. An RHC submits a claim for its professional services on the UB-04 Form/837I Electronic Format. <See *Medicare Claims Processing Manual*, Chapter 9 § 50; *Medicare Billing: 837I and Form CMS-1450* Fact Sheet>

The NUBC manual, which contains the official code descriptions for fields on the UB-04, can be obtained by subscribing to the current version of the manual on the NUBC website: www.nubc.org.

CMS has also instructed providers to obtain the field code descriptions from the local Medicare Administrative Contractor (MAC).

- 1. In certain circumstances, non-RHC services provided by an independent practitioner are submitted to the Part B MAC on Form CMS-1500/837P (discussed later).

General billing and claims processing information for professional services can be found in the Medicare Claims Processing Manual, Chapter 12.

III. Completion of Key Fields on the UB-04 Claim Form

- A. The following information addresses key fields that are required on the RHC claim. See the *Medicare Claims Processing Manual*, Chapter 9 § 50 for details about other fields that are not discussed in this section.

Handout 20 provides an example of the UB-04 claim form and the 1500 claim form.

Handout 21 is Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs), Revised 10-14-16

B. Type of Bill (TOB)

1. An RHC reports their services on TOB 071X. <Medicare Claims Processing Manual, Chapter 25, §75.1 (FL 4)>
2. The TOB is a four-digit alphanumeric code that gives three specific pieces of information.
 - a. The first digit is always a leading zero and is ignored by CMS.
 - b. The second digit identifies the type of facility.
 - i. 7 – Special facility (clinic)
 - c. The third digit identifies the type of care.
 - i. 1 – Rural Health Clinic
 - d. The fourth digit identifies the bill sequence or frequency.

The most commonly used TOBs in an RHC:

- 0710 = non-payment/zero claim that contains only non-covered charges (when no payment from Medicare is anticipated)
- 0711 = admit through discharge (original claim)
- 0717 = replacement of a prior claim (used to correct a previously submitted claim)
- 0718 = void prior claim (used to cancel a previously processed claim)

C. From/Through Dates

1. RHC claims cannot overlap calendar years. Services must be billed in the same calendar year for the application of the annual Part B deductible and coinsurance. <See Medicare Claims Processing Manual, Chapter 9 § 100>

D. Revenue Codes

1. Revenue codes indicate the appropriate revenue center for each charge included on the bill for cost/charge-based payment purposes and for cost report reconciliation.

2. In most circumstances, all charges for the services that are eligible for an all-inclusive rate (AIR) payment are bundled into one line item using a revenue code from 052X Free Standing Clinic or 0900 Mental Health Treatment. <See *Medicare One Time Notification Transmittal 1637*; see Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs), revised October 14, 2016>
 - a. Other medically necessary services should be reported with the most appropriate revenue code that describes the service being performed (e.g., 0300 venipuncture, 0730 EKG).
 - i. The additional revenue lines with detailed HCPCS code(s) and charges are informational only. <See *Medicare Claims Processing Manual*, Chapter 9 § 60.1>

A qualifying visit is reported under one of the following revenue codes:

- 0521 = Clinic visit by member to an RHC
- 0522 = Home visit by an RHC practitioner
- 0524 = Visit by an RHC practitioner to a member in a SNF or skilled swing bed in a covered Part A SNF stay <Official UB-04 Data Specifications Manual>
- 0525 = Visit by an RHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF or other residential facility
- 0527 = RHC visiting nurse service to a member's home when in a home health shortage area
- 0528 = Visit by an RHC practitioner to other non-RHC site (i.e., scene of accident)
- 0900 = Mental health treatment/services

The following revenue codes are excluded from reporting on an RHC claim:

- 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x
- **NOTE:** Revenue codes 96X, 97X, and 98X are used for reporting professional services on a critical access hospital type of bill 085X and may not be used on an RHC claim.

E. HCPCS Codes

1. An RHC is required to report the appropriate HCPCS code for a qualifying visit. <See *One Time Notification Transmittal 1637*>
 - a. Although an appropriate revenue code and HCPCS code, if applicable, are required for each item or service provided during or incident to a qualifying visit, only the line reported with a qualifying visit HCPCS code is eligible for payment under the AIR (discussed in a later module).

Calculation of the deductible and coinsurance will be applied to the qualifying visit line only.

F. Modifiers

1. Reporting modifier -25 or -59
 - a. When appropriate, modifier -25 or -59 may be reported with a subsequent qualifying visit HCPCS code when multiple medical visits occur on the same date of service (discussed in detail later in this module).
2. Reporting modifier -CG (policy criteria applied)
 - a. Modifier -CG is required to identify the qualifying visit reported with revenue code 052x and/or 0900 that may be eligible for an AIR payment. <See Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs), revised October 14, 2016; see *MLN Matters SE1611*, revised June 6, 2019>

The qualifying visit HCPCS code reported with modifier -CG includes the total charge for the visit and other medically necessary items or services subject to cost sharing. The line reported with modifier -CG will be subject to application of the deductible and coinsurance, except for certain preventive

- b. Modifier -CG is only reported once per date of service for a medically necessary medical visit or preventive service reported with revenue code 052X and/or once per date of service for a medically necessary mental health visit reported with revenue code 0900. <See Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs), revised October 14, 2016>
 - i. Exception for reporting modifier -CG with a preventive service

- a) Modifier -CG should not be reported with the Initial Preventive Physical Examination (IPPE) HCPCS code, whether it is billed alone or with other payable services on the same claim (discussed in detail later in this module).
 - c. Each additional item or service furnished incident to the qualifying visit should be reported on a separate line with the appropriate revenue code, HCPCS code without modifier -CG and charges equal to or greater than \$0.01.
 - i. The additional lines of medically necessary items or services are for informational purposes only and will not receive a separate AIR.
3. Reporting modifier -CS for COVID-19 testing-related services
- a. CMS had previously designated modifier -CS for the gulf oil spill in 2010. CMS has since repurposed the modifier for the COVID-19 PHE. <MLN Matters Article SE20011, revised September 8, 2021>
 - b. For services furnished on March 18, 2020 and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use modifier -CS on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services. <MLN Matters Article SE20011, revised September 8, 2021>
 - i. Modifier -CS should be reported on applicable claim lines whether the testing-related services are performed face-to-face or via telehealth, which will be discussed later in this module. <MLN Matters Article SE20016, revised January 13, 2022>
 - c. Medicare deductible and/or coinsurance for COVID-19 testing related services are waived for medical visits that result in the ordering of a test for COVID-19. <MLN Matters Article SE20011, revised September 8, 2021; Families First Coronavirus Response Act, Section 6002>
 - d. When the following four requirements for waiver of deductible and/or coinsurance are met, the COVID-19 testing related visit service is billed with modifier -CS and facilities should not charge the patient for any deductible and/or coinsurance amount. <MLN Matters Article SE20011, revised September 8, 2021; IOCE Specifications (v21.2), Section 5.1.3>
 - i. A specified visit service:
 - a) Visit (E/M service);

- b) Critical care (99291); or
- c) Hospital COVID-19 specimen collection (C9803¹). <IOCE Specifications v21.2; Section 5.1.3>
- ii. The visit is provided on March 18, 2020 through the end of the COVID-19 PHE. <MLN Matters Article SE20011, revised September 8, 2021>
- iii. The visit results in an order for or administration of a COVID-19 test. <MLN Matters Article SE20011; Families First Coronavirus Response Act, Section 6002>

Note: The MLN Matters Special Edition explaining this provision only mentions the laboratory tests U0001, U0002, and 87635. Subsequent to its original publishing, additional COVID-19 laboratory testing codes were adopted, including U0003 and U0004 for high throughput tests; and 86769 and 86328 for antibody testing. Presumably, the deductible and/or coinsurance waiver also applies when the visit results in the ordering of one of these additional test codes as well. Providers should confirm application of the waiver to these additional codes with their MAC.

- iv. The visit relates to the furnishing or administration of the COVID-19 test or to the evaluation of an individual for determining the need for the COVID 19- test. <MLN Matters Article SE20011, revised September 8, 2021; Families First Coronavirus Response Act, Section 6002>

Note: Providers, including RHCs, should refer to SE20011, revised September 8, 2021, for applicable links to a listing of current HCPCS codes that support the reporting of modifier –CS, resulting in the waiver of otherwise applicable cost sharing amounts. Attaching modifier—CS to ineligible codes will trigger IOCE edit 114, resulting in a disposition of

4. Reporting modifier -CS for certain preventive services

¹ Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2)(coronavirus disease [COVID-19], any specimen source

- a. For covered preventive services provided via telehealth on or after July 1, 2020, that have cost sharing waived, RHCs must report the RHC telehealth code (G2025) with the -CS, as well as the -CG, modifier attached. The rules for billing and payment of RHC telehealth services will be discussed in detail later in this module. <MLN Matters Article SE20016, revised January 13, 2022>

G. Service Units

1. The service unit represents a single visit for which a separate AIR is paid, regardless of whether other services are provided during the same visit or on the same date of service (e.g., a qualifying visit and an injection incident to the visit). <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.3; see *Medicare Claims Processing Manual*, Chapter 9, §§ 20.1, 50>
 - a. In general, multiple visits with more than one RHC practitioner on the same day, or multiple encounters with the same practitioner on the same day, constitute a single visit and are only payable as one qualifying visit.
 - b. Unless an exception is met (discussed in detail later), 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 to the subsequent visit.

H. Total Charges

1. The total charge for the qualifying visit and all items or services provided incident to the visit subject to coinsurance and deductibles are reported on the qualifying visit line. <See One Time Notification Transmittal 1637>
 - a. Each additional line must include a charge; however, the payment for the additional lines is packaged/bundled into the AIR.
 - b. CMS will accept additional service lines reported with charges equal to or greater than \$0.01 up to the actual charge. <See
 - c. Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked

The “total line (0001 revenue code)” is the sum of all charges reported on the claim which includes the charges for the qualifying visit and the additional service lines. The AIR payment is only based on the qualifying visit and the total line (0001 revenue code) is not adjudicated.

Questions (FAQs) revised October 14, 2016; see *MLN Matters SE1611*>

IV. Integrated Outpatient Code Editor (IOCE)

A. Purpose of the IOCE

1. The IOCE is software used by the Fiscal Intermediary Shared System (FISS) to edit outpatient claims and return a series of edit flags. <See *Integrated OCE (IOCE) CMS Specifications: 3 Introduction to the IOCE*>
 - a. CMS publishes an *IOCE Specifications* document containing descriptions of the edits and logic included in the IOCE.

Link: [OCE Specifications under Medicare-Related Sites - Hospital](#)

- b. Handout 22 includes applicable excerpts for RHCs from the current version of the IOCE.

B. Applicability to RHC Claims

1. All institutional outpatient Part B claims are processed through the IOCE, including certain non-OPPS providers, such as RHCs and FQHCs. <See *Integrated OCE (IOCE) CMS Specifications: 4 Processing that Applies to Both OPPS and Non-OPPS Claims*>
2. In general, the edits are driven by the ICD-10-CM diagnosis codes, the HCPCS codes, and any modifiers reported on the claim. <See *Integrated OCE (IOCE) CMS Specifications: 3 Introduction to the IOCE*>
 - a. The *IOCE Specifications* sometimes answer billing/coding questions that are not clearly answered anywhere else.
3. IOCE edits specific for RHCs
 - a. Edit 72 will be bypassed when certain HCPCS codes with status indicator (SI) M that are not billable to the MAC are usually line item rejected. <See *Integrated OCE (IOCE) CMS Specifications: 5.23 Rural Health Clinic Processing*>

- i. For the list of HCPCS codes applicable to the edit 72 bypass condition, see the HCPCS Table within the quarterly data files.

Link: OCE Specifications under Medicare-Related Sites – Hospital

- Open the appropriate IOCE Quarterly Data File based on date of service.
- Open DATA TABLE REPORTS file.
- Open the DATA_HCPCS file and reference column BYPASS_E72_FQHC_RHC.

- b. Edit 91 will be triggered when non-covered services from the Federally Qualified Health Center (FQHC) list is applied to RHC claims with bill type 71x. The line will be rejected. <See *Integrated OCE (IOCE) CMS Specifications: 5.23 Rural Health Clinic Processing*>
- c. Edit 104 will be triggered when certain services are deemed incorrectly reported with modifier -CG. The line will be rejected as not being included in the RHC all-inclusive rate. <See *Integrated OCE (IOCE) CMS Specifications: 5.23 Rural Health Clinic Processing*>

Link: OCE Specifications under Medicare-Related Sites – Hospital

- Open the appropriate IOCE Quarterly Data File based on date of service.
- Open DATA TABLE REPORTS file.
- Open Map_Conflict_RHC file.

V. General Billing Requirements for Qualifying Visits, Preventive Services, and Other Special Services

A. Qualifying Visit

1. Prior to January 1, 2017, CMS provided a Qualifying Visit List (QVL) that included frequently reported HCPCS codes for a face-to-face visit between the patient and an RHC practitioner.
 - a. The list was last updated on August 1, 2016, and was not intended to be a complete list of stand-alone billable visits in an RHC.

- b. A HCPCS code that is not on the QVL can be billed as a stand-alone billable visit if the service meets Medicare coverage requirements, is within the scope of the RHC benefit, and is not being furnished solely as incident to a practitioner's service.

Caution: Reporting of a HCPCS code as a qualifying visit does not guarantee payment of the service. All coverage requirements for an RHC visit must be met and the visit must be furnished in accordance with the applicable RHC regulations. IOCE edit 104 will be triggered if the HCPCS code reported with the –CG modifier is not recognized as a qualifying visit, resulting in a line-item rejection.

2. As noted earlier, a qualifying visit is typically a medically necessary one-on-one face-to-face medical or mental health visit, or a covered preventive health visit between the patient and a qualified RHC practitioner, such as a physician, NP, PA, CNM, CP or a CSW during which one or more RHC services are rendered. <42 C.F.R. 405.2463; see *Medicare Benefit Policy Manual*, Chapter 13 § 40; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.1, 20.1>
 - a. A qualifying medical visit includes medically necessary evaluation and management (E/M) services or certain covered preventive services and is reported with revenue code 052X. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40; 42 C.F.R. § 405.2463>
 - b. A qualifying mental health visit is typically a psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis between the patient and a clinic practitioner such as a CP or CSW and is reported with revenue code 0900. <See *Medicare Benefit Policy Manual*, Chapter 13 § 170; see *Medicare Claims Processing Manual*, Chapter 9 §§ 10.1, 20.1>
 - c. In general, multiple visits with more than one RHC practitioner on the same day, or multiple encounters with the same practitioner on the same day, constitute a single visit and are only payable as one qualifying visit, subject to certain exceptions discussed in more detail below.
3. In the following circumstances CMS permits RHCs to bill for multiple qualifying visits on the same date of service, for which each will be paid a separate AIR. <See Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs) revised October 14, 2016; see *Medicare Benefit Policy Manual*, Chapter 13 § 40.3; see *MLN Matters SE1611*>
 - a. After the first qualifying visit, the patient suffers an illness or injury that requires additional medically necessary treatment on the same day.

- i. Modifier –CG should be reported on the initial qualifying visit HCPCS code
 - ii. An RHC can report either modifier -25 or modifier -59 on the subsequent qualifying visit HCPCS code, but Modifier -CG should not be reported in addition to modifier -25 or modifier -59.
 - a) This is the only circumstance in which either of these modifiers should be used.
 - iii. Both qualifying visits will be paid a separate AIR.
- b. The patient has a medically necessary medical visit reported under revenue code 052X on the same day as a medically necessary mental health visit reported under revenue code 0900.
- i. Modifier -CG should be reported on both qualifying visit lines.
 - a) Modifier -25 or modifier -59 are not reported on either line in this scenario.
 - ii. Both qualifying visits will be paid a separate AIR.
- c. The patient has an IPPE and a separate medically necessary medical visit reported under revenue code 052X and/or medically necessary mental health visit reported under revenue code 0900 on the same day.
- i. When an IPPE is furnished with another medically necessary face-to-face visit, modifier -CG is only reported with the HCPCS code for the qualifying visit reported under revenue code 052X and/or 0900.
 - a) Modifier -CG should not be reported with the IPPE HCPCS code, whether it is billed alone or with other services on the same claim.
 - b) Modifier -25 or modifier -59 are not reported on any line in this scenario.
 - ii. Each qualifying visit and the IPPE will be paid a separate AIR.

Case Study 1

Facts: An established patient presents to the RHC at 8:30 a.m. for her scheduled IPPE (G0402) with her usual NP. During the exam, the patient complains of being short of breath and having a non-productive cough. The NP documents all elements of the IPPE and a Level 3 qualifying visit (99213) to evaluate the respiratory symptoms. The NP also gives the patient a breathing treatment (94640). The patient is also scheduled to see the CSW later that morning for an evaluation of a mental health condition (90792) with medication management (90785).

Charges for the services include:

- IPPE (G0402) \$175
- Medical visit (99213) \$160
- Breathing treatment (94640) \$40
- Mental health visit (90792/90785) \$150

- How would these services be reported to Medicare?
- Will the patient be responsible for deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Rev Code	HCP/CS/Mod	Charge	Deduct/Coins Yes/No?	AIR Yes/No?

Modified Facts: The patient leaves the RHC after the scheduled visits with the NP and CSW. Later that same day, the patient slips on the stairs in her home and twists her ankle. The patient returns to the RHC at 4:00 p.m. and is seen by the same NP who wraps the ankle and documents a Level 2 qualifying visit (99212).

Charge for the second visit:

- Medical visit (99212) \$100

- How would all of the services be reported to Medicare for the same date of service?
- Will the patient be responsible for any deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Rev Code	HCP/CS/Mod	Charge	Deduct/Coins Yes/No?	AIR Yes/No?

B. Preventive Services

1. An RHC is paid for the professional component of a preventive service, when all the conditions of coverage are met, and frequency limits have not been exceeded. <See *Medicare Benefit Policy Manual*, Chapter 13 § 220; see *Medicare Claims Processing Manual*, Chapter 9 § 70>
 - a. Under the Affordable Care Act and where applicable, the patient's deductible and/or coinsurance are waived for the IPPE and AWW, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B. <*Medicare Claims Processing Manual*, Chapter 18 § 1.2>
 - b. Handout 23 CMS Rural Health Clinic (RHC) Preventive Services Chart, revised August 10, 2016, provides a table of preventive services indicating if the deductible and/or coinsurance are waived. The table also identifies if the preventive service is eligible for an AIR payment when performed incident to a qualifying visit or as a stand-alone visit.

Link: Rural Health Clinics Center under the Medicare Related Sites – Rural Health

- c. A complete list of covered preventive services, including coding and billing requirements and statutorily waived deductible and coinsurance amounts, can be found in the *Medicare Claims Processing Manual*, Chapter 18.
- d. Other helpful resources for the coverage and billing of preventive services can be found in the MLN catalog found on the CMS MLN Publications website.

Link: MLN Publications under the Medicare Related Sites – General
Select the MLN Catalog button in the center of the page

C. Billing for a Preventive Service Only

1. When a preventive service is the sole reason for the qualifying visit, the service can be billed as a stand-alone visit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 220.1>
 - a. When all coverage requirements have been met and the frequency limits have not been exceeded, the preventive service will be paid an AIR. Where applicable, the deductible and coinsurance will be waived. <See *Medicare Benefit Policy Manual*, Chapter 13 § 220.1; see *Medicare Claims Processing Manual*, Chapter 9 § 70.1>

- b. In most circumstances, if the preventive service is the only service furnished during the qualifying visit, the RHC should report modifier -CG with the preventive HCPCS code that represents the primary reason for the visit. <See Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs), revised October 14, 2016>

2. Initial Preventive Physical Exam (IPPE)

- a. Medicare will cover one IPPE for a new beneficiary within the first 12 months of eligibility. <Medicare Claims Processing Manual, Chapter 18 § 80>
- b. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day or it can be furnished on the same day as another medical visit and/or mental health visit. <See Medicare Benefit Policy Manual, Chapter 13 §§ 220.1, 220.2; see Medicare Claims Processing Manual, Chapter 9, § 70.6; Medicare One Time Notification Transmittal 1434>
 - i. The IPPE must be billed on a separate line from any other qualifying visit using revenue code 052X, HCPCS code G0402, and the appropriate charge.
 - ii. Modifier -CG should not be reported with the IPPE HCPCS code whether it is billed alone or with other separately payable services on the claim. <See Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs) revised October 14, 2016>
 - iii. The patient's deductible and coinsurance will be waived for the IPPE, whether it is performed as the only service that day or performed in conjunction with another medical and/or mental health visit.
- c. When an EKG is performed in conjunction with the IPPE, the professional component of the diagnostic test is part of the qualifying visit. <See Medicare Claims Processing Manual, Chapter 9, § 70.6; see Medicare Claims Processing Manual, Chapter 18, § 80>
 - i. However, the technical component of the EKG is a non-RHC service and cannot be billed on TOB 071X.
 - a) If an EKG is performed in conjunction with the IPPE at an independent RHC, the practitioner who performs the service may bill the A/B MAC for the technical component on the 1500 claim form.

- b) If an EKG is performed in conjunction with the IPPE at a provider-based RHC, the technical component may be billed to the A/B MAC by the main provider on their usual outpatient bill type (i.e., TOB 0851 CAH or 0131 OPPS).

Case Study 2

Facts: A patient presents to a provider-based RHC that is owned by a CAH. The patient is scheduled for an IPPE under his Medicare benefit. In conjunction with the IPPE, the physician performs an EKG and documents the interpretation in the patient's record. The RHC nurse draws blood for a cardiovascular blood screening test that will be performed by the CAH. The patient also asks the physician to examine his back for chronic pain issues. The physician documents a Level 2 (99212) for the related evaluation. Charges for the services include:

- IPPE (G0402) \$175
- EKG (G0405) \$50
- Venipuncture (36415) \$25
- Medical visit (99212) \$115

- How would these services be reported to Medicare?
- Will the patient be responsible for any deductible and/or coinsurance?
- Will the RHC be paid an AIR?
- How will the non-RHC services be billed?

Rev Code	HCPCS/Mod	Charge	Deduct/Coins	AIR
			Yes/No?	Yes/No?

3. Annual Wellness Visit (AWV)

- a. The AWV is a personalized prevention plan for beneficiaries who are not within the first 12 months of Medicare eligibility and have not received an IPPE or AWV within the past 12 months. <Medicare Claims Processing Manual, Chapter 18, § 140.4>
- b. The AWV can be billed as a stand-alone visit, if it is the only medical service provided on that day. <See Medicare Benefit Policy Manual, Chapter 13 § 220.1>

- i. Unlike the IPPE, the AWW will not receive an additional AIR payment when it is performed on the same day as another qualifying medical visit.
- ii. The AWW must be billed on a separate line from a qualifying visit using a revenue code 052X, HCPCS code G0438 (initial) or G0439 (subsequent) and the appropriate charge.
- iii. Modifier -CG will only be reported if the AWW is the only medical service provided that day.
- iv. The patient's deductible and coinsurance will be waived for the AWW, whether it is performed as the only service that day or performed in conjunction with another qualifying medical visit. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 220.1, 220.2>

NOTE: When charges for separately billable incident to services are included in the total charge for the qualifying visit line reported with a preventive service HCPCS code for which cost sharing is waived, cost sharing for the incident to services will also be waived. Payment will be at 100% of the AIR.

Case Study 3

Facts: The patient presents to the independent RHC for her AWW (G0439). The deductible and coinsurance will be waived, per statute. During the visit, the physician also asks the nurse to draw blood for a laboratory test that is performed in the RHC.

Charges for the services include:

- AWW (G0439) \$215
- Venipuncture (36415) \$25

- How would these services be reported to Medicare?
- Will the patient be responsible for deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Rev Code	HCPCS/Mod	Charge	Deduct/Coins Yes/No?	AIR Yes/No?

D. Billing a Qualifying Medical Visit and a Preventive Service During the Same Encounter

1. In certain circumstances, a preventive service may be provided as part of a qualifying visit. When the deductible and/or coinsurance is waived for the preventive service, the charge for the preventive service must be deducted from the total charge for the visit. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 220.1, 220.2; see *Medicare Claims Processing Manual*, Chapter 9, § 70.1; *Medicare One Time Notification Transmittal 1434*>
 - a. The total charge for the qualifying visit and incident to services subject to cost sharing are billed on the qualifying visit charge line and will receive an AIR payment.
 - b. The patient will be liable for any unmet deductible and coinsurance equal to 20% of the total billed charges less any unmet deductible paid.
 - c. The preventive service is billed on a separate line with the appropriate revenue code, HCPCS code, and actual charge. Payment for the preventive service is included in the AIR payment for the qualifying visit.

Case Study 4

Facts: The patient presents to the RHC for her annual cancer screening pelvic and clinical breast exam (G0101). The deductible and coinsurance will be waived per statute. During the visit, the patient asks the physician to look at a healing laceration on her palm that was red and swollen. The physician documents a level 2 office visit (99212).

Charges for the services include:

- Screening pelvic/breast (G0101) \$100
- Medical visit (99212) \$125

- How would these services be reported to Medicare?
- Will the patient be responsible for deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Rev Code	HCPCS/Mod	Charge	Deduct/Coins Yes/No?	AIR Yes/No?

E. Advance Care Planning (ACP)

1. Voluntary advance care planning is a face-to-face visit between the patient and a physician or other qualified healthcare professional to discuss advance directives, with or without completing relevant legal forms. <Medicare Benefit Policy Manual Transmittal 216>

An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment in the future should he/she lack decisional capacity at that time.

2. An RHC may report HCPCS code 99497 for the first 30 minutes of ACP and add-on HCPCS code 99498 for each additional 30 minutes of planning services. <Medicare Claims Processing Manual Transmittal 3428; Medicare Claims Processing Manual, Chapter 18, § 140.8>
 - a. When ACP is furnished with an AWW, only the AWW will be paid an AIR.
 - i. When ACP is furnished as part of an AWW (G0438 or G0439), the deductible and coinsurance are waived for both the ACP and AWW.
 - ii. ACP HCPCS code(s) must be billed with modifier -33 (preventive services) to waive the deductible and coinsurance.
 - iii. Modifier -33 should not be reported with either AWW HCPCS code.
 - iv. Waiver of the deductible and coinsurance for ACP performed with the AWW is limited to once per year.
 - b. ACP may be provided with services other than the AWW.
 - i. When ACP is furnished as a stand-alone visit, it will be paid an AIR.
 - ii. When ACP is furnished with other billable services on the same day, only one qualifying visit will be paid an AIR. <Medicare One Time Notification Transmittal 1516>

The deductible and coinsurance will be applied when ACP is billed alone or with services other than an AWW. When ACP is billed alone or with other separately billable services on the same day, modifier -33 should not be reported.

F. Vaccines and Injections

Additional information on vaccines and their administration can be found in the Medicare Benefit Policy Manual, Chapter 15.

1. Influenza and pneumonia vaccines and administration

- a. Influenza and pneumonia vaccines and their administration are not reported on an RHC claim; however, the costs are included on the cost report. <See *Medicare Benefit Policy Manual*, Chapter 13, § 220.1; see *Medicare Claims Processing Manual*, Chapter 9, § 70.4; *Medicare Claims Processing Manual*, Chapter 18, §10.2.2.2>
 - i. The vaccines and their administration will be reimbursed at 100% of reasonable cost through the cost report settlement process.
 - ii. Deductible and coinsurance do not apply to these vaccines.
- b. When an RHC practitioner sees the patient for the sole purpose of administering the influenza or pneumonia vaccine, a qualifying visit cannot be separately billed.
 - i. The costs of the vaccine and the administration may be included on the cost report.

2. Hepatitis B vaccine and administration

- a. Hepatitis B vaccine and the administration HCPCS codes are reported on an RHC claim. <See *Medicare Benefit Policy Manual*, Chapter 13, § 220.1; see *Medicare Claims Processing Manual*, Chapter 9, § 70.4; *Medicare Claims Processing Manual*, Chapter 18, § 10.2.2.2>
 - i. The charges are included in the line with the qualifying visit charge and payment will be made under the AIR for the qualifying visit, and deductible and coinsurance will be applied.

In 2021, CMS implemented waiver of deductible and coinsurance for hepatitis B vaccine (see One Time Notification Transmittal 10769). Although the RHC chapters of the Benefit Policy and Claims Processing Manuals indicate the charge for the hepatitis B vaccine and administration should be included in the qualifying visit charge, this appears to conflict with the general guidance on preventative services. This will result in deductible and coinsurance applying in appropriately to the hepatitis B vaccine and administration. RHCs may wish to seek clarification from their MAC.

- ii. When an RHC practitioner sees the patient for the sole purpose of administering the vaccine, a qualifying visit cannot be separately billed.

- a) The cost of the vaccine and administration can be reported on the cost report.

3. Other injections

- a. The charge for an injection that is provided incident to a qualifying visit performed on a different day may be included in the charge for the qualifying visit. The conditions of coverage must be met, and the service must be furnished in a "medically appropriate" timeframe. <See *Medicare Benefit Policy Manual*, Chapter 13 § 120.3>
 - i. CMS does not define what it considers to be a medically appropriate time frame. An RHC should develop a policy for consistent billing practices.
 - ii. If a qualifying visit was previously billed and the injection occurred within a medically appropriate timeframe, the RHC may correct the original claim using TOB 0717 (replacement claim).
 - a) The charges for the injection can be added to the qualifying visit charge and the claim rebilled using the date of service for the qualifying visit.
 - b) The deductible and coinsurance will be based on the total amount for the rebilled qualifying visit. The RHC will not receive an additional AIR for the replacement claim.
- b. If an injection is the only service that was provided on a specific date of service and a qualifying visit does not occur within the RHC's medically appropriate timeframe policy, the charge for the injection is not eligible to be separately billed as a qualifying visit.
 - i. The cost of the injection can be reported on the cost report.

4. COVID-19 Vaccine and Administration

- a. Any vaccine that receives FDA authorization (through EUA or licensed under BLA) will be covered under Medicare at no cost to beneficiaries (Original Medicare and MA). <CMS.gov "Medicare Billing for COVID-19 Vaccine Shot Administration">

- b. For RHCs, costs should generally be reported on the cost report and will be paid at 100% of reasonable costs through the cost report settlement process.
- c. Alternatively, RHCs may request lump-sum payments in advance of cost report settlement, which will be paid at 100% of reasonable costs.

5. Monoclonal Antibodies to treat COVID-19 and Administration

- a. Although treated as preventive vaccines, and, therefore, not subject to cost-sharing, a physician order is required for the administration, unlike other COVID-19 vaccines.
- b. Costs should be reported on the cost report and will be paid at 100% through the cost report settlement process.

G. Billing for Other "Incident to" Services without a Qualifying Visit

- 1. All services and supplies provided incident to an RHC practitioner's visit must meet the following requirements:
 - a. Be a result of the patient's encounter with an RHC practitioner;
 - b. Be performed under the appropriate level of supervision;
 - c. Be performed by a nurse, a medical assistant, or other qualified auxiliary personnel who is an employee of or working under contract to the RHC;
 - i. Services that are not considered incident to include services furnished by a nurse, a medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the RHC, including services provided by a third party under contract.
 - d. Be provided in a medically appropriate timeframe. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120.1, 120.3>
 - i. Examples of incident to services furnished by RHC staff include blood pressure checks, wound care, and other routine nursing services. These types of services do not generate a separately billable qualifying visit alone; however, the costs can be reported on the cost report.

- ii. Incident to services provided on a different day as a separately billable qualifying visit may be included in the charge for the qualifying visit if they are furnished in a medically appropriate timeframe like injections (see above).

Case Study 5

Facts: On March 1st, an established patient presents to an independent RHC for continuing care of a wound infection treated by a community hospital. The patient sees their usual NP for assessment of the wound and evaluation of her diabetes complications. During the initial visit, the dressing was changed and an injection of Rocephin was given. The NP orders an additional 3-day course of Rocephin injections (750 mg each) and dressing changes to be performed by the nurse. The NP will reevaluate the patient in the RHC after completion of the antibiotic injections and dressing changes.

The following services were provided on March 1st:

- E/M (99214) \$185.00
- Injection, intramuscular (96372) \$60.00
- Injection, ceftriaxone sodium, per 250 mg (J0696) \$18.00 (each X3)

The following services were provided on each subsequent day for March 2nd, 3rd, 4th:

- E/M (99211; incident to nursing service with dressing change) \$45.00
- Injection, intramuscular (96372) \$60.00
- Injection, ceftriaxone sodium, per 250 mg (J0696) \$18.00 (each X3)

- How would these services be reported to Medicare?
- Will the patient be responsible for any deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Rev Code	HCPCS/Mod	Charge	Deduct/Coins	AIR
			Yes/No?	Yes/No?

H. Drugs Provided During a Qualifying Visit or Incident to a Qualifying Visit

1. HCPCS codes

- a. Drugs and biologicals are billed with a HCPCS code, if one exists, and units of service consistent with the HCPCS code description. <Medicare Claims Processing Manual, Chapter 17 § 10, 90.2>
- b. If the provider furnishes a dose of a drug that does not equal a multiple of the units specified in the HCPCS code for the drug, the provider should round to the next highest unit when reporting the drug. <Medicare Claims Processing Manual, Chapter 17 § 10, 40>

Example: A patient is administered 7 mgs of a drug. The HCPCS code long descriptor indicates “per 5 mgs”. The RHC should charge for 2 units of the drug. Drug units are rounded up for charging the drug itself; however, a MAC may require an RHC to report only one unit of service for the drug HCPCS code on the claim.

2. Revenue codes

- a. Drugs with HCPCS codes should be reported with revenue code 0636 “Drugs Requiring Detailed Coding”. <National Uniform Billing Committee UB-04 Data Specifications Manual, Program Memorandum A-02-129>
- b. Drugs that do not have a HCPCS code should be billed with the appropriate revenue code in the “General Pharmacy” revenue code series 025X, which does not require a HCPCS code for reporting. <National Uniform Billing Committee UB-04 Data Specifications Manual>
- c. When a self-administered drug (SAD) is integral to a procedure and is considered to be a “supply”, the SAD should be reported under revenue code 0250. <Medicare Benefit Policy Manual, Chapter 15 § 50.2 M>

3. Drug administration

- a. When appropriate, drug administration HCPCS codes should be billed in addition to the HCPCS code for the drug administered, if one exists. <Medicare Claims Processing Manual, Chapter 4 § 230.2; Medicare Claims Processing Manual, Chapter 17 § 10>

4. Billing for non-covered drugs

- a. Non-covered self-administered drugs may be billed to Medicare under revenue code 0637 ("Self-administrable Drugs"), with or without a HCPCS code. <NUBC Official UB-04 Specifications Manual; IOCE Specification, Appendix F(a)>
 - i. If no drug HCPCS code is available for the self-administered drug, and the provider wishes to bill with a modifier (e.g., -GY indicating an item or service is statutorily excluded from the Medicare benefit), the provider may use HCPCS code A9270 ("Non-covered Item or Service"). <Medicare Claims Processing Manual, Chapter 1 § 60.4.2>
- b. The DHHS Office of Inspector General has stated that hospitals will not be subject to administrative sanctions if they discount or waive amounts owed for non-covered self-administered drugs, subject to the following conditions:
 - i. The discounts or waivers are for drugs received for ingestion or administration in outpatient settings;
 - ii. The policy is uniformly applied without regard to diagnosis or type of treatment;
 - iii. The policy is not marketed or advertised; and
 - iv. The hospital does not claim the discounted or waived amounts as bad debt or otherwise shift the burden of these costs to the Medicare or Medicaid program, other payers, or individuals. <OIG Policy Statement Regarding Hospitals That Discount or Waive Amounts Owed by Medicare Beneficiaries for Self-Administered Drugs Dispensed in Outpatient Settings, dated October 29, 2015>

NOTE: Although the OIG Policy Statement is directed at hospitals, presumably, the above conditions apply to any setting that reports self-administered drugs, including an RHC.

Case Study 6

Facts: Patient presents to an RHC for a possible infection in a prior laceration repair site. After examination, the NP orders a 10-day course of oral antibiotics. The patient's usual pharmacy has closed for the day and the NP gives the patient two tablets of the oral antibiotic. She informs the patient that the remainder of the prescription will be available the following day at the local pharmacy.

- Will the oral antibiotics provided to the patient during the RHC visit be covered by Medicare?
- To bill the patient for the tablets, how would the drug be reported on the claim (revenue code, HCPCS code, modifier, charge column)?

I. Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)

1. When all conditions of coverage are met, DSMT and MNT services that are provided by a registered dietician or nutrition professional may be considered incident to a visit with an RHC practitioner. <42 C.F.R. 405.2463; see *Medicare Benefit Policy Manual*, Chapter 13 § 220.1; see *Medicare Claims Processing Manual*, Chapter 9, § 70.5>
 - a. DSMT and MNT services alone cannot be billed as a qualifying visit and are not eligible for payment under the AIR.
 - i. An RHC can become a certified provider of DSMT services and report the costs of the services on the cost report, which are used to compute the AIR.
 - ii. The deductible and coinsurance will apply to DSMT and MNT services billed as incident to a qualifying visit.

Medicare recognizes three types of care management services:

- Transitional Care Management (TCM) – billed with 99495 or 99496
- General Care Management (GCM) which includes Chronic Care Management (CCM), Principal Care Management (PCM), Chronic Pain Management (CPM) and general Behavioral Health Integration (BHI) – billed with G0511
- Psychiatric Collaborative Care Model (CoCM) – billed with G0512

J. Transitional Care Management (TCM)

1. An RHC may be paid for TCM services as a billable visit when coverage requirements are met. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.1>
 - a. TCM services provided incident to the RHC practitioner by auxiliary personnel may be furnished under general supervision. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120.1, 230>
2. TCM services support the patient's transition from an inpatient setting to a community setting during the 30 days following their discharge.
 - a. TCM services must be furnished within 30 days of the date of the patient's discharge from:
 - i. A hospital, including outpatient observation or partial hospitalization;
 - ii. A SNF; or
 - iii. A community mental health center (CMHC). <MLN Booklet *Transitional Care Management Services*, August 2022>
 - b. The patient must be discharged to a community setting, which may include their home, domiciliary, nursing facility, or assisted living facility. <MLN Booklet *Transitional Care Management Services*, August 2022>
 - c. The 30 day period begins on the day of discharge and continues for the next 29 days. <MLN Booklet *Transitional Care Management Services*, August 2022>
3. Required TCM Components:
 - a. Direct contact with the patient or caregiver via phone, email, or face-to-face within two business days after the patient's discharge from the inpatient setting. <MLN Booklet *Transitional Care Management Services*, August 2022>

If the practitioner makes two or more unsuccessful attempts to contact the patient in a timely manner, TCM may still be reported if:

- The attempts are documented in the medical record;
- All other TCM coverage criteria are met;
- Attempts are made until successful.

- b. Non-face-to-face services, including review of discharge information; assistance with follow-up and scheduling of needed diagnostic tests, treatments, and specialists; patient education; and referral to community resources. <MLN Booklet *Transitional Care Management Services*, August 2022>
 - i. Refer to the MLN Booklet *Transitional Care Management Services*, August 2022 for more information, including services that may be provided by auxiliary staff under general supervision.
 - c. A face-to-face visit with an RHC practitioner within the following specific timeframes:
 - i. A face-to-face visit must occur within 14 calendar days of discharge with moderate complexity decision making (99495); or,
 - ii. A face-to-face visit must occur within 7 calendar days of discharge with high complexity decision making (99496). <MLN Booklet *Transitional Care Management Services*, August 2022>
 - iii. Medication reconciliation and management must be completed no later than the date of the face-to-face visit.
 - d. Medicare reconciliation and management must be completed no later than the date of the face-to-face visit. <MLN Booklet *Transitional Care Management Services*, August 2022>
4. Only one practitioner (i.e., an RHC practitioner or a non-RHC practitioner) may report and be paid for TCM services furnished during the 30-day post-discharge period. <MLN Booklet *Transitional Care Management Services*, August 2022>

5. Billing and Payment of TCM Services

- a. If the TCM visit is the only service provided on that day, the RHC bills the appropriate TCM face-to-face code (99495 or 99496) as a qualifying visit in the 052X revenue code series with modifier -CG and the date of the face-to-face visit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.1; *Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), Frequently Asked Questions*, December 2019>
 - i. The RHC will be paid an AIR, subject to deductible and coinsurance.
- b. If the TCM visit occurs on the same day as another qualifying medical visit, preventative visit, or mental health visit, only one visit (with modifier -CG) is paid. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.1>
- c. For dates of services on and after January 1, 202, RHCs may bill for both TCM and other care management services (e.g., GCM or CoCM) provided during the same month for the same beneficiary. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230>

K. General Care Management (GCM)

1. General care management (GCM) includes Chronic Care Management (CCM), Principal Care Management (PCM), Chronic Pain Management (CPM), and General Behavioral Health Integration (BHI) services. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2; see *CMS Rural Health Clinic Center website*>
 - a. The face-to-face visit requirement does not apply to the services included in GCM. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230>
 - b. GCM services provided incident to the RHC practitioner by auxiliary personnel may be furnished under general supervision. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120.1, 230>
 - c. The patient must consent (orally or in writing) to receive GCM services from the RHC and the consent must be documented in the medical record before GCM services are provided. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2>
 - i. The consent must include specific elements as discussed in the *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.

- d. A separately billable initiating visit (E/M, AWW, or IPPE) with an RHC practitioner (physician, NP, PA, or CNM) is required no more than one year prior to the start of GCM. GCM does not need to be discussed during the visit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2>

2. Requirements for Chronic Care Management (CCM)

- a. An RHC may bill for CCM services for non-face-to-face care coordination when a minimum of 20 minutes of CCM services are provided during the calendar month. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.1>
- b. CCM is provided to patients with multiple chronic conditions that are expected to last at least 12 months or until death and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.1>
- c. CCM includes 24/7 access to the physician or other qualified health professional or clinical staff, comprehensive care planning and management, coordination with providers, and enhanced opportunities for patient and caregiver communication. For a full list of included services, see the Care Management site on the CMS website.

Link: Care Management Physician Center under Medicare-Related Sites – Physician/Practitioner

3. Requirements for Principal Care Management (PCM)

- a. An RHC may bill for PCM services when a minimum of 30 minutes of PCM services are provided during the calendar month and these coverage requirements are met:
 - i. The patient has a single complex chronic condition lasting at least three months, which is the focus of the care plan;
 - ii. The condition is of sufficient severity to place the patient at risk of hospitalization or have been the cause of a recent hospitalization;
 - iii. The condition requires development or revision of a disease-specific care plan;
 - iv. The condition requires frequent adjustments in the medication regimen;

- v. The condition is unusually complex due to comorbidities. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.2>
 - b. For more information on the requirements for PCM, see the *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.2.
 - 4. Requirement for Chronic Pain Management (CPM)
 - a. An RHC may bill for CPM services when a minimum of 30 minutes of CPM are provided during the calendar month. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.3>
 - b. CPM is provided to patients with persistent or recurrent pain lasting longer than 3 months and includes person centered care planning, care coordination, medication management, and other aspects of pain care. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.3>
 - c. For more information on the requirements for CPM, see the CY2023 Medicare Physician Fee Schedule.
 - 5. Requirements for General Behavioral Health Integration (BHI)
 - a. An RHC may bill for BHI services when a minimum of 20 minutes of BHI services are provided during the calendar month. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.4>
 - b. General BHI is provided to patients with one or more new or pre-existing behavioral health or psychiatric conditions, including substance use disorders. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.2.4>
 - c. General BHI includes assessment and ongoing monitoring, behavioral health care planning, coordination of psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation. For more information on general BHI, see the Care Management site on the CMS website.
- Link: [Care Management Physician Center under Medicare-Related Sites – Physician/Practitioner](#)
- 6. Billing and Payment of GCM
 - a. GCM is reported with HCPCS code G0511 in the 052X revenue code series. <See *Medicare Benefit Policy Manual*, Chapter 13 §230.2.5; see *Medicare Claims Processing Manual*, Chapter 9 § 70.8>

- i. HCPCS code G0511 is not reported with modifier -CG. <See *Medicare Claims Processing Manual*, Chapter 9 § 70.8>
 - ii. GCM can be billed alone or with another qualifying visit on the same date of service. <See *Medicare Benefit Policy Manual*, Chapter 13 §230.2.5>
 - iii. GCM cannot be billed by the RHC and another practitioner/facility for the same beneficiary for the same timeframe/month. <See *Medicare Benefit Policy Manual*, Chapter 13 §230.2>
 - b. Medicare pays for GCM separately from the RHC's AIR at a rate established based on the average MPFS rate for these services. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 230, 230.2.5>
 - i. For CY2023, the national payment rate for G0511 is \$77.94.
 - ii. MPFS deductible and coinsurance apply to GCM.
 - c. GCM costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC specific AIR.
- L. Psychiatric Collaborative Care Model (CoCM)
- 1. Psychiatric CoCM is a specific model of care provided by a primary care team which must consist of a primary care practitioner, a behavioral healthcare manager, and a psychiatric consultant. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3; see Care Management Services in an RHC and FQHC FAQs, December 2019>
 - a. CoCM includes regular psychiatric inter-specialty consultation with the primary care team and a patient with mental health, behavioral health, or psychiatric conditions, including substance use disorders, whose conditions are not improving.
 - i. The RHC practitioner is a primary care physician, NP, PA, or CNM who directs the care management team.
 - ii. The behavioral healthcare manager is a designated individual with formal education or specialized training in behavioral health and has a minimum of a bachelor's degree in a behavioral health field.

The behavioral manager furnishes both face-to-face and non-face-to-face services under general supervision. Other RHC staff may provide related services under general supervision.

- iii. The psychiatric consultant is a medical professional trained in psychiatry and is qualified to prescribe the full range of medications. The consultant is not required to be on-site or have face-to-face contact with the patient.
 - b. At least 70 minutes of CoCM services must be furnished in the first month and at least 60 minutes of CoCM services must be furnished in subsequent months to bill for CoCM. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - c. The patient must consent (orally or in writing) to receive CoCM from the RHC and their consent must be documented in the medical record before CoCM services are provided. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - i. The consent must include specific elements as discussed in the *Medicare Benefit Policy Manual*, Chapter 13 § 230.3.
 - d. A separately billable initiating visit (E/M, AWW, or IPPE) with an RHC practitioner (physician, NP, PA, or CNM) is required no more than one year prior to the start of the CoCM. CoCM does not need to be discussed during the visit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - e. For more information on CoCM services, see *Medicare Benefit Policy Manual*, Chapter 13 § 230.3.
2. Billing and Payment of CoCM
- a. CoCM is reported with HCPCS code G0512. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - i. HCPCS code G0512 is not reported with modifier -CG. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - ii. CoCM can be billed alone or with another qualifying visit on the same date of service. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - iii. CoCM cannot be billed by the RHC and another practitioner/facility for the same beneficiary for the same timeframe/month. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>

- b. Medicare pays for CoCM separately from the RHC's AIR at a rate established based on the average MPFS rate for these services. <See *Medicare Benefit Policy Manual*, Chapter 13 § 230.3>
 - i. For CY2023, the national payment rate is \$146.73.
 - ii. MPFS deductible and coinsurance apply.
- c. CoCM cost are reported in the non-reimbursable section of the cost report and are not used in determining the RHC specific AIR.

M. Virtual Communication Services (VCS)

1. Effective for dates of service on or after January 1, 2019, an RHC may receive an additional payment for the costs of certain communication technology-based services or remote evaluation services that are not already captured in the RHC AIR payment when the following conditions are met. <See *Medicare Benefit Policy Manual*, Chapter 13 § 240; see Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions December 2018; see *CMS Rural Health Clinic Center* website>
 - a. An RHC practitioner must provide at least 5 minutes of certain communications-based technology or remote evaluation services to a patient who has been seen in the RHC within the previous year.
 - i. Face-to-face requirements are waived.
 - ii. The medical discussion or remote evaluation must be for a condition that is not related to an RHC service provided within the previous seven days and does not lead to an RHC service within the next 24 hours or at the soonest available appointment.
 - iii. If the discussion between the patient and the RHC practitioner is related to a prior billable visit furnished by the RHC within the previous seven days or within the next 24 hours or at the soonest available appointment, the cost of the RHC practitioner's time would be included in the RHC AIR payment for the visit and is not separately billable as VCS.
 - iv. VCS services performed by RHCs are reported with HCPCS code G0071

- b. Initially VCS services billable by RHCs and reported with G0071 included only those services described by HCPCS codes G2010 or G2012. For dates of service on or after January 1, 2021, CMS has replaced the original codes with HCPCS codes G2250, G2251 and G2252 to describe the services reportable by RHCs with VCS HCPCS code G0071:
 - i. HCPCS G2250 - Remote assessment of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; replaces HCPCS code G2010;
 - ii. HCPCS G2251 - Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available, 5-10 minutes; replaces HCPCS code G2012;
 - iii. HCPCS G2252 – Same definition as G2251, except 11-20 minutes
- 2. For dates of service on or after March 1, 2020 and throughout the duration of the COVID-19 PHE, CMS is also expanding VCS (reportable by RHCs with HCPCS G0071) to include certain additional online digital evaluation and management services using patient portals.
 - a. Online digital evaluation and management services are non-face-to face, patient-initiated, digital communications using a patient portal, that require a clinical decision that otherwise typically would have been provided in the clinic by an RHC practitioner.
 - b. A patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an Internet connection by using a secure username and password
 - c. The following codes describe the expanded VCS services which are reportable with HCPCS code G0071 during the PHE:
 - i. 99421 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 5-10 minutes);
 - ii. 99422 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 11-20 minutes); and,

- iii. 99423 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 21 or more minutes).
 - d. An RHC practitioner can respond from any location during time scheduled to work in the RHC.
 - 3. Services described by the expanded online digital assessment codes, as well as those described by HCPCS codes G2010 and G2012 (or their replacement codes), should be billed by RHCs using HCPCS code G0071.
 - a. Although VCS is an RHC service, it is paid under the MPFS, not the RHC AIR.
 - i. For CY 2023, the payment rate for G0071 is \$23.72.
 - ii. MPFS deductible and coinsurance apply.
 - b. When VCS is furnished with another separately billable qualifying visit, modifier -CG must be reported with that qualifying visit to receive an AIR payment.
 - i. Modifier -CG is not reported with HCPCS code G0071.
 - c. Because these codes are for a minimum 7-day period of time, RHCs cannot bill G0071 more frequently than once every 7 days.
 - d. VCS may be provided to new and established patients, as long as there is patient consent.

Link: Rural Health Clinics Center under Medicare Related Sites – Rural Health

Select COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) under the Frequently Asked Questions section.

N. Telehealth Services

1. Originating site telehealth services

- a. Although telehealth is not an RHC benefit, the clinic may serve as an originating site for telehealth services. Originating site refers to the location of the patient at the time the service is being furnished via telecommunications systems. <See *Medicare Benefit Policy Manual*, Chapter 13 § 200>
 - b. The originating site facility fee is reported with revenue code 0780 and HCPCS code Q3014.
 - i. The payment rate for originating site telehealth services is made under the MPFS and is updated annually.
 - ii. For CY 2023, the payment rate for HCPCS code Q3014 is the lesser of \$28.64 or billed charges. <*Medicare Claims Processing Manual* Transmittal 10505>
 - iii. MPFS deductible and/or coinsurance will apply.
 - c. Exception for telehealth services during the COVID-19 PHE
 - i. Effective for dates of service on or after March 6, 2020, an eligible originating site location includes the patient's home. <*MLN Matters SE20016*, revised January 13, 2022>
 - d. An originating site facility service may be billed as the only billable service provided or in addition to a qualifying visit billed with revenue code 052X and/or 0900. <*Medicare One Time Notification Transmittal 1540*>
 - i. When the originating site facility service is furnished with a qualifying visit, modifier -CG must be reported with the qualifying visit to receive an AIR payment.
 - ii. Modifier -CG is not reported with HCPCS code Q3014.
 - e. Although the charges for originating site services are reported on the claim, they are reported in a special section in the cost report and are not taken into consideration in the calculation of the AIR.
2. Distant site telehealth services
- a. Usually, an RHC may not serve as a distant site for telehealth services. Distant site refers to the location of the practitioner at the time of the service. <See *Medicare Benefit Policy Manual*, Chapter 13, § 200>
 - b. Exception during the COVID-19 PHE

- i. Prior to January 27, 2020, distant site services could not be billed by an RHC. This includes telehealth services that are furnished by an RHC practitioner who is employed by or under contract with the RHC or a non-RHC practitioner furnishing services through a direct or indirect contract. <MLN Matters SE20016, revised January 13, 2022>
- ii. Section 3704 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) authorizes RHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. <CARES Act>
 - a) Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. <MLN Matters SE20016, revised January 13, 2022>
 - b) Distant site telehealth services can be furnished by any health care practitioner working for the RHC within their scope of practice from any location, including their home, during the time that they are working for the RHC and can furnish any telehealth service that is approved as a distant site telehealth service under the Medicare Physician Fee Schedule (MPFS). <MLN Matters SE20016, revised January 13, 2022; see CMS Rural Health Clinic Center website>

Link: Telehealth under Medicare Related Sites – Physician/Practitioner

See left navigation for a list of telehealth services

- iii. For distant site telehealth services beginning January 27, 2020, RHCs must report HCPCS code G2025 for any covered service on the CMS telehealth list. <See MLN Matters SE20016, revised January 13, 2022; see CMS Rural Health Clinic Center website>
 - a) Initially, CMS provided the following additional billing guidance for RHC telehealth services:
 - 1) For dates of service from January 27, 2020, through June 30, 2020, modifier –CG should be attached.
 - 2) For dates of service from July 1, 2020, through the end of the PHE, modifier –CG should not be attached.
 - 3) For COVID-19 testing-related services and preventive services not subject to cost sharing, RHCs must waive collection of

deductibles and coinsurance from beneficiaries and attach modifier –CS to receive full payment from Medicare.

- 4) Modifier -95 is optional and modifier –CR should not be reported.
- b) Effective March 1, 2020, CMS included CPT codes 99441, 99442, and 99443 (which are audio-only telephone evaluation and management (E/M) services) in the list of covered telehealth services. RHCs can also furnish and bill for these services using HCPCS code G2025, as long as the following requirements are met.
- 1) At least 5 minutes of medical discussion for a telephone E/M service by a physician or other qualified health care professional who may report E/M services are provided to a new or established patient, parent, or guardian.
 - 2) These services do not originate from a related E/M service provided within the previous 7 days or lead to another E/M service or a procedure within the next 24 hours or the soonest available appointment, including a service furnished via telehealth. <COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, updated 09/11/20>
 - 3) All otherwise applicable billing requirements for distant site telehealth services are met, including the reporting of modifiers –CG and/or –CS, when appropriate. <See *MLN Matters SE20016*, revised January 13, 2022>
- c) Initially, for dates of service from January 27, 2020, through the end of CY 2020, RHCs were to receive payment for telehealth services at the RHC rate of \$92.03. This amount reflected the average amount in 2020 for all services on CMS’s telehealth list, weighted by volume.
- 1) However, for claims billed with G2025 (with modifier –CG) and processed from January 27, 2020, through June 30, 2020, RHCs were initially to be paid at their AIR. These claims were automatically to be reprocessed beginning on July 1, 2020, and paid at the RHC rate of \$92.03
 - 2) Claims billed with G2025 (without modifier –CG) and processed on or after July 1, 2020, were to be paid at the RHC rate of \$92.03.

- d) Initially, payment was based on the actual RHC rate, not the lesser of the RHC rate or billed charges. Initially, coinsurance for distant site services was 20% of billed charges and payment was 80% of the RHC rate (\$92.03) minus coinsurance. The intent, however, was for coinsurance and payment to be based on the lesser of the RHC rate or billed charges.
 - 1) Subsequently, MACs were to automatically reprocess any RHC claims with HCPCS code G2025 for services furnished on or after January 27, 2020, through November 16, 2020, that were paid before the claims processing system was updated to pay HCPCS code G2025 based on the "lesser of" methodology. That is, coinsurance was to be based on 20% of the lesser of the RHC rate or billed charges, and payment was to be based on the lesser of 80% of the RHC rate or billed charges. <See *MLN Matters SE20016*, revised January 13, 2022>
- e) For dates of service during CY 2021, RHC payment for HCPCS code G2025 is based upon the updated national rate of \$99.45, utilizing the "lesser of" methodology. MACs will automatically reprocess any RHC claims with HCPCS code G2025 for services furnished on or after January 1, 2021, that were paid before the claims processing system was updated to reflect the CY 2021 national payment rate. <See *MLN Matters SE20016*, revised January 13, 2022>
- f) For dates of service during CY 2022, RHC payment for HCPCS code G2025 is based upon the updated national rate of \$97.24, utilizing the "lesser of" methodology. <See *MLN Matters SE20016*, revised January 13, 2022; see *CMS Rural Health Clinic Center* website>
- g) For dates of service during CY 2023, RHC payment for HCPCS code G2025 is based upon the updated national rate of \$98.27, utilizing the "lesser of" methodology. <See *CMS Rural Health Clinic Center* website>

3. Cost reporting for telehealth services during the COVID-19 PHE

- a. Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR rate; however, the costs must be reported on the appropriate cost report form. <*MLN Matters SE20016*, revised January 13, 2022>
- i. RHCs must report both originating site 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."

4. Virtual mental health services

- a. Beginning January 1, 2022, CMS allows RHCs to report and receive payment for virtual mental health visits in the same manner as if the visit was provided in-person. <See 86 Fed. Reg. 39229; see *CMS Rural Health Clinic Center* website>
- b. Generally, these visits are furnished using two-way (audio/video) interactive real-time telecommunications technology. There is an exception that permits audio-only visits when the beneficiary is not capable of, or does not consent to, use of video technology.
 - i. When furnished using two-way technology, RHCs should attach modifier --95.
 - ii. When furnished with audio only, RHCs should report modifier –FQ.
- c. An initial in-person, non-telehealth visit is required within six months prior to initiation of virtual mental health services. At least one additional in-person, non-telehealth visit is required every 12 months thereafter.
 - i. An exception to the 12-month in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record).
 - ii. More frequent visits are allowed, as driven by clinical needs on a case-by-case basis.

O. Services Provided to a Hospice Patient

1. An RHC may provide care to a hospice patient for any medical condition that is not related to their terminal illness. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
2. In most cases, if the patient receives care from an RHC practitioner during clinic hours for a condition that is related to the terminal illness, the RHC cannot separately bill for or be reimbursed for the face-to-face visit, even if it is medically necessary.
 - a. Exceptions

- i. The RHC has a contract with the hospice provider to furnish core hospice services when extraordinary circumstances exist within the hospice such as temporary staffing shortages, unanticipated high census, or temporary travel by the patient outside of their hospice's service area. <42 C.F.R. 418.64; see *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
 - ii. The RHC has a contract with the hospice provider to furnish highly specialized nursing services that are not usually provided by the hospice and for the hospice to employ a nurse with that skill would be impractical and expensive. <42 C.F.R. 418.64; see *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
 - a) Costs associated with these hospice exceptions should not be reported on the clinic's cost report since the RHC is reimbursed by the hospice under its contract.
 - iii. Effective January 1, 2022, RHCs can bill and receive payment under the RHC AIR, when a designated attending physician, NP, or PA who is employed by or working under contract with the RHC furnishes hospice attending services during the patient's hospice election. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.1; see *Medicare Claims Processing Manual*, Chapter 9 § 60.6>
 - a) Modifier -GV must be reported on the claim line along with modifier -CG each day a hospice attending physician services are furnished. <See *Medicare Claims Processing Manual*, Chapter 9 § 60.6>
 - b) When the RHC furnishes a hospice attending physician service that has a technical component, the technical component must be billed separately to the hospice for payment.
 - c) Coinsurance and deductibles apply.
2. Unless prohibited by their employment contract or scope of practice, a practitioner who is employed by the RHC can provide hospice services when he or she is not working at the RHC. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.1>

Any service provided to a hospice patient by an RHC practitioner must comply with the prohibition on commingling and the practitioner would bill the hospice service to Part B under his or her own provider number.

P. Visiting Nurse Services

1. The following requirements must be met for a visiting nurse service to be considered a covered RHC visit. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 190.2, 190.3, 190.4>
 - a. There is a shortage of home health agencies in the area where the RHC is located, as determined by CMS.
 - i. An RHC located in an area that does not have a current home health shortage may make a written request to the CMS Regional Office for authorization to provide visiting nurse services.
 - b. The patient is confined to the home. <*Social Security Act* § 1835(a)>
 - c. The services are furnished under a written plan of treatment and under the supervision of a physician, NP, PA, CNM, or CP. <See *Medicare Benefit Policy Manual*, Chapter 13 § 190.5>
 - i. The plan of treatment must be reviewed by the supervising practitioner at least once every 60 days.
 - ii. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated unless:
 - a) The supervising practitioner has made a recertification within the 60-day period and the lapse of visits is part of the treatment plan; or,
 - b) The documentation supports that visiting nurse services are required at predictable intervals that occur less than once every 60 days (i.e., once every 90 days).
 - d. The nursing services are furnished on a part-time or intermittent basis only.
 - e. Drugs and biological products are not provided during the visit.
2. A visiting nurse may provide skilled nursing services in a patient's home as determined by an RHC practitioner to be medically necessary for the diagnosis and treatment of an illness or injury based on the patient's unique medical condition. <See *Medicare Benefit Policy Manual*, Chapter 13 § 190.1>
 - a. The determination of whether visiting nurse services are reasonable and necessary is made by the RHC practitioner, 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.

3. For the duration of the COVID-19 PHE, CMS is revising certain requirements for coverage of visiting nurse services. <COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)>
 - a. CMS will assume that the area typically served by the RHC has a shortage of home health agencies, and no explicit shortage determination is required.
 - b. However, an RHC must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.
 - c. Visiting nurse services are only billable as an RHC visit when they require skilled nursing services.
 - i. For example, a nurse's collection of specimen to test for Covid-19 would not be a billable visit since no skilled services were provided.

Link: Rural Health Clinics Center under Medicare Related Sites – Rural Health
 Select COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) under the Frequently Asked Questions section.

Q. Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) Services

1. PT, OT, and SLP services may be performed by a physician, NP, or PA when the services provided are within their scope of practice and state law. <See *Medicare Benefit Policy Manual*, Chapter 13 § 180>
 - a. A physician, NP, or PA may also supervise a therapist who provides services incident to a qualifying visit in the RHC.
 - i. A therapist providing incident to services may be employed or contracted by the RHC.
 - b. The charges for the therapy services are included in the qualifying visit if:
 - i. The therapy services are furnished by a qualified therapist as part of an otherwise billable visit, and the service is within the scope of practice of the therapist.

- ii. If the services are provided by a therapist on a day when a qualifying visit was not provided, the therapy service would only be reported on the cost report.

If a therapist in private practice furnishes services in the RHC, the charges may not be reported on the RHC claim. All associated costs must also be carved out of the RHC's cost report.

VI. General Billing Requirements for Diagnostic Tests and Laboratory Services

A. Diagnostic Services

1. Generally, only the professional component of a diagnostic test is a benefit in an RHC. The technical component of a diagnostic test is not a benefit of an RHC and cannot be billed on TOB 071X. <See *Medicare Claims Processing Manual*, Chapter 9, §§ 60, 90>
 - a. Technical services/components of diagnostic tests performed by an independent RHC are billed to the Part B MAC on the CMS-1500 claim form. <*Medicare Claims Processing Manual*, Chapter 12, § 80.2>
 - b. Technical services/components of diagnostic tests performed by a provider-based RHC are billed to the Part A MAC on the UB-04 claim form with an appropriate base-provider bill type (i.e., TOB 085X CAH or TOB 0131 OPPS). <*Medicare Claims Processing Manual*, Chapter 4, § 280>

B. Laboratory Services

1. Under its CMS certification, an RHC must be able to furnish the following laboratory services onsite for the immediate diagnosis and treatment of its patients:
 - a. Urinalysis by dipstick or tablet method;
 - b. Hemoglobin or hematocrit;
 - c. Blood glucose;
 - d. Occult blood stool examination;
 - e. Pregnancy tests; and
 - f. Primary culturing for transmittal to a certified laboratory. <See 42 *C.F.R.* 491.9; see *Medicare Claims Processing Manual*, Chapter 9, § 90>

2. However, laboratory services are non-RHC services and are not included in the AIR payment. Excluding venipuncture, all laboratory services must be billed separately on the appropriate claim form (i.e., 1500 or UB04), and the costs of the space, equipment, supplies, facility overhead and staff associated with the laboratory services may not be reported on the RHC cost report. <See *Medicare Claims Processing Manual*, Chapter 9 § 90; see *Medicare Benefit Policy Manual*, Chapter 13 § 60.1>

Laboratory services performed by an **independent** RHC will be billed to the Part B MAC on the 1500 claim form. Payment will be made under the CLFS amount.

Laboratory services performed by a **provider-based** RHC will be billed to the Part A MAC on the UB-04 claim form using the applicable main provider's bill type. Payment will be made under the appropriate payment methodology to the main provider.

3. When performed by the physician, non-physician practitioner, or other qualified staff incident to a qualifying visit, the cost associated with the venipuncture is included in the AIR payment. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60.1; see *Medicare Claims Processing Manual*, Chapter 9 § 90>
 - a. The venipuncture charge is included with the charge for the qualifying visit.
 - b. The venipuncture is also reported on a separate line with the appropriate revenue code, HCPCS code, and charge.
 - c. If the venipuncture is the only service provided without a qualifying visit, the service cannot be billed separately on the RHC claim.
 - i. If a qualifying visit was previously billed and the venipuncture occurred within a medically appropriate timeframe, the RHC may correct the original claim using TOB 0717 (replacement claim).
 - a) The charge for the venipuncture can be added to the qualifying visit charge and the claim rebilled using the date of service for the qualifying visit.
 - b) The deductible and coinsurance will be based on the total amount for the rebilled qualifying visit. The RHC will not receive an additional AIR for the replacement claim.

- d. If the venipuncture is the only service that was provided on a specific date and a qualifying visit does not exist within the RHC's medically appropriate timeframe policy, the charge for the venipuncture is not eligible to be separately billed as a qualifying visit.
- i. The cost of the venipuncture can be reported on the cost report.

Case Study 7

Facts: A patient presents to the provider-based RHC with a chief complaint of chest palpitations. The patient's usual physician completes a Level 4 evaluation (99214) and performs an EKG (93010). The physician documents the interpretation of the EKG separate from the visit note. During the visit, the physician requests a telehealth consult with a cardiologist at another hospital that is located 50 miles from the RHC. After the telehealth consult, the RHC nurse draws blood for a lab test that will be performed by the PPS hospital.

Charges for the services include:

- Medical visit (99214) \$250
- EKG (93010) \$50
- Venipuncture (36415) \$25
- Originating site (Q3014) \$45

- How would these services be reported to Medicare?
- Will the patient be responsible for any deductible and/or coinsurance?
- Will the RHC be paid an AIR?
- How will the non-RHC services be billed?

Rev Code	HCPCS/Mod	Charge	Deduct/Coins Yes/No?	AIR Yes/No?

VII. Special Billing Considerations

A. Exclusion from the Three-Day Payment Window

1. Even though an RHC is an “entity” under the three-day payment window, CMS does not apply this policy to the RHC setting. <76 *Fed. Reg.* 73281-82; see *Medicare Benefit Policy Manual*, Chapter 13 § 40.5>

The three-day payment window does not include professional services. CMS has stated that since an RHC is paid under the AIR, it would be difficult to distinguish between the professional and technical components of the payment rate. If in the future an RHC is not paid under an AIR, a distinction could be made, and the payment window policy could apply.

B. RHC Practitioner Visits to Swing Bed Patients

1. To address the shortage of skilled nursing facility beds, rural hospitals with fewer than 100 beds may be reimbursed for furnishing post-hospital extended care services to Medicare beneficiaries. <*Medicare Benefit Policy Manual*, Chapter 8 § 10.3>
 - a. This type of hospital may “swing” its beds between acute hospital care and a SNF level of care, on an as needed basis, if it has obtained swing bed approval from CMS.
2. As discussed earlier in this module, revenue code 0524 (Visit by an RHC practitioner to a member in a SNF or skilled swing bed in a covered Part A SNF stay) may be reported for a qualifying visit to a patient in a SNF or skilled swing bed in a covered Part A SNF stay.
 - a. When a hospital or CAH is providing extended care services, it will be treated as a SNF for purposes of applying coverage rules. This means that services provided in the swing bed are subject to the same Part A coverage, deductible, coinsurance, and physician certification and recertification provisions that are applicable to SNF extended care services. <*Medicare Benefit Policy Manual*, Chapter 8 § 10.3>
 - b. Although a CAH’s swing bed patient is receiving a SNF level of care and the CAH is reimbursed for providing skilled care, a CAH swing bed patient is not a SNF patient and instead, is a patient of the CAH. <*Medicare State Operations Manual*, Appendix W § 485.645>

An RHC should seek further clarification from their MAC and/or CMS Regional Office Rural Health Coordinators as to whether it is appropriate to report revenue code 0524 for a qualifying visit to a swing bed patient in a

C. Application of Global Surgery Concept

1. Surgical procedures furnished in the RHC during a qualifying visit are included in the AIR payment. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.4>

If a procedure is associated with an RHC qualifying visit, the charge for the procedure is reported on the qualifying visit line and reported on a separate line with the applicable revenue code, HCPCS code, and charge. Medicare global billing requirements do not apply in an RHC.

2. If an RHC provides services to a patient who had a surgical procedure elsewhere and the patient is still in the global billing period, the RHC must determine if the services it provides are already included in another facility's or clinic's surgical global billing period and payment. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.4>
 - a. The RHC may bill for a qualifying visit during the global surgical period if the visit is for a service that is not part of the usual surgical service, including: <See *Medicare Claims Processing Manual*, Chapter 12 § 40.1>
 - i. An initial consultation to determine the need for a major surgery;
 - ii. A medical visit unrelated to the diagnosis for which the surgical procedure was performed; or,
 - iii. A medical visit due to complications from the surgery, treatment for the underlying condition, or an added course of treatment which is not part of the normal recovery period.

VIII. Appropriate Use Criteria (AUC) for Advanced Imaging Services

A. General Overview

1. An ordering physician must consult a qualified Clinical Decision Support Mechanism (CDSM) before ordering certain advanced imaging services for a Medicare patient. <See *Medicare One Time Notification Transmittal 2404*>
 - a. Advanced imaging services include MRI, CT scans, nuclear medicine, and PET scans.
 - b. Information about the CDSM, or an exception, must be reported on the claim for the advanced imaging service that is performed in an applicable setting, in order for the claim to be paid under an applicable payment system.

B. Applicable Settings and Payment Systems

1. A CDSM consultation must take place for any applicable imaging service ordered by a practitioner that would be furnished in an applicable setting and would be paid under an applicable payment system. <See *Medicare One Time Notification Transmittal 2404*>

The applicable setting is where the imaging service is performed, not the setting where the imaging service is ordered.

- a. Settings that must report CDSM information on their claim include physician offices, independent diagnostic testing facilities (IDTF), ambulatory surgery centers (ASC), and hospital outpatient departments, including emergency departments. <See *Medicare One Time Notification Transmittal 2404*; 42 C.F.R. § 414.94(a)>
- b. Payment systems that require reporting CDSM information on their claims include the Medicare Physician Fee Schedule (MPFS), the Outpatient Prospective Payment System (OPPS), and the Ambulatory Surgery Center (ASC) payment system. <See *Medicare One Time Notification Transmittal 2404*; 42 C.F.R. § 414.94(a)>
 - i. A CAH is paid under the cost-based methodology and is not required to report the informational HCPCS G-codes or related modifiers -MA through -MH obtained through the CDSM. <*MLN Matters SE20002*>
 - ii. In general, an RHC is paid under the all-inclusive rate (AIR) for its visits and incident to services.
 - a) An RHC is also paid under the MPFS for certain services, such as Care Management Services, Virtual Communication Services, and telehealth.
 - b) However, if an RHC practitioner orders an advanced imaging service for a Medicare patient that will be furnished in an applicable setting and paid under an applicable payment system, the CDSM must be consulted and the information must be provided to the furnishing practitioner to include on their claim.

C. Ordering Practitioner Requirements

1. When ordering an advanced imaging service that will be furnished in an applicable setting and paid under an applicable payment system, the ordering practitioner must consult a CDSM, unless an exception applies. <See

Medicare One Time Notification Transmittal 2404; 42 C.F.R. § 414.94(j) and (k)>

2. Exceptions to consulting CDSM for AUC:

- a. Emergency services provided to patients with emergency medical conditions, as defined under EMTALA (modifier -MA);
- b. Tests ordered for inpatients or paid under Part A;
- c. Significant hardship for the ordering practitioner due to insufficient internet access (modifier -MB), EHR or CDSM vendor issues (modifier -MC), or extreme and uncontrollable circumstances (modifier -MD). <42 C.F.R. § 414.94(j) and (k); 83 Fed. Reg. 59697-700>
 - i. If a significant hardship applies, the ordering practitioner self-attests at the time of ordering the advanced imaging service and communicates this to the furnishing provider who will include the appropriate modifier on the CPT code for the applicable advanced imaging service. <83 Fed. Reg. 59697-700; see *Medicare One Time Notification Transmittal 2404*>
 - ii. For more details on circumstances representing a significant hardship, see the CY 2019 Medicare Physician Fee Schedule Final Rule, 83 Fed. Reg. 59699-700.

3. The requirement to consult a CDSM may be met by delegating to clinical staff acting under the direction of the ordering practitioner. <42 C.F.R. § 414.94(j)(2)>

- a. The individual performing the consultation must have sufficient clinical knowledge to interact with the CDSM and communicate the information to the ordering practitioner.

D. Applicable Advanced Imaging Services

- 1. CMS has provided a list of CPT codes that represent applicable advanced imaging services, including CT, PET, MRI, and other nuclear medicine tests, included in the materials behind the outline. <See *Medicare One Time Notification Transmittal 2404*>

E. Qualified Clinical Decision Support Mechanisms (CDSM)

1. A qualified CDSM is an interactive, electronic tool for use by clinicians that communicates appropriate use criteria (AUC) information to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition.

Link: Appropriate Use Criteria Program under Medicare Related Sites – Physician/Practitioner

Use links on the left navigation to access qualified CDSM and related codes.

2. CDSM tools may be modules within or available through certified electronic health record (EHR) technology.

F. Implementation

1. CMS initially designated CY 2020 as the Educational and Operational Testing Period for AUC reporting requirements and claims for imaging services provided in the applicable settings. Claims will not be denied for failure to report or misreporting AUC/CDSM information. <See *Medicare One Time Notification Transmittal 2404*>
 - a. Even though claims will not be denied, the ordering practitioner is required to consult the CDSM and the performing provider is required to report AUC/CDSM information on claims, effective January 1, 2020. <See *Medicare One Time Notification Transmittal 2404*; 42 C.F.R. § 414.94(j) and (k)>
2. Initially, CMS expected the AUC requirements to be fully implemented by January 1, 2021, in order for the hospital's claim to be paid appropriately. <See *Medicare One Time Notification Transmittal 2404*>
 - a. However, the Educational and Operational Testing Period for the AUC Program has been extended through CY 2022.
 - b. Although there are no payment consequences associated with the AUC program during CY s 2020 through CY 2022, CMS is encouraging stakeholders to use this period to learn, test and prepare for the AUC program.

Link: Appropriate Use Criteria Program under Medicare Related Sites – Physician/Practitioner

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: An established patient presents to the RHC at 8:30 a.m. for her scheduled IPPE (G0402) with her usual NP. During the exam, the patient complains of being short of breath and having a non-productive cough. The NP documents all elements of the IPPE and a Level 3 qualifying visit (99213) to evaluate the respiratory symptoms. The NP also gives the patient a breathing treatment (94640). The patient is also scheduled to see the CSW later that morning for an evaluation of a mental health condition (90792) with medication management (90785).

Charges for the services include:

- IPPE (G0402) \$175
 - Medical visit (99213) \$160
 - Breathing treatment (94640) \$40
 - Mental health visit (90792/90785) \$150
- How would these services be reported to Medicare?
 - Will the patient be responsible for deductible and/or coinsurance?
 - Will the RHC be paid an AIR?

Analysis:

Rev Code	HCPCS/ Mod	Charge	Deduct/ Coins	AIR
0521	G0402	\$175.00	No	Yes
0521	99213CG	\$200.00 (charge for initial medical visit + breathing treatment)	Yes	Yes
0412	94640	\$ 0.01	No	No
0900	90792CG	\$150.00	Yes	Yes

NOTE: In this scenario, the RHC would be paid for 3 separate AIR payments. Only the medical visit and the mental health visit would require reporting of modifier -CG. The patient's deductible and coinsurance would be applied to the medical visit and the mental health visit only. The deductible and coinsurance for the IPPE are waived per statute.

Modified Facts: The patient leaves the RHC after the scheduled visits with the NP and CSW. Later that same day, the patient slips on the stairs in her home and twists her ankle. The patient returns to the RHC at 4:00 p.m. and is seen by the same NP who wraps the ankle and documents a Level 2 qualifying visit (99212). The total charge for the service is \$100.

Charge for the second visit:

– Medical visit (99212) \$100

- How would all of the services be reported to Medicare for the same date of service?
- Will the patient be responsible for any deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Analysis:

Rev Code	HCP/CSW/Mod	Charge	Deduct/Coins	AIR
0521	G0402	\$175.00	No	Yes
0521	99213CG	\$200.00 (charge for initial medical visit + breathing treatment)	Yes	Yes
0412	94640	\$ 0.01	No	No
0900	90792CG	\$150.00	Yes	Yes
0521	9921225	\$100.00	Yes	Yes

NOTE: In this scenario, the RHC would be paid 4 separate AIR payments. Only the initial medical visit and the mental health visit would require reporting of modifier -CG. The return visit to the RHC would be reported with modifier -25 or modifier -59 to indicate it was a separate and unrelated visit on the same day. Modifier -CG is not reported on the same line as modifier -25 or -59. The patient's deductible and coinsurance would be applied to both medical visits and the mental health visit. The deductible and coinsurance for the IPPE are waived per statute.

Case Study 2

Facts: A patient presents to a provider-based RHC that is owned by a CAH. The patient is scheduled for an IPPE under his Medicare benefit. In conjunction with the IPPE, the physician performs an EKG and documents the interpretation in the patient's record. The RHC nurse draws blood for a cardiovascular blood screening test that will be performed by the CAH. The patient also asks the physician to examine his back for chronic pain issues. The physician documents a Level 2 (99212) for the related evaluation.

Charges for the services include:

- IPPE (G0402) \$175
 - EKG (G0405) \$50
 - Venipuncture (36415) \$25
 - Medical visit (99212) \$115
- How would these services be reported to Medicare?
 - Will the patient be responsible for any deductible and/or coinsurance?
 - Will the RHC be paid an AIR?
 - How will the non-RHC services be billed?

Analysis:

Rev Code	HCPCS/Mod	Charge	Deduct/Coins	AIR
0521	99212CG	\$190.00 (charge for medical visit + EKG interpretation/report + venipuncture)	Yes	Yes
0521	G0402	\$175.00	No	Yes
0730	G0405	\$ 0.01	No	No
0300	36415	\$ 0.01	No	No

NOTE: In this scenario, the RHC would be paid 2 separate AIR payments. The medical visit would require reporting of modifier -CG; however, modifier -CG is not reported with the IPPE. The patient's deductible and coinsurance would be applied to the medical visit, EKG interpretation, and venipuncture. Even though the EKG is performed in conjunction with the IPPE, the deductible and coinsurance are not waived. The IPPE deductible and coinsurance are waived per statute. The CAH will bill for the EKG tracing (G0404) that was performed in conjunction with the IPPE and the screening lab test.

The CAH will be paid under their usual cost reimbursement and the patient's deductible and coinsurance will only apply to the EKG tracing.

Case Study 3

Facts: The patient presents to the independent RHC for her AWV (G0439). The deductible and coinsurance will be waived, per statute. During the visit, the physician also asks the nurse to draw blood for a laboratory test that is performed in the RHC.

Charges for the services include:

- AWV (G0439) \$215
- Venipuncture (36415) \$25

- How would these services be reported to Medicare?
- Will the patient be responsible for deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Analysis:

Rev Code	HCPCS/Mod	Charge	Deduct/Coins	AIR
0521	G0439CG	\$240.00 (charge for preventive service and venipuncture)	No	Yes
0300	36415	\$ 0.01	No	No

NOTE: In this scenario, Medicare will pay 100% of the AIR for the preventive service rather than the usual 80% of the AIR. The independent RHC would bill the lab test performed in the RHC on the 1500 claim form and be reimbursed for the services under the CLFS. The patient will not be responsible for the deductible and coinsurance for the venipuncture since the charge is included in the preventive service line.

Case Study 4

Facts: The patient presents to the RHC for her annual cancer screening pelvic and clinical breast exam (G0101). The deductible and coinsurance will be waived per statute. During the visit, the patient asks the physician to look at a healing laceration on her palm that was red and swollen. The physician documents a level 2 office visit (99212).

Charges for the services include:

- Screening pelvic/breast (G0101) \$100
- Medical visit (99212) \$125

- How would these services be reported to Medicare?
- Will the patient be responsible for deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Analysis:

Rev Code	HCPCS/Mod	Charge	Deduct/Coins	AIR
0521	G0101	\$100.00	No	No
0521	99212CG	\$125.00	Yes	Yes

NOTE: The charge for the preventive service is reported on a separate line to prevent calculation of the patient's deductible and coinsurance. In this scenario, the RHC will be paid one AIR payment.

Case Study 5

Facts: On March 1st, an established patient presents to an independent RHC for continuing care of a wound infection treated by a community hospital. The patient sees their usual NP for assessment of the wound and evaluation of her diabetes complications. During the initial visit, the dressing was changed and an injection of Rocephin was given. The NP orders an additional 3-day course of Rocephin injections (750 mg each) and dressing changes to be performed by the nurse. The NP will reevaluate the patient in the RHC after completion of the antibiotic injections and dressing changes.

The following services were provided on March 1st:

- E/M (99214) \$185.00
- Injection, intramuscular (96372) \$60.00
- Injection, ceftriaxone sodium, per 250 mg (J0696) \$18.00 (each X3)

The following services were provided on each subsequent day for March 2nd, 3rd, 4th:

- E/M (99211; incident to nursing service with dressing change) \$45.00
- Injection, intramuscular (96372) \$60.00
- Injection, ceftriaxone sodium, per 250 mg (J0696) \$18.00 (each X3)

- How would these services be reported to Medicare?
- Will the patient be responsible for any deductible and/or coinsurance?
- Will the RHC be paid an AIR?

Analysis:

Rev Code	HCPCS/Mod	Charge	Deduct/Coins	AIR
0521	99214CG	\$776.00 (charge for initial medical visit, nursing visits, and all injections with medications)	Yes	Yes
0521	96372	\$ 0.01	No	No
0636	J0696	\$ 0.01	No	No

NOTE: In this scenario, the RHC would be paid one AIR payment. The medical visit would require reporting of modifier -CG. The patient's deductible and coinsurance would be applied to the total charge for the qualifying medical visit. All incident to nursing charges from the subsequent days would be included in the qualifying visit charge, including the injections and medications. If this was the initial claim, the RHC would report on TOB 0711. If this was a replacement of a previously billed claim, the charges for the nursing services would be added to the initial visit within the RHC's policy and the RHC would report on TOB 0717.

Case Study 6

Facts: Patient presents to an RHC for a possible infection in a prior laceration repair site. After examination, the NP orders a 10-day course of oral antibiotics. The patient's usual pharmacy has closed for the day and the NP gives the patient two tablets of the oral antibiotic. She informs the patient that the remainder of the prescription will be available the following day at the local pharmacy.

- Will the oral antibiotics provided to the patient during the RHC visit be covered by Medicare?
- To bill the patient for the tablets, how would the drug be reported on the claim (revenue code, HCPCS code, modifier, charge column)?

Analysis: No, the oral tablets would be a SAD and would not be covered by Medicare. Drugs administered by any method other than injection and infusion are considered to be SADs, with limited exceptions. The tablets would be reported under revenue code 0637. Since a HCPCS code does not exist for the oral tablets, the RHC can report generic A9270 with modifier -GY, unit of 1, and charges reported in the non-covered column.

Case Study 7

Facts: A patient presents to the provider-based RHC with a chief complaint of chest palpitations. The patient's usual physician completes a Level 4 evaluation (99214) and performs an EKG (93010). The physician documents the interpretation of the EKG separate from the visit note. During the visit, the physician requests a telehealth consult with a cardiologist at another hospital that is located 50 miles from the RHC. After the telehealth consult, the RHC nurse draws blood for a lab test that will be performed by the PPS hospital.

Charges for the services include:

- Medical visit (99214) \$250
 - EKG (93010) \$50
 - Venipuncture (36415) \$25
 - Originating site (Q3014) \$45
- How would these services be reported to Medicare?
 - Will the patient be responsible for any deductible and/or coinsurance?
 - Will the RHC be paid an AIR?
 - How will the non-RHC services be billed?

Analysis:

Rev Code	HCPCS/Mod	Charge	Deduct/Coins	AIR
0521	99214CG	\$325.00 (charge for medical visit + EKG interpretation + venipuncture)	Yes	Yes
0730	93010	\$ 0.01	No	No
0300	36415	\$ 0.01	No	No
0780	Q3014	\$ 45.00	Yes	No

NOTE: In this scenario, the RHC would be paid one AIR payment. The qualifying visit line would require reporting modifier -CG. The patient's deductible and coinsurance would be applied to the total charge for the qualifying medical visit which also includes the charge for the venipuncture and EKG interpretation. The originating site fee for the telehealth services are reported on a separate line, without modifier -CG. Telehealth service is reimbursed under MPFS and the patient's deductible and coinsurance will apply. The EKG tracing (93005) and the lab tests will be billed by the hospital to the Part A MAC on the UB-04 claim form using TOB 131. The hospital will be reimbursed under OPFS.

NOTE: A global HCPCS code (i.e., 93000) would not be billed on an RHC claim. When both a technical and professional component are described by separate HCPCS codes, only the professional component is reported on the RHC claim.

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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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. *However, effective January 1, 2022, 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. 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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),
- the scene of an accident, *or*
- *the location of the patient during a Hospice election, including a patient's residence or a Medicare certified facility*

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 *(except when the RHC/FQHC is furnishing hospice attending physician services during a hospice election)*, 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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 medical visit and a 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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, *COVID-19* vaccinations, *and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19*;
- 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, pneumococcal *and COVID-19* vaccines, *and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* 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.

Note: Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

50.2 - FQHC Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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, pneumococcal *and COVID-19* vaccines, *and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* 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).

Note: Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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 *(with the exception of hospice attending physician 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

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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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. *Effective January 1, 2022, 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.*

The CAA, 2023 extends the telehealth policies of the CAA, 2022 through December 31, 2024 if the PHE ends prior to that date. The in-person visit requirements for mental health telehealth services and mental health visits furnished by RHCs and FQHCs begin on January 1, 2025 if the PHE ends prior to that date. There must be an in-person mental health service furnished within 6 months prior to the furnishing of the mental health service furnished via telecommunications 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.

RHCs and FQHCs are instructed to append modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) in instances where the mental health visit was furnished using audio-video communication technology and to append modifier 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System) in cases where the service was furnished using audio-only communication.

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 *Physician Services Payment*

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Medicare beneficiaries who elect the Medicare hospice benefit may choose either an individual physician, *NP* or *PA* to serve as their *designated* attending practitioner (Section 1861(dd) of the Act). *Beginning January 1, 2022, under section 132 of the CAA 2021*, RHCs and FQHCs are authorized to serve in this role. A physician, *NP*, or *PA* who works for an RHC or FQHC may provide hospice attending *physician* services during a time when he/she is working for the RHC or FQHC (unless prohibited by their RHC or FQHC contract

or employment agreement). *The RHC or FQHC would bill for these services as they would for any other qualified service to be paid the RHC AIR or the FQHC PPS rate, respectively.*

A physician, NP, or PA 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 and the physician or NP would bill for these 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

For hospice services that are not described above in section 210.1, 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 AWV, 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Influenza (G0008), Pneumococcal (G0009) and COVID-19 vaccines, and certain COVID-19 monoclonal antibody products

Influenza, pneumococcal *and COVID-19 vaccines and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* 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 AWV 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 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 RHC practitioner. If the AWV 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 dietitian 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 dieticians 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 (O0091)

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 (G0472) 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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/policies_regulations/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), Pneumococcal (G0009) and COVID-19 vaccines and certain COVID-19 monoclonal antibody products

Influenza, pneumococcal and COVID-19 vaccines and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 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 AWW 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 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 FQHC practitioner. If the AWW 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 dietitian 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 (O0091)

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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Care management services are RHC and FQHC services and include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), *chronic pain management (CPM)*, 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. *However effective January 1, 2022*, RHCs and FQHCs may bill for care management and TCM services *and other* 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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 healthcenter.

Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT code 99495), or within 7 days of discharge for high complexity decision making (CPT code 99496).

The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-discharge period.

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

230.2 – General Care Management Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

General Care Management Services include: *Chronic Care Management (CCM)*, *Principal Care Management (PCM)*, *Chronic Pain Management (CPM)* and *general Behavioral Health Integration (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, *PCM*, *CPM* and *general* 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, *PCM*, *CPM* or *general* 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.

230.2.1– Chronic Care Management (CCM) Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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.

230.2.2– Principal Care Management (PCM) Services
(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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.

230.2.3– Chronic Pain Management (CPM) Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Effective January 1, 2023, RHCs and FQHCs are paid for CPM services when a minimum of 30 minutes of qualifying non-face-to-face CPM services are furnished during a calendar month. CPM services may be furnished to patients with multiple chronic conditions that involve chronic pain, and may include a person-centered plan of care, care coordination, medication management, and other aspects of pain care.

230.2.4– General Behavioral Health Integration (BHI) Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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 ratingscales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose statuschanges;
- 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.

***230.2.5– Payment for General Care Management Services
(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)***

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 *CPT* codes *99424* (30 minutes or more of PCM services furnished by physicians or non-physician practitioners (NPPs)) and *99426* (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.

CCM, PCM, CPM or general BHI services furnished on or after January 1, 2023 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, 99491, 99424 and 99426 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.

Coinurance 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, AWW, or IPPE visit, and must occur no more than one-year prior to commencing care management services.

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

Coinurance 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.

Version 02/27/2023
Check for Updates

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 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.

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 reported 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

Medicare Claims Processing Manual, Chapter 9

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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