



Medicare Rural Health Clinic Version

KEY CONCEPTS OUTLINE

Module 2: 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 2 provides an example of the UB-04 claim form and the 1500 claim form.

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 Handout 3 – 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 Handout 3 - 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 Handout 3 – 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 Handout 3 – Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs) revised October 14, 2016; see MLN Matters SE1611>

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.

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 Handout 4 *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 4 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 Handout 4 *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 Handout 4 *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 Handout 4 *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 Handout 4 *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 Handout 4 *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 Handout 3 – 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	HCPCS/Mod	Charge	Deduct/Coins	AIR
			Yes/No?	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	HCPCS/Mod	Charge	Deduct/Coins	AIR
			Yes/No?	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 5 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 Handout 5 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 Handout 5 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 OPSS).

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	AIR
			Yes/No?	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	AIR
			Yes/No?	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, 2022, 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 G205 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	AIR
			Yes/No?	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	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
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.

Version 03/15/2023
Check for Updates

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 OPPS.

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.

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10729	Date: April 26, 2021
	Change Request 12252

SUBJECT: Updates to Medicare Benefit Policy Manual for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (Manual Updates Only)

I. SUMMARY OF CHANGES: This Change Request (CR) revises the Medicare Benefit Policy Manual, chapter 13, to reflect changes made in the Calendar Year (CY) 2021 Physician Fee Schedule Final Rule.

EFFECTIVE DATE: January 1, 2021

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

IMPLEMENTATION DATE: May 26, 2021

Disclaimer for manual changes only: *The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/Table of Contents
R	13/Index of Acronyms
R	13/230/Care Management Services
R	13/230.2/General Care Management Services – Chronic Care

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 10729	Date: April 26, 2021	Change Request: 12252
-------------	--------------------	----------------------	-----------------------

SUBJECT: Updates to Medicare Benefit Policy Manual for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (Manual Updates Only)

EFFECTIVE DATE: January 1, 2021

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

IMPLEMENTATION DATE: May 26, 2021

I. GENERAL INFORMATION

A. Background: CMS finalized Principal Care Management (PCM) policies related to the RHC and FQHC Services in the CY 2021 Physician Fee Schedule Final Rule.

B. Policy: This CR updates the Medicare Benefit Policy Manual by revising chapter 13, the RHC and FQHC Services.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
12252.1	Medicare contractors shall be aware of changes to the Medicare Benefit Policy Manual contained in this CR.	X	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E M A C	C E D I		
		A	B	H H H				
	None							

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Lisa Parker, 410-786-4949 or Lisa.Parker1@cms.hhs.gov, Glenn McGuirk, 410-786-5723 or Glenn.McGuirk@cms.hhs.gov.

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Version 03/15/2023
Check for Updates

Medicare Benefit Policy Manual

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

Table of Contents
(Rev. 10729, 04-26-21)

Transmittals for Chapter 13

230.2 - General Care Management Services – Chronic Care Management, *Principal Care Management*, and General Behavioral Health Integration Services

Version 03/15/2023
Check for Updates

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

PCM – Principal Care Management

Version 03/15/2023
Check for Updates

230 – Care Management Services

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

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

230.2 – General Care Management Services – Chronic Care

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

General Care Management Services includes CCM, *PCM* and BHI services. A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before care management services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services. Care management services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for CCM and BHI services as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of care management services. Beneficiary consent to receive care management services must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, may be written or verbal and must be documented in the patient's medical record before CCM or BHI services are furnished. The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:

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

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

CCM

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

and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CCM service requirements include:

- Structured recording of patient health information using Certified EHR Technology including demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care;
- 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications;
- Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
- Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver;
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
- Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record; and
- Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

PCM

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

PCM service requirements include:

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

General BHI

BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions. Effective January 1, 2018, RHCs and FQHCs are paid for general BHI services when a minimum of 20 minutes of qualifying general BHI services during a

calendar month is furnished to patients with one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services. General BHI service requirements include:

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

Payment for General Care Management Services

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

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

CCM or general BHI services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491 (30 minutes or more of CCM furnished by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM, PCM or general BHI services furnished on or after January 1, 2021 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491, and HCPCS codes G2064 (30 minutes or more of PCM services furnished by physicians or non-physician practitioners (NPPs)) and G2065 (30 minutes or more of PCM services furnished by clinical staff under the direct supervision of a physician or NPP), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

Coinsurance for care management services is 20 percent of lesser of submitted charges or the payment rate for G0511. Care management costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate. G0511 can be billed once per month per beneficiary when at least 20 minutes of CCM services, *at least 30 minutes of PCM services*, or at least 20 minutes of general BHI services have been furnished and all other requirements have been met. Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 20 minutes that is required to bill for *CCM and general BHI services and the minimum 30 minutes that is required to bill for PCM services*, and does not include administrative activities such as transcription or translation services.