DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Implementation Date: April 1, 2016

Effective Date: April 4, 2016

Required Billing Updates for Rural Health Clinics

Note: This article was revised on February 29, 2016, to clarify the billing instructions, especially in the examples provided in the article. All other information is unchanged.

Provider Types Affected

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

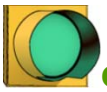
Provider Action Needed


STOP – Impact to You

Change Request (CR) 9269 provides instructions to the MACs to accept Healthcare Common Procedure Coding System (HCPCS) coding on RHC claims.


CAUTION – What You Need to Know

Effective April 1, 2016, RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes. Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met. There is no change to the AIR system and payment methodology, including the "carve out" methodology for coinsurance calculation, due to this reporting requirement.



GO – What You Need to Do

Make sure that your billing staffs are aware of these RHC-related changes for 2016.

Background

Beginning on April 1, 2005, through December 31, 2010, RHCs billing under the AIR system were not required to report HCPCS coding when billing for RHC services, absent a few exceptions. Generally, it has not been necessary to require reporting of HCPCS since the AIR system was designed to provide payment for all of the costs associated with an encounter for a single day.

Provisions of the Affordable Care Act of 2010 further modified the billing requirements for RHCs. Effective January 1, 2011, Section 4104 of the Affordable Care Act waived the coinsurance and deductible for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. In accordance with this provision, RHCs have been required to report HCPCS codes when furnishing certain preventive services since January 1, 2011.

CMS regulations require covered entities to report standard medical code sets for electronic health care transactions, although CMS program instructions have directed RHCs to submit HCPCS codes only for preventive services. Such standard medical code sets are defined as Level I and Level II of the HCPCS. In the CY 2016 Physician Fee Schedule (PFS) proposed rule (80 FR 41943), CMS proposed that all RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), be required to submit HCPCS and other codes as required on claims for services furnished. The requirements for RHCs to submit HCPCS codes were finalized in the CY 2016 PFS final rule with comment period (80 FR 71088).

CR9269 Changes

Basic Guidelines on RHC Visits and Billing for 71X Types of Bills (TOBs)

An RHC visit is defined as a medically necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and an RHC practitioner during which time one or more RHC services are furnished. A Transitional Care Management (TCM) service can also be an RHC visit. Additional information on what constitutes a RHC visit can be found in the "Medicare Benefit Policy Manual," Chapter 13.

Qualified preventive health services include the IPPE, the AWV, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. For a complete list of preventive services and their coinsurance and deductible requirements, see the "RHC Preventive Services Chart" on the **CMS RHC center webpage**.

Beginning on April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with a revenue code on their Medicare claims. Services furnished through March 31, 2016, should be billed without a HCPCS code under the previous guidelines.

A RHC visit must include one of the services listed on the *RHC Qualifying Visit List*, which is shown below. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the **CMS RHC center webpage**. RHCs can subscribe to the center page for email updates.

Service Level Information:

- The professional component of qualifying medical services and approved preventive health services are billed using revenue code 052X.
- Qualifying mental health services are billed using revenue code 0900.
- Telehealth originating site facility fees are billed using revenue code 0780.

Billing Qualifying Visits under the HCPCS Reporting Requirement

An encounter must include one of the services listed under the *RHC Qualifying Visit List*. The total charges for the encounter must be included on the qualifying visit line minus any charge for an approved preventive service. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying visit line. All other RHC services furnished during the encounter are also reported with a charge and payment for these lines is included in the AIR.

NOTE: The examples listed below include form locators (FL) from the UB-04.

Example 1: Medical Services

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the *RHC Qualifying Visit List*. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line. All other RHC services furnished during the encounter are also reported with the charge for the service.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$76.40[2]	AIR	Yes
0300	36415	04/1/2016	1	$3.00[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*

[2]Total charges for the encounter
[3]Charge for the service

Example 2: Medical Services and Preventive Services
If an approved preventive service is furnished with a medical visit, the RHC shall report the preventive service on an additional 052X service line with the associated charges. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service. Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$76.40[2]	AIR	Yes
052X	G0101	04/01/2016	1	$38.67[3]	Included in the AIR	No
0300	36415	04/01/2016	1	$3.00[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges minus charge for approved preventive service
[3]Charge for the service

See the *Coinsurance* section below for information applicable to Example 2.

Example 3: Preventive Service Only Encounter
When a preventive health service is the only qualifying visit reported for the encounter, the payment and applicable coinsurance and/or deductible will be based upon the associated charges for this service line. Frequency edits will apply.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	G0101[1]	04/01/2016	1	$38.67[2]	AIR	No[3]

[1]Preventive service HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for encounter
[3]Coinsurance and deductible are waived when appropriate

Example 4: Mental Health Services

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a qualifying mental health visit from the *RHC Qualifying Visit List*. The qualifying mental health visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
0900	90834[1]	04/01/2016	1	$110.63[2]	AIR	Yes
0900	90863	04/01/2016	1	$25.42[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charge for the encounter
[3]Charge for the service

Example 5: Multiple Medical Services

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the *RHC Qualifying Visit List*. Each additional medical service furnished should be reported with revenue code 052X. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$183.32[2]	AIR	Yes
052X	12002	04/01/2016	1	$109.92[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for the counter
[3]Charge for the service

Example 6: Medical Services and Incident to Services

Services and supplies furnished incident to a RHC visit are considered RHC services. They are included in the payment of a qualifying visit and are not separately payable as stand-alone services. The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-

088x, 093x, or 096x-310x. RHCs should report the most appropriate revenue code for the services being performed.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$139.11[2]	AIR	Yes
0300	36415	04/01/2016	1	$3.00[3]	Included in the AIR	No
0636	90746	04/01/2016	1	$59.71[3]	Included in the AIR	No
0771	G0010	04/01/2016	1	$5.00[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charge for the encounter
[3]Charge for the service

For any service line included in the AIR payment, the following remittance codes will be received:

- Group code CO- Contractual obligation;
- CARC 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present; and
- RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Billing for Multiple Visits on the Same Day

Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate

times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

- The patient has a qualifying medical visit and a qualifying mental health visit on the same day. The RHC shall follow the guidelines in the *Billing Qualifying Visits under the HCPCS Reporting Requirement* section of this article to bill for a medical and mental health visit. The qualifying medical visit line should include the total charges for the medical services and the qualifying mental health visit line should include the total charges for the mental health services.

- The patient has an IPPE and a separate medical and/or mental health visit on the same day. IPPE is a once in a lifetime benefit and is billed using HCPCS code G0402 and revenue code 052X. The beneficiary coinsurance and deductible are waived.

Coinsurance

When reporting a qualifying medical visit and an approved preventive service, the 052X revenue line with the qualifying medical visit must include the total charges for all of the services provided during the encounter, minus any charges for the approved preventive service.

The charges for the approved preventive service must be deducted from the qualifying medical visit line for the purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is $150.00, and $50.00 of that is for a qualified preventive service, the beneficiary coinsurance is based on $100.00 of the total charge.

Returned Claims

MACs will return to the RHC all claims with service lines that do not contain a valid HCPCS code. MACs will also return to the RHC all claims that contain more than one qualifying visit HCPCS code (from the *RHC Qualifying Visit List*) billed under revenue code 052X for medical service lines (excluding approved preventive services and modifier 59) and mental health services billed under revenue code 0900 with the same date of service.

Additional Information

The official instruction, CR9269 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1596OTN.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

Document History

Date of Change	Description
February 29, 2016	Revised to provide clarifying information, especially in the billing examples provided.
February 10, 2016	Revised to add examples 5 and 6 on page 5 and to correct the language regarding the coinsurance amount in the text under "Coinsurance" on page 6.
February 1, 2016	Initial issuance

RHC Qualifying Visit List

Medical Services

HCPCS Code	Short Descriptor
92002	Eye exam new patient
92004	Eye exam new patient
92012	Eye exam establish patient
92014	Eye exam&tx estab pt 1/>vst
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessmnt
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est pat
99341	Home visit new patient

HCPCS Code	Short Descriptor
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min

Approved Preventive Health Services

HCPCS Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0102*	Prostate ca screening; dre
G0117*	Glaucoma scrn hgh risk direc
G0118*	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

****Coinsurance and deductible are not waived***

Mental Health Services

HCPCS Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

Effective January 1, 2016, CPT code 99490 (chronic care management) is paid based on the Medicare Physician Fee Schedule (MPFS) national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC claim.