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| **MLN Matters® Number: MM8981** | **Related Change Request (CR) #: CR 8981** |
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# 2015 Update of the Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

## Provider Types Affected

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

## Provider Action Needed

Change Request (CR) 8981 advises MACs of updates to Chapter 13 of the "Medicare Benefit Policy Manual." These updates include new and clarifying information on the FQHC Prospective Payment System (PPS) rate, adjustments, payment codes, and qualifying visits; RHC employment requirements; RHC and FQHC preventive health services; and other issues related to RHC and FQHC billing and services.

## Background

The Centers for Medicare & Medicaid Services (CMS) has released an update to the "Medicare Benefit Policy Manual," Chapter 13, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services." Some of the key section updates as a result of CR8981 are as follows:

- **Section 10.1 - RHC General Information**
  **Clarification** - A provider-based CMS Certification Number is not an indication that the RHC has a provider-based determination for purposes of an exception to the payment limit.
- **Section 10.2 - FQHC General Information**
  **New** - On or after October 1, 2014, FQHCs began to transition to the FQHC PPS as required by Section 10501(i)(3)(B) of the Affordable Care Act.
- **Section 30.1.1 – RHC Requirements**
  **Clarification** - An Advanced Practice Registered Nurse who is not a Nurse Practitioner (NP), or Physician Assistant (PA), or a NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician, would not satisfy the RHC employment requirements.

  **New** - As of July 1, 2014, RHCs may contract with NPs, PAs, certified nurse midwives, clinical psychologists, or clinical social workers as long as at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at Section 1861(aa)(7) of the Social Security Act).

- **Section 40 - RHC and FQHC Visits**
  **New** - A list of qualifying visits for FQHCs paid under the PPS is located on the FQHC PPS webpage at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHC/index.html** on the CMS website.

- **Section 40.3 - Multiple Visits on Same Day *and Exceptions***
  **Clarification**- Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit ***and is payable as one visit.*** This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, ***or whether the first visit is related or unrelated to the subsequent visit.*** This would include situations where a RHC or FQHC patient has a medically-necessary face-to-face visit with a RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner (including a specialist) for evaluation of a different condition on the same day.

**New -** Exceptions for FQHCs that are authorized to bill under the PPS

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC) (2 visits can be billed), or
- The patient has a medical visit and a mental health visit on the same day (2 visits can be billed).

- **50.1 - RHC Services**

  **New** – RHC services includes Hepatitis C screenings.

  **Clarification** - Except for influenza and pneumococcal vaccines and their administration, which are paid through the cost report, RHCs are paid for the professional component of these services based on their AIR.

- **50.2 – FQHC Services**

  **New** – FQHC services includes Hepatitis C screenings.

  **Clarification/New** - Except for influenza and pneumococcal vaccines and their administration which are paid through the cost report, FQHCs are paid for the professional component of these services based on their AIR, or, for FQHCs that are authorized to bill under the PPS, based on the lesser of the FQHC's charge or the PPS rate for the specific payment code.

- **Section 70.1.2 – FQHC Per-Visit Payment Limit**

  **New** – FQHCs that bill under the AIR and are located within a Metropolitan Statistical Area are considered urban FQHCs. MSAs are Core-Based Statistical Areas that are associated with at least one urbanized area that has a population of at least 50,000 people.

- **Section 70.2 – FQHCs Billing Under the PPS Payment Rate and Adjustments**

  **New** - For FQHCs that are authorized to bill under the PPS, Medicare pays 80 percent of the lesser of the FQHC's charge or the PPS payment rate for the specific payment code, unless otherwise noted. The PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment, and other applicable adjustments as described below. The PPS base rate will be updated annually by the Medicare Economic Index (MEI) or by a FQHC market basket.

  Geographic Adjustment: The PPS base rate will be adjusted for each FQHC based on its location by the FQHC Geographic Adjustment Factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished. Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs are available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHC/.html** on the CMS website.

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

IPPE and AWV Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary.

- **Section 70.2.1 – Payment Codes for FQHCs Billing Under the PPS**
  **New** - FQHCs that are authorized to bill under the PPS must include a FQHC payment code on their claim for payment. FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G-code. The five specific payment codes to be used by FQHCs submitting claims under the PPS are:

  G0466 – FQHC visit, new patient

  G0467 – FQHC visit, established patient

  G0468 – FQHC visit, Initial Preventative Physical Exam (IPPE) or AWV

  G0469– FQHC visit, mental health, new patient

  G0470 – FQHC visit, mental health, established patient

- **Section 70.3 - Cost Reports**
  **New** - FQHCs that are authorized to bill under the FQHC PPS are required to file a cost report annually and are paid for the costs of GME, bad debt, and influenza and pneumococcal vaccines and their administration through the cost report.

- **Section 70.4 – Productivity Standards**
  **New** - FQHCs that are authorized to bill under the FQHC PPS are not subject to the productivity standards.

- **Section 80 - RHC and FQHC Patient Charges, Coinsurance, Deductible, and Waivers**
  **New** - For FQHCs billing under the PPS, the coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate.

- **Section 100.4 – Transitional Care Management (TCM) Services**
  **Clarification** - TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

- **Section 110.3 - Payment for Incident to Services and Supplies**
  **Clarification** - If a Medicare-covered Part B drug is furnished by a RHC or FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its

administration is included in the RHC or FQHC's AIR or the FQHC's PPS payment. RHCs and FQHCs cannot bill separately for Part B drugs or other incident to services or supplies.

- **Section 170 - Physical and Occupational Therapy**
  **New** - PT and OT therapists who provide services incident to a physician, NP, or PA visit may be an employee of the RHC or FQHC or contracted to the RHC or FQHC.

- **Section 190 - Telehealth Services**
  **Clarification** - RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract.

- **Section 210 - Preventive Health Services**
  **Clarification -** RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Healthcare Common Procedure Coding System (HCPCS) coding is required on all claims to allow for the coinsurance and deductible to be waived.

- **Section 210.1 - Preventive Health Services in RHCs**
  **Clarification** – HCPCS codes, payment and billing, and coinsurance and deductible information is provided for Influenza (G0008) and Pneumococcal Vaccines (G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Screening Pelvic and Clinical Breast Examination (G0101), Screening Papanicolaou Smear (Q0091); Prostate Cancer Screening (G0102), and Glaucoma Screening (G0117 and G0118).

  **New** - Hepatitis C Screening (GO472)
  Hepatitis C screening is included in a RHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the RHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance and deductible are waived.

- **210.3 - Preventive Health Services in FQHCs**
  **Clarification** - HCPCS codes, payment and billing, and coinsurance information is provided for Influenza and Pneumococcal Vaccines G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Diabetes Counseling and Medical Nutrition Services, Screening Pelvic and Clinical Breast Examination (G0101), Screening Papanicolaou Smear (Q0091),Prostate Cancer Screening (G0102),Glaucoma Screening (G0117 and G0118).

**New** - Hepatitis C Screening (GO472)
Hepatitis C screening is included in a FQHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the FQHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance is waived.

- **Section 210.4 - Copayment for FQHC Preventive Health Services**
  **Clarification** - When one or more qualified preventive service is provided as part of a FQHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment is based on $100 of the total charge, and Medicare would pay 80 percent of the $100, and 100 percent of the $50. If no other FQHC service took place along with the preventive service, there would be no copayment applied, and Medicare would pay 100 percent of the payment amount.

  **New -** FQHCs that are authorized to bill under the FQHC PPS would follow the same process, but would deduct the total charges for the preventive services from the lesser of the FQHC's charge or the PPS rate.

## Additional Information

The official instruction, CR8981, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R201BP.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.