DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Medicare Benefit Policy Manual – Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) Update - Chapter 13

Note: This article was revised on January 18, 2016, due to an updated Change Request (CR). The CR deleted Sections 180.5 and 210.2.1 from the chapter as the information has been reorganized to Sections 190.5 and 220.3 respectively. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same.

Provider Types Affected

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

What You Need to Know

CR 9442 informs MACs that Chapter 13 of the "Medicare Benefit Policy Manual" is updated to include new information, clarification of existing policies, and editorial changes.

Background

New Information Includes:

- Section 30.1 states that a RHC can count the time of a nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) when furnishing direct patient care in a patient's home or another location towards the requirement that an NP, PA, or CNM be available to furnish care at least 50 percent of the time the RHC is open to provide patient care.

- Section 110.5 states that payment for chronic care management (CCM) services is authorized for RHCs and FQHCs beginning on January 1, 2016, and provides an overview of the requirements.
- Sections 220.1 and 220.3 state that lung cancer screening using low-dose computed tomography is a covered preventive service and can be billed as a stand-alone visit if it is the only service furnished on that day with a RHC or FQHC practitioner, and applicable coinsurance and deductibles are waived.

Clarifying Information Includes:

- Use of Modifier 59 (Section 40.3)
- Payment for procedures (Section 40.4)
- Description of ambulance services that are non-covered (Section 60.1)
- Description of group services that are non-covered (Section 60.1)
- Information on payment codes for FQHCs (Section 70.4)
- Cost reporting requirements (Section 80.1 and 80.2)
- Billable visits by dentists, podiatrist, optometrists, and chiropractors (Section 110.1)
- Description of mental health visits, billing for mental health visits, and payment for medication management (Section 170)
- Hepatitis C screening in RHCs and FQHCs (Sections 220.1 and 220.2).

Additional Information

The official instruction, CR9442, issued to your MAC regarding this change, is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R220BP.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
January 18, 2016	**The** article was revised on January 18, 2016, due to an updated CR. The CR deleted sections 180.5 and 210.2.1 from the chapter as the information has been reorganized to sections 190.5 and 220.3 respectively. The CR release date, transmittal number and link to the transmittal were also changed.