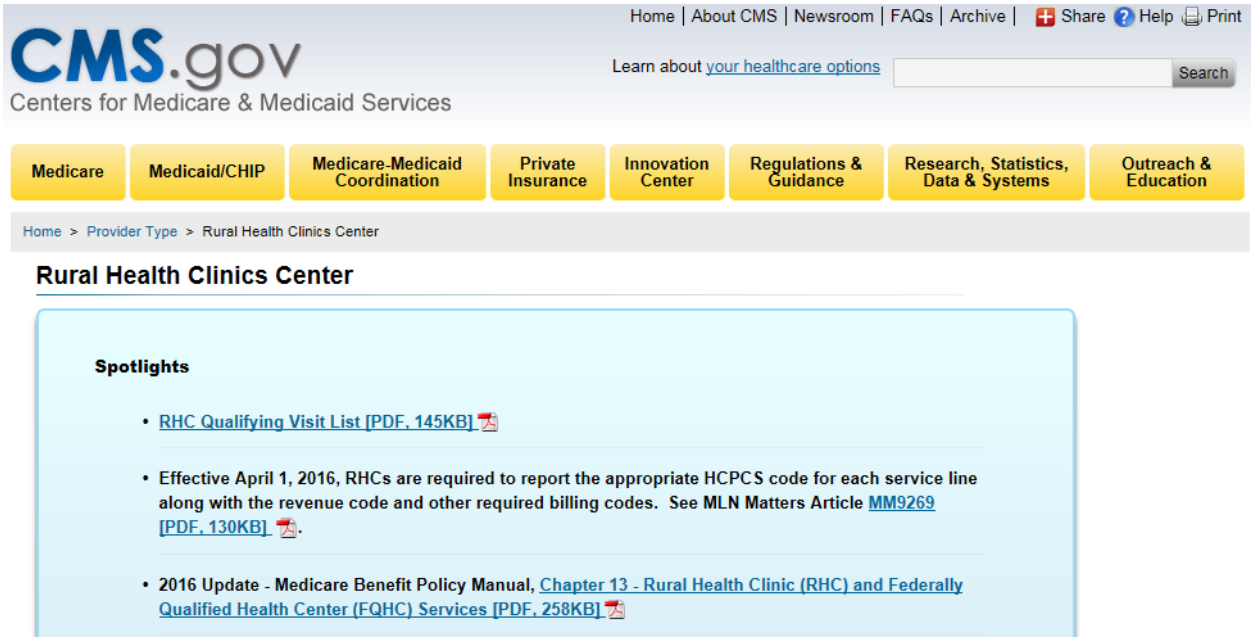
New RHC Billing Requirements Effective April 1, 2016

In the 2016 Medicare Physician Fee Schedule Final Rule, Medicare changed the billing rules for all Rural Health Clinics. RHCs will be required to report all services using HCPCS Level I (CPT®) and HCPCS Level II codes effective April 1, 2016.

Update as of March 24, 2016: CMS updated the Rural Health Clinic (RHC) Qualifying Visit List to include additional medically-necessary billable visits effective April 01, 2016, **but are not payable until October 01, 2016. RHCs should hold claims for these billable visits added to the Qualifying Visit List until October 01, when these claims will begin to process for reimbursement.**

The link below is to the CMS Rural Health Home Page and a link to the complete Qualifying Visit List:

https://www.cms.gov/center/provider-type/rural-health-clinics-center.html



A link and an excerpt from the final rule is provided below:

https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#h-266

"We appreciate the support for our proposal to require RHCs to report HCPCS on RHC claims for Medicare services. We want to clarify that the reporting of HCPCS does not

necessarily convey eligibility to participate in PQRS and other value-based payments since these programs have additional eligibility requirements that RHCs may be unable to meet. We do not believe there will be an operational challenge for providers to capture the charge for all services provided. There is no change to the methodology for reporting charges under this requirement. We acknowledge the commenter's concerns about the system's readiness to process claims under the requirement and we have been working with the MACs to implement the required updates. We are finalizing the reporting requirement as proposed with an effective date of April 1, 2016 to allow the MACs additional time to implement the necessary claims processing systems changes completely."

Additionally, Medicare updated the Medicare Claims Processing Manual with the following transmittal, updated January 26, 2016:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1596OTN.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1596	Date: January 26, 2016
	Change Request 9269

Transmittal 1566, dated November 6, 2015, is being rescinded and replaced by Transmittal 1596 to re-issue it as no longer sensitive/controversial and add a provider education requirement. In the policy section, it also clarifies that there are no changes to the all-inclusive rate system, uses the term qualifying visit instead of HCPCS code, and removes outdated language. All other information remains the same.

SUBJECT: Required Billing Updates for Rural Health Clinics

Excerpts from Transmittal 1596 include:

"Beginning with dates of service on or after April 1, 2016, when billing Medicare, RHCs are required to report the appropriate HCPCS code for each line item along with revenue code.

RHC qualifying visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. See Attachment A for a list of HCPCS codes that are defined as qualifying visits, which corresponds with the following guidance on service level information.

Service Level Information:

- The professional component of qualified medical services are reported on a line item using revenue 052X (free-standing clinic).
- When an approved preventive health service is furnished, report it on an additional 052X service line.

- Mental health services are reported on a line item using revenue code 0900 (mental health treatment services).

RHCs shall report one service line per encounter/visit with revenue code 052X and a medical service qualifying visit from Attachment A. Payment will be applied to the service line with revenue code 052X and a valid medical service qualifying visit, and coinsurance and/or deductible will be applied to this line. When a preventive health service is reported on an additional 052X line it is not eligible for a separate per diem payment, except for the initial preventive physical exam (IPPE).

When a preventive health service is the only qualifying visit reported for the encounter, payment will be applied to this service line with revenue code 052X. For approved preventive services, frequency edits apply and coinsurance and/or deductible will be waived for the line.

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a mental health service qualifying visit from Attachment A."

Medical Services

HCPCS Code	Short Descriptor
10040[1]	*Acne surgery*
10060[1]	*Drainage of skin abscess*
10061[1]	*Drainage of skin abscess*
10080[1]	*Drainage of pilonidal cyst*
10081[1]	*Drainage of pilonidal cyst*
10120[1]	*Remove foreign body*
10121[1]	*Remove foreign body*
10140[1]	*Drainage of hematoma/fluid*
10160[1]	*Puncture drainage of lesion*
11000[1]	*Debride infected skin*
11010[1]	*Debride skin at fx site*
11011[1]	*Debride skin musc at fx site*
11042[1]	*Deb subq tissue 20 sq cm/<*
11055[1]	*Trim skin lesion*
11056[1]	*Trim skin lesions 2 to 4*
11057[1]	*Trim skin lesions over 4*