CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12941	**Date: October 31, 2024**
	Change Request 13817

SUBJECT: Updates to Allow Category II Codes to be Submitted on Rural Health Clinic (RHC) Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to allow category II codes to be submitted on a claim by an RHC.

EFFECTIVE DATE: April 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 7, 2025

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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

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EFFECTIVE DATE: April 1, 2025
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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to allow category II codes to be submitted on a claim by an RHC.

II. GENERAL INFORMATION

A. Background: RHCs are currently unable to report CPT Category II codes on their Medicare FFS claims because of systems edits. Specifically, when these informational-only codes are reported, the entire claim is rejected. There are no Medicare FFS payment policies that use these codes for payment or quality reporting purposes; however, reporting informational-only codes on a claim for value-based arrangements may facilitate quality reporting for other programs.

B. Policy: There is no policy change associated with the change request.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13817.1	Contractors shall allow category II Healthcare Common Procedure Coding System (HCPCS) codes with a status indicator of 'M' or 'E1' to be submitted on RHC claims, 71X type of bill (TOB).					X				
13817.2	The Contractor shall modify their system to bypass any reason code(s) that prevent RHC claims, 71X TOB, from billing category II HCPCS codes with a status indicator of 'M' or 'EI', for example reason code 31836.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13817.3	The Contractor shall assign line level reason code 31837on RHC claims, 71X TOB when a claim is submitted with a category II HCPCS code that contains a status indicator of 'M' or 'E1'.					X				
13817.3.1	The Contractor shall use the following American National Standards Institute (ANSI) information: Group Code CO – Contractual obligation Claim Adjustment Reason Code (CARC) 246: This non-payable code is for required reporting only. Remittance Advice Remark Code (RARC) N620 Alert: This procedure code is for quality reporting/informational purposes only**.** Medicare Summary Notice *(*MSN) 36.7: This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount.	X								
13817.4	The Contractors shall bypass Medicare Secondary Payer (MSP)-PAY for codes, with "M" or "E1" status indicator.	X				X				

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. 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

VI. CONTACTS

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

VII. FUNDING

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ATTACHMENTS: 0