CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2118	**Date: August 10, 2018**
	Change Request 10843

NOTE: This Transmittal is no longer sensitive and is being re-communicated January 16, 2019. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Communication Technology Based Services and Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

I. SUMMARY OF CHANGES: This Change Request (CR) provides instructions for payment to Rural Health Clinics (RHCs) billing under the All-Inclusive Rate (AIR), and Federally Qualified Health Centers (FQHCs) billing under the Prospective Payment System (PPS), for communication technology based services for dates of service on or after January 1, 2019.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2019

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: January 1, 2019
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IMPLEMENTATION DATE: January 7, 2019

I. GENERAL INFORMATION

A. Background: This Change Request (CR) provides instructions for payment to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) furnishing General Care Management (Healthcare Common Procedure Coding System (HCPCS) code G0511), Psychiatric Collaborative Care Model (CoCM) (HCPCS code G0512), and Virtual Communications (HCPCS code G0071).

In the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) established payment for General Care Management (HCPCS code G0511) and Psychiatric CoCM (HCPCS code G0512) for RHCs and FQHCs only, effective January 1, 2018. In the CY 2019 PFS final rule, CMS finalized a policy that RHCs and FQHCs receive payment for communication technology-based services ("virtual check-in") or remote evaluation services, effective January 1, 2019. CMS created a new Virtual Communications G code for use by RHCs and FQHCs only, with the payment rate set at the average of the PFS non-facility payment rate for communication technology-based services and remote evaluation services.

B. Policy: Effective for services furnished on or after January 1, 2018, RHCs and FQHCs are paid for General Care Management or Psychiatric CoCM services when G0511 or G0512 is billed alone or with other payable services on an RHC or FQHC claim. HCPCS code G0511 or G0512 can only be billed once per month per beneficiary, and cannot be billed if other care management services are billed for the same time period.

Effective for services furnished on or after January 1, 2019, RHCs and FQHCs are paid for Virtual Communication services when G0071 is billed alone or with other payable services on an RHC or FQHC claim.

Payment, Coinsurance, and Deductible

Contractors shall generally pay 80 percent of the lesser of the RHC or FQHC's charge for G0511, G0512, and G0071 or the corresponding rate. The rates are updated annually based on the PFS amounts and are set as follows:

- G0511 is set at the average of the 4 national non-facility PFS payment rates for the Chronic Care Management (CCM) (Current Procedural Terminology (CPT) code 99490, CPT code 99487, and the service for 30 minutes of professional time) and general Behavioral Health Integration (BHI) (HCPCS code G0507).
- G0512 is set at the average of the 2 national non-facility PFS payment rates for CoCM (HCPCS code G0502 and HCPCS code G0503).
- G0071 is set at the average of the 2 national non-facility PFS payment rates for communication technology-based services and remote evaluation services.

Contractors shall apply coinsurance to RHC and FQHC services. Coinsurance will generally be 20 percent of the lesser of the RHC or FQHC's charge for G0511, G0512, and G0071 or the corresponding rate. Contractors shall exclude HCPCS codes G0511, G0512, and G0071 from the FQHC Prospective Payment System coinsurance calculation.

Contractors shall apply deductible to RHCs services. Medicare payment for RHC services begins only after the beneficiary has incurred the deductible.

Contractors shall not apply deductible to FQHC services. Medicare payment for services covered under the FQHC benefit is not subject to the usual Part B deductible.

Other Information

Contractors shall only allow revenue code 052x with the new HCPCS code G0071 and continue to allow revenue code 052x with HCPCS code G0511 and G0512. HCPCS codes G0071, G0511 and G0512 should not be billed with modifier CG for payment on RHC claims. The CG modifier is only billed with services that are eligible for the RHC all-inclusive rate (AIR). As noted in the "Payment, Coinsurance, and Deductible" section above, HCPCS codes G0511, G0512, and G0071 are paid based on the lesser of the charges or the rate (not the RHC AIR).

Requirements for Virtual Communications (HCPCS code G0071)

The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient. RHCs and FQHCs receive payment for communication technology-based services or remote evaluation services when at least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to an established patient (i.e. a patient who has had an RHC or FQHC billable visit at that RHC or FQHC within the previous year). These services may only be billed when the medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC service within the next 24 hours or at the soonest available appointment, since in those situations the services are already paid as part of the RHC or FQHC per-visit payment.

II. BUSINESS REQUIREMENTS TABLE

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

Number	**Requirement**	**Responsibility**								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10843.1	Contractors shall accept Virtual Communication services, HCPCS codes G0071 on all RHC (71X) and FQHC (77X) claims.	X								IOCE
10843.2	Contractors shall pay RHCs and FQHCs based on the lesser of the charges or the rate from the Medicare Physician Fee Schedule (MPFS) for HCPCS codes G0071, G0511 and G0512 .					X				IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	For RHC claims, these codes cannot be billed with a CG modifier, Integrated Outpatient Code Editor (IOCE) edit W7104 assign.									
10843.3	Contractors shall allow payment for HCPCS codes G0071, G0511 and G0512 with or without an encounter/visit on RHC and FQHC claims.					X				IOCE
10843.4	Contractors shall ensure deductible is applied to RHC claims after the lesser of the charges or the rate is determined for HCPCS codes G0071, G0511 and G0512.					X				
10843.5	Contractors shall apply coinsurance for HCPCS codes G0071, G0511 and G0512 based on the lesser of the charges or the rate.					X				
10843.6	The IOCE shall send a payment indicator flag of '2' for HCPCS codes G0071 for FQHC PPS claims.									IOCE
10843.7	Contractors shall suppress the Medicare Summary Notice (MSN) for Virtual Communication services, HCPCS codes G0071 for all Tribal FQHCs claims.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10843.8	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get	X				

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. 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

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or tracey.mackey@hhs.cms.gov , Simone Dennis, 410-786-8409 or Simone.Dennis@cms.hhs.gov

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0