CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2186	**Date: March 28, 2011**
	Change Request 7208

NOTE: Transmittal 2122, dated December 21, 2010, is being rescinded and replaced by Transmittal 2186, dated March 28, 2011, to remove Attachment A. CMS is also adding a link to CR 7012 that contains a list of preventive services HCPCS codes. All other information remains the same.

SUBJECT: Waiver of Coinsurance and Deductible for Preventive Services in Rural Health Clinics (RHCs), Section 4104 of Affordable Care Act (ACA).

I. SUMMARY OF CHANGES: This instruction waives coinsurance and deductible for preventive services with a USPSTF grade of A or B when provided in RHCs.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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
R	9/120/General Billing Requirements for Preventive Services
R	9/160/Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2186	Date: March 28, 2011	Change Request: 7208

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SUBJECT: Waiver of Coinsurance and Deductible for Preventive Services for Rural Health Clinics (RHCs), Section 4104 of the Affordable Care Act (ACA)

Effective Date: January 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background:

Provisions of the Affordable Care Act waive coinsurance and deductible for the initial preventive physical examination (IPPE), the annual wellness visit, and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services when submitted by RHCs on a 71X type of bill with dates of service on or after 01/01/2011.

B. Policy:

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. HCPCS coding is required to allow for the coinsurance and deductible to be waived for IPPE, the annual wellness visit, and those Medicare covered preventive services recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual. The Affordable Care Act also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayments and deductibles. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment and deductible is based on $100 of the total charge. If no other RHC service took place along with the preventive service, there would be no copayment or deductible applied.

Refer to CR 7012 for a list of HCPCS codes that are defined as preventive services under Medicare and the HCPCS codes for IPPE and the annual wellness visit.

http://www.cms.gov/transmittals/downloads/R864OTN.pdf

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7208.1	Effective for DOS 01/01/11 and after, Contractors shall allow additional revenue lines containing preventive services HCPCS codes on 71X types of bills. Note: As outlined in CR 7012, coinsurance and deductible are not applicable.	X		X			X				
7208.2	Contractors shall not make an additional payment for service lines containing preventive services HCPCS codes on 71X types of bills (excluding IPPE).						X				
7208.2.1	Medicare systems shall use group code CO and reason code 97 –"The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **NOTE:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present".	X		X			X				

III. PROVIDER EDUCATION TABLE

Number	**Requirement**	**Responsibility (place an "X" in each applicable column)**									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7208.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the Contractors next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey (claims processing) 410-786-5736 or Corinne Axelrod (policy) 410-786-5620

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

120 – General Billing Requirements for Preventive Services

(Rev. 2186, Issued: 03-28-11 Effective: 01-01-11, Implementation: 04-04-11)

Professional components of preventive services are part of the overall encounter, and for TOBs 71x or 73x/*77x*, have always been billed on lines with the appropriate site of service revenue code in the 052x series. In addition to previous requirements for independent FQHCs exclusively, all RHCs/FQHCs had been required to report HCPCS codes for certain preventive services subject to frequency limits.

For dates of service on or after April 1, 2005 through *December 31, 2010*, RHCs and FQHCs do not have to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71x *or* 73x/*77x* absent a few exceptions.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for preventive services. RHCs and FQHCs must provide detailed HCPCS coding for preventives services to ensure coinsurance and deductible are not applied.

An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service HCPCS code and the associated charges. For example, if the total charge for the visit is $150.00, and $50.00 of that is a qualified preventive service, the service lines should be coded as follows:

Line	*Revenue Code*	*HCPCS code*	*Date of Service*	*Charges*
1	*052X*		*01/01/2011*	*100.00*
2	*052X*	*preventive service code*	*01/01/2011*	*50.00*

The services reported under the first revenue line will receive an encounter/visit. Payment will be based on the all-inclusive rate, coinsurance and deductible will be applied. The qualified preventive service reported on the second revenue line will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable.

If the only services provided were preventives, report the appropriate site of service revenue code (052X) with the preventive service HCPCS code(s). The services reported under the first revenue line will receive an encounter/visit. Coinsurance and deductible are not applicable.

***NOTE:** This example does not apply to the initial preventive physical examination (IPPE), individual Diabetes Self Management (DSMT), and individual Medical Nutrition Therapy (MNT) as these preventives services are eligible to receive an additional encounter payment at the all-inclusive rate, coinsurance and deductible are not applicable. DSMT and MNT apply to FQHCs only. Coinsurance is applicable for DSMT.*

For vaccines, RHCs/FQHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x *or* 73x/*77x* claims. Costs for the influenza virus or

pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. Neither co-insurance nor deductible apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. An encounter can not be billed if vaccine administration is the only service the RHC/FQHC provides.

RHCs/FQHCs do not receive any reimbursement on TOBs 71x *or* 73x/*77x* for technical components of services provided by clinics/centers. This is because the technical components of services are not within the scope of Medicare-covered RHC/FQHC services. The associated technical components of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

Though most preventive services have HCPCS codes that allow separate billing of professional and technical components, mammography and prostate PSA do not. However, RHCs/FQHCs still may provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using the appropriate site of service revenue code in the 052x series.

Additional information on vaccines can be found in Chapter 1, section 10 of this manual. Additional coverage requirements for pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in Publication 100-02, the Medicare Benefit Policy Manual, Chapter 15.

160 – Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

(Rev. 2186, Issued: 03-28-11 Effective: 01-01-11, Implementation: 04-04-11)

Section 5112 of the Deficit Reduction Act of 2005 amended the Social Security Act to provide coverage under Part B of the Medicare program for a one-time ultrasound screening for abdominal aortic aneurysms (AAA). Payment for the professional services that meet all of the program requirements will be made under the all-inclusive rate. For RHCs the Part B deductible for screening AAA is waived for dates of service on or after January 1, 2007. FQHC services are always exempt from the Part B deductible. Coinsurance is applicable. *For RHCs and FQHCs, coinsurance for screening AAA is waived for dates of service on or after January 1, 2011*. Additional information on AAA can be found in Chapter 18, section 110 of this manual.

If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or Part A MAC using TOBs 71X and 73X/*77X*, respectively, and the appropriate site of service revenue code in the 052X revenue code series and must include HCPCS *code* G0389.

If the AAA screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier or Part B MAC under the practitioner's ID following instructions for submitting practitioner claims.

If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI or Part A MAC under the base provider's ID, following instructions for submitting claims to the FI/Part A MAC from the base provider.