Supporting Statement – Part A
Rural Health Clinics (RHCs) Reporting of Healthcare Common Procedure Coding System (HCPCS) and Other Codes as Required for RHC Claims and Supporting Regulations in 42 CFR 405.2462(g)(3)
CMS-10568 (OMB 0938-1287)

This package is associated with a November 16, 2015, final rule (80 FR 70886) (CMS-1631-FC; RIN 0938-AS40).

Background

For dates of service on or after April 1, 2005 through December 31, 2010, RHCs billing under the all-inclusive rate (AIR) were not required to report HCPCS coding when billing for RHC services, absent a few exceptions. Specifically, using subregulatory guidance, the Centers for Medicare and Medicaid Services (CMS) no longer required HCPCS coding for RHCs, except for a few services, such as certain preventive health services eligible for a waiver of deductible, services subject to frequency limits, and services eligible for payments in addition to the all-inclusive rate. Effective January 1, 2011, Section 4104 of the Affordable Care Act, waived the coinsurance and deductible for the initial preventive physical examination, the annual wellness visit, and other Medicare covered preventive services recommended by the United States Preventive Services Task Force with a grade of A or B. In accordance with policy, RHCs have been required to report HCPCS codes when furnishing certain preventive services since January 1, 2011.

A. Justification

1. Need and Legal Basis

CMS regulations require covered entities to report a standard medical code set for electronic health care transactions, although CMS program instructions have directed RHCs to submit HCPCS coding only for approved preventive services. Under section 1862(a)(22) of the Social Security Act (the Act), payment under Medicare Part A and B shall only be made for claims submitted in electronic form, subject to exceptions under section 1862(h) of the Act. Section 1173(a)(1) of the Act authorized the Secretary to adopt standards and data elements for financial and administrative transactions exchanged electronically. The regulations at 45 CFR 162.1000, define level I and level II of the HCPCS coding as standard medical code sets for healthcare transactions.

In the CY 2016 Physician Fee Schedule (PFS) proposed rule (July 15, 2015; 80 FR 41685), CMS proposed to modify the regulations at §405.2462(g)(3) to require all RHCs, including RHCs exempt from electronic reporting under §424.32(d)(3), to submit HCPCS and other codes as required when reporting services furnished on RHC claims beginning on January 1, 2016. We are finalizing the reporting requirement as proposed with an effective date of April 1, 2016 to allow the Medicare Administrative Contractors (MACs) additional time to implement the necessary claims processing systems changes completely.

2. Information Users

The use of HCPCS codes on RHC claims would ensure that RHCs comply with laws pertaining to electronic healthcare transactions set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Act. The Medicare Administrative Contractors that process RHC claims for payment would ensure that RHC claims include HCPCS coding and other codes as required, and subject certain HCPCS codes for preventive services to frequency limitations.

3. Use of Information Technology

The Act requires Medicare Part A and B claims to be submitted electronically. Majority of claims are transmitted electronically, except for the small number of providers exempt from electronic reporting under section 1862(h) of the Act. In general, claims are submitted electronically to a MAC from a RHC using a computer with software that meets electronic filing requirements as established by the HIPAA claim standard and by meeting CMS coverage and payment policy requirements. Medicare claims are stored in the data extract system, chronic conditions data warehouse, and the integrated data repository.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

In accordance with section 1862(h) of the Act, in limited situations RHCs that are unable to submit electronic claims and RHCs with fewer than ten full time equivalent employees are exempt from submitting claims electronically. In the CY 2016 PFS proposed rule, we propose that RHCs exempt from electronic reporting under 1862(h) of the Act must also report all services furnished during an encounter using HCPCS coding via paper claims. This proposal would necessitate new billing practices for such RHCs, but we believe there would be no significant burden for the limited number of RHCs exempt from electronic billing.

6. Less Frequent Collection

If HCPCS codes are not reported on RHC claims or reported infrequently, RHCs would continue to be out of compliance with the HIPPA, the Act, and CMS Regulations. Additionally, RHCs would continue to be out of compliance with healthcare transaction standards established by the National Uniform Billing Committee and Accredited Standards Committee X12.

7. Special Circumstances

There are no special circumstances for this information collection.

8. Federal Register/Outside Consultation

The NPRM served as the 60-day Federal Register notice which published on July 15, 2015 (80 FR 41685). The NPRM was placed on public inspection on July 8 whereby comments were due on Sept 8. No PRA-related comments were received.

The final rule is serving as the 30-day Federal Register notice (November 16, 2015; 80 FR 70886). The final rule was placed on public inspection on October 30 whereby comments are due on/by December 29, 2015.

9. Payments/Gifts to Respondents

There will be no payments or gifts to respondents.

10. Confidentiality

Medicare claims are subject to beneficiary protections set forth in HIPPA.

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimates (Hours & Wages)

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates for all salary estimates (www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits, and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Billing and Posting Clerks	43-3021	17.10	9.58*	26.68

*For fringe benefits, we are using the December 2014 Employer Costs for Employee Compensation (http://www.bls.gov/news.release/archives/ecec_03112015.pdf).

Burden Estimates

The ongoing burden associated with the requirements under §405.2462(g)(3) is the time and effort it would take each of the approximately 4,000 Medicare certified RHCs to report the services furnished to a Medicare beneficiary during a RHC visit using HCPCS

and other codes as required. We believe that most RHCs are familiar with the use of HCPCS coding already since RHCs typically record HCPCS coding through their billing software or electronic health record systems and already could be subject to HCPCS reporting in accordance with the National Uniform Billing Committee and Accredited Standards Committee X12 standards. We recognize some RHCs may need to make minor updates in their systems, but more so, RHC billing staff will need education in HCPCS coding associated with Medicare payable RHC visits. Due to the scope of services payable as a RHC visit, we do not anticipate RHCs will face a significant burden in training and education of billing staff. We plan to provide educational information on how RHCs are to report HCPCS and other codes as required and clarify other appropriate RHC billing procedures through sub-regulatory guidance.

We estimate that it will take 2 to 5 additional minutes to report HCPCS codes on RHC claims and we estimate a median of 3.5 additional minutes in the calculations below. We estimate the total annual reporting burden for the number of respondents to be approximately 522,912 hours and estimate the total burden per RHC to be 131 hours. The total annual cost burden to all respondents is estimated to be $13,951,296 and the total annual cost burden per RHC is estimated to be $3,488.

8,964,208 Medicare claims in 2013 x 3.5 min / 60 min = 522,912.13 hr (aggregate)

522,912.13 hrs / 4,000 RHCs = 130.73 hr (per RHC)

522,912.13 hrs x $26.68/hr = $13,951,295.63 additional cost (aggregate)

$13,951,295.63 / 4,000 RHCs = $3,487.82 per RHC

Summary

Section(s) in title 42 of the CFR	**Respondents**	**Responses (total)**	**Burden per Response**	**Total Annual Burden (hr)**	**Labor Rate for Reporting ($/hr)**	**Total Cost ($)**
405.2462(g)(3)	4,000	8,964,208	3.5 min	522,912.13	26.68	13,951,296

13. Capital Costs

This information collection does not incur any capital costs for RHCs.

14. Cost to Federal Government

At this time, we estimate minimal costs to the Federal government. The current claims processing system is designed to accept HCPCS codes on Medicare Part A and B claims, however, we will need to direct the MACs to accept these codes on RHC claims. Through a change request, we will communicate these business requirements to the MACs and will include a statement of costs to the federal government when that information becomes

available.

15. Changes to Burden

    There are no changes. This is a new collection.

16. Publication/Tabulation Dates

    The results of this collection of information will not be published.

17. Expiration Date

    This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement

    There are no exceptions for the certification statement.

B. Collection of Information Employing Statistical Methods

These information collection requirements do not employ statistical methods.