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Rural Health Clinics: Coverage and Billing

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- After today's session, attendees will be able to
  - Discuss coverage and requirements for RHC services
  - Properly bill RHC services to Medicare
  - Understand how RHC services are reimbursed
  - Know where to go for more information

Agenda

- Background and Requirements
- Billing
- Reimbursement and Cost Reports
- Resources, Wrap-Up and Questions

RHC Background and Requirements

Background of RHC Program

- Established to address inadequate supply of physicians in underserved rural areas
  - Increased utilization of NPs and PAs
- Provides:
  - Primary health services
  - Qualified preventive health services

Covered RHC Services

- Physician services
- Services and supplies furnished incident to physician's services
- NP, PA, CNM, CP and CSW services
- Services and supplies furnished incident to NP, PA, CNM, CP or CSW services
- Certain nursing visits to homebound individuals furnished by RN or LPN

Hospice Attending Physician Services

- Beginning 1/1/2022
  - RHCs eligible for payment for hospice attending physician services provided by RHC physician, NP, or PA
    - Employed or working under contract for RHC but not employed by a hospice program
- During hospice election, can take place at:
  - Patient's home
  - Medicare-certified hospice freestanding facility
  - Skilled nursing facility
  - Hospital

Did You Know

- Services, supplies, and drugs incident to covered RHC services covered if:
  - Furnished as incidental but integral part of physician/NPP professional services
  - Commonly rendered either without charge or included in RHC bill
- Not included
  - Supplies and drugs that must be billed to DME MAC or Part D

Nursing Visits to Homebound Patients

- All of the following conditions must be met:
  - Patient homebound
  - RHC located in area with shortage of HHAs
  - Services provided under plan of treatment
    - Written and reviewed by physician, NP, PA, CNM, CP or CSW
  - Furnished on intermittent basis
  - Does **not** include drugs and biologicals

Noncovered RHC Services

- Medicare exclusions (routine physicals, dental care, routine eye exams, hearing tests)
- Technical component of RHC services
- Laboratory services
  - Note - venipuncture included in AIR when furnished in RHC or incident to RHC service
- DME (crutches, hospital beds, wheelchairs)
- Ambulance services

Noncovered RHC Services

- Prosthetic devices which replace all or part of an internal body organ
- Body braces
- Practitioner services furnished to inpatients/ outpatients of:
  - Hospitals (including CAHs), ASCs, CORFs
- Telehealth services

RHC Requirements

- Must directly furnish routine diagnostic and laboratory services
  - Must furnish the following six laboratory tests onsite
    - Urine chemical examination by stick and/or tablet method
    - Hemoglobin or hematocrit
    - Blood sugar
    - Examination of stool specimens for occult blood
    - Pregnancy tests
    - Primary culturing for transmittal to certified laboratory

RHC Requirements

- Must have arrangements with one or more hospitals to furnish medically necessary services not available in RHC
- Must have available drugs and biologicals necessary for treatment of emergencies
- Not concurrently be approved as FQHC
- Not be rehabilitation agency or facility primarily for mental health treatment

Did You Know?

- NPP services for RHC beneficiaries must be
  - Provided by RHC employee
  - Under general/direct physician supervision
  - Type of service legally permitted by state to furnish
  - Follow state guidelines, RHC policies
  - Covered when provided by physician

RHC Reimbursement

- One AIR payment made for all professional services for each covered visit – “bundled payment”
  - Includes all covered services provided (limited exceptions)
  - Subject to maximum payment per visit

AIR Payment Limit

- No payment beyond specified limit amount per visit for most services
  - For certain preventive services (such as IPPE and AWV) full AIR paid and no deductible or coinsurance applies
  - For most other services, Medicare Part B deductible and coinsurance rates apply
    - Once patients meet their Part B deductible, Medicare pays 80% of the AIR and patient pays remaining 20%
- Payment limits differ based on type of RHC

AIR Payment Limit Changes

- As of 1/1/2021 AIR calculation changed for most RHCs
  - Section 130 of the CAA as amended by Section 2 of Publication Law 117-7
  - MM21285 - *Update to Rural Health Clinic (RHC) Payment Limits*

AIR Payment Limit Changes

- National statutory payment limit per visit for:
  - Independent RHCs
  - PB RHCs in hospital with 50 or more beds
  - RHCs enrolled in Medicare on or after 1/1/2021
- Increase in payment limits per visit over an eight-year period from 2021 – 2028
  - In subsequent years, limit updated by percentage increase in MEI

AIR Payment Limit Staged Increases

- 2021 (after March 31) = $100 per visit
- 2022 = $113 per visit
- 2023 = $126 per visit
- 2024 = $139 per visit
- 2025 = $152 per visit
- 2026 = $165 per visit
- 2027 = $178 per visit
- 2028 = $190 per visit

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AIR Payment Limit Changes

- PB RHCs in hospital with less than 50 beds and enrolled in Medicare as of 12/31/2019
  - Payment limit calculated per visit based on average allowable costs (“grandfathered”)
    - Total allowable costs divided by number of actual visits
  - Begins with 2020 per-visit rate and updated annually by percentage increase in MEI

Cost Report

- Submitted annually by provider for prior 12-month period
- Due no later than five months after end of cost reporting period
  - Upload via MCRef or send through US Mail
  - Failure to submit cost report may result in reduction/suspension of Medicare payments

Cost Report

- Once submitted, NGS reviews and finalizes cost report
  - Determines payment rate and reconcile if overpayment or underpayment
  - Reconciles interim payments and determine if adjustments needed (Flu/PPV vaccines, bad debt, etc.)
- CMS Publication 15-2, *Provider Reimbursement Manual – Part 2*

Beneficiary Cost Sharing

- Beneficiary pays deductible and 20% coinsurance amounts
  - Coinsurance based on Total Charges reported on visit line
  - Exception: Certain preventive services where coinsurance waived per ACA

RHC Billing

Timely Filing Guidelines

- One-year timely filing rule, based on date of service
  - THROUGH date used to determine timely filing for institutional claims containing span level DOS, i.e., “FROM” and “THROUGH” date span
- Effective for all Medicare claims
- Adjustment claims must also follow timely filing regulations

Notes for Upcoming Claim Examples

- HCPCS codes and associated charges used in examples are for illustration purposes only
- Examples assume that all coverage criteria have been met
- All other coding requirements (diagnosis, condition, occurrence, value codes, etc.) and claim elements apply

RHC Bill Types

- TOB = 71X
  - 710 = nonpayment/zero claim (all charges are noncovered)
  - 711 = admit through discharge
  - 717 = claim adjustment
  - 718 = claim cancel
- DOS cannot overlap calendar years
  - Split billing periods that overlap calendar year
    - Reference: CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 9, Section 100A

RHC Visit Definition

- Medically necessary, face-to-face medical or mental health or qualified preventive visit between patient and physician, NP, PA, CNM, CP or CSW during which RHC service furnished
- TCM service
- Certain LPN or RN visits to homebound patient

RHC Visit Locations

- RHC visits may take place in/at
  - RHC
  - Patient's residence
  - Assisted living facility
  - Medicare Part A skilled nursing facility
  - Scene of accident
  - Hospice (new)

RHC Visit Locations

- RHC visits may **not** take place in
  - Inpatient or outpatient hospital department
  - CAH
  - Facility that excludes RHC visits (e.g. hospice, CORF)

RHC Billable Visit Revenue Codes

Code	Description
0521	Clinic visit
0522	Home visit
0524	Visit for beneficiary in covered Part A SNF stay
0525	Visit for beneficiary in noncovered Part A SNF stay (or other residential facility)
0527	Visiting nurse service at beneficiary's home when in HH shortage area
0528	Visit to other non-RHC site (scene of accident)
0780	Telehealth
0900	Psychological services provided by CP, CSW

RHC Qualifying Visit List (QVL)

- RHC Reporting Requirement FAQs
- QVL used as guide to services that generally qualify as stand-alone billable visits
- RHC stand-alone billable visits
  - Use HCPCS reporting requirements to determine
  - Typically evaluation and management type of services or screenings for certain preventive services
  - Reported with the CG modifier

RHC QVL

- Medically necessary service not included on QVL can be billed as stand-alone visit if:
  - Meets Medicare coverage requirements
  - Within scope of RHC benefit
  - Not furnished incident-to physician's service

Reporting Qualifying Visit HCPC Code

- Claims and adjustments must include modifier CG on one line
  - Reported on line with medical and/or medical HCPCS code that represents primary reason for medically necessary face-to-face visit
  - Must include bundled charges for all services subject to coinsurance and deductible

Claim Example: Reporting Qualified Medical Visit

- Claim generates AIR payment
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on qualified visit line

FL 42 Rev Code	FL 44 HCPC	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges
052X	99213 CG	4/1/2022	1	$115
0001				$115

Claim Example: Reporting Qualified Mental Health Visit

- Claim generates AIR payment
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on qualified visit line

FL 42 Rev Code	FL 44 HCPC	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges
0900	90834 CG	4/1/2022	1	$170
0001				$170

Report All Services Provided During Visit

- RHCs required to report appropriate HCPCS code for each service on separate claim line along with revenue code
  - Also applies to RHCs exempt from electronic reporting under Section 424.32(d)(3)
  - Additional claim lines do not generate additional reimbursement
  - All other billing requirements still apply

Report All Services Provided During Visit

- Claim lines for services/supplies furnished "incident to" visit should report
  - Appropriate revenue code
    - RHCs can report incident to services using all valid revenue codes except 002X–024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X–072X, 080X–088X, 093X, 096X–310X
  - Applicable CPT/HCPCS code
  - One unit
  - Charges that apply to service

Report All Services Provided During Visit

- Qualifying visit line must include visit charge and total charges for all incident to services provided during visit
  - Coinsurance based on Total Charges on visit claim line
  - 0001 Totals line must calculate accurately
  - AIR generated based on billable visit revenue code

Claim Example: Reporting Qualified Medical Visit with Incident to Services

- Claim generates one AIR payment
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on qualified visit line

Claim Example: Reporting Qualified Medical Visit with Incident to Services

FL 42 Rev Code	FL 44 HCPC	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges
052X	99213 CG ($115)	4/1/2022	1	$205
0300	36415	4/1/2022	1	$55
0636	90746	4/1/2022	1	$25
0771	G0010	4/1/2022	1	$10
0001				$295

Multiple Visits on Same Day

- Bill for one visit (one unit)
  - Visits with more than one practitioner on same day
  - Multiple visits with same practitioner on same day
- Applies regardless
  - Length or complexity of visit
  - Number/type of practitioners seen
  - Subsequent visit scheduled or not
  - Initial visit related or not to subsequent visit

Multiple Visits on Same Day - Exceptions

- Bill for two visits
  - Illness/inquiry occurs after initial visit requiring diagnosis/treatment on same day
    - Primary visit billed with CG modifier
    - Subsequent medical visit billed with 052X revenue code, qualifying visit HCPCS code and modifier 59, one unit, total charges associated with visit
  - Medical visit and mental health visit same day
    - Both lines billed with CG modifier

Multiple Visits on Same Day - Exceptions

- Bill for two visits
  - IPPE and separate medical or mental health visit on same day
  - Do not report CG modifier on IPPE line
- Bill for three visits
  - IPPE and separate medical and mental health visit on same day
  - Do not report CG modifier on IPPE line

Reporting Multiple Qualified Visits

- Report claim line and incident to line(s) for each qualifying visit
  - Only one line has CG modifier unless mental and medical
- Total charges report on qualifying visit claim line must include associated incident to charges
- AIR generated for each qualifying visit claim line
- Coinsurance applies to each qualifying visit claim line (20% total charges)

Claim Example: Reporting Multiple Qualified Medical Visits

- Claim generates two AIR payments
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on each qualified visit line

FL 42 Rev Code	FL 44 HCPC	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges
052X	99213 CG	4/1/2022	1	$115
052X	99214 59	4/1/2022	1	$95
0001				$210

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Billing RHC Preventive Services

Approved Preventive Services

HCPCS Code	Short Descriptor	Coinsurance/Deductible Waived?
G0101	Ca screen; pelvic/breast exam	Yes
G0102	Prostate ca screening; dre	No
G0117	Glaucoma scrn hgh risk direc	No
G0118	Glaucoma scrn hgh risk direc	No
G0296	Visit to determ LDCT elig	Yes
G0402	Initial preventive exam	Yes
99406*	Tobacco-use consel 3–10 min	Yes
99407*	Tobacco-use consel >10 min	Yes
G0438	Ppps, initial visit	Yes
G0439	Ppps, subseq visit	Yes

Approved Preventive Services

HCPCS Code	Short Descriptor	Coinsurance/Deductible Waived?
G0442	Annual alcohol screen 15 min	Yes
G0443	Brief alcohol misuse counsel	Yes
G0444	Depression screen annual	Yes
G0445	High inten beh couns std 30 min	Yes
G0446	Intens behav ther cardio dx	Yes
G0447	Behavior counsel obesity 15 min	Yes
Q0091	Obtaining screen pap smear	Yes

Billing Preventive Services

- Reporting approved preventive service with qualifying medical visit
  - On separate claim line report
    - Revenue code 052X with preventive service CPT/HCPCS code
    - One unit with associated charges
- Do not include preventive service charges in qualifying visit total charges
  - Ensure coinsurance does not include preventive service costs

Claim Example: Reporting Qualified Medical Visit with Preventive Service

- Claim generates one AIR payment
  - Deductible applies
  - Coinsurance applies to nonpreventive claim lines
    - 20% total charges on qualified visit line

FL 42 Rev Code	FL 44 HCPC	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges
052X	99213 CG ($115)	4/1/2022	1	$115
052X	G0101	4/1/2022	1	$35
0001				$150

Billing Preventive Services

- Reporting approved preventive service with qualifying medical visit when coinsurance/ deductible are not waived
  - On separate claim line report
    - Revenue code 052X with preventive service CPT/HCPCS code
    - One unit with associated charges
- Include preventive service charges in qualifying visit total charges

Billing Preventive Services

- Reporting approved preventive service as qualifying medical visit
  - When only services provided on DOS
    - Revenue code 052X with preventive service CPT/HCPCS code
    - One unit with associated charges
- AIR payment generated
  - Coinsurance waived based on CPT/HCPCS

Claim Example: Reporting Preventive Service as the Qualified Medical Visit

- Claim generates one AIR payment
  - Deductible waived
  - Coinsurance waived

FL 42 Rev Code	FL 44 HCPC	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges
052X	G0101 CG	4/1/2022	1	$35
0001				$35

Billing Hepatitis B Vaccine

- If vaccine/administration are only services provided, do not submit claim
  - Settled on cost report
- If provided with billable visit, report as incident-to services
  - Include vaccine/administration charges on CG modifier line total charges
  - Coinsurance applicable
  - Payment included in AIR

Billing Influenza and Pneumococcal Pneumonia Vaccines

- Influenza and pneumococcal vaccines and administration not reported on RHC claims
- Coinsurance and deductible do not apply
- Payment made through cost report process

COVID-19 Vaccines

- COVID-19 FAQs on Medicare Fee for Service Billing
  - Question/Answer #7 under Section BB. Drugs & Vaccines under Part B
    - FQHCs and RHCs paid through the cost report process
- Medicare Part A and B Billing for the COVID-19 Vaccine and Monoclonal Antibody

Billing Guidelines – Other RHC Services

Advanced Care Planning

- Optional element of AWV
  - Voluntary ACP = face-to-face service between physician and patient discussing advance directives
  - Considered preventive service when furnished on same day as AWV
  - Generates separate MPFS payment
    - Coinsurance waived

Billing ACP - Element of AWV

- Report claim line for qualifying visit
  - Revenue code 052X with AWV qualifying visit HCPCS code G0438 or G0439
  - One unit with total charges for qualifying visit (only)
- Report claim line for ACP
  - Revenue code 052X with CPT code 99497
  - One unit with total charges for ACP
- 0001 Totals line must calculate appropriately

Billing ACP - Stand-Alone Encounter

- Report claim line for ACP
  - Revenue code 052X with CPT code 99497
    - Reported with CG modifier if only preventive services furnished and ACP primary reason for visit
  - One unit and total charges for ACP
- 0001 Totals line must calculate appropriately
- Generates separate MPFS payment

Care Management Services

- TCM
- General Care Management
  - CCM
  - BHI
  - PCM
- CoCM

Transitional Care Management Services

- Services required following discharge from inpatient hospital setting
  - 30-day period beginning date of discharge
- Physician/NPP accepts care of beneficiary post-discharge from facility setting without gap
  - Takes responsibility for beneficiary's care
- Medical/psychosocial issues require moderate-high/complexity medical decision making

TCM Guidelines

- If TCM visit occurs same day as another billable visit, generally only one visit billed
  - As of 1/1/2022 can bill TCM and general care management services for same patient during same time period
    - RHC must meet requirements for billing each code

TCM Guidelines

- Only one health care professional may report TCM services
- One TCM visit covered per beneficiary per post-discharge period
- Services provided not in post-op global period
- Subject to Part B coinsurance

Billing for TCM Services

- DOS = day face-to-face visit takes place
- Revenue code = 0521
- Qualifying visit HCPCS codes
  - 99495 for moderate-complexity decision making
  - 99496 for high-complexity decision making
- One unit
- Total Charges
- 0001 total charges

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General Care Management Services

- Separate payment
  - CCM
  - BHI
  - PCM
- No face-to-face requirement, auxiliary personnel may provide under general supervision

General Care Management Services

- Can only bill once per month per beneficiary
  - Do not bill if other care management services are billed for same time period by any practitioner or facility
  - Except TCM for DOS on/after 1/1/2022
- Can be billed alone or on qualifying visit claim
- Line item reporting - HCPCS code G0511
  - Do not apply modifier CG to these services
- Coinsurance and deductible applied

Principal Care Management Services

- PCM services describes comprehensive care management services of single high-risk disease or complex condition
  - Bill G0511 (general care management) for PCM services, either billed alone or other payable services
  - Payment rate includes PCM HCPCS G2064 and G2065
    - CR 12252
    - CMS IOM 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 230.2

Psychiatric Collaborative Care Model (CoCM)

- Can only bill once per month per beneficiary
  - Do not bill if other care management services are billed for same time period by any practitioner or facility
- Can be billed alone or on qualifying visit claim
- Line item reporting - HCPCS code G0512
  - Do not apply modifier CG to these services
- Coinsurance and deductible applied

Telehealth Services

- RHC is originating site
  - Service is billed separately, no other visit reported
    - Revenue code 0780
    - HCPCS Q3014
  - Subject to Part B deductible and coinsurance
- RHCs not authorized to serve as distant site

Global Surgeries

- Surgical procedures furnished in RHC included in AIR
- Surgical procedures furnished at other locations, follow global billing guidelines
  - Bill for visit during global period if visit for service not included in global package
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12 Section 40 and 40.1

Virtual Communication Services

- RHCs virtual communication services
  - At least five minutes of communication technology-based or remote evaluation services
  - Patient had at least one face-to-face billable visit within previous year
  - Medical discussion or remote evaluation must meet both of the following requirements
    - Condition not related to RHC service provided within last seven days
    - Does not lead to RHC visit within next 24 hours or soonest available appointment

Virtual Communication Services

- Can be billed alone or with other payable services
- Submit claim with HCPCS code G0071
- RHC face-to-face requirement waived
- Medicare coinsurance and deductible apply
- Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions

New and Expanded Flexibilities for RHCs and FQHCs During the COVID-19 PHE

- New and Expanded Flexibilities for RHCs and FQHCs During the COVID-19 PHE
  - SE20016
- Flexibilities extended for duration of current COVID-19 PHE
  - For additional information, please see RHC/FQHC COVID-19 FAQs

Resources and Wrap Up

What You Should Do Now?

- Share this presentation with other internal staff members
- Develop/update any internal procedures or processes, as appropriate
- Review available references and resources for additional information
- Attend future NGS' training events

CMS Rural Health Open Door Forum

- Free CMS teleconferences addressing RHC, FQHC and CAH issues
  - Rural Health Open Door Forum Mailing List Sign-Up
- For more information, registration and handouts
  - Rural Health Open Door Forum

CMS Resources

- RHC Center
- RHC Fact Sheet
- RHC Preventive Services Chart
- MLN Matters® MM10175 Revised: *Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)*

CMS Resources

- CMS IOMs
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Preventive and Screening Services

Other Resources

- CPT Standard Edition
  - Published by the American Medical Association
- National Uniform Billing Committee website
  - NUBC Official UB-04 Data Specifications Manual
  - Annual fee
  - Providers also receive updates throughout the year
- U.S. Preventive Services Task Force Website
  - Provides Grade A and B preventive services

NGS Resources

- Revenue codes and HCPCS codes files available in FISS DDE
- Our Website
  - Upcoming training events
  - Medicare updates and educational materials
  - Contact information for
    - Provider Contact Center
    - IVR
    - Written inquiries

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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