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Rural Health Clinics: Coverage and Payment

April 18, 2024

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2598_0424

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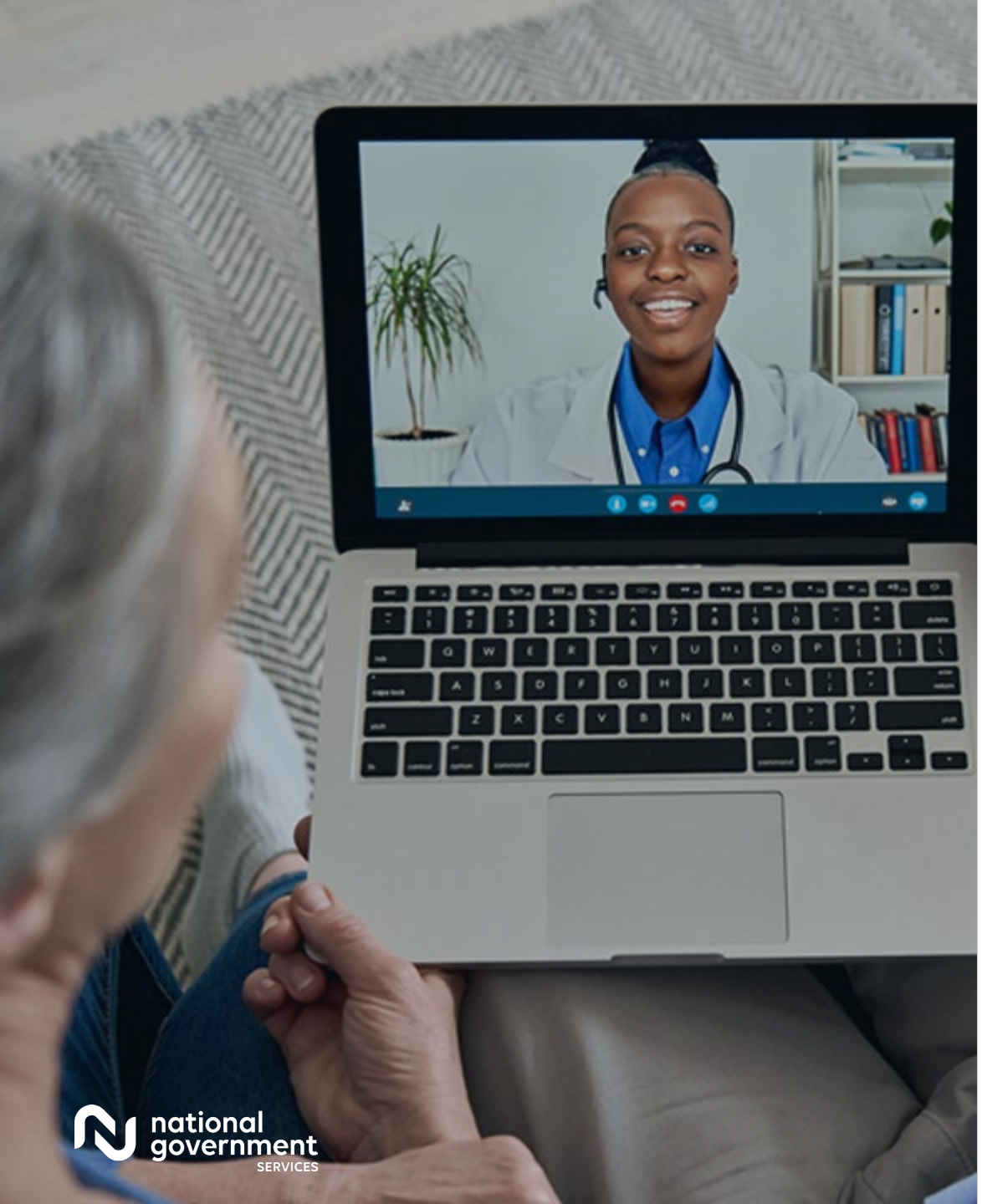

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Objective

After today's session, attendees will gain an understanding of RHC coverage requirements as well as how RHC services are reimbursed and where to go for more information.

Today's Presenters

Provider Outreach and Education Consultants

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- Mimi Vier

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Agenda

- RHC Overview
- Coverage
- Reimbursement
- Resources and References
- Questions and Answers

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RHC Overview

What is an RHC?

- Established in 1978 to address inadequate supply of physicians in underserved rural areas
- Facility engaged primarily in providing services typically furnished in outpatient clinic setting
  - Defined in section 1861(aa)(2) of Social Security Act

Medicare-Certified RHCs

- To be eligible, must meet both location requirements
  - Non-urbanized area, as determined by U.S. Census Bureau
  - Area designated or certified within previous four years by Secretary, HHS, as one of four types of shortage areas accepted for RHC certification
- Mobile clinics
  - Must have fixed schedule specifying date and location for services
  - Each location must meet location requirements
- Existing RHCs
  - Not currently required to continue to meet location requirements
  - If plan to relocate or expand, contact CMS Regional Office for location requirements

RHC Requirements

- Can be either independent or provider-based
- Cannot be rehabilitation agency, facility primarily for mental health treatment or concurrently approved as FQHC
- Must have arrangements with one or more hospitals to furnish medically necessary services not available in RHC
- Must employ a NP or PA
- Must have NP, PA, or CNM working at least 50 percent of time clinic open to provide patient care
  - Does not include travel time

RHC Requirements (continued)

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

Coverage

RHC Visit Definition

- Encounter between patient and physician, NP, PA, CNM, CP or CSW during which allowed RHC service(s) furnished
  - Medically necessary medical visit, mental health visit, or qualified preventive health visit
- RHC visits that must be face-to-face (one-on-one)
  - Medical visit
  - Qualified preventive visit
  - Transitional Care Management (TCM) service
  - Certain LPN or RN visits to homebound patient
- Mental health visits can be either
  - Face-to-face
  - Furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions (when specific criteria met)

RHC Visit Locations

- Allowed
  - Assisted living facility
  - Hospice
  - Medicare Part A skilled nursing facility
  - Patient's residence
  - RHC
  - Scene of accident
- Not Allowed
  - CAH
  - Facility that excludes RHC visits
    - ✓ Example - CORF
  - Inpatient hospital department
  - Outpatient hospital department

RHC Qualifying Visit List (QVL)

- QVL used as guide to services which generally qualify as stand-alone billable visits
  - Typically evaluation and management type of services or screenings for certain preventive services
- 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

Counting Visits

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

More Than One Visit

- Two visits
  - Illness/inquiry occurs after initial visit requiring diagnosis/treatment on same day
  - Medical visit and mental health visit same day
  - IPPE and separate medical or mental health visit on same day
- Three visits
  - IPPE and separate medical and mental health visit on same day

RHC Services

- Physician services
- Services and supplies furnished incident to physician's services
- NP, PA, CNM, CP or CSW services
  - Within scope of practice under state law
- Services and supplies furnished incident to NP, PA, CNM, or CP services
- Certain nursing visits to homebound individuals furnished by RN or LPN
- Certain preventive services

Did You Know?

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

Hospice Attending Physician Services

- 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

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

Care Management Services

- TCM
- General Care Management
  - Chronic Care Management (CCM)
  - General Behavioral Health Integration (BHI)
  - Principal Care Management (PCM)
- Psychiatric Collaborative Care Model (CoCM)

Global Surgeries

- Surgical procedures furnished in RHC included in visit payment
- 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

TCM 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

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

General Care Management Services

- Separate payment
  - Complex Chronic Care Management (CCM)
  - General Behavioral Health Integration (BHI)
  - Principal Care Management (PCM)
- No face-to-face requirement, auxiliary personnel may provide under general supervision
- Can only bill once per month per beneficiary
  - Do not bill if other care management services (except TCM) billed for same time period by any practitioner or facility
  - Can be billed alone or on qualifying visit claim
- Coinsurance and deductible applied

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
- Coinsurance and deductible applied

Telehealth Services

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

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

Preventive Services

- Preventive services paid as stand-alone visits if no other service furnished on same day
- Except for IPPE, preventive services furnished on same day as another medical visit considered one single visit
  - Two visits may be billed if IPPE visit occurs on same day as another billable visit
- Most preventive services do not have coinsurance or deductible applied, except:
  - Prostate Cancer Screening
  - Glaucoma Screening
  - Screening Pap Test

Preventive Services Covered in RHC Setting

- Alcohol Screening and Behavioral Counseling
- AWV
- Glaucoma Screening
- IPPE
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Lung Cancer Screening With LDCT
- Prostate Cancer Screening
- Screening for Depression
- Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling
- Screening Pap Test
- Screening Pelvic Exam
- Smoking and Tobacco Cessation Counseling

Vaccines

- COVID-19, influenza and pneumococcal vaccines and administration
  - Coinsurance and deductible do not apply
  - Not submitted on RHC claims
  - Paid through cost report process
- Hepatitis B vaccination
  - If provided with qualified visit, report as incident-to service
    - ✓ Coinsurance applicable
    - ✓ Payment included in qualified visit
  - If vaccine/administration are only services provided, do not submit claim

Noncovered RHC Services

- Medicare exclusions
  - Routine physicals, dental care, routine eye exams, hearing tests
- Practitioner services furnished to inpatients/ outpatients of
  - Hospitals (including CAHs), ASCs, CORFs
- Technical component of RHC services
- Laboratory services
  - Note - venipuncture included in AIR when furnished in RHC or incident to RHC service
- Ambulance services
- Telehealth services

Noncovered RHC Services

- Drugs that must be billed to Medicare Part D
- DME (crutches, hospital beds, wheelchairs)
- Prosthetic devices which replace all or part of an internal body organ
- Body braces

Reimbursement

RHC Reimbursement

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

- National statutory payment limit per visit for:
  - Independent RHCs
  - Provider-based RHCs in hospital with 50 or more beds
  - RHCs enrolled in Medicare on or after January 1, 2021
- Staged increase in payment limits per visit from 2021 – 2028
  - 2024 = $139 per visit
  - 2025 = $152 per visit
  - 2026 = $165 per visit
  - 2027 = $178 per visit
  - 2028 = $190 per visit
- 2029 and beyond - limit updated by percentage increase in Medicare Economic Index (MEI)

AIR Payment Limit – Grandfathered RHCs

- Provider-based 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
  - Total allowable costs divided by number of actual visits
  - Begins with 2020 per-visit rate and updated annually by percentage increase in MEI

Credit Balance Reports

- Required to submit CBR every quarter
  - Preferred method – NGSConnex online portal
  - CMS-838 Medicare Credit Balance Report
  - Medicare Credit Balance Report (CMS-838) Excel Spreadsheet
- If no credit balance to report, must still complete certification page
  - Check bottom box certifying that no monies owed to Medicare for this quarter
- If credit balance exists as of last day of reporting quarter
  - Complete certification page with middle box checked (all 10 fields must be completed to avoid rejection)
  - Complete 838 detail page (all 15 columns must be completed for each credit balance identified)

CBR Due Dates

- Based on end of each calendar quarter
  - 30 days after
    - ✓ CBR final due date
  - 45 days after
    - ✓ 15 days after CBR due date
    - ✓ Suspension warning letters issued to provider
  - 60 days after
    - ✓ 30 days after CBR due date
    - ✓ Providers placed on 100% payment suspension

Quarter End	CBR Due Date	Suspension Warning Letter Issued	Provider Placed on 100% Payment Suspension
March 31	April 30	May 15	May 30
June 30	July 30	August 14	August 29
September 30	October 30	November 14	November 29
December 31	January 30	February 14	February 29/ March 1

Cost Reports

- Required to submitted annually by provider for prior 12-month period
- Must be submitted within whichever is later
  - Five months of cost reporting fiscal year end
  - 60 days after cost report reminder letter sent to provider by NGS
- Grace period granted when submitted early (based on number of days filed early) to correct any issues noted if cost report rejected
- Must be submitted electronically
  - MCReF or approved software vendor
  - CD or DVD
    - ✓ CDs should be password protected and password sent under separate cover
  - 3½" diskette format or flash drive

Cost Reports (continued)

- Once submitted, NGS reviews and finalizes cost report
  - Determines payment rate and reconcile if overpayment or underpayment
- Failure to submit timely or if cost report rejected, payments reduced and demand letter issued for previous payments
  - Late cost report reviewed for acceptance after receipt before payment suspension released (up to 30 days from receipt)
- All inquiries related to PS&R reports should be directed to PSR@anthem.com

Resources and References

CMS References - General

- CMS Rural Health Clinics Center
- RHC Manual
  - CMS IOM 100-02, *Medicare Benefit Policy Manual*, Chapter 13
- RHC Reporting Requirement FAQs
- MLN Booklet: *Information for Rural Health Clinics*

CMS References - Coverage

- Global Surgery
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 40 and 40.1
- Care Management Services
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 230.2
- Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions
- Preventive Services
  - Rural Health Clinic (RHC) Preventive Services Chart
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 220.1

CMS References - Reimbursement

- AIR Payments
  - MM21285 - Update to Rural Health Clinic (RHC) Payment Limits
- Cost Reports
  - CMS IOM Publication 15-2, *Provider Reimbursement Manual – Part 2*
  - Health Clinic 222-1992 form – Cost report form for RHCs
  - Medicare Cost Report Electronic Filing (MCReF)
    - ✓ Medicare Cost Report e-Filing System User Manual
    - ✓ Final MCReF FAQs
    - ✓ MCReF - Sign In

NGS Resources

- Enrollment
- Overpayments
- Cost Reports
  - Cost Report Forms
  - CMS-Approved Cost Report Vendors
- NGS RuralServ
- POE Advisory Group

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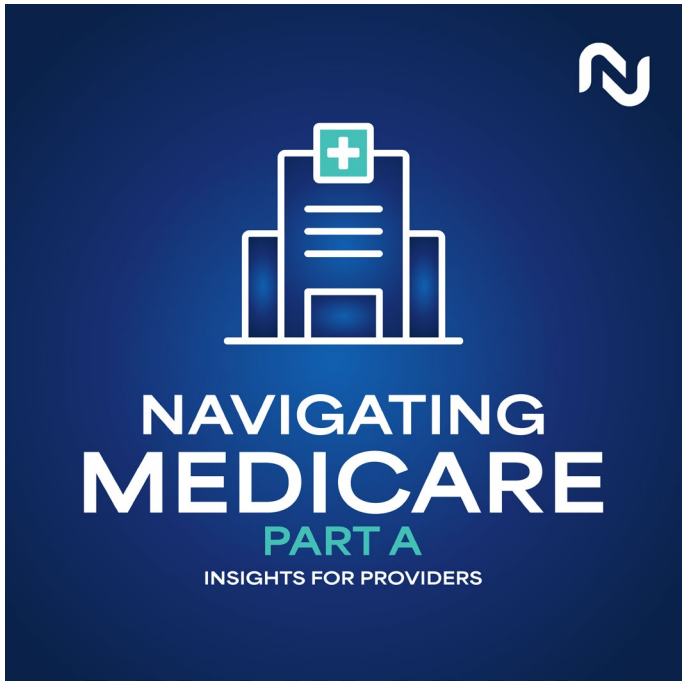

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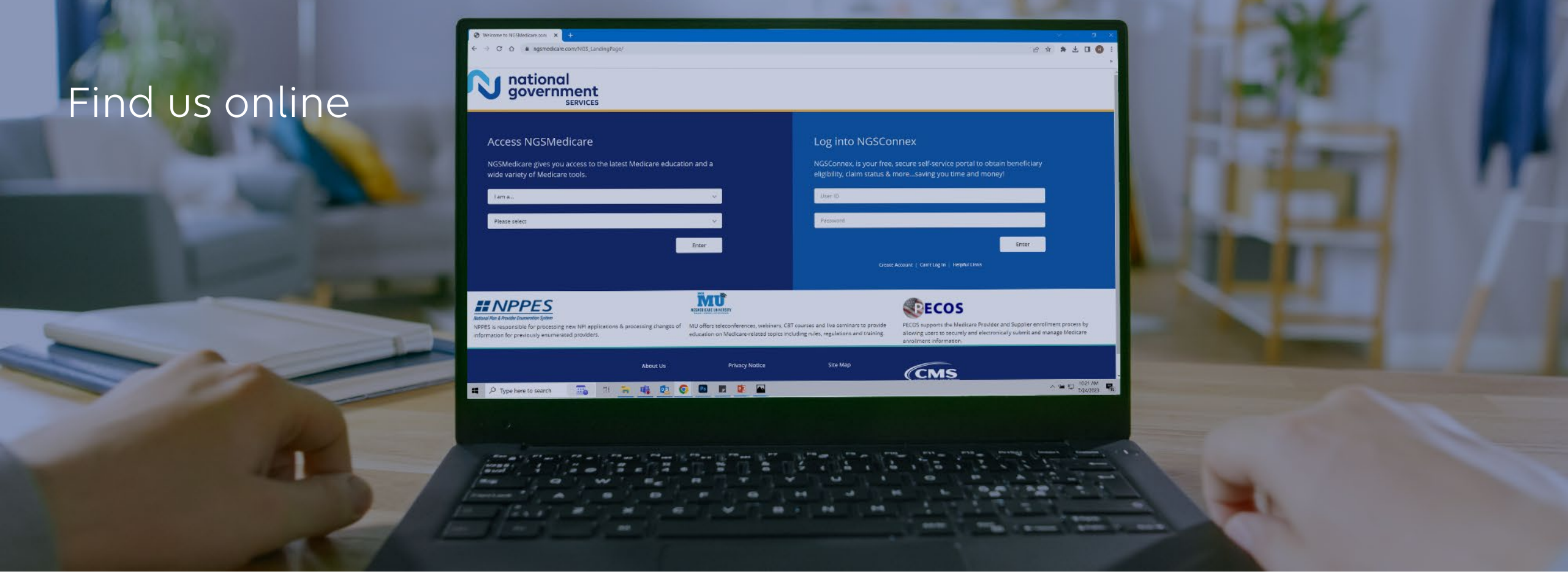

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