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Life After COVID-19: RHC Coverage & Billing Guidelines

2023 Spring Virtual Conference

5/17/2023

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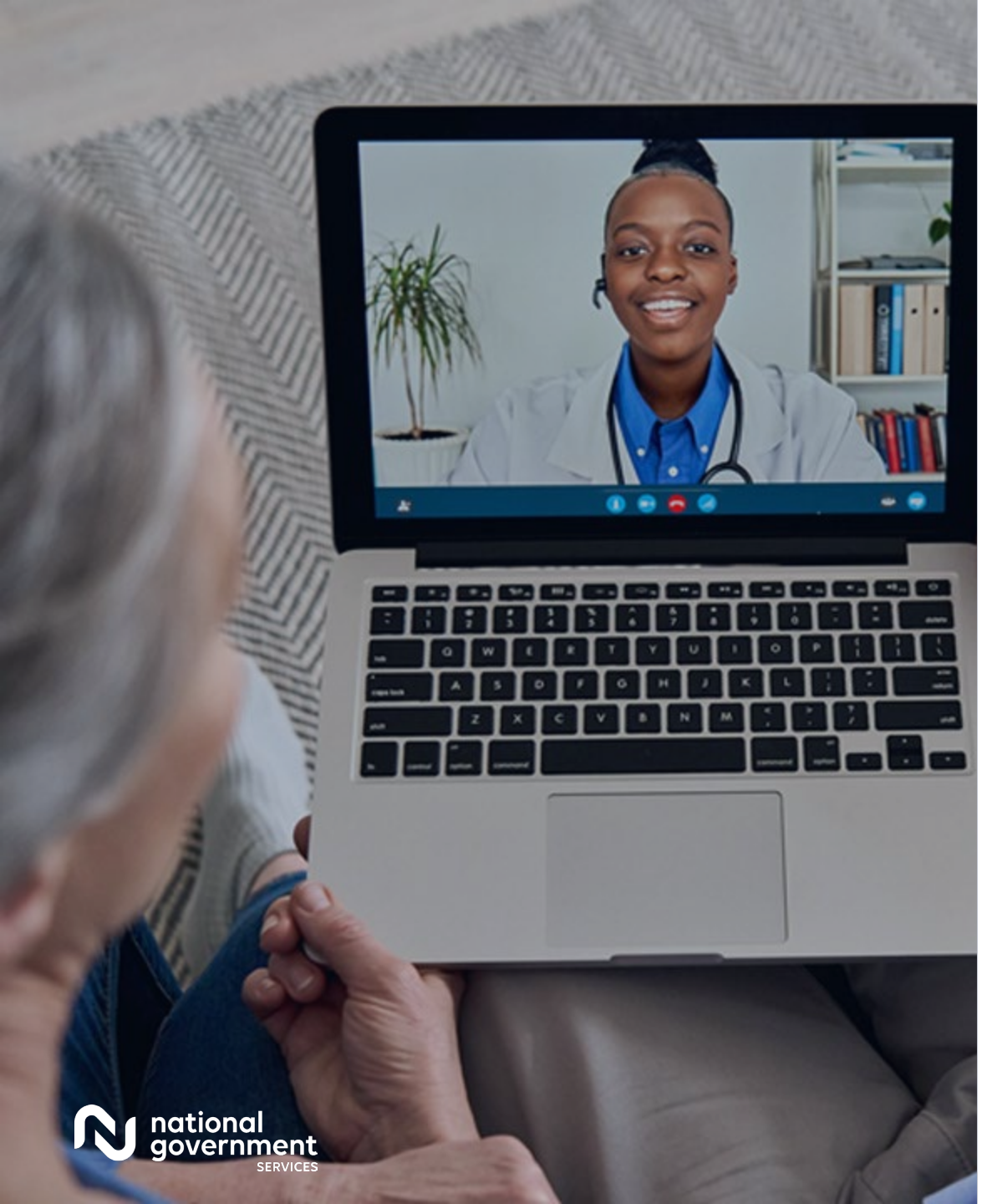

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Objectives

- To provide an overview of RHC coverage, billing, and reimbursement guidelines
- To review allowances afforded to RHCs during the PHE
- Changes that affect RHCs after the end of the PHE

Today's Presenters

- Provider Outreach and Education Consultants
  - Michael Dorris
  - Jhadi Grace

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Agenda

- RHC Program Basics
- RHC AIR Billing and Reimbursement
- What Will Change After the End of the COVID-19 PHE
- Resources and References

RHC Program Basics

RHC Requirements [1]

- 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

RHC Requirements [2]

- 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 Core Practitioners [1]

- Physician
- Nonphysician practitioner
  - PA
  - NP
  - CNM
  - CP
  - CSW

RHC Core Practitioners [2]

- Physician
  - Covered: professional services furnished to RHC patient
    - ✓ Includes diagnosis, therapy, surgery, consultation
  - Covered: services, supplies incident to physician's services
    - ✓ Commonly furnished in doctor's office/clinic
    - ✓ Drugs and biologicals not usually self-administered
    - ✓ Bandages, gauze, oxygen, etc.
    - ✓ Auxiliary personnel under supervision of physician

RHC Core Practitioners [3]

- NP, PA, CNM
  - Covered: professional services furnished to RHC patient
    - ✓ That would be covered if furnished by physician
    - ✓ Under general medical supervision of physician (or direct supervision, if state law requires)
    - ✓ Includes diagnosis, therapy, consultation
  - Covered: services, supplies incident to NP, PA, CNM services
    - ✓ Commonly furnished in physician's office
    - ✓ Furnished under direct supervision of NP, PA, CNM

RHC Core Practitioners [4]

- CP and CSW
  - Covered: professional services furnished to RHC patient
    - ✓ That would be covered if furnished by physician
    - ✓ Includes diagnosis, therapy, consultation
  - Covered: services, supplies incident to CP, CSW services
    - ✓ Mental health services commonly performed in CP office
    - ✓ Furnished under direct supervision of CP, CSW

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

Visiting Nurse

- Visiting nurse (RN or LPN)
  - Covered: skilled nursing services
    - ✓ All following criteria must be met
      - Patient is 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

Did You Know?

- Services, supplies, and drugs that are incident to covered RHC services are covered if they are
  - Furnished as incidental, but integral part of physician/NPP professional services
  - A type commonly rendered either without charge or included in RHC bill
- Drugs that must be billed to DME MAC or Part D are NOT included

Noncovered RHC Services [1]

- Medicare exclusions
- Technical components of RHC services
- Laboratory services (not part of preventive service)
  - Note - venipuncture included in AIR when furnished in RHC or incident to RHC service
  - Will be addressed during the COVID discussion
- DME
- Ambulance services

Noncovered RHC Services [2]

- Prosthetic devices that replace all or part of an internal body organ and supplies directly related to care and replacement of such devices
- Body braces
- Practitioner services furnished to inpatients/outpatients of hospitals (including CAHs), ASCs, CORFs
- Telehealth distant site services
  - Will be addressed during the COVID discussion

RHC Visit Locations

- RHC visits may take place in/at
  - RHC
  - Patient's residence
  - Assisted living facility
  - Medicare Part A SNF
  - Scene of accident
  - Hospice (new)
- RHC visits may not take place in
  - Inpatient or outpatient hospital department
  - CAH
  - Facility that excludes RHC visits (e.g. CORF)

RHC Visits

- Visit defined
  - Medically-necessary, face-to-face (one-on-one) interaction between patient and physician or NPP during which RHC covered service is performed
  - Sometimes referred to as “encounter”
- RHCs are reimbursed for professional services of each covered visit
  - Visits with more than one health professional on same day for same condition = one visit
  - More than one visit to same health professional on same day = one visit

RHC Reimbursement

- One all-inclusive rate (AIR) payment made for all professional services for each covered visit – “bundled payment”
  - Includes all covered services billed as incident-to (limited exceptions)
  - AIR calculated by MAC by dividing total allowable costs by total number of visits for all patients
- Once Part B deductible is met, Medicare pays 80% of the AIR, coinsurance may apply
  - CY 2023 annual Part B deductible = $226

AIR Payment Limit

- AIR reimbursement subject to maximum payment per visit
- No payment beyond specified limit amount per visit for most services
  - For most other services, Medicare Part B deductible and coinsurance rates apply
- Payment limits differ based on type of RHC

AIR Payment Limit Increase

- Per visit payment limits increase over eight-year period from 2021-2028
  - In subsequent years, limit updated by percentage increase in MEI
- Applies to
  - Independent RHCs
  - Provider-based RHCs in hospital with 50 or more beds
  - RHCs enrolled in Medicare on or after 1/1/2021

AIR Payment Limit Increases 2021-2028

- 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

AIR Payment Limit for Grandfathered RHCs

- Per visit payment limit is the greater of
  - Payment limit per visit established for prior year, increased by MEI (3.8%), or
  - Payment limit per visit for independent RHCs ($126 per visit for CY 2023)
- Applies to provider-based RHCs in hospital with less than 50 beds, and
  - Enrolled in Medicare as of 12/31/2020, or
  - Submitted enrollment application prior to 1/1/2021

Beneficiary Cost Sharing

- Unless specifically noted, beneficiary is responsible for annual deductible and coinsurance
  - CY 2023 annual Part B deductible = $226
  - Coinsurance = 20% of Total Charges
- Coinsurance based on Total Charges reported on QVL line

RHC AIR Billing and Reimbursement

Frequency of Billing

- Monthly billing for RHCs is encouraged
- DOS cannot overlap calendar years; statement dates must always be in the same calendar year
  - Billing periods that overlap the calendar year should be split
    - ✓ Reference: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100A
- Timely filing guidelines
  - One-year timely filing rule, based on DOS
  - Adjustment claims must also follow timely filing regulations

RHC Bill Types

- TOB = 71X
  - 710 = nonpayment/zero claim (all charges are noncovered)
  - 711 = admit through discharge
  - 717 = claim adjustment
  - 718 = claim cancel

RHC Billable Visit Revenue Codes

Revenue 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 at other non-RHC site (scene of accident)
0780	Telehealth originating site facility fee
0900	Psychological services provided by CP, CSW

Qualifying Visit List (QVL)

- QVL used as guide to services that generally qualify as stand-alone billable visits
- Rural Health Clinic Qualifying Visit List (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 HCPCS Codes

- Report billable visit revenue code
- Report HCPCS code that describes the qualifying visit from QVL
- Report modifier –CG with QVL HCPCS code
- Report one (1) unit of service
- Total Charges should include charges for all services reported
  - Visit charge + all incident-to charges subject to Deductible and coinsurance

Reporting All Services Provided During Visit

- RHCs required to report appropriate HCPCS code for each service on separate claim line along with revenue code and actual charges
  - 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
- All valid UB-04 revenue codes may be used to report additional services with the exception of the following

002X–024X	029X	045X	054X
056X	060X	065X	067X–072X
080X–088X	093X	096X–310X	

Setting Up the Claim [1]

- Report qualifying visit using billable visit revenue code
  - 052X (medical visit)
  - 0900 (MH visit)
- Report QVL HCPCS/CPT code with modifier –CG
- Report one (1) unit
- Report total charges of all services reported on claim
  - Visit charge + all incident-to charges subject to Deductible and coinsurance

Setting Up the Claim [2]

- Report incident-to services on subsequent claim lines
  - Report nonbillable visit revenue code
  - Report incident-to CPT/HCPCS code
  - Report one (1) unit
  - Report actual charges in Total Charges field
- 0001 Totals line must be calculated accurately

Note for Claim Examples

- Let's assume the following
  - Part A and Part B coverage are effective
  - Timely filing guidelines are met
  - Beneficiary coverage criteria are met
  - Services provided in clinic setting (unless otherwise noted)
- HCPCS codes and associated charges used in examples are for illustration purposes only
  - Amounts used are not reflective of actual charges and should not be used as guideline for setting rates

Claim Example: Qualified Medical Visit

- Billable visit revenue code reported
- QVL HCPCS code reported with modifier –CG
- $115 represents charge for total visit

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Office/outpatient visit ($115)	**99213 CG (QVL HCPCS code)**	010123	1	**$115 (Actual charge)**
0001	Total				$115 (Sum of above charges)

Reimbursement Example: Qualified Medical Visit

- Claim generates AIR payment
  - Deductible applies
  - Coinsurance is 20% of total charge reported on QVL –CG line
    - ✓ $115 x 20% = $23

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Office/outpatient visit ($115)	**99213 CG (QVL HCPCS code)**	010123	1	**$115 (Total visit charges)**
0001	Total				$115 (Sum of above charges)

Claim Example: Qualified Medical Visit With Incident-to Services

- Additional services reported on separate claim lines
- $170 represents charge for total visit

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Office/outpatient visit ($115)	**99213 CG (QVL HCPCS code)**	010123	1	**$170 (QVL + incident-to charges)**
0300	Venipuncture (Incident-to service, $55)	36415	010123	1	$55
0001	Total				$225 (Sum of above charges)

Reimbursement Example: Qualified Medical Visit With Incident-to Services

- Claim generates AIR payment
  - Deductible applies
  - Coinsurance is 20% of total charge reported on QVL –CG line
    - ✓ $170 x 20% = $34

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Office/outpatient visit, ($115)	**99213 CG (QVL HCPCS code)**	010123	1	**$170 (QVL + incident-to charges)**
0300	Venipuncture (Incident-to service, $55)	36415	010123	1	$55
0001	Total				$225 (Sum of above charges)

Multiple Visits on Same DOS [1]

- Patient suffers illness/injury that requires additional diagnosis/treatment on same day
  - Report primary visit with modifier –CG
  - Report subsequent visit with modifier –59 or –25
- Medical visit and mental health visit on same day
  - Report both medical and mental health visits with modifier –CG

Claim/Reimbursement Example: Two Unrelated Medical visits

- Claim generates two AIR payments
  - Deductible applies
  - Coinsurance is 20% of total charges reported on QVL –CG and QVL –59 lines
    - ✓ $115 x 20% = $23 and
    - ✓ $147 x 20% = $29.40

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	Office visit ($115)	**99214 CG**	010123	1	**$115 (Actual charge)**
0521	Office visit estab pt ($147)	**99213 59**	010123	1	**$147 (Actual charge)**
0001	Total				$262 (Sum of above charges)

Claim/Reimbursement Example: Medical and Mental Health visit

- Claim generates two AIR payments
  - Deductible applies
  - Coinsurance is 20% of total charges reported on QVL –CG lines
    - ✓ $115 x 20% = $23 and
    - ✓ $250 x 20% = $50

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Office/outpatient visit ($115)	**99213 CG**	010123	1	**$115 (Actual charge)**
0900	Psych evaluation ($250)	**90791 CG**	010123	1	**$250 (Actual charge)**
0001	Total				$365 (Sum of above charges)

Preventive Services

- All services covered under the Medicare Preventive Services program are covered for RHC beneficiaries
  - Exception: HIV Screening
  - See charts on following slides
- May be billed alone or with covered visit
- Payment included in AIR reimbursement
  - Cost-sharing may apply

Approved Preventive Services – Cost-Sharing Waived

HCPCS Code	Description	HCPCS Code	Description
G0010	Hepatitis B vaccine*	G0444	Screening for depression
G0402	IPPE	G0445	Screening for STIs and HIBC
G0438	AWV, initial visit	G0446	Intensive behavioral counseling for CVD
G0439	AWV, subsequent visits	G0447	IBT for obesity
G0101	Screening pelvic exam	99406	Smoking and tobacco-use cessation counseling (3-10 min)
Q0091	Screening Pap smear	99407	Smoking and tobacco-use cessation counseling (> 10 min)
G0442	Annual alcohol abuse screening	G0296	Lung cancer screening
G0443	Brief alcohol abuse screening	** See special billing instructions on next slide*	

Billing Hepatitis B Vaccine

- If vaccine/administration are only services provided, do not report on claim
  - Settled on cost report
- If provided with billable visit, report as incident-to visit
  - Revenue code 052X, preventive service CPT/HCPCS code G0010, actual charges
  - Do NOT include charges for cost-sharing waived preventive service in QVL total

Billing for Preventive Services – CS Waived

- If approved preventive service is only service provided, bill as visit
  - Revenue code 052X
  - Preventive service CPT/HCPCS code with modifier –CG
  - Actual charges reported
- If approved preventive service is provided with qualifying visit, bill as incident to
  - Revenue code 052X, preventive service CPT/HCPCS code without modifier –CG, actual charges
  - Do NOT include charges for cost-sharing waived preventive service in QVL total

Claim/Reimbursement Example: Preventive Service Only

- Claim generates AIR payment
  - Cost-sharing waived as appropriate based on HCPCS/CPT code reported

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Screening pelvic exam ($45)	**G0101 CG**	010123	1	**$45 (Actual charge)**
0001	Total				$45 (Sum of above charges)

Claim/Reimbursement Example: QVL Visit With Preventive Service – CS Waived

- Claim generates AIR payment
  - Deductible applies to QVL –CG visit
  - Coinsurance based on QVL –CG charges reported
    - ✓ Which do NOT include preventive service charges
    - ✓ $115 x 20% = $23

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Office visit ($115)	**99214 CG**	010123	1	**$115 (Actual charge)**
0521	Screening pelvic exam ($45)	**G0101**	010123	1	**$45 (Actual charge)**
0001	Total				$160 (Sum of above charges)

Approved Preventive Services – CS NOT Waived

HCPCS Code	Description
G0102	Prostate cancer screening
G0117	Glaucoma screening (furnished by optometrist/ophthalmologist)
G0118	Glaucoma screening (furnished under direct supervision of optometrist/ophthalmologist)

Billing for Preventive Services – CS NOT Waived

- If approved preventive service is only service provided, bill as visit
  - Revenue code 052X
  - Preventive service CPT/HCPCS code with modifier –CG
  - Actual charges reported
- If approved preventive service is provided with qualifying visit, bill as incident to
  - Revenue code 052X, preventive service CPT/HCPCS code without modifier –CG, actual charges
  - INCLUDE charges for preventive service in QVL total

Claim/Reimbursement Example: QVL Visit with Preventive Service – CS NOT Waived

- Claim generates AIR payment
  - Deductible applies
  - Coinsurance based on QVL –CG charges reported, which include preventive service charges
    - ✓ $185 x 20% = $37

Rev Code	Description	HCPC	Service Date	Service Units	Total Charges
0521	Office visit ($115)	**99214 CG**	010123	1	**$185 (QVL + preventive charges)**
0521	Prostate cancer screening ($70)	**G0102**	010123	1	**$70 (Actual charge)**
0001	Total				$255 (Sum of above charges)

Multiple Billable Visits on Same DOS [2]

- IPPE and separate qualified medical and/or mental health visits on same day
  - Report IPPE without modifier –CG
  - Report subsequent visit(s) with modifier –CG

Claim/Reimbursement Example: IPPE and Medical Visit

- Claim generates two AIR payments
  - Deductible applies to QVL –CG line
  - Coinsurance based on QVL –CG charges reported
    - ✓ $147 x 20% = $29.40

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	IPPE ($130)	**G0402**	010123	1	**$130 (Actual charge)**
0521	Office visit estab pt ($147)	**99213 CG**	010123	1	**$147 (Actual charge)**
0001	Total				$277 (Sum of above charges)

Influenza or Pneumococcal Pneumonia Vaccines

- Do not submit influenza or pneumococcal pneumonia vaccine administration on claim
  - Whether or not it is only service provided
- Services reported and reimbursed based on cost report
  - 100% of reasonable cost for vaccine and administration
  - Cost-sharing waived

COVID-19 Vaccines

- Do not submit COVID-19 vaccine administration on claim
  - Whether or not it is only service provided
- Services reported and reimbursed based on cost report
  - 100% of reasonable cost for vaccine and administration
  - Cost-sharing waived

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
  - CY 2023 rate = $85.23

Billing for ACP [1]

- If ACP is furnished on same DOS as AWV, bill as incident-to AWV
  - Revenue code 052X with AWV QVL HCPCS code G0438 or G0439 and modifier -CG
  - Total charges for AWV visit (only)
- Report claim line for ACP
  - Revenue code 052X with CPT code 99497
  - Total charges for ACP
- The claim would generate and AIR payment and MPFS reimbursement based on the current payment rate
  - CY 2023 payment rate for 99497 is $85.93
  - Cost-sharing waived as appropriate based on HCPCS/CPT codes reported

Billing for ACP [2]

- If ACP is the only medical service provided on the DOS, bill as a visit
  - Report revenue code 052X, ACP QVL HCPCS code 99497 with modifier -CG
- The claim would generate payment based on the current payment rate
  - CY 2023 payment rate for 99497 is $85.93
- When ACP is provided on different DOS as AWV, deductible and coinsurance apply

Transitional Care Management Services

- TCM services must be furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or community mental health center
  - One TCM visit paid for services furnished during the 30-day post-discharge period
- Communication (direct contact, telephone, or electronic) must begin within two business days of discharge
- Face-to-face visit must occur
  - Within 14 days of discharge for moderate complexity decision making, or
  - Within seven days of discharge for high complexity decision making

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

- If TCM is the only medical service provided on the DOS, bill as a visit
  - Report revenue code 052X, QVL HCPCS code 99495 or 99496 with modifier -CG
  - The claim would generate AIR reimbursement
- If TCM is furnished on the same DOS as another visit, bill as incident-to the visit
  - Report revenue code 052X, CPT code 99495 or 99496 on separate claim line
  - The claim would generate no additional reimbursement (payment included in AIR)

General Care Management Services

- Includes Chronic Care Management (CCM), Principal Care Management (PCM), Chronic Pain Management (CPM), Behavioral Health Integration (BHI)
- Separately billable initiating visit required within one year before care management services furnished
- Beneficiary must consent (written or verbal)

Chronic Care Management Services

- Furnished to patients with multiple chronic conditions
  - Expected to last at least 12 months
  - At risk of death or functional decline
- Include care coordination and care management
- Minimum 20 minutes of qualifying CCM services provided in calendar month

Principal Care Management Services

- Comprehensive care management services provided to patients with single high-risk disease or complex condition
  - Lasting at least three months
  - At risk of hospitalization
  - Requires development of disease-specific care plan
  - Requires frequent adjustment to medication regimen
  - Complex due to comorbidities
- Minimum 30 minutes of qualifying PCM services provided in calendar month

Chronic Pain Management Services [NEW!]

- Effective on/after January 1, 2023
- Furnished to patients with multiple chronic conditions
  - Involve chronic pain
- May include person-centered plan of care, care coordination, medication management
- Minimum 30 minutes of qualifying non-face-to-face CPM services provided in calendar month

Behavioral Health Integration Services [NEW!]

- Furnished to patients with one or more behavioral health conditions
  - Include substance use disorders that warrant BHI services
- Includes a team-based, collaborative approach to address primary care and mental/behavioral conditions
- Minimum 20 minutes of qualifying BHI services provided in calendar month

Billing for CCM, PCM, CPM, BHI Services

- General Care Management can be billed once per month per beneficiary
- Report services using revenue code 052X with HCPCS code G0511
- This claim line would generate separate reimbursement based on the current payment rate
  - CY 2023 payment rate for G0511 is $77.94
  - Deductible and coinsurance apply

Psychiatric Collaborative Care Model Services

- Furnished to patients receiving behavioral health treatment
  - Includes regular consultation with primary care team
- Psychiatric CoCM must be provided
  - At least 70 minutes in the first calendar month, and
  - At least 60 minutes in subsequent calendar months
- Do not bill if other care management services are billed for same time period by any practitioner or facility

Billing for Psychiatric (CoCM) Services

- Psychiatric CoCM services can be billed once per month per beneficiary
- Report services using revenue code 052X and HCPCS code G0512
- This claim line would generate separate reimbursement based on the current payment rate
  - CY 2023 payment rate for G0512 is $146.73
  - Deductible and coinsurance apply

Virtual Communication Services

- Virtual communication services include communications-based technology and remote evaluation services
  - At least five minutes
  - Patient had billable visit within previous year
  - Not related to condition addressed within previous seven days
  - Does not lead to service within next 24 hours or soonest available appointment

Billing for Virtual Communication Services

- Virtual Communication services can be billed once per week per beneficiary
- Report services using revenue code 052X with HCPCS code G0071
- This claim line would generate separate reimbursement based on the current payment rate
  - CY 2023 payment rate for G0071 is $23.72
  - Deductible and coinsurance apply

Originating Site Telehealth Services

- RHCs may serve as the originating site for telehealth services
  - Location of eligible Medicare beneficiary at the time service being furnished via telecommunications system
- Report services using revenue code 078X with HCPCS code Q3014
- This claim would generate originating site facility fee
  - CY 2023 payment rate for Q3014 is $28.64
  - Deductible and coinsurance apply

Distant Site Telehealth Services [1]

- RHCs may NOT serve as the distant site for telehealth services
  - Location of practitioner at the time service being furnished via telecommunications system
- CMS allowed RHCs to serve as distant site providers during the PHE and until DOS 12/31/2024
- For DOS on/after 12/31/2024, RHCs will no longer be covered or reimbursed for this service

Mental Health Services Provided via Telehealth [NEW!]

- RHCs can furnish mental health services via telehealth
  - Interactive audio and video telecommunications system
    - ✓ Includes audio-only services
- Furnished to beneficiary in any location, including the patient's home
- For DOS on/after 1/1/2025, in-person mental health service must be furnished
  - Within 6 months prior to telehealth visit, and
  - At least every 12 months

Billing for Mental Health Services Provided via Telehealth

- Report services with revenue code 0900 and an appropriate MH QVL HCPCS/CPT code with modifier -CG, and
  - Modifier 95 for services furnished via audio/video telecommunications, or
  - Modifier FQ for services furnished via audio only
- This claim would generate AIR reimbursement
  - Deductible and coinsurance apply

Hospice Attending Physician Services

- Applies when physician, NP or PA provides hospice attending physician services to beneficiary who elected hospice
  - Patient's home
  - Medicare-certified hospice freestanding facility
  - Skilled nursing facility
  - Hospital
- Report services with revenue code 0900 and an appropriate QVL HCPCS/CPT code with modifier –CG and modifier –GV
  - Technical component billed to hospice for payment
- This claim would generate AIR reimbursement
  - Deductible and coinsurance apply

Visiting Nursing Services

- Visiting nurse provides skilled services based on
  - Complexity of service
  - Condition of patient
  - Accepted standards of medical/nursing practice
- RHCs can bill for visiting nursing services
  - Furnished on part-time or intermittent basis by RN or LPN
  - Homebound patient
  - Written plan of treatment
    - ✓ Must be written and reviewed by supervising physician/NPP at least once every 60 days
  - In area with shortage of HHAs
    - ✓ No participating HHA in area
    - ✓ Patient's home not within reasonable traveling distance to participating HHA

Billing for Visiting Nurse Services

- Report with revenue code 0527
  - QVL HCPCS code G0490 with modifier –CG
- This claim would generate AIR reimbursement
  - Deductible and coinsurance apply

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 service not included in global package
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12 Section 40 and 40.1

What Will Change After the End of the COVID-19 PHE

The End of the PHE

- CMS declared that the COVID-19 PHE will expire at the end of the day May 11, 2023
- During the PHE, healthcare providers received maximum flexibility to streamline delivery and allow access to care
  - Some changes permanent/extended; some will expire
- Expiration dates listed on upcoming slides

COVID-19 Testing-Related Services

- Physician/NPP orders or administers COVID-19 lab test
  - Services relate to providing test or evaluation to determine need for test
- Medical visit identified by specific E&M HCPCS codes
  - HCPCS codes for RHCs
- Report COVID-19 Testing-Related Services using the appropriate HCPCS code (from the link above) with revenue code 052X and modifier -CS
  - Cost-sharing does not apply
- After the end of the PHE, COVID-19 testing-related services will remain covered without cost-sharing

Virtual Communication Services

- During PHE, virtual communication includes digital assessment services
  - Non-face-to-face, patient-initiated, digital communications using a secure online patient portal
- After the end of the COVID-19 PHE, these digital assessment codes are not covered
  - CPT code 99421 (5-10 minutes over a 7-day period)
  - CPT code 99422 (11-20 minutes over a 7-day period)
  - CPT code 99423 (21 minutes or more over a 7-day period)
- HCPCS code G0071 will still be used to represent covered virtual communication services
  - HCPCS code G2012 (communication technology-based services)
  - HCPCS code G2010 (remote evaluation services)

Distant Site Telehealth Services [2]

- During the PHE, RHCs can furnish distant site telehealth services
  - Interactive audio and video telecommunications system
    - ✓ Furnished from any location, including the practitioner's home
  - At least five minutes of medical discussion by physician or NPP
  - Any approved telehealth service found on CMS list
    - ✓ Whether or not the service is included on the QVL HCPCS code list
    - ✓ Additional services added to accommodate patients
    - ✓ https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
  - Not billable if telehealth contact
    - ✓ Originates from a related E&M service provided within 7 days
    - ✓ Leads to E&M service/procedure within 24 hours (or soonest available)

Distant Site Telehealth Services [3]

- After the end of the PHE
  - Services temporarily included on the telehealth services list will be extended for 151 days
    - ✓ October 9, 2023
  - RHCs can furnish distant site telehealth services until December 31, 2024

Billing for Distant Site Telehealth Services

- Report Distant Site Telehealth Services using revenue code 052X with HCPCS code G2025
  - Modifier –95 optional
- This claim line would generate separate reimbursement based on the current payment rate
  - CY 2023 payment rate for G2025 is $98.27
  - Deductible and coinsurance apply
    - ✓ Append modifier –CS for services in which Medicare waives coinsurance

Visiting Nursing Services

- During PHE, all RHC service areas are determined to have shortage of HHAs
- After the end of the PHE, an RHC is in an area with shortage of HHAs if
  - There are no participating HHAs in area
  - Patient's home not within reasonable traveling distance to participating HHA
- RHCs located in area not determined to have HHA shortage must make request to CMS Regional Office

Virtual Supervision

- During the PHE, “direct supervision” expanded to allow supervising professional to be available virtually
  - Real-time audio/visual technology instead of physical presence
- After the end of the PHE, this flexibility will expire
  - December 31, 2023

Resources and References

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 [1]

- 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)
- RHC Reporting Requirement FAQs

CMS Resources [2]

- 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

References [1]

- CR10843: Communication Technology Based Services and Payment for Rural Health Clinic (RHCs) and Federally Qualified Health Centers (FQHCs)
  - MLN Matters® MM10843: Communication Technology Based Services and Payment for Rural Health Clinic (RHCs) and Federally Qualified Health Centers (FQHCs)

References [2]

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 240 – Virtual Communication Services
- MLN® Booklet Rural Providers & Suppliers Billing
- CMS FAQs, December 2018, Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

References [3]

- COVID-19 Vaccine Policies & Guidance
- COVID-19 Accelerated and Advance Payment Program
- MLN Matters® SE20011 Revised: Medicare FFS Response to the PHE on the COVID-19
  - HCPCS codes for RHCs

References [4]

- MLN Matters® SE20016 Revised: New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE
  - List of Telehealth Services
- COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

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

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

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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