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Rural Health Clinics: Coverage and Payment

3/26/2025

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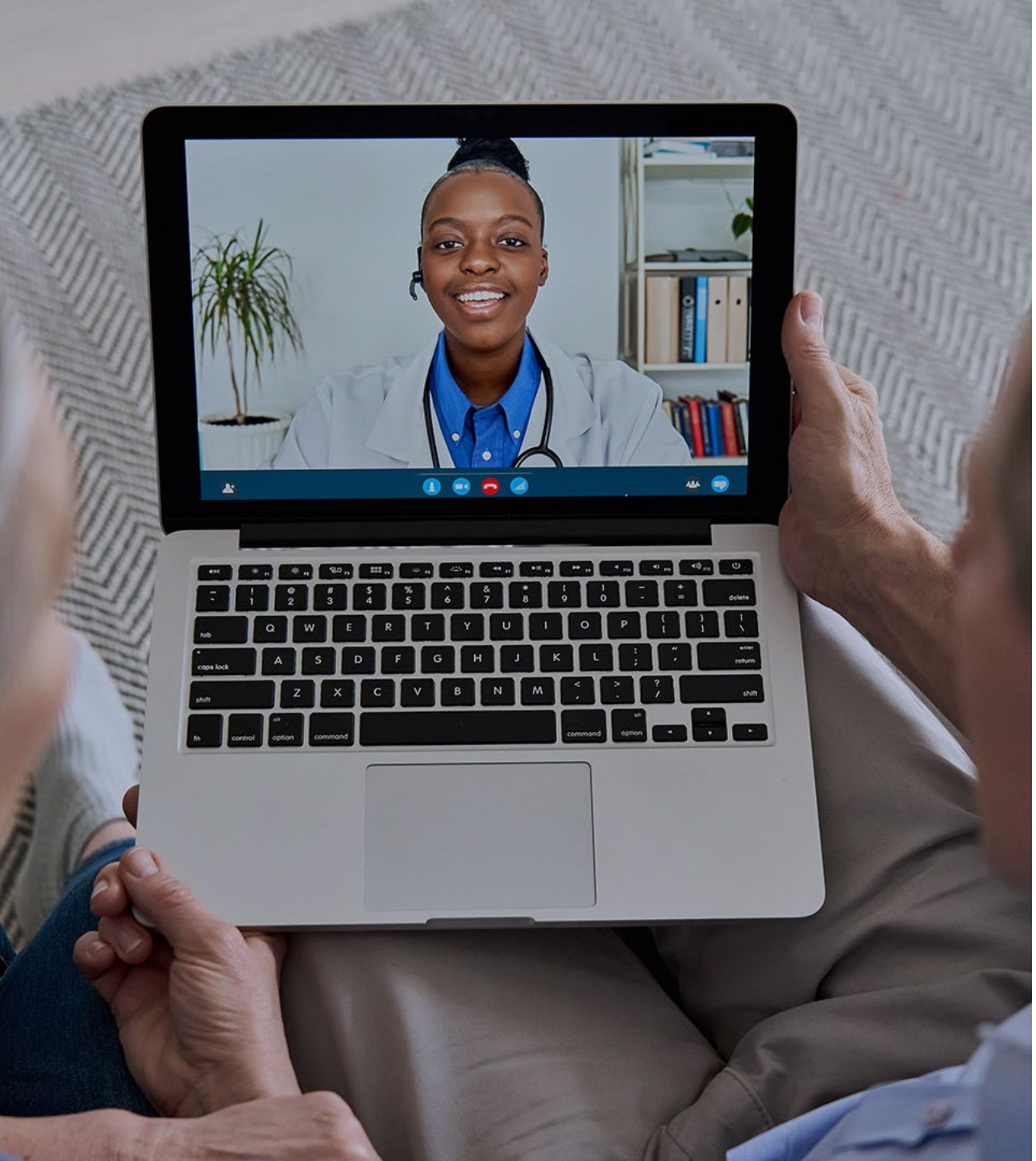

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Objective

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
  - Andrea Freibauer
  - Jean Roberts, RN, BSN, CPC
  - Mimi Vier

Agenda

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

RHC Overview

What Is an RHC?

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

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 nurse practitioner (NP) or PA
- Must have NP, PA, or certified nurse midwife (CNM) working at least 50% of time clinic open to provide patient care
  - Does not include travel time

RHC Requirements

- 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

- Medically necessary encounter where allowed RHC service(s) furnished in covered visit location
- Encounter between beneficiary and physician or
  - NP
  - PA
  - CNM
  - Clinical psychologist (CP)
  - Clinical social worker (CSW)
  - Marriage and family therapist (MFT)
  - Mental health counselor (MHC)
- Types of RHC visits
  - Medical
  - Mental health
  - Qualified preventive health visit

Types of RHC Visits

- RHC visits must be face-to-face (one-on-one)
  - Medical visit
  - Qualified preventive visit
  - Transitional Care Management (TCM) service
  - Certain licensed practical nurse (LPN) or registered nurse (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 Services

- Physician services, including primary care
- Services performed by NP, PA, CNM, CP, CSW, MFT, or MHC (per state law for scope of practice)
- Services and supplies furnished incident to physician's, NP, PA, CNM, CSW, MFT, or MHC services
- Certain preventive services
- IOP services
- Virtual communication services, like communications-based technology and remote evaluation services

RHC Services

- Certain care management services, including
  - TCM
  - Chronic care management (CCM)
  - General behavioral health integration (BHI)
  - Principal care management (PCM)
  - Psychiatric collaborative care model (CoCM)
  - Chronic pain management services (CPM)
- General care management (effective 1/1/2024)
  - Remote physiologic monitoring (RPM)
  - Remote therapeutic monitoring (RTM)
  - Community health integration (CHI)
  - Principal illness navigation (PIN)
  - PIN-peer support (PIN-PS)

RHC Services

- Mental health services using telehealth
  - Interactive, real-time telecommunications technology
- Intermittent visiting nurse services for homebound beneficiaries
  - Provided by RN or LPN under plan of treatment
  - In CMS-certified HHA shortage areas
  - Does not include drugs and biologicals
- Hospice attending physician services performed
  - By RHC physician, NP, or PA employed or working under contract for RHC (not by hospice)
  - During hospice election
  - At beneficiary's home, Medicare-certified hospice freestanding facility, SNF or hospital

New for 2025

- As of January 1, 2025
  - Dental services that align with policies and operational requirements in physician setting
    - Paid under RHC AIR even when furnished on same day as medical visit
  - Hepatitis B vaccines and their administration paid at 100% of reasonable cost
- As of July 1, 2025
  - Bill and be paid for pneumococcal, flu, hepatitis B and COVID-19 vaccines and their administration at time of service
    - Payments annually reconciled with facility's vaccine costs on their cost reports

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/injury 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
  - IOP services and medical visit same day
- Three visits
  - IPPE and separate medical and mental health visit on same day

Did You Know?

- Nonphysician practitioner (NPP) services must follow state guidelines and RHC policies and be
  - Provided by RHC employee
  - Performed under general/direct physician supervision
  - Type of service legally permitted by state to furnish
  - Covered when provided by physician

Preventive Services

- Paid as stand-alone visits if no other service furnished on same day
  - Starting July 1, 2025, can bill for pneumococcal, influenza, hepatitis B, and COVID-19 vaccines and their administration at time of service with or without qualifying visit
- 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
- IBT for Cardiovascular Disease
- IBT for Obesity
- Lung Cancer Screening With LDCT
- Prostate Cancer Screening
- Screening for Depression
- Screening for STIs and High Intensity Behavioral Counseling
- Screening Pap Test
- Screening Pelvic Exam
- Smoking and Tobacco Cessation Counseling

Preventive Services References

- Rural Health Clinic (RHC) Preventive Services Chart
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 220.1
- Preventive Vaccines
  - MLN® Matters *MM13923: Payment for Medicare Part B Preventive Vaccines & Their Administration for Rural Health Clinics & Federally Qualified Health Centers*
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10.2
  - Vaccine Pricing

IOP

- Distinct and organized OP program of psychiatric services provided to beneficiaries who have acute mental illness
- Requires individualized, written plan of treatment established and reviewed (no less than every other month) by physician in consultation with appropriate staff
  - Physician's diagnosis, type, amount, frequency, and duration of items and services provided under plan, and goals for treatment under plan
  - Physician certification that beneficiary needs IOP services for minimum of nine hours per week of therapeutic services

IOP Scope of Benefits

- Items and services available under IOP benefit include
  - Individual and group therapy with physicians or psychologists or other mental health professionals to extent authorized under state law
  - OT by qualified occupational therapist or by occupational therapy assistant under appropriate supervision
  - Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients
  - Drugs and biologicals provided for therapeutic purposes (not self-administered)
  - Individualized activity therapies (not primarily recreational or diversionary)
  - Family counseling with primary purpose of treatment of beneficiary's condition
  - Beneficiary training and education (closely and clearly related to care/treatment)
  - Diagnostic services
- Certain IOP services payable via IOP payment amount but not payable as RHC services, such as group therapy

IOP - Multiple Visits

- When IOP services provided
  - On same day as mental health visit or medical visit, all services covered under Medicare Part B
  - On same day as mental health visit, one Medicare payment at IOP rate (includes payment for mental health visit)
  - As medical visit, counts as two visits - one payment for medical visit under AIR and one payment for IOP services at IOP rate

IOP References

- MLN® Matters *MM13264: Billing Requirements for Intensive Outpatient Program Services for Federally Qualified Health Centers and Rural Health Clinics*
- MLN® Booklet: *Information For Rural Health Clinics (MLN006398)*
- List of IOP codes and services in Attachment A of CR 13264

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
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Sections 40 and 40.1

General Care Coordination Services

- No face-to-face requirement, auxiliary personnel may provide under general supervision
- Separate payment for CCM, BHI, PCM
- 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
- Resources
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 230.2
  - Chronic Care Management Frequently Asked Questions

TCM Services

- Services required following discharge from inpatient hospital setting
  - 30-day period beginning date of discharge
- Physician/NPP accepts responsibility for care of beneficiary post-discharge from facility setting without gap
- Medical/psychosocial issues require moderate-high/complexity medical decision making
- MLN® Booklet: *Transitional Care Management Services*

TCM Guidelines

- One TCM visit covered per beneficiary per post-discharge period
- Services provided not in post-op global period
- Only one healthcare 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

CoCM

- Must provide at least 70 minutes in first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services
- Can only be billed once per month per beneficiary when time threshold met and services meet all other requirements
  - Count only RHC practitioner or auxiliary personnel services within scope of service elements toward 60-minute psychiatric CoCM billing minimum
  - Don't include administrative activities like transcription or translation services
- Subject to Part B coinsurance

CPM

- Payable when minimum of 30 minutes of qualifying non-face-to-face CPM services provided during calendar month
- May be furnished to beneficiaries with multiple chronic conditions that involve chronic pain
  - May include person-centered plan of care, care coordination, medication management, and other aspects of pain care
- MLN® Matters *MM13063: Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update*

New for 2025 - APCM

- Advanced Primary Care Management (APCM) services
  - CY 2025 MFPS Final Rule
- Combines elements of several existing care management and communication technology-based services into one payment bundle
  - Principal care management (PCM)
  - Transitional care management (TCM)
  - CCM
- Communication technology-based services include:
  - Virtual check-ins
  - Remote evaluations of pre-recorded patient information
  - Interprofessional consultations

APCM

- Who can perform
  - Physician responsible and focal point for all of beneficiary's primary care services
  - NPP, including NP, PA or CNS
  - Auxiliary personnel as incident to professional services of provider who bills initiating visit (if required) and associated APCM services
    - Work under general supervision
- Frequency
  - Once per patient per calendar month

APCM Requirements

- Written or verbal beneficiary consent to participate in APCM services documented in medical record
  - Only needed once but required before starting APCM services
  - By giving consent, beneficiary agrees they understand that
    - Only one provider can furnish/be paid for APCM services during calendar month
    - They have the right to stop services at any time
    - Cost sharing may apply
  - Certain elements required as clinically appropriate for individual beneficiary
    - Not all elements need to be provided every month

APCM Required Elements

- Conduct initiating visit for new patients
  - Not required if you or another provider in your practice have:
    - Seen beneficiary within past 3 years
    - Provided another care management service (APCM, CCM, or PCM) to beneficiary within past year
  - AWV may qualify if provider responsible for providing APCM performed AWV
- Provide 24/7 access and continuity of care
- Provide comprehensive care management
- Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan

APCM Required Elements

- Coordinate care transitions between and among health care providers and settings
- Coordinate practitioner, home-, and community-based care
- Provide enhanced communication opportunities
- Conduct patient population-level management
- Measure and report performance, including assessment of primary care quality, total cost of care, and meaningful use of Certified EHR Technology (CEHRT)

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 in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions*

Interactive Telecommunications System – Audio Only

- May include two-way, real-time, audio only communication
  - New or established patients
  - Distant site physician/practitioner using interactive telecommunications system
  - Beneficiary in their home and either not capable of or does not consent to use of video technology
- MLN® Matters *SE22001: Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers*

Telehealth Extension 3/31/2025

- Section 3207 of the American Relief Act, 2025 extended telehealth waivers until 3/31/2025
  - Pay claims through 3/31/2025 with the same flexibilities as 2024
  - May receive telehealth service regardless of geographic location
  - Beneficiaries may continue to receive telehealth services at home
  - No practitioner restrictions
  - In-person mental health services requirement delayed until 1/1/2026
- Telehealth FAQ 2025 (published 1/8/2025)

Originating Site

- FQHC/RHC is originating site (where beneficiary located)
- Through 3/31/2025
  - Beneficiaries can get telehealth wherever they are located
  - No geographic location restrictions
- On or after 4/1/2025
  - Non-behavioral health
    - Reverts to prior regulations for originating site requirements and geographic location restrictions
  - Behavioral or mental services
    - All beneficiaries can continue to get telehealth wherever located
    - No originating site requirements or geographic location restrictions

Distant Site

- Where physician or practitioner provides telehealth from (including their home)
- Through 3/31/2025
  - All providers eligible to bill Medicare for professional services can provide distant site telehealth
- On or after 4/1/2025
  - Reverts to original regulations unless Congress enacts additional legislation

Medicare Telehealth Services Categorized

- List of Telehealth Services for Calendar Year 2025
  - Category Column added 11/1/2023
    - Provisional codes
      - May be granted permanent status or removed in future
      - No set time frame for reevaluation
      - Services monitored for patient safety
      - Will never be assigned when improbable that code would ever achieve permanent status
    - Permanent codes
      - On CMS telehealth list before COVID-19 PHE extensions and waivers
      - Will remain on list of telehealth services
  - Audio-only column removed

Mental Health Telehealth Services

- Continued indefinitely for purpose of diagnosis, evaluation, or treatment of mental health disorders
- Originating sites expanded to include
  - Beneficiary home
  - Temporary lodging (hotels, homeless shelters, nursing homes)
- In-person visit requirement delayed until 1/1/2026

Mental Health Audio-Only Telehealth

- Audio-only communication permitted for new or established patients in their home
- Must meet one or more of the following:
  - No technical capacity for two-way, audio-visual communication
  - No availability of real-time audio and visual interactive telecommunication
  - Does not consent to use of two-way, audio/video technology
- Medical record documentation must support reason for using audio-only communication

Telehealth Documentation

- Same as any face-to-face beneficiary encounter, along with
  - Statement indicating telehealth service
  - Beneficiary location
  - Provider location
  - Names of all persons participating in service and their role in encounter
- Time-based services
  - Document start/stop time or total time

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

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 for all professional services for each covered visit
  - Subject to maximum payment per visit
- Payment limits differ based on type of RHC
  - CMS Change Request 13866 - *Update to RHC AIR Payment Limit for CY 2025*
- No payment beyond limit amount per visit for most services
  - Certain preventive services (such as IPPE and AWV)
    - Full AIR paid and no deductible or coinsurance applies
  - Most other services – Part B deductible and coinsurance rates apply
    - Once Part B deductible met, Medicare pays 80% of AIR and beneficiary pays remaining 20%

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
  - 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 CBRs as credits occur
  - Quarterly Credit Balance Reports No Longer Required as of 12/1/2024
- How to submit CBRs
  - NGSConnex online portal – preferred method
  - US Mail
  - Fax
- Credit Balance Reporting
  - CMS-838 Medicare Credit Balance Report
  - Medicare Credit Balance Report (CMS-838) Excel Spreadsheet

Cost Reports

- Providers required to submit annually for prior 12-month period
  - Prepare and Submit a Cost Report
  - Cost Report Submission Checklist
- Know which form to use
  - Independent RHCs - Form CMS-222-17
  - Provider-based RHCs located in hospital - entire M series of worksheets CMS-2552-10
  - Provider-based RHCs not affiliated with hospital - Form CMS-222-17
  - Low and No Medicare Utilization Cost Reports
- Annual cost reports must be submitted by later of
  - Five months from cost reporting fiscal year end
  - 60 days after cost report reminder letter sent to provider by NGS

Cost Reports

- Submission methods
  - Preferred method – online through MCReF or approved software vendor
  - CD, DVD, 3½" diskette format or flash drive
    - CDs should be password-protected and password sent under separate cover
- Once submitted, NGS reviews and finalizes cost report
  - Determines payment rate and reconciles if overpayment or underpayment
  - When submitted early, grace period granted to correct any issues noted if rejected
- 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)

PS&R Reports

- Tool used by Part A providers and MACs to prepare and process Medicare cost reports
  - Get Your PS&R Reports
- Access PS&R summary report using CMS Enterprise Portal
  - Do not contact NGS to receive PS&R summary reports
- PS&R detail report request - PSR Form
  - Allowed one request aligning with your current cost report year at no charge
    - Includes patient specific data on individual claim basis
  - Any non-aligning or additional requests require PSR Form and payment of $200 per request/year

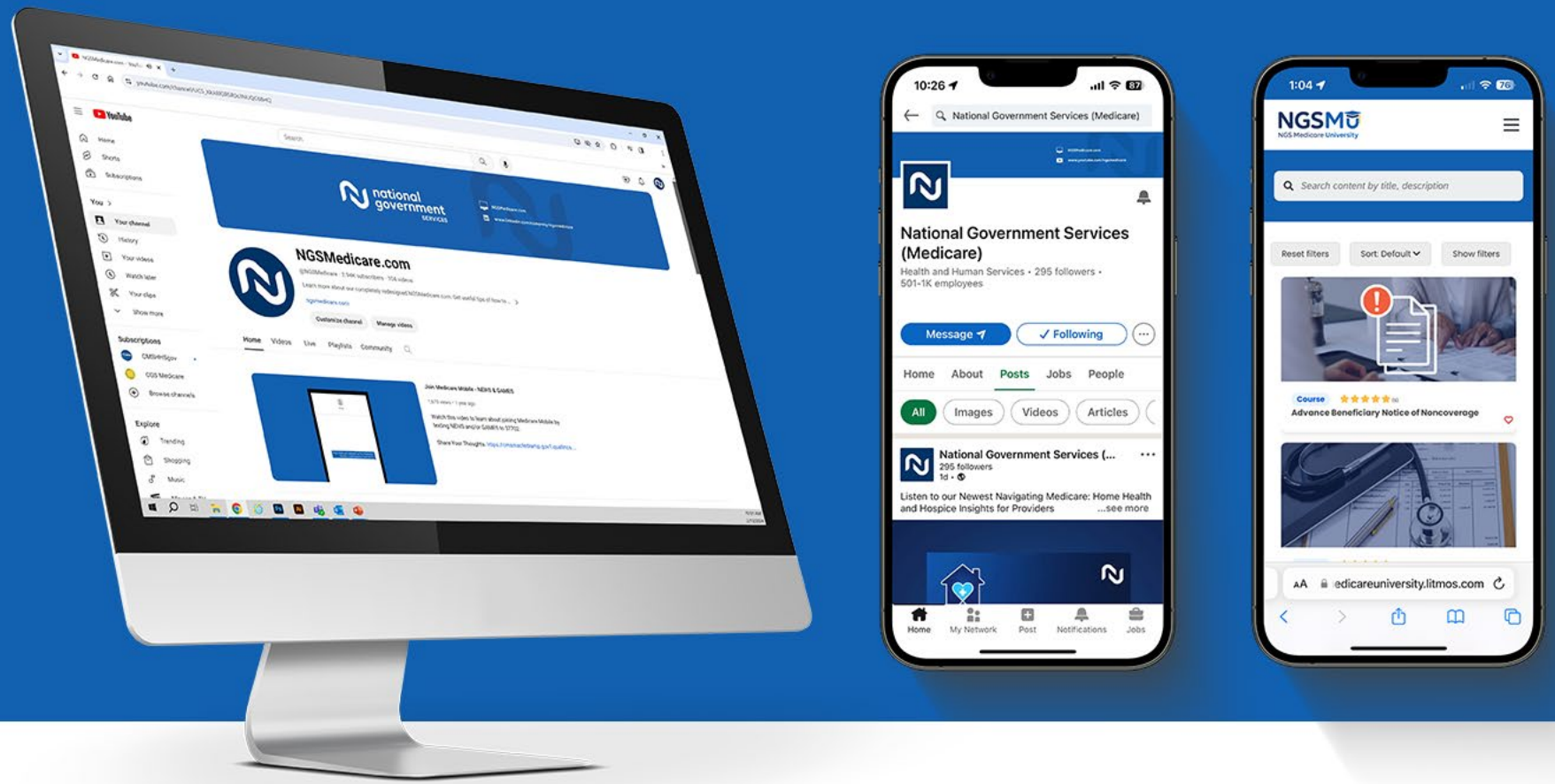
Resources and References

References and Resouces

- CMS
  - Rural Health Clinics Center
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13
  - RHC Reporting Requirement FAQs
  - MLN® Booklet: *Information For Rural Health Clinics* (MLN006398)
- HHS
  - Medicare payment policies
  - Telehealth policy updates

Questions?

Thank you!



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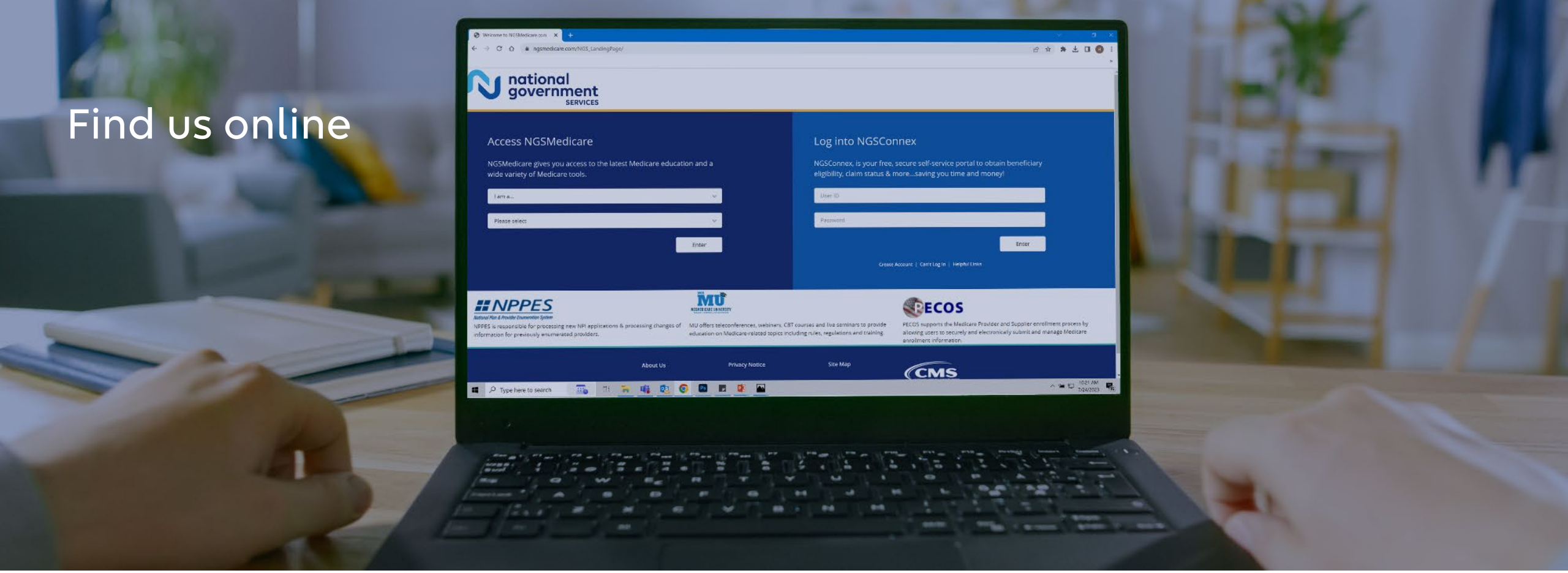

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