Healthcare Regulatory Round-Up #65

Rural Health Clinic Opportunities

February 21, 2024

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Introductions

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Why Be an RHC?

- Enhanced traditional Medicare and Medicaid reimbursement for RHC Services
  - State Medicaid programs generally follow traditional Medicare payment methodologies
  - Negotiated rates for Medicare Advantage (unlike FQHCs, no wrap-around payments), commercial payers
- FQHC vs. RHC
  - Sliding fee schedule
  - Governing body requirements
  - 340B Drug Pricing Program
  - Federal Tort Claims Act protections
  - Dedicated grant funding

RHC Qualifications

- Located in rural area designated as shortage or underserved area by Health Resources and Services Administration (HRSA) within last 4 years
  - Tools on HRSA website to determine eligibility*
  - No de-certification if location loses geographic eligibility and/or shortage designation
- Satisfy Medicare RHC Conditions of Certification (42 CFR Part 491) as demonstrated through state agency survey
  - Staffing
    - Employ at least one nurse practitioner (NP) or physician assistant (PA)
    - Have NP, PA, or certified nurse midwife (CNM) working on-site to see patients at least 50% of time clinic is open
  - Perform specified CLIA-waived lab tests on-site
  - Provide "first response" services to common life-threatening injuries and acute illnesses
  - Provide primary care services 51% of total practitioner hours (FP, IM, OB, Peds)
- Each permanent location must be independently certified

- https://data.hrsa.gov/maps/map-tool/

RHC Traditional Medicare Reimbursement

- RHC Services
  1. RHC Visit
  2. Telehealth Services
  3. Care Management Services
  4. Communication Technology Based Services
  5. Vaccinations
- Non-RHC Services

1. RHC Visit – All-Inclusive Rate (AIR)

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- Provider-based vs. Independent RHCs
  - Provider-based RHCs in hospitals with < 50 beds certified prior to 12/29/2020 (i.e., grandfathered RHCs) receive cost-based reimbursement
    - Consolidated Appropriations Act, 2021
    - Can re-locate permanent location but cannot expand to additional permanent locations
  - All others (non-grandfathered provider-based and all independent RHCs) receive standardized national AIR
    - $87.52 prior to 03/31/2021
    - $139 in 2024
    - Annual increases up to $190 in 2028; inflation adjusted thereafter

1. RHC Visit - Defined

- Face-to-face medically necessary medical or mental health visit or qualified preventive health visit between patient and RHC practitioner
  - Physician, PA, NP, CNM, clinical psychologist, clinical social worker, *licensed marriage and family therapist*, *licensed mental health counselor*, visiting nurse (limited circumstances)
  - Any location except hospital inpatient/outpatient setting and facility with specific requirements that preclude RHC visits (CORF, ASC)
    - Beneficiary's residence, SNF Part A stay, hospice, scene of accident
  - For behavioral health services, may use telehealth in place of face-to-face encounter (more later)
- Qualifying Visit List (QVL)*
  - *Non-exclusive* list of HCPCS codes that qualify as RHC visit (E/M, procedures)
    - Procedures on QVL performed by RHC practitioner in hospital setting paid on MPFS, not AIR
  - Last updated in 2016

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

1. RHC Visit - Preventive Services (no co-pay)

- Initial Preventive Physical Exam (IPPE) - G0402
- Annual Wellness Visit (AWV) - G0438 and G0439
- Screening Pelvic Exam - G0101
- Prostate Cancer Screening - G0102
- Glaucoma Screening - G0117 and G0118
- Screening Pap Test - Q0091
- Alcohol Screening and Behavior Counseling - G0442 and G0443
- Screening for Depression - G0444
- Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling - G0445
- Intensive Behavioral Therapy for Cardiovascular Disease - G0446
- Intensive Behavioral Therapy for Obesity - G0447
- Smoking and Tobacco Cessation Counseling - 99406, 99407
- Lung Cancer Screening with Low Dose CT -G0296

https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/rhc-preventive-services.pdf

1. RHC Visit - What Does Not Qualify

- Visits for medication refills, lab results, injections, blood pressure monitoring
- Suture removal or dressing change without additional face-to-face visit
- Visits billed under CPT 99211 (nursing visits)
- PT, OT, or SLP services by non-RHC practitioner

1. RHC Visit - Reimbursement

- Medicare pays RHCs 80% of applicable AIR for (nearly) all goods and services furnished as part of RHC visit
  - Qualifying preventive services paid at 100% of AIR when only service provided that day
  - Less 2% sequestration
- Beneficiary co-insurance = 20% of RHC changes (not 20% of AIR)
- Part B deductible applied to RHC services

1. RHC Visit - All-Inclusive

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- Encounters with 1+ practitioner and multiple encounters with same practitioner on same day at single location = single visit, unless patient—
  - Suffers illness/injury after 1st visit that requires additional diagnosis/treatment on same day
  - Has medical visit and behavioral health visit on same day
  - Has IPPE visit and separate medical or behavioral health visit on same day
- Services and supplies furnished ‘incident to’ RHC practitioner’s services
  - Including those furnished within a medically reasonable timeframe before/after RHC visit (DOS = date of RHC visit)
- Professional component of diagnostic testing performed in RHC facility
  - Technical component = non-RHC service (more later)
- Minor surgical procedures performed at RHC facility
  - Not subject to Medicare global billing requirements
  - Services performed during global period for procedure performed at ASC/hospital not separately payable

1. RHC Visit – Claim Submission

- List line-item, detail codes for all services furnished during RHC visit
  - Append CG modifier to code that identifies primary reason for visit
    - CG modifier x 2 if two separately payable services furnished on same day (e.g., medical and behavioral health visit)
  - List associated charge for each code, but roll up all charges to CG modifier line EXCEPT preventive services
    - CG modifier line used to calculate co-insurance (20% of total amount)
  - Use CG modifier for behavioral health service, 25 modifier for separate E/M service, 59 modifier for IPPE performed on same day as other medical visit

	Rev CD	Desc	HCPCS/CPT	DOS	Units	Charge
1	0521	Office Visit Est III	99213 CG	01/03/2024	1	320.00
2	0521	O/O E/M Add-on	G2211	01/03/2024	1	*20.00*
3	0521	EKG-PC	93010	01/03/2024	1	*30.00*
4	0521	Venipuncture	36416	01/03/2024	1	*20.00*
5	0521	Injection Admin	96372	01/03/2024	1	*20.00*
6	0521	Toradol	J1885	01/03/2024	1	*30.00*
7	0521	Screen Pelvic Exam	G0101	01/03/2024	1	50.00
8	0900	Psychotherapy – 30 min	90832 CG	01/03/2024	1	150.00
9	0522	Home Visit Est II	99348 25	01/03/2024	1	150.00

- Assume charge for CPT 99213 = $200
- Assume AIR = $139
- RHC would receive $333.60 from Medicare
  - ($139 x 3) x 0.8
- RHC would charge $124 co-payment
  - ($320 + $150 + $150) x 0.2

1. Revenue Codes

- 0521 - Clinic Visit by member to RHC
- 0522 - Home visit by RHC practitioner
- 0524 - Visit by RHC practitioner to member in covered Part A SNF stay
- 0525 - Visit by RHC practitioner to member in SNF (not covered Part A stay) or other residential facility
- 0527 - RHC Visiting Nurse Service(s) to member's home when in Home Health Shortage Area
- 0523 - Visit by RHC practitioner to other non RHC site (e.g., scene of accident)
- 0900 - Behavioral Health Treatments/Services

2. Telehealth – Behavioral Health Services

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- New coverage created under Consolidated Appropriations Act, 2021
- Qualifies as RHC visit (and thus pays AIR) if –
  - Use audio/visual connection (audio only if patient cannot/does not want to connect visually)
  - Effective 01/01/2025 -
    - In-person mental health service furnished within 6 months prior to furnishing telehealth services (unless those services initiated before 01/01/2025)
    - In-person, non-telehealth visit furnished at least every 12 months
      - May be waived; reason documented in medical record
- Bill revenue code 0900 with appropriate HCPCS/CPT code and modifier CG
  - Use modifier 95 for audio/visual connection; modifier FQ for audio only

2. Telehealth – Medical Services

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- Coverage through 12/31/24 created under Consolidated Appropriations Act, 2023
  - Thereafter, no coverage absent Congressional action
- Service must be included on CMS approved list of telehealth services*
  - Includes telephone only codes (CPT 99441)
    - At least 5 minutes of telephone E/M service by physician or APP provided to an **established patient**, parent, or guardian; cannot be billed if originate from related E/M service within previous 7 days or lead to E/M service or procedure within next 24 hours or soonest available appointment
- Bill under G2025 (vs. HCPCS/CPT for service furnished via telehealth)
  - Revenue code 0521
  - Reimbursed at $95.29 (2024 rate)

*https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes

2. Telehealth – Originating Site Fee

- Billed when patient physically present at RHC facility receives telehealth service from distant site provider
  - Q3014 (revenue code 078x)
  - 2024 reimbursement = $29.96
- Distant site provider separately bills for professional services using POS 02 (patient not physically present in home)
  - RHC not required to obtain provider's notes to bill Q3014

3. Care Management Services

- Bill G0511 for following services furnished by qualified RHC staff under general supervision of RHC practitioner in compliance with applicable billing rules (2024 reimbursement = $71.71)
  - Chronic care management
  - Principal care management
  - General behavioral health integration
  - Chronic pain management
  - Community health integration services*
  - Principal illness navigation services*
  - Remote physiological monitoring*
  - Remote therapeutic monitoring*
- General supervision ≠ physical presence, co-signature
- Bill G0512 (revenue code 0521) for Psychiatric Collaborative Care Model (CoCM) (2024 reimbursement = $144.07)

*New for 2024

3. Care Management Services

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- New in 2024: may bill G0511 multiple times in calendar month, provided all requirements are met and resource costs not counted more than once
  - Bill G0511 for each 20 minutes of chronic care management services?
  - Bill G0511 for each component of remote monitoring services?
    - CPT 99453 – Education and set-up
    - CPT 99454 – Monthly monitoring fee
    - CPT 99457 – Treatment management services, initial 20 minutes
    - CPT 99458 – Treatment management services, add'l 20-minut increments
- G0511 and G0512 payable if billed on same day as RHC visit (not rolled into AIR)

4. Communication Technology-Based Services

- Billed under G0071 - $13.10 (revenue code 0521)
  - At least 5 minutes of virtual (non-face-to-face) communication between RHC practitioner and patient, or at least 5 minutes of remote evaluation of recorded video and/or images by RHC practitioner
- Billing rules
  - Patient must have been seen at RHC within last year
  - Patient must consent to services
  - Must be in lieu of in-person visit, i.e., not originating from a related E/M service provided within the previous 7 days nor leading to E/M service or procedure within the next 24 hours or soonest available appointment

5. Vaccinations

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- Influenza (G0008) and Pneumococcal Vaccines (G0009)
  - Influenza and pneumococcal vaccines and their administration paid at 100% of reasonable cost through cost report
  - Report charges on cost report Worksheet M-4 (provider-based) or B-1 (independent)
  - Do not report on UB-04
  - Coinsurance waived

Non-RHC Services

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- Includes -
  - Clinical laboratory tests performed at RHC (venipuncture included in AIR)
    - Independent RHC bills to Part B on CMS 1500; services furnished in provider-based RHC billed by parent hospital on UB-04
  - Technical component of diagnostic tests performed at RHC (e.g., x-rays, EKGs)
    - Same as clinical laboratory tests
  - Professional services furnished in hospital inpatient and outpatient settings
    - Both independent and provider-based RHCs bill to Part B on CMS-1500
    - CAH Method II billing for practitioners' professional services in the hospital billed on UB-04
- All costs associated with non-RHC services (i.e., space, equipment, supplies, facility, overhead, personnel) must be removed from cost report
  - Including space leased to visiting physician who bills separately for services

Merit-Based Incentive Payment Program (MIPS)

- RHC services not subject to MIPS adjustments
- Non-RHC services furnished by RHC practitioner subject to MIPS reporting requirements if clinician exceeds low volume threshold:
    - $90,000 Medicare Part B payments,
    - 200 Medicare Part B patients
    - 200 covered services to Medicare Part B patients
- Services reimbursed under CAH Method II billing included in calculations for low volume threshold
    - MIPS adjustment to payments made to CAH

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