Rural Health Clinic Opportunities – Webinar Transcript

SPEAKERS
Martie Ross, Traci Waugh

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SUMMARY:

Marty Ross and Tracy Waugh discussed the benefits of the Rural Health Clinic (RHC) program for rural healthcare providers, highlighting key differences between RHCs and Federally Qualified Health Centers (FQHCs). Speaker 1 and Speaker 2 discussed the complexities of billing and reimbursement for RHCs, including staffing requirements, lab tests, first response capabilities, and primary care services. They emphasized the importance of compliance with regulations for reimbursement under Medicare and provided insights into new care management codes. Speaker 1 and Speaker 2 also discussed the rules for billing and reimbursement for services provided in an RHC, including the use of modifiers to identify primary reasons for visits and separate payable services.

Outline

Rural health clinic program and its reimbursement.

- Presenters Marty Ross and Tracy Waugh discuss the history and challenges of rural health clinics in the US.
- RHCs receive enhanced Medicare and Medicaid reimbursement for services, while FQHCs have additional reimbursement for serving lower-income populations.

RHC certification requirements and benefits.

- Speaker discusses differences between RHCs and FQHCs, highlighting RHCs' location requirements, lack of sliding fee schedule, and limited access to 340B drug pricing program.
- Speaker provides steps to become an RHC, including location designation and eligibility tools available on HRSA website.
- Speaker 1 explains that Rural Health Clinics (RHCs) must employ at least one nurse practitioner or physician assistant and have a non-physician practitioner available to provide services 50% of the time the clinic is open.
- RHCs must have the capacity to perform CLIA-waived lab tests and provide "first response services" to common life-threatening injuries or acute illnesses on site.

Rural Health Clinic reimbursement and certification requirements.

- RHCs must have separate CCN numbers for each location, with compliance requirements for certification.
- Provider-based RHCs enjoy locked-in cost-based reimbursement, while non-grandfathered RHCs receive standardized national air.
- RHC reimbursement rates increase significantly from $87.52 to $190 by 2028, creating new opportunities for independent physician practices in rural areas.

Rural Health Clinic visits and preventative services.

- Rural health clinic visits must have a face-to-face visit with an RHC practitioner.
- Preventative services covered under ACA with no copay if approved by US Preventive Services Task Force.

Medicare reimbursement for RHC visits.

- Speaker 1 explains that Medicare reimburses RHCs at 80% of the applicable air for nearly all goods and services provided during an RHC visit, with a 2% sequestration deduction.
- Beneficiary coinsurance for RHC services is 20% of charges, not air, and the Part B deductible applies to RHC services.
- Exceptions to single visit rule include injury, medical/behavioral health combo, IPP services.
- RHC practitioners can bill separately for follow-up visits if different services are provided.

Medical billing for RHC visits with CG modifiers.

- CG modifier used for behavioral health services, preventive services excluded.
- Practitioners must use modifier 25 or 59 to indicate separately payable services in RHC billing.

RHC billing with examples.

- Speaker explains how to calculate charges for additional services provided during a home visit.
- New add-on code G22 for longitudinal care in office outpatient e&m services may increase beneficiary copay.
- Speaker discusses billing for RHC visits, including use of modifiers and revenue codes.
- Home visit and psychotherapy services are separately billable, with different modifiers and revenue codes.

Telehealth services for RHCs and medical services.

- Telehealth visits for behavioral health services will require an in-person visit every 12 months, except when waived by the practitioner for specific reasons.
- Speaker 1 explains how to bill for telehealth services, including modifiers CG, 95, and FQ.

RHC billing and care management services.

- RHCs can bill for telehealth services provided in-person at their facility.

- RHCs can now bill for remote care management services with general supervision from practitioners.
- CMS clarifies Gao 511 billing for RHCs, creating new opportunities for care management services.

RHC billing and MIPS requirements.

- Practitioners can bill for virtual non-face-to-face communication services with patients who have had a recent face-to-face visit.
- Speaker 2 explains that non-RHC services, such as lab tests and diagnostic tests, are included on the hospital's UB-04 for independent RHCs, but not on the RHC bill.
- Non-RHC services, including professional services, must be removed from the cost report to avoid double billing and ensure accurate reimbursement.
- Speaker 1 explains that RHC services can be provided in separate visits from non-RHC services, and MIPS applies to non-RHC services furnished by RFC practitioners.
- Speaker 2 adds that convenience and doing the right thing are important considerations for managing RHC and non-RHC services.
- Webinar presenters Marty and Tracy provide updates on regulatory changes impacting rural healthcare.

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SUMMARY KEYWORDS

services, visit, bill, provider, modifier, rural health clinics, telehealth services, furnished, program, included, patient, talk, practitioner, reimbursement, reimbursed, fqhcs, rh, telehealth, separate, receive

SPEAKERS

Traci Waugh, Martie Ross

00:06
Thank you for joining us. The webinar will begin shortly and opportunities. PYA is happy to present today's webinar on this important topic. I would like to introduce our presenters Marty Ross and Tracy law.

Martie Ross 00:21
Gonna get your ever greetings from Kansas City How have your back to back Super Bowl champions and Mardi Gras joined today by Tracy Waugh, who is in Kalispell, Montana. And when you think rural, you think Kansas in Montana. In fact, going back to the 90s, I'm dating myself that back to the 90s with the original each peach demonstration project that eventually became the critical access program those that was Kansas and Montana. Now, Bob Dole and Max Baucus, that program for us so, but we're excited to talk about the rural health clinic program today and back it predates critical access hospitals, sole community hospitals, rural referral centers, this program goes back to the late 1970s. And it was

intended sort of this first special payment model within the Medicare program intended to fill that gap between high cost of providing services and lower volume of services. And that is the challenge in rural health care is that we have the same high fixed costs for delivering care, but lower volumes, so it's more difficult to make the math work. And so the rural health clinic program was intended to provide that additional reimbursement to rural providers, there are approximately 4500 rural health clinics throughout the United States. That number is growing. We'll talk about the reasons that more clinics are pursuing the rural health clinic program today. Why do you want to be an RHC main dominant reason is that you're going to receive enhanced traditional Medicare and Medicaid reimbursement for RHC services. RHC services should have quotes around it. It's a defined term, we're going to spend a lot of time talking about that term, state Medicaid programs generally follow the traditional Medicare payment methodology. So we're going to focus on those traditional Medicare payment methodologies today. But there is variation as we always say, there's not one Medicaid program, there are 56 Medicaid programs, those in states where there are HCS. To trend to treat, you know, there'll be a few clicks, a few changes here and there. That will vary reimbursement, but for other payers, including Medicare Advantage is a matter of negotiated rates between the payer and the RHC. And note that for Medicare Advantage, in particular, there is no wraparound payment for our HCS. For an FQHC there is additional reimbursement available to FQHCs to make up the difference between traditional Medicare and Medicare Advantage rates, but there is no similar wraparound payment in the RHC program. So let's delve into that. Let's talk about the difference between RH C's and FQHCs. Because this is a matter of confusion, in large part, because if you go to the section in the Code of Federal Regulations that talks about the conditions of coverage to be part of the rural health clinic program, it is also the same provision that addresses federally qualified health centers. And again, the FQHC program is the OG program because it goes back to 1965. When you created the Medicare program, it same thing, it was intended to provide additional special reimbursement for clinics that serve lower income populations, and provide access to care to those individuals. So the two are aligned. They're both a special payment methodology to help providers that serve a particular population. That kind of that's where the similarities end. And there are a lot of times we'll hear people say, Well, this does apply to an RHC. And like no, that's an FQHC role. So let's let's distinguish between the two. If you're a federally qualified health center, one of your core requirements is to have a sliding fee schedule, which means that you provide care regardless of a bit of beneficiary's ability to pay or any person's ability to pay. That is not true for the RHC program. You do not have to have a sliding fee schedule as a condition of being an RHC and the FQHC world there are specific rules regarding the governing body and that in fact, FQHCs are limited to not for profit organizations or public entities and the governing board has to consist of at least 51% of patient or patient representatives. Again, not true on the RHC side, rural health clinics can be and often are for profit organizations, no special rules regarding their governance. The 340 IV drug price egg pricing program is one of the significant benefits to the FQHCs that is not available to rural health clinics. question that we receive frequently is how do we gain access to that three four TB drug pricing program? What have we created An RHC that's not going to get you there, they do not participate in the program. Now, if you are a provider base RHC to a critical access hospital, the critical access hospital enjoys 340 B program participation and through that relationship as a provider, provider based department of the hospital or HCS can access 340 B program, but it independent RHC does not have access to 340 B FQHCs. Enjoy Federal Tort Claims Act protection, which obviously significantly lowers the malpractice costs for those clinics that is not available to rural health clinics. Finally, our federally qualified health centers have a dedicated grant funding to the

community health center program run by HERSA. Again, there is no additional payment to an RHC beyond that enhanced reimbursement that they received the Medicare Medicaid program. So there's our groundwork of why you want to be an RHC and why you'd really sometimes like to be FQHC, certainly a different set of issues associated there.

Martie Ross 06:01
So let's talk about how to become an RHC. You have to be located in a rural area that is updated, that has been designated as a shortage or underserved area by the Health Resources Services Administration. HRSA. But then the last four years, and there are tools available on hearses website that you can look at your location and determine your eligibility. You see at the bottom of the page, the link to those resources. The good news is that there's no decertification process. So if you are designated as a RHC, because you're eligible by location, if that is no longer a rural location, and that does shift based on census data, or if it's no longer a shortage area or an underserved area, then you're going to maintain your RHC certification. That's the that's the reliability built into the program. By comparison, again, FQHCs have to serve a population that is in a medically underserved area, or a medically underserved population. Those rules do not apply to RH C's, it's truly just where you're located is going to determine whether you're eligible for the program. The clinic then must satisfy the Medicare conditions of certification that is accomplished through a state survey agency doing it on site both of the desk based and an on site survey to determine compliance with those requirements. The most intensive requirements so let's highlight those include staffing that to be an RHC you must employ at least one nurse practitioner or physician assistant key word there is employ not an independent contractor relationship that must be a direct employee of the RHC. You also must have a non physician practitioner, specifically, nurse practitioner or physician assistant or a certified nurse midwife working on site see patients at least 50% of the time the clinic is open to provide services. And again, these are happy employees, this can be through an independent contractor relationship. But if you're open from if you're open 40 hours a week to provide services and RHC, then you're going to have to have a non physician practitioner available to provide services 20 of those hours, so they get not just physically present, but available to provide services at least 50% of the time. Also, to qualify as an RHC, you must perform within the facility specified CLIA waived lab tests. So very basic lab tests, we'll talk about the fact that those lab tests are actually not RHC services. But that's one of those intricacies of the program we'll talk about, but you do have to have the capacity to perform those in the clinic site, you must be capable of providing, quote, first response services to common life threatening injuries or acute illnesses. So it's not certainly not emergency level care provided through the RHC. But typically, you have to have the capacity of an urgent care clinic to be able to respond to those those conditions that were present on site. It's very mushy Mashie as you read through both the regulations and then the interpretive guidelines as to this first response requirement. But generally having that capacity to respond doesn't require additional hours that you're open available to provide those services. But when you are a bit, you have those capabilities. And finally, you have to provide primary care services 51% of total practitioner hours and primary care services generally defined as family practice, internal medicine, OB and pediatrics. So if you look at the total number of hours being provided in the clinic, it should be performed by physicians or non physician practitioners that would qualify as providing primary care services that again, common misconception you can provide specialist services through an RHC either the common arrangement is leasing space to the specialist that comes to the clinic for a certain number of hours and that specialist just builds the services themselves on the Medicare

Physician Fee Schedule, or we do have some arrangements where you'll Have a specialist who divides time across multiple rural health clinics and does a reassignment. And in fact, those are billed as RHC services and appropriately. So. Finally, each permanent location of the RHC must be independently certified. So each location is going to have its own CCN number that's again, different than FQHCs. Because FQHC is going to have multiple sites that are billing under the FQHC CCN 10. But for our HCS hospital, for example, may have three four provider based RH C's, those are each going to have separate CCS and have to each demonstrate compliance with the certification

Traci Waugh 10:40
requirements. And Marty, just to add, so, you know, you covered you know, some of the qualifications, but there's additional things to be aware of, if you're preparing for that survey, that you need to be aware of their specific signage requirements and lifting of ours. And so just know that there's another checklist to be conscious of, as you get prepared for becoming an ARD seat, or you may be re surveyed.

Martie Ross 11:05
Exactly, exactly, then the RE survey, it's very important Tracy survey sort of shut down during COVID does have resources that were getting C's are war state survey on site going up and around. Unfortunately, we didn't have a two hour webinar today. So he just wanted to hit the highlights of those requirements. Absolutely. So let's talk about RFC traditional Medicare reimbursement. We're going to start and focus on what are referred to as RHC services. You'll see there are five categories of RHC services. And then near the end, hopefully, before that we the clock strikes at the top of the hour, we'll talk about our HC billing for non RHC services. Yes, that sounds counterintuitive. But rural health clinics can bill for what are non RHC services. So starting down the road with the all inclusive visit rates all inclusive. Right? Exactly. And this is where we get into the distinction between a provider based RHC and an independent RHC. Because the air is different for the two. If you are a provider based RHC that is associated with a hospital that has fewer than 50 beds, and you were certified as an RHC. Prior to 1229 2020 are the date that the Consolidated Appropriations Act 2021 was signed into law these are referred to as grandfathered our HCS your air is based on a cost based reimbursement model. And those errors can be significant. They can be in the 200 plus range for their rates, and they will continue to receive that cost based reimbursement through the adjusted air. Note and this is important if you are a grandfathered RHC you are permitted to change your permanent location and maintain your grandfathered status. But you cannot expand that grandfathered status to additional permanent locations. Remember, each location has to have its own CCN and that grandfathered status travels with the CCN. Nor can a provider based organizations sell its RHC to an independent physician practice that's not permitted because the provider based status has to remain with the hospital. So there's not a way around for capturing that higher air that a provider based are grandfathered provider based RHC enjoy these. They're locked in we know who those clinics are. And again, they can relocate, but they cannot they cannot expand to additional facilities nor can they sell to a third party. Everybody else so that's your non grandfathered provider based RH C's as well as your independent RH C's receive a standardized national air. The air does not adjust by geography. So this is not like the physician fee schedule where you always are looking at what geography Am I n because it adjusts based primarily on workforce costs. Nope. This air is the same across the United States. Now if we go back to before the passage of the Consolidated Appropriations Act 2021, specifically before April one of 2021, that rate

was $87.52. And you know what the math didn't work. That's why we didn't have very many independent RH C's it was better for most physician practices, even if located in a rural area to continue to build services on the physician fee schedule. There just wasn't enough juice to go through the additional requirements of being an RHC. But then comes the Consolidated Appropriations Act. It shut down cost based reimbursement for any new provider based RFCs but it also started ramping up the national standardized air. So where are we said today in 2024, that rate is now $139. And that will continue to increase on an annual basis until 2028, we will reach $190 As the air, and then going forward, it will be adjusted for inflation similar to the PPS models that we have today. So that's pretty significant shift than the RHC program. And now creating this opportunity for independent physician practices that are located in rural areas to convert to RHC. As we've been doing math, or from practices that are considering this to pretty, it's obviously going to depend on your Medicare Medicaid mix. But in most cases, it is a compelling financial case, transitioning to RFCs processing another a number of health systems, urban based health systems that have clinics and outreach areas in rural areas. And again, they never saw the advantage of transitioning to an RHC because they were they had been provider based but it was they had more than 50 beds. But now, again, that increase in air creates a really significant new opportunity for practitioners in rural areas to receive this additional reimbursement.

Traci Waugh 16:16
So let's talk about what defines an RFC, a rural health clinic visit. So what's very important is what you see right there face to face, there needs to be a face to face visit with an RHC practitioner. This can be the physician, the nurse practitioner, that certified nurse midwife, all those providers listed there on the slide, there are limited circumstances in which a visiting nurse service is included, which we can talk about later and the location, it's anywhere but the hospital inpatient outpatient setting, being conscious of if you're RHC provider, if your provider base specifically and your provider goes over to the hospital and does services, that's not under the RHC bill that would fall into the hospital. There's also a link on the bottom here that talks about not a non exclusive list of qualified qualifying visits. So there is a list of hick pick codes that are qualified for each state visits the e&m and procedures. Again, it's important to realize with there's some of those minor procedures that can be performed in your RIT. See, that same providers going over to the hospital to perform them that separate that doesn't get get included within your RHC air that's on the hospital side, again, for provider based that that list, there's a link there and that was last updated in 2016. So you know, a few years have passed since that list has been included with lots of changes going on.

Martie Ross 17:52
And no real additional guidance coming out of CMS on what type of visit is going to be a qualifying visit. And the only other thing, Tracy, just to highlight and we'll talk more about this we get to telehealth. There are different rules for behavioral health services. They can be performed via telehealth as opposed to be face to face. But let's talk about that when we get to telehealth. Right, right.

Traci Waugh 18:13
On the next slide, we talk about preventative services. So this is important to know that the list below of all these preventative services are part of the all inclusive rate except and then if you have an initial preventive physical, physical exam, all preventive services can are finished on the same day or are one

billable service but if you have an IPP E with another service, that could be two visits on that bill, that's the one exception on there. And I know I was initially confused when I set the lung cancer screening with low dose use T scan. That's really the evaluation to see if you qualify for getting that low dose CT in the hospital setting. And again, if noted, there's no copay,

Martie Ross 18:59
right? This is yeah, there's provisions of the ACA. It says in Medicare, you don't pay a copay if it's a preventative services that had been approved by the US Preventive Services Task Force is designated as part as a Level A or Level B protect preventative service. So that's what this list is generated from. It isn't just hey, let's think of some preventative services. These are the actual approved preventative services. Yes, yep.

Traci Waugh 19:23
And then services that do not qualify as an RHC visit, you know, these are the ones that genuinely might be just being done by the nurse if there's just a refill, the you know, review of the lab results that occurred a few days before just taking a blood pressure, you know, patient may have went to the ER had some stitches and then have to have those removed, that's not going to count as a face to face visit that you can charge there are if physical therapy, occupational therapy, sleep therapy services are those if they're provided by a non RHC provide practitioner that was don't qualify as an RHC visit. And I think yeah, we're up to you now,

Martie Ross 20:08
Marty. Okay, so we know what an RHC visit is now, how do we reimburse it?

Traci Waugh 20:13
I know for Marty to cover

Martie Ross 20:18
we all struggle with, show me the money, Tracy, here we go. Medicare is going to pay an RHC 80% of the applicable air for nearly all goods and services that are furnished as part of an RHC visit. So that's why it's an all inclusive rate because you have the visit, which is a point in time and place, everything that you provide. At that point in time in place, it's going to be reimbursed by Medicare under the air. So you're going to get 80% of either your cost base reimbursed air or that national standardized air however, qualifying preventative care services are paid at 100% of air if it's the only service provided that day. So if a person comes in for an IPP IP rights are to cedras the IP PE, and that's the only service you provide that day, then you're going to be paid your full air raid. That's redundant air raid is redundant, I apologize. But you're going to get your full air and you're not going to have a copay to bill to the beneficiary. If you provide any other service that day, though, then we get into the rolling it up to the CG line talking about the second that preventative service, of course forever and ever, at least for what long after I retire. And at this rate Tracy probably long after you retire. Um, it's still subject to the 2% sequestration, so you don't get 80% It's actually 80% Minus the 2% sequestration. The beneficiary coinsurance and an RHC is 20% of RHC charges, not the air. And there is confusion around the Senate back there are some Mac's that will say in on their websites that RHC co pays are 30% of air. And in fact very clear in the regulations that you calculate the copay based on 20% of charges. And you'll see

in a few minutes how impactful that can be. Remember, also the Part B deductible does apply to RHC services. So you would look for if it's early in the year, you look for first dollar payment coming from the beneficiary or their supplemental plan, if appropriate. What is all inclusive, and we have a very complex set of rules here, we'll try and simplify them as best we can. And again, as I said, it's a time and location issue. But encounters with one or more practitioners, or multiple encounters with the same practitioner on the same day at a single location equal a single visit with three exceptions. So everything you do for the patient that day, whether it's one provider season, or two, or three or four, but is it a roll in to the air with three exceptions. Number one, that patient suffers an injury or illness that occurs after the initial visit, that requires additional diagnosis, diagnostic or treatment services that same day. So they're treated in the RSC, they go outside, they get hit by a bus, while minor injury by the bus, okay, they go back into the RHC to be treated for that injury, that's going to be two separate visits. So to separate errors paid. Second is you have a medical visit and a behavioral health visit on the same day. So you have the services that distinctly qualify as an e&m service or a procedure that is performed. And you have the state service that meets the requirements to bill for behavioral health service. Again, that's going to be considered two visits. Third, a beneficiary that has an IPP E and a separate medical or behavioral health visit on the same day. And it's just the IPP is the only preventative services supplies to in that case that would be to visits and to heirs will be paid. Also that included in that includes afraid are going to be those services and supplies furnished incident to the RHC practitioner services. That's going to include interestingly services that are furnished within a medically reasonable timeframe before or after the RHC visits. So for example, if you have a series of injections you're going to be doing before or after an RHC visit. Those are going to all again fall into the all inclusive reimbursement. When you bill for those the date of service is always going to be the date of the RHC visit don't do a two from or the system literally explodes if you do that. Also included the RHC visit is the professional component of any diagnostic test aid that's performed in the RHC facility. Okay, so if you run an x ray and the doc interprets the X ray to have professional component is going to be part of that all inclusive, visit the tech component is a non RHC service, we'll talk about that in a minute. Then minor surgical procedures that are performed at the RHC facility are also going to roll in if it service is performed at the RHC, then the global billing requirements that would associate with that procedure do not apply. So many follow on visits would be separate visits separately reimbursable, unlike if it's performed in the hospital, where the rules would apply. So even if you have an RHC practitioner, who performs a procedure at an ASC or a hospital, in that case, the rules the global billing rules would apply. So that patient comes down for a follow up visit to the RHC. And I got the global billing, right because the patient that that practitioner was reimbursed at a global rate for the service provided in the hospital or in the ASC. So it'd be inappropriate then, for the RHC to drop a claim for that follow up visit. That would be inappropriate, unless, of course, some other service was provided at that visit, that would be separate and apart different from the surgical follow up care. And Marty

Traci Waugh 26:13
is that regardless of who performs the service at the ASC if a different provider sees them with our HC,

Martie Ross 26:20
correct, right, unless it's unrelated, I mean, remember the global surgical period is attaches to the NPI that provide the warm service. And so if it's, if it's a another RHC practitioner performed the service and they're seen by a different RHC practitioner than work, right, then the RHC, but if it's a non RHC

practitioner provides that service and then the patient shows up, then that could be an RHC service. That's just how the global billing rules work. Okay, so let's get into some fun on claim submission. So buckle down, we're going to go into a lot of detail here, and it may get very confusing. When you submit a claim for an RHC visit, you're going to lists on the claim by line item, detail codes for all the services that are furnished. During that visit. You will append the CG modifier to that code that identifies the primary reason for the visit. Typically, that's going to be the e&m code, and then the e&m code is going to carry that CG modifier. And then any other service that's performed, as part of that RHC visit is going to be separately listed by the CPT code. There are instances Oh, there's instances where you could have two CG modifiers peering if there are two separately payable services furnished on the same day, and in particular, this is going to occur when you have a behavioral health visit. And a medical visit occurring on the same day remember to that means to heirs. So that means we're gonna have to see two lines on our claim for that day that are going to have the CG modifier attached to them. You then this is this is where it gets begins becoming very confusing. You will list on the claim your charge for every service that you're going to roll them up to the CG modifier line, except those preventative services that Tracy talked about, because remember, there's no copay, associated with preventive services. So we can't roll up the charge for preventive service into that top CG modifier line. That's because the CG modifier line is how we calculate coinsurance. So it's all your charges for the services rolled in to that CG modifier line, except preventative services. That's going to be the number where we're going to calculate our beneficiary coinsurance off of you will use the CG modifier for behavioral health services. If you had two separate nm services provided on the same day, so remember, the patient walks out and gets hit by a bus. In that case, the second e&m codes going to carry a 25 modifier on it and that again will also indicate to the Mac that's a separately payable service. Then you're going to use the 59 modifier course. Right? If you did an IPP E on the same day as a medical visit or behavioral health visit, this 59 modifier applies to non e&m services. An IPP E is a non e&m service. So you would use the 59 modifier in that instance. This was a question and I appreciate everyone who when they registered for this webinar included questions because it's very helpful. For us to make sure we're hitting all the relevant content. This was one of the questions that folks pose is when do you use the 25 modifier, when to use the 59 modifier. Again, you're only going to use CG modifier twice, or the 25 modifier or the 59 modifier on the line. That is, in fact separately payable as its own air, you do not list the 25 modifier on all those services that were provided as part of one RHC visit. So let's get into this table and try and walk you through how a charge would work. So we're going to talk about one day, I chose January 3 2024. And this may be one of the most complicated RHC bills you can imagine. But it's going to illustrate how these different rules work together. So pay in our case, a patient's going to show up for an office there, a traditional established patient office visit the good ol CPT 99213. We know they're also going to be visiting with a behavioral health specialist, we're going to have some psychotherapy that's going to be before him that day. And then in our example, patient goes home after having been at the RHC falls ill and the RHC practitioner actually goes to the patient's home to see the patient. So this is an illness that was not part of the original bill the visit. So we have a home visit that occurs after that RHC visit. I want you to assume for the purposes of our example, that the RH C's charge for that 99213 is $200. Okay, so let's see how we roll these charges up. So again, you'll see that line one, you'll see the office visit, which is the primary reason for the visit. It has the CG modifier attached to it. I remember the charge, the RFCs charge for that service is $200. But I have listed here 320, how do I get to that? Because I have these additional services that are listed on the client that were part of that RHC visit, including the professional component of an EKG venipuncture injection

administration toradol. So we've got to draw some blood from this person, we're going to give them an injection with toradol. And we're, we're also going to do a screening pelvic exam. Why not? I tried to make this medically reasonable, it most likely isn't. But so we've got a lot going on with this visit. And all of those different elements. Again, they're all have their own code to meet the code requirements, you're going to include that on the claim. And what we have listed then, are the charges for the services. All of those charges that are in italics, end up being rolled into the CG modifier line. And so that gets you to $320. So 200 for the original nm plus 120 for these additional services. Note, that screening pelvic exam, that $50 charge does not get rolled in because it's one of the preventative services for which there's no copay obligation for the beneficiary. That's I can't roll that charge up because why I use the CG modifier line to calculate the beneficiary's coinsurance 20% of charges. I want to draw your attention to line number two, where I have an office outpatient e&m add on code, the brand new reimbursable g 22. A little bit back two weeks ago today, we did a lengthy webinar on billing for G2211 had a lot of questions from rural health clinics regarding what's the impact of this new complexity add on code for Rh C's. If you're not familiar with G2211. It is a new reimbursement this year on the Medicare Physician Fee Schedule to reimburse or office and outpatient e&m services, very limited range of codes. You include this add on code, which is intended to reimburse for the longitudinal care of a patient. So a primary care physician that cares for a patient over a number of years, or a specialist that's managing a condition over a period of time. Those are referred to as longitudinal relationships. There's now an opportunity to bill for that on the Physician Fee Schedule reimbursement is about $17 Additional to the e&m codes was always an add on to an office outpatient established in MK a new or established patient e&m code. So do you include that on the RHC claim? It's not going to change your air.

Martie Ross 34:49
It's not going to add the reimbursement coming from Medicare. What the inclusion of that code on your claim will do is impact beneficiary coinsurance because it's There's a $20 charge for you include the add on, that's going to increase that number wrapped into the CG modifier line. And that's you're going to end up with the higher paid beneficiary copay. So the Medicare supplemental plan ends up paying you more, if there's a supplemental plan that that beneficiary has available to them or their pension benefit, or whatever it may be. Or in those cases that patients have to pay for that expense out of pocket, it's going to increase their out of pocket costs. So in this example, that's how you get to that CG modifier wine with a charge of three $20. Now, again, remember, we also this patient also received psychotherapy services, which is a separate behavioral health service, that will also carry separate air and so you'll have the CG modifier listed there. Okay. But then we had again, patient gets sick practitioner goes to their home, so we have a home visit for an established patient. And that instance, I'm going to list the CPT code, they preferred CPT code there, I put the 25 modifier, that's going to indicate to the pet to the payer to the Mac, that's also a separately payable line. So in this one day, this beneficiary has three RHC visits or would qualify for payment of three air. So if the air is as it is, today, under $39, we'll say this is a non grandfather, their payment from Medicare would be $333.60, which is simply three times the air multiplied by 80%. The copay then, for this visit would be $124. And how do we get to that? It's added the modifier lines, the CG modifier lines, so that's 320. The first line there charged for the psychotherapy was 150, the charge to the home visit was $150. You have that amount together, multiply it by 20%. That gives you the copay amount. I hope you don't have many days like this in your RHC. But that illustrates to you how the dollars roll into the air but also illness and that how

that impacts beneficiary coinsurance, but then also how you list on the claim those separate surfaces. Now if we really got creative and this person also received an IP PE the same day, it'd be another line that would list the 59 modifier in that circumstance. And again, that'd be another payable air, but nothing could ever really make that all medically necessary, but at least for illustrative purposes, that's how that would end up being billed. revenue codes very briefly, claims must include the revenue code and most frequent revenue code listed as Oh 521 which is the service provided in an RHC if we go back to our table, you can see the revenue codes oh, five to one except the last one. Remember, it was a home visit. So that is revenue code. Oh 522. What important to note here also is behavioral health visits are not in the oh five 2x list they are instead Oh 900. So that would be the list the revenue code you will list for those purposes. So that's RHC visit. Other services that qualify as RHC services are telehealth services. And we're going to talk about two kinds of telehealth behavioral health services medical services behavioral health services when furnished via telehealth, thanks to the Consolidated Appropriations Act 2021. Those are actually our HC visits because they're going to be reimbursed at the full air. Okay, so it's going to qualify as an RHC visit that telehealth visit is accomplished using an audio visual connection. Or you can use audio only if the patient cannot or does not want to connect visually. Effective beginning next year, we're going to have the initial face to face requirements kick in, and this has been it's been suspended by the Consolidated Appropriations Act 2023. But when the telehealth rules change at the beginning of 2025 Absent congressional action to provide a telehealth behavioral health visit this reimbursed under air, you will need to have had an in person mental health service furnished six months prior to furnish and telehealth services. Of course, if the telehealth services have been initiated prior to January 1 2025, the initial visit requirement will not apply. But you're going to have to have that initial visit at the RHC tree CBA for health services going forward then the inperson required will also require an in person non telehealth visits furnish at least every 12 months. Exception is the rule here because CMS has said that this can be waived. So long as the practitioner documents the reason for waiver of the in person every 12 month requirement. When you bill for these telebehavioral health services, you're going to use revenue code 900. And you're going to list the appropriate hickspicks CPT code and include modifier C G against this always going to be the primary reason to get that air reimburse. You're also going to add a modifier 95 When it's an audio visual connection, and you're going to use modifier FQ if it's audio only. So with that string of modifiers, what you're telling the Mac is this is a telehealth visit. It was performed. It qualifies for air. That's the CG modifier. It was one performed via telehealth either audio visual connection, modifier 95, or audio only. That's FQ. Switching gears, let's talk about telehealth for medical services. And here we live in the shadow of the public health emergencies still, because these will continue to be covered for an RHC through the end of this year. Again, the Consolidated Appropriations Act 2023. Thereafter, this all goes away absent congressional action. The service you provide that medical telehealth service must be a service that is listed on the CMS approved list of telehealth services you see there the link to that listing about 300 CPT codes know that that list includes telephone only codes I 9441. That is at least five minutes of a telephone e&m service that is not attached to a prior or subsequent visit. So if you provided that service, you have the opportunity to bill for medical services. You're going to bill for this using code g 2025.

Martie Ross 42:09
You're not going to use the CPT code for the service you furnish via telehealth so you're not going to put CPT 99441 on the claim it will appear. Instead, that telehealth services of medical telehealth service

regardless of the nature of the service, so long as it's one of the listed telehealth services, it's all going to get billed at 2020. On g 2025. You're going to list Revenue Code Oh 521 for that, and 2024. This service is reimbursing at $95.29, not the air. Instead, it's a national standardized them out for bid for medical telehealth services is $95.29. So that service again, the example there is if you are providing services that would meet the definition of 99441, which on the fee schedule is reimbursed at like 20 bucks, it's going to be reimbursed for an RHC at about $95. So this again, opportunity continues to exist through the end of this year. Please please remember this hard distinction between telebehavioral health services furnished by an RHC and medical services furnished via telehealth as this is always going to continue this being behavioral health. This is continue to be an air reimbursement forever and ever. You're going to add the in person requirement. It's going forward. It's a covered RHC service versus medical telehealth services. That benefit is going to go away and no longer will an RHC be able to bill for telehealth services medical services. Originating Site B is to close up the loop here if you can build the RH you can build the originating Site B when a patient is physically present at the RHC facility to receive telehealth services from a distance ICT provider say patient comes to your facility. The distance sized provider the specialist the rheumatologist, the oncologist, whoever it may be provides a telehealth service while the patient's sitting there near RHC. You build the originating site fee using g 3014. Revenue Code 07 8x. The reimbursement for 2024 is just shy of $30 that goes up every year based on inflation. Appreciate that that distance site provider is going to separately bill for their professional services using places service to being telehealth services for the patient not physically present in the home. The RHC is not required to provide to obtain the providers notes to bill for g 314. What has to be documented is the fact that you've had the patient physically present and presented them for purposes of receiving services from the distant provider. Their service is separate and apart from the service furnished by the RHC Third type of RHC service. So we talked about RFC visits, we've talked about telehealth. This is number three care management services furnished by our agencies. This is billed under g o 511. This is Bill for when one of the following services those listed on this slide are furnished by qualified RHC staff under the general supervision of an RHC. practitioner, we're in compliance with the bill Abigal billing codes for that service. The reimbursement in 2024 for any of these care management services is $71.71. Those that are marked with an asterick, beginning with community health integration going through remote therapeutic monitoring, those are all new in 2024. So this opportunity has expanded significantly, far HCS that now they're able to be reimbursed for providing remote monitoring services, as well as principal illness navigation and community health integration, as well as those core services that have previously been provided. Also, the beauty here is this is not practitioner time, the practitioner is providing general supervision for appropriately qualified staff. For most of the services that is going to be clinical staff. But note, we get deeper into the rules for community health integration and principal illness navigation. Those are services typically provided by an individual who would be a community health worker, and that person is not necessarily clinically trained. Again, that's a broader opportunity for our HCS. General Supervision does not require physical presence at the time that the service is being provided, nor does it require a co signature on every note prepared by that RHC staff and furnishing these services. There is one exception, a different care management code, which is g o 512, which is the psychiatric collaborative care model revenue reimbursement they're significantly higher at about $185. But it is a very distinct service. We'll go into detail here on the requirements for billing, like epic collaborative care model, but that reimbursement is available. Also new in 2024, is cms telling us very clearly and the final rule that a RHC may build G oh five one multiple times in a calendar month, provided all requirements are met and resource count of

source resource costs are not counted more than once. Back in December 2019, CMS published FAQs that explicitly said one unit of Gao 511 per month, that's it. So this is a change, and really creates a significant opportunity for care management services in our HCS. Now we've got some other questions. Okay. We don't know. For example, if you are providing chronic care management services before this final rule was published, you build one unit of Gao five one, regardless of who provided 20 minutes of services, 40 minutes of services, 60 minutes to services, which is different than the fee schedule, because they're separate codes you bill for those additional 20 minute increments. Now, the question is, hey, if I do bill, if I have already managed care management services, can I build two units of geo phi one, one, CMS just has directly addressed that question. Hopefully, they will soon. And then there's the whole issue of remote monitoring services, because that is a multi component service. As you see there, there are for at least four codes associated remote patient monitoring. Are we going to build geo 511 for each separate component? Not exactly explicitly addressed an answer by CMS? I think the answer is yes, based on my best reading of the guidance, but again, not directly addressed this issue here. also appreciate that both GMO 511 and geo 512 are payable if billed on the same day as an RHC visit. So these don't roll into the air, they're going to be standing on the road, you're gonna have a line that says do 511 You're charged for it not going to roll in to the air and it will be reimbursed to that 7171.

Traci Waugh 48:59
All right, now we move to the fourth opportunity, which is community technology based services. And a service that can be built under the G 0071 includes virtual non face to face communication between the patient and RHC practitioner. This must be at least for five minutes qualify however, the patient may has had to have had a face to face visit within the last year. Of course, they have to consent to receive this type of service. In addition, the medical discussion or remote evaluation is for a condition not related to services provided within the previous days and then does and cannot lead into a visit within the next 24 hours or soon as available appointment. So there's a cab yard of that timing of when that geo 0071 can be billed. So you have to be watching for those parameters of prior to and after to see if it's going to be separately billable. The fifth component includes our vaccinations for influenza and pneumococcal. And this includes the administration of including it as well as the vaccinate vaccine. Their charges are, these charges are reported on the cost report for provider based RH C's, they get placed on your works worksheet and for for independent RH C's they're placed on the b1 portion of that you don't you do not bill these are reported on your ubo for and again, these are situations in which your coinsurance copay would be would be waived for those particular vaccinations. Now rolling

Martie Ross 51:03
those charges into the CG line.

Traci Waugh 51:07
So here, we're going to talk about some non RHC services, okay? It's not that you can't provide them. And as, as Marty included on her example, the charges get placed on that bill, but they're there. They're not obviously services you can provide. It's confusing anyway, for example, these are the lab tests that are done or four independent RFCs. You know, these are things for example, in the lab for an independent rec may perform the lab that goes on your Part B or 1500. For your provider based, that bill would go on the hospital's uveal for however, the cursor vino picture becomes part of that that error

rate. The same sort of method applies for diagnostic tests that are done in the RHC, such as X rays, EKGs, and so forth. The professional admission earlier professional services that an RHC practitioner provides in that hospital or outpatient setting, does not get included on that RHC bill or are included in the error rate that again gets separated to be on that 1500. Note, if you're a critical access hospital and have elected to Bill method to that professional component doesn't hit the 1500. But you can include it on the hospital's uveal for bill for that professional component. All the costs associated with non our services. So your space, your overhead, your your equipment must be removed from your cost report. In addition, if you have some extra space in your RHC, which you have visiting providers coming in and using that that leased space time also needs to be and they bill for it separately that also needs to be removed out of that cost report. So there's considerations that you need to be monitoring specifically for your cost report contending on how you're going to get reimbursed for that.

Martie Ross 53:15
Yeah, I mean, Tracy, it's, this is just hard to get your head around, I think it's as if you got the RHC doing the RHC services. And then the same place you got a physician practice, that would be a physician practice providing non RHC services, and it's billing those on the fee schedule, just like any physician practice was just, there's this little unit of services that qualifies RHC services that are built in the ways we've been talking about but once you get off that out of those services, you get these different built the briny services in the hospital or the technical part of tests, all that's going to be treated on the fee schedule. And remember there's no rule you have to provide certain services in the RFC. And that's that's a whole nother art form is figuring out when it should be provided the hospital and when it should be provided the RHC and and there's no rules that you can't you can separate visits, you can do preventative services on a different day than you do e&m services. So there's there's no mandatory putting it all in one visit. It's again, you have to manage it, make sure you're getting appropriate reimbursement and also not making your patients mad because they don't want to come see you every day. Right?

Traci Waugh 54:22
Dance of you know, convenience, the right thing to do, right. Yeah, exactly.

Martie Ross 54:29
Very quickly. Let's just add on MIPS, because why not already services are not ever separate trips adjustments because they just aren't Part A reimbursed. They're not part B they're not subject to MIPS. However, when a RFC practitioner furnishes a non RHC service we just been talking about because again, it's just the normal physician practice next door and co located with a RHC they are going to be subjected to MIPS for those services. The exception of course is if you meet the low volume threshold, you See the requirements for that here on the screen. If you've got services that are reimbursed under comment the two, again services furnished in the hospital that are built by that QA and receive 115 150% of the Medicare Physician Fee Schedule. They are going to be included in the calculations for low volume thresholds. And the MIPS adjustment will actually apply to what the caller receives and this reimbursement. So that's made for some interesting issues going forward that. So there's our whirlwind through the wonderful world of Rh CES, we are next regulatory roundup webinar on March 6, you are ever in for a treat. Very Mathis is going to talk about cybersecurity and how there have been some significant changes in that landscape and regulatory assets. Please, please, please, if you all have

questions after this presentation, stick around complete that survey. Two questions, three questions, but there's a chance for you to add questions in and send us those questions. We do respond by email. Sometimes we're a little slow. I still have about 10 questions to go from the G2211. webinar. I apologize like one of those people that have gotten a response yet, but we will get to those questions. We want to be able to help and make sure you've received all the information you need. So there you go, Tracy, anything on the way out the door?

Traci Waugh 56:10
No, thank you. I hope you I hope you got it, you're gonna hit the ground running.

Martie Ross 56:15
Awesome. Again, if you don't have a thing, if you've got other topics that are impacting rural health, you'd like to have us address, drop that note as well. We want to make sure we're providing relevant content for you all. So thanks so much, Trevor, back to you.

56:29
Thanks to our presenters, Marty and Tracy. Please remember to stay on the line once the webinar disconnects to complete a short survey. Later today, you will receive an email with their contact information and a recording of the webinar. Also, the slides and recordings for every episode of PYA's healthcare regulatory roundup series are available on the Insights page of PYAs website www.pyapc.com. While at our website, you may register for other PYAwebinars and learn more about the full range of services offered by PYAEA. Please remember to stay on the line once the webinar disconnects to complete a short survey and post any questions you may have. On behalf of QA. Thank you for joining us and have a great rest of your day.