Advanced RHC Billing

Amanda Dennison, MBA, CPC, CRHCP
Manager, Blue & Co., LLC

CPAs / ADVISORS

blue

What we will cover today:

- Preventive Services
- Care Management Services
- Hospice Attending Physician
- Telehealth Originating Site
- Telehealth Distant Site
- Mental Health Telehealth
- Non-Covered Services
- Other Payors

CPAs / ADVISORS
blue

Please Note…

- The content of this presentation is current as of today. Healthcare rules and regulations, and payer guidelines change frequently. You should always do your own research as to current guidelines and regulations as they are subject to change.
- **This majority of this presentation will cover the traditional Medicare billing guidelines for RHCs. We will, however, discuss RHC impacts to other payors.**

Care Management Services

- CMS includes the following as Care Management Services:
  - Transitional Care Management (TCM)
  - Chronic Care Management (CCM)
  - Principal Care Management (PCM)
  - Chronic Pain Management (CPM) – *New as of January 1, 2023*
  - General Behavioral Health Integration (BHI)
  - Psychiatric Collaborative Care Model (CoCM)

Reference: CMS Benefit Policy Manual, Chapter 13, Section 230

CPAs / ADVISORS
blue

Transitional Care Management

- Billable if the only RHC service provided on that date of services
- Effective January 1, 2022 – TCM may be billed concurrently with Chronic Care Management (CCM) services provided during the same 30-day period
- Bill using CPT code 99495 or 99496, as appropriate:
  - 99495 – TCM services with moderate MDM complexity; face-to-face visit within 14 days of discharge
  - 99496 – TCM services with high MDM complexity; face-to-face visit within 7 days of discharge

Reference: CMS Benefit Policy Manual, Chapter 13, Section 230.1

CPAs / ADVISORS
blue

General Care Management Services

- Effective January 1, 2018, CMS created RHC/FQHC specific G-codes to use when billing for General Care Management Services
- General Care Management services include the following types of services:
  - Chronic care management (CCM)
  - General behavioral health integration (general BHI)
  - Principal care management (PCM) (added January 1, 2021)
  - Chronic pain management (CPM) (added January 1, 2023)
  - Psychiatric collaborative care model (COCM)
- Coinsurance for care management services is charged at the lesser of 20% of charges for each code, or the payment rate for each code.

CPAs / ADVISORS

blue

Reference: CMS Claims Processing Manual, Chapter 9, Section 70.8; CMS Benefit Policy Manual, Chapter 13, Section 230.2

General Care Management Services: G0511

- RHC/FQHC-specific G-codes:
  - G0511 – CCM, PCM, CPM, or BHI
    - Requires 20+ minutes of time per month for CCM, BHI; 30+ minutes for PCM, CPM
    - Can bill for the initiating visit separately as E/M, AWV, IPPE
    - Payment is based on the national PFS payment for applicable codes ($79.25 in 2022)
    - Payment is per member, per month
    - Can be included on the claim with other RHC services, or separately
    - Only one provider may bill these services
    - Patient must consent to these services
    - Other requirements: Care Management Services in RHCs and FQHCs - FAQs

Reference: CMS Claims Processing Manual, Chapter 9, Section 70.8; CMS Benefit Policy Manual, Chapter 13, Section 230.2

CPAs / ADVISORS
blue

Chronic Care Management Services (CCM)

- Effective January 1, 2016 – RHCs may bill for Chronic Care Management (CCM) services using G0511
- Chronic Care Management is for those patients with only **2 or more** chronic condition being managed by the RHC provider
  - Conditions are expected to last for at least the next 12 months or until death of the patient
  - Conditions place patient at significant risk of death, acute exacerbation, decompensation, or functional decline.
- A minimum of ***20 minutes*** of clinical time must be completed in a calendar month
  - Time can be complete by clinical staff once the initiating appointment is completed by RHC provider.
  - RHC provider should still periodically meet with the patient if there are needed changes to the patient's care plan.
- Payment is based on the payment rules for G0511

Reference: CMS Benefit Policy Manual, Chapter 13, Section 230.2.1

CPAs / ADVISORS
blue

Principal Care Management Services (PCM)

- Effective January 1, 2021 – RHCs may bill for Principal Care Management (PCM) services using G0511
- Principal Care Management is for those patients with only **1** chronic condition being managed by the RHC provider
  - Condition may have led to a recent hospitalization
  - Condition may place patient at significant risk of death
  - Condition requires development or revision of disease-specific care plan
  - Condition requires frequent adjustments to medication(s)
  - Condition is unusually complex due to comorbidities
- All requirements for G0511 still apply, but there must be a minimum of ***30 minutes*** of clinical time completed in a calendar month
- Payment is based on the payment rules for G0511

Reference: CMS Benefit Policy Manual, Chapter 13, Section 230.2.2

CPAs / ADVISORS
blue

Chronic Pain Management (CPM)

- Effective January 1, 2023, RHCs may bill for Chronic Pain Management (CPM) when provided by a qualifying RHC provider
  - Must be a minimum of 30 minutes of time in a single calendar month
  - Must be face-to-face time
  - May be provided to patient with multiple chronic conditions involving chronic pain
  - Main include a person-centered plan of care, care coordination, medication management, and other aspects of pain care
- Billed under G0511

Reference: CMS Benefit Policy Manual, Chapter 13, Section 230.2.3

CPAs / ADVISORS
blue

General Behavioral Health Integration (BHI)

- Effective January 1, 2018 – RHCs may provide general BHI services using G0511
- BHI is a team-based , collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
  - Must be a minimum of **20 minutes** of time in a single calendar month
  - Patient must have one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC primary care provider
    - Can include substance abuse disorders
    - Conditions may also be such that in the clinical judgement of the RHC provider, warrants general BHI services
- Billed under G0511

Reference: CMS Benefit Policy Manual, Chapter 13, Section 230.2.4

CPAs / ADVISORS
blue

General Care Management Services: G0512

- RHC/FQHC-specific G-codes:
  - G0512 – Psychiatric Collaborative Care Model (CoCM)
    - Requires 70+ minutes the first month, and 60+ minutes in any subsequent month
    - Can bill for the initiating visit separately as E/M, AWV, IPPE
    - Payment is based on the national PFS payment for applicable codes ($151.23 in 2022)
    - Payment is per member, per month
    - Can be included on the claim with other RHC services, or separately
    - Only one provider may bill these services
    - Patient must consent to these services
    - Other requirements: Care Management Services in RHCs and FQHCs - FAQs

Reference: CMS Benefit Policy Manual, Chapter 13, Section 230.3

CPAs / ADVISORS
blue

Hospice Attending Physician Services

- Effective January 1, 2022 RHCs may be reimbursed according to their AIR when an RHC physician provides hospice attending physician services during a patient's hospice election
- Report the services with modifier GV, in addition to the required modifier CG each day a hospice attending physician service is provided
- Coinsurance and deductible do apply

Reference: CMS Claims Processing Manual, Chapter 9, Section 60.6; CMS Benefit Policy Manual, Chapter 13, Section 210

CPAs / ADVISORS
blue

Telehealth – Originating Site

- RHCs are authorized to serve as the originating site during a telehealth encounter
  - Originating site = location of *patient* during the encounter
- RHCs should bill using Q3014 with revenue code 0780
- Payment for 2023 = $28.64

Reference: CMS Claims Processing Manual, Chapter 9, Section 80; CMS Benefit Policy Manual, Chapter 13, Section 200

CPAs / ADVISORS
blue

RHC as Distant Site for Telehealth, Medical

- The Consolidated Appropriations Act of 2023 extended current CMS telehealth flexibilities for RHCs until the end of 2024.
- Until December 31, 2024, RHCs are authorized to serve as the distant site for telehealth services
  - Distant site = location of the *provider* during the encounter
  - Both patient and provider can be in any location (including their home) during the encounter
    - Must be during RHC hours
- The distant site service only qualifies for reimbursement if it is on the CMS list of approved telehealth services: List of Telehealth Services for Calendar Year 2023 – *last updated May 9, 2023*

CPAs / ADVISORS
blue

RHC as Distant Site for Telehealth, Medical

- Qualifying RHC distant site services should be billed using the RHC-specific G-code G2025
  - For dates of service on or after 7/1/2020:
    - Bill using G2025 and optional modifier 95 along with the appropriate 052X revenue code
    - **Do not** include HCPCS codes for services provided during the telehealth encounter
- Payment rates for G2025 are as follows:
  - DOS 2023: $98.27
- This does NOT apply to qualifying RHC mental health telehealth visits with DOS beginning January 1, 2022
- MLN Matters SE 20016 - New and Expanded Flexibilities for RHCs and FQHCs – *last updated May 12, 2023*

CPAs / ADVISORS
blue

Mental Health Telehealth Visits

- Effective January 1, 2022 RHCs may provide mental health visits via telecommunications technology. These visits may be audio-video or audio only.
  - Audio only is acceptable when:
    - the patient does not have access to audio-video technology; or
    - does not consent to the use of audio-video technology.
- In person requirements:
  - Must be an in-person mental health visit 6 months prior to the mental health telehealth visit; and
  - Must be at least one in-person mental health visit every 12 months while the patient is receiving mental health services via telehealth.
  - *Delayed until December 31, 2024*

Reference: CMS Benefit Policy Manual, Chapter 13, Section 170

CPAs / ADVISORS
blue

Billing and Reimbursement for Mental Health Telehealth Visits

- Mental health telehealth visits will be reimbursed at a rate equivalent to an in-person visit
- How you bill for these depends on if the visit is completed using audio-video or audio only technology

Audio-Video:

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit payment code)	***95 (audio-video)*** CG (required)

Audio-Only:

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit payment code)	***FQ or 93 (audio only)*** CG (required)

CPAs / ADVISORS

blue

Resource: MLN Matters SE22001: Mental Health Visits via Telecommunications for RHCs & FQHCs

Claim Example

RHC Encounter – Mental Health Visit, In-Person

- Scenario: RHC Provider completed 45 minutes of psychotherapy with a patient. Charge for the visit is $200.00.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0900	RURAL HEALTH CLINIC, MENTAL HEALTH	90834 CG	07/01/2023	1	200.00	00.00	
0001	PAGE 1 OF 1	CREATION DATE	07/01/2023	TOTALS	200.00		

CPAs / ADVISORS

blue

Claim Example

RHC Encounter – Mental Health Visit, Telehealth

- Scenario: RHC Provider completed psychotherapy via telehealth using via audio-video technology. Charge for the visit is $200.00.

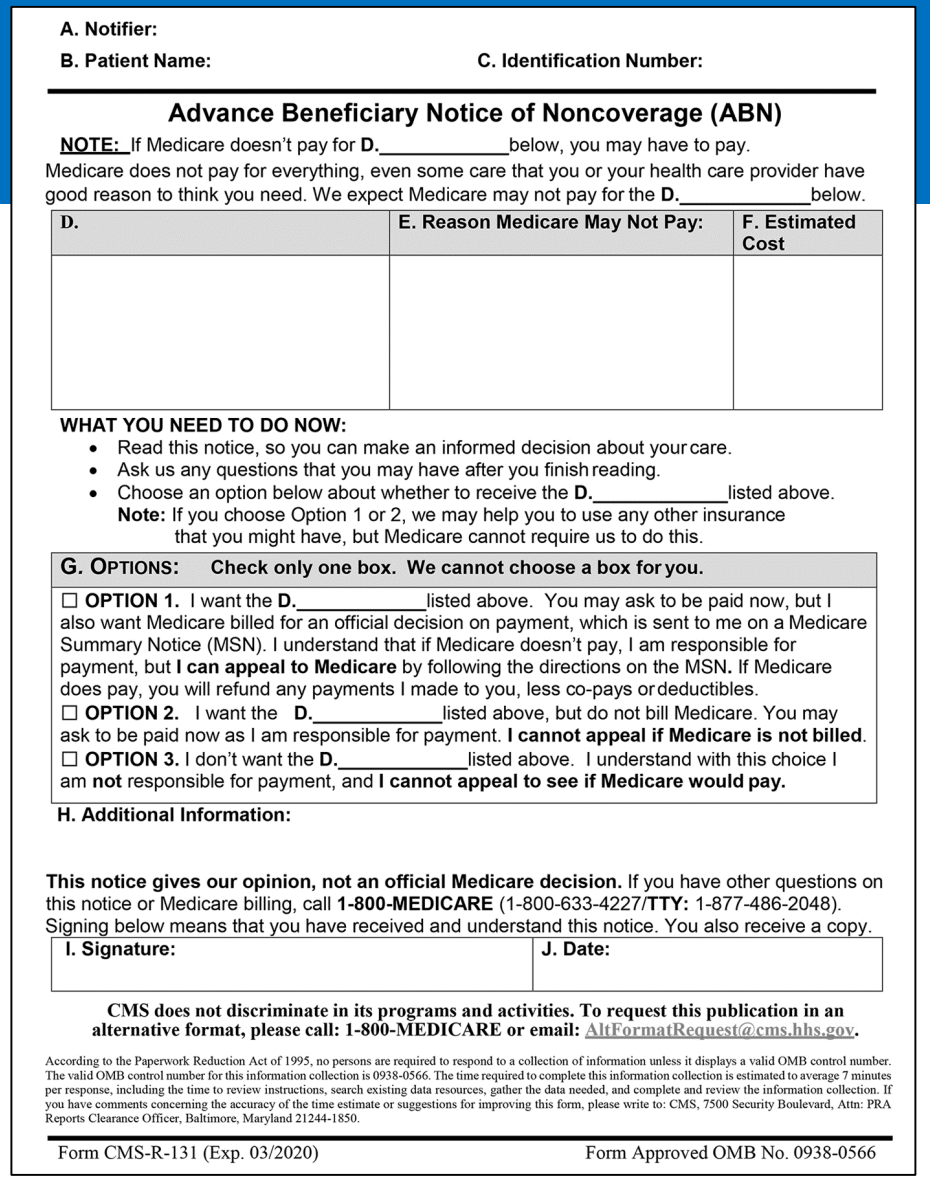
	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0900	RURAL HEALTH CLINIC, MENTAL HEALTH	90834 CG, 95	07/01/2023	1	200.00	00.00		1
2									2
3									3
4									4
5									5
6									6
23	0001	PAGE 1 OF 1	CREATION DATE	07/01/2023	TOTALS	200.00			23

CPAs / ADVISORS

blue

Non-Covered Services

- Non covered services are not considered medically-necessary, therefore not covered by the RHC benefit, nor any Medicare benefit
- The RHC should complete an Advance Beneficiary Notice of Non-Coverage (ABN) for all non covered services.
- Submit these charges using TOB 710
- Payment for charges associated with non covered services is the responsibility of the patient.



A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

ABN Requirements

- The ABN notifies Medicare beneficiaries that a particular service is non covered, or that Medicare may deny payment for a particular service. In these cases, the patient is responsible for the charges.
- The ABN should be given to patients ***before*** they receive the service.
  - If it is given to them after they receive the service, it is not valid, and the RHC may by liable for any amounts Medicare does not pay. You may not bill the patient for those services.
- The ABN must include a ***reasonable estimate*** for the cost of the service to be provided.
  - "Reasonable estimate" is defined as within $100 or 25% of the total cost, whichever is greater.

CPAs / ADVISORS
blue

RHC Status and Other Payers

- Medicare Advantage Plans
  - More than 3000 Medicare Advantage Plans across the US
  - MA plans reimburse RHCs according to how you are contracted with each specific plan
  - RHCs can choose to update their contractual language with MA plans, but it is not a requirement
    - Currently a lot of difficulty/lack of understanding of RHCs by a lot of MA plans
    - Some will pay you your AIR, same as regular Medicare
    - Some will contract with you as RHC, but still pay you FFS
    - Regardless, how you bill your MA plans is always contract-based
  - A lot of patients either do not know what their MA plan covers or have no idea they even have a MA plan – educate your patients!
    - Medicare Advantage is not always ADVANTAGEOUS for the patient

CPAs / ADVISORS
blue

RHC Status and Other Payers

- Medicaid
  - Less of a difference in how you bill the claim, but a difference in how you are paid
    - Regular Medicaid
      - pays your PPS/RHC-specific rate (similar to the AIR for Medicare)
      - Some states require a T1015 code to be present on the claim
    - Medicaid Managed Care Plans/Entities/Organizations
      - Reimburse you according to your agreed upon fee schedule for each service
      - State makes you whole between what you received from the MCE and what your PPS/RHC-specific rate is
        - Often called “wrap payments”
      - May still require T1015 for proper adjudication
      - May have specific modifiers required for certain services
      - Can reimburse FFS for certain services outside of RHC payment – state specific
  - Medicaid eligible providers for RHC differ from Medicare eligible providers
  - POS 72 may need to be used on your Medicaid claims

CPAs / ADVISORS
blue

RHC Status and Other Payers

- Commercial Payers
  - Commercial payers do not recognize RHC status
  - Little to no changes to current billing processes and payment
  - If RHC chooses to obtain a new NPI number for RHC billing, there are two options for commercial payers:
    - Bill using new RHC NPI number
      - requires communication to commercial payers of updated NPI
      - Processes/paperwork varies by payer
    - Bill using existing non-RHC NPI number
      - Only Medicare and Medicaid would be billed under new RHC NPI
  - Be careful that your enrollments are accurate, and you don't risk issues of commingling

CPAs / ADVISORS
blue

Helpful RHC Resources

- Medicare Benefit Policy Manual, Chapter 13
- Medicare Claims Processing Manual, Chapter 9
- CMS Rural Health Clinics Center
- NARHC Resource Center

CPAs / ADVISORS
blue

Questions?

CPAs / ADVISORS

blue

Contact me!

Amanda Dennison, MBA, CPC, CRHCP

Manager

Blue & Co., LLC

502.992.3518

adennison@blueandco.com

CPAs / ADVISORS

blue