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39th Annual Oregon
Rural Health Conference

OPPORTUNITY Just knock.

The Rural Health Clinic Workshop Presents
RHC Medicare Billing Update

Speaker:

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RHC Medicare Billing Update

Oregon Rural Health Annual Conference
RHC Workshop
Wednesday, October 12, 2022

inQuiseek Consulting

Topics included in this session

Medicare Billing Reminders

- What is an Encounter?
  - CG Modifier
  - Split Billing
  - Medical Telehealth During the PHE
  - Medicare Immunizations

Changes to RHC Coding and Billing for 2022

- Proposed MPFS Rule
- Mental Health Telemedicine Encounters
- Hospice Services

What is an RHC Encounter?

- RHC visits (encounters) are medically necessary face-to-face medical or mental health visits or qualified preventive visits between the patient and a physician, NP, PA, CNM, CP, or CSW during which a qualified RHC core service is furnished.

- The service must be an RHC encounter if the AIR is to be reimbursed.

- Qualified preventive and screening services may also be standalone RHC visits as well as Transitional Care Management.

- Care Coordination and Virtual Communication Services are exceptions to the face-to-face requirement for a billable service

FACE-TO-FACE, ONE ON ONE (PHYSICIAN, NP, PA or LCSW↑)

+

MEDICALLY NECESSARY

+

LEVEL 2 OR HIGHER E & M Requires a Provider*

=

RHC ENCOUNTER (Billable and Pays AIR)

* Or a procedure such as those on the QVL, a preventive service, transitional care management and advanced care planning.

Qualifying Visit List

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

- All codes in either red or black ink on the list can be used for services after 10/01/2016.
- At least one code from the QVL should appear on a claim and be appended by –CG.
- QVL is not exclusive list. However, most MACs have written their claims processing rules based on the QVL.
- CMS can update this list quarterly through OCE edits, but the document itself has not been updated since October 2016.

Rural Health Clinic Qualifying Visit List (RHC QVL)

(8-01-16)

The RHC QVL is intended as guidance for RHCs beginning to report HCPCS codes. It consists of frequently reported Healthcare Common Procedure Coding System (HCPCS) codes that qualify as a face-to-face visit between the patient and an RHC practitioner and it is not an all-inclusive list of stand-alone billable visits for RHCs. More information on what is considered a RHC visit is included in the "RHC Visits" section of this guidance.

Medical Services	
HCPCS Code	**Short Descriptor**
10081[1]	*Drainage of pilonidal cyst*
10120[1]	*Remove foreign body*
10121[1]	*Remove foreign body*
10140[1]	*Drainage of hematoma/fluid*
10160[1]	*Puncture drainage of lesion*
11000[1]	*Debride infected skin*
11010[1]	*Debride skin at fx site*
11011[1]	*Debride skin musc at fx site*
11042[1]	*Deb subq tissue 20 sq cm/<*
11055[1]	*Trim skin lesion*
11056[1]	*Trim skin lesions 2 to 4*
11057[1]	*Trim skin lesions over 4*
11100[1]	*Biopsy skin lesion*
11200[1]	*Removal of skin tags <w/15*
11300[1]	*Shave skin lesion 0.5 cm/<*

Evaluation & Management Services

99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq

Approved Preventive Health Services	
HCPCS Code	**Short Descriptor**
99406[4]	*Behav chng smoking 3-10 min*
99407[4]	*Behav chng smoking > 10 min*
G0101	Ca screen; pelvic/breast exam
G0102[5]	Prostate ca screening; dre
G0117[5]	Glaucoma scrn hgh risk direc
G0118[5]	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

Medicare Billing Reminders

CG MODIFIER USE

SPLIT BILLING

SERVICES PAID AT FFS

Reporting Modifier CG

Q1. When should modifier CG be reported?

A1. RHCs should report modifier CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit. This line should have the bundled charges for all services that are subject to coinsurance and the deductible (e.g., charges for all services furnished during the visit minus the charges for preventive services for which the coinsurance and/or deductible are waived).

If only preventive services are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the medically necessary face-to-face visit and the bundled charges.

Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

-CG Modifier Reminders

- There must be on one line on the claim with the –CG Modifier for Services Paid at the AIR.
- Each claim for an encounter must have a –CG modifier if paid at the rate.
- The –CG is appended to a code on the Qualifying Visit List.
- The revenue code for the –CG line should be either a 052X code or a 0900. Your system may not display the leading zero.
- All line item charges roll up to the –CG line.
- The –CG line reports that an encounter occurred which will pay the AIR.
- The –CG line will be the only line processed.
- The deductible and coinsurance will be calculated from the summed total on the –CG line. There are some exceptions for preventive services.
- For medical and mental health encounters reported on the same claim for the same date of service, the –CG will appended to both line items. Two AIR payments will result.

RHC Medical Encounter with Multiple Services

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2021	1	190.00
0521	Inj Admin	96372	11/01/2021	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2021	2	50.00
0001	Total Charge				255.00

$125 + $15 + $65 = $190

Report other lines at regular charge or at .01.

Provider performed an E & M service ($125) and an abx injection ($15 + $50) during the same visit. Also, a UA and an x-ray were performed in the RHC. Total RHC services would be $190.00. The patient would be responsible for a $38.00 co-insurance payment. The total 001 line appears overstated. ***Lab and x-ray services would be billed separately under the appropriate method for the type of RHC.***

001 Line will be overstated

RHC Encounter: Medical Visit and Mental Health Visit on Same Date of Service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV New	99204 CG	11/01/2021	1	175.00
0900	Psych Eval	90791 CG	11/01/2021	1	200.00
0001	Total Charge				375.00

The physician performed an sick visit ($175) and the behavioral health provider performed a psych eval ($200) on the same date of service. Both services would be reported separately with the –CG modifier. Total RHC services would be $375.00. The patient would be responsible for a $40.00 co-insurance payment. Medication management for behavioral health if it were incidental-to the medical visit would not be a separately billable mental health visit.

RHC Encounter: IPPE and Sick Visit on same date of service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2021	1	150.00
0521	IPPE	G0402	11/01/2021	1	200.00
0001	Total Charge				350.00

The physician performed IPPE ($200) and an E & M ($150) for a problem visit on the same date of service. The office visit is listed first with the -CG modifier. The patient has no cost share for the IPPE service because the deductible and co-insurance is waived. The co-insurance amount due for the sick visit is $30.00. The RHC will receive two AIR payments for this visit.

You should track all preventive services for cost-reporting purposes.

Transitional Care Management (TCM)

- Face-to-face visit within 14 days of discharge
  - 99495 – moderate medical decision complexity
  - 99496 – high medical decision complexity
- Only 1 health care professional may report TCM
- Report once per beneficiary during TCM
- **For RHC, Date of service used is the Face-to-Face visit day**
- **Reimburses the AIR rate**
- TCM cannot be billed during a global period
- Documentation required:
  - Date of discharge
  - Date of interactive contact with bene and/or caregiver
  - Date of face-to-face visit
  - Complexity of Medical Decision making

ModifierS -59 or -25

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has an injury and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit code, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

This is an unconventional use of -59 and is only used in this way, unique to RHC billing of multiple visits on the same date of service.

Use of modifiers (-59, -25) other than the -CG modifier on Medicare claims with multiple services may trigger an incorrect overpayment.

When NOT to use the –CG Modifier

- Do not append the –CG modifier to these codes
  - G2025- Telehealth
  - G0071 Virtual Communication Services
  - G0511 Care Management Services (Chronic or Principal Care Management)
  - Preventive Services When Reported with other Services
  - Do not use the –CG modifier more than once on a claims for a medical encounter. If more than one service is on the QVL (an E & M and a Procedure code), append the –CG to the primary reason for the visit. Roll all other services to the –CG line.
  - Do not use –CG on non-Medicare claims UNLESS the payor has asked for it. Some MA plans will use the –CG modifier. Most Medicaid plans will NOT.

Preventative Services Guide

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

This CMS reference give examples of preventative services and indicates when the AIR is received and how the deductible and coinsurance amounts are applied.

The –CG modifier is appended if the only service provided is the preventative service. The –CG modifier if not needed for the IPPE but may be added. Preventative services provided on the same day as a qualifying medical visit are reported but are not bundled into the –CG line.

IPPE is the ONLY preventive service which will qualify for an additional AIR on the same DOS as a sick visit.

Preventive services should be tracked for cost-reporting.

Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
IPPE	G0402	Initial preventive exam	Yes	Yes	Waived	Ch. 9 §150 Ch. 18 §80
AWV	G0438	Ppps, initial visit	Yes	No	Waived	Ch. 18 §140
	G0439	Ppps, subseq visit	Yes	No	Waived	
Screening Pelvic Exam	G0101	Ca screen; pelvic/breast exam	Yes	No	Waived	Ch. 18 §40

Prostate Cancer Screening	G0102	Prostate ca screening; dre	Yes	No	Not Waived	Ch. 18 §50
Glaucoma Screening	G0117	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	Ch. 18 §70
	G0118	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	
Screening Pap Test	Q0091	Obtaining screen pap smear	Yes	No	Waived	Ch. 18 §30
Alcohol Screening and Behavioral Counseling	G0442	Annual alcohol screen 15 min	Yes	No	Waived	Ch. 18 §180
	G0443	Brief alcohol misuse counsel	Yes	No	Waived	
Screening for Depression	G0444	Depression screen annual	Yes	No	Waived	Ch. 18 §190

Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling	G0445	High inten beh couns std 30m	Yes	No	Waived	Ch. 18 §170
Intensive Behavioral Therapy for Cardiovascular Disease	G0446	Intens behave ther cardio dx	Yes	No	Waived	Ch. 18 §160
Intensive Behavioral Therapy for Obesity	G0447	Behavior counsel obesity 15m	Yes	No	Waived	Ch.18 §200

Smoking and Tobacco Cessation Counseling	*99406*[1]	*Behav chng smoking 3-10 min*	Yes	No	Waived	Ch. 18 §150
	99407[1]	*Behav chng smoking > 10 min*	Yes	No	Waived	
Lung Cancer Screening With Low Dose Computed Tomography	G0296	Visit to determ LDCT elig	Yes	No	Waived	Ch. 18 §220

[1] HCPCS code G0436 and G0437 will be discontinued effective 10/1/2016. CPT codes 99406 and 99407 are the remaining codes for tobacco cessation counseling.

RHC Encounter: IPPE Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2018	1	200.00
0001	Total Charge				200.00

The physician performed IPPE (Welcome to Medicare) service on this date of service. No –CG modifier is required. The patient has no cost share for this visit because the deductible and co-insurance is waived.

Is the IPPE the same as a beneficiary's yearly physical?
No. The IPPE is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

Medicare Annual Wellness Visit

- Is NOT a routine physical exam.
- Must include certain components
- Is payable as a stand-alone RHC visit when it is the only service performed
- Is not payable as a separate service when performed on the same day of service as other medical or screening services.

Is the AWV the same as a beneficiary's yearly physical? No. The AWV is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

RHC Encounter: "Woman Well Visit" AWV and Other Screenings

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	**AWV-Subsequent**	G0439 CG	11/01/2018	1	150.00
0521	Breast/Pelvic	G0101	11/01/2018	1	100.00
0521	Pap Smear	Q0091	11/01/2018	1	50.00
0001	Total Charge				300.00

The patient received a subsequent AWV along with other preventive services on the same date of service. The –CG is appended to the AWV. There is no cost share for this visit. The breast and pelvic screening must both be done to report G0101.

Example of CCM Billing

CCM Reported Alone

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	CCM	G0511	02/01/2021	1	75.00
0001	Total Charge				75.00

The –CG Modifier is NOT appended to G0511 because the service is paid under fee-for-service reimbursement. The fee schedule amount for RHCs is $67.03 for 2019. Deductibles and co-insurance apply. The patient will have a cost share.

Example of CCM Billed with an Encounter

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213-CG	02/28/2018	1	100.00
0521	CCM	G0511	02/28/2018	1	75.00
0001	Total Charge				175.00

If CCM is billed with another RHC service, the charge for CCM is NOT added to the first line. The –CG modifier is only added on the first line. The clinic will receive the RHC all-inclusive rate for the office visit/encounter and the $62.28 for the CCM. The coinsurance will be $20.00 for the office visit and another $13.40 for the CCM (Total $33.40). It is important to explain to the patient the value of the CCM when enrolling them.

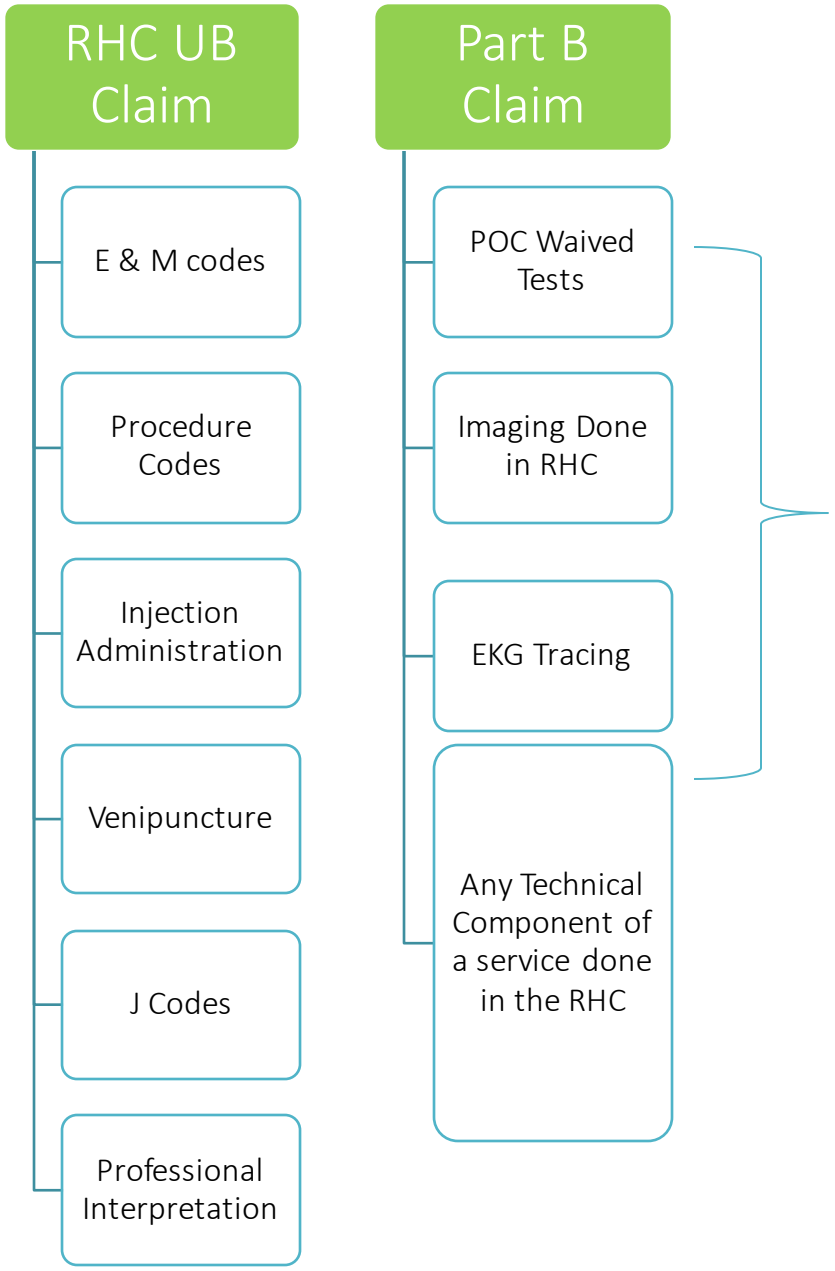
Medicare Split Billing

NON-RHC SERVICES

LAB SERVICES (INCLUDING REQUIRED TESTS

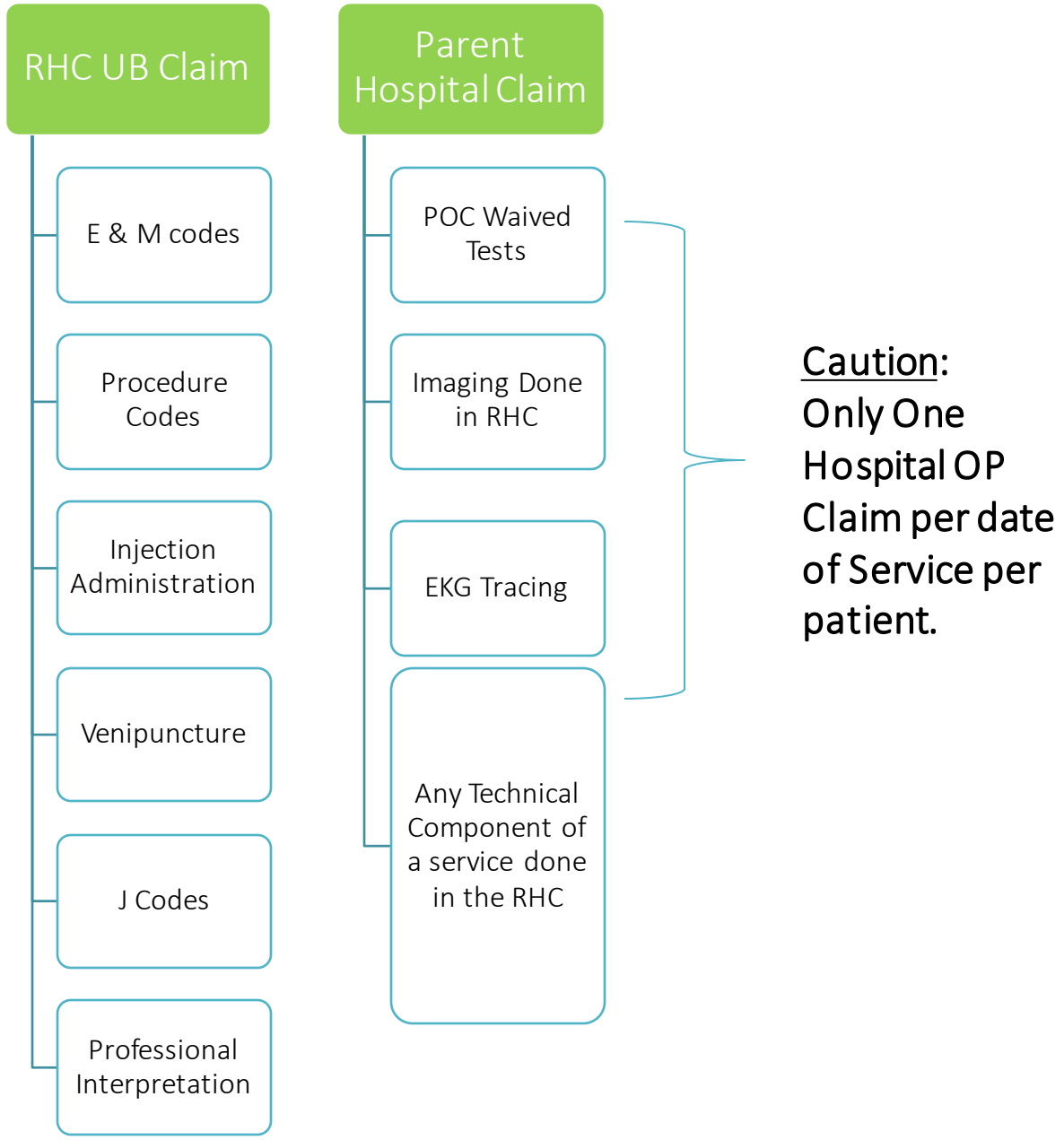
ANY OTHER TECHNICAL SERVICE

Medicare Split Billing Independent RHC



- You should not bill professional procedures to Part B for increased reimbursement.
- You should NOT have a separate “treatment” room in your RHC.
- Do not include the six required tests on the RHC UB Medicare Claim.

Medicare Split Billing PBRHC



Caution:
Only One Hospital OP Claim per date of Service per patient.

Type of RHC	Encounter Professional Services RHC Service	CLIA Lab Performed in RHC	Other Technical Components Performed in RHC- EKG, X-ray, Imaging	Professional Services Outside RHC Hours- Hospital Services
Provider-Based	Part A UB-04 Using the RHC NPI And Parent Entity EIN	Billed to MAC by Parent hospital TOB 141/131 for PPS hospital; CAH: 851.	Billed to MAC by Parent hospital TOB 131 for PPS hospital; CAH:851	Billed to MAC as a professional service or CAH Method II Billing.
Independent	Part A UB-04 Using RHC NPI and RHC EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B Professional Group PTAN to which the provider is linked.

Lab Services

- The venipuncture is inclusive to the AIR. The draw is not split-billed. Revenue Code 300 is reported with the venipuncture.
- ALL lab services are split billed.
- The six required tests are NOT included in the AIR. Do not include these tests on the UBB-04 Claim for either an independent or provider-based RHC. These are split-billed. If you include these on the UB-04 claim and they roll up to the –CG line, your patient will be overcharged coinsurance.
- When you split bill labs, do NOT include pass-through billing. Send out lab should be billed by the lab that actually performs the test.
- When Point of cares test are done in the clinic and there are also labs sent to the parent hospital, all the outpatient services should be on the same claim. There can only be one outpatient claim per DOS per patient. If multiple claims are submitted, only the first claim will pay.

Immunizations in the RHC

What You need to know about reporting Medicare immunizations

- Flu, Pneumococcal, COVID-19 Immunizations monoclonal antibody infusions are NOT reported on claims at all. Do not report with a zero charge. Do not include any line items on the UB-04 claim. These immunizations are reported on the cost report.
- Consult your cost report preparer on what documentation they will need. Logs, vaccine invoices, and nursing time will need to be documented or submitted.
- COVID-19 Vaccines and infusions for Medicare Advantage Plans are reported to the MA Plan. Do not include these on your cost report.
- Follow MA Plan guidelines for billing flu and pneumococcal.
- Hep B and Tetanus (for injuries) immunizations are included on the UB-04 claim inclusive to the AIR. These are not separately reimbursed.
- ALL OTHER ADULT IMMUNIZATIONS ARE PART D PHARMACY BENEFITS AND ARE NOT REIMBURSEABLE THROUGH PART B. If you use a 3rd-Party Vaccine Vendor, please discuss this with your cost report preparer.

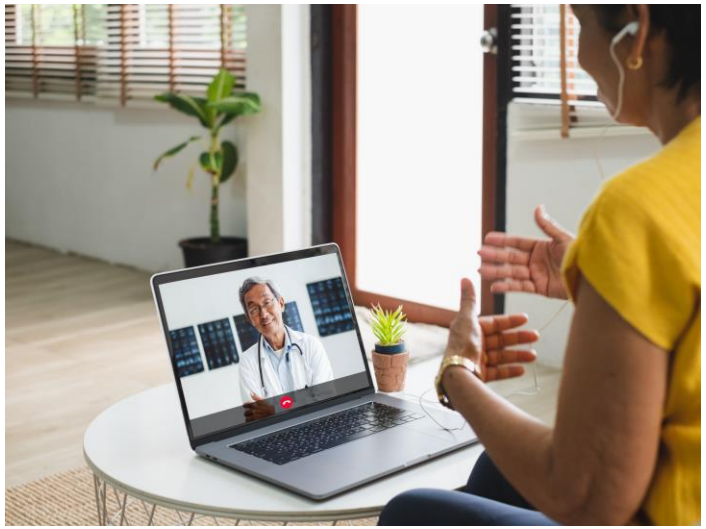
Medical Telehealth during the PHE

G2025

ENDS WITH THEN THE PHE ENDS

Telehealth Site Definitions

Originating Site versus Distant Site



Originating Site: This is the location of the patient who is receiving the telehealth service. **Use Q3014 with Rev Code 780.**

Distant Site: This is the location of the healthcare provider who is rendering the telehealth service. Use G2025 with the appropriate 52X revenue code.

Be very careful when entering into agreements for contracted telehealth. Make sure contract terms align with RHC reimbursement methodology.

RHC Distant Site Medical Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	05/15/2022	1	100.00
0001	Total Charge				100.00

Optional

Effective January 1, 2022, the payment rate for distant site medical telehealth services is $97.24. This is a composite fee schedule amount.

Add the -CS Modifier if G2025 is reporting a preventive service that would not be subject to deductible and coinsurance.

No –CG Modifier since this does not reimburse at the AIR. Not an encounter.

New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MLN Matters Number: SE20016 Revised

Related Change Request (CR) Number: N/A

Article Release Date: January 13, 2022

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

Beginning July 1, 2020, you should no longer put the CG modifier on claims with HCPCS code G2025.

Table 1. RHC Claims for Telehealth Services from January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95 (optional)

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Mental Health Telemedicine RHC Encounters Now

2022 Mental Health Telehealth Example

These visits are different from telehealth services provided during the Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See MLN Matters Article SE20016 for information on billing G2025 for professional telehealth distant site services other than mental health visits during the PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 Revised on 05/05/2022 : -CG now required
- Is an encounter; pays at the AIR.

2022 Mental Health Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Telehealth	90791 CG and either FQ or 95	05/05.2022	1	100.00
0001	Total Charge				100.00

Mental Health Services

HCPCS Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

- Mental Health Codes on the QVL
- Do NOT use –CG on medical telehealth visits
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001

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Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE22001 Revised

Related Change Request (CR) Number: N/A

Article Release Date: May 5, 2022

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this Article to show that RHCs must include modifier CG on claims for mental health visits via telecommunications. This change is in dark red font on page 2. All other information is the same.

Services to Hospice Patients by RHC Providers

New in 2022!

- The final rule now allows RHC providers who are also the attending hospice physician to bill hospice care as RHC encounters.

- RHC claims will be appended with both the –CG modifier and the new –GV modifier. Appropriate revenue codes are used.

- Non-hospice related services provided by regular RHC practitioners would be billed as they currently are with the 07 condition code and –GW modifier **with a non-hospice diagnosis.**

- Coinsurance and deductible amounts apply.

Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

MLN Matters Number: MM12357 Revised
Related Change Request (CR) Number: 12357
Related CR Release Date: January 12, 2021
Effective Date: January 1, 2022
Related CR Transmittal Number: R11200CP
Implementation Date: January 3, 2022

Note: We revised this Article to reflect a revised CR 12357. The CR revision didn't impact the substance of the Article. We did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected

This MLN Matters Article is for RHCs and FQHCs billing hospice attending physician services to Medicare Administrative Contractors (MACs) on behalf of Medicare patients.

Provider Action Needed

In this Article, you'll learn about:

- When RHCs report the GV modifier
- When FQHCs report the GV modifier

CCM and TCM Billed in Same Month

WHEN PERFORMED BY THE RHC

Transitional Care Management and other Care Management Services may now be billed within the same 30-day period when provided by the RHC when both services are medically necessary and neither service has been performed and reported by another provider.

What to expect in 2023?

- The 2023 Proposed MPFS Rule doesn't specially address very much about Rural Health Clinic Services.
- There is the possibility that we will see additional care management services added under the G0511 umbrella including general behavioral health integration and pain management services.
- Pain Management is often regulated at the state level. RHCs will need to make sure that those services if approved for RHCs at the federal level, the clinic still stays in compliance with state medical board or state agency regulations.
- NARHC has submitted comments on several topics in the MPFS.
- The proposed rule failed to address Remote Patient Monitoring for RHCs so we do not have new guidance on those services which for now are considered incident-to care management and are not separately billable.
- Look for more guidance from CMS on transitioning telehealth after the PHE ends.

Questions or Comments?

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Patty Harper is one of the principals of InQuiseek Consulting, a rural healthcare consulting company. She has over 24 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. She has held memberships regional, state and national organizations throughout her healthcare career including NARHC, NRHA, AHIMA, MGMA, and HFMA. Patty currently serves on the Board of NARHC.

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