PREVENTIVE SERVICES FOR RHCS: BEYOND ANNUAL WELLNESS VISITS

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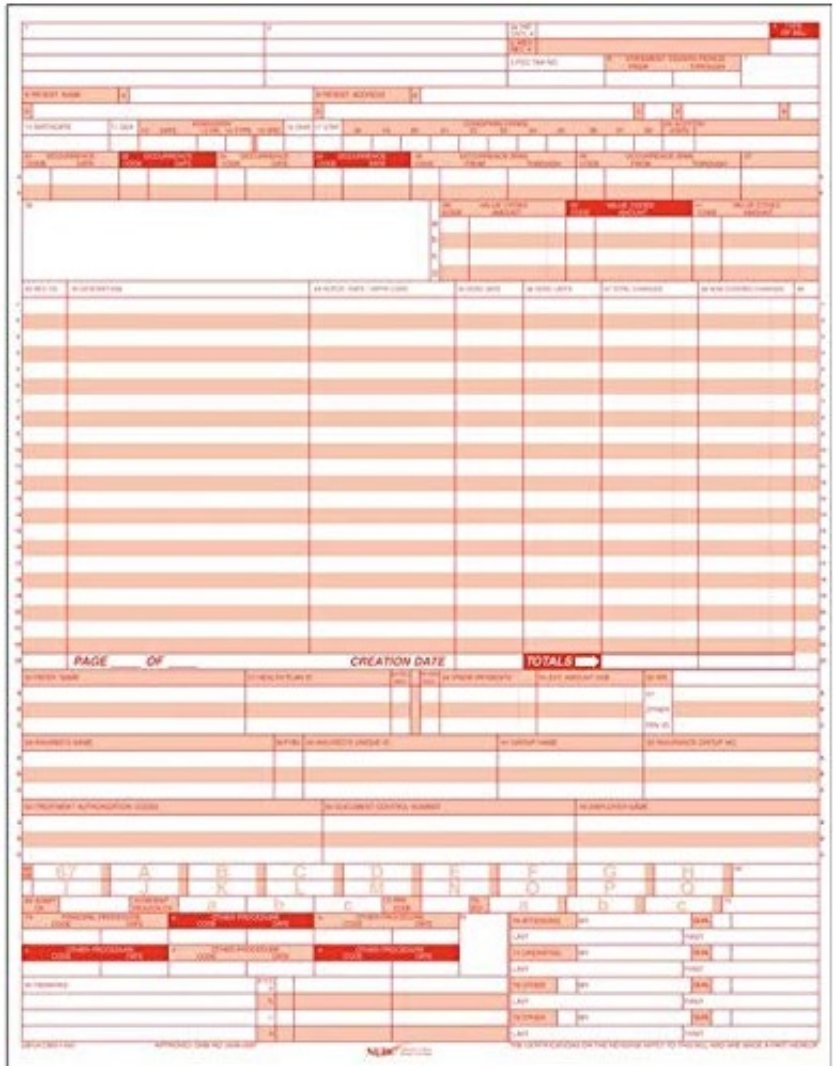
CLAIM SCENARIOS AND REMIT SAMPLES

- ✓ Medicare CG Modifier Review
- ✓ Qualifying Visit List
- ✓ Reporting Preventive Services
- ✓ “Same-Day” vs “Stand-Alone”
- ✓ Welcome to Medicare with Clinical Visit
- ✓ Stand-Alone Preventive with Clinical Visit
- ✓ !!!Reporting ADDITIONAL Services!!!
- ✓ G2025 and Medicare Telehealth



MOST RHCS ARE NOT REPORTING QUALITY VISITS CORRECTLY.

ONE IN TEN REVIEWED BY THE AUTHOR HAVE BEEN CORRECT.

COMMON MISCONCEPTIONS

An RHC claim MUST have an Evaluation and Management code: FALSE.

Only one encounter is paid, so we CANNOT provide a sick visit and AWV/SAWV at the same time: FALSE.

In most circumstances, only one encounter is PAYABLE. All are REPORTABLE!

PATIENT TRANSPORTATION SECURITY

CMS does NOT allow a policy of requiring patients to return on a different day/time in order to provide annual wellness visits, or vice-versa.

CMS wants us to treat the patient while they are there.

There IS flexibility for Medical Judgement.

PROVIDING ANNUAL WELLNESS VISITS AND SICK VISITS

Often patients come to the RHC and want an Annual Wellness visit, but they are SICK. It is often impossible to perform an annual wellness visit on someone with multiple, raging chronic conditions.

This is when medical judgement and patient needs override the need to meet quality metrics.

WHAT WE ALREADY KNOW: QUALIFYING VISITS

Medical Services RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

RHC Qualifying Visit List

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

MEDICARE PREVENTIVE SERVICES (MPS)

"RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits (where applicable) have not been exceeded. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade or A or B."

Medicare Benefit Policy Manual – Chapter 13

220 - Preventive Health Services

CG MODIFIER PLACEMENT

"Modifier CG should only be used to indicate which revenue code 052x and/or 0900 service line should receive the all-inclusive rate (AIR) and be subject to coinsurance and deductible."

RHC Qualifying Visit List

DEDUCT PREVENTIVE SERVICES FROM CG LINE!!

RHC QVL FAQ: THE BEST RHC BUNDLING RESOURCE!

- ✓ The qualifying visit line should be the ***sum of all RHC charges minus any preventive services***.

When one or more qualified preventive service is provided as part of a RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment and deductible.

RHC QUALIFYING VISIT LIST

"RHCs are allowed to report additional 052x or 0900 revenue code lines."

RHC Qualifying Visit List

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

PREVENTIVE SERVICES AND SAME DAY BILLING

"RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the [Certain Preventive Services] when they are performed on the same day."

The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.

BILLING EXAMPLE: IPPE ONLY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	01/05/2023	1	$ 200.00
0001	Total Charge				$ 200.00

"Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service." RHC Reporting FAQ

BILLING EXAMPLE: IPPE PLUS OFFICE VISIT => 2 AIR PAYMENTS!

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	01/05/2023	1	$ 150.00
0521	IPPE	G0402	01/05/2023	1	$ 200.00
0001	Total Charge				$ 350.00

"When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service."

RHC Reporting FAQ

PREVENTIVE SERVICES AND STAND-ALONE ENCOUNTERS

- ✓ Other preventive screenings are “stand-alone” encounters.
- ✓ If a “stand-alone” encounter is the only service rendered on a particular date of service, then it will be paid at the AIR.
- ✓ If it is furnished on the same day as another medical visit, it is not a separately ***payable*** visit – BUT IT SHOULD BE REPORTED!
- ✓ No beneficiary coinsurance and deductible is applied, depending on the service rendered.

STAND ALONE ENCOUNTERS

The beneficiary coinsurance and deductible may be waived, depending on the service rendered.

- ✓ Annual Wellness Visit (AWV) and Personalized Prevention Plan Services (PPPS)
- ✓ Subsequent Annual Wellness Visit
- ✓ Advanced Care Planning
- ✓ Medicare Preventive Screenings

ARE “ROUTINE” VISITS THE SAME AS AWV? NO!

Medicare Physical Exams Coverage

Initial Preventive Physical Exam (IPPE)

Review of medical and social health history and preventive services education.

✓ New Medicare patients within 12 months of first Part B coverage period

✓ Patients pay nothing (if provider accepts assignment)

Annual Wellness Visit (AWV)

Visit to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA).

✓ Covered once every 12 months

✓ Patients pay nothing (if provider accepts assignment)

Routine Physical Exam

Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

✗ Medicare doesn’t cover a routine physical (it’s prohibited by statute), but the IPPE, AWV, or other Medicare benefits cover certain routine physical elements

✗ Patients pay 100% out-of-pocket

WHERE DO NURSES FIT IN?

Nurses can perform Subsequent AWVs.

- ✓ An AWV/SAWV on the same day as a clinical visit SHOULD be submitted on a claim, even though only one encounter will be paid.
- ✓ A nurse-performed SAWV on the same day as a clinical visit **SHOULD BE REPORTED ON THE RHC ENCOUNTER!!**

HOW TO INTEGRATE NURSES INTO ANNUAL WELLNESS VISITS

AWVs include Personalized Care Plan and Health Risk Assessment.

- ✓ Patient performed questionnaires are acceptable for Health Risk Assessments (HRA).
- ✓ Nurses can review patient performed HRA and document review.

PROVIDER PORTION OF AWV

In order to bill an RHC encounter, the billing RHC provider will approve Care Plan, provide final patient evaluation, and sign encounter.

If a clinical visit has already been performed

BILLING EXAMPLE: ANNUAL WELLNESS VISIT

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Annual Wellness Visit	G0438CG	04/02/2022	1	$ 120.00
0001	Total Charge				$ 120.00

"If only preventive services for which the coinsurance and/or deductible are waived are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the visit."

RHC Reporting FAQ

STAND ALONE ENCOUNTERS

"Stand Alone" encounter is the only service rendered on a particular date of service, then it will be paid at the AIR.

Stand-Alone Encounters on the same RHC claim as another is not separately reimbursed.

IT SHOULD/MUST BE REPORTED on the RHC claim!!

BILLING EXAMPLE: OFFICE VISIT W/ ANNUAL WELLNESS VISIT

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	04/02/2022	1	$ 150.00
0521	Annual Wellness Visit	G0438	04/02/2022	1	$ 120.00
0001	Total Charge				$ 270.00

"Modifier CG should be reported only with the medical service HCPCS code that represents the primary reason for the medically necessary face-to-face visit when medical and preventive services are furnished on the same day."

RHC Reporting FAQ

RHC USE OF MODIFIERS -59 AND -25

Modifier-59 indicates that separate conditions on the same treated are unrelated. This is used only a subsequent illness or injury on the same day as another visit. Modifier-25 in an RHC in interchangeable with -59!

- Modifier-59 and -25 indicate two encounters. -25 is different in an RHC. Modifier 25 or 59 is only on the SECOND line item UB-04 on a claim form.
- **RHC Pro Tip:** Modifier-25 is NOT used to distinguish an Evaluation and Management Service from a procedure **OR AWV/SAWV.**

W.RVUS FOR PREVENTIVE SERVICES

2022 National Physician Fee Schedule Relative Value File April Release

HCPCS	MOD	DESCRIPTION	CODE	RVU	PE RVU	PE RVU	RVU	TOTAL	TOTAL
G0402		Initial preventive exam	A	2.60	2.13	1.13	0.17	4.90	3.90
G0438		Ppps, initial visit	A	2.60	2.13	2.13	0.17	4.90	4.90
G0439		Ppps, subseq visit	A	1.92	1.80	1.80	0.11	3.83	3.83
G0442		Annual alcohol screen 15 min	A	0.18	0.36	0.08	0.01	0.55	0.27
G0443		Brief alcohol misuse counsel	A	0.45	0.28	0.20	0.04	0.77	0.69
G0444		Depression screen annual	A	0.18	0.35	0.08	0.01	0.54	0.27
G0445		High inten beh couns std 30m	A	0.45	0.31	0.18	0.04	0.80	0.67
G0446		Intens behave ther cardio dx	A	0.45	0.28	0.20	0.04	0.77	0.69
G0447		Behavior counsel obesity 15m	A	0.45	0.28	0.19	0.04	0.77	0.68

WHAT INCENTIVE DO PROVIDERS HAVE? RVUS.

2023 National Physician Fee Schedule Relative Value File

HCPCS	MOD	DESCRIPTION	RVU
G0438		Ppps, initial visit	2.60
G0439		Ppps, subseq visit	1.92
G0442		Annual alcohol screen 15 min	0.18
G0443		Brief alcohol misuse counsel	0.45
G0444		Depression screen annual	0.18
G0445		High inten beh couns std 30m	0.45
G0446		Intens behave ther cardio dx	0.45
G0447		Behavior counsel obesity 15m	0.45
99406		Behav chng smoking 3-10 min	0.24
99407		Behav chng smoking > 10 min	0.50
99497		Advncd care plan 30 min	1.50
99498		Advncd care plan addl 30 min	1.40

2023 National Physician Fee Schedule Relative Value File

HCPCS	DESCRIPTION	RVU
99202	Office New Patient SF	0.93
99203	Office New Patient LOW	1.60
99204	Office New Patient MOD	2.60
99205	Office New Patient HIGH	3.50
99211	Nurse Visit	0.18
99212	Office Est SF	0.70
99213	Office Est LOW	1.30
99214	Office Est MOD	1.92
99215	Office o/p est HIGH	2.80

ADVANCED CARE PLANNING AND AWV: 99497 AND 99498

No copayment, coinsurance, or deductible for Advance Care Planning when provided as optional AWV element

- Bill using modifier –33 (Preventive Service) on same AWV claim
- Must deliver on same day by same AWV provider

ADVANCED CARE PLANNING: 99497 AND 99498

Patient Pays

G0438 and G0439:

- No copayment, coinsurance, or deductible

G0468:

- You must provide AWV or IPPE with a standard bundle of services available to all patients; get more information at section 60.2 of Medicare Claims Processing Manual, Chapter 9
- No copayment, coinsurance, or deductible

99497 and 99498:

- No copayment, coinsurance, or deductible for Advance Care Planning when provided as optional AWV element
  - Bill using modifier –33 (Preventive Service) on same AWV claim
  - Must deliver on same day by same AWV provider

Other Notes

- Advance Care Planning is an optional preventive service when provided with an AWV.
  - You may deliver Advance Care Planning (ACP) outside the AWV multiple times in a year. You must document a patient's health change for each additional ACP service in a year.
  - Deductible and coinsurance apply when delivering ACP outside an AWV.
- Medicare Wellness Visits educational tool has more information.

OFFICE VISIT AND ANNUAL WELLNESS VISIT/ACP

An established patient is seen and a qualifying visit of 99214 for $150 is generated. An Annual Wellness Visit was also performed for $120.00. A venipuncture was performed for $20.00.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 4	99214 CG	01/09/2023	1	$ 170.00
0521	Annual Wellness Visit	G0438	01/09/2023	1	$ 120.00
0521	Advanced Care Planning	99496	01/09/2023	1	$ 100.00
0001	Total Charge				$ 390.00

- ✓ The charge for the AWV and ACP are NOT be bundled in the 99214 line.
- ✓ The AWV and ACP do not result in direct reimbursement.
- ✓ If properly reported, this visit represents 6.02 wRVUs!!

BILLING EXAMPLE: WELL-WOMAN EXAM

Medicare does not pay a well-woman exams (99381-99387). An annual or subsequent wellness visit (G0438/G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091). This visit would be paid as ONE encounter.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Subsq AWV	G0439 CG	04/02/2023	1	$ 175.00
0521	Breast/Pelvic	G0101	04/02/2023	1	$ 75.00
0521	Pap Smear	Q0091	04/02/2023	1	$ 50.00
0001	Total Charge				$ 300.00

All Preventive Services are listed to capture quality measure and to report utilization to Medicare for COB. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

BILLING EXAMPLE: OFFICE VISIT WITH DIABETIC COUNSELING*

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	04/02/2022	1	$ 150.00
0521	DSMT	G0108	04/02/2022	1	$ 80.00
0521	Medical Nutrition Therapy	97803	04/02/2022	1	$ 80.00
0001	Total Charge				$ 310.00

The MD/DO/NP/PA has seen the patient and a Diabetic Nurse Educator comes in to provide additional counseling and nutrition training.

*Coinsurance will be applied to this encounter!

BILLING EXAMPLE: TOBACCO CESSATION!!!

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	04/02/2022	1	$ 150.00
0521	Tobacco Cessation > 3 Min	99406	04/02/2022	1	$ 15.00
0001	Total Charge				$ 165.00

- ✓ Tobacco Cessation will not increase co-insurance.
- ✓ Charges for Preventive Services are NEVER bundled with the CG Line Item.
- ✓ 99406 is for information only, but critically important to report!

BILLING EXAMPLE: TOBACCO CESSATION!!!

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Tobacco Cessation > 3 Min	99406	04/02/2022	1	$ 15.00
0001	Total Charge				$ 15.00

ANY of the Stand-Alone Medicare Preventive Screenings are paid as RHC Encounters when no other services are rendered.
Co-Insurance is not applied.

BILLING EXAMPLE: IBT OBESITY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	IBT Obesity	G0447	01/05/2023	1	$ 100.00
0001	Total Charge				$ 100.00

Frequency:

We pay up to 22 visits billed with codes G0447 and G0473, combined, in a 12-month period:

- First month: 1 face-to-face visit every week.
- Months 2–6: 1 face-to-face visit every other week.
- Months 7–12: 1 face-to-face visit every month if patient meets certain requirements.

BILLING EXAMPLE: OFFICE VISIT WITH PREVENTIVE SERVICES

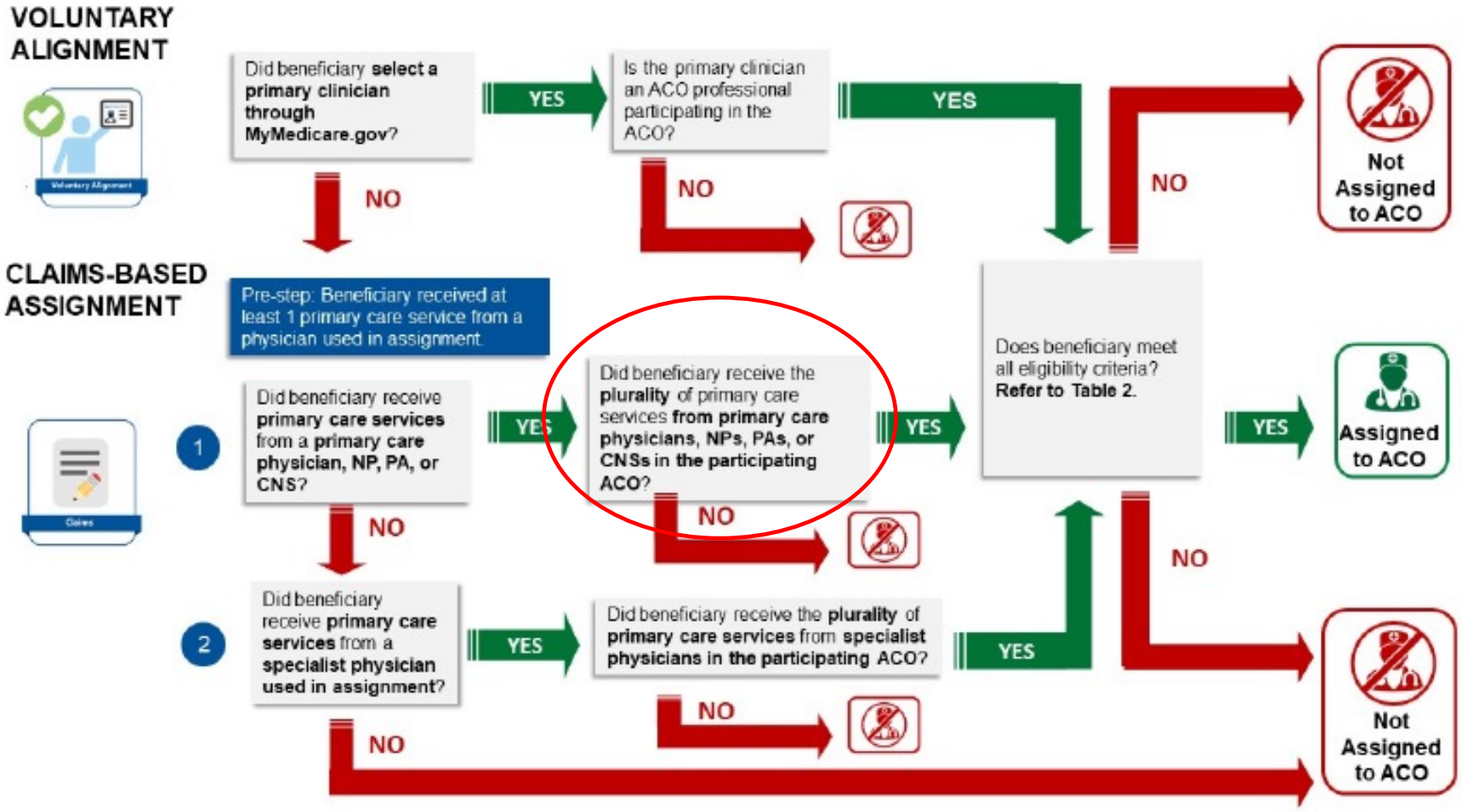
FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214 CG	04/02/2022	1	$ 150.00
0521	Advanced Care Planning	99497	04/02/2022	1	$ 75.00
0521	Alcohol Screening	G0422	04/02/2022	1	$ 50.00
0521	IBT for Obesity	G0447	04/02/2022	1	$ 50.00
0001	Total Charge				$ 325.00

Modifier CG identifies the line service for which co-insurance and deductible should be applied. The additional preventive services are for information only.

MEDICARE PREVENTIVE SERVICES CHART

WHO ARE YOUR MEDICARE PATIENTS…ACCORDING TO MEDICARE?

MEDICARE SHARED SAVINGS PROGRAM



ANNUAL WELLNESS VISITS DRIVE PATIENT ATTRIBUTION

Patient attribution is based on which provider saw the patient for a plurality” of services. AWVs and additional Preventive Services will help “win plurality.”

HCC CODES: THE DIAGNOSTIC PORTION OF THE AWV

Paraphrasing AAFP HCC Coding:

Hierarchical condition category (HCC) coding is a risk-adjustment model originally designed to estimate future health care costs for patients.

INFLUENZA (G0008) AND PNEUMOCOCCAL AND VACCINES (G0009)

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost ***through the cost report***.

- ✓ No line items should be billed.
- ✓ These costs should not be included on a claim.
- ✓ These are the only injections that are payable outside of RHC claims.
- ✓ The beneficiary coinsurance and deductible are waived.
- ✓ MOST Medicaid plans do NOT cover Flu and Pneumo.

ANNUAL WELLNESS VISITS AND TELEPHONE ONLY

For the duration of the public health emergency, the AWV may be administered using audio-only technology, if a video connection with the patient is not possible. If the patient can self-report elements of the AWV (i.e., height. weight, blood pressure, other measurements deemed appropriate based on medical and family history), those measurements may be included and recorded in the medical record as reported by the patient.

SE20016

MEDICARE *TELEPHONE ONLY VISITS*

RHCs and FQHCs ***can*** furnish and bill for these services using HCPCS code G2025. To bill for these services:

- ✓ at least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
- ✓ These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

SE20016 REVISED: CS – MODIFIER

CS - Cost-sharing waived:

- ✓ **for specified COVID-19** testing-related services that result in and order for or administration of a COVID-19 test, **and/or**
- ✓ *for **cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics** and Federally Qualified Health Centers during the COVID-19 public health emergency.*

TELEHEALTH CO-INSURANCE AND DEDUCTIBLE

Medicare WILL apply cost-sharing (co-insurance and deductible) to Telehealth services unless the are COVID-related, or preventive services.

QUESTION – ANNUAL WELLNESS VS CLINICAL WITH G2025:

How do you track detail for Telehealth services reported to Medicare with G2025?

Answer: Good Question. It is the author's recommendation to post the detail using a zero charge and suppress the line item from submitting on the claim.

QUESTION: DOES MEDICARE COB WORK WHEN AWVS ARE PROVIDED VIA G2025?

- ✓ Answer: NO.

HCC REPORTING

- ✓ HCCs are reported at least once a year
- ✓ Must be captured in a face-to-face setting
  - Telehealth utilizing audio AND video qualifies
  - Telehealth by audio only does not qualify
- ✓ The visit note must be in the medical record along with patient identification, date of visit, and provider signature.

IMPORTANCE OF HCC

Each January 1, the RA slate is wiped clean. All your Medicare patients are considered completely healthy until diagnosis codes are reported on claims.

Chronic conditions must be reported once per year.

HOW ABOUT CPT LEVEL II CODES?

BEST PRACTICE:

Check with your MAC.

Submit relevant CPT II Codes on RHC claims for Medicare AND Medicare Advantage.

Line Item must be > $.00. Recommend $.01.

DO NOT BUNDLE WITH CG Modifier!!!!!

RESULTS: SAMPLE PROVIDER PATIENT ATTRIBUTION DATA

Provider Last Name, First Name*	NPI	Attributed Patients	Risk Adjusted Total PMPY	Average HCC Risk Score	AWV Compliance	ER Visits/1000	Inpatient Visits/1000	Readmission Rate
Race, Randall	1234567890	54	$ 36,636.68	2.40	0%	2980	431	27%
Johnson, Elizabeth	1234567891	168	$ 7,620.95	1.15	0%	881	133	11%
*Fictitious	**Total**	**222**	**$ 22,128.82**	**1.78**	**0%**	**1931**	**282**	**19%**

FINAL THOUGHT:
REPORT ALL PREVENTIVE SERVICES FOR MEDICARE ADVANTAGE PATIENTS!

IT IS TIME TO CHANGE HOW WE THINK.

The priority is no longer whether two encounters are PAID. The priority is that all preventive services are performed and REPORTED!!!

RHC - CMS RESOURCES

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Benefit Policy Manual- Chapter 15 Other Services

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

RHC - CMS RESOURCES

See Rural Providers & Suppliers Billing_MLN006762. July 2021.

State Operations Manual Appendix G (Updated 2.10.20)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) FAQ

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

QUESTIONS? COMMENTS?

THANK YOU FOR BEING HERE THIS AFTERNOON!

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