RHC UPDATES 2022

APRIL 26, 2022

OREGON OFFICE OF RURAL HEALTH

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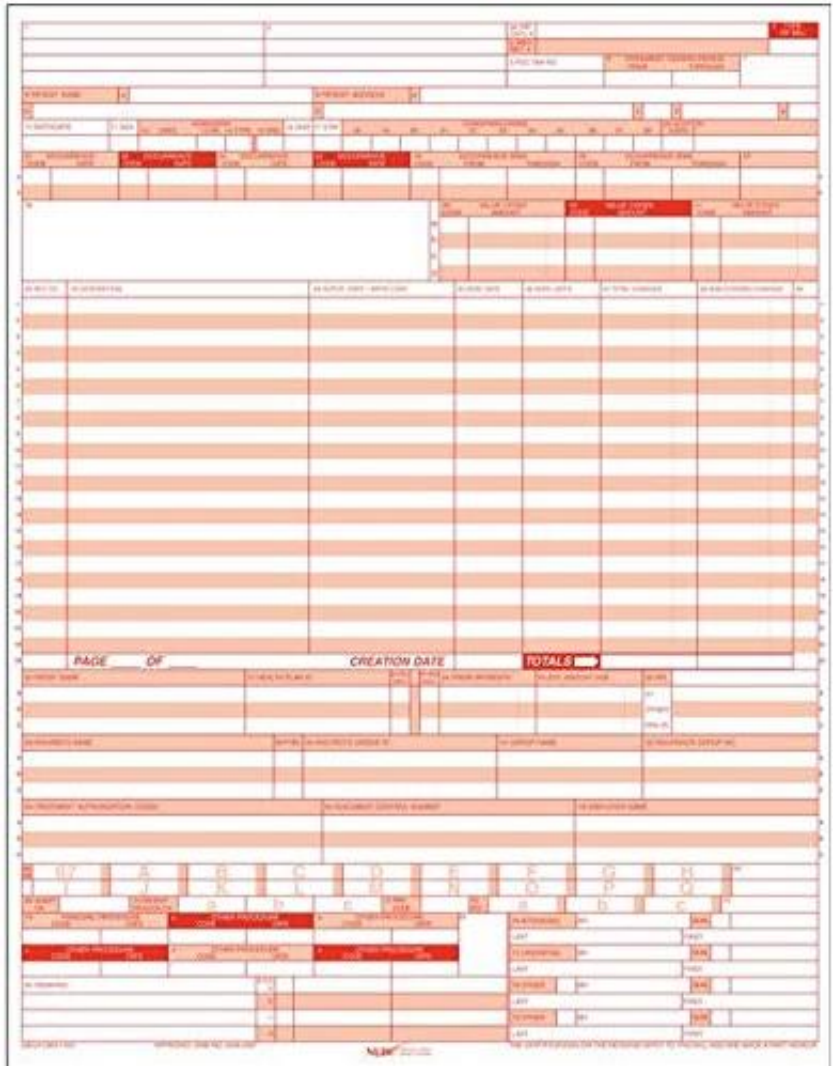
PRESENTATION TOPICS

- ✓ Change to RHC Encounter Definition
- ✓ Change to RHC Locations (Hospice)
- ✓ Discuss Grandfathered PBRHC rate issues
- ✓ Mental Health Services via Telehealth
- ✓ Physician Assistants and Medicare
- ✓ G2025 Status



PRESENTATION OBJECTIVES: BREAKING NEWS!!

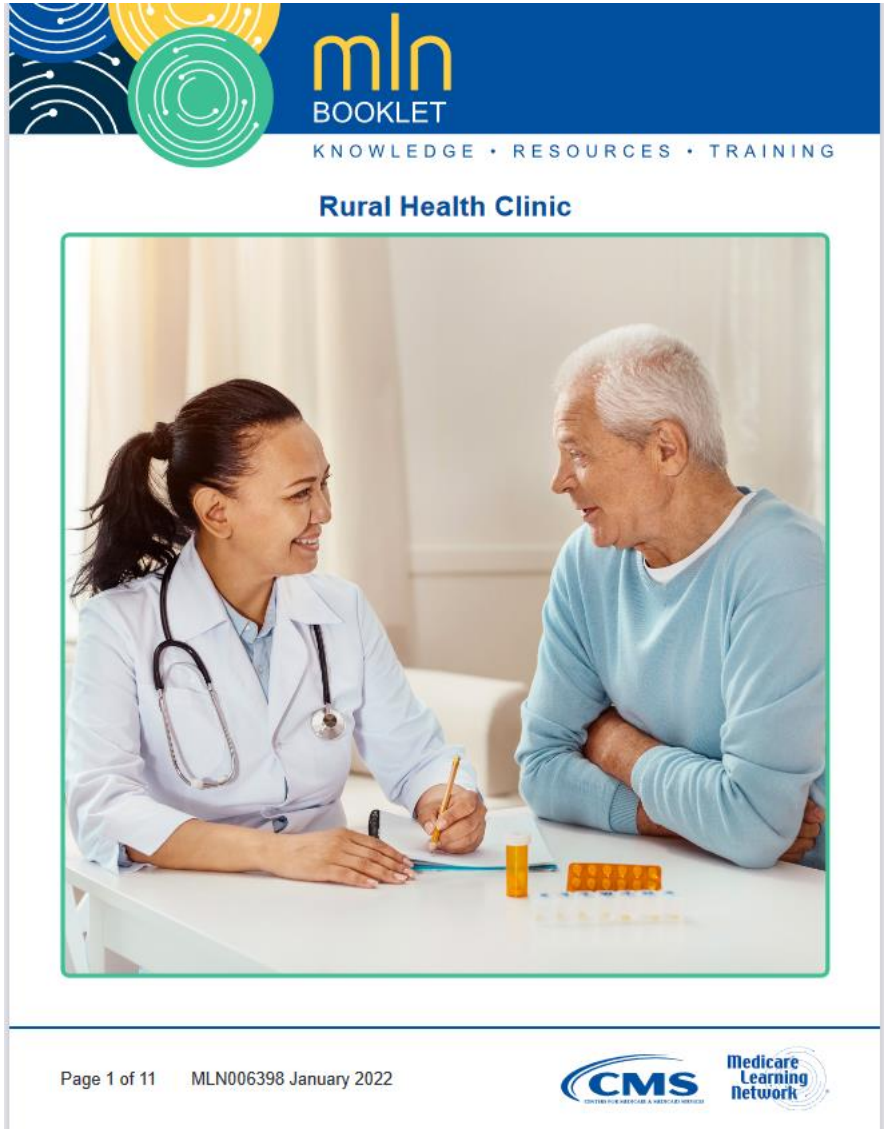
CY 2022 Medicare Physician Fee Schedule Final Rule

CY 2022 Medicare Hospital Outpatient Prospective Payment System Final Rule (CMS-1753-P)

RHC UPDATES ON CMS

CMS Rural Health Clinic Website:

CMS RHC Fact Sheet was updated January 1, 2022.



MAJOR CHANGES

§ 405.2463 WHAT CONSTITUTES A VISIT

A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio only interactions in cases where the patient is not capable of, or does not consent to, the use of technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder…

MENTAL HEALTH VISITS FURNISHED USING TELEHEALTH

Beginning January 1, 2022, RHC mental health visits will include visits furnished using interactive, real-time telecommunications technology.

This change will allow RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, *including audio-only visits* when the beneficiary is not capable of, or does not consent to, the use of video technology.

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IN-PERSON VISITS

“There must be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that, in general, An in-person, non-telehealth visit must be furnished at least every 12 months for these services;”

CMS Rural Health Clinic Center

MENTAL HEALTH VISITS FURNISHED USING TELEHEALTH

“however, we may make exceptions to the in-person visit requirement based on patient circumstances (with the reason documented in the patient’s medical record)

and also allow more frequent visits as driven by clinical needs on a case-by-case basis.”

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BEHAVIORAL HEALTH CLAIMS VIA TELEHEALTH

"RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only."

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BEHAVIORAL HEALTH => TELEHEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min	90832 CG 95	01/01/2022	1	$ 120.00
0001	Total Charge				$ 120.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min	90832 CG FQ	01/01/2022	1	$ 120.00
0001	Total Charge				$ 120.00

CLINICAL VISITS: G2025 ONLY

RHCs and FQHCs must use HCPCS code G2025, the new RHC/FQHC specific G-code for distant site telehealth services, to identify services that were furnished via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective.

https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx).

HOSPICE BENEFIT – EFFECTIVE 1.1.2022

Allows Rural Health Clinics (RHCs) to furnish and bill for hospice attending physician* services when RHC patients become terminally ill and elect the hospice benefit beginning January 1, 2022.

ADDED HOSPICE AS A SERVICE LOCATION

RHC visits can take place at:

- ✓ RHC
- ✓ Patient's home, including an assisted living facility
- ✓ Medicare-covered Part A skilled nursing facility
- ✓ Scene of an accident
- ✓ Hospice*

HOSPICE AS AN RHC LOCATION

60.6 - RHCs and FQHCs for billing Hospice Attending Physician Services

(Rev. 11200, Issued :01-12-22, Effective: 01-01-22, Implementation: 01-03-22)

Effective for services furnished on or after January 1, 2022, RHCs or FQHCs can bill and receive payment under the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS), when a designated attending physician employed by or working under contract with the RHC or FQHC furnishes hospice attending physician services during a patient's hospice election.

RHCs must report a GV modifier on the claim line for payment (that is, along with the CG modifier) each day a hospice attending physician service is furnished.

Claim Processing Manual Chapter 9

HOSPICE CLAIM

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99214CG GV	04/02/2022	1	$ 160.00
0001	Total Charge				$ 160.00

RHCs must report a GV modifier on the claim line for payment (that is, along with the CG modifier) each day a hospice attending physician service is furnished.

TRANSITIONAL CARE AND CARE MANAGEMENT SERVICES

Beginning January 1, 2022, RHCs can bill TCM *and general care management services* furnished for the same patient during the same service period, if the RHC meets the requirements for billing each code.

CARE MANAGEMENT SERVICES EXPANDED

General Care Management

Chronic Care Management (CCM)

General Behavioral Health Integration (BHI)

Principal Care Management (PCM)

Psychiatric Collaborative Care Model (CoCM)

PRINCIPAL CARE MANAGEMENT EFFECTIVE 1.1.2021

Effective January 1, 2021, RHCs and FQHCs are paid for PCM services when a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month. PCM services may be furnished to patients with a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death.

PCM SERVICE REQUIREMENTS INCLUDE:

- ✓ A single complex chronic condition lasting at least 3 months, which is the focus of the care plan;
- ✓ The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
- ✓ The condition requires development or revision of disease-specific care plan;
- ✓ The condition requires frequent adjustments in the medication regiment; and
- ✓ The condition is unusually complex due to comorbidities.

G0511 PAYMENT 2022

CCM or general BHI services furnished on or after January 1, 2022, are paid at the average of the national non-facility PFS payment rate for CPT codes 99484, 99487, 99490, and 99491 (30 minutes or more of CCM services furnished by a physician or other qualified health care professional) and 99424 and 99426 (30 minutes or more of principal care management (PCM) services furnished by a physician or other qualified health care professional, when general care management HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

The CY 2022 rate for G0511 is $79.25.

PSYCHIATRIC COORDINATION OF CARE

Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when psychiatric CoCM HCPCS code, G0512, is on an RHC claim, either alone or with other payable services. This rate is updated annually based on the PFS amounts for these codes. At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service. The CY 2022 rate for G0512 is $151.23.

CLINICAL ACTIVITY – NOT ADMINISTRATIVE

Only services furnished by an RHC or FQHC practitioner or auxiliary [clinical] personnel that are within the scope of service elements can be counted toward the minimum 20 minutes that is required to bill for CCM and general BHI services and the minimum 30 minutes that is required to bill for PCM services, and does not include administrative activities such as transcription or translation services.

§ 405.2463 WHAT CONSTITUTES A VISIT

A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio only interactions in cases where the patient is not capable of, or does not consent to, the use of technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder, including an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record, between an RHC or FQHC patient.

RURAL HEALTH CLINIC (RHC) PAYMENT LIMIT PER-VISIT

Then, in subsequent years, the limit is updated by the percentage increase in Medicare Economic Index (MEI).

Also beginning April 1, 2021, section 130 as amended requires that a payment limit per-visit be established for smaller provider-based RHCs enrolled before January 1, 2021.

Lastly, *section 130 of the CAA subjects all newly enrolled RHCs (as of January 1, 2021, and after), both independent and provider-based, to a national payment limit per-visit.*

RURAL HEALTH CLINIC (RHC) PAYMENT LIMIT PER-VISIT

Section 130 of the CAA as amended by section 2 of P.L. 117-7, requires that, beginning April 1, 2021, independent RHCs and provider-based RHCs in a hospital with 50 or more beds receive an increase in their payment limit per visit over an 8-year period, with a prescribed amount for each year from 2021 through 2028.

RURAL HEALTH CLINIC (RHC) PAYMENT LIMIT PER-VISIT

The national statutory payment limit for RHCs over an 8-year period is as follows:

In 2021, after March 31, at $100 per visit;

In 2022, at $113 per visit;

In 2023, at $126 per visit;

In 2024, at $139 per visit;

In 2025, at $152 per visit;

In 2026, at $165 per visit;

In 2027, at $178 per visit;

In 2028, at $190 per visit.

GRANDFATHERED RHC RATE SETTING

Instead of being subjected to a single uniform cap, all currently uncapped RHCs enrolled in Medicare are grandfathered in at the clinic's 2020 All-inclusive rate.

Each uncapped RHC will have a clinic specific cap based on their 2020 AIR rather than being subject to the new RHC cap that will apply to all new RHCs or RHCs that were already subjected to the cap.

The clinic-specific cap for the grandfathered RHCs will grow annually at the rate of medical inflation (MEI).

ALL NEW RHCS ENROLLED AFTER 12.31.2020

Technical Correction:

This provision also subjects all new RHCs (including provider-based RHCs in a hospital with less than 50 beds and enrolled in Medicare after ***December 31, 2020***) to the national statutory payment limit.

[Changed from original December 31, 2019]

SETTING THE GRANDFATHERED RATE

The “per visit payment amount” will align with the interim rate process the MACs use in determining an RHC’s AIR (discussed above in section III.A.2. of [the] Final rule).

- ✓ The AIR is determined by using the most recently available cost report for “services furnished in 2020”, or the period during which the services were furnished in 2020 and the costs for those services were reported.
- ✓ There may be more than one cost report that reports costs for services furnished in calendar year 2020.
- ✓ Section 130 of the CAA 2021 states that the “per visit payment amount” is to be increased by the CY 2021 MEI.
- ✓ If a provider has a cost reporting period that differs from a calendar year period, the MACs should use data based on the relevant cost report period ending in 2020.

Note: Cost Report will not be finalized/reconciled before 2022. Medicare has 1-year.

JUST LIKE FLU SHOTS: COVID VACCINE ADMINISTRATION FOR RHC

We note further that we also assign a payment rate for administering these preventive vaccines under the Outpatient Prospective Payment System (OPPS), and those payment rates are for hospitals and home health agencies for preventive vaccine administration."

"Certain other types of providers and suppliers, such as RHCs, FQHCs and critical access hospitals (CAHs), are paid based on reasonable cost for vaccine administration."

"We also note that these payments are geographically adjusted based on the provider's wage index."

FLU, PNEUMOCOCCAL, & COVID-19 SHOTS & COVID-19 MONOCLONAL ANTIBODY PRODUCTS

We pay for flu, pneumococcal, COVID-19 shots, and COVID-19 monoclonal antibody products and their administration at 100% of reasonable cost. RHCs report these services on a separate cost report worksheet.

RHCs shouldn't report these services on their RHC billing claims.

Note: We updated the RHC cost report to reflect costs related to COVID-19 shots and COVID-19 monoclonal antibody products and their administration.

COVID VACCINES ONLY

"For ***Medicare Advantage*** patients, RHCs and FQHCs should submit COVID-19 vaccine administration claims to the Medicare Advantage Plan for dates of service on or after January 1, 2022. Original Medicare won't pay for these claims beginning in January 2022. For dates of service in 2021, RHCs and FQHCs should use the cost report to bill for administering COVID-19 vaccines. For additional information, please see https://www.cms.gov/covidvax."

(CMS RHC Website. Accessed 4.26.2022.)

PHYSICIAN ASSISTANT (PA) SERVICES

Section 403 of the Consolidated Appropriations Act, 2021 (CAA) (Pub. L. 116-260, December 27, 2020), amended section 1842(b)(6)(C)(i) of the Act to remove the requirement to make payment for PA services only to the employer of a PA effective January 1, 2022. With the removal of this requirement, PAs will be authorized to bill the Medicare program and be paid directly for their services in the same way that NPs and CNSs do. Effective with this amendment, PAs also may reassign their rights to payment for their services, and may choose to incorporate as a group comprised solely of practitioners in their specialty and bill the Medicare program, in the same way that NPs and CNSs may do.

MEDICARE TELEHEALTH: EFFECTIVE MARCH 27, 2020

On March 27, 2020, the (CARES Act) was signed into law. Section 3704 authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE.

- ✓ Medicare telehealth services require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient.
- ✓ *RHCs and FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.*

G2025 ONLY

RHCs and FQHCs must use HCPCS code G2025, the new RHC/FQHC specific G code for distant site telehealth services, to identify services that were furnished via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective.

(see https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx).

Changes in *eligible originating site locations*, including the patient's home during the COVID-19 PHE *are effective beginning March 6, 2020*.

DISTANT SITE PROVIDERS

Distant site telehealth services can be furnished by *any health care practitioner* working for the RHC or the FQHC within their scope of practice. (This includes 99201 and 99211.)

Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS)!!

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

MEDICARE PATIENT CONSENT

Patient Consent: Beneficiary consent is required for all services, including non-face-to-face services.

For RHCs and FQHCs, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the FQHC or FQHC practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the FQHC or FQHC practitioner.

(see: https://www.cms.gov/files/document/covid-final-ifc.pdf).

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.

ANNUAL WELLNESS VISITS AND TELEHEALTH

“Currently, Medicare policy allows for the billing of the AWV (G0438-G0439) when delivered via telehealth provided that all elements of the AWV are provided (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf).

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.

CS MODIFIER FOR COVID-RELATED SERVICES: CO-INSURANCE MUST BE WAIVED

For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries.

- ✓ For COVID-related services in which the coinsurance is waived, RHCs and FQHCs must report the “CS” modifier on the service line.
- ✓ The CS-modifier NOW also applies to preventive services rendered via telehealth, where patient cost sharing should not apply.

TELEHEALTH CO-INSURANCE AND DEDUCTIBLE

Medicare Telehealth

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

TELEHEALTH COST REPORTING

- ✓ Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rates but must be reported on the appropriate cost report form.
- ✓ RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled “Cost Other Than RHC Services.”

RHC TELEHEALTH DISTANT SITE SERVICES:

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025	08/21/2020	1	$ 97.24
0001	Total Charge				$ 97.24

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

These claims will be paid at the $97.24.

VIRTUAL COMMUNICATION SERVICES

RHCs can receive payment for Virtual Communication Services when *at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner* to a patient who has had an RHC billable visit within the previous year.

- ✓ The medical discussion or remote evaluation is for a condition *not related to an RHC service* provided within the previous 7 days, and -

- ✓ The medical discussion or remote evaluation ***does not lead*** *to an RHC visit* within the next 24 hours or at the soonest available appointment.

VIRTUAL COMMUNICATION SERVICES – BILLING

G0071 (Virtual Communication Services) is billed either alone or with other payable services.

Payment for G0071 is temporarily set at the PFS national average of the non-facility average for G2010, G2012, 99421, 99422, and 99423.

"January 1 – December 31, 2021, we'll pay $23.73 for claims submitted with G0071.

January 1 – December 31, 2022, we'll pay the new rate of $23.88 for claims submitted with G0071."

G0071 FAQ: TYPES OF COMMUNICATION

Virtual communication services would be initiated by the patient contacting the RHC or FQHC by:

- ✓ ***a telephone call;***
- ✓ integrated audio/video system;
- ✓ a store-and-forward method such as sending a picture or video to the RHC or FQHC practitioner for evaluation and follow up within 24 hours.

The RHC or FQHC practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

G0071: VIRTUAL CHECK-IN

Virtual Check-In (Brief Communication Technology-based Service):

- ✓ MUST be initiated by the patient. The provider cannot call the patient.
- ✓ Performed by a physician or other qualified health care professional;
- ✓ provided to an established patient (Waived for COVID-19)
- ✓ COVID-19: Available to ALL patients, including new effective 3.17.2020.
- ✓ not originating from a related E/M service provided within the previous 7 days;
- ✓ nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment;
- ✓ 5-10 minutes of medical discussion.

G0071 FAQ: VIRTUAL COMMUNICATION SERVICES

- ✓ Coinsurance and deductibles apply to RHC claims for G0071 and coinsurance applies to FQHC claims for G0071.
- ✓ Coinsurance is 20 percent of the lesser of the charged amount or the payment amount for code G0071.
- ✓ Beneficiary consent should be obtained before virtual communication services are furnished in order to bill for the service.

EVISITS: MEDICARE TELEHEALTH VIA PATIENT PORTAL

The G0071 payment is the average of the National Physician Fee Schedule amounts for the following CPT codes:

Medicare Telehealth/Patient Portal Codes: (99421 – 99423)	
Description: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during 7 days.	
99421	5-10 minutes
99422	11—20 minutes
99423	21 or more minutes

VIRTUAL CHECK-IN RHC CLAIM EXAMPLE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Virtual Check-In	G0071	4/2/2022	1	$ 25.00
0001	Total Charge				$ 25.00

- ✓ G0071 is for RHCs only.
- ✓ We do not bill G2010, G2012, 99421, 99422, 99423.
- ✓ Virtual Check-In G0071 encompasses Remote Check-In AND Remote Evaluation.
- ✓ It does NOT include remote monitoring.

CLAIM EXAMPLES

ANNUAL WELLNESS VISIT + SICK VISIT => WHICH GETS THE CG MODIFIER?

OFFICE VISIT AND PREVENTIVE W. ANCILLARY

An established patient is seen and a qualifying visit of 99213 for $100 is generated. An Annual Wellness Visit was also performed for $100.00. A venipuncture was performed for $20.00. CG Modifier is reported in the primary purpose of the visit.

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	AWV	G0438 CG	04/02/2022	1	$ 140.00
0521	OV Est 3	99213	04/02/2022	1	$ 120.00
0300	Venipuncture	36415	04/02/2022	1	$ 20.00
0001	Total Charge				$ 280.00

- ✓ CG is reported in the line item representing the primary purpose of the visit.
- ✓ The charge for the AWV should NOT be bundled in the 99213 line.
- ✓ The $20.00 venipuncture charge will be bundled with the 99213 charge for $100.00.

PREVENTIVE PLUS CLINICAL VISIT

Remittance Advice Sample

NOVITAS SOLUTIONS
MEDICARE A
P O BOX 3103
MECHANICSBURG, PA 170551819

Printed:
February 23, 2022

Standard Paper Remittance
(SPR)
Advice Notice

NPI #: 1234567890
ISSUE DATE: 04/21/21
PROD DATE: 04/20/21
CHECK/EFT #: PMT123456
CHECK AMT: 2740.55

REND PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COPAY	COINS	GRP/RC-AMT	PROV PD
PATIENT: Smith, J					ACNT		ICN: XXXXXXXXXXXXXXXXX			MOA: MA01 M15	
Claim Period:	031221 031221										
1234567890	031221 031221		1	G0439 CG REV CODE: 0521	200.00	200.00	0.00	0.00	0.00 CO-45	113.69	86.31
1234567890	031221 031221		1	G0444 REV CODE: 0521	25.00	25.00	0.00	0.00	0.00 CO-97	25.00	0.00
1234567890	031221 031221		1	99173 REV CODE: 0521	35.00	35.00	0.00	0.00	0.00 CO-97	35.00	0.00
1234567890	031221 031221		1	99213 REV CODE: 0521	110.00	110.00	0.00	0.00	0.00 CO-97	110.00	0.00
PT RESP: 0.00				CLAIM TOTALS:	370.00	370.00	0.00	0.00	0.00	283.69	86.31
ADJ TO TOTALS	PREV PAID: 0.00			INTEREST: 0.00		LATE FILING CHARGE: 0.00					NET: 86.31

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL CARC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK
	1	370.00	370.00	0.00	0.00	283.69	86.31	0.00	2740.55

GLOSSARY: Group, Reason, MOA, MIA, Remark and Adjustment Codes:

CODE	DESCRIPTION
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late. (Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)

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	04/02/2021	1	$ 175.00
0521	Breast/Pelvic	G0101	04/02/2021	1	$ 75.00
0521	Pap Smear	Q0091	04/02/2021	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.

MULTIPLE ENCOUNTERS ARE ALLOWED WHEN:

- ✓ The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (2 visits), or
- ✓ The patient has a medical visit and a Behavioral health visit on the same day (2 visits), or
- ✓ The patient has his/her IPPE and a separate medical and/or Behavioral health visit on the same day (2 or 3 visits).

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

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.

See Questions 13 – 15 on RHC Reporting FAQ.

See Medicare Benefit Policy Manual Chapter 13 Section 40.3.

CG MODIFIER FAQ: SUBSEQUENT ILLNESS OR INJURY

Q13. Is modifier CG reported when a subsequent medically necessary visit that qualifies as a separate payment occurs on the same day as an earlier medically-necessary visit?

A13. No. he RHC should report modifier 25 or modifier 59 on the line with the medical service that represents the primary reason for the subsequent visit.

Q14. Should modifier CG and modifier 25 or modifier 59 be reported on the same service line together to indicate a ***subsequent*** medically necessary visit?

A14. No.

Q15. Modifier 25 or modifier 59 are to be reported on the primary subsequent visit, but should it also be reported with the HCPCS code(s) for the services furnished during the subsequent visit?

A15. Modifier 25 or 59 is reported only on the line that represents the primary reason for the subsequent visit.

MODIFIER-59 EXAMPLE: SUBSEQUENT INJURY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	04/02/2020	1	$ 350.00
521	Laceration Repair	12002 59	04/02/2020	1	$ 0.01
0001	Total Charge				$ 350.01

Modifier CG and modifiers 25/59 are NOT reported on the same service line together to indicate a subsequent medically necessary visit.

RHC REGULATIONS AND INTERPRETIVE GUIDELINES

Social Security Act Section 1861(aa)(2)(K)

42 CFR §405.2402 (Basic Requirements)

42 CFR Part 491, Subpart A (Conditions for Participation!)

State Operations Manual – Appendix G (Surveyor Guidance)

Accreditation Organization Standards:

- AAAASF
- The Compliance Team

RHC - CMS RESOURCES

Virtual Communication FAQ

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

State Operations Manual Appendix G

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

Provider-Based Rules (42 CFR 413.65)

https://www.law.cornell.edu/cfr/text/42/413.65

RHC - CMS RESOURCES

"New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE". Centers for Medicare and Medicaid Services. MLN SE20016 Revised. Article Release Date: January 13, 2022. website: https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf. Accessed 01.28.2022.

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