

Rural Health Clinic (RHC) Billing

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Today's agenda

Top tips to enhance your billing process

- RHC overview
- RHC services
- Preventive services in the RHC
- Non-RHC services
- RHC care management services
- Payment for services
- Filing an RHC claim
- Telehealth COVID-19 waivers
- Virtual care

A man and a woman are standing in a laboratory or office setting, looking at a tablet together. The man is on the left, wearing a checkered shirt and a lanyard. The woman is on the right, wearing a white lab coat and a lanyard. They are both smiling and appear to be engaged in a collaborative task. The background shows a modern building with large windows and trees. The entire image has a blue tint.

RHC

overview

RHC overview

What is an RHC?

RHC certification is a designation from the Centers for Medicare & Medicaid Services (CMS) to clinics providing primary care in certain rural, underserved areas and provides an alternative, cost-based reimbursement system for treating Medicare and Medicaid beneficiaries.

RHC overview

RHC requirements

- Must be engaged primarily in providing primary care services: family medicine, internal medicine, women's health, pediatrics, "urgent care"
- *Rural* is defined as an area "that is not an urbanized area as defined by the U.S. Census Bureau" <http://www.raconline.org/amirural/tool>
- Current underserved designation (within the last four years)
- Non-physician practitioner available to see patients at least 50% of time clinic is open
 - ▶ At least one must be employed

RHC overview

RHC requirements

Ability to perform (furnish) six basic lab tests:

- Chemical examinations of urine
- Hemoglobin or hematocrit
- Blood sugar
- Examination of stool specimens
- Pregnancy tests
- Primary culturing for transmittal to a certified laboratory

RHC overview

How are RHCs paid?

RHCs are paid a flat rate for each face-to-face encounter based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs (i.e., cost report) occurring at the end of the fiscal year.

Cost-based reimbursement is determined on the average cost per visit. A visit is defined as a medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist or clinical social worker and a patient.

In general, if there is no “visit,” there is no RHC payment.

RHC overview

RHC cost-per-visit

$$\frac{\textit{Allowable RHC costs}}{\textit{RHC visits}} = \text{RHC cost per visit (rate)}$$

(Not to exceed the maximum reimbursement limits)

RHC overview

What is different about RHC billing?

RHC services are billed to Medicare (and Medicaid in some states) using a unique format that facilitates an all-inclusive payment rate for each medically necessary RHC encounter.

RHC services are billed to Medicare on the CMS-1450 (UB-04) claim form instead of the CMS 1500 form often used for billing physician services.

In general, RHCs do not charge any differently for the services they provide, although the actual format of the Medicare/Medicaid claim form may be substantially different.

One common billing difference is the use of the “CG” modifier for Medicare to identify a “billable RHC encounter.”

RHC overview

CG modifier

The CG modifier is used to identify the “billable RHC encounter.” When billing Medicare, 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 encounter.

If only an office visit is performed, as in the example below, the claim will appear to be fairly similar to most other billings:

RHC billing

Example 1:

FL42	FL43	FL44	FL45	FL46	FL47
Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	\$ 100.00
0001	Total Charge				\$ 100.00

RHC overview

CG modifier

If multiple services are provided, the Medicare claim can appear quite unusual when compared with most other billings:

RHC billing	FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
Example 2:	0521	OV Est 3	99213 CG	4/2/2016	1	\$ 115.00
	0636	Allergy Injection	95115	4/2/2016	1	\$ 15.00
	0001	Total Charge				\$ 130.00

The charge amount for the Allergy Injection (\$15.00) will be added to the 99213 (\$100) for a qualifying visit line of \$115.00. The total charge line is overstated.

RHC overview

Modifier -25 or -59, multiple visits

If multiple billable encounters are provided on the same day, the Medicare claim includes a modifier

Reporting Modifier 25 or Modifier 59

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. If an illness or injury that wasn't present during the first visit requires additional diagnosis or treatment on the same day (for example, a patient sees an RHC practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC), the RHC should report modifier 25 or modifier 59 on the line with the medical service that represents the primary reason for the subsequent visit and has the bundled charges for all services for the subsequent visit. Modifier 59 or Modifier 25 should be reported with a medical service using revenue code 052x.

RHC overview

RHC billing example 3

The CG Modifier will amend the initial visit. The 59 modifier will amend the subsequent visit laceration repair. The CG modifier should NOT accompany the subsequent visit code.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 4	99214 CG	4/2/2016	1	\$ 340.00
0521	Laceration	12002 59	4/2/2016	1	\$ 200.00
0001	Total Charge				\$ 540.00

RHC overview

What is different about RHC billing?

Another common billing difference is when incidental services are provided to a Medicare beneficiary without a “billable encounter.”

RHC overview

Q18. Can RHCs combine incident to services furnished on a different date of service from the qualifying visit on one claim? For example, an office visit is furnished on April 1 and venipuncture is furnished on April 4.

A18. Yes, the RHC can combine incident to services furnished on a different date of service on one claim as long as they are furnished in a medically appropriate period and are incident to the service being billed. Incident to services should not be reported with modifier CG.

“RHC reporting requirements FAQs,” CMS, revised 10/14/2016.



RHC overview

RHC billing
example 2:

Bundled Injection/Different Dates

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	\$ 115.00
0636	Allergy Injection	95115	4/2/2016	1	\$ 15.00
0001	Total Charge				\$ 130.00

The charge amount for the Allergy Injection (\$15.00) will be added to the 99213 (\$100) for a qualifying visit line of \$115.00. The total charge line is overstated.

RHC overview

RHC billing
example 2a:

Bundled Injection/Different Dates

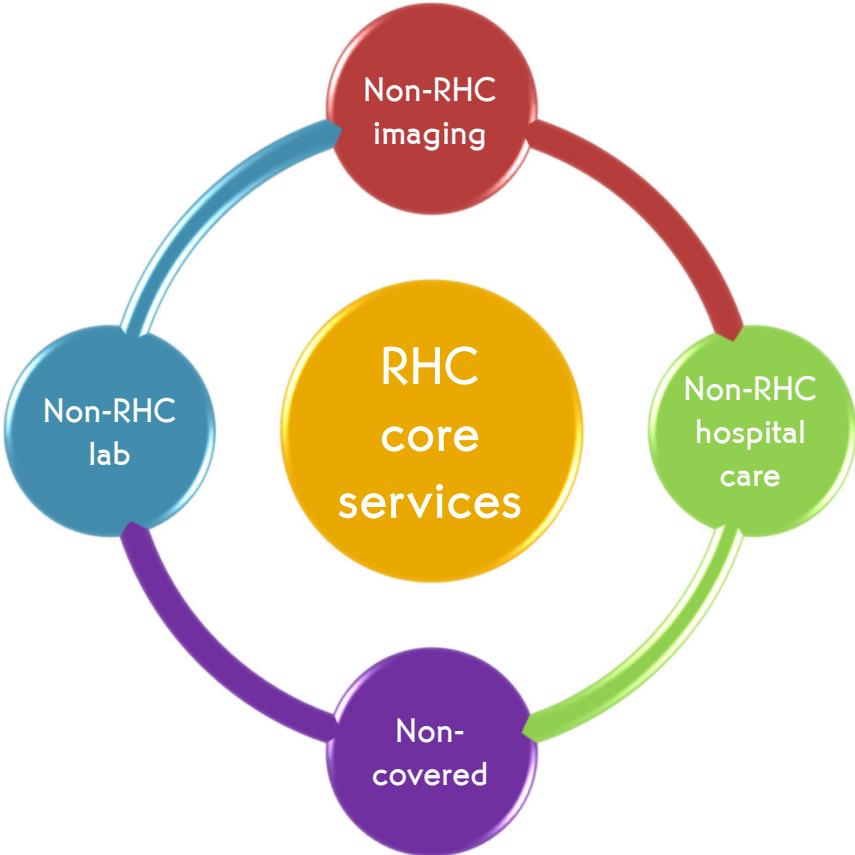
FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	\$ 115.01
0636	Allergy Injection	95115	4/2/2016	1	\$ 0.01
0001	Total Charge				\$ 115.02

The Allergy injection charge amount (\$15.00) plus \$.01 for the line item is bundled with the \$100 charge on the 99213 qualifying visit line. Medicare will use the line with the qualifying visit code (99213) to determine the total charge and calculate co-insurance.

The image shows two healthcare professionals, likely nurses or doctors, in a clinical setting. They are both wearing stethoscopes and are focused on a document or chart. One person is holding a pen and appears to be writing. The entire image is overlaid with a blue color filter. A white rectangular box is positioned on the left side of the image, containing the text 'RHC services' in a blue, sans-serif font.

RHC services

RHC services



RHC services

RHC billing differences (core services)

Service	Independent	Provider-based
RHC services (face-to-face encounter in RHC site of service)	Billed to independent RHC regional fiscal intermediary - RHC provider number on Form UB-04	Billed to host provider fiscal intermediary - RHC provider number on Form UB-04

RHC services

RHC billing differences (non-RHC services)

Service	Independent	Provider-based
Laboratory (excluding the draw procedure, e.g., CPT 36415)	Billed to Part B carrier - Existing group number on Form 1500	Billed on hospital O/P claim type (14x, 13x or 85x) on Form UB-04
Other diagnostic/radiology - professional component	May be billed with encounter. If read by non-RHC provider, they will bill the carrier	May be billed with encounter. If read by hospital radiologist, bill the carrier
Other diagnostic/radiology - technical component	Billed to Part B carrier - Existing group number on Form 1500	Billed on hospital O/P claim type (13x or 85x) on Form UB-04
Non-RHC professional services (I/P, ER, other O/P services)	Billed to Part B carrier - Existing group number on Form 1500	Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for O/P pro fees)

RHC services

- Physician services
- Services of nonphysician practitioners (NPPs), which include physician assistants, nurse practitioners and certified nurse midwives (does not include clinical nurse specialists)
- Services and supplies incident to physicians and NPPs
- Visiting nurse services to the homebound
- Clinical psychologist and clinical social worker services
- Services and supplies incident to clinical psychologist and clinical social workers
- Physician services for beneficiaries in Part A stay in SNF (including hospital swing bed) separately billable effective January 1, 2005

RHC services

Services and supplies are furnished incident to physician services::

- Furnished as an incidental, integral part of professional services
- Commonly rendered either without charge or otherwise chargeable
 - ▶ Cannot bill carrier or intermediary separately!
 - ▶ Costs are included in the cost report as part of the all-inclusive encounter rate
- Commonly furnished in a physician's office
- Furnished by a clinic employee (staff)
- Includes services of clinic staff (e.g., nurse, therapist, technician or other aide):
 - ▶ Example: Medicare-covered drug administration (see PM A-01-49 CR1600 4/5/01)
- Supplies such as bandages and tongue depressors are included in the office visit as packaged services

RHC services

Visiting nurse services

- Covered if service area is considered to have a shortage of home health agencies
- Services rendered to homebound patients
- Patient furnished part-time/intermittent nursing care by RN, LPN or licensed vocational nurse
- Needs to be an employee of RHC
- Services furnished under written POT:
 - ▶ Reviewed once every 62 days by supervising physician of RHC

RHC services

Hepatitis vaccines



See CMS Publ. 100-02, Chapter 13, Section 210.1.2

Hepatitis vaccines and their administration are included in the RHC visit and are not separately billable. The cost of the vaccines and administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the RHC provides.

Preventive services

in the RHC



Preventive services in the RHC

See <http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

- All preventive services furnished on the same day as another medical visit constitute a single billable visit, except for initial preventive physical examination (IPPE)
- If an IPPE visit occurs on the same day as another billable visit, two visits may be billed, i.e., “eligible for same day billing”
- All of the preventive visits listed may be billed as a standalone visit if no other service is furnished on the same day, i.e., “paid at the AIR”
- Copayment and deductible are waived by the ACA for the IPPE and annual wellness visit (AWV) and for Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force with a grade of “A” or “B”

Preventive services in the RHC

See <http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Service	HCPCS code	Long description	Paid at the AIR	Eligible for same-day billing	Coinsur./deduct.
Initial Preventive Physical Exam (IPPE)	G0402	IPPE; face-to-face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	Yes	Yes	Waived

Preventive services in the RHC

Medicare Preventive Service	HCPCS Code/ Short Description	AIR?	Same Day?	Coins/Ded
Annual Wellness Visit – Initial	G0438/ AWV - I	Yes	No	Waived
Annual Wellness Visit – Subsq	G0439/ AWV-S	Yes	No	Waived
Screening Pelvic Exam	G0101/ Pelvic-breast Exam	Yes	No	Waived
Prostate Cancer Screening	G0102/ Prostate Screening	Yes	No	Not Waived
Glaucoma Screening	G0117 Glaucoma	Yes	No	Not Waived
Glaucoma Screening	G0118 Glaucoma	Yes	No	Not Waived
Screening Pap Test	Q0091 Obtaining Pap Smear	Yes	No	Waived
Alcohol Screening /Behavioral Counseling	G0442 Alcohol Screen 15 min	Yes	No	Waived
Alcohol Screening /Behavioral Counseling	G0443 Brief alcohol misuse counseling	Yes	No	Waived
Screening for Depression	G0444 Depression screen annual	Yes	No	Waived

Preventive services in the RHC

Medicare Preventive Service	HCPCS Code/ Short Description	AIR?	Same Day?	Coins/Ded
Screening for Sexually Transmitted Infections	G0445/ STD 30 Minutes	Yes	No	Waived
Intensive Behavioral Therapy for Cardiovascular Disease	G0446/ Cardio-disease	Yes	No	Waived
Intensive Behavioral Therapy for Obesity	G0447/ Obesity 15 minutes	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99406 ¹ /Smoking 3-10 minutes	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99407 ¹ /Smoking > 10 Minutes	Yes	No	Waived
Lung Cancer Screening With Low Dose Computed Tomography	G0296/ Lung Cancer LDCT	Yes	No	Waived

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.

Preventive services in the RHC

RHC billing
example 4:

Multiple Preventive Stand Alone Encounters

A breast and pelvic exam (G0101) and a pap collection (Q0091) were performed on the same day. Both services are “stand-alone” preventive services. Report one of these with the CG modifier. No co-insurance or deductible amount should be applied.

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Breast/Pelvic	G0101 CG	4/2/2016	1	\$ 75.00
0521	Pap Collection	Q0091	4/2/2016	1	\$ 40.00
0001	Total Charge				\$ 115.00

Preventive services in the RHC

RHC billing
example 5:

Preventative Services

An established patient is seen and a qualifying visit of 99213 for \$100 is generated. A breast/pelvic exam was performed for \$75.00. A venipuncture was performed for \$20.00.

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	\$ 120.00
0521	Breast/Pelvic	G0101	4/2/2016	1	\$ 75.00
0300	Venipuncture	36415	4/2/2016	1	\$ 20.00
0001	Total Charge				\$ 215.00

The charge for the pelvic exam should NOT be bundled in the 99213 line since there will be no co-insurance applied to the preventive service. The \$20.00 venipuncture charge will be bundled with the 99213 charge for \$100.00.

Preventive services in the RHC

RHC billing
example 6:

IPPE and a Medical Visit

“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.” RHC Reporting FAQ

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Est Pt Level 3	99213CG	4/2/2016	1	\$ 100.00
0521	IPPE	G0402	4/2/2016	1	\$ 200.00
0001	Total Charge				\$ 300.00

Preventive services in the RHC

Pneumococcal and influenza vaccines

See CMS Publ. 100-02, Chapter 13, Section 210.1.1

Pneumococcal and influenza vaccines and their administration are paid at 100 percent of reasonable cost. When an RHC practitioner (physician, NP, PA or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the cost of the vaccines and administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should not be reported on an RHC claim when billing for RHC services, and the beneficiary pays no Part B deductible or coinsurance for these services.



Preventive services in the RHC

Covid-19 vaccines

Rural health clinics will claim costs for Covid-19 vaccinations on the Medicare cost report in order to receive cost-based reimbursement. Note that both direct Medicare AND Medicare Advantage injections should be claimed through this mechanism.

Rural Health Clinics have the ability to request a lump sum adjustment for Covid-19 vaccinations.

Non-RHC services



Non-RHC services

- DME
- Ambulance services
- Technical component of diagnostic tests such as X-rays and EKGs
- Lab test (although required for certification, must be able to perform six required tests in RHC)
- Screening mammography services
- Prosthetic devices
- Services provided to hospital patients (except those in a swing bed)

Non-RHC services

Billing lab services performed in an RHC

Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see Section 1861(aa)(2)(G) of the Act and for FQHCs see Section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. **This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.**

MLN Matters Number MM8504, November 22, 2013

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Non-RHC services

Special billing – other diagnostic services

Example billing for EKGs:

- Bill technical component of EKG using 93005 (EKG) to Part B carrier or hospital FI

RHC (professional) service:

- Follow normal RHC billing if attending physician is also interpreting test; charge added (bundled) with office visit
- Revenue code 52x

Non-RHC services

Telehealth services

Special billing – telehealth services

Telehealth services (originating site) are non-RHC services. Originating site will receive separate payment. Coinsurance and deductible apply.

RHC (originating site):

This is the only service that may be included on an RHC bill (bill type 71x) with another RHC service (e.g., Rev. Code 521).

Bill telehealth service under Rev. Code 0780 with HCPCS Q3014.

Requires HCPCS Code Q3014 (reimbursement approximately \$25).

Non-RHC services

Telehealth services

Special billing – telehealth services

Physician service (distant site):

Bill as if the patient were with you “face to face”.

Payment made based on current fee schedule for service provided as if the patient were with the provider.



RHC care

management services

RHC care management services

Principal Care Management Code – G0511 (changes effective 1/1/2021)

- Used for CCM or general BHI services
- Payment amount is set at the average of the national non-facility PFS payment rates for CCM Code 99490, 99487, 99484, 99491 and as of 1/1/2021 G2064 & G2065
- Code can be billed once a month per beneficiary when the 20-minute threshold is met for either CCM or general BHI

RHC care management services

Psychiatric Care Management Code – G0512

- Used for psychiatric CoCM services
- Payment amount is set at the average of the national non-facility PFS payment rates for psychiatric CoCM CPT Code 99492 and psychiatric CoCM Code 99493
- Code can be billed once a month per beneficiary when the 60- or 70- minute threshold is met for either initial or subsequent psychiatric CoCM

Payment

for services



Payment for services

Payment calculations

- Payments for covered RHC services by physician, PA, NP, CNM, CP, CSW and visiting nurse are under an all-inclusive rate for each visit
- Each provider's interim rate is based on the all-inclusive rate per visit (determined based on the cost report)
- Established by your Medicare Administrative Contractor:
 - ▶ Determined by dividing total allowable cost by the number of total visits for RHC services
 - ▶ Rate may be adjusted during reporting period

Payment for services

Payment calculations

- The upper payment limit for independent and newly-certified RHCs for April 1, 2021 through December 31, 2021, is \$100.00 per visit.
- “Grandfathered” RHCs will be based off amounts paid for RHC services either in 2020 or 2021.



Payment for services

Payment calculations

Part B deductible

- The Part B annual deductible applies to services covered under the RHC benefit Part B coinsurance
- If the item or service is covered under the RHC benefit, the beneficiary is responsible for 20% of the customary charge
- If the service is not covered under the RHC benefit and is covered under Part B, the beneficiary is responsible for 20% of the Medicare-approved charge (MFS)

Payment for services

Payment calculations

RHC payment example

- Customary charge for 99213 is \$120
- Assume Medicare fee schedule allowable is \$100
- Medicare encounter rate is \$160 as a “Grandfathered” RHC
- Limited to \$100 for independent/newly-certified RHC
- No limit for provider-based RHC - available beds < 50
- Deductibles have been met already

Payment for services

Payment calculations

Comparison between RHCs and Part B payment example

Description	RHC amount (independent/ newly- certified)	RHC amount (grandfathered)	Part B amount
Customary charge	\$120.00	\$120.00	\$120.00
Patient copay	24.00	24.00	20.00
Medicare pays	80.00	128.00	80.00
Total payment	104.00	152.00	100.00
Contractual adjustment	16.00	(32.00)	20.00

Payment for services

Payment calculations

Does it matter how we code the visit if we get paid the same rate?

- Patient payment is affected
- Medicare considers overcoding a violation of the fraud and abuse regulations because of the additional reimbursement
- Medicare considers undercoding a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic

Conclusion: Yes, it matters!



Filing an

RHC claim

Filing an RHC claim

- UB-04 (CMS Form 1450); 837I electronic claim format
- Bill type 71x
- CPT/HCPCS for all services required beginning April 1, 2016
- Separate RHC billing number (for each RHC)
- Only RHC services on RHC billing number
- Bill all non-RHC ancillary services **separately!**
 - ▶ Independent - To Part B carrier using existing group number
 - ▶ Provider-based - Through the hospital provider number on 13x, 85x or 14x type of bill (A-00-36 7/28/00)
- Non-RHC professional services billed to Part B carrier utilizing existing group number (or to FI/MAC under CAH Method II billing)

Filing an RHC claim

RHC bill types (UB-04 claim form, 71x):

- 710 Claim with only non-covered charges
- 711 Original claim
- 715 Late charge – adjustment to prior claim
- 717 Replacement claim – adjustment to prior claim
- 718 Void/cancel previous claim

ensure that all sections of the claim form are fully completed. Note that claims payment may be delayed if the form are not completed in full. The form should be returned to us within six months of the initial invoice date.

enclose the original invoices, photocopies, receipts and credit card vouchers and write clearly in black ink and BLOCK CAPITALS.

complete a new / separate claim form for each patient

enclose the original invoices, photocopies, receipts and credit card vouchers and write clearly in black ink and BLOCK CAPITALS.

1. ensure that all sections of the claim form are fully completed. Note that claims payment may be delayed if the form are not completed in full. The form should be returned to us within six months of the initial invoice date.

2. MDX

3. EA

4. enclose the original invoices, photocopies, receipts and credit card vouchers and write clearly in black ink and BLOCK CAPITALS.

5. ensure that all sections of the claim form are fully completed. Note that claims payment may be delayed if the form are not completed in full. The form should be returned to us within six months of the initial invoice date.

Filing an RHC claim

Traditional RHC revenue codes

- 0522 Home visit by RHC/FQHC
- 0521 Clinic visit at RHC/FQHC
- 0524 Visit by RHC/FQHC practitioner in Part A stay SNF
- 0525 Visit by RHC/FQHC practitioner in an NF or ICF or residential facility
- 0527 RHC/FQHC visiting nurse (must have special designation)
- 0528 RHC/FQHC visit other locations (e.g., scene of an accident)
- 0780 Telehealth services (Note: not an RHC service)
- 0900 Mental health visits
- Sometimes referred to as place of service with respect to RHCs/FQHCs

Filing an RHC claim

Beginning April 1, 2016, all revenue codes are valid except:

- 002x – 024x
- 029x
- 045x
- 054x
- 056x
- 060x
- 065x
- 067x – 072x
- 080x – 088x
- 093x
- 096x – 310x

A complete list of revenue codes can be found in a National Uniform Billing Committee publication.

Filing an RHC claim

Commonly used additional RHC revenue codes (> 4/01/16):

- 0250 Pharmacy (does not need HCPCS)
- 0300 Venipuncture
- 0636 Injection/immunization
- 0780 Telehealth
- 0900 Behavioral health



Telehealth

COVID-19 waivers

Telehealth – COVID-19 waivers

- Expands services that can be furnished via telehealth
- Diagnosis does not have to be specific to COVID-19
- RHCs are eligible to furnish the distant-site service
- Patient's home is eligible as an originating site
- Type of modality can include the use of a smartphone or computer-based audio/video
- Can be new or established patient (removal of the pre-existing relationship clause)
- Waives requirements that physicians/NPPs perform in-person visits for nursing home residents
- Removes frequency limitations on subsequent SNF visits (every 30 days)

Telehealth visits

- RHC distant-site services (During COVID-19 PHE period)

Type of Service	What is the Service?	Modality	CPT/HCPCS	Brief Description	How to Report
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient	Synchronous (Telephone Audio/Video)	99201-99205	New & Patient Office Visits *	G2025
			99212-99215	Est. Patient Office Visits	
			99304-99306	Initial SNF visit *	
			99307-99308	Subsequent SNF visits	
			99315-99316	Nursing Fac D/C day *	
			99495-99496	TCM Services	
			99497-99498	Advanced Care Planning	

- ▶ On April 30, 2020, CMS announced audio-only services such as audio E/M services 99441, 99442, and 99443 may also be reported as a distant-site service with G2025.

Distant-site services – RHCs

- Distant-site telehealth services can be furnished by any healthcare practitioner working for the RHC within their scope of practice
- Practitioners can furnish distant-site telehealth services from any location, including their home, during the time they are working for the RHC and can furnish any telehealth service that is approved as a distant-site telehealth service under the Physician Fee Schedule
- RHCs cannot bill the originating and distant site service; when the location of the patient is in the home, no originating site fee is billed.

Reporting distant site services – RHCs

- RHCs report G2025 for all distant-site visits
- Between January 27, 2020, and June 30, 2020, report G2025 with modifier CG
- Beginning July 1, 2020, RHCs will no longer need modifier CG
- Modifier 95 is optional on all claims
- Payment made based on fee schedule (\$99.45 as if 1/1/2021, with lesser of fee schedule or charge considered).

RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020

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

RHC Claims for Telehealth Services starting July 1, 2020

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

Cost sharing related to COVID-19 testing

- For services furnished from March 18, 2020, through the duration of the COVID-19 PHE, CMS will pay all the reasonable costs for specified categories of E/M services (including applicable telehealth services)
 - ▶ If they result in an order or administration of a COVID-19 test and relate to the furnishing or administration of such test
 - ▶ Or the evaluation of an individual for purposes of determining the need for such test

Cost sharing related to COVID-19 testing

- RHCs must waive the collection of coinsurance for E/M services related to COVID-19 testing (including when furnished via telehealth)
 - ▶ For services for which the coinsurance is waived, RHCs and FQHCs must put the CS modifier on the service line
 - ▶ Cost-sharing waiver applies regardless of the result of the test (does not have to be positive for COVID-19)

Virtual care



Virtual care – Pre-COVID-19

- For RHCs, Medicare coverage was limited to remote evaluation of recorded video or images (HCPCS Code G2010) and brief check-ins (G2012), both of which are reported with G0071
- Payment based on average national non-facility PFS rate for G2010 and G2012, which was \$13.51 per visit
- Were available only to patients who had a previous RHC visit within the last 12 months
- Patient consent was required prior to the service being rendered

Virtual care – Pre-COVID-19 waivers

- Expanded coverage to include online digital evaluation and management services (99421-99423), which are non-face-to-face, patient-initiated, digital communications using a secure patient portal
 - ▶ CPT code 99421 (5-10 minutes over a seven-day period)
 - ▶ CPT code 99422 (11-20 minutes over a seven-day period)
 - ▶ CPT code 99423 (21 minutes or more over a seven-day period)
- Must be five minutes or more of medical discussion or remote evaluation for a condition not related to an RHC service within the previous seven days, that does not lead to an RHC visit within the next 24 hours

Virtual care – Pre-COVID-19 waivers

- Available to patients who have not been seen in the RHC in the previous 12 months
- Patient has coinsurance and deductible; may be waived under WAIVER 1135
- Consent can be obtained at the time the services are furnished (versus prior to) but must be obtained before the services are billed
- Consent can be obtained by staff under general supervision by the RHC provider

Virtual care – RHC reporting

- G0071 is reported for all virtual check-in and visits

Type of Service	What is the Service?	Modality	CPT/HCPCS	Brief Description	How to Report
VIRTUAL CHECK-IN	Brief (5-10 minutes) check in with our practitioner online portal or other	Asynchronous	G2010	Remote evaluation of recorded video and/or images	G0071
			G2012	Brief communication technology-based service, e.g., virtual check-in	
E-VISITS	A communication between a patient and their provider through an online portal		99421	Online digital evaluation; 5-10 minutes	
			99422	Online digital evaluation; 11-20 minutes	
			99423	Online digital evaluation, 21+ minutes	

Virtual care – RHC reporting

- The payment rate for HCPCS Code G0071 was temporarily increased to \$24.76 based on the national average PFS non-facility payment rate for G2010, G2012 and 99421-99423. As of 1/1/2021, the rate is \$23.73
- Virtual check-in and visits do not utilize the 95 modifier
- Codes for virtual check-in (telephone), visits (portal) and telehealth (audio-visual) cannot be billed together for the same patient on the same date

Questions?

The

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Your presenter



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