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REVENUE CYCLE RESOURCES

RHC Roundtable

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2025 RHC Changes

RHC Vaccine Billing - Current

- **Influenza, Pneumococcal, COVID-19 Vaccines and Administration:**
  - Cannot be reported on an RHC claim, even if provided with a qualified stand-alone service
  - Vaccine and administration paid at 100% of reasonable cost through the cost report
  - Tracking process to report individual vaccines provided
- **Hepatitis B Vaccine and Administration:**
  - **Prior to January 1st, 2025**
    - Could be included in the line item for the otherwise qualifying visit
      - Not considered a stand-alone RHC visit
    - Did not need to track for cost report purposes
  - **Effective January 1st, 2025**
    - Paid at 100% of reasonable cost
    - Follows same payment process as influenza, Pneumococcal, and COVID-19 vaccines

RHC Vaccine Billing - July 1st, 2025

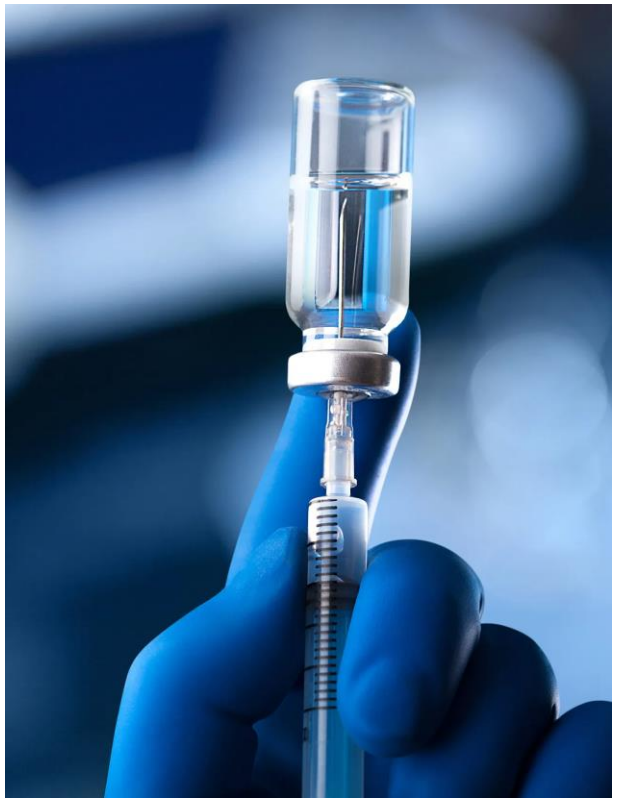
Influenza, Pneumococcal, COVID-19, Hepatitis B Vaccines

Starting July 1st, 2025, payment will be made at time of service

- **Payment**:
  - Vaccine: 95% of Average Wholesale Price (AWP)
  - Administration: Part B Vaccine Administration National Fee Schedule

- **Cost Report Settlement**
  - RHCs will still reconcile with CMS on an annual basis
  - Receive 100% of their vaccine and administration cost

- **HCPCS M0201, Administration In Home**
  - Utilized for Part B vaccination administration in a patient's home



RHC Vaccine Resources

- **MLN 13923- Payment for Medicare Part B Preventive Vaccines & Their Administration for Rural Health Clinics & Federally Qualified Health Centers**
- **CMS Change Request 13923**
  - Billable on 71X TOB
  - Appropriate Revenue Code
    - 771-Vaccine Administration (G0008, G0009, G0010, 90480, and M0201)
    - 636- Vaccine
  - No CG Modifier
  - Payable alone or with a qualifying encounter
    - If billed with a qualifying encounter, payment for the vaccine administration and vaccine will be paid separately from the AIR

RHC Category II Codes

- **Change Request: 13817**
- Effective April 1, 2025, RHCs can submit quality reporting, category II HCPCS codes, including information only codes for quality reporting
- No Medicare FFS payment policies that use these codes for payment or quality reporting purposes

Care Coordination Services Billing - 2024

Billing & Payment Effective 2024 (Optional Jan 1st- June 30th, 2025):

- **Billing:**
  - HCPCS G0511 may be bill multiple times in a month, for the following codes:
    - **CCM**:99487, 99490, 99491 **PCM**: 99424, 99426 **CPM**: G3002 **General BHI**: 99484 **RPM**: 99453, 99454, 99457, 99091 **RTM:** 98975, 98976, 98977, 98980 **CHI**: G0019 **PIN**: G0023 **PIN-Peer Support**: G0140
    - Example: G0511 x2 billed for 20 minutes of CCM and 30 minutes of PCM, as long as clinical staff minutes do not overlap
  - Revenue code 521
  - Bill either alone or with other payable services
  - NO CG Modifier

- **Payment:**
  - Fee Schedule for 2025: $54.67
  - Coinsurance & Deductible Assessed

Care Management Services Billing - 2025

Billing & Payment Effective January 1st, 2025 (Enforced July 1st, 2025):

- **Billing:**
  - Applicable Code On ***RHC/FQHC CY 2025 Payment Rates for Care Coordination*** File
    - G0511 is deleted
  - Revenue Code 521
  - NO CG Modifier
  - Bill either alone or with other payable services on RHC Claim
- **Payment:**
  - Fee Schedule Rates For Individual Codes Provided In: ***RHC/FQHC CY 2025 Payment Rates for Care Coordination*** *File*
  - Coinsurance & Deductible Assessed

Should We Switch Now?

- **Yes!**
- **Chronic Care Management Payment Example:**
  - 2025 Reimbursement for G0511: $54.67
  - 2025 Reimbursement for 99490: $60.49
- **Warning - WPS does not appear to have updated their system**
  - Reprocessing of claims should occur once transmittal to MACs from CMS

Lab Changes

- **Hemoglobin and Hematocrit:**
  - Infrequently ordered in RHCs
  - CMS recognized the cost and burden of maintaining lab equipment for infrequently ordered tests
  - Removed requirement for RHCs to perform
- **Examination of Stool Specimens for Occult Blood**
  - CMS recognized that RHCs typically do not perform primary culturing
    - Instead, they collect and send specimens using proper techniques
  - Removed requirement for RHCs to provide examination of stool specimens

Primary Care Requirement

- **Per the CMS State Operations Manual, "RHCs may not be primarily engaged in specialized services"**
  - "Primarily Engaged" is determined by calculating the total hours of an RHC's operation and whether more than 50% of these hours involve providing specialty outpatient health services

- **2025 Change**
  - CMS maintains the requirement for RHCs to provide primary care
    - However, CMS will no longer enforce the "primarily engaged" standard (>50% primary care)
  - Provides RHCs more flexibility to offer specialty services without volume-based restrictions tied to primary care

Productivity Standards

- **RHCs Subject to Productivity Standards Since 1970s**
  - Standards Required:
    - 4,200 visits per full-time equivalent (FTE) physician
    - 2,100 visits per FTE non-physician practitioner
  - If actual visits fell below these standards:
    - The cost per visit was calculated using the productivity standard, not actual visits
    - Resulted in a lower cost per visit and reduced reimbursement
  - CMS acknowledged the productivity standards are outdated
    - Due to payment limits set, CMS will eliminate the standards to avoid redundancy
    - Change is effective for cost reporting periods ending after December 31, 2024

Advanced Primary Care Management

- **Advanced Primary Care Management**
  - RHCs can utilize these codes as appropriate
  - Paid on Fee Schedule
    - G0556- $15.20
    - G0557- $48.84
    - G0558- $107.07
  - Billable alone or with other payable services
  - No CG modifier


RHC Hot Topics

Discussion

- What Are Your HOT Topics?
- Pain Points?
- Compliance Concerns?

Medicare Advantage

Medicare Advantage Billing Rules

- **Medicare Advantage *should* follow traditional Medicare billing and reimbursement rules**

- **Deviations apply for services that traditional Medicare would reimburse within the cost report**
  - Nurse Only Visits
  - Vaccines

It’s All About The Contracting!

- **Medicare Advantage plans do not understand the intricacies behind RHC billing and payment methodology**
  - Contract language often deviates from CMS RHC Guidelines
- **Thoroughly read and understand your contracts!**
- **Issues Frequently Identified:**
  - Reimbursement methodology for non-RHC services:
    - Lab and radiology technical fees “paid on Medicare fee schedule”
  - Reimbursement methodology for nurse-only services
    - Often silent in contracts
  - Vaccination Billing
    - Specifically absent

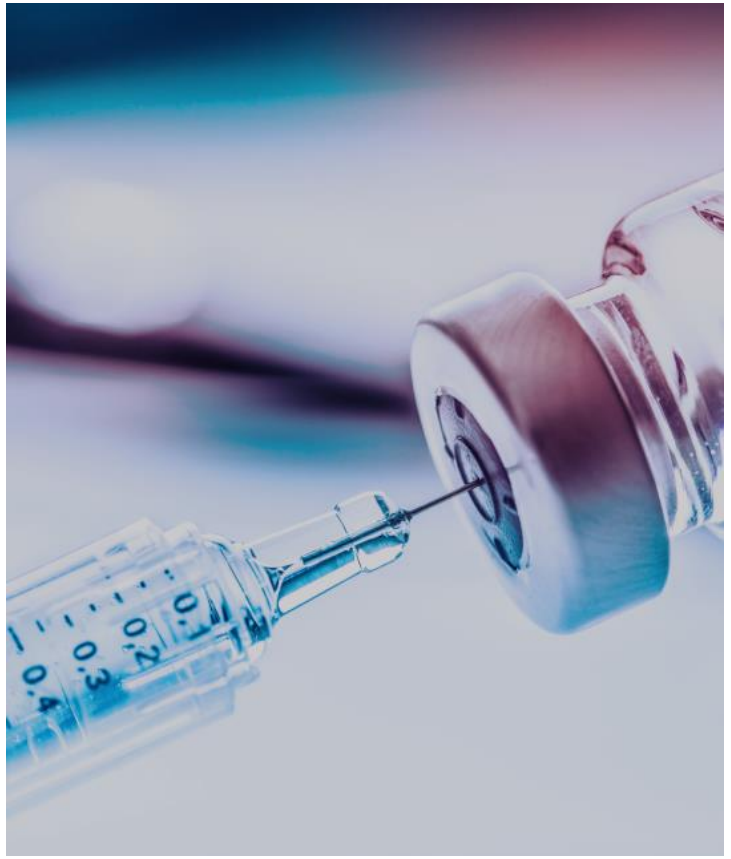
MA Part B Vaccinations

Part B Vaccinations

- Influenza, Pneumococcal, COVID-19, and Hepatitis B

- **How Are They Billed?**
  - **Contract Dependent**
    - If silent, recommend billing on a 1500
    - UB Billing
      - Do not roll charges into the Qualifying Visit Line
      - Perform reimbursement audit to ensure separate vaccine and administration payment!
        - MA plans often incorrectly adjust to CO-97 and pay only AIR

- **How Are They Paid?**
  - MPFS Fee Schedule
  - Do NOT include in your cost-reporting vaccine statistics



AIR Reimbursement Methodology

- **Based on Contract**
  - Typically, 100% of RHC's AIR
    - Allowable is usually 100% of the AIR
    - Coinsurance is not off of charges
  - May have copays applied or coinsurance

Cost Report Settlement

- **Majority of Medicare Advantage plans do NOT perform cost report settlements**
  - Verify charges normally included within the cost report for traditional Medicare, are billed and reimbursed separately!
    - Nurse Visits
    - Vaccinations

Multiple Visits on Same Day

Multiple Visits on The Same Day

- **Multiple encounters for the same patient on the same day count as <u>a single visit</u>, regardless of:**
  - Visit length or complexity
  - Number or type of practitioners (including specialists)
  - Whether the second visit is scheduled or unscheduled
  - Whether the first visit relates to the subsequent one

Exceptions

More than one visit can be billed in a day if:

1. The patient returns after the first visit for an unrelated illness/injury that requires additional diagnosis or treatment
2. The patient has a medical visit and a mental health visit on the same day
3. The patient has an Initial Preventive Physical Exam (IPPE) and a separate medical and/or mental health visit on the same day
4. An IOP (Intensive Outpatient) service and medical visit on the same day

Returned to RHC - Same Day Example

Charges/Modifiers

- Office visit for medical service reported with 99213 CG - $150
- Laceration repair (second visit for unrelated DX) reported with 12011-59 - $200

Roll Up

- Do NOT roll up 59 modifier line into the CG line
  - If “incident to” charges, roll up to the appropriate visit line (either CG or 59)

Payment

- Two AIRs will be reimbursed
- Coinsurance/deductible assessed to both line items

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	0521	OV ESTABLISHED LEVEL 3	99213CG	010125	1	150 00
2	0521	SIMPLE REPAIR FACE	1201159	010125	1	200 00
3						
4						

Modifier 25 & 59

Modifiers 25 & 59 should not be reported UNLESS there is a subsequent visit that qualifies as a separate payment per CMS guidelines

Correct

- One AIR Reimbursed

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
0521	DESTRUCT LESION, FIRST	17000CG	013125	1	250 00
0521	DESTRUCT LESION, 2ND-14TH	17110	013125	1	100 00

Incorrect:

- TWO AIRs Reimbursed
- Considered a Medicare Overpayment

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
0521	DESTRUCT LESION, FIRST	17000CG	013125	1	250 00
0521	DESTRUCT LESION, 2ND-14TH	1711059	013125	1	100 00

Mental Health & Acute Visit - Same Day

Charges/Modifiers:

- Medical service visit, CPT 99213 CG - $150
  - Incident to charge, CPT 93415 - $25
- Mental Health visit, CPT 90834 CG - $200

Roll Up

- Do NOT roll up either CG line
  - If “incident to” charges performed, roll up to appropriate qualifying visit line

Payment

- Two AIRs will be reimbursed
- Coinsurance/deductible assessed to both line items

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
0521	OV ESTABLISHED LEVEL 3	99213CG	010125	1	175 00
0300	VENIPUNCTURE	36415	010125	1	25 00
0900	IND PSYCHOTHERAPY 45 MIN	90834CG	010125	1	200 00

Three Visits - Same Day

Charges/Modifiers

- Medical visit, CPT 99213 CG - $150
- Mental Health visit, CPT 90834 CG - $200
- IPPE, HCPCS G0402 - $200
  - CG Not required for IPPE

Roll Up

- **Do NOT roll up IPPE or either CG line**
  - If “incident to” charges performed, roll up to appropriate qualifying visit line

Payment

- **Three** AIRs will be reimbursed
- Coinsurance/deductible
  - Assessed to Mental Health and Medical Visit
  - Waived for IPPE

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	0521	OV ESTABLISHED LEVEL 3	99213CG	010125	1	150 00
2	0900	IND PSYCHOTHERAPY 45 MIN	90834CG	010125	1	200 00
3	0521	IPPE	G0402	010125	1	200 00