



RHC UPDATES 2023

APRIL 26, 2023

MICHIGAN RURAL HEALTH ASSOCIATION

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PRESENTATION OBJECTIVES

- ✓ Telehealth Status – Public Health Emergency
- ✓ Behavioral Health Provider Definition
- ✓ G2025 Utilization
- ✓ Care Management Services – G-CODE Payment Amounts
- ✓ LCSW/LPC/MFH Status



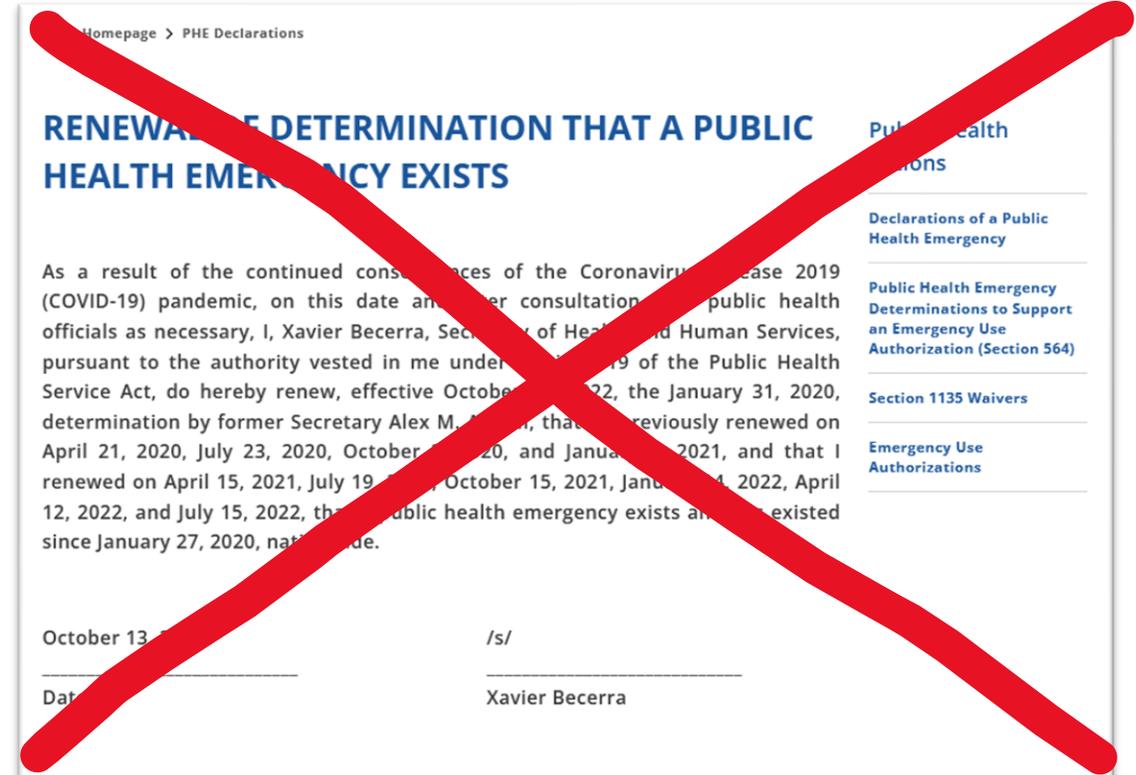


PHE TERMINATION: MAY 11, 2023

G2025 EXTENSION

PUBLIC HEALTH EMERGENCY ENDS MAY 11, 2023!

“Based on current COVID-19 trends, the Department of Health and Human Services (HHS) is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, *to expire at the end of the day on May 11, 2023.*”



COVID FLEXIBILITIES ISSUED IN 2020

Medicare Telehealth Services

Eligible Providers

Hospitals, Psychiatric Hospitals, and
Critical Access Hospitals (CAHs)

Long-Term Care Facilities

Rural Health Clinic/FQHC



12/01/2020

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. **These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS's regional offices.**



CMS UPDATED BLANKET WAIVERS UPDATED 4.20.2023

CMS updated all of the blanket waivers on 4.20.2023. Please see the link above. The RHC Impact is on:

- ✓ Telehealth Flexibility
- ✓ Certain Staffing Requirements
- ✓ Physician Supervision Requirements
- ✓ Temporary Expansion Locations

G2025 HAS BEEN EXTENDED TO 12.31.2024

- All Telehealth waivers have been extended to December 31, 2024.
- G2025 is continued for clinical visits.
- Telephone-only visits are included.



RHC TELEHEALTH CLINICAL SERVICE:

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025	08/21/2023	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.



FQHC TELEHEALTH CLINICAL SERVICES:

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	FQHC Distant Site	G202595	7/1/2023	1	\$94.00
0001	Total Charges				\$94.00

Beginning February 23, 2021:

- ✓ FQHCs should no longer report the FQHC Payment Code for Telehealth Services.
- ✓ CS is ONLY for COVID related services.
- ✓ Modifier-95 is optional but recommended.
- ✓ These claims will be paid at the lesser of the charge amount or \$99.45.
- ✓ Medicare WILL apply cost-sharing (co-insurance) to Telehealth services.



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.



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.”



G-CODE PAYMENT RATES 2023

CMS RHC Payment rates for 2023:

Care Management:

G0511: \$77.94

G0512: \$147.07

Telehealth Visits (non-mental health):

G2025: \$98.25

Virtual Care Communication:

G0071: \$23.72



PROVIDERS MAY WAIVE CO-INSURANCE AT THEIR DISCRETION: **EXPIRED!**

In response to the unique circumstances resulting from the outbreak of 2019 novel coronavirus (COVID-19), the HHS Office of Inspector General (OIG) provided flexibility for healthcare providers to reduce or waive beneficiary cost-sharing for telehealth visits paid for by Federal health care programs through a policy statement issued on March 17, 2020.

Ordinarily, if physicians or practitioners routinely reduce or waive costs owed by Federal health care program beneficiaries, including cost-sharing amounts such as copayments, coinsurance and deductibles, they would potentially implicate the Federal anti-kickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries.

The policy statement notified providers that OIG will not enforce these statutes if providers choose to reduce or waive cost sharing for telehealth visits during the COVID-19 public health emergency, which the HHS Secretary determined exists and has existed since January 27, 2020.

[HHS Office of Inspector General Fact Sheet – March 2020](#)



MAJOR LEGISLATIVE/POLICY CHANGES





RHC ENCOUNTER CHANGES

VIRTUAL BEHAVIORAL HEALTH = RHC ENCOUNTER

**PAYMENT FOR
RURAL HEALTH
CLINIC AND
FEDERALLY
QUALIFIED
HEALTH CENTER
SERVICES (§§
405.2460 -
405.2472)**

§ 405.2460 Applicability of general payment exclusions.

§ 405.2462 Payment for RHC and FQHC services.

§ 405.2463 What constitutes a visit.

§ 405.2464 Payment rate.

§ 405.2466 Annual reconciliation.

§ 405.2467 Requirements of the FQHC PPS.

§ 405.2468 Allowable costs.

§ 405.2469 FQHC supplemental payments.

§ 405.2470 Reports and maintenance of records.

§ 405.2472 Beneficiary appeals.

Source: 57 FR 24976, 24977, June 12, 1992, unless otherwise noted.



§ 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.

[CMS Rural Health Clinic Center](#)

IN-PERSON VISITS - DELAYED

“Section 4113 of the CAA, 2023 delayed the in-person requirements under Medicare for mental health services furnished through telehealth under the PFS and for mental health visits furnished by RHCs via telecommunications technology. **For RHCs, in-person visits will not be required until January 1, 2025,** if the PHE ends prior to that date.”

[CMS Rural Health Clinic Center](#)

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.”

[CMS Rural Health Clinic Center](#)

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



EXPANDED RHC PROVIDERS

LPC/LMFT EXPANSION

EXPANDED BEHAVIORAL HEALTH PROVIDERS: 2023 CMS FINAL RULE

Therefore, CMS is finalizing the proposal to add an exception to the direct supervision requirement under our “incident to” regulation at 42 CFR 410.26 to **allow behavioral health services to be provided under the general supervision** of a physician or non-physician practitioner (NPP), rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel, such as LPCs and LMFTs, incident to the services of a physician (or NPP).

CONSOLIDATED APPROPRIATIONS ACT 2023 H.R.2617

(MARRIAGE AND FAMILY THERAPIST SERVICES; MARRIAGE AND FAMILY THERAPIST; MENTAL HEALTH COUNSELOR SERVICES, MENTAL HEALTH COUNSELOR —The term ‘marriage and family therapist services’ means services furnished by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the marriage and family therapist is legally authorized to perform under State law of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service.



MEDICARE RHC -FQHC PROVIDERS 2023 (CMS FINAL RULE FY2023)

Medicare RHC -FQHC Providers 2023	
Physician	Podiatrist
Physician assistant	Psychologist
Advanced practice registered nurse (SA – Only if employed by clinic/group)	Optometrist
Clinical Psychologist	General Supervision:
Clinical Social Worker (AJ)	Licensed clinical addiction counselors
Dentist	Licensed marriage and family therapists
Chiropractor	Licensed mental health counselors



MEDICARE RHC -FQHC PROVIDERS 2024 (H.R. 2617)

Medicare RHC -FQHC Providers 2024	
Physician	Podiatrist
Physician assistant	Psychologist
Advanced practice registered nurse (SA – Only if employed by clinic/group)	Optometrist
Clinical Psychologist	Approved RHC Providers 2024:
Clinical Social Worker (AJ)	Licensed clinical addiction counselors
Dentist	Licensed marriage and family therapists
Chiropractor	Licensed mental health counselors





CARE MANAGEMENT SERVICES 2023

CARE/PRINCIPLE CARE MANAGEMENT 2023



CARE MANAGEMENT SERVICES EXPANDED

Chronic Care Management (CCM)

General Behavioral Health Integration (BHI)

Principal Care Management (PCM)

Psychiatric Collaborative Care Model (CoCM)

Virtual Care Management

Transitional Care Management and CCM

G0511: GENERAL CARE MANAGEMENT SERVICES

G0511: General Care Management Services

- ✓ billed alone or with other payable services on a RHC or FQHC claim.
- ✓ This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.
- ✓ Payment for G0511 is set at the average of the 3 national non-facility PFS payment rates for the CCM (CPT code 99490 and CPT code 99487) and general BHI (CPT code 99484).
- ✓ *The current 2023 payment rate is \$\$77.94.*
- ✓ The rate is updated annually based on the PFS amounts and coinsurance applies.

G0511 BILLING REQUIREMENTS

Initiating Visit: An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred **no more than one-year** prior to commencing care coordination services. This would be billed as an RHC or FQHC visit.

Billing Requirements: At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the RHC or FQHC physician, NP, PA, or CNM, and b) by an RHC or FQHC practitioner, or by clinical personnel under general supervision.

G0511 PATIENT ELIGIBILITY

Option A: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, OR

Option B: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.



G0511: OPTION B SERVICE REQUIREMENTS

For patients meeting the eligibility requirements of Option B, the RHC or FQHC must meet all of the following requirements:

- ✓ Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
- ✓ Behavioral health care planning in relation to behavioral/psychiatric health problems.
- ✓ including revision for patients who are not progressing or whose status changes.
- ✓ Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation).
- ✓ Continuity of care with a designated member of the care team.

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 2023 rate for G0512 is \$146.73.**

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.

VIRTUAL COMMUNICATION SERVICES (G0071)

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.



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 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.



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	4/2/2023	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.



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.



HOSPICE, AND RHC RATES POST-MODERNIZATION ACT

FINAL NOTES



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 Level IV	99214CG GV	04/02/2023	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.

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.

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.

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

CMS Rural Health Center:

<https://www.cms.gov/center/provider-type/rural-health-clinics-center>

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>

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