2022 Annual Rural Health Clinic Conference

Rural Health Clinic Compliance & Billing Update

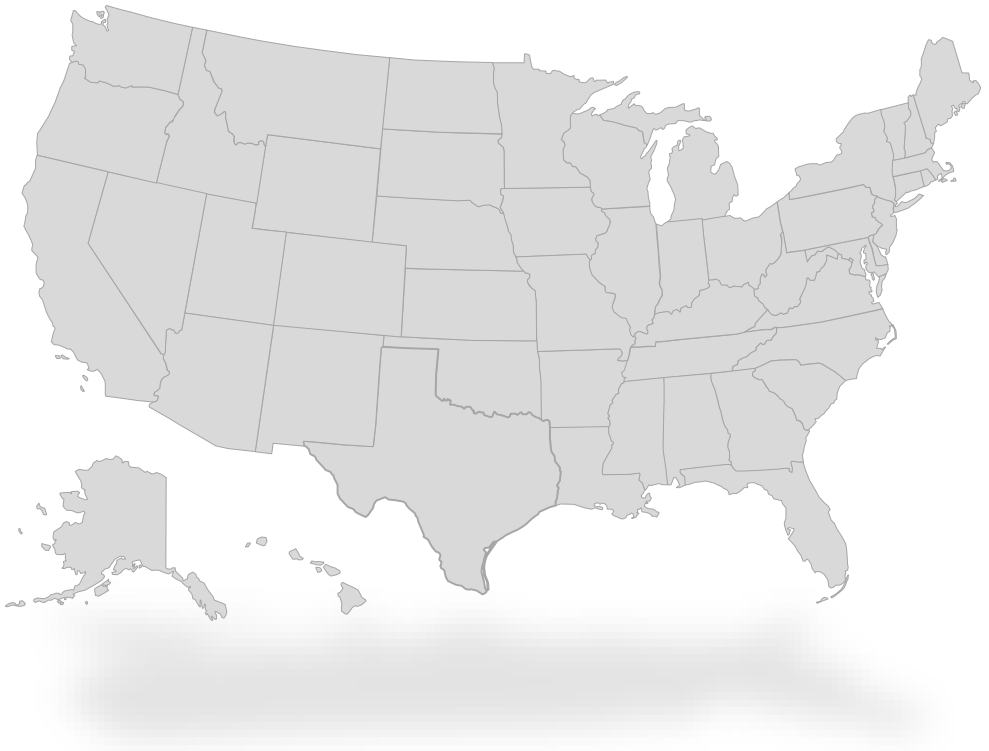
Patty Harper, RHIA, CHC

October 27, 2022

inQuiseek Consulting

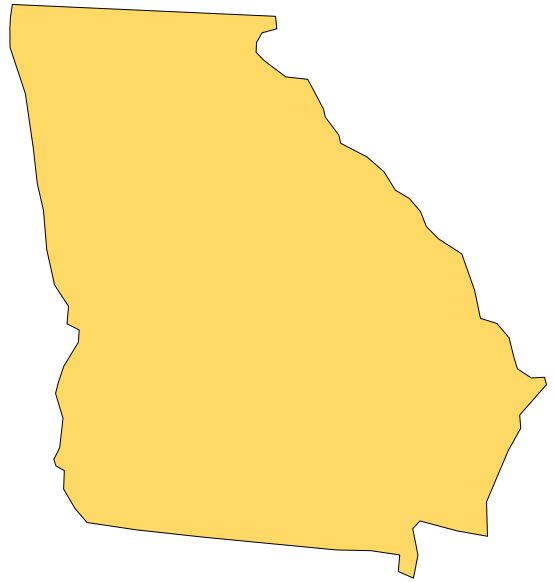
How Many RHCs Are There Now?

- As of 10/26/2022, there are has 5,178 RHC listed in QCOR.
- Net increase in Total RHCs since 2020 = 373
- During Covid
- Since the RHC Modernization Act



How Many RHCs Does Georgia Have Now?

- As of 10/26/2022, Georgia has 101 RHC listed in QCOR.
- Net increase in Georgia RHCs since 2020 = 5
- Following national growth pattern but still fewer RHCs than comparable states due to Medicaid policy and scope of practice limitations.



What is ahead for RHCs?

Compass or Crystal Ball?

COVID-19 PHE Extended into January 2023

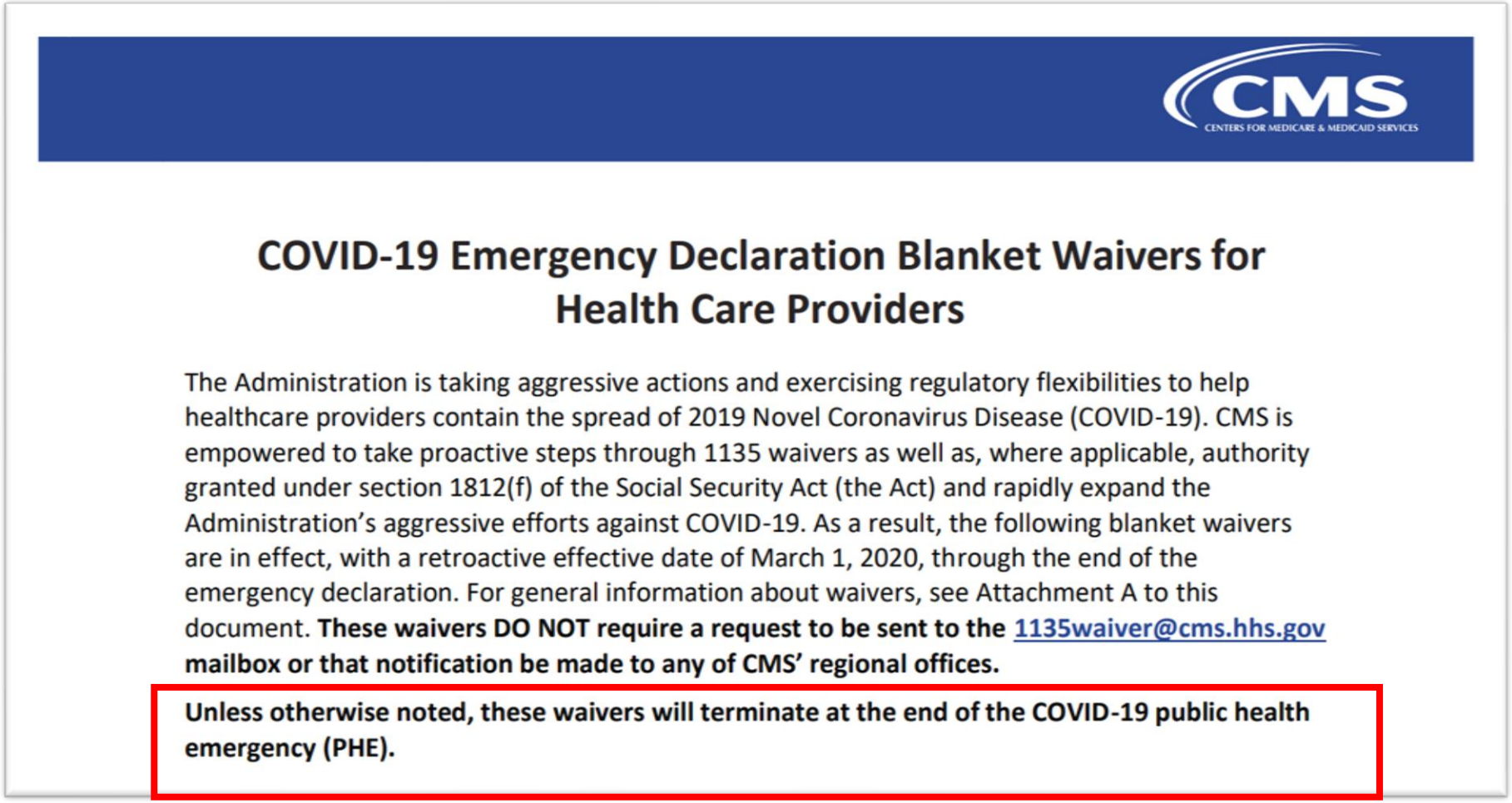
Title	Disaster Type	State/ Territory	Signed Date
Renewal of Determination that a Public Health Emergency Exists As a Result of the Countinued Consequences of the Coronavirus Disease 2019 (COVID-19) Pandemic	COVID-19	National	October 13, 2022

What will happen when the PHE ends?

- The blanket waivers will end or be phased out.
- Telehealth may be extended in some way through 2024. More clarification is need for Rural Health Clinics.
- The COVID Vaccine Mandate will still be in effect. Masking depends on future federal guidance, your state requirements AND your own accommodation and mitigation policies.
- Emergency Preparedness Risk Assessments will still need to include Emerging Infectious Disease and your EPP will need a continuing activation plan. Example: Monkey Pox.

CMS Roadmap for ending PHE

https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The 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' regional offices.**

Unless otherwise noted, these waivers will terminate at the end of the COVID-19 public health emergency (PHE).

RHC Blanket Waivers: Staffing Requirements

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Certain staffing requirements***:* CMS has been waiving the requirement in the second sentence of 42 CFR §491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50% of the time the RHC and FQHC operates. CMS is not waiving the first sentence of §491.8(a)(6), which requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE. CMS is exploring options to make this flexibility permanent.

This waiver will end when the PHE ends.

Blanket Waiver: PA/NP Staffing

- An RHC must staff the RHC with an PA or NP **at least 50%** of the posted patient care hours.
- During COVID-19 this was waived to allow for providers who were infected or for staffing shortages. Now is the time to remedy staffing shortages or provider mix issues.
- At least one PA or NP must be a direct W-2 employee of the legal entity that owns the rural health clinic. Be careful with management agreements or 3rd party payroll agreements.
- Other PAs or NPs can be 1099 contractors but at least one must be a W-2 employee.

Physician Supervision Blanket Waiver

- Physician Supervision of NPs in RHCs and FQHCs. 42 CFR 491.8(b)(1). We are modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

This flexibility is currently set to return to pre-PHE rules at the end of the calendar year that the PHE ends. CMS is exploring options to make this flexibility permanent.

All RHCs must have a Medical Director

- There must be a physician who is responsible for the medical direction of the clinic. This is a condition for certification in 42 CFR 491.8(b).

Physician responsibilities. The physician performs the following:

(1) Except for services furnished by a clinical psychologist in an FQHC, which State law permits to be provided without physician supervision, provides medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff.

(2) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the clinic's or center's written policies and the services provided to Federal program patients.

(3) Periodically reviews the clinic's or center's patient records, provides medical orders, and provides medical care services to the patients of the clinic or center.

- This is a federal requirement. Even if a state has independent PA/NP practice, an RHC must have a medical director who can fulfil 491.8(b).
- The stricter of federal or state scope of practice regulations prevail. A collaborative or supervising physician is a state licensing requirement.

Expansion Locations END when the PHE ENDS

Temporary Expansion Locations. CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii), which require RHCs and FQHCs to be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement, removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand service locations to meet the needs of Medicare beneficiaries. This flexibility includes areas that may be outside of the location requirements 42 CFR §491.5(a)(1) and (2), but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

Each RHC location must be uniquely certified when the PHE ends. These is no phasing out of satellite locations which have been used during the PHE. If you have been performing services at a location which does not have RHC certification, services at that location will have to cease.

Telehealth Flexibilities and the 151-day period

What is being phased out?

At the end of the 151-day waiting period identified by the Consolidated Appropriations Act, 2022 (PDF) the following policies are set to end:

- Increased flexibility regarding where the patient receives Medicare telehealth services, as well as where the services originate will revert back to match the restrictions that were in place prior to the COVID-19 public health emergency.
- Medicare reimbursement for mental health telehealth services will again require an in-person visit within 6 months of initial assessment and every 12 months following.
- Medicare reimbursement for telehealth visits furnished by physical therapists, occupational therapists, speech language pathologists, and audiologists will no longer be allowed.
- Medicare will no longer cover audio-only visits for physical health encounters.
- FQHCs and RHCs will no longer be able to be reimbursed as distant site telehealth providers for non-mental health services.

https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/policy-changes-after-the-covid-19-public-health-emergency/#what-is-being-phased-out

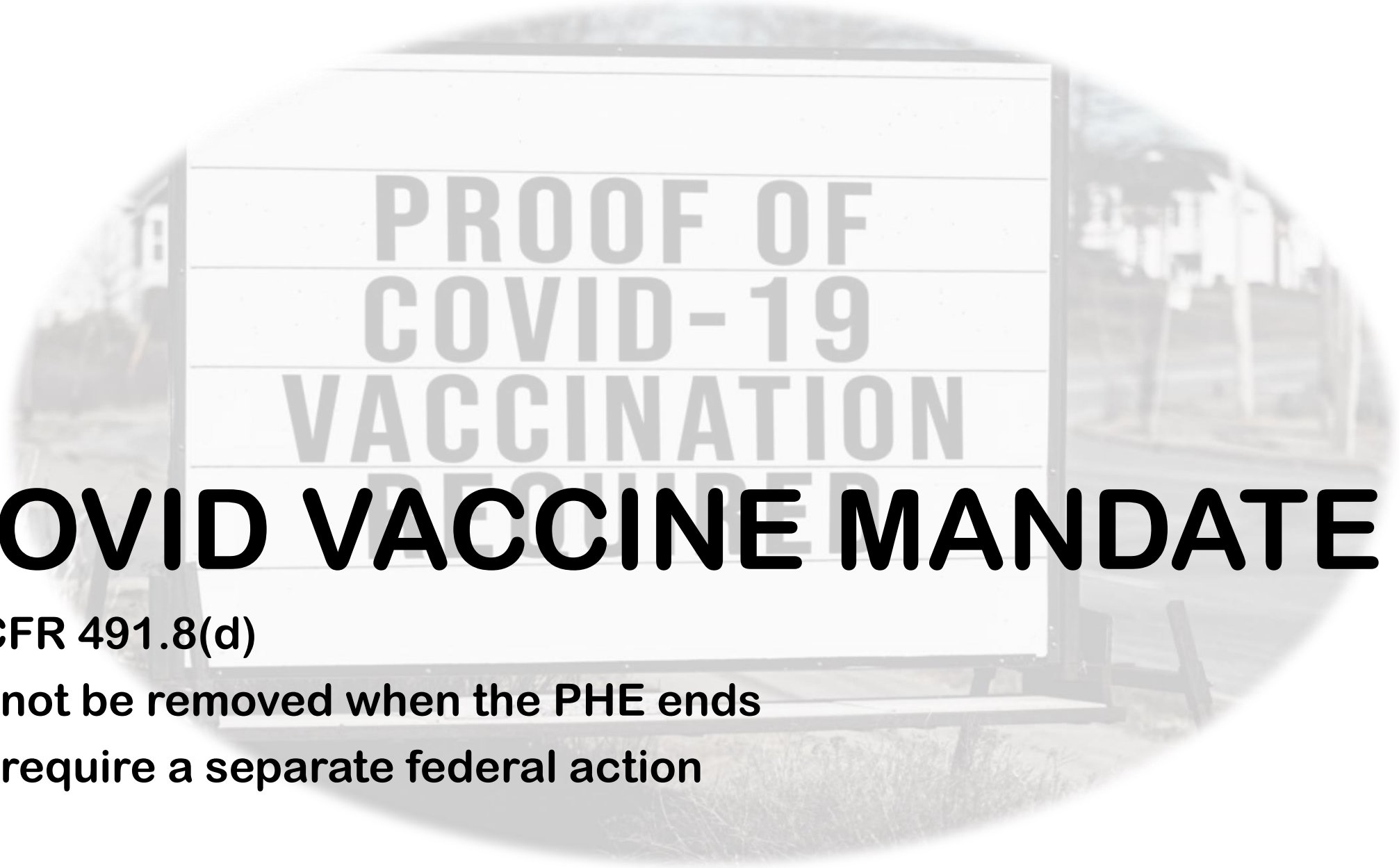
H.R. 4040 (has passed the House)
Advancing Telehealth Beyond COVID–19 Act of 2021

Specifically, the bill provides that certain flexibilities continue to apply until December 31, 2024, if the emergency period ends before that date. The bill allows

- beneficiaries to continue to receive telehealth services at any site, regardless of type or location (e.g., the beneficiary's home);
- occupational therapists, physical therapists, speech-language pathologists, and audiologists to continue to furnish telehealth services;
- federally qualified health centers and rural health clinics to continue to serve as the distant site (i.e., the location of the health care practitioner);
- evaluation and management and behavioral health services to continue to be provided via audio-only technology; and
- hospice physicians and nurse practitioners to continue to complete certain requirements relating to patient recertifications via telehealth.
- The bill also delays implementation of certain in-person evaluation requirements for mental health telehealth services until January 1, 2025, or the first day after the end of the emergency period, whichever is later.

RHC Telehealth Unknowns

- If extended, will be still only have G2025 as a billable code.
- What will the reimbursement be moving forward?
- Will we see the definition of a medical encounter change to include telehealth? If so, how? When?
- Will HR 4040, if approved by the Senate, still phase out audio-only services?
- What administration guidance will CMS issue in respect to the legislation? How will that guidance apply to RHCs?



COVID VACCINE MANDATE

42 CFR 491.8(d)

Will not be removed when the PHE ends

Will require a separate federal action

COVID-19 Vaccination Audit Validation

- CMS has contracted auditors in the field NOW validating compliance with the COVID-19 Vaccination Mandate for all certified facility types including RHCs.
- Auditors will look for 100% compliance. Evidence will be needed to support vaccine mandate policies & procedures, recordkeeping, education, employee accommodation and contingency plans.
- All employees must be fully vaccinated ten days prior to beginning work OR have an approved medical or religious exemption prior to beginning work. There are no phase in periods now for any state.
- The decision to continue masking and maintaining other mitigation efforts will vary from state to state and facility to facility.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-22-11-ALL

DATE: **January 20, 2022**

TO: State Survey Agency Directors

FROM: Directors
Quality, Safety & Oversight Group (QSOG) and Surv
Group (SOG)

SUBJECT: Guidance for the Interim Final Rule - Medicare and M
COVID-19 Health Care Staff Vaccination

Rural Health Clinic/Federally Qualified Health Clinic (RHC/FQHC) Attachment
QSO-22-07-ALL

This attachment is a supplement to and should be used in conjunction with QSO 22-07-ALL memorandum: Guidance for the Interim Final Rule – Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination.

The regulations and guidance described in this attachment do not apply to the following states at this time: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming. **Surveyors in these states should not undertake any efforts to implement or enforce the regulation.**

J-0110
§ 491.8 Staffing and staff responsibilities.

(d) *COVID-19 vaccination of staff*. The RHC/FQHC must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For

Vaccine Mandate Requirements

- 100% RHC Compliance with Mandate: Vaccinated Staff + Those with Granted Exemptions (Medical or Religious)
- Written Policies on How the RHC will Comply with the Mandate
  - Education and Vaccine Availability
  - Record-Keeping of Vaccine & Booster Status
  - Exemption Approval Processes
  - Employee Accommodation- How will you keep the unvaccinated employees protected and how will you keep patients protected from unvaccinated staff.
  - COVID Contingency Plan
  - Increased Infection Control and Mitigation Plan
- Emerging Infectious Disease in your EPP

Emergency Preparedness

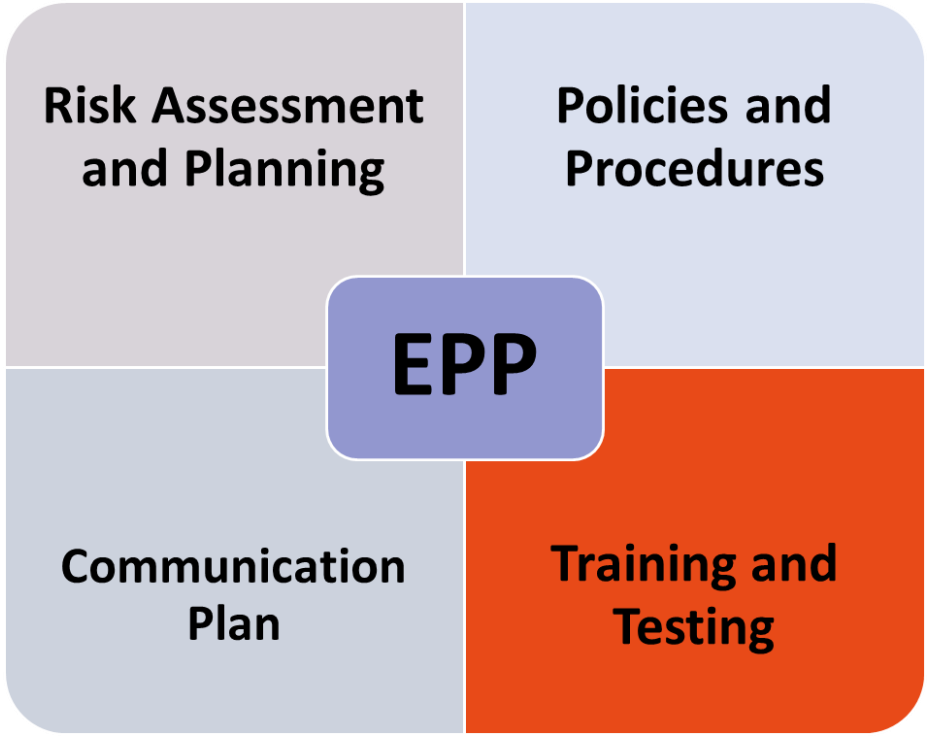
42 CFR 491.12

Frequency of Testing/Activation Exemption

Emerging Infectious Disease (EID)

§ 491.12 Emergency preparedness.

The Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) must comply with all applicable Federal, State, and local emergency preparedness requirements. The RHC/FQHC must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:



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Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-41-ALL
REVISED 06.21.2021
REVISED 05.26.2022

DATE: **September 28, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance related to Emergency Preparedness- Exercise Exemption based on A Facility's Activation of their Emergency Plan

For providers of outpatient services: These providers must continue to test their program annually, by participating in a community-based full-scale exercise (if available) or conduct an individual facility-based functional exercise every other year. In the opposite years off the full- scale exercise, the providers are required to conduct a testing exercise of their choice, which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a table-top exercise or workshop that includes a group discussion led by a facilitator.

Outpatient providers and suppliers include: Ambulatory Surgical Centers (ASCs), freestanding/home-based hospice, Program for the All-Inclusive Care for the Elderly (PACE), Home Health Agencies (HHAs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Organizations (which include Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services), Community Mental Health Clinics (CMHCs), Organ Procurement Organizations (OPOs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and End-Stage Renal Disease (ESRD) facilities.

Exemption Based on Actual Natural or Man-made Emergency

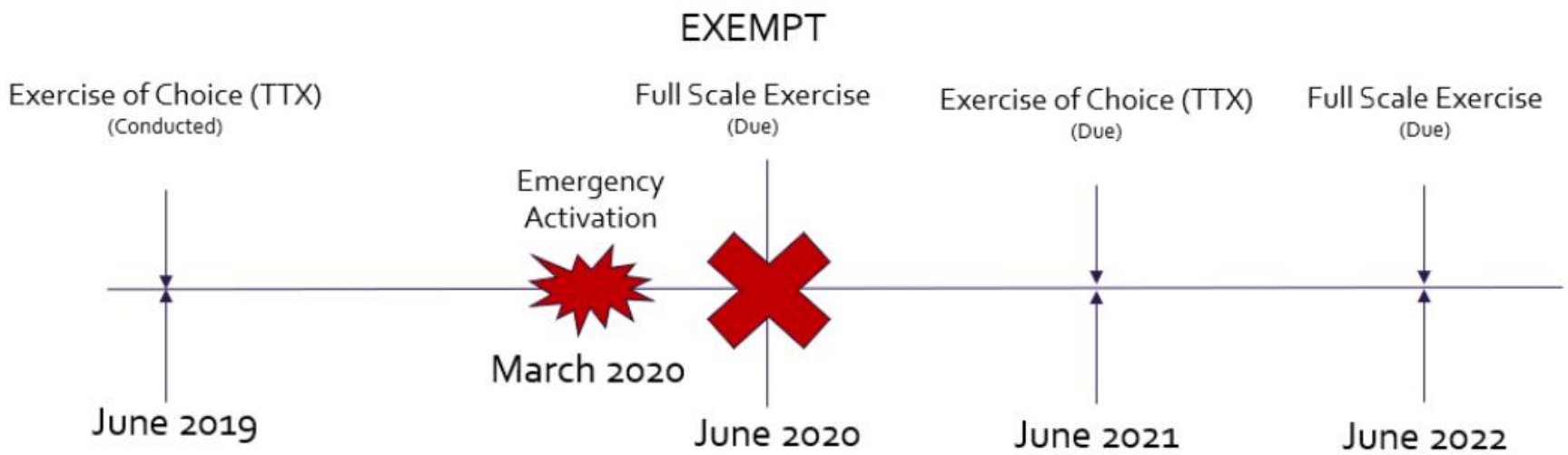
The emergency preparedness regulations allow an exemption for providers or suppliers that experience a natural or man-made event requiring activation of their emergency plan. On Friday, March 13, 2020, the President declared a national emergency due to COVID-19 and subsequently many providers and suppliers have activated their emergency plans in order to address surge and coordinate response activities. **Facilities that activate their emergency plans are exempt from the next required full-scale community-based or individual, facility-based functional exercise.** Facilities must be able to demonstrate, through written documentation, that they activated their program due to the emergency.

For Outpatient Providers: *If the facility claimed the full-scale exercise exemption in 2020 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2022, unless it has reactivated its emergency plan for an actual emergency during its 12-month cycle for 2022. If the facility claimed the full-scale exercise exemption in 2021 based on its activated emergency plan for COVID-19 response and has since resumed normal operating status, the outpatient provider/supplier is expected to complete its required full-scale exercise in 2024.*

Scenario #3. Facility Z conducted a table-top exercise in June 2019 (based on its annual cycle). It is scheduled to conduct a full-scale exercise in June 2020. In March 2020, Facility Z activates its emergency preparedness program due to the COVID-19 PHE.

When must the facility conduct its next required full-scale exercise? What is the exemption based on the requirements?

Answer: The facility is exempt from the June 2020 scheduled full-scale exercise for that "annual year" and is required to complete an exercise of choice in June 2021, and a following full-scale exercise in June 2022. It is exempt from its **next required** full-scale or individual facility-based exercise which would have been in June 2020.



An emergency and exemption is good for a 12-month cycle only.

- You must reactivate the activation if it lasts more than 12 months
- You must document that the response was reactivated.
- End the first activation.
  - Hot Wash
  - After Action Report
  - Training and Education Records
  - Revise Activation Plan Based on Lessons Learned

- Activate new emergency response for continuing situation
- For COVID-19 Activation to fully count as an exemption, it would need to be reactivated after 12 months.

COVID-19 EMERGENCY ACTIVATION PLAN AND RECORD OF DOCUMENTED RESPONSE*

RHC NAME: _____

Located in the County and State _____

Date Emergency Plan Activated: _____ Date Activation Concluded: _____

Emergence of the Pandemic

Emerging Infectious Disease

Emerging Infectious Diseases (EIDs)

As facilities develop or make revisions to their emergency preparedness plans, EID's are a potential threat which can impact the operations and continuity of care within a healthcare setting and should be considered. The type of infectious diseases to consider or the care-related emergencies that are a result of infectious diseases are not specified. Adding EID's within a facility's risk assessment ensures that facilities consider having infection prevention personnel involved in the planning, development and revisions to the emergency preparedness program, as these individuals would likely be coordinating activities within the facility during a potential surge of patients.

Some examples of EID's may include, but are not limited to:

- *Potentially infectious Bio-Hazardous Waste*
- *Bioterrorism*
- *Pandemic Flu*
- *Highly Communicable Diseases (such as Ebola, Zika Virus, SARS, or novel COVID-19 or SARS-CoV-2)*

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-21-15-ALL

DATE: **March 26, 2021**

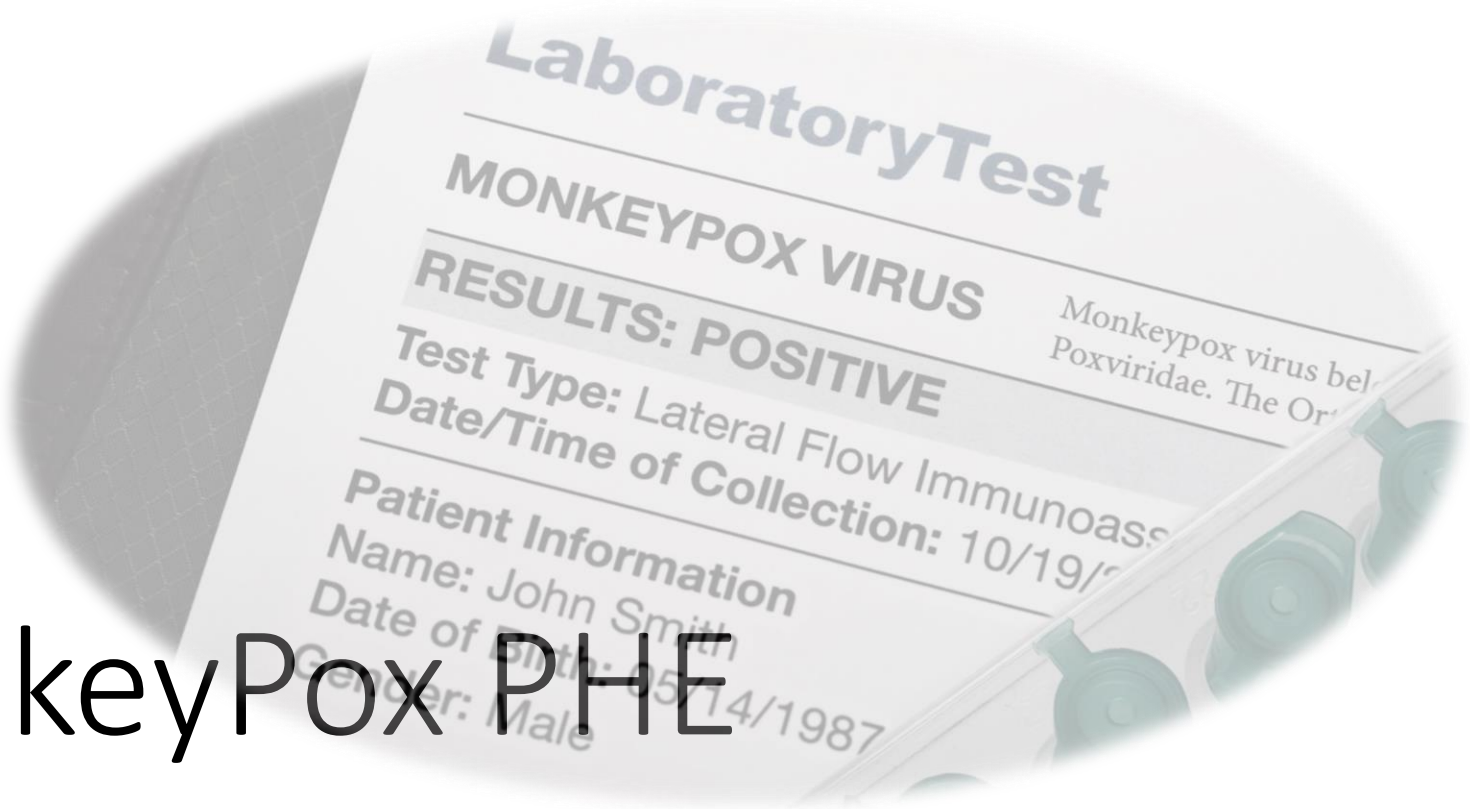
TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual (SOM)

What needs to Change in your EPP?

- Read the QSO-21-15-ALL and Appendix Z. Appendix Z applies to all 17 facility types. What your hospital is required to do may not apply to your RHC.
- Change pandemic, epidemic or community-wide disease references to the updated language of "emerging infectious disease."
- Include EID in your All Hazard Risk Assessment
- Include these elements in your activation plan for EID:
  - Staffing and Surges; Relocation of Providers
  - PPE, Infection Control, Disease Mitigation
  - Alternative Site for Services
  - How to Implement Changes in Provision of Services
  - Community Response
  - Design Plan Based on Lessons Learned during the COVID-19 PHE



MonkeyPox PHE

AUGUST 2022

N0 BLANKET WAIVERS ISSUED YET

SHOULD BE IN YOUR EID

DETERMINATION THAT A PUBLIC HEALTH EMERGENCY EXISTS

As a result of the consequences of an outbreak of monkeypox cases across multiple states, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby determine that a public health emergency exists nationwide.

August 4, 2022 /s/

Who Has Been Minding the Store?

Top Deficiencies

Picking Up the Pieces

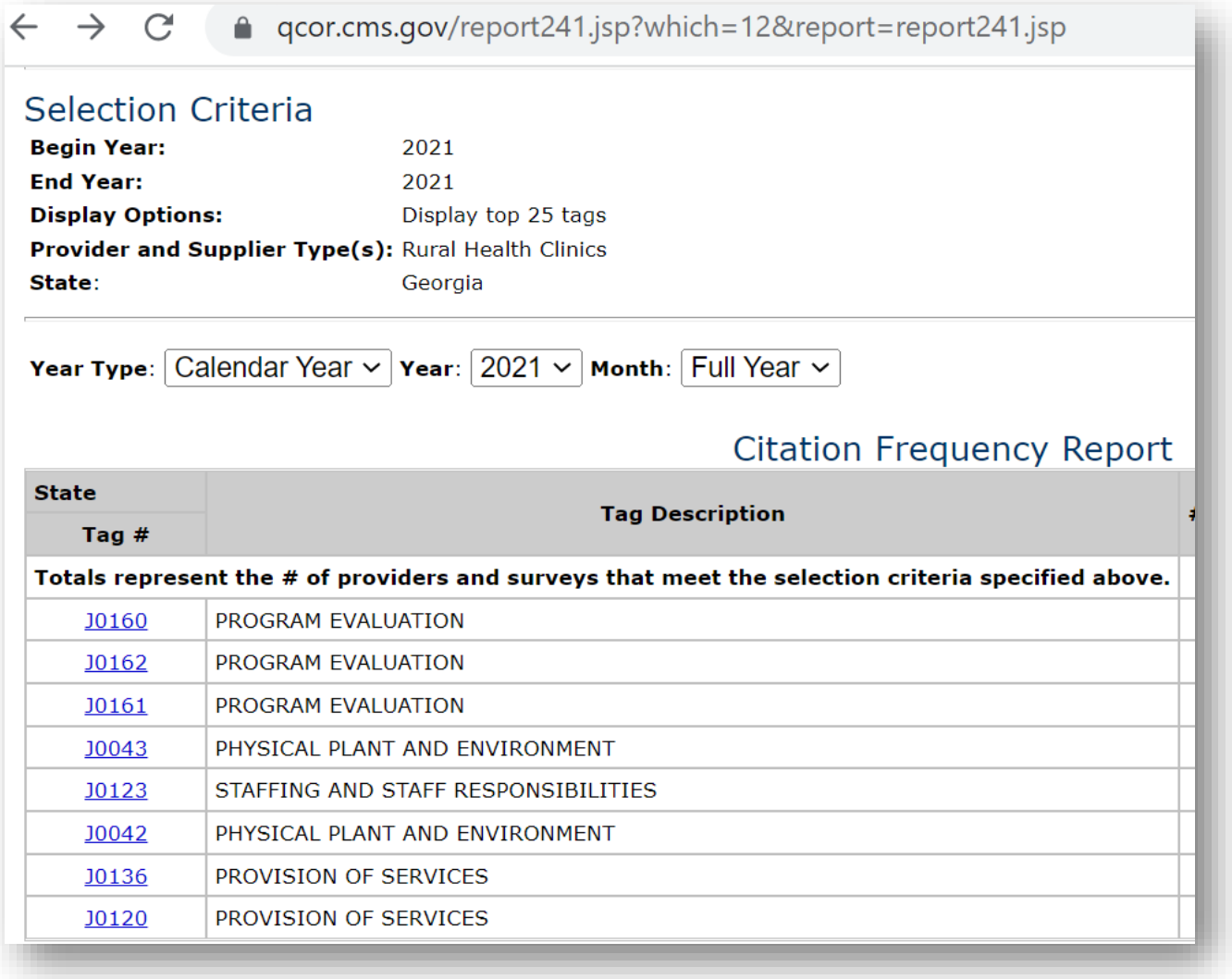
Getting Back on Track with Compliance

Be Proactive on Getting Caught Up

- Do your own mock survey using an audit or survey tool
- Get help from your consultant or your SORH
- Review your Accrediting Organization’s standards
- Refer to State Operations Manual, Appendix G
- Check QCOR for the most common deficiencies in your state

Top RHC Survey Deficiencies

For Georgia in 2021



Qcor.cms.gov

Biennial program evaluation: No evaluation performed; missing components of the evaluation; no documentation that findings were presented, or that corrective actions taken.

Biennial review of policies: No proof of medical director and/or provider review of policies.

Drug Storage and Handling Deficiencies: Expirations,: Inventory Management, and MDV labeling.

No preventive maintenance program for essential equipment. Inspection and tagging of equipment.

Emergency Care: Requirement for Emergency Kit.

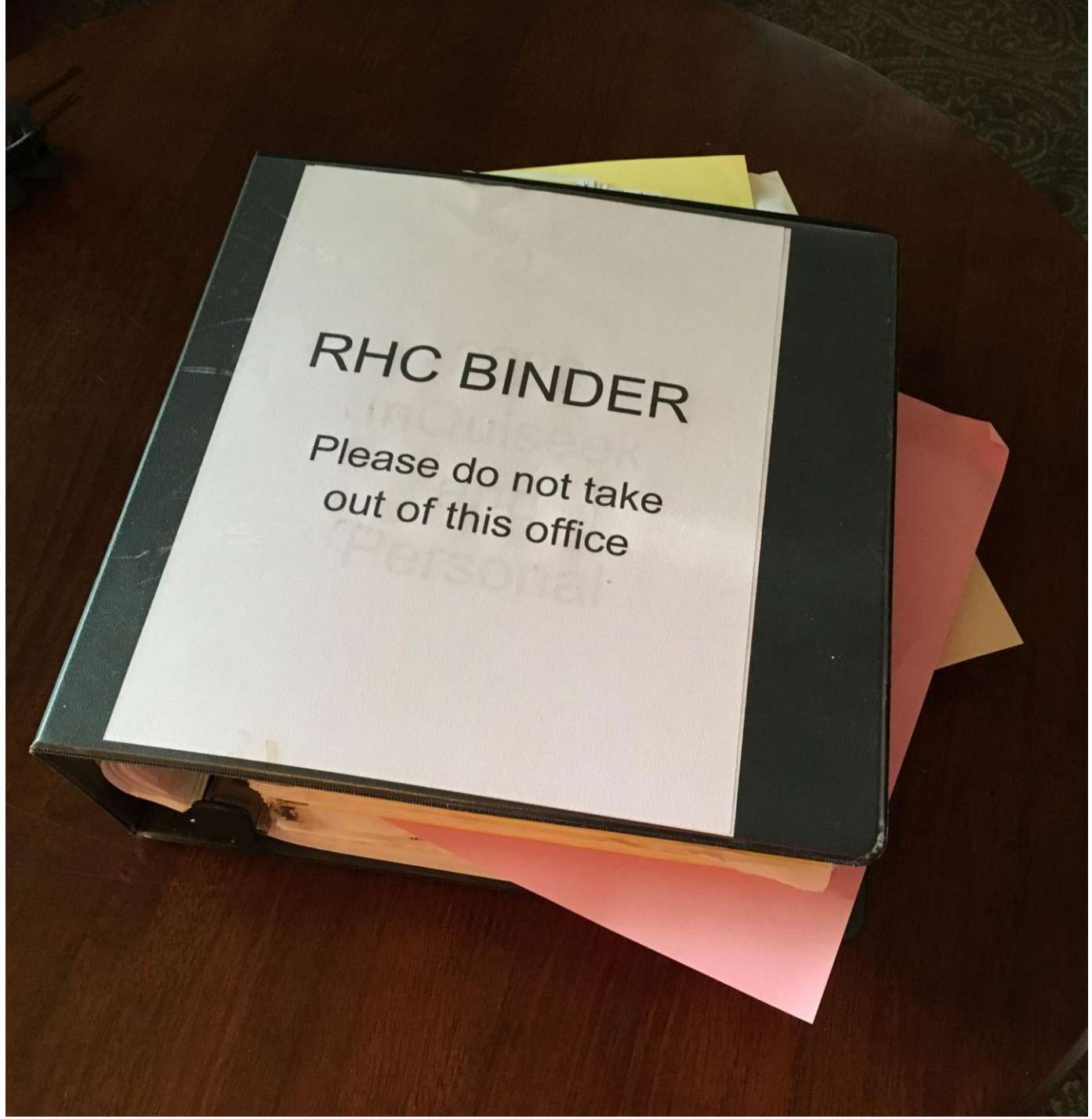
Not Providing Required RHC Services: Not performing required services; performing non-RHC services; no referral of services.

THE COMPLIANCE TEAM SURVEY TOOL
Organized By Standard

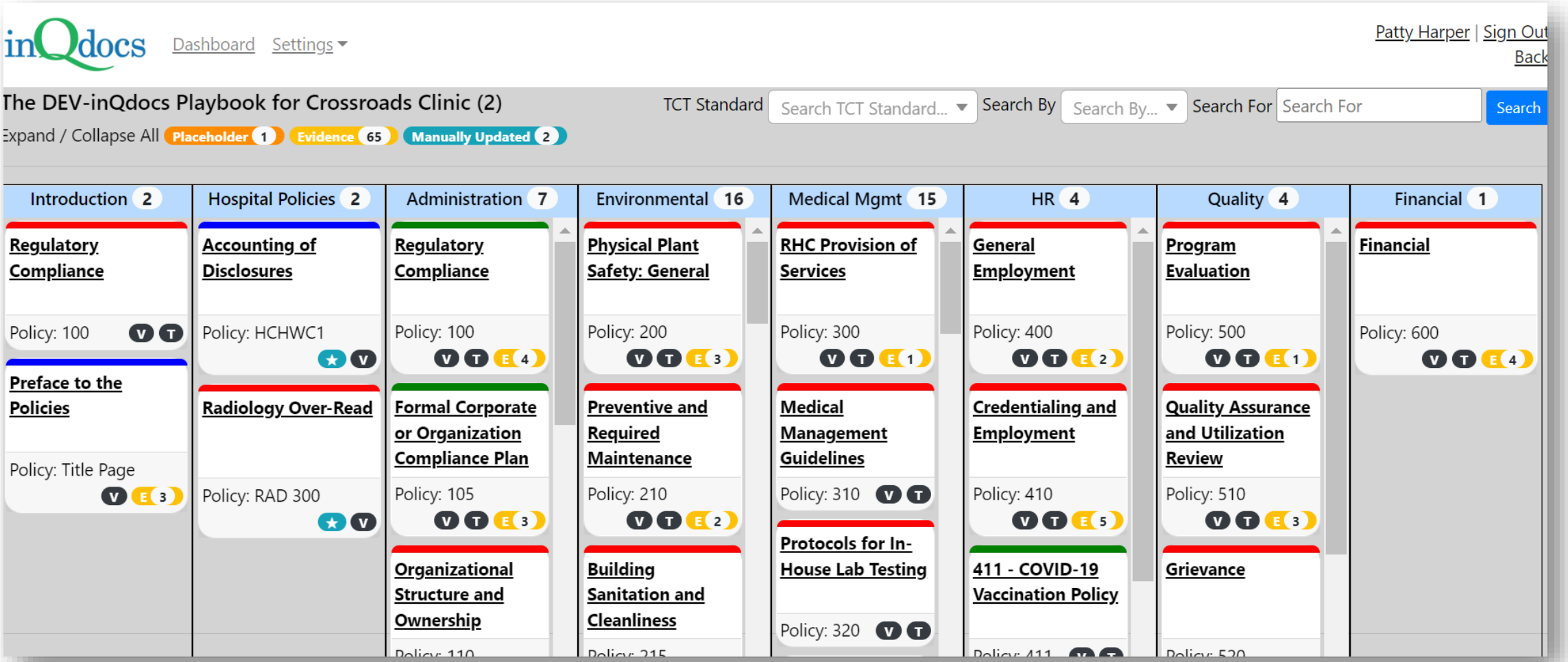
Facility Name/Clinic:	**Surveyor Number(s):**	
	Survey Start Date:	**Survey End Date:**
Total Number of Exam Rooms:	**Time In:** **Time Out:**	**Hours Onsite:**

CORPORATE COMPLIANCE	STANDARD	YES	NO	COMMENTS
The Clinic is in good standing with the Medicare/Medicaid Programs.	COM 2.0			
The clinic that participates in Medicare/Medicaid programs has been free of sanctions for a period of at least 2 years.	COM 2.0.1			
The clinic prohibits employment/contracting with individuals or companies, which have been convicted of a criminal felony offense related to healthcare.	COM 2.0.2			
Clinic can provide evidence of verification of individuals through OIG exclusion database.	COM 2.0.2(a)			
Evidence of the process and documentation upon hire and re-verification at a minimum annually.	COM 2.0.2(b)			
Staff of the clinic are licensed, certified, or registered in accordance with applicable State and local laws. (§491.4(b))	COM 3.0			
The clinic has a process to verify personnel are licensed, certified, or registered with applicable State laws.	COM 3.0.1			
This information is documented and tracked in an organized format.	COM 3.0.2			
ADMINISTRATION	**STANDARD**	**YES**	**NO**	**COMMENTS**
The clinics hours of operation are posted outside the clinic.	ADM 3.0.4			

Review Your Policies and Update Your Evidence Documents


RHC BINDER
Please do not take
out of this office

Review Your Policies and Update your Evidence Documents



RHC Medicare Billing Update

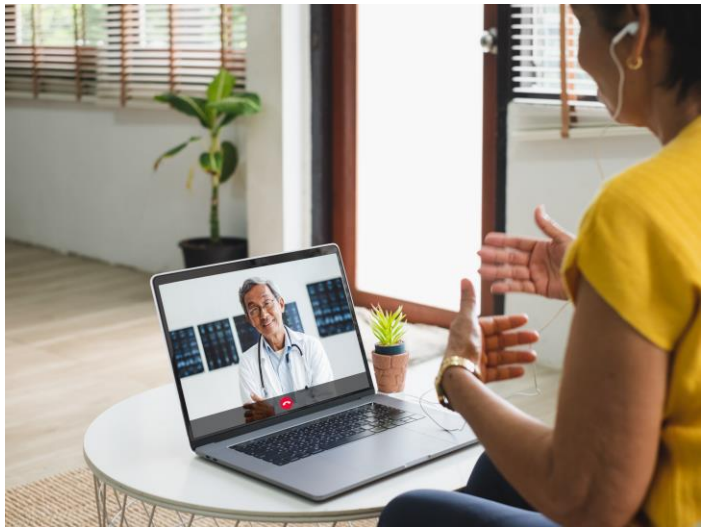
MEDICAL TELEHEALTH

MENTAL HEALTH TELEMEDICINE SERVICES

HOSPICE SERVICES

Telehealth Site Definitions

Originating Site versus Distant Site



Originating Site: This is the location of the patient who is receiving the telehealth service.

Distant Site: This is the location of the healthcare provider who is rendering the telehealth service.

Be very careful when entering into agreements for contracted telehealth. Make sure contract terms align with RHC reimbursement methodology.

Medical Telehealth RHC Encounters during the PHE

SE20016

RHC Distant Site Medical Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	05/15/2022	1	100.00
0001	Total Charge				100.00

Optional

Effective January 1, 2022, the payment rate for distant site medical telehealth services is $97.24. This is a composite fee schedule amount.

Add the -CS Modifier if G2025 is reporting a preventive service that would not be subject to deductible and coinsurance.

No –CG Modifier since this does not reimburse at the AIR. Not an encounter.

New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MLN Matters Number: SE20016 Revised

Related Change Request (CR) Number: N/A

Article Release Date: January 13, 2022

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

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

Table 1. RHC Claims for Telehealth Services from January 27 – June 30, 2020

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

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

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

Mental Health Telemedicine RHC Encounters Now

2022 Mental Health Telehealth Example

These visits are different from telehealth services provided during the Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See MLN Matters Article SE20016 for information on billing G2025 for professional telehealth distant site services other than mental health visits during the PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 Revised on 05/05/2022 : -CG now required
- Is an encounter; pays at the AIR.

2022 Mental Health Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Telehealth	90791 CG and either FQ or 95	05/05.2022	1	100.00
0001	Total Charge				100.00

Mental Health Services

HCPCS Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

- Mental Health Codes on the QVL
- Do NOT use –CG on medical telehealth visits
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001

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Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE22001 Revised
Related Change Request (CR) Number: N/A
Article Release Date: May 5, 2022
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Note: We revised this Article to show that RHCs must include modifier CG on claims for mental health visits via telecommunications. This change is in dark red font on page 2. All other information is the same.

Services to Hospice Patients by RHC Providers

New in 2022!

- The final rule now allows RHC providers who are also the attending hospice physician to bill hospice care as RHC encounters.
- RHC claims will be appended with both the –CG modifier and the new –GV modifier. Appropriate revenue codes are used.
- Non-hospice related services provided by regular RHC practitioners would be billed as they currently are with the 07 condition code and –GW modifier **with a non-hospice diagnosis.**
- Coinsurance and deductible amounts apply.

Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

MLN Matters Number: MM12357 Revised
Related Change Request (CR) Number: 12357
Related CR Release Date: January 12, 2021
Effective Date: January 1, 2022
Related CR Transmittal Number: R11200CP
Implementation Date: January 3, 2022

Note: We revised this Article to reflect a revised CR 12357. The CR revision didn't impact the substance of the Article. We did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected

This MLN Matters Article is for RHCs and FQHCs billing hospice attending physician services to Medicare Administrative Contractors (MACs) on behalf of Medicare patients.

Provider Action Needed

In this Article, you'll learn about:

- When RHCs report the GV modifier
- When FQHCs report the GV modifier

Medicare Part B Premium and Deductible

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A.

Each year the Medicare Part B premium, deductible, and coinsurance rates are determined according to the Social Security Act. The standard monthly premium for Medicare Part B enrollees will be $164.90 for 2023, a decrease of $5.20 from $170.10 in 2022. The annual deductible for all Medicare Part B beneficiaries is $226 in 2023, a decrease of $7 from the annual deductible of $233 in 2022.

Part B Deductible is $226 for 2023. Train front desk staff on how to verify if the deductible has been met, how to update secondary payer info and how you want upfront collections to be handled. Remember that the deductible will create negative remits so you want to know how to get the money back that Medicare has assumed you will collect.

Questions or Comments?

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 24 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. She has held memberships regional, state and national organizations throughout her healthcare career including NARHC, NRHA, AHIMA, MGMA, and HFMA. Patty currently serves on the Board of NARHC.