Rural Health Clinics and Medicare

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

General Information

- What is a Rural Health Clinic (RHC)?
  - Must be located in a non-urbanized area
  - Area designated or certified within the previous 4 years
  - Can be independent (stand-alone/freestanding) or provider based (an integral and subordinate part of a hospital)
  - Has a separate reimbursement structure

- The Rural Health Clinic Services Act of 1977 was enacted to:
  - Address an inadequate supply of physicians serving Medicare patients in rural areas, and
  - Increase the use of non-physician practitioners in rural areas

RHC Provider Numbers and TOB

Freestanding RHCs	Provider-Based RHCs
3800 - 3974	3400 – 3499
8900-8999	3975 - 3999
	8500 - 8899

Type of Bills

- 710 – Nonpayment claim
- 711 – Admit through discharge claim
- 717 – Adjustment claim
- 718 – Void/cancel claim

RHC Visits

RHC visits are defined as:

- A medically necessary, face-to-face (one-on-one) medical or mental health visit, or a qualified preventive health visit, between the patient and an RHC practitioner during which time one or more RHC services are furnished

RHC visits may take place:

- In the RHC;
- At the patient's residence (including an assisted living facility);
- In a Medicare covered Part A SNF, or
- At the scene of an accident

RHC visits may NOT take place at:

- An inpatient or outpatient hospital (including a Critical Access Hospital (CAH)) or
- A facility which has specific requirements that preclude RHC visits

RHC Practitioners

- Physicians
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse Midwife (CNM)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)

RHC Services

RHC services as:

- Physician services and services and supplies incident to the services of a physician;
- NP, PA, CNM, CP and CSW services and services and supplies incident to the services of a physician, NP, PA, CNM, CP and CSW;
- Medicare Part B covered drugs furnished incident to services of an RHC practitioner
- Visiting nurse services to a homebound patient where CMS states there is a shortage of HHA's
- Care Management and Virtual communication services

RHC Services

Preventive services:

- Influenza, Pneumococcal, Hepatitis B vaccinations;
- Initial Preventive Physical Exam (IPPE);
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.

RHC services do not include:

- Laboratory tests (excluding venipuncture) and technical components of RHC services, which are paid separately.

RHC Payments

- Paid an All Inclusive Rate (AIR), subject to a maximum payment per visit that is established by Congress and updated annually
- The per-visit limit does not apply to RHCs determined to be an integral and subordinate part of a hospital with fewer than 50 beds.
- The coinsurance for Medicare patients is 20% of total charges (except for certain preventive services).
- The Part B deductible applies to most RHC services.
- After the deductible is met, RHCs are paid 80% of the AIR for each RHC visit, with the exception of any preventive services reimbursed by Medicare at 100% of cost.

CY 2019 Payment Rate Increase

Effective January 1, 2019 through December 31, 2019:

- The RHC payment limit per visit for CY 2019 is $84.70.
- This is a 1.5 percent increase above the CY 2018 payment limit of $83.45.

CMS MLN Matters article MM10989:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10989.pdf

Physician Services

- Term “physician” includes a licensed doctor of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractic
- Physician services are professional services to RHC patient include:
  - Diagnosis
  - Therapy
  - Surgery
  - Consultation
- Physician must
  - Examine patient in person
  - Be able to visualize directly some aspect of patient’s condition without the intervening of a third party’s view/judgment
- Qualified services furnished at RHC by RHC physician are payable only to the RHC.

Services/Supplies Furnished "Incident to" Physician's Services

- "Incident to" refers to services/supplies that are integral, though incidental, part of the physician's professional service and are:
  - Commonly rendered without change and included in RHC payment
  - Commonly furnished in outpatient setting
  - Furnished under physician's direct supervision
  - Furnished by RHC auxiliary personnel

- Incident to services and supplies include
  - Drugs and biological
  - Venipuncture
  - Bandages, gauze, oxygen, and other supplies
  - Services furnished by auxiliary personal

NP, PA, CNM Services

- Professional services provided by an NP, PA, or CNM to an RHC patient are:
  - Considered covered physician services under Medicare
  - Permitted by state laws and RHC
- Provider must:
  - Directly examine the patient, or
  - Directly review the patient's medical information
- Services performed must be:
  - Furnished under the medical supervision of a physician
  - Furnished in accordance with RHC policies and physician medical orders
  - Service must be legally permitted to be performed in state service rendered
  - In accordance with RHC policies
  - Service which would be covered under Medicare if furnished by a physician

Services/Supplies Furnished "Incident to" NP, PA, CNM Services

- Services and supplies that are integral, though incident to an NP, PA, or CNM service are:
  - Commonly rendered without charge or
  - Included in the RHC payment
  - Commonly furnished in an outpatient clinic setting
  - Furnished under the direct supervision of an NP, PA, CNM, except for authorized care management services which may be furnished under general supervision
  - Furnished by a member of the RHC staff

Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services

- Services may include:
  - Diagnosis
  - Treatment
  - Consultation
- Services performed by CPs and CSWs must be:
  - Furnished in accordance with RHC policies and
  - Any physician medical orders for the treatment of patient
  - Service must be legally permitted to be performed in state service rendered
  - Furnished in accordance with state restrictions as to setting and supervision including any physician supervision requirements

Services/Supplies Furnished "Incident to" CP and CSW Services

- Services and supplies that are integral, though incident to an CP and CSW service are:
  - Commonly rendered without charge or
  - Included in the RHC payment
  - Commonly furnished in an outpatient clinic setting
  - Furnished under the direct supervision of an CP or CSW except for authorized care management services which may be furnished under general supervision
  - Furnished by a member of the RHC staff

Telehealth Services

- RHC may serve as an originating site
- When RHC serves as originating site, it is paid an originating site facility fee
- Not authorized to serve as a distant site for telehealth consultations
- More information on Medicare telehealth services:
  - Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
  - Pub. 100-04, Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Preventive Health Services

- RHCs are paid for the professional component of allowable preventive services when program requirements are met and frequency limits have not been exceeded
- All preventive services furnished on the same day as another medical visit constitutes a single billable visit, except for the Initial Preventive Physical Exam (IPPE).
- Copayment and deductible amounts are waived by:
  - Affordable Care Act for the IPPE and Annual Wellness visit
  - Medicare-covered preventive services recommended by the USPSTF with a grade of A or B
- List of preventive services are found: Chapter 13, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, Section 220 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Transitional Care Management (TCM) Services

- Must be furnished within 30 days of the date of discharge from a hospital (including outpatient observation or partial hospitalization), Skilled Nursing Facility (SNF) or Community Mental Health Center
- Direct contact, telephone or electronic communication with patient/caregiver must begin within two business days of discharge.
- A face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT code 99495), or within 7 days of discharge for high complexity decision making (CPT code 99496).
- Billed on the day the visit takes place
- Only one TCM visit paid for 30-day post discharge period
- May be billed as a stand-alone visit
- If furnished on the same day as another visit, only one visit may be billed.

Chronic Care Management (CCM) Services

Effective January 1, 2016:

- Paid when a minimum of 20 minutes of qualifying CCM services during a calendar month is furnished to patients with:
  - Multiple (two or more) chronic conditions
  - Expected to last at least 12 months (or until the death of the patient)
  - Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Face-to-face requirement is waived
- Effective January 1, 2017, services furnished by auxiliary personnel incident to a TCM visit may be furnished under general supervision.

CCM Requirements

Include:

- Structured recording of patient health information using Certified EHR Technology.
- 24/7 access to physicians
- Comprehensive care management
- Comprehensive care plan
- Management of care transitions
- Coordination with home and community based clinical service providers
- Enhanced opportunities for patient and any caregiver to communicate with the practitioner regarding patient's care

Behavioral Health Integration Services (BHI) and Requirements

Effective January 1, 2018

- Team-based collaborative approach to care focusing on integrative treatment of patients with primary care and mental or behavioral health conditions
- Paid when a minimum of 20 minutes of qualifying BHI services during a calendar month
- Requirements
  - Initial assessment
  - Behavioral health care planning
  - Facilitating and coordinating treatment
  - Continuity of care with designated care team member

CCM and/or BHI Payment

- Average of the national non facility PFS payment rate for CPT code 99490, 99487, 99484, and 99491 when HCPCS G0511 is on the claim.
  - G0511 can be billed stand alone or with other payable services
  - G0511 is updated annually based on PFS amounts
- The rate has no geographic adjustment.
- The RHC face-to-face requirements are waived when CCM services are furnished to an RHC patient.
- Coinsurance and deductibles apply as applicable to RHC claims.
- RHCs continue to be required to meet the RHC Conditions of Participation and any additional RHC payment requirements.

Psychiatric Collaborative Care Model (CoCM) Services

- Specific model of care
- Provided by primary care team consisting of:
  - Primary care provider
  - Health care manager
  - Psychiatric consultant
- Integrate primary health care with care management support for patients receiving behavioral health treatment
- Includes regular psychiatric inter-specialty consultation
- Patients with particular conditions may be eligible for psychiatric CoCM services, as determined by RHC primary care practitioner
- A separate visit with the RHC PCP is required prior
  - Visit can be E/M, AWV, or IPPE
  - Must occur no more than one year prior

CCM, BHI, CoCM Resources

- Medicare Benefit Policy Manual, Chapter 13 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- Care Management Services in Rural Health Clinics and Federally Qualified Health Centers FAQs: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
- Care Coordination Services and Payment for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

Virtual Communications Services

- Services that include communications-based technology and remote evaluation services
- Face to face requirements are waived when services are rendered to RHC patient
- RHC receive additional payment for costs of communication technology based services or remote evaluations that are not captured in the RHC AIR.
- Requirements are:
  - At least 5 minutes of communication based technology or remote evaluation
  - The discussion or remote evaluation must be for a condition not related to an RHC service provided within the previous 7 days
  - Does not lead to an RHC service within the next 24 hours or soonest available appointment

Virtual Communication Services Payment

- Paid at the average of the national non facility PFS payment rate for:
  - HCPCS G2012 (Communication technology based services)
  - HCPCS G2010 (Remote evaluation services)
- HCPCS G0071 (Virtual Communication)must be on claim
- G0071 can either be billed alone or with other payable services
- Payment rate for HCPCS G0071 is updated annually based on the PFS amounts for these codes.

Encounter Revenue Codes

Revenue Code	Description
0521	Clinic visit by member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at a SNF
0525	Visit by RHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC Visiting Nurse service to a member's home when in a home health shortage area
0528	Visit by RHC practitioner to other non-RHC/FQHC site (e.g., scene of an accident)
0780	Telehealth originating site facility fee
0900	Mental Health Treatment/Services

Other Revenue Codes

- For additional lines, any valid revenue code except 002X-024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X-072X, 080X-088X, 093X, or 096X-310X.
- A complete list of revenue codes can be obtained from the National Uniform Billing Committee (NUBC): https://www.nubc.org/

HCPCS Codes

Effective for dates of service on and after April 1, 2016:

- RHCs are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes.

CMS MLN Matters article MM9269: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf

Modifier CG

Beginning on October 1, 2016, for claims with the dates of service on or after April 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible.

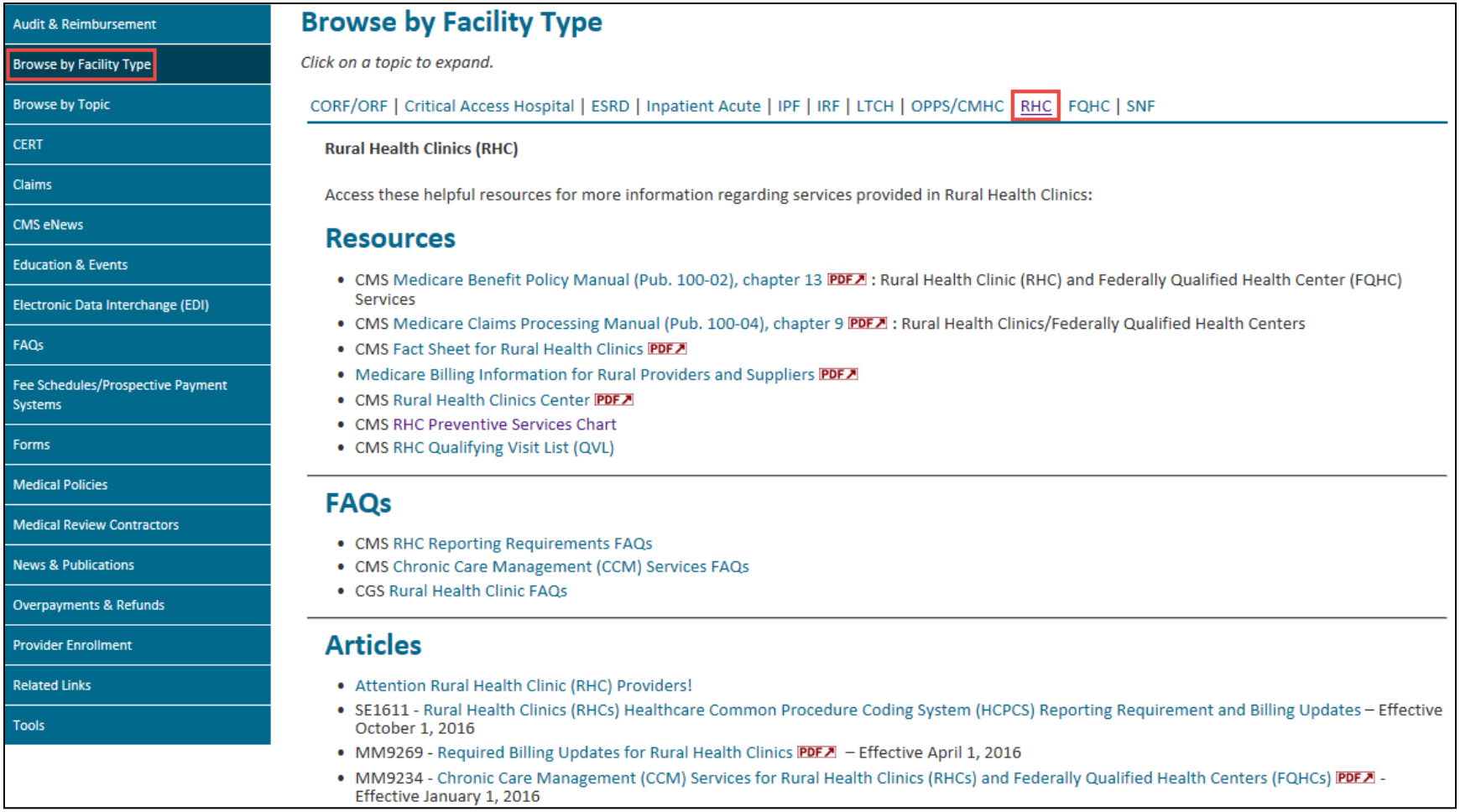
- CMS MLN Matters article SE1611: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf
- RHC Reporting Requirements FAQs: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf

Multiple Visits on Same Day

- Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, **constitute a single RHC visit and is payable as one visit.**
- Exceptions:
  - The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day.
    - The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59 or modifier 25.
  - The patient has a qualified medical visit and a qualified mental health visit on the same day.
    - The qualifying medical visit line should include the total charges for the medical services (revenue code 052x) and the qualifying mental health visit line should include the total charges for the mental health services (revenue code 0900).
  - The patient has an Initial Preventive Physical Examination (IPPE) and a separate medical and/or mental health visit on the same day.
    - IPPE is a once in a lifetime benefit and is billed using HCPCS code G0402 and revenue code 052X. The beneficiary coinsurance and deductible are waived.

CGS RHC Resources

http://www.cgsmedicare.com/parta/facility/index.html#



CGS RHC Resources

- CGS Part A Rural Health Frequently Asked Questions: https://cgsmedicare.com/medicare_dynamic/faqs/display_faqs_j15a.asp?69
- Part A Claims Processing Issues Log: http://cgsmedicare.com/parta/claims/issues_log.html
- CGS Reason Code Search and Resolution: https://cgsmedicare.com/medicare_dynamic/j15/j15a_reasoncodes.asp
- CGS EDI: http://www.cgsmedicare.com/parta/edi/index.html
- DDE User Manual: http://cgsmedicare.com/parta/claims/DDE.html

CMS RHC Resources

- CMS Provider Type Information: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html
- Billing Information for Rural Providers and Suppliers: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralChart.pdf
- Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC)and Federally Qualified Health Center (FQHC) Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- MLN Matters Number: MM10989 [Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2019]: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10989.pdf
- MLN Matters Number: MM10843 [Communication Technology Based Services and Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)]: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10843.pdf
- Telehealth Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf