RHC Billing 101

Monday, May 22, 2023 2:00 PM • 1:17:02 total length

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Sarah Hohman 00:11

Hello everyone. Thank you so much for joining us today for our technical assistance webinar. I'm going to give everyone just a few minutes to hop on. There's a large group registered today so I want to give everyone a chance to log on before we get started. Okay, I see that we still continue to have people joining us which is great, but Amanda has a lot to cover today. So I want to ensure that we use all the time that she is so generously given us and and get started. So welcome to today's rural health clinic technical assistance webinar. My name is Sarah Holman. I'm the director of government affairs for the National Association of rural health clinics and I'm here with Nathan BA, and IRH C's Executive Director. Today's topic for our webinar is RHC billing 101 ad this webinar series is sponsored by hearses Federal Office of Rural Health Policy, and done together with us here at the National Association of rural health clinics. As you can see on your screen, we are supported by a cooperative agreement through fo rhp, allowing us to bring you these webinars free of charge. The purpose of this series is to provide RHC staff with valuable technical assistance and RHC specific information. As always, we ask that you help us spread the word about these free webinars accessible to everyone by encouraging those who may benefit from the information to sign up for our listserv so that they can receive the announcements about future dates, topics and speakers through our website. So during the q&a portion of today's presentation, we will certainly welcome all of your all of your questions. On on today's topics specifically, we know there are a lot of you. And there's a lot we're going to cover today. But we do ask that you hold your questions until we get to the q&a portion. Amanda has a has a lot to cover, as I said, and I want to make sure that we wait and see all that she covers before we before we ask questions. As with all webinars, were at the mercy of good bandwidth for all parties, we know that connectivity can vary. If you have any audio or visual issues, please just briefly leave the webinar and then come back in that usually fixes it but if not, the recording will be available on our website. In the next few days. The slides and the transcript are are available there as well. Okay, so with that, I am very happy to turn it over to Amanda Dennison. Amanda is a manager at blue ink company. And she is also on an IRA cheese board of directors. And so I'm happy to turn it over to her for today's presentation on our YouTube billing.

Amanda Dennison 04:07

Awesome. Thanks so much, Sarah. And thank you all for joining today. I know that maybe billing is not exactly the most exciting topic to talk about on a Monday. But again, this is going to be RHC billing 101. So these are a few of the topics that we're going to attempt to get through today in the hour and then a little bit that we might have together. So I apologize in advance if I move quickly, but I want to make sure I give you the most broad overview of RHC billing that I possibly can. Okay, so we're going to try and touch on a lot of highlights a lot of basics that you need to know for billing as a rural health clinic. A couple of quick notes before we jump in. The content of this presentation is current as of today or Friday when I sent it over to Sarah. So please always do your due diligence and make sure that whatever billing guidance you're reading rinsing is the most current, okay? So go out there and check the CMS website, make sure that this is the most current information if you're referencing this at a future date, okay? And it's important to note that this presentation is going to cover the traditional Medicare billing guidelines for Rh C's. Okay? And that's because traditional Medicare billing guidelines apply to all RH C's, regardless of type and regardless of what state you're in. Okay, so there are some notes here about Medicare Advantage and Medicaid, but again, those are going to be pretty specific depending on contractor state. Okay, so let's jump right in. When it comes to our HC billing, the first thing we kind of have to define is what is an RHC visit or an RHC encounter? And the best place to look for that information is in the Medicare benefits policy manual chapter 13. Specifically, that's one of two documents that I lovingly call the RHC billing Bible. The other one is going to be the Medicare claims processing manual chapter nine. Okay. So Medicare specifically says that a rural health clinic visit is a medically necessary medical or mental health visit, or a qualified preventive health visit. That visit must be a face to face and one on one encounter between the patient and one of the providers that you see listed on your screen. Okay, now, there is sort of a note that I want to point out here that the benefit policy manual was updated recently to add the language that says that mental health telehealth visits as of January 1 of 2022, do also qualify as an encounter even though they don't meet that face to face element. Okay, so that's sort of the exception to the face to face rule. Now, who are your RHC Medicare eligible providers? One thing I want to point out here is that Medicare and Medicaid generally do have different eligible providers, okay, so your states may allow additional provider types to provide RHC services, but these are the reimbursable provider types for Medicare. Okay, so a physician, a nurse practitioner, a physician assistants, a certified nurse midwife, a certified psychologist, and a licensed clinical social worker, those are our providers. As of today, starting January, one of 2024, CMS is adding two additional eligible provider types. And that's a licensed Marriage and Family Therapist, as well as a licensed mental health counselor. Now, there's still some more details that we're going to need from CMS about those last two. So again, make sure you keep up to date either on the NAR HC website, or with CMS directly for any of those details. So what does not qualify as a rural health clinic encounter? Okay, so the things that you see listed here on the screen don't qualify as an encounter on their own, simply because they don't meet one of the criteria for an RHC encounter. Okay, so visits only for medication refills, visits only for lab results, visits only for injections. And I want to pause here for a second because when we say injections, these are things such as allergy injections, B 12, injections, testosterone injections, so generally injections that are given by your clinical staff, it is not things like trigger point injections that rise to the level or skill level of a provider. Okay, so that is going to be completely different suture removal or dressing change without an additional face to face visit. And then as a general catch all any visits that would have been built using that 99211 Nursing visit, okay. So again, typically, it's because these are provided by your clinical staff, or maybe it's not medically necessary to have a visit only for some of these specifics, okay. Let's talk about your claim forms and build types for your RHC services. All of your RHC services are going to be built on a UB oh four. So that is the 837 i which is an institutional claim, it can get a little bit confusing because our

HC services at their nature, our professional services, but when you're an RHC, you build your RHC services as the facility not as each of your individual providers. Okay. And so these are your bill types that you see here on the right hand side, a 711 is your original claim, you're going to use that quite a bit. 710 is a non payment or zero claim. Okay, so that's going to be for something you need to submit to Medicare for non covered services, so that you can get a denial to fall to patient responsibility. Okay. 717 is an adjustment claim to have your pretty common scenarios in the RHC space or when we're going to use a 717. When you have injectable medications that have a specific dosage and we have units that we have to put on there. A lot of times we get that unit a little bit off, and so we have to submit an adjusted claim in order to get that unit correct. The other time when we would use an adjusted claim the RFC space is two Add incident to services onto a claim, okay, and we'll talk about that in a little bit more detail here in a little bit. And then a 718 is going to be your cancelled claim. So if you have a duplicate claim, or you put the wrong claim in for the wrong RFC, if you have multiple rmcs, that's when you'd use that 718. Okay. Every single service provided during an RHC encounter has to have the appropriate associated revenue code. And these revenue codes on the screen are RHC. And technically FQHC specific, but we're only talking about RFCs today. So 521 is just going to be when you have a patient that comes into the RHC to have services provided, okay? A 522 is a home visit by your RHC providers. And that can either be their actual residence their home, okay, it can also be a residential living facility that can be used with 522 524 and 525 are our revenue codes that are going to be for our nursing home stay. And that's going to depend on the type of stay that the patient is in. Okay, whether that be a covered part a stay, or a non part a stay will determine which of those two revenue codes are going to use. Revenue Code 527 is going to be one of the only times when you have an RN or an LPN, that is able to provide a billable service, okay. And that's for visiting nursing services to a member's home. But the catch is that you do have to be located in a home health shortage area, okay. 528 is a visit to another non RHC site. And the example that CMS gives us is the scene of an accident. Okay, so this is not meant for when you have a patient who's in the hospital and your RHC provider is rounding on in the hospital, that doesn't qualify as a non RHC site for instances of 528. Okay, so it's a very rare revenue code, I haven't seen it used a whole lot, but you can do it. Okay. And then Revenue Code 900 is for your mental health visits, whether that be in person or via telehealth. Now, these are a few other common revenue codes that you're gonna see used on some of your additional services you might provide in the RHC. Revenue Code. 250 is for your pharmacy codes. So that's any drug that doesn't have that detailed je code assigned to it. Revenue Code 300 is for VENA puncture only, okay, the associated labs for those are going to be built differently. And we're going to talk about that in a little bit as well. Revenue Code 636 is for any of your drugs that do have that detailed je code. Okay, so your injectable medications, and then Revenue Code 780 is for the telehealth originating site only. Okay, we'll cover the difference in originating site and distant site towards the end. Now, let's get into sort of all of these other RHC claim details that we need to know in addition to our revenue codes, and our bill types and things of that nature, this is kind of got a lot of information on it. But if you are more visual in nature, like myself, I do have some claim examples that we're going to take a look at here in a minute, that will kind of pull this all together if you're a visual and not an auditory learner. Okay? So RH C's are required to line item detail code for all services provided during the RHC encounter, okay, so that's going to be all your RHC services, any incident to services, any applicable professional components, and also any preventive services that are provided. Okay, now, the charges associated with any of these additional line items, services can be reported one of two ways you can report with actual charges. So if your actual charge for an injection is $20 per unit, you can charge it at $20 per unit, you can also choose to report that with what we call the penny method, okay, so a penny or more. Now, whether or not you use actual charges, or the penny method is largely going to be based on the functionality of your billing system. Some billing systems aren't capable of handling all of these different Penny charges and what the actual associated charges in the

background and making the roll up happened appropriately. So again, some of it's the billing system, some of it's also just personal preference. Me personally, I prefer actual charges. Just because you already know what those charges are in for a couple other reasons that we'll discuss in just a second. Regardless of how you report those charges, all of your charges for your services on your claim are going to roll up to what we call the qualifying qualifying visit line excuse me, or the CG modifier line. Okay. The only exception to that rule is for your qualifying preventive health services, okay. You do not want those to be rolled into that qualifying visit line. Your total charges are still going to total at the bottom, that 0001 line that you're used to seeing on a UB, but that line is not actually used to adjudicate payment for Medicare for our HCS. Okay, so it's just kind of a line that they ignore. Okay. And that's because we have a qualifying visit line in the CG modifier line, which actually communicates to Medicare, what line is supposed to be used for the our total charges, okay, so every claim has to have at least one qualifying visit line. And typically, there's only one CG modifier, except in a few rare instances. Okay, there is a link here and you will get a copy of these slides after today's presentation. So there is a link there to the qualifying visit list that gives you a list of all services that can stand alone as a billable RHC encounter. It hasn't been updated in a while, but it is still a very comprehensive list if you're just looking for something to get you started. Okay. So that modifier CG tells Medicare which line to use to calculate your applicable coinsurance and deductible for your patient. So that's why they don't use that 0001 line for anything. It's the CG modifier line that tells Medicare what to use for calculation purposes. Okay. So let's talk about the instances when you might have more than one CG modifier on a claim. Okay. And again, there are only three. So the first is what we call subsequent illness or injury. Okay, so the scenario here would be that you have a patient who comes in in the morning for a follow up for a chronic condition with their primary care provider. Okay, let's say that the provider does a level three office visit, patient leaves, they go home, they are working outside in their garden, because it's such a nice day, or at least it is here for me today. And they fall and they cut their leg, okay, they come back to the RHC. And whether they see the same provider or a different provider at the site at that RHC you can get a second billable visit out of that. Okay, whether the follow up is a procedure or just an e&m visit, that's one of the only times you're going to use this modifier 59 or 25 in the RHC. So if you work with our HC us and you have a billing background in just a physician office, you use 25 and 59 a lot in a physician office setting, those don't mean the same thing in the RHC space as they do in a physician office space. Okay? So you're gonna have to sort of do some unlearning, at least on the Medicare side of things for when to use those modifiers. Okay, your second scenario for when you might have more than one CG modifier on a claim is if you were to have a qualified medical visit, and a qualified mental health visit on the same day, okay, so you're gonna have a CG modifier that shows the primary reason for the visit, for the medical visit, and then another CG modifier indicating the primary reason for the mental health visit that day. Okay. And then the third example, which is a very rare example, would be if you happen to have a patient who has their IPP E. Okay. So that's that one time only visit that your Medicare beneficiaries are eligible for within their first 12 months of eligibility. And then they were to also have a medical visit and a mental health visit on the same day. Okay, you can get up to three billable visits out of that encounter. Okay? Again, there's a link here to the CMS RHC reporting requirements FAQ. It's a very helpful document that was put out by CMS back in 2016, when they changed the billing rules for Rh C's and introduced the CG modifier. So I challenge you to go out there and kind of take a look at that. And they will go through some of these multiple visit examples when you should and should not be using the CG modifier. So let's talk about your actual payment from Medicare as a rural health clinic. So if you've ever done a billing webinar before, you hear consultants, such as myself say that RH C's are reimbursed, they're all inclusive rate for services, and that's technically only 78.4%. True. Okay, your actual payment for Medicare is 80% of your all inclusive rate, less 2% sequestration, okay? So when you do all that math, if you take your all inclusive rate and multiply it out by 78.4%, that will get you what your actual payment is from Medicare.

Okay? The exception for that, again, is those qualifying preventive services. Because if you have a qualifying preventive service, it's paid at 100% of the all inclusive rate. Again, more on that here in a few minutes. Now, all new RH C's as of 2021 are subject to the specific upper payment limits that were set in statute. Okay. So starting with this year, the rate is $126 a visit. And it kind of stair steps by about $13 a visit every year until we reach 2028 When it reaches its cap of $190 a visit. Okay. So for 2029, and beyond that $190 is going to be moderately adjusted by the Medicare economic index. Okay, so that's between one and 3%. Most years, okay? Now, if you are a grandfathered, RHC, so you are an RHC, that was in existence prior to 2021. Or you didn't have your 855 in prior to the cut off, you may have a higher kept all inclusive rate. Okay. So again, this is all set out in statute. If you want more information about this specifically, in our HC has a lot about that on their site that you can go and read more into. Okay, so your payment from Medicare, this is important, is not based on the charges you're submitting on the RHC claim. Okay, so the million dollar question that I get from a lot of Rh C's is, well, if our payment isn't based on our charges, then shouldn't we just go ahead and set our charges are equal to our all inclusive rates? And the answer to that is no. Okay, you still need to have a structured methodology for setting your charges, okay, whether that be a percentage of the Physician Fee Schedule, whether you do it based off of some commercial allowable, however you do it, you do need to still have that structured methodology. But the other reason you shouldn't set your charges equal to your all inclusive rate is because you have to charge all patients the same, regardless of payer. So if you were to set your charges equal to your all inclusive rate, so $126 For this year, you would have to do that for all of your payers. Okay, that doesn't really make a whole lot of sense in some instances. Okay. So while your Medicare payment isn't based off of your charge amounts, your patient coinsurance amounts are dependent on those charges that you submit, okay? And that's because coinsurance in the RHC is slightly different than it is in a physician office, okay? Your coinsurance is equal to 20% of the total charges submitted on your claim. So it's not the Medicare allowable amount. Again, it is calculated off of that qualifying visit line where all of your charges for services roll up. Okay? So that CG modifier line, once again, coinsurance, and deductible are going to be waived for qualifying preventive health services. So that's why I can't stress enough the importance of not rolling those into that qualifying visit line. Okay? Rh C's are responsible for collecting that coinsurance from their patients. You can't really collect it upfront, like you would a copay from a commercial patient. So it is a little bit different of a process, but you are still responsible for collecting that. Your RHC patients do still have to meet their Part B deductible each year. Okay. So if you have a patient who only has Medicare Part A coverage, they are not covered. Right? And this can get confusing, too, because you filed an 855 A, you're a part a facility, so why do I have to worry about the Part B deductible because the RHC program is paid for by Part B. Okay, so when you get your EOB from Medicare, they're actually coming from Part B. Okay, so the Part B deductible for 2023 is $226. Once your patient has satisfied that deductible, which you as an RHC are responsible for collecting, then Medicare will start making payments according to that 80% Less 2% sequestration, okay? Now, every year at the beginning of the year when those deductibles reset, okay, you will notice that you might have what we call negative reimbursement or what looks like a take back from CMS at the beginning of the year. Okay. Now, again, because this is a bill in 101 presentation, we're not going to get into the specifics of negative reimbursements and what those look like because that could be its own presentation, quite honestly. But just be aware, you need to be careful how you post or account for these. Okay. So, I promised those of you who are visual in nature that we would have some claim examples. So here we go. These are pretty basic, straightforward examples. This is an e&m office visit only. So you'll see you have the 521 Revenue Code. Okay, you have the 99213 office visit, you have the CG modifier, identifying the primary reason for the patient encounter that day, and again, just your straight $100 Charge. Okay, pretty, pretty simple. You can also have a procedure only that qualifies as an RHC encounter. Again, same revenue code if it was done in the RHC this time you have a procedure code listed rather than an e&m

code listed, still have your CG modifier, and then whatever your associated charge is for this service. Okay? Either one of these is fine. Now what if you have the visit and the procedure on the same date of service? Well, then you're combining them onto one claim. And this is where we start to see that roll up, that's happening. Okay. Again, we've got our 521 revenue codes, we have the 99213. And then we also have the procedure code. But we now have to identify the primary reason for the patient encounter that day. And this CG modifier is what tells us that you'll also see over here when we get to our charge line for the CG modifier. This $250 includes your $100 charge for the e&m and your $150 charge you see here, okay, for that procedure. So this 0001 line still totals all of that, but it does not matter for purposes of payment. Okay. Now, what if we had a, say an office visit and an injection, so we're starting to get into some of these incident two type services, okay. And this is where I'm going to point out the sort of the two options that you have for reporting charges for any additional line items. Okay, so this first one we're reporting are additional line items with their actual charges, okay, we have a nine, nine to one for office visits. That's the primary reason for the patient encounter that day $150 charge, but then we have to roll up these charges in addition to that, so that's what gets us our total charge here of $207. Okay, the other option you have for reporting these, you'll see over here in red, what the difference is, is reporting those additional line items with a penny charge, okay, you're still going to have your same 207 that it rolls up to, and then your pennies that rolled up. But this total charge line here at the bottom looks less inflated. And that is why some people prefer the pity method. Again, me personally, I prefer this actual charges method because you're not doing anything wrong. By billing this way. Yes, your charges at the bottom might look overly stated. But that's how you have to bill as an RHC. So those are your two options. Okay. Now, let's say you have an office visit and a preventive service. Again, we don't want to roll the charges for that preventive service into that qualifying visit line. Okay, so this is a very common thing that happens in a lot of offices, you have a patient who comes in, and maybe you have a provider who says well, while you're here, let's go ahead and do your annual wellness visit. Perfectly fine to do, you are only going to receive one all inclusive rate payment for both services. Okay. So that's what happens when you have the preventive do not roll those charges. Now, let's get into the examples that we talked about where you have multiple CG modifiers on the same day, okay. So this is that scenario that we talked about where where they come in for a chronic condition in the morning, they fall at home and cut their leg, they come back, and they either see the same provider or a different provider at the RHC. So they had in this case, a laceration repair when they came back a second CG modifier because there is separate diagnosis and treatment. Okay. And you'll see here, we now have the 59 modifier. Okay, we don't have that, and very many other claims. So do you know that 59 that's there. Okay. And again, because we have separate CG modifiers we don't have the roll up that's happening because those charges are separated out. This is the second example where you'd have multiple CG modifiers you have that medical visit and that mental health visit. You'll note here the difference in revenue codes between the medical visit and the mental health visit. Okay. And then again, you have one CG modifier to identify the primary reason for the medical visit one CG modifier to identify the primary reason for the mental health visit. And again, there's no roll up happening here if all we have is the office visit. Now if you did have this office visit here and you did have say an injection and a medication, you would have additional line items under there that would roll up to that CG modifier and that's okay. And this is your last example of the multiple CG modifiers on one claim, where you'd have the IP PE, a medical visit and a mental health visit on the same day. Now I do want to make a note here, this G Oh 402 which is the code to use for your IP PE. You'll note that it does not have a CG modifier attached to it. It is one of the only codes that does not require the CG modifier in order to be paid. Now, I do know that WPS does require it for proper adjudication on their claim. So if you live in a state where WPS is your Mac, you'll want to make sure that it still gets that CG modifier on it. Okay. So on this claim, you're going to have two all inclusive rates paid one for the medical visit and one for the mental health visit at the 80%, less 2%

sequestration, and then you're going to have another all inclusive rate paid for this IPP E. But it's going to be at 100%. Okay, because again, if you have that, that visit, specifically, it is paid at 100% of your all inclusive rate. It's not based on these charges, it's based on your all inclusive rate. So let's talk about incident to services, incident to services, we've kind of already looked at a claim sort of showing you what that looks like on the claim. This can kind of be a tricky subject to talk about. Because incident two services are that take place on a different date than your office visit or your qualifying visit can be tricky to capture. Okay, so your incident two services in general are generally things that are done by your clinical staff, okay. They are usually furnished under direct supervision with some exceptions, they are commonly furnished in an outpatient setting, they are commonly rendered without charge, okay. And then the payment for them is generally included within your all inclusive, right. Okay. So if you have an encounter that only has incident to services, okay, so again, you've got a nursing visit, because a patient came in only for a B 12 injection, and there was no other face to face visit, that on its own does not generate a billable visit. Okay. So let's jump forward here. Here's your options for how you deal with these incident two services, okay, you really have two options. And one option has two options within that. Okay, so your first option is to add these incident to services to a qualifying claim that takes place within a medically appropriate timeframe. Okay, so you're gonna hear that called the 30 day rule a lot, because 30 days is very common practice, okay, that requires the RHC to do one of two things in order to add that incident to service onto that claim. So either the RHC is going to have to hold claims until the end of each month, and then add on any of those incident to services. Or each time that the incident to service is rendered the RHC will submit an adjusted claim. So that type of bill 717 that we talked about earlier, in order to get them onto a claim, okay. Now, I didn't say that either of those examples were good options for how you have to deal with them. But if you do want to get them onto the claim, those are your two options for how you do that. Make sure that if you are going to use this option that the date of service of the qualifying visit is also the date of service you use for those incident to services, okay, you you shouldn't have span dates on your RHC claim. Because then Medicare's going to think you've had this patient at your RHC that whole time, we hope that they haven't been there that long. Okay. Your other option for dealing with these if you don't want to have to hold claims or submit these adjusted claims, every time that you have these incident to services, is simply to adjust them off, and then claim them on the cost report. Okay. If you're going to do that, you do need to make sure you have appropriate tracking in place for any expenses related to those incident to services. So any supplies, any overhead or staffing time related to that, we need to make sure that we're able to accurately capture that in order to claim it on the cost report. Okay. Regardless of how you choose to deal with these, the key takeaway here is that your incident two services do not generate separate payment from Medicare, but they do increase your patient coinsurance, okay, so when you're deciding how to deal with these, that is a very important thing to remember is that your incident to services do increase your patient coinsurance. Okay. Now, there are certain services that RH C's can furnish that are considered beyond the scope of the RHC benefit, okay? And because they're beyond the scope of the benefit, that is why we call them non RHC services. Okay. So there's a list that you'll see here. These are the examples that CMS gives of those non RHC services. probably your most common two from an RHC standpoint, are going to be the technical component of an RHC service. So that's going to be for your X rays or your EKGs and then any of your lab services. Okay, and I do want to point this out. Yes, This even applies to the six lab tests that you are required to have the ability to provide. Okay? So even though you have to provide them, if it's resulted at the RHC, it's considered a non RHC service. Now, this is important. So don't miss this. Non RH C does not mean non payable. That's a common misconception. When I do these billing trainings for people, they'll say, Well, if it's non RHC, we don't get paid for it. And that's not true, it means that your payment is based on a different payment structure than your RHC services. So basically, it's not part of your all inclusive rate payment, it's going to be billed differently. Okay. So your non RHC services are

billed separately to your Mac, under whatever the specific payment rules are for the service you're providing. Okay, so if you are an independent RH C, you're going to build those RH C services to part B, using your RH Cid numbers. And you're going to get payment for those according to some sort of fee schedule, a lab fee schedule, some sort of imaging fee schedule, okay, so you're still getting paid for him, it's outside your all inclusive rate. Now, if you're a provider based RHC, you're going to be billing for those non RHC services under your parents hospital ID numbers, okay. And whether you are provider based to a critical access hospital, or provider base to a PPS hospital will depend on how you're paid for those services. Okay. So for critical access, the payment is based on cost for those non RHC services, and for PPS hospitals, or provider based rural health clinics to a PPS hospital payment will be again, according to a fee schedule. Okay, either way, if your independent provider base any of your costs associated with these non RHC services, okay, so again, that space equipment supplies needs to be removed from the cost report. Okay. So this is a helpful sort of grid, whether you are independent or provider based, and depending on the type of service that you're providing across the top there and navy blue, okay. So whether you're independent or provider based, your encounter for RHC services is billed the same way billed to part a, on a UB under your RHC PT number. Okay, now, your middle two here, these are your CLIA labs, and then those technical components, both considered non RHC services, okay. So if you're an independent RHC, you're going to build those services to part B on a 1500 claim form, using your RH C's ID numbers. If you're a provider based RHC, again, for those non RHC services billed by the parent hospital, on a separate UB, then your RHC services, okay, and the type of bill for the service will depend on what type of hospital it is. Okay? Professional Services, so services that your RHC providers are providing at the hospital, those are going to be outside of your RHC billing because again, whatever the rules are for providing that service at the hospital, those hospital roundings. Again, part B 1500, under your Medicare group, okay. So this is a claim example for what one of those non RHC services would look like. So this is going to be for the EKG specifically, okay, you have a patient who comes in for an office visit, they also have an EKG. One important note here, if you have a third party that does the interpretation and report for your EKGs. So they're, they're reading those EKGs or those x rays, then you the RHC are not going to be billing for those unless that third party is contracted as an RHC provider. Okay, and that gets into a whole other thing. So make sure that if you are billing for that professional component that 93010 On your RHC claim that it was reported or interpreted and reported by your RHC providers. Okay, so again, you've got that charge for it, it rolls up, same as here. So you're gonna get the additional coinsurance from that professional component. Payment for Medicare will be the same because it's part of your all inclusive, right. The technical part of that, okay, is going to vary whether you're independent or provider based, and that's what we just covered in that earlier grid. Okay. Now, EKG specifically has separate CPT codes for their technical component and professional component. If it's some sort of X ray that doesn't have specific CPT codes That's when you're going to use either the 26 or the TC modifiers to indicate one versus the other. Okay, so again, independent to part B on a 1500 for fee schedule payment provider based RHC billed under the parent entity. And it's either going to be a fee schedule payment, or costs if you're a critical access hospital. Okay, preventive health services. So we've kind of already talked a little bit about these, we looked at an example when you have an annual wellness visit, we looked at an example when you have an IPP II, okay, so let's just make sure we highlight these, if you're billing for those preventive health services, do not include those charges in your roll up so that CMS does not calculate coinsurance and deductible for those since they're waived. Okay, now, Medicare does pay for qualifying preventive health services at 100% of your all inclusive rate, if they are the only qualifying service for that date of service. Okay. So if you go out and you read the claims processing manual and the benefit policy manual, they highlight specifics for several different preventive services. They talk about an annual wellness visit, they talk about the screening Pap smear, they talk about a screening, colonoscopy, things of that nature, all of them have language in there that

says payable if the only service provided on that date of service. Okay, so if there's any other service that takes place that day, it's included in your all inclusive rate payment. Okay. The only exception to that is the IPP, ie, whether it is done in conjunction with the billable visit or on its own, you will generate an all inclusive rate payment. Okay, these are two helpful resources when it comes to your preventive health services. That first link here is to your RHC preventive services chart, it's a helpful cheat sheet that goes through all of the preventive services for an RHC gives you the hickspicks code to use for billing, lets you know if it is going to generate the AR and lets you know if it's eligible for same day billing, and then whether or not coinsurance and deductible are waived. Okay, and for most of them they are and then the second resource there has several different rule providers and suppliers that's going to include critical access hospitals, and FQHCs. But again, it's kind of a different way of looking at the preventive services chart. Okay. Flu and pneumococcal, since we're talking about preventive services, RH C's are reimbursed for flu and pneumococcal and their administration through your cost report. Okay, so you are not going to be reporting those on your RHC claim. Okay, you might have a system that allows you to track these based on hickspicks codes, if you can put it with a zero charge, okay? Usually, that means that it's going to drop off the claim. And it's still going to capture it so that you can have a way of tracking those, but it's not going to go out the claim or out on the claim to be billed on to a patient. Okay, it will fall off. Whether you track it that way, or whether you track it with a manual log does not matter. But you do need to make sure you have some sort of tracking mechanism in place for those vaccines and their administration's for your cost report for repair. Okay, they're going to need that report, they will separate out the Medicare specific portions of that. And then they also we're going to have to have things like the invoices or purchase orders for the vaccine. So you'll be reimbursed at reasonable cost through the class report for those COVID-19 vaccines are reimbursed similarly, okay. Again, this hasn't always been the case, because obviously COVID is something that kind of hit us all a little bit quickly. But again, those are reimbursed through the cost report. So make sure that you do also have a mechanism in place for capturing those. Okay. All right, let's talk about telehealth quickly. Okay. Prior to the public health emergency, RH C's were only authorized to serve as the telehealth originating site. And the originating site is the location of a patient during the telehealth encounter. So essentially, CMS is paying you to host to the patient in your RHC. And they're generally seeing a specialist in most cases that is physically distant, usually in an urban area. It was a way of allowing rural patients to still get care from certain specialists that they needed without having to travel really far distances. Okay. If you're going to be billing and you can still build for that today, as the originating site, you're going to use queue 3014 As your hickspicks code and then that revenue code 780 If you are going to be billing as the originating site, okay, payment for that is $28.64. Now, what RH C's are newly able to provide, at least for now is distant site services for telehealth. And specifically in this slide, we're talking about medical services. Okay, we will talk about the mental health telehealth services in just a minute. So, during COVID, we were authorized our agencies were authorized to serve as distant site services for telehealth that has been extended through the Consolidated Appropriations Act of 2023. So our agencies will be able to provide distant site services until the end of 2024. Okay, so the distant site is the location of the provider during the encounter, okay, both the patient and the provider right now can be located in any location, including their, their home for the patient or provider during that encounter. Now, the caveat to this is that it must be during rural health clinic hours. Okay. There are certain services that qualify for distant site reimbursement. So there is a link here, that will take you to a zip file that is updated by CMS about quarterly. This last update was actually just a couple of weeks ago on May the ninth right before the PHP expired. Okay, so before you provide a service, make sure you do go out there and make sure that the service is on that list. Now, how do you bill for these distant site services? So CMS created this RH C specific G code, okay, this g 2025 for us to use to build these services, okay. You can also include an optional modifier 95. And then the appropriate five to x Revenue Code, okay. You do not also need to

include the hickspicks code for whatever service was provided, you are only reporting the G to zero to five, okay. payment for that is a flat rate payment. Okay, so you're not getting your all inclusive rate for these distance site services that are medical services. Okay. The flat rate payment fee for 2023 is 9827. So it is less than your all inclusive rates. Okay. And again, that does not apply to these mental health telehealth visits. Okay, as of January one of 2022. There's a link here to an mln matters article. This is where CMS has kind of been updating all of their new and expanded flexibilities for RHC is related to telehealth and it was just updated about a week and a half ago. Okay. Now, mental health telehealth visits Okay, so these were D linked from all of the other telehealth a distance site requirements and flexibilities. These are not going to expire at the end of 2024. Because these have been sort of separated out and written into regulation. Okay, so effective with January 1 of 2022. Rh C's can provide mental health visits via telecommunication and CMS is allowing these to be audio, video or audio only. Okay, if it is going to be an audio only service, it should only be provided under a couple of conditions. Either the patient doesn't have access to audio video technology, or the patient does not consent to the use of audio video technology. Either way your providers need to make sure and document in the patient note when they do these mental health telehealth visits, why they're using an audio only as opposed to audio video. Okay. Now there are going to eventually be certain in person requirements. Okay. If you go out to some of the guidance that you see out there, you'll see some more information on these in person requirements. Those have also been delayed until the end of 2024. As they stand today, what those requirements are going to be would be that there's an in person mental health visit at least six months prior to the mental health telehealth visit and that there would be at least one in person mental health visit every 12 months while they're still receiving those telehealth services. Again, not required right now delayed until the end of 2024. And potentially those could change by that point too. So how do you bill for these mental health telehealth visits? Okay, you're going to bill for them the way that you would bill for a regular in person mental health visit with the exception of some additional modifiers we have to add. Okay, so what's important here is that these mental health telehealth visits are reimbursed at the equivalent of And in person visits so you will receive your all inclusive rate for these services. Okay? If you have an audio video mental health telehealth visit, still that same revenue code 900. Still whatever the qualifying mental health visit code is still the CG modifier. The addition here is for audio video, you have to include that modifier 95. Okay, when you have that audio only service, same revenue code 900, same qualifying mental health payment code, same CG modifier, but now we're using an F q modifier for audio only. Okay. And then again, there's that link down there for all of the Mental Health telehealth visit information from CMS. So this is again, the difference in what that looks like for in person versus telehealth. And the only difference is the addition of that modifier 95. When you have that telehealth visit, okay. Here are several helpful RHC resources. I tried to keep them either CMS or NAR HC specific because we know that those are pretty accurate information. So again, the Medicare benefits policy manual, chapter 13, and the Medicare claims processing manual, chapter nine, your RHC sort of billing Bible, if you will. And then the CMS rural health clinic center, that is where all of the most up to date information from CMS gets posted for our HCS. And then obviously the NAR HC Resource Center. They have a lot of good news bulletins and updates as they come from the hill. So that is a good resource as well. Now questions, because I'm sure we have plenty of them.

Sarah Hohman 51:47

You definitely do. Thank you so much, Amanda. For all of that information, we are going to go ahead and and just get started. We will for everyone on the call, we will go until 315. Eastern time. And with questions, we'll get through what we can. And then following those that we aren't able to get to, we aren't able to consolidate you're welcome to reach out to us with those follow ups. And we will get you

get your answers. We are going to try to focus these questions on on Amanda's presentation today. Um, just so that that folks can get those answered. Okay. First question is from Brooke. She asks if a patient has a qualified medical visit and a qualified mental health visit on the same day to billable visits, will both visits be paid? Well, the all inclusive rate be paid twice for twice the all inclusive rate reimbursement? or would there only be one AR payment for the claim that includes two billable visits? All right,

Amanda Dennison 52:52

Brooke. So yes, you will receive two all inclusive rate payments, you will receive one all inclusive rate payment for the medical visit, and one all inclusive rate payment for the mental health visit. There's not a reduction in your second all inclusive rate payment it is the same all inclusive rate payment twice.

Sarah Hohman 53:17

Nathan, you want to ask the next one?

Nathan Baugh 53:21

Sure. Teresa asks, Would a vaccine clinic be billable as RHC? Believe you answered this in the presentation. But,

Amanda Dennison 53:29

um, well. So if you're having a vaccine clinic, you have to remember that for Medicare, you're not going to be billing those on the claim you're going to be claiming them through the cost report. So for your other payers, you know, you're you're free to do that. But for Medicare, you're not billing them out on a claim you're going to need to track them for claiming on the cost report.

Sarah Hohman 53:51

Sir Christina asks, Where do you find out if you're a home health shortage area? Um,

Amanda Dennison 53:58

that's a really good question. I believe that there might be some information from HERSA on some of those home health shortage areas in the same way that you can look up, you know, a primary care shortage area and things of that nature. We may have to get back to you.

Nathan Baugh 54:13

Yeah, it's basically it's basically I don't think there is a good resource on it. Unfortunately, at the national level, you have to sort of enquire with your state to see if the state has sort of adjudicated certain areas of the home health shortage area. I wish there was a good website or a good resource. I'm not aware of any. It's it's one of those ones that it's it's, it's just not used a lot. I think we could get some improvement here in terms of clarifying what is and what isn't and what areas are considered Home Health shortage areas, but it's but it's I would look at the state level because I do not believe there's a federal resource. Good to know. Okay, sir, is it it's me? Yeah. Okay. Brandy asks, are all je codes required to be on a 636 Revenue Code? Or can they be on a five to one?

Amanda Dennison 55:30

They should be under 636. That's the Revenue Code specific to those injectable medications.

Sarah Hohman 55:40

Nicholas asks, are 80s typically billed charges on a ubo? For however, when a provider performs a procedure in the RHC, that is not a qualifying visit? But no, no visit occurred should that procedure be billed on a 1500 so long as those non RHC charges do not exceed 49% of the offices total charges?

Amanda Dennison 56:05

Well, if you have a provider who is in your RHC, and they are an RHC, provider doing a procedure, and it is medically necessary for that provider to do that procedure, it's billable as an RHC visit, and you should bill it as an RHC visit. If you were to bill it differently, you can get yourself into some commingling issues that you don't want any part of.

Nathan Baugh 56:33

Monica asks, Where can I get information on how to post some negative payments? Um,

Amanda Dennison 56:40

where's Patti? Um, I believe Patti did a really good presentation at the spring. In our HC conference that did have some information about this. I know, Mark Lin has also done some information on it. So I don't really know you can email me if you want in here, I'll advance the next slide that has my contact information. If you want to email me, I can send you where to go to get.

Sarah Hohman 57:13

Sir. Hector asks, are all procedure codes able to be built? Or is there a list to reference?

Amanda Dennison 57:21

There is a qualifying visit list to reference and technically speaking, CMS says that that's not an all inclusive list of the services that are billable as RHC services, but it is still really comprehensive. Okay, if there's any like new or updated CPT codes, they're not going to be on there because it hasn't been updated since 2016. But that's a good list to go off of. But generally speaking, if it is medically necessary, it is done face to face and it's with a reimbursable or eligible provider, then that procedure is eligible. And if it's covered by Medicare, I should also include that.

Nathan Baugh 58:02

Okay, I think you answered this, but Ashton asks, Can we build an e&m along with the procedure code, for instance, to patients comes in for ind? And that's all do we code a level and and the AI ind.

Amanda Dennison 58:18

So you would have to separately be able to have documentation that supports both the e&m and the separate procedure? Okay, so your coding rules still apply. But if you have both of those that are done on the same day, yes, you can bill for them on the same day, but you're only going to get one all inclusive rate payment. Okay, now, if you only had the procedure, then that's fine. You're getting the all inclusive rate payment for the procedure only. It's gonna depend on whether or not you have documentation to support each code that you're billing,

Nathan Baugh 58:51

right. And if you add it in e&m plus the procedure code, your reimbursement is still going to be one rec encounter, but the patient's coinsurance is likely going to be more your patient's

Sarah Hohman 59:05

coinsurance will be 20% of the charge for both services. Kelly asks, How are we to report radiology pro fees on the Archie claim? When it's read by the Archie provider, we know that this will be included in the All Inclusive rate or is it not reportable on a claim?

Amanda Dennison 59:25

So that's let me scroll back up here really quick. Sorry if that makes anybody dizzy. So that's going to be similar to this. So instead of your EKG here, you're going to have whatever the you know, X ray code is the 7000 series. And then if it doesn't have a specific professional component, you're going to have the 26 modifier on here, and the charge just for the professional component, okay, so it'd be similar to this claim example number nine.

Nathan Baugh 59:57

Interesting question here from Lacey. If you have multiple RFPs will you receive that AAR, if there are visits in different clinics in the same day, if they share a single tax ID?

Amanda Dennison 1:00:10

Yes, because they have different NPI numbers. So it is common for a hospital to have multiple RH C's under the same tax ID number. So let's say you have an RHC, that's in Suite A, and then you have maybe a women's health clinic that also is an RHC. And suite B, you have a patient that goes to suite a, they have a service, they get the all inclusive rate payment there, they go over to suite B, which is a separate RHC with a separate NPI number, you would get a separate all inclusive rate payment for those services. Okay, now, if those were in the same clinic, so let's say you have a primary care office that also has women's health in it, and they go see the primary care doctor and they go see an OB, they're under the same NPI number. You're only gonna get one all inclusive rate payment, even if they see both of those providers.

Sarah Hohman 1:01:10

Nicholas was referring to claim example, seven or eight and he says, Can a medical visit and a mental health visit on the same day be built on separate claims? If they both have a CG modifier? Or do they need to be combined into one claim?

Amanda Dennison 1:01:23

Some of that is going to be dependent on your billing system. So I work with a number of clients who have Athena and Athena does want you to combine them. I don't know that it's a requirement that they're combined, but they should be payable whether they're on separate claims or together.

Nathan Baugh 1:01:45

Judy asks, as the annual wellness visit takes significant planning, generally the annual wellness visit is what is scheduled as the primary reason the patient is presenting for care. And then chronic illnesses are also addressed in this instance. I think she's asking what the correct reporting be G 0439 With modifier CG followed by the nine nine to 1x.

Amanda Dennison 1:02:11

That's a great question and logic would tell me that yes, that would make sense. However, if you go out to that CMS reporting requirement FAQ, that is one of the questions on there, and CMS has specifically said to put the CG modifier on the e&m visit.

Sarah Hohman 1:02:27

Sir, how are category two codes reported on a qualifying claim?

Amanda Dennison 1:02:38

Question. So you cannot you can build them up included category to code on your claim, but it doesn't get communicated across anywhere to Medicare. Okay. There are I think some Mac's as well that will deny the claim if it has category two codes. So if you're part of an ACO or you're trying to report those quality metrics, you're generally going to have to report them through some sort of registry rather than on a claims basis.

Nathan Baugh 1:03:09

Great, thanks. Elaine asked can you build for a VENA puncture unit provider based I'd see on a type of bill 851 with the lab tests or is it part of the AAR?

Amanda Dennison 1:03:19

Davina puncture is part of your ACR so it's going to go on the claim with whatever office visit they had that day, and then the lab will get billed out separately, but being a puncture specifically should still be included on the RHC claim and is included in your all inclusive rate payment.

Sarah Hohman 1:03:39

Brooke asks, How would an RHC medical visit using telehealth audio only, or audio visual be reported when it's on the same day as an RHC mental health qualifying visit? Would it be G 2025 under the five to one Revenue Code, which is not considered a true RHC encounter? And has not paid the AR bill along with the mental health code under Oh 900 Revenue Code?

Amanda Dennison 1:04:02

Yes. So you have to go according to the specific billing requirements for each of those individual services, right. And so for a medical service for telehealth, right now we have to build that with the 521. There's no other really good way to build it. And then you have to use that g 2025. And then the mental health service will be under 900. It will have whatever the actual mental health visit code is. And then if it's audio only it's going to have that FQ modifier in addition to your CG modifier so you'll get a flat rate payment for the G 2025. That's not based on your all inclusive rate. And then you would get a second payment that is your all inclusive rate for the mental health visit.

Nathan Baugh 1:04:48

So William asks, If CMS can choose to continue the G two zero to five past the end of 2024 Apart from a statutory option authorization The answer to that, in my opinion is no that Congress would need to authorize what telehealth looks like beyond the end of 2024, with, you know, a bill that is signed into law. So, again, as Amanda mentioned already, though, the mental health, telehealth coverage is extended permanently. So, we're really just talking about medical health telehealth that is potentially going to end at the end of 2024. But I don't think I'm going too far out on a limb by saying that Congress is expected to pass something before the end of 2024 to extend it, if not permanently, at least temporarily.

Amanda Dennison 1:05:48

Well, it's kind of the whole idea that once you let the cat out of the bag, you can't really put the cat back in the bag. Like, that's not an easy thing to do. So, hopefully, and that's the goal fingers crossed, that we'll be able to do that. People and ask them to support something of that nature.

Nathan Baugh 1:06:06

Well, we can't advocate, Amanda. Let's not go there. I'm gonna keep it to the facts. No way, no problem. No problem. We just can't advocate on this call. Sarah,

Sarah Hohman 1:06:19

a couple of different questions here on if the RHC can build both the distance site and originating originating site visits for telehealth,

Amanda Dennison 1:06:29

though this has come up a couple of times, and there isn't really anywhere that it like, clearly says it in writing. But I guess I can say this is opinion, you're not intended to be both the originating site and the distant site at for the same encounter, okay. So if you have a patient who is physically present in the RHC, for the encounter, but your provider is at home, okay. I would bill as the distant site, okay, because you're gonna get your G 2025. Payment, okay, you are authorized to do it that way right now. But really, when you're the originating site is kind of more intended for when they're seeing a specialist who is really not with your RHC. Maybe they're with another group, and they're in an urban area, because you don't have that specialists close to where your RHC is located. But you have a lot of patients who need to have a console with a cardiologist, for example, they're not really intended to be both at the same time.

Nathan Baugh 1:07:39

Awesome, thanks. Carol asks, the update. So the updated modifiers are to be used now and not after 2024. So the exact billing rules post 2024 are going to depend on what Congress does. So they are definitely the modifiers that FQ right? And what's the other 195 95 is for the video? Yeah, so that's what you use for now. And stay tuned for what you use and 2025. So I guess I already answered that. So go to the next one. If a patient wants to see a non Medicare eligible provider, like, like, currently an LMS T, but not next year, are they allowed to pay cash and we not bill Medicare?

Amanda Dennison 1:08:26

Hmm. That's a really good question. And I don't know that I know 100% The correct answer. So I may have to do some research and get back to you. If you want to shoot me an email with that question. I'll do a little research and let you know. Yeah,

Nathan Baugh 1:08:44

I mean, I have a guest, but we'll move on. So do you have a question?

Sarah Hohman 1:08:51

Do we need to use the CG modifier on GT zero to five?

Amanda Dennison 1:08:55

No, you no longer have to do that as of I believe July 1 of 2020. So no longer use the CG modifier here, I'm going to have the G 2025. And that optional modifier 95. But again, that's only for the G 2025. That's different for your other mental health telehealth.

Nathan Baugh 1:09:16

Okay, one asked a very specific question. Okay, how do we bill for hickspicks code? J code with? I'm gonna butcher this Rosa, Thien, Rosa fine. one milligram units for per hickspicks. Level two are billing 250 milligrams per unit if we give one whole milligram do we see on claim units of one or quantity? Does that make sense to

Amanda Dennison 1:09:47

you? Coding related question based on what the specific hickspicks code says about the dosage and some EHR systems and you might check on that Do have a helpful way of making sure you're billing the right number of units according to the dosage for each of those. So I can't say that I'm an expert in billing for units of injectable medications, even though I am a coder. It is a really difficult topic, but it's going to be based on the dosage by each

Sarah Hohman 1:10:18

hickspicks code. Sir Am I right that sometimes you get paid your cost? Sometimes you get paid the all inclusive rate and sometimes a percentage of the all inclusive rate,

Amanda Dennison 1:10:33

not for qualifying encounters No. for qualifying encounters, you're going to receive your all inclusive rate payment. Now, it may be at 80%. If it is, you know, according to your Medicare payment, or if it's a preventive health service, you'd get it at 100%. But no, there aren't instances when you would get a percentage of your all inclusive rate. Or not at all. That could be different for Medicaid, there are certain states where for Medicaid purposes, you might be able to bill something outside of your encounter rate. But that's going to be on a state by state basis.

Nathan Baugh 1:11:10

Yeah. And I'll just I would throw out that you do get paid your cost for pneumo. And correctly quarterly. Or I'm sorry, annually, right, Amanda?

Amanda Dennison 1:11:24

Right. You get that on your cost report. So you are gonna get cost for those. But for RHC services, specifically, you're going to be getting your all inclusive rate payment. Right.

Nathan Baugh 1:11:39

Okay, next question. Is there such a thing? Or can you talk about what constitutes a qualified rec dental visit.

Amanda Dennison 1:11:47

So dentists can provide services in the RHC. But again, it would have to be a doctor of like, they're a doctor of dentistry, which is a thing. But you have to be careful with dentistry because it can sort of tip this whole primary care versus non primary care mix. There is a section in I believe the benefits policy manual specific to dentistry and you know, being a chiropractor and things of that nature, so I would go out to that document and see what the guidance is specific to dentistry.

Nathan Baugh 1:12:28

Right. And, I mean, correct me if I'm wrong, but traditional Medicare doesn't really cover.

Amanda Dennison 1:12:36

Much from a dental standpoint. Yeah.

Nathan Baugh 1:12:42

Oh, go ahead, Sara.

Sarah Hohman 1:12:43

I'm going to answer just a couple telehealth related questions real quick. So questions about where the provider and patient can be located in terms of telehealth, at least through the end of 2024. There are no requirements as to where patients and or providers are located for telehealth services, like Amanda said, does need to be during RHC hours. But in terms of locations that can be in different places, the one kind of caveat and someone asked a question about this as well is different states for where the where the patient is located and things like that. This is vary state to state specific. Traditionally, the provider needs to be licensed in the area where the patient is. Although during COVID There's been a lot of flexibilities around this a lot of state to state kind of compacts and things like that. So I would encourage you to look at the telehealth resources on our website for some resources around that. That hit on a bunch of different questions in the in the telehealth space. Like Amanda said telehealth visits. Non mental health telehealth visits are covered through the end of 2024. As of right now, those are the ones that you bill due to zero to five. Just a bunch of those I wanted to hit them at once.

Nathan Baugh 1:14:15

Okay, I know we're at 314 I know that there are a lot of questions that we're obviously not going to be able to get to I have seen the this this portion of the webinar will be this it's still being recorded and so it will be up and we so we will have the q&a is there. We might be able to get to these other questions in a written format and post those at a later time to sort of answer some of the questions that weren't be able to be asked we we post those if we do those, which we've done. We post those When we when we can, on the same place that we posted a recording, it'll just be you'll see the like the q&a transcript and our answers to the questions that we haven't been able to get to. Is there any last question that you want to ask Sarah and and then we'll close it out? Just

Sarah Hohman 1:15:18

one No, I was just going to thank everyone, the 900 plus people who who stuck through to the end of the q&a, I know that there are a lot of questions that you weren't able to get to. We do have a lot of resources to, you know, available on some of these things. But like Nathan said, I would encourage you to keep an eye on our TA webinars page. For those that we aren't able to get to, I do my best to pull together a recap of those for you to look there. I'd also encourage folks to attend our bi weekly office hours with some of these questions, too. We don't we don't always have our billing experts like Amanda on on the phone with us. But we it is a place to ask questions and have those conversations. So I encourage you to join us there as well. But I wanted to thank everyone for joining and to especially Amanda for her presentation, as well as the Federal Office of Rural Health Policy for sponsoring this technical assistance series. If you have ideas for future webinars, please put them in the survey that you're prompted with at the end of at the end of the presentation or email Nathan ri with those ideas. For CRTP. Folks, the CEU code can be found after you take the survey that you're prompted with when you leave the webinar. And as always, we will send out and post all the details when we schedule our

next webinar. So thank you again for being here. Thank you to Amanda. And this concludes today's presentation. Thank you