Rural Health Clinic
Technical Assistance Webinar

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CMS Final Rules Overview
Impacts for RHCs Beginning January 1, 2024

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Executive Director
National Association of Rural Health Clinics

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Director of Government Affairs
National Association of Rural Health Clinics
Agenda

• **2024 Payment Rates Published**
  • All-Inclusive Rate and Medicare Economic Index (MEI)
  • G-code Rates

• **Final Rules for 2024**
  • 2024 Medicare Physician Fee Schedule (MPFS)
    • New Billable Providers in RHCs
    • Changes to Care Management Services and Billing
    • Telehealth
    • Definition of Nurse Practitioner
  • 2024 Hospital Outpatient Prospective Payment System (OPPS)
    • Intensive Outpatient Program
# 2024 Special Payment Codes and Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2023</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0511</td>
<td>General Care Management</td>
<td>$77.94</td>
<td>$71.68</td>
</tr>
<tr>
<td>G0512</td>
<td>Psychiatric Care Management</td>
<td>$146.73</td>
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<tr>
<td>G0071</td>
<td>Digital E-Visit</td>
<td>$23.72</td>
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<td>G2025</td>
<td>Telehealth Visit</td>
<td>$98.27</td>
<td>$95.37</td>
</tr>
<tr>
<td>Q3014</td>
<td>Originating Site</td>
<td>$28.64</td>
<td>$29.96</td>
</tr>
</tbody>
</table>

2024 Upper Payment Limits

• (Non-Grandfathered) Upper Payment Limit : $139.00

• (Grandfathered RHCs) MEI adjustment to Upper Payment Limit: 4.6% or $139.00 whichever is greater

• Grandfathered RHCs = Provider-Based RHCs owned by hospitals with less than 50 beds that were in operation on or had submitted their 855A by December 31, 2020

New Medicare Billable Providers in RHCs

• Marriage and Family Therapist (MFT)
  o An individual who:
    • Possesses a master’s or doctor’s degree which qualifies for licensure or certification as a MFT pursuant to State law of the State in which such individual furnishes marriage and family therapist services;
    • Is licensed or certified as a MFT by the State in which such individual furnishes such services;
    • After obtaining such degree has performed at least 2 years (or 3,000 hours) of clinical supervised experience in marriage and family therapy; and
    • Meets such other requirements as specified by the Secretary.

• Mental Health Counselor (MHC)*
  o An individual who:
    • Possesses a master’s or doctor’s degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC services;
    • Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
    • After obtaining such degree has performed at least 2 years (or 3,000 hours) of clinical supervised experience in mental health counseling; and
    • Meets such other requirements as specified by the Secretary.

*Addiction counselors who meet all applicable requirements can also enroll as Medicare providers under MHC category.
Changes to the Regulation

§ 405.2401 Scope and definitions
§ 405.2411 Scope of benefits
§ 405.2415 Incident to services and direct supervision
§ 405.2463 What constitutes a visit
§ 405.2468 Allowable costs
§ 491.8 Staffing and staff responsibilities

MFTs and MHCs can generate a Medicare encounter, reimbursable at the RHC’s All-Inclusive Rate (AIR). They will be subject to the same policies as a PA, NP, CNM, CP, and CSW in the RHC. These provider types may serve as the RHC owner or an employee, or be under contract. Additionally, MFTs and MHCs can fulfill the requirement that a provider must be available to furnish care at all times the clinic is open.
Other Clarifications & Resources

• MFTs/MHCs can begin the Medicare enrollment process to begin billing January 1, 2024.
  o CMS enrollment FAQ

• MFTs/MHCs will not be subject to a productivity standard in RHCs.

• MFTs/MHCs can:
  o Bill G0511 for General Behavioral Health Integration services (GBHI).
  o Furnish telehealth services.

• The majority of Medicaid plans cover these provider types, but not all.
Poll Questions
Major Changes to Care Management Services (G0511)

- Adding in four new buckets of care management:
  - Remote Physiologic Monitoring (RPM)
  - Remote Therapeutic Monitoring (RTM)
  - Community Health Integration (CHI)
  - Principal Illness Navigation (PIN)

- Allowing multiple G0511s per patient per month
# 2023 Care Management (G0511) Codes

<table>
<thead>
<tr>
<th>Physician Fee Schedule Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0323</td>
<td>General Behavioral Health Integration (BHI)</td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM (over 60 minutes of care management per month)</td>
</tr>
<tr>
<td>99490</td>
<td>Basic CCM (20 minutes of care management)</td>
</tr>
<tr>
<td>99491</td>
<td>30 minutes or more of CCM furnished by a physician or other qualified health professional</td>
</tr>
<tr>
<td>99424</td>
<td>30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners</td>
</tr>
<tr>
<td>99426</td>
<td>30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner</td>
</tr>
<tr>
<td>G3002</td>
<td>Chronic Pain Management and treatment first 30 minutes</td>
</tr>
<tr>
<td>G3003</td>
<td>Chronic Pain Management (each additional 15 minutes)</td>
</tr>
</tbody>
</table>
### 2024 Care Management Codes:

- **BOLD** = New for 2024

<table>
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</tr>
<tr>
<td>99453</td>
<td>Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment</td>
</tr>
<tr>
<td>99454</td>
<td>Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days</td>
</tr>
<tr>
<td>99457</td>
<td>Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes</td>
</tr>
<tr>
<td>99458</td>
<td>Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes</td>
</tr>
<tr>
<td>99091</td>
<td>Collection and interpretation of physiologic data (e.g., Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days</td>
</tr>
<tr>
<td>98975</td>
<td>Remote therapeutic monitoring (e.g., therapy adherence, therapy response); initial set-up and patient education on use of equipment</td>
</tr>
<tr>
<td>98976</td>
<td>Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days</td>
</tr>
<tr>
<td>98977</td>
<td>Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days</td>
</tr>
<tr>
<td>98980</td>
<td>Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes</td>
</tr>
<tr>
<td>98981</td>
<td>Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes</td>
</tr>
<tr>
<td>G0019</td>
<td>Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit</td>
</tr>
<tr>
<td>G0022</td>
<td>Community health integration services, each additional 30 minutes per calendar month</td>
</tr>
<tr>
<td>G0023</td>
<td>Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month,</td>
</tr>
<tr>
<td>G0024</td>
<td>Principal Illness Navigation services, additional 30 minutes per calendar month</td>
</tr>
</tbody>
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2023 Care Management (G0511) Policy

• One G0511 reimbursable per patient per month

• From Medicare Claims Processing Manual Chapter 9:

70.8- General Care Management Services – Chronic Care or Psychiatric Collaborative Care Model (CoCM) Services

Effective for services furnished on or after January 1, 2018, RHCs and FQHCs are paid for General Care Management or Psychiatric CoCM services when G0511 or G0512 is billed alone or with other payable services on an RHC or FQHC claim. HCPCS code G0511 or G0512 can only be billed once per month per beneficiary, and cannot be billed if other care management services are billed for the same time period.

HCPCS codes G0511 and G0512 are subject to coinsurance and deductibles on RHC claims. Only coinsurance applies on FQHC claims. Coinsurance is 20 percent of the lesser of the RHC or FQHC’s charge for HCPCS codes G0511 and G0512, or the corresponding rate.
2024 Care Management (G0511) Policy

• "An RHC or FQHC may bill HCPCS code G0511 multiple times in a calendar month as long as all requirements are met and there is not double counting."

• "As we clarified above, RHCs and FQHCs may bill HCPCS code G0511 multiple times in a calendar month, as long as all of the requirements are met and resource costs are not counted more than once."
Care Management Policy 2024 Questions

• What services can be billed together?

• What care management services are mutually exclusive?

• How many care management services could be billed per patient per month?
# CHI and PIN Services

<table>
<thead>
<tr>
<th>CPT Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>G0019</td>
<td>Community health integration services performed by certified or trained auxiliary personnel, including a <strong>community health worker</strong>, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit</td>
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</tr>
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<td>G0024</td>
<td>Principal Illness Navigation services, additional 30 minutes per calendar month</td>
</tr>
<tr>
<td>RPM CPT Code</td>
<td>Remote Physiologic Monitoring Description</td>
</tr>
<tr>
<td>--------------</td>
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<td>99453</td>
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</tr>
<tr>
<td>RTM CPT Codes</td>
<td>Remote Therapeutic Monitoring Descriptions</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>98975</td>
<td>Remote therapeutic monitoring (eg, therapy adherence, therapy response); <strong>initial set-up</strong> and patient education on use of equipment</td>
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RPM and RTM are mutually exclusive

• "Practitioners may bill RPM or RTM, but not both RPM and RTM, concurrently with the following care management services: CCM/TCM/BHI, PCM, and CPM."

• "Our intention is to allow the maximum flexibility for a given practitioner to select the appropriate mix of care management services, without creating significant issues of possible fraud, waste, and abuse associated with overbilling of these services."

• MPFS Final Rule
Principal Care Management and Chronic Care Management

• Can CCM and principal care management (PCM) be billed concurrently? Can they be billed for the same practice in a multispecialty group that has a PCP and a specialist?
  o "Yes. As discussed in the CY 2020 PFS final rule (84 FR 62697), CCM and PCM cannot be billed by the same practitioner for the same patient in the same month. However, it is allowable, for instance, for a primary care practitioner to offer CCM and a specialist to offer PCM (or vice versa, as appropriate). The conditions being addressed by CCM and PCM must be different.

  If CCM and PCM are provided concurrently, two care plans would be required. Note, however, that for PCM, the care plan needs only to be “disease-specific.” Refer to the CY 2020 PFS final rule (84 FR 62695-62696) for a comparison of the CCM and PCM scope of service requirements, including the care plan."

CCM Add-on Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99437</td>
<td>Chronic care management services, provided personally by a physician or other qualified health care professional, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>99439</td>
<td>Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month</td>
</tr>
</tbody>
</table>

Are these codes a part of the G0511 suite?

CMS has not formally proposed to put these codes in the G0511 suite, although they were used to weigh G0511.
Clarity Needed ~ 40 minute CCM visit

• Would a 99490 (20 min basic CCM) + a 99439 (20 minute add-on) generate one G0511 code or two G0511 codes on an RHC claim?

• Awaiting guidance to answer this question.

• NB Thoughts: The CCM add-on codes (99439 and 99437) are not mentioned as part of G0511 in the final rule but given that the other add-on codes are explicitly added into the suite of G0511 it would make logical sense for these to be included.
How many G0511s per claim?

- Principal Care Management
- Principal Illness Navigation 1st 20
- Principal Illness Navigation 20 min add-on
- Remote Physiological Monitoring Device
- Remote Physiological Monitoring Initial Setup
- Remote Physiological Monitoring services 1st 20
- Remote Physiological Monitoring services 2nd 20
- Remote Physiological Monitoring data collection and interpretation

- Could we be reimbursed for 8 G0511s on a claim? Would MACs be able to adjudicate this properly?
G0511 Closing Thoughts

• Be on the lookout for additional guidance

• Don’t concurrently bill care management codes that are mutually exclusive

• Unclear how quickly claims adjudication systems will be updated to handle the new policy

• Coinsurance still applies

• Once the dust settles, evaluate your care management offerings
Other New Related Codes

G2211 – New Complex Condition Add-On

- Complex E/M visit **add on** that can be reported in conjunction with E/M visit to "better account for additional resources associated with primary care, or similarly ongoing medical care related to a patient’s single, serious condition, or complex condition."

- For RHCs: Will not generate a second All-Inclusive Rate or other add-on payment when performed as part of an RHC encounter

- Added to Medicare telehealth list (including via audio-only)
  - Can be billed by RHC as G2025

G0136 – Administration of a Social Determinants of Health Risk Assessment

- "A review of the individual’s SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions," 5-15 min; no more frequently than every 6 months.

- For RHCs: Will not generate an add-on payment when performed as part of an RHC encounter

- Added to Medicare telehealth list (including via audio-only)
  - Can be billed by RHC as G2025
Poll Questions
Telehealth

Implements the various telehealth provisions established in the Consolidated Appropriations Act of 2023, and makes necessary technical changes in the regulation for the following:

- **Through December 31, 2024:**
  - Extends RHC medical telehealth flexibilities including reimbursement through G2025.
  - Removes originating and geographic site requirements, allowing patients to be located at any location during the telehealth service, including a patient’s home.
  - Delays the in-person requirement for mental health visits furnished via telehealth, which can now be permanently offered by RHCs and reimburses at the RHC's All-Inclusive Rate.
  - Extends audio-only coverage for those denoted as billable via audio-only communications on Medicare’s telehealth list.

- Allows for physician or practitioner “direct supervision” of incident to services to be performed via two-way, real time-audio visual technology, as opposed to immediately available in the physical space of the RHC.
- Expands the list of telehealth distant site practitioners to include Marriage and Family Therapists and Mental Health Counselors beginning January 1, 2024.
- Adds Social Determinants of Health (SDOH) Risk Assessment to Medicare's telehealth list.
Telehealth & RHC Hours of Operation

NARHC Comments: "Finally, NARHC requests guidance from CMS to clarify for the RHC community if distant site telehealth services may be provided outside the RHC’s hours of operation. NARHC believes that RHCs should not be limited to only offering telehealth during the hours of operation of the physical RHC as such a policy would only limit access to care for safety-net patients."

CMS Response: "Currently, RHCs and FQHCs are required to furnish services during their hours of operation and if services are furnished at times other than the RHC’s or FQHC’s posted hours of operation, they may not be billed to Medicare Part B if the practitioner’s compensation for these services is included in the RHC/FQHC cost report."
Poll Questions
Nurse Practitioner Definition Change

§491.2 Definitions.

Nurse practitioner means a registered professional nurse who is currently licensed to practice in the State, who meets the State’s requirements governing the qualifications of nurse practitioners, and who meets one of the following conditions:

(1) Is currently certified as a primary care nurse practitioner by the American Nurses’ Association or by the National Board of Pediatric Nurse Practitioners and Associates, a recognized national certifying body that has established standards for nurse practitioners and possess a master’s degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree; or

(2) Has satisfactorily completed a formal 1 academic year educational program that:
   (i) Prepares registered nurses to perform an expanded role in the delivery of primary care;
   (ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and
   (iii) Awards a degree, diploma, or certificate to persons who successfully complete the program; or

(3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of paragraph (2) of this definition, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

This will allow NPs who have trained in populations other than primary care to be employed or under contract with your RHC and permits other national certifying bodies to grant these certifications for practice.
Intensive Outpatient Program (IOP) Services

Quick Details:

• New behavioral health treatment category billable in RHCs beginning January 1, 2024

• Intended for patients with an acute mental illness (including depression, schizophrenia, substance use disorders, etc.) that need between 9-19 hours of care per week
  o Higher level of care than occasional outpatient visit; less intensive than partial hospitalization programs
  o These services are to be provided in person

• Reimburses through a "special payment rule," not the AIR/encounter rate
  o $284.00 per patient per day
  o Reimbursement corresponds to 3* distinct, qualifying services per day
  o Costs associated with IOP services must be carved out of RHC cost report

• An IOP service and a separate mental health encounter would not be eligible for same day billing (RHC All-Inclusive Rate reimbursement plus $284). However, RHCs could bill for IOP services and a separate medical visit for the same patient on the same day when appropriate

Three (or fewer services per day) would accommodate occasional instances when a patient is unable to complete a full day of PHP or IOP. CMS expects that days with fewer than three services would be very infrequent and intends to monitor the provision of these days among providers and individual patients.
Intensive Outpatient Program Patient Eligibility

- Physician* certifies (initially within 30 days and then at least once every other month) that a patient needs behavioral health services between 9-19 hours per week and:
  - Is likely to benefit from these coordinated services more than they would individual sessions of outpatient treatment
  - Does not need 24-hour care
  - Has a separate support system outside of the IOP
  - Has received a mental health diagnosis
  - Is not a danger to themselves or others
  - Has the cognitive and emotional ability to tolerate the IOP

Congress specified in CAA, 2023 that the certifying provider be a physician (MD or DO); this certifying provider cannot be a psychiatric NP or other mental health professional.
Intensive Outpatient Program Services

- Individual and group therapy with physicians, psychologists, and other mental health professionals as authorized by state law
- Occupational therapy
- Furnishing of drugs and biologics for therapeutic purposes that are not self-administered
- Family counseling (as part of treatment of the patient’s condition)
- Patient training and education
- Individualized activity therapies
- Diagnostic services
- Other related services for diagnosis and active treatment intended to improve or maintain the patient’s condition and function
At least one service must come from this "primary" list:

**TABLE 99: FINAL PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT PRIMARY SERVICES**

<table>
<thead>
<tr>
<th>HCPCS/HCPT</th>
<th>Short Description</th>
<th>Final Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>90812</td>
<td>Psych pts &amp; family 30 minutes</td>
<td>Add</td>
</tr>
<tr>
<td>90824</td>
<td>Psych pts &amp; family 45 minutes</td>
<td>Add</td>
</tr>
<tr>
<td>90837</td>
<td>Psych pts &amp; family 60 minutes</td>
<td>Add</td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>Add</td>
</tr>
<tr>
<td>90846</td>
<td>Family psyx w/ patient</td>
<td>Add</td>
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<tr>
<td>90847</td>
<td>Family psyx w/ patient</td>
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<tr>
<td>90853</td>
<td>Group psychotherapy</td>
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<td>90855</td>
<td>Narcoanalgesia</td>
<td>Remove</td>
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<tr>
<td>90880</td>
<td>Hypnotherapy</td>
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<td>96116</td>
<td>Neurobehavioral status exam</td>
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<tr>
<td>96130</td>
<td>Psychological testing by physicians/qualified health professionals; first hour</td>
<td>Add</td>
</tr>
<tr>
<td>96132</td>
<td>Neurobehavioral testing evaluation by physicians/qualified health care professionals; first hour</td>
<td>Add</td>
</tr>
<tr>
<td>96136</td>
<td>Psychological/neuropsychological testing by physicians/qualified health care profession; first 30 minutes</td>
<td>Add</td>
</tr>
<tr>
<td>96138</td>
<td>Psychological/neuropsychological testing by technician; first 30 minutes</td>
<td>Add</td>
</tr>
<tr>
<td>G0410</td>
<td>Grp psych partial hsp/rip 45-50</td>
<td>Update</td>
</tr>
<tr>
<td>G0411</td>
<td>Inter active grp psych PHP/rip</td>
<td>Update</td>
</tr>
</tbody>
</table>
Poll Questions
Example: Consolidated Appropriations Act, 2023 granted Medicare coverage of MFTs/MHCs.

CMS promulgated these regulations in the Medicare Physician Fee Schedule.

Changes will need to be made in guidance documents like Medicare Benefit Policy Manual Ch. 13, State Operations Manuals, etc.

https://www.narhc.org/narhc/RHC_Statute_Regulation_and_Guidance.asp
Rulemaking Process

July – MPFS and OPPS Proposed Rules Released

September – Comments Due (regulations.gov)
   • NARHC’s comments are reviewed by the Policy Committee and available on NARHC.org

November – Final Rules Released

January – Provisions go into effect; CMS issues additional guidance

*November – March – CMS considers what to include in 2025 proposed rules
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    - Policy and Advocacy
- FORHP Announcements
- State rural health organizations & offices of rural health
- RHInet
- CMS RHC Center
Questions?

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