Rural Health Clinic Technical Assistance Webinar

This webinar is brought to you by the National Association of Rural Health Clinics and is supported by cooperative agreement UG6RH28684 from the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA). It is intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and guest speakers.

Reminders

- All participants are muted upon entry
- Questions will be accepted via the Q&A box at the end of today's presentation
- For any technical issues please email asst@narhc.org
- Slides will be available via the chat box and can also be downloaded on NARHC.org
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Disclaimer

At this time, the webinar presentation is now transitioning from a government supported presentation to an external speaker. Thank you.

Back to the Basics – Rural Health Clinic Billing

March 2025

CHANGES EVERYTHING.

WIPFLI

Overview of today's discussion points

RHC Basics

What is an RHC?

- The RHC certification is a designation from the Centers for Medicare & Medicaid Services (CMS) to clinics providing outpatient care in certain rural, underserved areas and provides an alternative, cost-based reimbursement system for treating Medicare and Medicaid beneficiaries.
- One of the benefits of RHC certification is enhanced traditional Medicare and Medicaid reimbursement.
- Proper billing and system set-up is essential to ensure that your RHC is receiving correct reimbursement.

RHC Billing

Traditional Medicare

Direct Medicare services include payment at the RHC all-inclusive encounter rate. Certain services, although provided in the RHC are billed and paid outside of the RHC rate. It is imperative that prior to RHC certification, that the set-up of your billing build is done correctly.

Medicaid

Know your state's RHC billing requirements (UB04 vs. 1500). Some states pay at the cost-per-visit, some pay fee for service and settle-up through a wrap payment. Some require the use of a T1015 code. Each state's definition of RHC practitioners, RHC visits, and services included in the RHC payment can differ.

Commercial Plans (including Medicare Advantage)

Commercial plans do not recognize RHC certification. Clinics should continue to bill as contracted. Medicare Advantage plans may pay at Traditional Medicare RHC rates if your clinic contracts with them as such.

How are RHCs paid from Medicare?

- RHCs are paid a flat rate for each face-to-face encounter based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs (i.e., cost report) occurring at the end of the fiscal year.
- Cost-based reimbursement is determined on the average cost per visit. A visit is defined as a medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, clinical social worker, mental health counselor, licensed marriage and family therapist and a patient AND distant site mental health services.
- In general, if there is no “visit,” there is no RHC payment.

Caps for “newly certified” or freestanding RHCs

- New limitations for independent RHCs, those with hospitals greater than 50 beds, and all “new” provider-based RHCs with hospitals less than 50 beds.

2025	$152.00
2026	$165.00
2027	$178.00
2028	$190.00

After 2028 and in subsequent years, the cap is increased by the Medicare Economic Index (MEI).

Caps for “grandfathered RHCs”

- “Grandfathered RHCs” are provider-based RHCs owned by a hospital with less than 50 beds that were furnishing services as of December 31, 2020. These RHC’s base year rates will be established based on the finalized 2020 Medicare cost report OR the first finalized Medicare cost report which contains the clinic’s expenses for a full year.
- This base year rate (“limit”) will be increased annually by the Medicare Economic Index (MEI).
- MEI for CY 2025 was 3.5%.

RHC cost-per-visit

$$\frac{\textit{Allowable RHC costs}}{\textit{RHC visits}} = \text{RHC cost per visit (rate)}$$

RHC billing differences

- RHC services are billed to Medicare (and Medicaid in some states) using a unique format that facilitates an all-inclusive payment rate for each medically necessary RHC encounter.
- RHC services are billed to Medicare on the CMS-1450 (UB-04) claim form instead of the CMS 1500 form often used for billing physician services.
- In general, RHCs do not charge any differently for the services they provide, although the actual format of the Medicare/Medicaid claim form may be substantially different.
- One common billing difference is the use of the “CG” modifier for Medicare to identify a “billable RHC encounter.”

Total Medicare RHC reimbursement

- RHCs are paid a flat rate for each face-to-face encounter based Total reimbursement includes the following:
  - Medicare pays 80% of the interim rate for qualifying RHC encounters.
  - Patient coinsurance is based on 20% of the total charges.
- In addition, Medicare flu, pneumonia, and COVID-19 vaccinations are paid at cost on the Medicare cost report (changes coming in July 2025).
- Medicare bad debt can also be claimed on the year end Medicare cost report and paid at a percentage (65%).
- Laboratory services and the technical component of diagnostics (i.e. – EKGs and CSTs) are billed to the Part B carrier and paid at fee schedule amounts.

RHC Billing

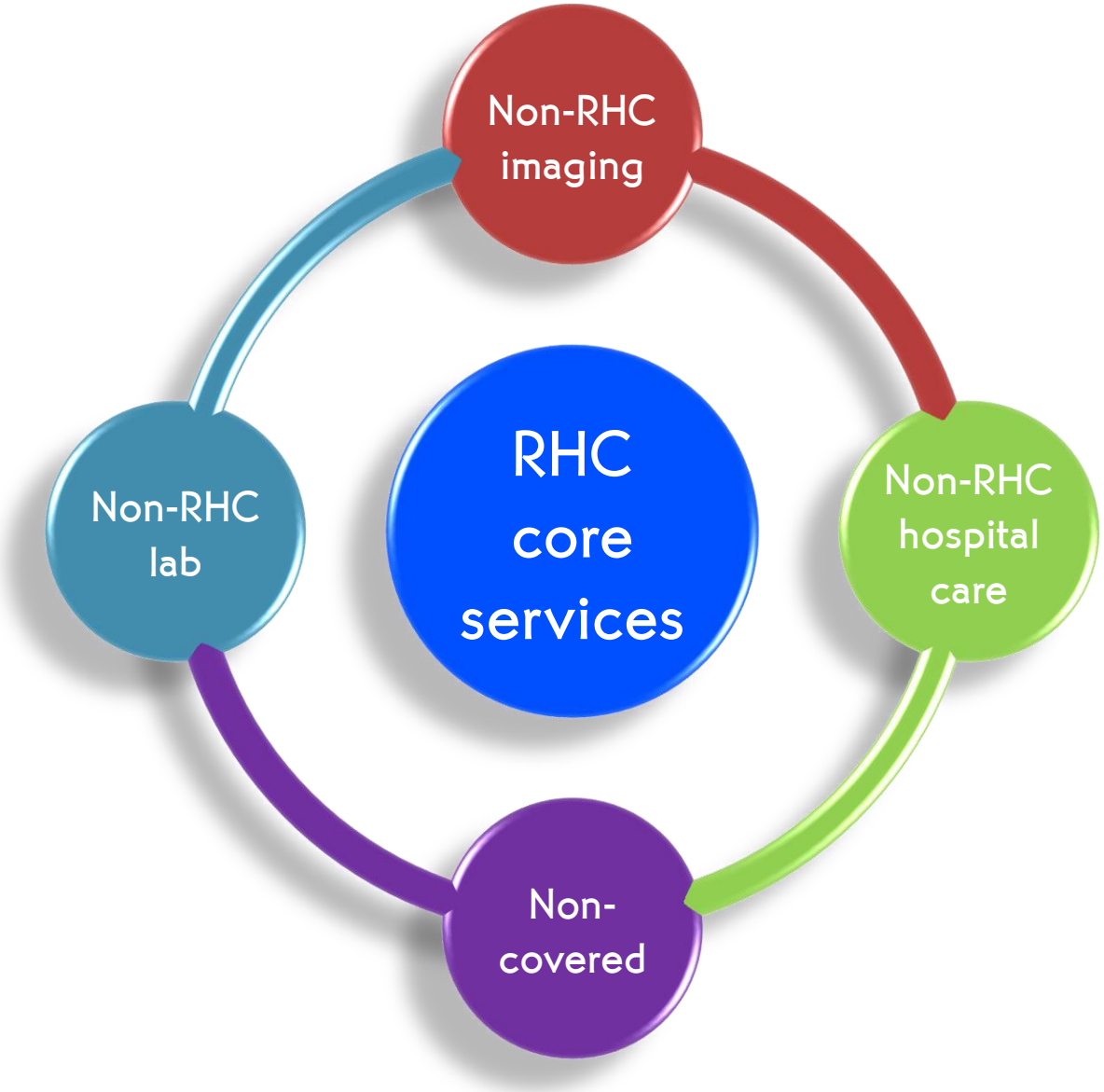
RHC Services Paid under the AIR on the RHC Claim Form

Non-RHC Services Not Billed on the RHC Claim Form

Non-RHC Services Billed on the RHC Claim Form but paid at fee schedule

RHC/Non-RHC Services

Where & What?



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RHC Services

RHC Services

RHC billing differences (RHC services)

Service	Independent	Provider-based
RHC services (face-to-face encounter in RHC site of service)	Billed to independent RHC regional fiscal intermediary - RHC provider number on Form UB-04	Billed to host provider fiscal intermediary - RHC provider number on Form UB-04

RHC Services

- Physician services
- Services of nonphysician practitioners (NPPs), which include physician assistants (PAs), nurse practitioners (NPs) and certified nurse midwives (CNMs), clinical psychologists (CPs), clinical social workers (CSWs), mental health counselors (MHCs), and licensed marriage and family therapists (LMFTs).
- Services and supplies incident to RHC practitioner services
- Visiting nurse services to the homebound (with a home health shortage designation)
- RHC practitioner services for beneficiaries in Part A stay in Skilled Nursing Facility (SNF) (including hospital swing bed) separately billable

RHC Services

Services and supplies are furnished incident to physician services:

- Furnished as an incidental, integral part of professional services
- Commonly rendered either without charge or otherwise chargeable
  - Cannot bill carrier or intermediary separately!
  - Costs are included in the cost report as part of the all-inclusive encounter rate
- Commonly furnished in a physician's office
- Furnished by a clinic employee (staff)
- Includes services of clinic staff (e.g., nurse, therapist, technician or other aide)
- Supplies such as bandages and tongue depressors are included in the office visit as packaged services

Mental Health Distant Site Telehealth Services

- Beginning January 1, 2022, RHC mental health visits were included as defined RHC visits furnished using interactive, real-time telecommunications technology.
- This allows RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of or does not consent to, the use of video technology.

Mental Health Distant Site Telehealth Services (cont.)

- There must be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that, in general, an in-person, non-telehealth visit must be furnished at least every 12 months for these services. "however, we may make exceptions to the in-person visit requirement based on patient circumstances (with the reason documented in the patient's medical record and also allow more frequent visits as driven by clinical needs on a case-by-case basis.") (delayed until 4/1/2025).
- In order to bill for mental health visits furnished via telecommunications for dates of service on or after January 1, 2022, RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only.

Preventive Services

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Preventive services in the RHC

Service	HCPCS code	Long description	Paid at the AIR	Eligible for same-day billing	Coinsur./ deduct.
Initial Preventive Physical Exam (IPPE)	G0402	IPPE; face-to-face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	Yes	Yes	Waived

Preventive services in the RHC

Medicare Preventive Service	HCPCS Code/ Short Description	AIR?	Same Day?	Coins/Ded
Annual Wellness Visit – Initial	G0438/ AWV - I	Yes	No	Waived
Annual Wellness Visit – Subsq	G0439/ AWV-S	Yes	No	Waived
Screening Pelvic Exam	G0101/ Pelvic-breast Exam	Yes	No	Waived
Prostate Cancer Screening	G0102/ Prostate Screening	Yes	No	Not Waived
Glaucoma Screening	G0117 Glaucoma	Yes	No	Not Waived
Glaucoma Screening	G0118 Glaucoma	Yes	No	Not Waived
Screening Pap Test	Q0091 Obtaining Pap Smear	Yes	No	Waived
Alcohol Screening /Behavioral Counseling	G0442 Alcohol Screen 15 min	Yes	No	Waived
Alcohol Screening /Behavioral Counseling	G0443 Brief alcohol misuse counseling	Yes	No	Waived
Screening for Depression	G0444 Depression screen annual	Yes	No	Waived

Preventive services in the RHC

Medicare Preventive Service	HCPCS Code/ Short Description	AIR?	Same Day?	Coins/Ded
Screening for Sexually Transmitted Infections	G0445/ STD 30 Minutes	Yes	No	Waived
Intensive Behavioral Therapy for Cardiovascular Disease	G0446/ Cardio-disease	Yes	No	Waived
Intensive Behavioral Therapy for Obesity	G0447/ Obesity 15 minutes	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99406[1]/Smoking 3-10 minutes	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99407[1]/Smoking > 10 Minutes	Yes	No	Waived
Lung Cancer Screening With Low Dose Computed Tomography	G0296/ Lung Cancer LDCT	Yes	No	Waived

[1] HCPCS code G0436 and G0437 will be discontinued effective 10/1/2016. CPT codes 99406 and 99407 are the remaining codes for tobacco cessation counseling.

Pneumococcal, Influenza, Covid-19 vaccines –

- Until July 1, 2025, pneumococcal, influenza, and COVID-19 vaccines and their administration are paid at 100 percent of reasonable cost.
- When an RHC practitioner sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit;
- The cost of the vaccines and administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should not be reported on an RHC claim when billing for RHC services, and the beneficiary pays no Part B deductible or coinsurance for these services.

Pneumococcal, Influenza, Covid-19 & Hep B vaccines –

2025 changes

- Beginning July 1, 2025, RHCs can bill for administration of Part B preventive vaccines (COVID-19, pneumococcal, influenza, and Hepatitis B) at time of service, not entirely in a lump sum settlement on cost report, beginning July 1, 2025.
- RHCs will still settle up to cost on the Medicare cost report (less what was paid during the year)
- Is this optional or mandatory??

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Non-RHC Services

Non-RHC Services

- DME
- Ambulance services
- Technical component of diagnostic tests such as X-rays and EKGs
- Lab test (although required for certification, must be able to perform four required tests in RHC) *(Until January 1, 2025 was six required lab tests)*
- Screening mammography services
- Prosthetic devices
- Services provided to hospital patients (except those in a swing bed)

Non-RHC Services

RHC billing differences (non-RHC services)

Service	Independent	Provider-based
Laboratory (excluding the draw procedure, e.g., CPT 36415)	Billed to Part B carrier - existing group number on Form 1500	Billed on hospital O/P claim type (14x, 13x or 85x) on Form UB-04*
Other diagnostic/radiology - professional component	May be billed with encounter. If read by non-RHC provider, they will bill the carrier.	May be billed with encounter. If read by hospital radiologist, bill the carrier.
Other diagnostic/radiology - technical component	Billed to Part B carrier - existing group number on Form 1500	Billed on hospital O/P claim type (13x or 85x) on Form UB-04*
Non-RHC professional services (I/P, ER, other O/P services)	Billed to Part B carrier - existing group number on Form 1500	Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for ER & other O/P pro fees)

Lab Services

- Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see Section 1861(aa)(2)(G) of the Act and for FQHCs see Section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.

Technical component of diagnostic services

Example billing for EKGs:

- Bill technical component of EKG using 93005 (EKG) to Part B carrier or hospital FI
- RHC (professional) service:
- Follow normal RHC billing if attending physician is also interpreting test; charge added (bundled) with office visit
- Revenue code 52x

Originating Site Telehealth Services

"Non-RHC" Billing – Telehealth Services

- Telehealth services (originating site) are non-RHC services. Originating site will
  receive separate payment. Coinsurance and deductible apply.
- RHC (originating site):
- This is the only service that may be included on an RHC bill (bill type 71x) with another RHC service (e.g., Rev. Code 521).
- Bill telehealth service under Rev. Code 0780 with HCPCS Q3014.
- Requires HCPCS Code Q3014 (reimbursement approximately $25).

Distant Site RHC Services Billed through the Covid-19 Waiver

RHC Distant-site services (G2025)

- Through March 31, 2025, RHCs can bill G2025 and get paid the weighted combined average of all telehealth services on the Medicare Physician Fee Schedule list

Type of Service	What is the Service?	Modality	CPT/HCPCS	Brief Description	How to Report
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient	Synchronious (Telephone Audio/Video)	99201-99205 99212-99215 99304-99306 99307-99308 99315-99316 99495-99496 99497-99498	New & Patient Office Visits * Est. Patient Office Visits Initial SNF visit * Subsequent SNF visits Nursing Fac D/C day * TCM Services Advanced Care Planning	G2025

Care coordination services

Care coordination services beginning 1/1/2025

- Starting January 1, 2025, care coordination services (previously care management services) provided in RHCs/FQHCs will include:
  - Advanced Primary Care Management Services (APCM) in the suites of care coordination services as well as
  - Transitional care management (TCM), Chronic care management (CCM),
  - Principal care management (PCM),
  - Chronic pain management (CPM), General behavioral health integration (BHI),
  - Remote physiologic monitoring (RPM), Remote therapeutic monitoring (RTM),
  - Community Health Integration (CHI),
  - Principal Illness Navigation (PIN) and
  - Principal Illness Navigation Peer-Support (PIN-PS).

Care coordination services (cont.)

Care coordination services beginning 1/1/2025

- RHCs/FQHCs will report the individual CPT/HCPCS base codes and add-on codes for each of the care coordination services which will replace HCPCS code G0511. These services will be paid at the national non-facility PFS payment rates: https://www.cms.gov/center/provider-type/rural-health-clinics-center)
- CMS has established a transition period for compliance with the new billing structure. From January 1, 2025, through July 1, 2025, RHCs may bill either G0511 or the individual CPT codes. After July 1, 2025, G0511 will no longer be reimbursable.
  - The billing method used during this transition must be at the facility level not the individual patient level (i.e. either the RHC uses G0511 or the individual CPT codes).

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Revenue Codes & Bill Types

RHC revenue codes

Traditional RHC revenue codes

- 0522 Home visit by RHC/FQHC
- 0521 Clinic visit at RHC/FQHC
- 0524 Visit by RHC/FQHC practitioner in Part A stay SNF
- 0525 Visit by RHC/FQHC practitioner in an NF or ICF or residential facility
- 0527 RHC/FQHC visiting nurse (must have special designation)
- 0528 RHC/FQHC visit other locations (e.g., scene of an accident)
- 0780 Telehealth services (Note: not an RHC service)
- 0900 Mental health visits

Sometimes referred to as place of service with respect to RHCs/FQHCs

RHC revenue codes (cont.)

All revenue codes are valid except:

- 002x – 024x
- 029x
- 045x
- 054x
- 056x
- 060x
- 065x
- 067x – 072x
- 080x – 088x
- 093x
- 096x – 310x

RHC Bill Types

UB-04 claim form, 71x – please see Medicare Claims Processing Manual Chapter 9 Section 50:

- 710 Claim with only non-covered charges
- 711 Original claim
- 717 Replacement claim – adjustment to prior claim
- 718 Void/cancel previous claim

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Billing examples

CG Modifier – Example 1

- The CG modifier is used to identify the “billable RHC encounter.” When billing Medicare, RHCs should report modifier CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face encounter.
- If only an office visit is performed, as in the example below, the claim will appear to be fairly similar to most other billings:

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	$ 100.00
0001	Total Charge				$ 100.00

CG Modifier – Example 2

- If multiple services are provided, the Medicare claim can appear quite unusual when compared with most other billings:
- Here, the charge amount the allergy injection of $15 will be combined with the 99312 charge of $100 on the qualifying visit line with the CG modifier
- Note that the total charge line is overstated

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	$ 115.00
0636	Allergy Injection	95115	4/2/2016	1	$ 15.00
0001	Total Charge				$ 130.00

CG Modifier – Example 3

- The “penny method” is also approved by CMS and lists the secondary service charges at $0.01.
- Note that this results in the same calculation of deductibles/coinsurance from the patient as well as the services provided.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	$ 115.01
0636	Allergy Injection	95115	4/2/2016	1	$ 0.01
0001	Total Charge				$ 115.02

Preventive Services – Example 4

- A breast and pelvic exam (G0101) and a pap collection (Q0091) were performed on the same day.
- Both services are “stand alone” preventive services.
- Report one of these with the CG modifier.
- No coinsurance or deductible amount should be applied.

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Breast/Pelvic	G0101 CG	4/2/2016	1	$ 75.00
0521	Pap Collection	Q0091	4/2/2016	1	$ 40.00
0001	Total Charge				$ 115.00

Preventive Services – Example 5

- An established patient is seen and a qualifying visit of 99213 of $100 is generated
- A breast/pelvic example was performed for $75
- A venipuncture was performed for $20
- A lab service was performed for $80

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	OV Est 3	99213 CG	4/2/2016	1	$ 120.00
0521	Breast/Pelvic	G0101	4/2/2016	1	$ 75.00
0300	Venipuncture	36415	4/2/2016	1	$ 20.00
0001	Total Charge				$ 215.00

- The charge for the b/p should NOT be bundled with the 99213 since coinsurance and deductibles are not applicable
- The venipuncture charge is combined with the 99213 charge
- Note that the lab service is not on this claim

Preventive Services – Example 6

- IPPE and a medical visit
- An RHC receives a separate payment for an encounter in addition to the payment for the IPPE when performed on the same day.

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Est Pt Level 3	99213CG	4/2/2016	1	$ 100.00
0521	IPPE	G0402	4/2/2016	1	$ 200.00
0001	Total Charge				$ 300.00

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RHC Payment

Payment for services

Payment calculations

- Payments for covered RHC services by physician, PA, NP, CNM, CP, CSW, MHC, LMFT and visiting nurse are under an all-inclusive rate for each visit with Medicare paying 80% of the interim rate
- Each provider's interim rate is based on the all-inclusive rate per visit (determined based on the cost report)
- Established by your Medicare Administrative Contractor:
- Determined by dividing total allowable cost by the number of total visits for RHC services
- Rate may be adjusted during reporting period

Payment for services (cont.)

Payment calculations

- The upper payment limit for independent and newly-certified RHCs for 2025 is $152.00 per visit.
- “Grandfathered” RHCs will be based off amounts paid for RHC services either in 2020 or the first full year’s finalized Medicare cost report.

Payment for services (cont.)

Part B deductible

- The Part B annual deductible applies to services covered under the RHC benefit Part B coinsurance
- If the item or service is covered under the RHC benefit, the beneficiary is responsible for 20% of the customary charge
- If the service is not covered under the RHC benefit and is covered under Part B, the beneficiary is responsible for 20% of the Medicare-approved charge (MFS)
- Note: RHCs receive 78.4% of their rate due to the Medicare sequester

RHC Payment Example

Visit example

- Customary charge for 99213 is $150
- Assume Medicare Physician Fee Schedule allowable is $100
- Medicare encounter rate is $250 as a “Grandfathered” RHC
- Limited to $152 for independent/newly-certified RHC
- Deductibles have been met already

RHC Payment Example (cont.)

Description	RHC amount (independent /newly-certified)	RHC amount (grandfathered)	Part B amount
Customary charge	$150.00	$150.00	$150.00
Patient copay	30.00	30.00	20.00
Medicare pays	121.60	200.00	80.00
Total payment	151.60	230.00	100.00
Contractual adjustment	(1.60)	(80.00)	50.00

RHC Payment Example (cont.)

Does it matter how we code the visit if we get paid the same rate?

- Yes
- Patient payment is affected
- Medicare considers overcoding a violation of the fraud and abuse regulations because of the additional reimbursement
- Medicare considers undercoding a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic

Closing Thoughts

Closing Comments

RHC certification means increased reimbursement only when your clinic is billing and collecting properly!

1. **Ensure your billing build is correct upon certification and a change in an EHR**
2. **Provide regular education for billers**
3. **Complete periodic audits of claims and remits**
4. **Know the differences between Traditional Medicare & your state's Medicaid RHC billing**

Katie Jo Raebel, CPA
Partner
kraebel@wipfli.com
509 232 2044

wipfli.com