



October 5, 2020

The Honorable Seema Verma, Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-1734-P  
P.O. Box 8016  
Baltimore, MD 21244-1850

Dear Administrator Verma:

On behalf of the National Association of Rural Health Clinics (NARHC) and the over 4,500 federally certified Rural Health Clinics (RHC) in the United States, we are pleased to provide the following comments on proposed 2021 Medicare Physician Fee Schedule (PFS). Our comments are focused on the following issues:

- Principal Care Management Services in Rural Health Clinics
- Modernizing the Definition of a RHC Visit
- Billing for COVID-19 Testing and Specimen Collection in 2021
- Digital E-Visits post PHE
- Telehealth Coding and Billing
- Billing for COVID-19 Vaccine Distribution

### **Payment for Principal Care Management (PCM) Services in Rural Health Clinics**

We are pleased to see that CMS is proposing a way for RHCs to furnish and bill for Principal Care Management Services as a part of the G0511 code in 2021. Furthermore, we thank CMS for acknowledging in the proposed rule that a national stakeholder organization representing rural health clinics requested that RHCs be allowed to furnish and bill for PCM services.

### **Modernizing the Definition of a RHC Visit**

While we are thankful for the inclusion of PCM in G0511, we continue to have reservations about how CMS handles adding new care management for rural health clinics. CMS reiterates their process in this proposed rule as follows:

As we stated in the CY 2018 PFS final rule, if a new care management code is proposed and subsequently finalized for practitioners billing under the PFS, we would review the new code to determine if it should be included in the calculation of the RHC and FQHC General Care Management Code. The determination of whether a new care management code should be added to the codes used to determine the payment rate is based on the applicability of the service in RHCs and FQHCs, and may result in either an increase or decrease in the payment amount for HCPCS code G0511.

NARHC is concerned that this is an unsustainable policy. As new care management services are added, G0511 will come to represent a wider array of services. Bundling new care management codes with G0511, G0512, or any other RHC/FQHC specific code will lead to an increasingly complicated RHC/FQHC-specific coding process. As more and more different fee-schedule codes are added to the RHC/FQHC specific G-code bundles, the accuracy of the claims data erodes, and problems arise.

For example, CMS is using a similar approach with regard to virtual care communications and concerns are beginning to arise. Starting in 2019, RHCs and FQHCs were able to use a RHC/FQHC specific code (G0071) to bill for either G2010 or G2012. When CMS began paying for digital e-visits in 2020, CMS did not create a way for RHC or FQHCs to provide those services. However, in response to COVID-19, CMS allowed RHCs and FQHCs to provide digital e-visits through a re-valued G0071 code.

As of the time of this writing G0071 represent one of 5 different CPT codes billed on the physician fee schedule: G2012, G2010, 99421, 99422, or 99423. While NARHC appreciates CMS expanding G0071 to include digital e-visits for the duration of the Public Health Emergency, this temporary policy exposes some of the flaws in the RHC/FQHC bundle approach to adding services.

The end policy is a set of coding rules for G2012, a different set of coding requirements for 99423, and then RHCs and FQHCs having to mesh all these coding requirements with G0071. This is a confusing approach to say the least.

NARHC appreciates that CMS is trying to allow RHCs and FQHCs to bill for these new and innovative services. However, we are concerned that bundling CPT codes into RHC/FQHC specific G-codes such as G5011, G5012, G0071, and G2025 is a band-aide solution to a core problem RHCs and FQHCs have, which is an outdated definition of a “visit.”

The following table breaks down some of these new innovative services that do not meet the definition of an RHC encounter. As you can see, in come cases, CMS has created a way for RHCs to bill for such services, in other cases there is not a billing mechanism for RHCs. As more and more services are added to this list, the reimbursement rules for RHCs get more and more complicated.

## Non-Face-to-Face Services CPT Codes and Corresponding RHC Codes Crosswalk Table

Services	PFS CPT Code(s)	RHC Code
Virtual Care Communications, Virtual Check-in	G2010, G2012	G0071
Digital E-visits	99421, 99422, 99423	G0071
General Care Management Chronic Care Management	99490, 99487, 99484	G0511
Principal Care Management	G2064, G2065	G0511
Psychiatric collaborative care model	99492, 99493	G0512
Diabetes Prevention Program	G9873, G9874, G9875 etc.	N/A
Remote Patient Monitoring	99453, 99454, 99457, 99091	N/A
Distant Site Telehealth Visit	238 different CPT codes	G2025

NARHC believes that CMS should consider redefining what constitutes a billable RHC visit. The current definition worked in a time when healthcare was delivered via in-person face-to-face office visits. However, as we begin to recognize (and pay for) other healthcare services outside the traditional office visit model, the definition of a RHC visit increasingly begins to show its age.

CMS defines a Rural Health Clinic “visit” in 42 CFR 405.2463 as:

### § 405.2463 What constitutes a visit.

#### (a) *Visit - General.*

(1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter between a RHC patient and one of the following:

- (A) Physician.
- (B) Physician assistant.
- (C) Nurse practitioner.
- (D) Certified nurse midwife.
- (E) Visiting registered professional or licensed practical nurse.
- (G) Clinical psychologist.
- (H) Clinical social worker.

(ii) Qualified transitional care management service.

#### (b) *Visit - Medical.*

(1) A medical visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:

- (i) Physician.
- (ii) Physician assistant.
- (iii) Nurse practitioner.
- (iv) Certified nurse midwife.
- (v) Visiting registered professional or licensed practical nurse.

(2) A medical visit for a FQHC patient may be either of the following:

- (i) Medical nutrition therapy visit.
- (ii) Diabetes outpatient self-management training visit.

**(3) Visit - Mental health.** A mental health visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:

**(i)** Clinical psychologist.

**(ii)** Clinical social worker.

**(iii)** Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

Chapter 13 of Medicare Benefit Policy Manual gives us the RHC “visit” definition in narrative form:

*An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner’s state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits.*

The problem with this definition is that it often does not mesh well with the new healthcare delivery models such as the diabetes prevention program, care management services, telehealth services, virtual communications services, and telehealth visits. None of these “new” healthcare services generate billable RHC visits.

We understand that some may argue that RHCs are already paid for these new healthcare models through the All-Inclusive Rate. One might theorize that because the RHC would have higher allowable costs delivering these services, and thus a higher AIR, they are paid for services they cannot bill through a higher reimbursement rate on those services that are billable. However, this argument only works if you ignore the fact that many RHCs have their AIR capped at an artificially low rate.

Furthermore, while they should not be compared, policymakers often compare a rural health clinic’s all-inclusive rate payment with the payment for a particular CPT code. This differential is often misconstrued to argue that RHCs should not be paid their AIR for one type of CPT service or another. As such RHCs look like they may be getting paid “too much” for a visit, but in fact it is because they are being paid through that AIR for all the services they are not allowed to bill. However, many policymakers still make this comparison as if it was apples to apple which is entirely incorrect.

NARHC hopes to engage in a dialogue with CMS over the coming year to create a new definition of what constitutes a “RHC visit” billable at the All-Inclusive rate.

We would like CMS to create a new definition of an “RHC visit” that is as expansive a definition as possible. These new healthcare services should be delivered through a cost-based model in RHCs, just like the traditional face-to-face office visit services. We would note that the statute does allow CMS to create a new definition of a “visit” via rulemaking and that rethinking this definition would NOT require any statutory changes.

CMS is preserving a cost-based model for traditional healthcare services, but rejecting the cost-based model for new healthcare services based on this outdated definition of a visit. We believe the cost-based model could work for all primary care services, new and old.

We look forward to discussing these concepts with CMS as the following issues are all related to this core problem.

### **Billing for COVID-19 Testing and Specimen Collection in 2021**

RHCs cannot bill Medicare for COVID-19 specimen collection. They also cannot bill Medicare for the laboratory portion of COVID-19 testing.

Because testing services such as specimen collection can be performed entirely by a registered nurse, and do not require a face-to-face visit with an RHC clinician, they are NOT billable to Medicare. This is a perfect example of why we need to expand the definition of an RHC visit or encounter. As we have just explained, folding the costs into the RHC's All-Inclusive Rate is not a real solution. It leaves our capped RHCs completely behind as their AIR payment cannot rise above the cap and it inflates the AIR for our uncapped RHCs.

If CMS is not going to solve the core issue here (i.e. the definition of an RHC visit), they should create a way for RHCs to bill for COVID testing similar to chronic care management of virtual care communications.

### **Billing for Digital E-visits**

Physician Fee Schedule providers were able to bill for digital e-visits on January 1, 2020. RHCs were not able to bill for these digital e-visits until CMS incorporated these services into our virtual care communications G-code (G0071). We are grateful for this inclusion but we are currently set to lose the ability to provide digital e-visits at the end of the public health emergency.

If CMS is not willing to rework the definition of an RHC encounter, CMS should create a way for RHCs to bill for digital e-visits beyond the end of the PHE. CMS could either create a new code that covers the digital e-visit codes or CMS could continue to fold them in with virtual care communications services and allow RHCs to continue to bill these as G0071 services.

### **Distant Site Telehealth Visits Coding and Billing**

While the NARHC is working with Congress to change the way distant site telehealth visits are paid in rural health clinics because we do not believe the composite payment rate is fair, should Congress extend the composite payment rate system beyond the end of the PHE, we believe CMS should allow for more accurate coding.

The current process of collapsing 238 CPT codes into one G2025 code creates numerous issues for RHCs. It obscures the actual services provided to patients and makes the claims data inaccurate. We believe that CMS should allow RHCs to use normal coding with the modifier 95 used to indicate that the service was provided via telehealth and should be paid the composite rate of \$92.03.

## **Billing for COVID Vaccination**

If a COVID vaccine is approved, NARHC requests that CMS allow RHCs to bill for vaccine administration and distribution in the same manner that RHCs are allowed to bill for flu and pneumococcal shots. We believe that this is the most logical and sensible way to encourage RHCs to provide and bill for COVID vaccinations.

If RHCs are asked to simply include the cost of COVID vaccination in their cost report but are not allowed to bill for it (as we are asked to do with COVID testing), it will discourage RHCs from administering the vaccine and our independent RHCs will essentially have no ability to be paid for vaccine distribution.

## **Conclusion**

Your consideration of these comments/questions is appreciated. Should you have any questions or need any additional information, please do not hesitate to contact Bill Finerfrock or Nathan Baugh at (202) 544-1880.

Sincerely,

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