RHC TA Webinar/Call
August 6, 2015

Proposed Medicare Policy to:

1. **Allow Medicare payments for Chronic Care Management services provided by Federally Certified RHCs;**
2. **Mandate use of HPCPS/CPT codes on RHC claims (UB 04)forms**
3. **“Clarification” of PQRS negative payment adjustments and RHC services.**

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Medicare Payment for Chronic Care Management and Rural Health Clinics

Beginning January 1, 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for **non-face-to-face** care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

Rural Health Clinics were not included as recognized providers for this service.

Examples of Chronic Conditions include (but are not limited to)

Chronic Condition	
Alzheimer's disease and related dementia	Arthritis (osteoarthritis and rheumatoid);
Asthma	Atrial fibrillation
Autism spectrum disorders	Cancer
Chronic Obstructive Pulmonary Disease	Depression
Diabetes	Heart failure
Hypertension	Ischemic heart disease
Osteoporosis	

Medicare Payment for Chronic Care Management and Rural Health Clinics

Shortly after the new coverage was announced for Fee-for-service providers, CMS reached out to NARHC to express a desire to provide similar coverage for RHCs; however, due to the unique way RHCs were paid (All-Inclusive Rate based on costs), it was not sure how to do this.

Between September, 2014 and December, 2014 CMS staff and NARHC staff engaged in a series of conversations about possible options for extending this benefit to RHCs.

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In early December, 2014, CMS asked NARHC to review 5 payment options and indicate possible pluses and minuses for each approach and also which approach might work best for Rural Health Clinics and their patients.

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The options under consideration were:

1. The RHC could put a modifier code on a billable visit for the CCM eligible patient that occurs each month and that would trigger an add-on payment for CCM related services. CCM services could be provided by any qualified individuals. The value of the add-on payment would be actuarially comparable to the value of the service if provided in a non-RHC setting to a Medicare beneficiary.
2. A CCM visit would be a billable RHC encounter even when performed by nurse or other qualified individual. This would only be billable if provided as a stand-alone service. RHC would receive their encounter rate as with any other RHC visit. If delivered in conjunction with another, otherwise billable RHC encounter, the clinic would only get one billable RHC visit.

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3. Exclude CCM as an RHC service (similar to a hospital visit) and have the RHC bill for this to traditional Part B, carving out cost, etc. to avoid duplicate payment.

4. Have the RHC capture all CCM related costs and report these on a separate form as part of the cost report. This would be similar to how we handle flu and pneumo with an end of year cost settlement with value/reimbursement set to approximate what RHC would have received for services if bill via traditional Part B.

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5. Establish a per-beneficiary monthly payment for CCM services. RHC would receive lump sum quarterly payment for CCM services after providing documentation of service provided to qualifying patients.

What is CMS proposing for RHCs?

Medicare Payment for Chronic Care Management and Rural Health Clinics

RHCs can bill for CCM services furnished by, **or incident to**, a physician, nurse practitioner, physician assistant, or certified nurse midwife for an RHC patient once per month, and that only one CCM payment per beneficiary per month can be paid.

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CMS proposes to make a separate payment to RHCs providing CCM services that is separate from the RHCs AIR. The proposed payment for CCM services will be based on the Physician Fee Schedule Payment for CPT code 99490.

The code could be billed as a stand-alone service **OR** with other payable services on the RHC claim. The actual rate will not be determined until publication of the Physician Fee Schedule in early November.

The payment rate for CPT code 99490 for 2015 is $42.91 per beneficiary per month.

CCM and RHCs

For this benefit, the face-to-face with a recognized RHC professional (physician, PA, NP, CNM, etc.) requirement would be WAIVED!

Coinsurance and deductibles would apply as applicable to RHC claims.

CMS will provide detailed billing instructions following publication of the final rule.

Other Requirements to Qualify for a CCM Payment

The following requirements will apply to RHCs seeking payment for CCM services. These requirements already apply to health professional paid under the Physician Fee Schedule seeking payment for CCM services. RHCs are not being asked to do anything MORE or anything Less than any other provider to qualify for this benefit payment.

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The requirements for payment for CCM services provided by RHC staff are the SAME as the requirements for payment for CCM services provided by health professional paid using the Physician Fee Schedule.

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CMS is proposing to establish payment, beginning on **January 1, 2016**, for RHCs who furnish:

1. a minimum of 20 minutes of qualifying CCM services during a calendar month, to
2. patients with multiple (two or more) chronic conditions that
3. are expected to last at least 12 months or until the death of the patient, and
4. that place the patient at significant risk of death, acute exacerbation-decompensation, or functional decline.

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For purposes of meeting the minimum 20-minute requirement, the RHC could

- Count the time of only one practitioner or auxiliary staff (for example, a nurse, medical assistant, or other individual working under the supervision of an RHC physician or other practitioner at a time, and
- Could **NOT** count overlapping intervals such as when two or more RHC practitioners are meeting about the patient.
- Only conversations that fall under the scope of CCM services would be included towards the time requirement.

Other CCM billing Requirements

1. The eligible beneficiary must be informed about the availability of CCM services from the RHC and provide his or her written agreement to have the services provided, including the electronic communication of the patient's information with other treating providers as part of care coordination.

2. RHC staff would discuss with the patient what CCM services are; how they differ from any other care management services the RHC provides; how these services are accessed, how the patient's information will be shared among others

3. Also, RHC staff will inform the patient that another provider cannot furnish or bill for CCM services during the same calendar month that the RHC furnishes CCM services. And,

4. The applicability of deductible and coinsurance even when CCM services are not delivered face-to-face in the RHC.

CMS proposes that **all** of the following scope of service requirements must be met to bill for CCM services

- Continuity of care with a designated RHC or FQHC practitioner with whom the patient is able to get successive routine appointments.

- Care management for chronic conditions, including systematic assessment of a patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

CMS propose that **all** of the following scope of service requirements must be met to bill for CCM services

- A patient-centered plan of care document created by the RHC or FQHC practitioner furnishing CCM services in consultation with the patient, caregiver, and other key practitioners treating the patient to assure that care is provided in a way that is congruent with patient choices and values.

Other CCM billing Requirements

- Creation of an electronic care plan that would be available 24 hours a day and 7 days a week to all practitioners within the RHC who are furnishing CCM services AND whose time counts towards the time requirement for billing the CCM code. It must be available to other practitioners and providers, as appropriate, who are furnishing care to the beneficiary, to address a patient's urgent chronic care needs.

Other CCM billing Requirements

- The RHC must be able to facilitate communication of relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions.

- No specific electronic solution or format is required to meet this scope of service element.

Other CCM billing Requirements

- Communication to and from home and community based providers regarding these clinical patient needs must be documented in the RHC's medical record system.

Other CCM billing Requirements

- Secure messaging, internet or other asynchronous non-face-to-face consultation methods for a patient and caregiver to communicate with the provider regarding the patient's care in addition to the use of the telephone.

- These methods would be required to be available, but would not be required to be used by every practitioner or for every patient receiving CCM services.

Use of an EHR

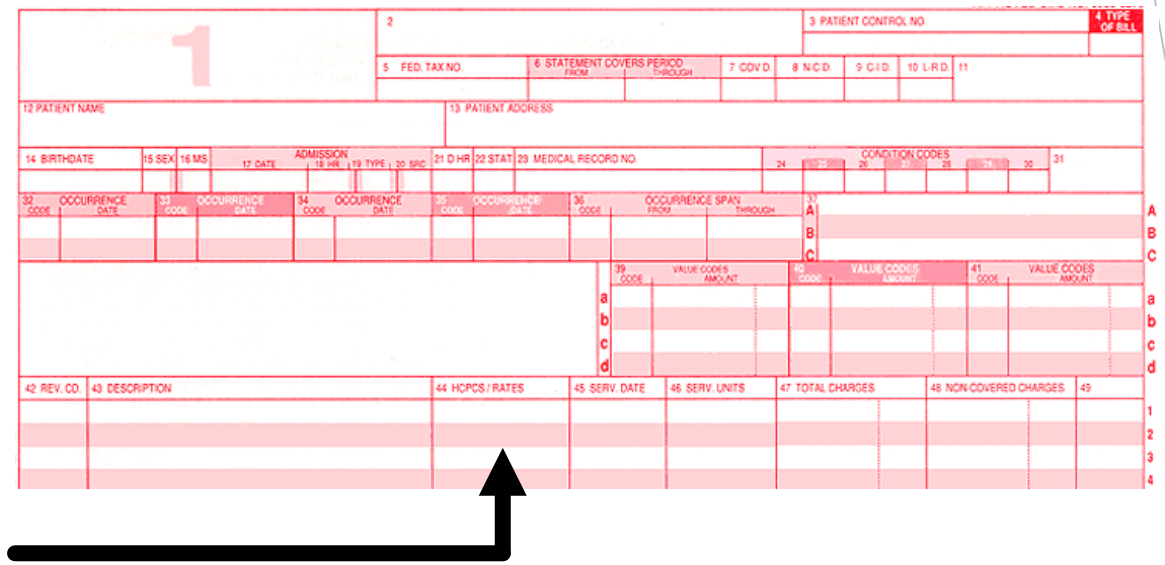
- Certified health IT must be used for the recording of demographic information, health related problems, medications, and medication allergies; a clinical summary record; and other scope of service requirements that reference a health or medical record.

Use of an EHR

- RHCs must use technology certified to the edition(s) of certification criteria that is, at a minimum, acceptable for the EHR Incentive Programs as of December 31st of the year preceding each CCM payment year.

CPT Code Billing Requirements

- Beginning January 1, 2016 all RHC Claims must include appropriate CPT/HCPCS Code
- A CPT/HCPCS code must be reported along with the presently required revenue code
- There will be no change in RHC payment
- Because RHCs should already be capturing CPT level data for preventive services, CMS does not consider new reporting requirements burdensome



PQRS Reporting Exemption

- CMS sought to clarify the RHC PQRS exemption in the 2016 Medicare Physician Fee Schedule by stating that Eligible Professionals (EPs) who practice in RHCs “would not be subject to the PQRS payment adjustment.”
- Unfortunately, CMS has operational issues and is currently not able to appropriately administer the PQRS exemption to all EPs working in RHCs.
- We are working with CMS to get this fixed and will update the Rural Health Clinic community through the NARHC listserv.

CMS invites public comments on all aspects of the proposed payment methodology and billing for CCM services in RHCs.

The deadline for submitting comments is September 8th.

Comments can be submitted electronically by going to:

http://www.regulations.gov and searching for the CMS comment section.

NARHC will be submitting comments on behalf of the Association and it's members in support of this proposed policy.

Questions?

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