NHA Revenue Cycle Residency Program

November Update: Hot Topics

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Introductions

Martie Ross
Principal
mross@pyapc.com

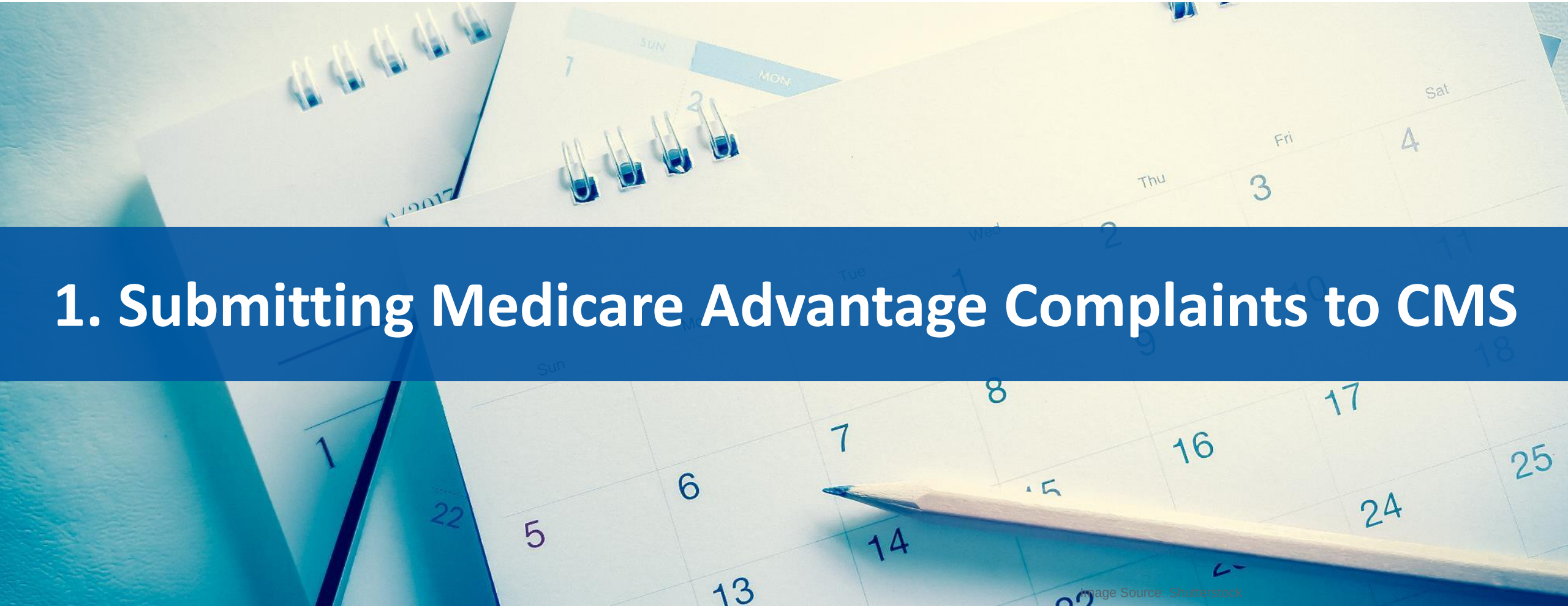
Kathy Reep
Senior Manager
kreep@pyapc.com

pyapc.com
800.270.9629

Agenda

1. Submitting Medicare Advantage Complaints to CMS
2. Commercial Payer Contracts – Key Terms
3. Appeal Rights for Certain Changes in Patient Status
4. RHC Billing/2025 Medicare Physician Fee Schedule Final Rule

1. Submitting Medicare Advantage Complaints to CMS



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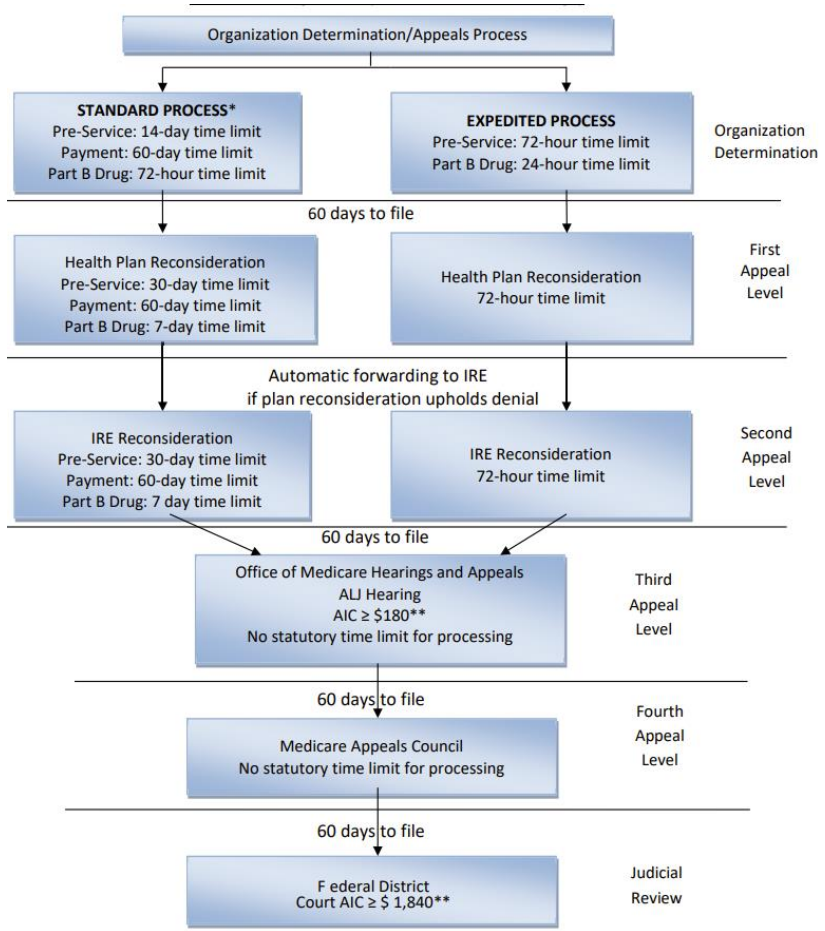
MA Organizational Determination/Appeals Process



- Applies to any decision made by MA plan regarding –
  - Authorization/payment for item or service
  - Amount MA plan requires enrollee to pay for item or service
  - Limit on quantity of items or services
- May be pursued by –
  - Enrollee/personal representative
  - Provider that furnishes, or intends to furnish, services to enrollee
- Updated guidance published in July 2024

https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf

Submitting Provider Complaints to CMS

- CMS recently launched new centralized process for provider complaints against MA plans
  - Provider appeal complaint – plan failed to follow applicable appeals process, e.g., failure to provide notice of appeal rights, failure to act within specified time frames
  - Claims payment dispute - provider's dispute over amount paid by plan for approved service on particular claim, e.g., plan's decision to partially approve, downcode, or bundle services or approve service at lower level of care than service billed
- Provider must submit completed Appeal / Claim Payment Dispute Cover Sheet* for each complaint (i.e., one cover sheet for each beneficiary case) in password-protected file to MedicarePartCDQuestions@cms.hhs.gov and part c part d audit@cms.hhs.gov
  - CMS will not process complaint unless provider previously communicated with plan
- CMS will facilitate plan-provider communication, track and trend types of complaints - but not resolve specific disputes
  - Input complaint into CMS Complaint Tracking Module (Star Rating measure = # of CTM complaints/1000 members)

*https://calhospital.org/wp-content/uploads/2024/08/instructions-for-organizations-representing-providers-to-submit-provider-complaints-related-to-medicare-advantage-organizatio.pdf

2. Commercial Payer Contracting – Key Terms

Image Source: Shutterstock

Payment Methodology – Inpatient

- DRG-based reimbursement
  - Specify year of Medicare DRG weights
  - Add-on reimbursement for high-cost drugs and implants, new technology?
  - Outlier reimbursement?
  - Reimbursement limits for readmissions, post-acute transfers, hospital-acquired infections?
  - Newborn reimbursement?
  - “Lesser of” language (pay charges if less than DRG rate)
- Percent of charges
  - Excluded charges (e.g., drugs, DME)?
  - Limits on rate increases?

Payment Methodology - Outpatient

- Fixed rate reimbursement (APCs, other case rates, per-visit rates, fee schedule rates for lab and radiology)
  - If based on Medicare rates, specify year used for rate calculations
  - Obtain all fee schedules from the payer to avoid misunderstandings
  - Obtain all mapping for surgical procedures paid under case rates, review payment rates for multiple procedures
  - Determine if drugs are add-on to per visit rates (or case rates) or if no additional payment
  - Site neutral payments?
  - “Lesser of” language?
- Percent of charges
  - Excluded charges (e.g., drugs, DME)?
  - Limits on rate increases?
- Adherence to Medicare inpatient only list (Status C codes)

Payment Methodology - Professional

- Percentage of Medicare Physician Fee Schedule rates
  - National or local payment rate? Current year or base year?
  - Rate adjustments for non-physician practitioners?
  - Fixed rates for anesthesia providers?
  - Multiple procedure discounts?
  - Behavioral health fee schedules by type of provider?
  - Carveouts for drugs, DME?
  - Treatment of telehealth services?
  - Excluded services (e.g., care management)?
  - Effective date for updates to MPFS (e.g., Medicare adjusts RVUs, expands coverage for new services, Congressional action)?
  - “Lesser of” language?

Process-Related Provisions

- Timely filing
  - Number of days in which provider must submit claim for service
  - Ideally 180 days for “unplanned events”
- Prompt payment
  - Adherence to state prompt payment law for state-regulated plans
  - For ERISA-regulated plans, specify time period to pay clean claims, take action on other claims (deny, request for additional payment); define ‘clean claim’
- Recoupment
  - Limit circumstances and time period in which payer may recoup payments
  - Incorporate notice and appeal rights specific to recoupments
  - Require review of individual claims to determine overpayments (i.e., prohibit extrapolation)
  - Permit provider to identify potential underpayments and to seek additional reimbursement

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Process-Related Provisions

- Prior authorization
  - No state prior authorization law; negotiate time periods with plans
  - New federal requirements effective in 2026
- Dispute resolution process
  - Well-defined, balanced process?
  - Qualifications of reviewers?
  - Hold harmless provision (i.e., cannot bill patient is unsuccessful on appeal)
- Payment policy changes
  - Timing and process (e.g., notice) for policy changes, economic impact, and ability to make provider “whole” on changes in payment policies that negatively impact reimbursement
- Annual payment increases specified in contract (amount, effective date)

Process-Related Provisions

- Credentialing
  - Avoid non-standard processes; instead, deem proof of current state licensure as satisfaction of payer's credentialing standard
  - Payment retroactive to date of application following approval
- Term and termination clauses
  - Reject provisions permitting payer's termination without cause prior to end of term (if provider refuses rate concessions)
- Contract amendments
  - Notice requirements, not effective until parties agree in writing
  - Economic impact clause
- Protections against "rented networks"
  - Restrictions on extending terms of other payers

3. Appeal Rights for Certain Changes in Patient Status

Image Source: Shutterstock

Applicability

- Applies to Medicare fee-for-service patients only, not Medicare Advantage
- Applies to Medicare patients initially admitted as inpatients but then reclassified to outpatient observation *but not enrolled in Part B at time of stay*
- Applies to those staying at the hospital for 3 or more consecutive days with less than 3 days as inpatient, but at least 1 inpatient day
  - Unless more than 30 days have passed between discharge from hospital and SNF admission
- New processes are in response to court order issued in *Alexander v. Azar*

Patient Notice

- New Medicare Change of Status Notification (MCSN)
  - Hospitals will be required to provide notice to patients while they are still in the hospital
    - Notice is intended to inform patient of status change, effect on Medicare coverage for the stay, and their appeal rights
      - Those without Part B coverage may be charged the full cost of the stay
    - Notice must be provided as soon as possible after status change, but no later than 4 hours prior to discharge
    - Form available at *https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10868* (multiple languages provided)

Appeal Rights

- Types of appeals
  - Prospective appeals
    - *Expedited appeals filed* prior to release from the hospital following change in status from inpatient to outpatient
      - Patient does not have to stay in the hospital during the appeal
    - Appeals conducted by BFCC-QIO following telephone or written request
      - Decisions to be completed and notification made within one calendar day of request
      - Unfavorable appeal decision: beneficiary could be responsible for Part B coinsurance and deductible for covered services and full cost of non-covered services
  - Standard appeals
    - Allowed for patients who do not file expedited appeal
    - Similar process as expedited appeals but does not follow expedited timeframes

Appeal Rights

- Types of appeals (cont'd)
  - Retrospective appeals
    - Allowed for status changes back to January 1, 2009
    - Determination flow follows current appeals process, starting with MAC, to QIC, ALJ, Medicare Appeals Council and judicial review
    - Patients will have 365 calendar days from rule implementation to file a request for a retrospective appeal
      - Providers will have 120 days to submit records in response to contractor request
      - Providers will not be penalized if unable to locate records (record retention requirements)
      - Providers have 365 days to submit a claim following favorable decision for the patient
        - Must first refund Part B payments before billing Part A; Part B will be recouped even if Part A not billed
        - Billing instructions under development/new condition codes and remark codes expected

Effective Date for Appeals

- Effective date yet to be announced
  - Per report to the court –
    - Retrospective appeals process should be operational by January 1, 2025
    - Prospective appeals process should be operational by February 15, 2025

4. RHC Billing/2025 MPFS Final Rule

Image Source: Shutterstock

1. RHC Visit

- Face-to-face encounter between patient and RHC practitioner during which RHC service is rendered
  - Physician, physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW), *licensed marriage and family therapist* (MFT), *mental health counselor* (MHC), or, in limited situation, visiting nurse (VN)
  - For behavioral health services, may use telehealth in place of face-to-face encounter (more later)
  - Excludes services furnished in hospital inpatient or outpatient setting (Method II billing)
- Encounters with more than one practitioner and multiple encounters with same practitioner on same day at single location constitute a single visit, except when patient—
  - Suffers illness/injury after first visit that requires additional diagnosis or treatment on same day
  - Has medical visit and behavioral health visit on same day
  - Has IPPE visit and separate medical or behavioral health visit on same day

Qualifying Visit List (QVL)

- *Non-exclusive* list of HCPCS codes that qualify as face-to-face visit between patient and RHC practitioner
- Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf
- Last updated in 2016

Preventive Services (no co-pay)

- IPPE - G0402
- AWV - G0438 and G0439
- Screening Pelvic Exam - G0101
- Prostate Cancer Screening - G0102
- Glaucoma Screening - G0117 and G0118
- Screening Pap Test - Q0091
- Alcohol Screening and Behavior Counseling - G0442 and G0443
- Screening for Depression - G0444
- Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling - G0445
- Intensive Behavioral Therapy for Cardiovascular Disease - G0446
- Intensive Behavioral Therapy for Obesity - G0447
- Smoking and Tobacco Cessation Counseling - 99406, 99407
- Lung Cancer Screening with Low Dose CT -G0296

https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/rhc-preventive-services.pdf

What Does Not Qualify As RHC Visit

- Visits for medication refills, lab results, injections
- Suture removal or dressing change without additional face-to-face visit
- Visits billed under CPT 99211 (nursing visits)
- PT, OT, or SLP services by non-RHC practitioner

Revenue Codes

- RHC services must be billed with appropriate RHC revenue code + Healthcare Current Procedural Coding System (HCPCS) code identifying service provided
  - 0521 - Clinic Visit by member to RHC
  - 0522 - Home visit by RHC practitioner
  - 0524 - Visit by RHC practitioner to member in covered Part A SNF stay
  - 0525 - Visit by RHC practitioner to member in SNF (not covered Part A stay) or other residential facility
  - 0527 - RHC Visiting Nurse Service(s) to member's home when in Home Health Shortage Area
  - 0523 - Visit by RHC practitioner to other non RHC site (e.g., scene of accident)
  - 0900 - Behavioral Health Treatments/Services
- Professional services furnished in hospital inpatient or outpatient setting ≠ RHC service

RHC Visit Reimbursement

- Medicare pays RHCs 80% of All-Inclusive Rate (AIR) for (nearly) all goods and services furnished as part of RHC visit
  - Qualifying preventive services paid at 100% of AIR when only service provided that day
  - Less 2% sequestration
- Beneficiary co-insurance = 20% of RHC changes (not 20% of AIR)
- Part B deductible applied to RHC services
- AIR varies by type of RHC
  - AIR for grandfathered RHCs (in existence prior to 12/27/20) based on costs
  - AIR for all other RHCs based on national standardized amount

Telehealth – Behavioral Health Services

- New coverage created under Consolidated Appropriations Act, 2021
- Qualifies as RHC visit (and thus pays AIR) if –
  - Service included on CMS approved list of telehealth services
    - Available at https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-code
  - Use audio/visual connection (audio only if patient cannot/does not want to connect visually)
  - Effective 01/01/2026 -
    - In-person mental health service furnished within 6 months prior to furnishing telehealth services (unless those services initiated during PHE)
    - In-person, non-telehealth visit furnished at least every 12 months (may be waived; reason documented in medical record)
- Bill revenue code 0900 with appropriate HCPCS code and modifier CG
  - Use modifier 95 for audio/visual connection; modifier FQ for audio only

Telehealth – Medical Services

- Continue current reimbursement methodology through 12/31/25 while evaluating alternatives
  - Service must be included on CMS approved list of telehealth services
    - Includes telephone only codes (CPT 99441 - at least 5 minutes of telephone E/M service by physician or APP provided to an established patient, parent, or guardian; cannot be billed if originate from related E/M service within previous 7 days or lead to E/M service or procedure within next 24 hours or soonest available appointment)
  - Not reimbursed AIR; instead, billed under G2025 (revenue code 0521) – reimbursed at $95.27 (2024 rate)
- May also bill telehealth originating site fee under Q3014 (revenue code 078x) – reimbursed at $29.96 (2023 rate)
  - Patient physically present at RHC facility receiving telehealth from distant site provider

Virtual Communication Services

- Billed under G0071 - $13.32 (revenue code 0521)
  - At least 5 minutes of virtual (non-face-to-face) communication between RHC practitioner and patient, or at least 5 minutes of remote evaluation of recorded video and/or images by RHC practitioner
- Billing rules
  - Patient must have been seen at RHC within last year
  - Patient must consent to services
  - Must be in lieu of in-person visit, i.e., not originating from a related E/M service provided within the previous 7 days nor leading to E/M service or procedure within the next 24 hours or soonest available appointment

RHC Care Management Services – 2024

- Non-face-to-face services billed under G0511 - General Care Management
  - Transitional care management
  - Chronic care management
  - Principal care management
  - General behavioral health integration
  - Chronic pain management
  - Community Health Integration
  - Principal Illness Navigation
  - Principal Illness Navigation – Peer Support
  - Remote Physiological Monitoring
  - Remote Therapeutic Monitoring
- G0511 rate = average of national non-facility payment rate for these services
  - For 2024, $72.98 (revenue code 0521)
- Psychiatric Collaborative Care Model (CoCM) billed under G0512 - $146.73 (no more than once/month) (revenue code 0521)

RHC Care Management Services - 2025

- Non-face-to-face services billed under assigned CPT code
  - Transitional Care Management
  - Chronic Care Management
  - Complex Chronic Care Management
  - Principal Care Management
  - Advanced Primary Care Management
  - Psychiatric Collaborative Care Model
  - General Behavioral Health Integration
  - Chronic Pain Management
  - Community Health Integration
  - Principal Illness Navigation
  - Principal Illness Navigation – Peer Support
  - Remote Physiological Monitoring
  - Remote Therapeutic Monitoring
- Each service reimbursed at national non-facility payment rate
- 6-month transition period; may continue to bill G0511 through 6/30/2025
- Continue to bill CoCM under G0512

Good or Bad?

- “We note that the payment amounts for some services that made up G0511 are less than the payment amount for G0511 and [clinics]could see a potential decline in payment. We are also proposing to allow RHCs and FQHCs to bill the add-on codes….This could potentially offset any decrease in payments.”

Code	2024B Payment Rate
HCPCS G0511	$72.90
CPT 99490 (CCM, 1st 20 min)	$62.58
CPT 99439 (CCM, each add’l 20 min)	$47.93
CPT 99453 (RPM monthly monitoring)	$47.27

RHC Claims Details

- Required to line-item, detail codes for all services furnished during RHC visit
  - Include HCPCS codes for all RHC services, incident to services, and applicable professional components performed during visit
- Charges for all services furnished during visit should be ‘rolled up’ to qualifying visit line/CG modifier line
  - QVL identifies primary reason for visit
  - Exception – charges for qualifying preventive health services (copayment waived)

Vaccinations - 2024

- Influenza, Pneumococcal, and COVID-19 Vaccines
  - Vaccines and their administration paid at 100% of reasonable cost through cost report
  - Report charges on cost report Worksheet M-4 (provider-based) or B-1 (independent)
  - Do not report on UB-04
  - Coinsurance waived
- Beginning January 1, 2025, apply same rules to Hepatitis B vaccine
  - No longer included in AIR
  - Including expanded coverage (doctor's order no longer required)

Vaccinations – After June 30, 2025

- Bill for Part B vaccine administration at time of service
  - Also bill M0201 for in-home administration
- Due to statutory requirement that RHCs be reimbursed 100% of costs for vaccines and vaccine administration, will reconcile annually as part of cost report
- Additional guidance (including updated cost report instructions) to be released in early 2025

Non-RHC Services

- Includes -
  - Clinical laboratory tests (venipuncture included in AIR)
    - Independent RHC bills to Part B on CMS 1500; services furnished in provider-based RHC billed by parent hospital on UB-04
  - Technical components for diagnostic tests (x-rays and EKGs)
    - Same as clinical laboratory tests
  - Professional services furnished in hospital inpatient and outpatient settings
    - Both independent and provider-based RHCs bill to Part B on CMS-1500
- All costs associated with non-RHC services (i.e., space, equipment, supplies, facility, overhead, personnel) should be removed from cost report
  - Even though care coordination services and vaccines billed outside the AIR, still qualify as RHC services

Conditions of Certification/Coverage

- No longer require >50% of RHC's total hours of operation must involve primary care services
  - Still must provide primary care services, but not at specified level
  - Still cannot be rehabilitation agency or facility primarily for treatment of 'mental diseases'
  - May provide outpatient specialty services within practitioner's scope of practice to meet community needs
- RHC clinical lab services
  - Remove hemoglobin and hematocrit from list of services RHC must provide directly
  - Change "primary culturing for transmittal to certified laboratory" to "collection of patient specimens for transmittal to a certified lab for culturing"

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