inQuiseek Consulting

NEBRASKA RHC WORKSHOP
MAY 24, 2023

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TODAY'S AGENDA

- RHC Introduction to Compliance and Medicare Billing
- The Status of Nebraska RHCs in 2023/Common Deficiencies
- 2023 RHC Billing and Compliance Update
- Program Evaluation
- Open Discussion/ Q & A

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PLAYING BY THE RULES AGAIN AFTER MAY 11TH.

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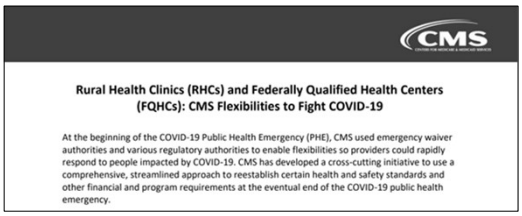
RURAL HEALTH CLINICS



Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS has developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.pdf

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Resources

February 27, 2023 CMS Fact Sheet: CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency **(The PDF version of this Fact Sheet can be found here - PDF.)**

February 9, 2023 HHS Secretary Xavier Becerra Letter to U.S. Governors

February 9, 2023 Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap

https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html

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THESE BLANKET WAIVERS FOR RHCS WILL END:

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Certain Staffing Requirements.** 42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.
- **Physician Supervision of NPs in RHCs and FQHCs.** 42 CFR 491.8(b)(1). We are modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

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THESE BLANKET WAIVERS WILL END:

- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

What about curbside or parking lot services?
What about offsite services?

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

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THIS MEANS: NO STAFFING WAIVERS AFTER THE PHE ENDS.

- The staffing requirements in 42 CFR § 491 must be in place:
  - NP or PA must be staffed at least 50% of all RHC Patient Care Hours as posted.
  - The RHC must have a designated Medical Director (Physician) who is responsible for the medical direction of the clinic and who performs chart audits to determine if NPP are following the medical management policies. The medical director must be able to see patients and provide medical services. The RHC Medical Director role is separate and distinct from any state required collaborative or supervisory role.
  - The flexibility for RHC providers to be working from home or alternate locations will end. RHC providers must provide face-to-face services in an approved encounter location.

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THIS MEANS: NO SATELLITE OR OFF SITE RHC LOCATIONS WHICH ARE NOT INDEPENDENTLY CERTIFIED AS NEW RHCS AFTER THE PHE ENDS.

- No RHC services can be performed off-site or at temporary or satellite locations.
  - Each location must be certified at a qualified location with its own CCN number.
  - Each location must be in a currently designated Primary Care Healthcare Shortage Area or in a currently designated Medically Underserved Area.
  - Each location must be in a rural area as defined by the Census Bureau.
  - If the temporary location is in the process of becoming certified but is not certified at the time that the PHE ends, the services at that location are not considered RHC services until the new certification is obtained.
  - No expansion site services can be held out as services of the main RHC after the PHE ends.

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WITH THE END OF THE PHE, IT MAY BECOME MORE DIFFICULT TO RECEIVE A PRODUCTIVITY STANDARD WAIVER

- RHCs have always had the ability to request a waiver from the productivity standards if circumstances warranted such a request.
  - Because of the staffing difficulties during COVID, the Medicare Contractors (MACs) granted all productivity standard waiver requests.
  - For many of the grandfathered provider-based RHCs, their grandfathered rate was determined while under a productivity waiver.
  - Therefore, many RHCs have a sizable AIR cap due to the waiver.
  - If volumes aren't back to before COVID times the AIR could take a hard hit.
  - Contact your cost report preparer to determine the effect of the productivity standards to next year's rate.

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WHAT ABOUT MEDICARE MEDICAL TELEHEALTH AFTER THE PHE ENDS?

- The flexibilities given to provide telehealth will not end until 12/31/2024.
- Congress overwhelming passed H.R. 4040, Advancing Telehealth Beyond COVID–19 Act of 2021. This legislation would extend a variety of Medicare telehealth flexibilities, currently set to expire on the 152nd day after the end of the Public Health Emergency (PHE), to now continue through December 31, 2024.

  Notably, this legislation would allow RHCs to continue as telehealth **distant site providers** through 12/31/2024 and delay the in-person requirements for mental health services furnished via telehealth for that duration as well. It also expands the duration for which certain telehealth services can be furnished via audio-only communications.

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WHERE TO FIND THE CMS APPROVED TELEMEDICINE LIST

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated February 13, 2023

Code	Short Descriptor	Can Audio-only Interaction Meet the Requirement	Medicare Payment Limitations
0362T	Bhv id suprt assmt ea 15 min		
0373T	Adapt bhv tx ea 15 min		
77427	Radiation tx management x5		
90785	Psytx complex interactive	Yes	
90791	Psych diagnostic evaluation	Yes	
90792	Psych diag eval w/med srvcs	Yes	
90832	Psytx w pt 30 minutes	Yes	
90833	Psytx w pt w e/m 30 min	Yes	
90834	Psytx w pt 45 minutes	Yes	
90836	Psytx w pt w e/m 45 min	Yes	
90837	Psytx w pt 60 minutes	Yes	
90838	Psytx w pt w e/m 60 min	Yes	
90839	Psytx crisis initial 60 min	Yes	
90840	Psytx crisis ea addl 30 min	Yes	
90845	Psychoanalysis	Yes	
90846	Family psytx w/o pt 50 min	Yes	
90847	Family psytx w/pt 50 min	Yes	
90853	Group psychotherapy	Yes	
90875	Psychophysiological therapy		Non-covered service
90901	Biofeedback train any meth		
90951	Esrd serv 4 visits p mo <2yr		
90952	Esrd serv 2-3 vsts p mo <2yr		
90953	Esrd serv 1 visit p mo <2yrs		

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Code

SAMPLE FOOTER TEXT 20XX 12

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CURRENT MEDICARE TELEHEALTH BILLING POLICIES

Name of Telehealth Service	Brief Description	How to Bill	Amount (2023)
Virtual Check-in or Virtual Care Communications	Remote evaluation – G2010 Brief communication with patient (5 min) – G2012	G0071 No modifier necessary Rev Code 052X	$23.72
Chronic Care Management	99484, 99487, 99490, 99491, 99424, and 99425 + G0511 99492, 99493 + G0512	G0511 – Care Management G0512 – Psychiatric Care Management	G0511 - $77.94 G0512 - $146.73
Digital e-visits	Online digital evaluation and management 99421-99423	G0071 No modifier Rev Code 052X	$23.72
Telehealth Visits	One to one substitutes for in-person services/visits List of allowable services maintained by CMS **Coverage through 12/31/2024**	**G2025** Modifier 95 optional Modifier CS (for services where cost sharing is waived) Rev Code 052X Costs and encounters carved out of cost report	$98.27
Mental Health Telehealth Visits	CPT Codes that can be billed with 0900 revenue code **Permanent coverage**	Rev Code 0900 Use proper mental health CPT code Modifier CG always Modifier 95 if audio-video Modifier FQ if audio-only Count costs and encounters on cost report	All-Inclusive Rate

Source: National Association of Rural Health Clinics
https://www.narhc.org/narhc/TA_Webinars1.asp

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Medicare Policy Area	Current Policy and Duration of Flexibility/Waiver
Originating Site/Geographic Requirements	Patients can receive telehealth services in their home or anywhere else through December 31, 2024.
Distant Site Requirements	RHC providers can serve as telehealth distant site providers through December 31, 2024. RHC providers can offer telehealth services from any location, including their home, during this period.
Billing/Cost Reporting Requirements	Please see table above. G2025 policy for medical telehealth visits remains in effect through December 31, 2024.
Modality	The Office of Civil Rights allows for "non-public facing" remote communication products to be used for telehealth services, "exercising discretion" on stringent HIPAA compliant platform requirements. This will end immediately when the federal PHE concludes.

Source: National Association of Rural Health Clinics
https://www.narhc.org/narhc/Telehealth_Policy.asp

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WHAT ABOUT MEDICARE MENTAL/BEHAVIORAL TELEHEALTH AFTER THE PHE ENDS?

- Mental and Behavioral Health services provided via telehealth are now recognized as RHC encounters and reimburse the AIR. This was a provision of the 2022 MPFS Final Rule.
- The end of the PHE does NOT change this.
- CMS is expected to give further clarification on whether these services must be distant site or if originating site services are also included. To pay the AIR we would expect the services to be distant site; however, CMS has not been clear on this.
- Billing guidance for these mental health telehealth services can be found in SE 22001.

https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf

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MENTAL HEALTH TELEHEALTH CODING & BILLING INFORMATION

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

Mental Health Services	
HCPCS Code	**Short Descriptor**
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

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COVID VACCINE MANDATE

DOES NOT END WITH THE PHE- NOT YET

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REQUIREMENTS FOR ALL CERTIFIED CMS FACILITIES

- All employees and staff (included contracted workers, students and non-patient individuals who are in the facility regularly with patient or employee contact) must be fully vaccinated 10 days prior to beginning work or must have a properly executed and approved exemption.
- Employers must accommodate those individuals to whom exemptions have been granted.
- Full recordkeeping of vaccine/immunization records for the initial dose(s) and any boosters.
- Proof of employee education on COVID-19
- **Contingency Plan** for the facility if infection rates for the community surge and/or if the workforce is impacted by surge or absences.
- Current federal conditions for certification—more binding than local or state policy. Separate federal action, does not end with the termination of the PHE.

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Immunization	10 days prior to beginning work
• Completed primary vaccine (one or two doses • Boosters not required; but must be documented if they did	
OR Valid Approved Exemption	Policy and Defined Process of Approval
• Medical condition from CDC list • Religious exemption	
Accommodation	Each exempted employee must be accommodated.
• Staff member and patients protected from risk	

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THE STATUS OF RHCS IN NEBRASKA

How many RHCs does Nebraska Have?

Are surveyors out and about?

What are the common deficiencies?

20XX

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Nebraska has 132 RHCs. Six Nebraska RHCs have closed since 2021.

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66% of all Nebraska RHCs are overdue for survey

Source: QCOR Database
www.qcor.cms.gov

Selection Criteria
Months Since Last Survey Date: 36
Provider and Supplier Type(s): Rural Health Clinics

View All States

Overdue Recertification Surveys Report

Region	Number of Late Surveys	% of Active Providers
(I) Boston	57	82.6%
(II) New York	11	21.6%
(III) Philadelphia	82	41.4%
(IV) Atlanta	782	54.8%
(V) Chicago	580	64.5%
(VI) Dallas	389	47.4%
(VII) Kansas City	496	57.8%
Iowa	75	35.9%
Kansas	155	82.4%
Missouri	180	54.5%
Nebraska	86	65.7%

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Nebraska Survey Findings

Selection Criteria
Begin Year: 2019
End Year: 2019
Display Options: Display all results
Provider and Supplier Type(s): Rural Health Clinics
State: Nebraska

Year Type: Fiscal Year **Year:** 2019 **Quarter:** Full Year

Citation Frequency Report

State Tag #	Tag Description
Totals represent the # of providers and surveys that meet the selection criteria specified above.	
30161	PROGRAM EVALUATION
E0020	Policies for Evac. and Primary/Alt. Comm.
30162	PROGRAM EVALUATION
30160	PROGRAM EVALUATION
30135	PROVISION OF SERVICES
30136	PROVISION OF SERVICES
30081	STAFFING AND STAFF RESPONSIBILITIES
30086	STAFFING AND STAFF RESPONSIBILITIES
30100	STAFFING AND STAFF RESPONSIBILITIES

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RHC CODING AND BILLING UPDATE 2023

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MEDICARE BILLING BASICS

- Roll up to the -CG Line. Only the –CG line is processed.
- No -25 or -59 unless there are two unrelated visits in one day
- Revenue Code and CPT Compatibility
- Split Billing
  - PBRHC labs and imaging are billed as if the hospital performed them. Even the six required tests
  - Independent RHCs bill to Part B

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Changes to E & M Coding Guidelines

AMA AMERICAN MEDICAL ASSOCIATION

CPT® Evaluation and Management (E/M)

Code and Guideline Changes

This document includes the following CPT E/M changes,

effective January 1, 2023:

- **E/M Introductory Guidelines related to Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239, Consultations codes 99242-99245, 99252-99255, Emergency Department Services codes 99281-99285, Nursing Facility Services codes 99304-99310, 99315, 99316, Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350**

https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

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New Home or Residential E & M Codes 99341-99342

99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
	INCLUDES Includes When reporting by time, 15 minutes or longer required
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
	INCLUDES Includes When reporting by time, 30 minutes or longer required
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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Where is the patient for these codes?


CPT © Code Section (99341-99350)

INCLUDES Services for new or established patient (99341 99345 99347 99350)
Services provided to patient in private home (e.g., assisted living facility, custodial care facility, group home, private residence, residential substance abuse treatment facility, temporary or short-term housing such as campground, cruise ship, hostel, or hotel)

EXCLUDES Admission to hospital inpatient/observation status (99221 99223)
Services provided to patient:
In group home designated as intermediate care facility for individuals with intellectual disabilities; report nursing facility services (99304 99318)
Under home health agency or hospice care (99374 99378)
Travel time to location

- Home
- Rest Home
- Assisted Living
- Group Home
- Temporary Lodging
- Other care facilities which are not inpatient, intermediate care, nursing home or skilled nursing.

Revenue Code = 522
No Additional Guidance for RHCs yet
Not all payers have added these codes or the revenue code

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Medical Telehealth RHC Encounters during the PHE

Look for changes as telehealth transitions after the end of the PHE.
Look for more updates on Georgia billing of telehealth for RHCs.

SE20016

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RHC Distant Site Medical Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	05/15/2022	1	100.00
0001	Total Charge				100.00

Optional

Effective January 1, 2023, the payment rate for distant site medical telehealth services is $98.27. This is a composite fee schedule amount. G2025 is reported on the UB-04 claim.

Add the -CS Modifier if G2025 is reporting a preventive service that would not be subject to deductible and coinsurance.

No –CG Modifier since this does not reimburse at the AIR. Not an encounter.

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New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MLN Matters Number: SE20016 Revised | Related Change Request (CR) Number: N/A
Article Release Date: January 13, 2022 | Effective Date: N/A
Related CR Transmittal Number: N/A | Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

Beginning July 1, 2020, you should no longer put the CG modifier on claims with HCPCS code G2025.

Table 1. RHC Claims for Telehealth Services from January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95 (optional)

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

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Mental Health Telemedicine are RHC Encounters Now

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2022 Mental Health Telehealth Example

These visits are different from telehealth services provided during the Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See MLN Matters Article SE20016 for information on billing G2025 for professional telehealth distant site services other than mental health visits during the PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 Revised on 05/05/2022 : -CG now required
- Is an encounter; pays at the AIR.

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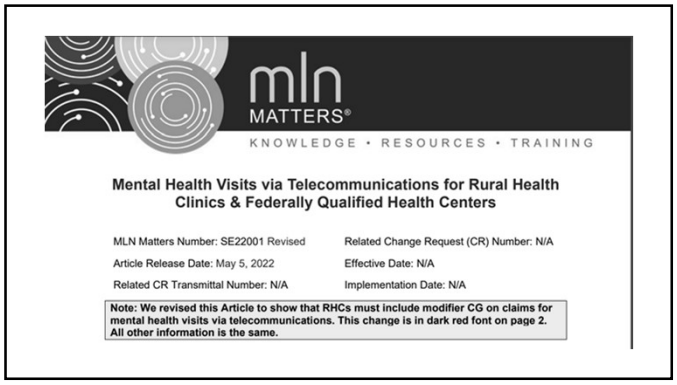
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MATTERS®
KNOWLEDGE • RESOURCES • TRAINING
Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
MLN Matters Number: SE22001 Revised
Related Change Request (CR) Number: N/A
Article Release Date: May 5, 2022
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A
Note: We revised this Article to show that RHCs must include modifier CG on claims for mental health visits via telecommunications. This change is in dark red font on page 2. All other information is the same.

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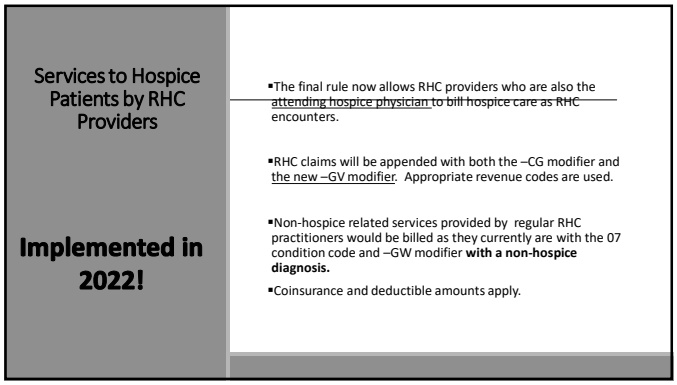
Services to Hospice Patients by RHC Providers
Implemented in 2022!
▪The final rule now allows RHC providers who are also the attending hospice physician to bill hospice care as RHC encounters.
▪RHC claims will be appended with both the –CG modifier and the new –GV modifier. Appropriate revenue codes are used.
▪Non-hospice related services provided by regular RHC practitioners would be billed as they currently are with the 07 condition code and –GW modifier with a non-hospice diagnosis.
▪Coinsurance and deductible amounts apply.

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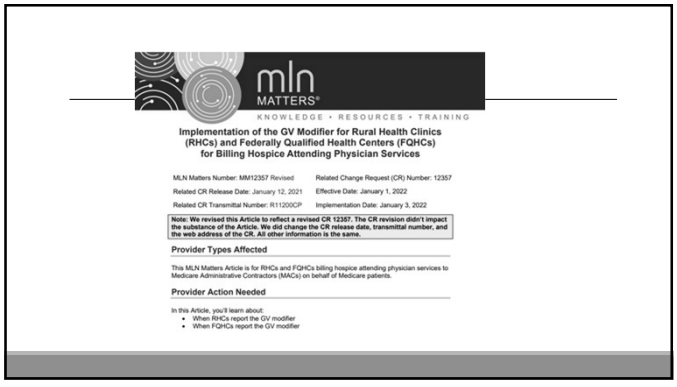
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MATTERS®
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Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services
MLN Matters Number: MM12357 Revised
Related Change Request (CR) Number: 12357
Related CR Release Date: January 12, 2021
Effective Date: January 1, 2022
Related CR Transmittal Number: R11200CP
Implementation Date: January 3, 2022
Note: We revised this Article to reflect a revised CR 12357. The CR revision didn't impact the substance of the Article. We did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.
Provider Types Affected
This MLN Matters Article is for RHCs and FQHCs billing hospice attending physician services to Medicare Administrative Contractors (MACs) on behalf of Medicare patients.
Provider Action Needed
In this Article, you'll learn about:
• When RHCs report the GV modifier
• When FQHCs report the GV modifier

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2023 MPFS HIGHLIGHTS FOR RHCS

- CARE MANAGEMENT G0511
  - Integrated Behavioral Health Care Management can be initiated by a Clinical Psychologist or LCSW.
  - Pain management as care management will be added to G0511. More guidance to come. State regulations on pain management may supersede this addition in some states where pain management is not allowed in primary care.
- MENTAL HEALTH PROVIDER TYPES
  - No new mental health provider types were added as qualified RHC providers through the MPFS Final Rule.
  - Discussion is still on the table.
  - State Medicaid programs may recognize different providers than Medicare.
- REMOTE PATIENT MONITORING
  - No Change to the CMS position that RPM is incident-to in an RHC and is not separately billable.
  - RPM cannot be billed to Part B when used for RHC Patients
  - Incident-to CCM
  - Discussion is still on the table.

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Changes to Policy Benefit Manual Chapter 13

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Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update

Related CR Release Date: January 26, 2023
Effective Date: January 1, 2023
Implementation Date: February 27, 2023
MLN Matters Number: MM13063
Related Change Request (CR) Number: CR 13063
Related CR Transmittal Number: R11803BP

Related CR Title: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

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Affected Providers

- RHCs
- FQHCs

Action Needed

Make sure your billing staff knows about:

- The 2022 and 2023 updates of the Medicare Benefit Policy Manual, Chapter 13
- All other revisions clarifying existing policy

Background

The 2022 and 2023 update of the Medicare Benefit Policy Manual, Chapter 13 gives information revised or clarified for RHCs and FQHCs.

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Background

The 2022 and 2023 update of the Medicare Benefit Policy Manual, Chapter 13 gives information revised or clarified for RHCs and FQHCs.

Key updates are:

- Effective January 1, 2022, a mental health visit may be a face-to-face encounter or an encounter provided using interactive, real-time, audio and video telecommunications technology or audio-only interactions where the patient isn't capable of, or doesn't consent to, the use of video technology for the purposes of diagnosis, evaluation, or treatment of a mental health disorder
- Effective January 1, 2022, RHCs and FQHCs can bill Transitional Care Management and general care management services provided for the same patient during the same service period if the RHC or FQHC meets the requirements for billing each code.
- An RHC and FQHC visit may include the location of the patient during a hospice election, including a patient's residence or a Medicare-certified facility

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- A physician, nurse practitioner, or physician assistant who works for an RHC or FQHC may provide hospice attending services during a time when they aren't working for the RHC or FQHC (unless prohibited by their RHC or FQHC contract or employment agreement)
- RHC and FQHC services include COVID-19 vaccinations and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19
- The in-person visit requirements for mental health telehealth services and mental health visits provided by RHCs and FQHCs start on January 1, 2025
- RHC and FQHC services include chronic pain management (CPM)
- Effective January 1, 2023, RHCs and FQHCs are paid for CPM services when a minimum of 30 minutes of qualifying non-face-to-face CPM services are provided during a calendar month
- Medicare pays Chronic Care Management (CCM), Principal Care Management (PCM), CPM, and general Behavioral Health Integration (BHI) services provided as of January 1, 2023, at the average of the national non-facility physician fee schedule payment rate for CPT codes 99490, 99487, 99484, 99491, 99424, and 99426 when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services
- The national statutory payment limit for RHCs in 2022 is $113 and in 2023 is $126 (See MLN Matters Article MM12999 for more details on payments for independent and provider-based RHCs in a hospital with 50 or more beds.)

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https://www.cms.gov/files/document/r11803BP.pdf#page=6

40 - RHC and FQHC Visits
(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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. *However, effective January 1, 2022, a mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder.* 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.

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70.2.1 – Payment Limits Applicable to Independent RHCs, Provider-Based RHCs in a Hospital with 50 or More Beds, and New RHCs
(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, independent RHCs, provider-based RHCs in a hospital with 50 or more beds, and RHCs enrolled under Medicare on or after January 1, 2021 will receive a prescribed national statutory payment limit per visit increase over an 8-year period for each year from 2021 through 2028.

The national statutory payment limit for RHCs over the 8-year period is as follows:

- *In 2021, after March 31, at $100 per visit;*
- *In 2022, at $113 per visit;*
- *In 2023, at $126 per visit;*
- *In 2024, at $139 per visit;*
- *In 2025, at $152 per visit;*
- *In 2026, at $165 per visit;*
- *In 2027, at $178 per visit; and*
- *In 2028, at $190 per visit.*

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Chronic Pain Management in RHCs

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G0511: Chronic Pain Care Management

230 – Care Management Services (Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23) Care management services are RHC and FQHC services and include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), chronic pain management (CPM), general behavioral health integration (BHI), and psychiatric collaborative care model (CoCM) services. The RHC and FQHC face-to face requirements are waived for these care management services.

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Policy Benefit Manual on CPM

230.2.3– Chronic Pain Management (CPM) Services
(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Effective January 1, 2023, RHCs and FQHCs are paid for CPM services when a minimum of 30 minutes of qualifying non-face-to-face CPM services are furnished during a calendar month. CPM services may be furnished to patients with multiple chronic conditions that involve chronic pain, and may include a person-centered plan of care, care coordination, medication management, and other aspects of pain care.

- Billed with G0511
- 30 minutes (code description still says 20 minutes)
- What is CPM?

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No DEA Waiver Needed Now

https://www.deadiversion.usdoj.gov/pubs/docs/index.html

Informational Documents

Dear Registrants:

On December 29, 2022, with the signing of the Consolidated Appropriations Act of 2023 (the Act), Congress eliminated the "DATA-Waiver Program."

DEA fully supports this significant policy reform. In this moment, when the United States is suffering tens of thousands of opioid-related drug poisoning deaths every year, the DEA's top priority is doing everything in our power to save lives. Medication for opioid use disorder helps those who are fighting to overcome opioid use disorder by sustaining recovery and preventing overdoses. At DEA, our goal is simple: we want medication for opioid use disorder to be readily and safely available to anyone in the country who needs it. The elimination of the X-Waiver will increase access to buprenorphine for those in need.

All DEA registrants should be aware of the following:

- A DATA-Waiver registration is no longer required to treat patients with buprenorphine for opioid use disorder.
- Going forward, all prescriptions for buprenorphine only require a standard DEA registration number. The previously used DATA-Waiver registration numbers are no longer needed for any prescription.
- There are no longer any limits or patient caps on the number of patients a prescriber may treat for opioid use disorder with buprenorphine.
- The Act does not impact existing state laws or regulations that may be applicable.

Separately, the Act also introduced new training requirements for all prescribers. These requirements will not go into effect until June 21, 2023. The DEA and SAMHSA are actively working to provide further guidance and DEA will follow up with additional information on these requirements shortly. Importantly, these new requirements do not impact the changes related to elimination of the DATA-Waiver Program described above.

Sincerely,

Anne Milgram
Administrator

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Pain Management and Suboxone (Buperenorphine)

Control Status:

Buprenorphine and all products containing buprenorphine are controlled in schedule III of the Controlled Substances Act. May 24, 2022

https://www.deadiversion.usdoj.gov › buprenorphine

BUPRENORPHINE - DEA Diversion

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Texas Definition of Pain Management Clinic

OCCUPATIONS CODE

TITLE 3. HEALTH PROFESSIONS

SUBTITLE B. PHYSICIANS

CHAPTER 168. REGULATION OF PAIN MANAGEMENT CLINICS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 168.001. DEFINITIONS. In this chapter:

(1) "Pain management clinic" means a publicly or privately owned facility for which a majority of patients are issued on a monthly basis a prescription for opioids, benzodiazepines, barbiturates, or carisoprodol, but not including suboxone.

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Texas NPs and Controlled Substances

<<Prev Rule Next Rule>>

Texas Administrative Code

TITLE 22	EXAMINING BOARDS
PART 11	TEXAS BOARD OF NURSING
CHAPTER 222	ADVANCED PRACTICE REGISTERED NURSES WITH PRESCRIPTIVE AUTHORITY
RULE §222.8	Authority to Order and Prescribe Controlled Substances

(a) APRNs with full licensure and a valid prescription authorization number are eligible to obtain authority to order and prescribe certain categories of controlled substances. The APRN must comply with all federal and state laws and regulations relating to the ordering and prescribing of controlled substances in Texas, including but not limited to, requirements set forth by the United States Drug Enforcement Administration.

(b) Orders and prescriptions for controlled substances in Schedules III through V may be authorized, provided the following criteria are met:

(1) Prescriptions for a controlled substance in Schedules III through V, including a refill of the prescription, shall not exceed a 90 day supply. This requirement includes a prescription, either in the form of a new prescription or in the form of a refill, for the same controlled substance that a patient has been previously issued within the time period described by this subsection.

(2) Beyond the initial 90 days, the refill of a prescription for a controlled substance in Schedules III through V shall not be authorized prior to consultation with the delegating physician and notation of the consultation in the patient's chart.

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 25 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. Patty currently serves on the Board of NARHC.

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