Are You Leaving Money on the Table?
And here’s our CFO spending some time in our labs obviously looking at something incredibly small.”

“Yes. Our profit margins.”
Opportunities for Reimbursement
Qualifying RHC Encounters

All inclusive
Medical Services

Sick Visits
• Most common type of clinic visit/encounter

Wellness/Preventive Visits

MEDICARE
• Initial Preventive Physical Exam (IPPE) - G0402
  • ONCE per lifetime; within 12 months of patient’s Part B enrollment
  • Is reimbursed separately, if billed same date as another RHC encounter
• Annual Wellness Visit (AWV) - G0438, G0439
  • Covered once every 12 months

LOUISIANA MEDICAID
• Preventive Care Visits (age specific) - 99381-99397
  • Includes EPSDT Screening Services for Birth through age 20

Specialty Visits
• Volume cannot exceed 49% of total RHC encounters
Behavioral Health (BH) Services

Mental Health or Substance Abuse Visits

• Must be rendered by a qualified BH provider
  • Psychiatrist
  • Clinical Psychologist
  • Licensed Clinical Social Worker

• Individual visits only *(Group visits not covered)*

• Can be billed on same day as a Medical or Dental encounter
  • As of **April 1, 2019**, LOUISIANA MEDICAID now pays for BH encounter on same day as Medical or Dental encounter
Dental Services

Not Common in an RHC Setting

• Can be billed on same day as Medical or Behavioral Health Encounter
MEDICARE

- Currently **only covers origination site** for RHCs
- Bill using HCPCS code **Q3014 ($26.15 for CY2019)**

LOUISIANA MEDICAID

- Only covers distance site provider for telemedicine services
- **Effective August 1, 2019**, providers should no longer use the –GT modifier to indicate services provided via Telemedicine.
  - As of 8/1/2019, use **Place of Service -02 and append modifier -95** to each service provided via telehealth
- Reimbursement is same as other RHC encounters and services
RHC Places of Service

- CLINIC
- NURSING HOME \((including \text{ SNF})\)
- PATIENT’S HOME
- SCENE OF AN ACCIDENT
Services Reimbursed in Addition to RHC Encounters
RHC Services
Care Management Services

**WHAT are they?**

**Covered by MEDICARE ONLY**

**Transitional Care Management (TCM)**
- NOT separately reimbursed, but DO qualify as a billable RHC encounter
- Time period for TCM is 30 days (day of discharge plus 29 more)

**General Care Management**
- Separately reimbursed (in addition to RHC encounter rate)
- Can be billed alone, or with another RHC encounter
- **Chronic Care Management (CCM)**
- **Behavioral Health Integration (BHI)**

**Psychiatric Coordination of Care Model (CoCM)**
- Separately reimbursed (in addition to RHC encounter rate)
- Can be billed alone, or with another RHC encounter
Transitional Care Management Services

**WHAT are they?**

**Transitional Care Management (TCM)**

*Transitional Care Management Services include the following required elements:*

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Certain non-face-to-face services
- One face-to-face TCM visit with qualified RHC provider
  - **99495** - Medical decision making of at least *moderate complexity* during the service period face-to-face visit, within **14 calendar days** of discharge.
  - OR
  - **99496** - Medical decision making of *high complexity* during the service period face-to-face visit, within **7 calendar days** of discharge.
Transitional Care Management (TCM)

• TCM can be billed alone or with other payable RHC services
• If TCM is the only service provided on that day, RHC providers are paid at the RHC encounter rate
• If TCM furnished on same day as another medical visit, only one RHC encounter will be paid
• Cannot bill for TCM on the same day as other care management services, such as CCM, BHI, etc.

You may access the following link for more detailed information on TCM

Care Management Services

WHAT are they?

General Care Management Requirements (CCM & BHI)

Initiating Visit

• Evaluation & Management (E/M) service, Medicare Initial Preventive Physical Exam (IPPE), Medicare Annual Wellness Visit (AWV) furnished by qualified RHC provider (physician, NP, PA, CNM)

• Has occurred no more than 1 year prior to commencing of care management services

Patient Consent

• Can be obtained during or after initiating visit, but must be before commencement of care management services (patient coinsurance applies)

• Can be written or verbal, but must be documented in medical record

Billing

• G0511 - 20 minutes or more of clinical staff time for Chronic Care Management (CCM) services or Behavioral Health Integration (BHI) services directed by an RHC practitioner (physician, NP, PA, or CNM), per calendar month.
Care Management Services

**WHAT are they?**

*General Care Management Requirements*

**Chronic Care Management (CCM)**

**Patient Eligibility**

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

**Service Elements**

- Using Certified EHR Technology, record specified patient health information (demographics, problems, medications, medication allergies)
- Provide patients/caregivers with 24/7 access to clinical staff to address urgent needs, regardless of time of day or day of week
- Provide continuity of care with a designated care team member with whom patient is able to schedule successive routine appointments.
WHAT are they?

General Care Management Requirements

Chronic Care Management (CCM)

Service Elements (cont’d)

• Provide patient with comprehensive care management including:
  • Systematic assessment of medical, functional, and psychosocial needs
  • Timely receipt of recommended preventive care services
  • Medication reconciliation
  • Oversight of patient self-management medications

• A Comprehensive Care Plan for all health issues, with particular focus on the chronic conditions being managed, including an inventory of resources and supports, and based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment

• Timely availability of electronic copy of Care Plan information (within and outside of RHC, as appropriate), and copy of plan of care provided to patient/caregiver
Care Management Services

**WHAT** are they?

**General Care Management Requirements**

**Chronic Care Management (CCM)**

**Service Elements (cont’d)**

- Management of care transitions and referrals between and among healthcare providers and settings
- Coordination with home and community-based clinical service providers, including medical record documentation of said communications regarding patient’s psychosocial needs and functional deficits
- Enhanced opportunities for patient (and caregivers) to communicate directly with practitioner regarding patient’s care via telephone, secure messaging, internet, or other asynchronous, non-face-to-face consultation methods
Care Management Services

**WHAT are they?**

**General Care Management Requirements**

**Behavioral Health Integration (BHI)**

**Patient Eligibility**

- Any behavioral health or psychiatric condition being treated by the RHC primary care practitioner, including substance use disorders, that, in the clinical judgement of the RHC practitioner, warrants BHI services

**Service Elements**

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
- Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
- Continuity of care with a designated member of the care team.
Care Management Services

**WHAT are they?**

**Psychiatric Collaborative Care Model (CoCM)**

- Initiating Visit
- Same as CCM and BHI
- Patient Consent
- Same as CCM and BHI
- Billing
  - **G0512** - 60 minutes or more of clinical staff time for Psychiatric CoCM services directed by an RHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.
  - **INITIAL** calendar month billing requires 70 minutes or more
- Patient Eligibility
  - Any behavioral health or psychiatric condition being treated by the RHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC practitioner, warrants psychiatric CoCM services
Care Management Services

**WHAT are they?**

**Psychiatric Collaborative Care Model (CoCM)**

Service Elements

- Psychiatric CoCM requires a TEAM that includes the following:
  - RHC Practitioner (physician, NP, PA, CNM)
  - Behavioral Health Care Manager
  - Psychiatric Consultant

For more information on service requirements for CCM, BHI and CoCM services, see Chapter 13 of the Medicare Benefit Policy Manual at:


Or at the following Q&A link:

- [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf)
WHY provide them?

**PROs**
- Only 5% of clinic patients account for over 50% of clinic’s utilization and cost of care
- Reimbursement trends are quickly moving toward value-based care

**CONs**
- Collecting, tracking, reporting data can be challenging
  - EHRs may not offer patient management tools, requiring manual data tracking
  - May require an added “patchwork” of products (cost prohibitive)
  - May require addition of manual work (labor intensive)
Care Management Services

**WHO can provide them?**

**CCM, BHI, and CoCM**

- Directed by the RHC primary care practitioner, who remains involved through ongoing oversight, management, collaboration and reassessment
- Furnished by an RHC practitioner, or by clinical personnel under general supervision
  - Care management services are typically furnished in a non-face-to-face setting by clinical personnel working under general supervision of the RHC primary care practitioner.
  - Direct supervision is not required
  - RHC Face-to-face requirements are WAIVED
Care Management Services

**WHO** can provide them?

**TCM**

- Initial contact can be made by a qualified RHC provider or clinical staff
- Non-face-to-face services can be provided by a qualified RHC provider OR by clinical staff under the direction of a qualified RHC provider
- Face-to-Face visit must be rendered by a qualified RHC provider
Care Management Services

HOW / WHEN to provide them?

CCM, BHI, or CoCM

- Services furnished on or after January 1, 2019 can be billed by adding the appropriate care management code, to an RHC claim, either alone or with other payable services.
  - G0511 for CCM or BHI services (2019 payment rate is $67.03)
  - G0512 for CoCM services (2019 payment rate is $145.96)

- CAN be billed once per month per beneficiary when the associated time threshold is met for any ONE care management service

- CAN be billed alone or in addition to other services furnished during the RHC visit

- CANNOT be billed if other care management services (such as TCM, CCM, BHI, CoCM, home health care supervision) are billed for the same time period

- CANNOT count time spent by administrative or clerical staff towards the time required to bill these services
Care Management Services

HOW / WHEN to provide them?

TCM

• Bill as an RHC encounter, upon completion of the required TCM services

• Use ONE of the following codes for billing TCM services
  • 99495 for moderately complex patients (must be furnished within 14 days of patient discharge)
  • 99496 for highly complex patients (must be furnished within 7 days of patient discharge)

• Cannot bill TCM services with other care management services
Virtual Communication Services (VCS)

Covered by MEDICARE ONLY

• Billable when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient who has had an RHC billable visit within the previous year, AND

• BOTH of the following conditions have been met
  • The medical discussion or remote evaluation is for a condition NOT related to an RHC service provided within the previous 7 days, and
  • The medical discussion or remote evaluation DOES NOT LEAD TO AN RHC VISIT within the next 24 hours or at the soonest available appointment.

• VCS must be initiated by the PATIENT!

• RHC provider must follow up within 24 hours of patient communication
Virtual Communication Services (VCS)

- **Types of communication technology**
  - Telephone call, integrated audio/video system, or through a store-and-forward method such as sending a picture or video to the RHC practitioner for evaluation and follow up within 24 hours.
  - The RHC practitioner may respond to the patient’s concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

- Document VCS in patient health record (include total time spent in medical discussion or remote evaluation)

- Bill using HCPCS code **G0071** (2019 payment rate is $13.69)

- No limit on number of VCS services by a single Medicare beneficiary
Reimbursement through your Medicare Cost Report

Vaccines administered to Medicare beneficiaries

• The cost and administration of Influenza and Pneumococcal vaccines are 100% reimbursable by Medicare

• Do NOT report on an RHC claim when billing for RHC services

• Must list on the appropriate worksheet on the annual Medicare cost report to receive reimbursement
Louisiana Medicaid

Long Acting Reversible Contraceptives (LARCs)

• Effective January 1, 2019 RHCs can be reimbursed for LARCs purchased for placement in the clinic setting.

• Bill using the CPT code for the appropriate LARC insertion and the LARC device (J-code), in addition to the T1015 RHC Encounter code and other detail lines for the encounter
  • NOTE: The LARC and LARC Insertion cannot be the only detail lines on the claim or the claim will deny

• Reimbursement will be the lesser of the Medicaid rate on file or the actual acquisition cost (AAC) of the LARC for entities participating in 340B, and can be found on the Medicaid DME Fee Schedule (see lamedicaid.com)

• You may access the following links for more information on ordering/billing for LARCs:
Non-RHC Services
Non-RHC Services

HOSPITAL SERVICES
- Inpatient
- Outpatient/Observation
- Emergency Department

DIAGNOSTIC SERVICES - Medicare ONLY
- Lab Services
  - Including CLIA waived tests
- Other Diagnostic Services (use appropriate code/modifier to bill technical component ONLY)
  - X-rays, Ultrasounds, EKGs, Bone Density Studies, etc.
- Provider-based RHC diagnostics must be billed by Hospital (even if performed in the clinic)
Revenue's been up since we changed our Wi-Fi policy around here.

Wi-Fi Passwords
$3.99

Please check in upon arrival.
Opportunities for Improvement
KIAZEN

Continual Improvement
(Everyday, Everybody, Everywhere)

- Constantly introducing small incremental changes to improve quality and/or efficiency.
- Empowers staff, recognizing they are the best people to identify room for improvement.

Kia Change
Zen for the Good
The Revenue Cycle
How Well Are You Managing Your Revenue Cycle?

**Revenue Cycle Management**

**Front Office**
- Pre-Appointment
- Registration
- Check-In/Check Out

**Clinical Staff**
- Charge Capture
- Coding

**Back Office**
- Claims Management
- Patient Billing/Collections
- Accounts Receivable Management
Break Down the Silos!

A great revenue cycle requires all departments to work TOGETHER
Scheduling and Registration

• Extended Hours
• Open or Hybrid Schedule
• Reschedule Cancellations
• Appointment Reminders
• Get demographic information when appointment is made
• Automate Eligibility Verification (or at least do it manually prior to appointment)
Check In and Check Out

• Confirm address, phone and insurance
• Collect copayments up front
• Collect coinsurance at check out
• Make follow up appointments at check out
• Add codes for ALL services provided (even if reimbursement is included in RHC all-inclusive encounter rate)

• Don’t forget administration codes for injections

• Tracking, Reporting and Coding of services paid monthly (i.e. CCM services)

• Technical services reimbursed outside of RHC encounter rate

• Services reimbursed in addition to RHC encounter rate

• Appropriate level of E/M Coding
Claims Management

• Daily claims filing is best, but at least file weekly
• Review and TRACK errors, rejections and denials
• Utilize Electronic Remittance Advice (ERA), when possible
• Post payments timely
• Work Denials timely
Patient Billing/Collections

• If you do patient billing, spread out statement processing throughout the month (don’t send them all out at once)

• Offer Sliding Fee Scale (consider offering a prompt payment discount for those who pay 100% at time of service)

• Offer payment plans, if needed
Accounts Receivable Management

Review A/R reports monthly

• Aging (15%-18% in >120 days)
• Transactions
• Denials (5%-10%)
• Analyze reports by
  • Payer
  • Provider
  • Location (if you have multiple facilities)

Calculate and trend Days in A/R (<45 days)
Calculate and trend Net Collection Rate (95-99%)
Don’t underestimate the value of working as a team.

Provide staff with necessary resources.

Important to Remember:

Happy staff are much more productive.

There is value in efficiency (time is money).

I love my job.
Access additional RHC resources at

CMS Rural Health Clinics Center
  • https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

La. Medicaid RHC Manual
  • https://www.lamedicaid.com/provweb1/Providermanuals/manuals/RHC/RHC.pdf

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