On July 8, 2015 CMS published the proposed rule for the 2016 Medicare Physician Fee Schedule. They were taking comments on it until Sept. 10th. CMS will likely issue the final rule (official policy) around November 1, 2015 with an EFFECTIVE DATE for the new policy of Jan. 1, 2016. We believe the following provisions are of interest to RHCs.

Proposed Chronic Care Management Benefit

As a part of their broader goal to integrate and coordinate services, CMS is proposing to extend the Chronic Care Management benefit to RHCs. Beginning on January 1, 2016 RHCs who furnish a minimum of 20 minutes per month of chronic care management (CCM) services to qualifying patients may begin billing for these services. RHCs would also be subject to all the other requirements of providing CCM services such as having up-to-date EHR software, maintaining an electronic beneficiary care plan, and beneficiary consent. You can find a primer on the current CCM benefit here.

The proposed rate for the CCM services will be based off the national average non facility payment rate for CPT code 99490 which was $42.91 per beneficiary per month in the first quarter of 2015. In evaluating the payment methodology for the CCM benefit, CMS specifically noted comments submitted by the National Association of Rural Health Clinics. CMS proposes to waive the face-to-face requirement in order to allow CCM services to be billed as part of the RHC benefit. We expect CCM services will be billed via the CPT code field on the standard UB 04 form. Further billing details will be released after adoption of a final rule later this year.

Proposed HCPCS Reporting Requirement for RHCs

CMS believes that requiring RHCs to report HCPCS (CPT) codes for all services would provide useful information on RHC patient characteristics, and the types of services being furnished by RHCs. As such CMS is proposing that all RHCs must report all services furnished during an encounter using standardized coding systems beginning January 1, 2016. The proposal requires an HCPCS (CPT) code to be reported along with the standard Medicare revenue code for each service furnished by an RHC to a Medicare patient. CMS is inviting comments from RHCs on the feasibility of updating their billing systems to meet the proposed implementation date of January 1, 2016.

Clarifying RHCs are not subject to PQRS Adjustments

CMS clarified that eligible professionals working in RHCs who perform non-RHC services (hospital inpatient visits, lab services, etc.) and bill Medicare Part B for these services, at RHCs are not subject to PQRS negative payment adjustments.

Comments Solicited for MIPS Low-Volume Threshold Exception

The Medicare Access and CHIP Reauthorization Act (MACRA) combines the PQRS, Meaningful Use, and Value Based Payment Modifier into one system called the Merit-Based Incentive Payment System (MIPS) beginning in 2019. MACRA requires the Secretary to create a low-volume exception, to exclude certain professionals who might otherwise qualify from the MIPS program. CMS is soliciting comments on what factor(s) should be used to establish this low-volume threshold.

New Exception to Physician Kickback Rule

CMS is proposing a new exception to the Physician Kickback Rule to permit remuneration from a hospital, FQHC, or RHC to a physician to assist with employing a PA, NP, CNS, or CNM. As currently proposed, the exception only applies when the PA/NP/CNS/CNM is a bona fide employee of the physician. As such, CMS is soliciting comments as to whether or not the exception should also apply to independent contractors. Additionally, CMS is soliciting comments on two methodologies to determine the geographic area served by FQHCs/RHCs. These definitions are intended to apply to RHCs/FQHCs in the same way that they apply to hospitals and rural hospitals, for purposes of the remuneration exception.