# Rural Health Clinics HCPCS Reporting Not a Precursor to PPS Payment

## Payment Model Change Would Require Act of Congress

On October 1, 2016 the RHC HCPCS reporting requirements changed once again. While NARHC believes the new process involving the "CG" modifier is an improvement from the previous "Qualifying Visit List" process, we understand that there are still issues with the new process. Most notably, we believe that the way RHCs are forced to report inaccurate charges will have negative long term implications and needs to be fixed.

We also wanted to take the time to address a notion that we have heard regarding what HCPCS reporting ***means*** for RHCs. It has been expressed by some that the purpose behind the HCPCS reporting requirements is to slowly move RHC Medicare reimbursement away from the All-Inclusive Rate and towards some sort of Prospective Payment System (PPS). **This is misleading and not very accurate.**

It is true that our safety-net peers, Federally Qualified Health Centers (FQHCs), began reporting HCPCS codes as a pre-requisite for a move towards a PPS system, but this shift in FQHC payment was made possible by Congress through the Patient Protection and Affordable Care Act (ACA) – not CMS.

It is also true that any switch away from the RHC All-Inclusive Rate to a PPS system is made more feasible by RHC HCPCS reporting, **but it is not currently within CMS's authority to make such a shift.**

Section 1833 of the Social Security Act states that payment for RHC services must be based upon "the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations…" This language is the basis for the RHC All-Inclusive Rate and would need to be amended if RHCs were ever to move towards a PPS system. Furthermore, we should note that there is no indication from Congress that they wish to change this.

## HCPCS Reporting Clarifications

There have been some frequently asked questions surrounding the "CG" modifier that we would like to address. The best resource from CMS on these changes remains this MLN Matters article: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf

However, we understand that certain items remain a bit unclear. The NARHC has confirmed that:

1) Every Medicare RHC claim must have one "CG" modifier on it. Even those claims with only one service.
2) If an RHC is billing for only a preventive service, you would still use the CG modifier
3) For the purposes of RHC billing, modifiers 25 and 59 are interchangeable
4) HCPCS codes G0436 and G0437 (tobacco cessation counseling) are discontinued for **dates of service** after 10/1/2016

**Nathan Baugh**
Director of Government Affairs
National Association of Rural Health Clinics