RHC Update Seminar

February 15, 2022

Agenda

Topics	Speaker	Organization	Time/minutes	Subject Matter
Introductions	Mark Lynn	Healthcare Business Specialists	10	Introduce Speakers and Administrative. Sponsor Message
RHC Billing	Charles James	North American HMS	15	Payment for attending physician services furnished by RHCs to hospice patients Mental Health Services furnished via telecommunications
CCM and Principal Care	Shannon O'Neal	Chart Span	10	Concurrent Billing for Chronic Care Management Services (CCM) and Transitional Care Management (TCM) Services for RHCs Change to the general care management HCPCS code G0511 to replace G2064 and G2065 with CPT code 99424 and 99426 Increased rates for CCM 7 Principal Care services in 2022.
Provider-based RHC Rates	Jonathan Pantenburg	Stroudwater Associates	10	Payment limit per visit changes for independent and provider-based RHCs
Medicare Bad Debts	Julie Quinn	Health Services Associates	5	The impact of higher Medicare caps on crossover bad debts.
Grants Management	Elizabeth Burrows, JD	Burrows Consulting, Inc.	10	Financial Management Reviews (FMR) for HRSA RHC Grant Recipients
PRF Fund Reporting	Mark Lynn	Healthcare Business Specialists	5	Period 2 PRF fund reporting for Independent RHCs/ No Surprise Act update

Summary of what has Changed

What's Changed?

- We pay Rural Health Clinics (RHCs) a bundled payment, or All-Inclusive Rate (AIR) per visit, for qualified primary care and preventive health services provided by an RHC practitioner (page 6)
- Added hospices as a location where RHC visits can take place (page 7)
- Beginning January 1, 2022, RHCs can bill Transitional Care Management (TCM) and general care management services furnished for the same patient during the same service period, if the RHC meets the requirements for billing each code (page 8)
- Beginning April 1, 2021, RHCs will receive a prescribed national statutory payment limit per visit increase over an 8-year period for each year from 2021 through 2028 (page 8)
- Added COVID-19 monoclonal antibody products as services Medicare covers (page 8)
- Beginning January 1, 2022, RHCs can report and get payment for mental health visits furnished via real-time telecommunication technology (page 9)
- Beginning January 1, 2022, RHCs are eligible to get payment for hospice attending physician services when provided by a RHC physician, nurse practitioner, or physician assistant who's employed or working under contract for an RHC, but isn't employed by a hospice program (page 10)

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf

Relevant Documentation of Changes

Date	Topic	Link
1/12/2021	Billing Hospice Attending physician services (GV modifier)	https://www.cms.gov/files/document/mm12357-implementation-gv-modifier-rural-health-clinics-rhcs-and-federally-qualified-health-centers.pdf
1/13/2022	Updated information on Telehealth Billing	https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf

Mental Health Services Billing in 2022

In addition, beginning January 1, 2022, RHC mental health visits will include visits furnished using interactive, real-time telecommunications technology. This change will allow RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology. Therefore, we are finalizing that there must be an **in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that in general, there must be an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months** while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders. However, exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record) and more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

In order to bill for mental health visits furnished via telecommunications for dates of service on or after **January 1, 2022, RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only.**

Source: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center

Care Management Services

CCM or general BHI services furnished on or after January 1, 2022, are paid at the average of the national non-facility PFS payment rate for CPT codes 99484, 99487, 99490, and **99491 (30 minutes or more of CCM services** furnished by a physician or other qualified health care professional) and 99424 and 99426 **(30 minutes or more of principal care management (PCM)** services furnished by a physician or other qualified health care professional, when general care management HCPCS code G0511 is updated annually based on the PFS amounts for these codes. **The CY 2022 rate for G0511 is $79.25.**

Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when psychiatric CoCM HCPCS code, G0512, is on an RHC claim, either alone or with other payable services. This rate is updated annually based on the PFS amounts for these codes. At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service. **The CY 2022 rate for G0512 is $151.23.**

Source: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center

How Does the No Surprises Act Impact RHCs? - Details on the Good Faith Estimate
Tuesday, December 14, 2021

- Webinar Recording
- Q&A Follow-Up
- Webinar Transcript (PDF)
- Slide Presentation (PDF)
- CMS Regulations
- Good Faith Estimate Disclaimer and Template

Ask the patient when scheduling "Are they going to use their insurance to pay for their healthcare or will it be self-pay"

Price Transparency Flow Chart – Cash Patient

If an uninsured or Insured but cash patient		Is a GFE required, and when?
Schedules an appointment:	10 or more business days in advance	Yes, within 3 business days of scheduling
	Between 3 to 9 business days in advance	Yes, within 1 business day of scheduling
	Less than 3 business days in advance	No

Patient Requests a Good Faith Estimate but DOES NOT schedule an appointment at this time

Requests a GFE, or otherwise asks about the cost of a service, but does not schedule appointment	Yes, within 3 business days of the request

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

ENFORCEMENT?

Although the law takes effect on January 1, 2022, CMS has acknowledged that providers will have difficulty getting charge information from outside providers to include in a GFE.

Therefore, even though the requirement to include information from the outside provider takes effect on Jan. 1, 2022, CMS has publicly stated that they **will not enforce this requirement until Jan. 1, 2023**.

CMS Rural Health Clinic Website

Spotlights

- **RHC Policies Addressed in the CY 2022 Physician Fee Schedule Final Rule**

  CMS issued the CY 2022 Medicare Physician Fee Schedule Final Rule which included several provisions that impacted RHCs. A list of provisions effective January 1, 2022 is outlined below. Information regarding each of these policies is available in the CY 2022 Medicare Physician Fee Schedule Final Rule Fact Sheet.

  - Payment limit per visit changes for independent and provider-based RHCs
  - Payment for attending physician services furnished by RHCs to hospice patients
  - Concurrent Billing for Chronic Care Management Services (CCM) and Transitional Care Management (TCM) Services for RHCs
  - Mental Health Services Furnished via Telecommunications Technologies for RHCs
  - Change to the general care management HCPCS code G0511 to replace G2064 and G2065 with CPT code 99424 and 99426

- **COVID-19 Public Health Emergency (PHE) - Updates for RHCs**

  To provide as much support as possible to RHCs and their patients during the COVID-19 (PHE), we have made several changes to RHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will continue to review our policies as the situation evolves. For additional information and other flexibilities, please see the link: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (PDF)

- **COVID-19 Vaccines in RHCs**

  COVID-19 vaccines and their administration will be paid the same way influenza and pneumococcal vaccines and their administration are paid in RHCs. Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The beneficiary coinsurance and deductible are waived. For Medicare Advantage patients, RHCs and FQHCs should submit COVID-19 vaccine administration claims to the Medicare Advantage Plan for dates of service on or after January 1, 2022. Original Medicare won't pay for these claims beginning in January 2022. For dates of service in 2021, RHCs and FQHCs should use the cost report to bill for administering COVID-19 vaccines. For additional information, please see https://www.cms.gov/covidvax.

- **Payment for Telehealth Services for RHCs During the COVID-19 PHE**

  On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. Section 3704 of the CARES Act authorizes RHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs with this capability can provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.

  Distant site telehealth services can be furnished by any health care practitioner working for the RHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). A list of these services can be found here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. Claims for G2025 are paid at the CY2021 rate of $99.45. The CY 2022 rate is $97.24.

  In addition, beginning January 1, 2022, RHC mental health visits will include visits furnished using interactive, real-time telecommunications technology. This change will allow RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology. Therefore, we are finalizing that there must be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that in general, there must be an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders. However, exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record) and more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

  In order to bill for mental health visits furnished via telecommunications for dates of service on or after January 1, 2022, RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only.

  For additional information on payment, billing, and claims processing, see https://www.cms.gov/files/document/se20016.pdf (PDF)

- **Expansion of Virtual Communication Services for RHCs During the COVID-19 PHE**

  During the COVID-19 PHE, payment for virtual communication services include digital assessment services. Digital assessment services are non-face-to-face, patient-initiated, digital communications using a secure online patient portal. The digital assessment codes that are billable during the COVID-19 PHE are CPT code 99421 (5-10 minutes over a 7-day period), CPT code 99422 (11-20 minutes over a 7-day period), and CPT code 99423 (21 minutes or more over a 7-day period).

  To receive payment for the new digital assessment service or virtual communication services (HCPCS codes G2012 and G2010), RHCs must submit an RHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for these 5 codes. Claims for G0071 will be paid at the CY 2021 rate of $13.53 and later reprocessed with the new rate of $24.76. The CY 2022 rate is $23.88. See Virtual Communication Services Frequently Asked Questions (PDF)

- **Care Management Services**

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- **Revision of RHC Home Health Agency Shortage Requirement for Visiting Nursing Services During the COVID-19 PHE**

  RHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020 and for the duration of the COVID-19 PHE, the area typically served by the RHC is determined to have a shortage of home health agencies, and no request for this determination is required. RHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.

Questions on RHC Issues? Email RHC@cms.hhs.gov

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You'll find substantive content updates in dark red font.

A Rural Health Clinic (RHC) is a clinic located in a rural, underserved area with a shortage of primary care providers, personal health services, or both. Currently, there are about 4,500 RHCs nationwide providing primary care and preventive health services in underserved rural areas.

Together we can advance health equity and help eliminate health disparities in rural populations. Find these resources and more from the CMS Office of Minority Health:

- Rural Health
- Data Stratified by Geography (Rural/Urban)
- Health Equity Technical Assistance Program

RHC Practitioners

RHCs and their staff must comply with all licensure and certification laws and regulations. Medicare pays RHCs for qualified primary and preventive health services provided by RHC practitioners, including:

- Physicians
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Certified Nurse-Midwives (CNMs)
- Clinical Psychologists (CPs)
- Clinical Social Workers (CSWs)

RHC Patient Services

RHCs provide:

- Primary care and preventive services
- Services and supplies furnished incident to RHC practitioner services, such as taking blood pressure or administering shots
- Homebound visiting nurse services in CMS-certified home health agency shortages
- Some care management services
- Some virtual communication services, such as communications-based technology and remote evaluation services

RHC Certification

To be certified as an RHC, a clinic must meet all state and federal requirements, including location, staffing, and health care services requirements. RHCs must also have a quality assessment and program improvement program.

Location Requirements

An RHC must:

- Be located in an area defined by the U.S. Census Bureau as non-urbanized
- Be located in an area currently designated by the Health Resources and Services Administration (HRSA) within the last 4 years as 1 of these:
  - Primary Care Geographic Health Professional Shortage Area
  - Primary Care Population-Group Health Professional Shortage Area
  - Medically Underserved Area
  - Governor-designated and Secretary-certified Shortage Area

Staffing Requirements

An RHC must:

- Employ an NP or PA (RHCs may contract with NPs, PAs, CNMs, CPs, and CSWs when the RHC employs at least 1 NP or PA)
- Have an NP, PA, or CNM working at least 50% of the time during operational hours
- Post operation days and hours

Health Care Services Requirements

An RHC must:

- Directly provide routine diagnostic and lab services
- Have arrangements with 1 or more hospitals to provide medically necessary services unavailable at the RHC
- Have drugs and biologicals available to treat emergencies
- Provide these lab tests on site:
  - Stick or tablet chemical urine exam or both
  - Hemoglobin or hematocrit
  - Blood sugar
  - Occult blood stool specimens exam

  - Pregnancy tests
  - Primary culturing to send to a certified lab
- Not be primarily a mental disease treatment facility or a rehabilitation agency
- Not be a Federally Qualified Health Center (FQHC)

RHC Payments

We pay RHCs a bundled payment, or All-Inclusive Rate (AIR) per visit, for qualified primary care and preventive health services an RHC practitioner provides. We subject the AIR to a payment limit per visit, meaning an RHC won't get any payment beyond the specified limit amount per visit.

For independent RHCs, provider-based RHCs in a hospital with 50 or more beds, and RHCs enrolled in Medicare on or after January 1, 2021:

- Payment limit per visit based on these national statutory limits:
  - January 1, 2021–March 31, 2021 = $87.52
  - April 1, 2021–December 31, 2021 = $100.00
  - Calendar Year (CY) 2022 = $113.00

For specified provider-based RHCs in a hospital with less than 50 beds:

- Medicare Administrative Contractors (MACs) calculate the payment limit per visit for provider-based RHCs that meet certain criteria

For certain preventive services like the Annual Wellness Visit (AWV) and the Initial Preventive Physical Exam (IPPE), we pay the full AIR and patients don't pay anything. For most other services, Medicare Part B deductible and coinsurance rates apply. This means that once patients meet their Part B deductible, we pay 80% of the AIR and the patient pays the remaining 20%.

RHC Visits

RHC visits must be:

- Medically necessary
- Medical or mental health visits, qualified preventive health visits, or face-to-face visits between the patient and an RHC practitioner
- A qualified RHC service needing an RHC practitioner

RHC visits **can** take place at:

- RHC
- Patient's home, including an assisted living facility
- Medicare-covered Part A skilled nursing facility
- Scene of an accident
- Hospice

RHC visits **can't** take place at:

- Inpatient or outpatient hospital department, including a critical access hospital
- Facility with specific requirements excluding RHC visits

Multiple Visits on the Same Day

Visits with more than 1 RHC practitioner on the same day, or multiple visits with the same RHC practitioner on the same day, count as a single visit, **except** when:

- Patient returns to the RHC for diagnosis or treatment of an injury or illness that happened after the initial visit; for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the RHC
- Patient has a qualified medical and mental health visit on the same day
- Patient has an IPPE and a separate medical or mental health visit on the same day

RHC Services

Care Management Services

RHCs may provide general care management services, such as:

- Transitional Care Management (TCM)
  - Beginning January 1, 2022, RHCs can bill TCM and general care management services furnished for the same patient during the same service period, if the RHC meets the requirements for billing each code
- General Care Management (G0511)
  - Chronic Care Management (CCM)
  - General Behavioral Health Integration (BHI)
  - Principal Care Management (PCM)
- Psychiatric Collaborative Care Model (CoCM) (G0512)

We don't require the RHC face-to-face services requirement for care management services. Auxiliary personnel may provide them under general supervision.

RHCs can't bill care management services if another practitioner or facility billed them during the same time period.

Flu, Pneumococcal, & COVID-19 Shots & COVID-19 Monoclonal Antibody Products

We pay for flu, pneumococcal, COVID-19 shots, and COVID-19 monoclonal antibody products and their administration at 100% of reasonable cost. RHCs report these services on a separate cost report worksheet. RHCs shouldn't report these services on their RHC billing claims.

Note: We updated the RHC cost report to reflect costs related to COVID-19 shots and COVID-19 monoclonal antibody products and their administration.

An RHC can't bill a visit when the practitioner only sees a patient to administer a shot. Instead, the RHC includes shots and their administration on the annual cost report and we reimburse them at cost settlement. Patients pay no Part B deductible or coinsurance for these services.

Hepatitis B Shot Administration & Payment

The bundled payment, or AIR, for an RHC visit includes the hepatitis B shot and its administration costs. This means you can't bill the shot or its administration separately from the visit, and you can't bill for a visit if shot administration is the only service you provided. However, you can include it on a separate line item when you submit the visit's bill, which ensures the patient pays no deductible or coinsurance. If the shot was the only service you provided, you can add it on a separate line item for the next visit.

Telehealth Services Payment

RHCs can be an "originating site" for telehealth services. An originating site is the location where an eligible patient gets telehealth services. A patient must go to an originating site for services located in a county outside a Metropolitan Statistical Area or in a rural Health Professional Shortage Area in a rural census tract. RHCs serving as telehealth originating sites get an originating site facility fee. You may include the originating site facility fee charges on the claim.

RHCs aren't authorized to serve as a "distant sites," except during the COVID-19 Public Health Emergency (PHE) (see COVID-19 Flexibilities). A distant site is where the practitioner is located during the telehealth service. You can't bill the visit's cost or include it on the cost report.

This means patients can go to the RHC to get telehealth services provided by practitioners located in other areas of the state or country, but practitioners in the RHC can't provide telehealth services, except during the COVID-19 PHE.

Mental Health Visits Furnished Using Telehealth

Beginning January 1, 2022, RHCs can report and get payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the patient isn't capable of, or doesn't consent to, using video technology.

An in-person, non-telehealth visit must be furnished at least every 12 months for these services; however, we may make exceptions to the in-person visit requirement based on patient circumstances (with the reason documented in the patient's medical record) and also allow more frequent visits as driven by clinical needs on a case-by-case basis.

Virtual Communication Services (G0071)

We pay for virtual communication services when an RHC practitioner meets certain requirements, including:

- Practitioner provides at least 5 minutes of billable RHC communication technology-based or remote evaluation service
- Patient had at least 1 face-to-face billable visit within previous year
- Virtual visit isn't related to service provided within last 7 days
- Virtual visit doesn't lead to in-person RHC service within the next 24 hours or at next appointment

When an RHC practitioner provides a patient with virtual communication service, we don't require the RHC face-to-face requirements and apply the coinsurance and deductible.

Virtual Communication Services FAQs has more information.

Hospice Attending Physician Services Payment

Beginning January 1, 2022, RHCs and FQHCs will be eligible to get payment for hospice attending physician services when provided by an RHC physician, NP, or PA who's employed or working under contract for an RHC, but isn't employed by a hospice program. During a hospice election, attending physician services can take place at the patient's home, a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital.

COVID-19 Flexibilities

MLN Matters® Article SE20016 has more information on new and expanded COVID-19 RHC flexibilities during the PHE.

Cost Reports

RHCs must file an annual cost report. Use Form CMS-222-17 to determine your payment rate and reconcile interim payments. Include graduate medical education adjustments, bad debt, shots, and their administration payments.

- Independent RHCs must complete Health Clinic Form (CMS-222-1992), Independent Rural Health Clinic and Freestanding Federally Qualified Health Center (HCLINIC) Cost Report
- Hospital-based RHCs must complete Hospital Form (CMS-2552-2010), Worksheet M, Hospital and Hospital Health Care Complex Cost Report
- Provider-based RHCs must complete the appropriate worksheet for RHC services within the parent provider's cost report

Provider Reimbursement Manual – Part 2 has more cost reports and forms.

Annual Reconciliation

At the end of the annual cost reporting period, RHCs submit a report to their MACs. The report includes total allowable costs, total RHC service visits, and other required reporting period information. After reviewing the report, MACs determine a final period rate by dividing allowable costs by the number of actual visits.

MACs determine the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. They review interim and final payment rates for productivity, reasonableness, and payment limitations.

For more information, find your MAC's website.

Resources

- Learn about covered services, visits, payment policies, and other information in Medicare Benefit Policy Manual, Chapter 13
- Learn how we process RHC claims in Medicare Claims Processing Manual, Chapter 9
- Learn how we evaluate state survey and certification efforts in State Operations Manual, Chapter 8
- Learn about RHC certification requirements in Medicare State Operations Manual, Chapter 2, Appendix G
- Learn about being certified as a Medicare RHC supplier by reviewing applicable laws, regulations, and compliance information
- Learn how RHC providers did on performance surveys by searching Survey and Certification's Quality, Certification and Oversight Reports (QCOR)
- Find more information about billing care management services in the Care Management Services in RHCs and FQHCs FAQs

Other Helpful Websites

- American Hospital Association Rural Health Services
- CMS's Rural Health Strategy
- Medicare Rural Health Clinics
- National Association of Rural Health Clinics
- National Rural Health Association
- Rural Health Information Hub

Regional Office Rural Health Coordinators

Get contact information for CMS Regional Office Rural Health Coordinators who offer technical, policy, and operational help on rural health issues.

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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

Make sure your billing staff knows about this requirement.

Background

Beginning January 1, 2022, an RHC or FQHC can bill and get payment under the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS), respectively, when their employed and designated attending physician provides services during a patient's hospice election.

To get the RHC AIR or payment under the FQHC PPS:

- RHCs must report the GV modifier on the claim line for payment (along with the CG modifier) each day they provide a hospice attending physician service
- FQHCs must report the GV modifier on the claim line with the payment code (G0466 – G0470) each day they provide a hospice attending physician service

This applies when a physician, Nurse Practitioner (NP), or Physician Assistant (PA), working for

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or is under contract to an RHC or FQHC, provides hospice attending physician services to a Medicare patient who has elected hospice. This is effective for dates of service on or after January 1, 2022.

The hospice attending physician services are subject to coinsurance and deductibles on RHC claims and only coinsurance on FQHC claims.

When the RHC or FQHC provides a hospice attending physician service that has a technical component (TC), the provider giving the TC would go to the hospice for payment as we discuss in Chapter 11 of the Medicare Claims Processing Manual.

More Information

We issued CR 12357 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
January 13, 2022	We revised the 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.
October 29, 2021	We revised the 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.
September 30, 2021	We revised the 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.
August 11, 2021	Initial article released.

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

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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.

Provider Types Affected

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services they provide to Medicare patients.

What You Need To Know

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and we (CMS) have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view the RHC/FQHC COVID-19 FAQs at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

Background

New Payment for Telehealth Services

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 3704 of the CARES Act authorizes RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and patient. If you have this capability, you can now provide and get paid for telehealth services to Medicare patients for the duration of the COVID-19 PHE.

Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site telehealth services (approved by Medicare as a distant site telehealth service under the Physician Fee Schedule (PFS)) from any location, including their home, during the time that they're working for you. A list of these services is available at https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.

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The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that we develop payment rates similar to the national average payment rates for comparable telehealth services under the PFS. You must use HCPCS code G2025 (the new RHC/FQHC specific G code for distant site telehealth services) to bill services provided via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective (see https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx).

Note that the changes in eligible originating site locations, including the patient's home, during the COVID-19 PHE are effective beginning March 6, 2020.

Effective January 1, 2022, the payment rate for distant site telehealth services is $97.24. From January 1 – December 31, 2021, the payment rate for distant site telehealth services was $99.45 (see page 3). For services between January 27 – December 31, 2020, your rate was set at $92.03. These rates are the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS during the given timeframes. Because we made these changes in policy on an emergency basis, we made changes to claims processing systems in several stages.

Claims Requirements for RHCs

For telehealth distant site services provided between January 27 – June 30, 2020, report HCPCS code G2025 on your claims with the CG modifier. You may also append Modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System), but this isn't required. We paid these claims at the RHC's all-inclusive rate (AIR), and the MAC automatically reprocessed these claims beginning on July 1, 2020, at the $92.03 rate. You don't need to resubmit these claims for the payment adjustment.

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)

Claims Requirements for FQHCs

For telehealth distant site services you provided between January 27 – June 30, 2020, that are also FQHC qualifying visits, report 3 HCPCS/CPT codes:

- The FQHC Prospective Payment System (PPS) specific payment code (G0466, G0467, G0468, G0469, or G0470)
- The HCPCS/CPT code that describes the services provided via telehealth with modifier 95

- G2025 with modifier 95

We paid these claims at the FQHC PPS rate until June 30, 2020, and the MAC automatically reprocessed these claims beginning on July 1, 2020, at the $92.03 rate. You don't need to resubmit these claims for the payment adjustment.

When providing services via telehealth that aren't FQHC qualifying visits, you should have held these claims until July 1, 2020, and then billed them with HCPCS code G2025. You may append Modifier 95 but it isn't required. (See https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf for a list of FQHC PPS specific payment codes). Beginning July 1, 2020, only submit G2025. You may append Modifier 95 but it isn't required.

Table 3. Example of FQHC Claims for Telehealth Services January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G0467 (or other appropriate FQHC Specific Payment Code	N/A
052X	99214 (or other FQHC PPS Qualifying Payment Code)	95
052X	G2025	95

Table 4. FQHC Claims for Telehealth Services starting July 1, 2020

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

Payment Rate for 2022

Effective January 1, 2022, the payment rate for distant site telehealth services is set at $97.24. From January 1 – December 31, 2021, your payment for distant site telehealth services was set at $99.45. The MAC will automatically reprocess claims with HCPCS code G2025 for dates of service on or after January 1, 2021, that we processed before the rate was updated in the system.

Medicare only authorizes payment for distant site telehealth services to RHCs and FQHCs provided during the COVID-19 PHE. If the COVID-19 PHE is in effect after December 31, 2022, we'll update this rate based on the CY 2023 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

Cost Reporting

We won't use costs for providing distant site telehealth services to decide the RHC AIR or the FQHC PPS rate, but these costs must be reported on the proper cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services." FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health

Center Cost Report, on line 66 of the Worksheet A, in the section titled "Other FQHC Services."

Medicare Advantage Wrap-Around

Since telehealth distant site services aren't paid under the RHC AIR or the FQHC PPS, the Medicare Advantage (MA) wrap-around payment doesn't apply to these services. MA plans will adjust wrap-around payment for distant site telehealth services.

Cost-Sharing Related to COVID-19 Testing

For services provided between March 18, 2020 and the duration of the COVID-19 PHE, we'll pay all of the reasonable costs for specified categories of evaluation and management (E/M) services if they result in an order for or administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of deciding the need for such test. This would include applicable telehealth services. (See MLN Matters article SE20011 for more information.) For the specified E/M services related to COVID-19 testing, including when provided via telehealth, you must waive the collection of coinsurance from patients. For services in which Medicare waives the coinsurance, you must put the "CS" modifier on the service line. **We paid your claims with the "CS" modifier with the coinsurance applied, and the MAC automatically reprocessed these claims beginning on July 1, 2020. Don't collect coinsurance from patients if the coinsurance is waived.**

Claims Examples:

Table 5. RHC Claims for Telehealth Services from January 27 – June 30, 2020, when we waive cost sharing:

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

Table 6. RHC Claims for Telehealth Services when we waive cost sharing starting July 1, 2020

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

Table 7. FQHC Claims for Telehealth Services January 27, 2020 – June 30, 2020, when we waive cost sharing

Revenue Code	HCPCS Code	Modifiers
052X	G0467 (or other appropriate FQHC Specific Payment Code	N/A
052X	G0446 (or other FQHC PPS Qualifying Payment Code)	CS, 95 (required)

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CS, 95 (required)

Table 8. FQHC Claims for Telehealth Services starting July 1, 2020, when we waive cost sharing

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

Other Telehealth Flexibilities

During the COVID-19 PHE, you can provide any Medicare-approved telehealth service under the PFS. (See https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.) Also, effective March 1, 2020, these services include CPT codes 99441, 99442, and 99443, which are audio-only telephone Evaluation and Management (E/M) services. You can provide and bill for these services using HCPCS code G2025. To bill for these services, a physician or Medicare provider who may report E/M services must provide at least 5 minutes of telephone E/M service to an established patient, parent, or guardian. You can't bill for these services if they start from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Telehealth Services with Cost Sharing

For the CPT and HCPCS codes included in the list of telehealth codes at the link above, we'll adjust the coinsurance and payment calculation for distant site telehealth services you provided to reflect the method used to calculate coinsurance and payment under the PFS. The coinsurance for these services will be 20% of the lesser of the allowed amount ($92.03 for 2020 claims, $99.45 for 2021, or $97.24 for 2022 claims based on date of service) or actual charges. The payment will be 80% of the lesser of the allowed amount ($92.03 for 2020 claims, $99.45 for 2021 claims, or $97.24 for 2022 claims based on date of service) or the actual charges.

Before the adjustment, the coinsurance for distant site services you provided was 20% of the actual charges and the payment was the allowed amount ($92.03 for 2020 claims, $99.45 for 2021 claims, or $97.24 for 2022 claims based on date of service) minus the coinsurance.

MACs will automatically reprocess any claims with HCPCS code G2025 for services you provided on or after January 27 – November 16, 2020, that we paid before we updated the claims processing system to pay HCPCS code G2025 based on the "lesser of" methodology, as described above.

Telehealth Services with Cost Sharing Waived

The list of telehealth codes at the link above includes several CPT and HCPCS codes that describe preventive services that have waived cost sharing. As stated earlier in this article, bill telehealth services on this list using HCPCS code G2025. To distinguish those telehealth services that don't have cost sharing waived from those that do, like some preventive services,

also report modifier CS. We've modified the descriptor of the CS modifier to account for this additional use as follows:

CS – Cost sharing waived for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services provided via telehealth in RHCs and FQHCs during the COVID-19 PHE.

For preventive services provided via telehealth that have cost sharing waived, RHCs must report G2025 on claims with the CG and CS modifier and FQHCs must report G2025 with the CS modifier on or after July 1, 2020.

See the above-referenced claim examples for Cost-Sharing Related to COVID-19 Testing. These examples will also apply to preventive services that have cost sharing waived.

Expansion of Virtual Communication Services

Payment for virtual communication services now includes online digital evaluation and management services. Online digital evaluation and management services are non-face-to-face, patient-initiated, digital communications using a secure patient portal. The online digital evaluation and management codes that are billable during the COVID-19 PHE are:

- CPT code 99421 (5-10 minutes over a 7-day period)
- CPT code 99422 (11-20 minutes over a 7-day period)
- CPT code 99423 (21 minutes or more over a 7-day period)

To get payment for the new online digital evaluation and management (CPT codes 99421, 99422, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), you must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for these 5 codes. We'll pay $24.76 for claims submitted with G0071 on or after March 1, 2020 – December 31, 2020.

From January 1 – December 31, 2021, we'll pay $23.73 for claims submitted with G0071. Effective January 1 – December 31, 2022, we'll pay the new rate of $23.88 for claims submitted with G0071.

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

You can bill for visiting nursing services provided by an Registered Nurse (RN) or Licensed Practical Nurse (LPN) to homebound individuals under a written treatment plan in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, we have found that the area typically served by the RHC, and the area included in the FQHC service area plan, have a shortage of HHAs, and this finding doesn't require a request. Check the HIPAA Eligibility Transaction System (HETS) before providing

visiting nurse services to make sure that the patient isn't already under a home health plan of care.

Consent for Care Management and Virtual Communication Services

Medicare requires patient consent for all services, including non-face-to-face services. During the COVID-19 PHE, you may get patient consent at the same time you initially provide the services. This means that someone working under your general supervision can get patient consent. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services. The person getting consent can be an employee, independent contractor, or leased employee of the billing practitioner. (See https://www.cms.gov/files/document/covid-final-ifc.pdf).

Revision of Bed Count Methodology for Determining Provider-Based RHCs Exemption to the RHC Payment Limit

Note: Section 132 of the Consolidated Appropriations Act, 2021, restructures the payment limits for all independent and provider-based RHCs beginning April 1, 2021. See CR12185 and CR12489 for more information on establishing certain provider-based RHC payment limits.

Prior to April 1, 2021, if you're an RHC provider based to a hospital with fewer than 50 beds, you're exempt from the national per-visit payment limit for RHCs. Due to the COVID-19 PHE, some hospitals have been or are planning to increase inpatient bed capacity to address the increased need for inpatient care. If you're currently exempt from the national per-visit payment, we're working to prevent you from losing your exemption due to the COVID-19 PHE and to encourage hospitals to increase bed capacity if needed. We'll use the number of beds from the cost reporting period prior to the start of the COVID-19 PHE as the official hospital bed count for deciding exemption to the payment limit.

Exception to the Productivity Standards for RHCs

We use productivity standards to help decide the average cost per patient for your Medicare reimbursement. Physicians, nurse practitioners, physician assistants, and certified nurse midwives are held to a minimum number of visits per Full-Time Employee (FTE) that they're expected to provide in the RHC. Failure to meet this minimum may show that they're operating at an excessive staffing level, thus, generating excessive cost.

Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID-19 PHE. As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, your MAC may grant exceptions to the productivity standard during the COVID-19 PHE. Your MAC will provide further direction.

More Information

View the complete list of coronavirus waivers.

Review information on the current emergencies webpage.

For more information, find your MAC's website.

DOCUMENT HISTORY

Date of Change	Description
January 13, 2022	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.
February 23, 2021	We revised this article to provide the updated rate effective January 1, 2021, for G2025. You'll find substantive content updates in dark red font (see pages 2, 3, and 5). We also updated the rate for G0071 on page 6.
December 3, 2020	We revised this article to provide additional guidance on telehealth services that have cost-sharing and cost-sharing waived. You'll find substantive content updates (see pages 5-6). We also made other language changes for clarity, but these changes didn't change the substance of the article.
July 6, 2020	We revised this article to provide: - Additional guidance on telehealth services that have cost sharing waived and additional claim examples - An additional section on the RHC Productivity Standards All other information remains the same.
April 30, 2020	We revised this article to provide: - Additional claims submission and processing instructions - Information on cost-sharing related to COVID-19 testing - Additional information on telehealth flexibilities - Information on provider-based RHCs exemption to the RHC payment limit All other information remains the same.
April 17, 2020	Initial article released.

OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

Appendix 2

Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act

(For use by health care providers no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage **both orally and in writing**, upon request **or** at the time of scheduling health care items and services.

This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of the expected charges they may be billed for receiving certain health care items and services. A good faith estimate must be provided within 3 business days upon request. Information regarding scheduled items and services must be furnished within 1 business day of scheduling an item or service to be provided in 3 business days; and within 3 business days of scheduling an item or service to be provided in at least 10 business days.

To use this model notice, the provider or facility must fill in the blanks with the appropriate information. HHS considers use of the model notice to be good faith compliance with the good faith estimate requirements to inform an individual of expected charges. Use of this model notice is not required and is provided as a means of facilitating compliance with the applicable notice requirements. However, some form of notice, including the provision of certain required information, is necessary to begin the patient-provider dispute resolution process.

NOTE: The information provided in these instructions is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Readers should refer to the applicable statutes, regulations, and other interpretive materials for complete and current information. [Link to IFR when available.]

Health care providers and facilities should not include these instructions with the documents given to patients.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or

suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code

If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled	
Date of Good Faith Estimate: _____/_____/_____	
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. [Include if items or services are reoccurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 1] $
Additional Health Care Provider/Facility Notes

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

[Provider/Facility 2] Estimate [Delete if not needed]

Details of Services and Items for [Provider/Facility 2]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 2] $
Additional Health Care Provider/Facility Notes

[Provider/Facility 3] Estimate [Delete if not needed]

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 3]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 3]$

Additional Health Care Provider/Facility Notes

Total estimated cost for all services and items: $

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call [HHS PHONE NUMBER].

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call [HHS NUMBER].

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.