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RURAL & COMMUNITY HEALTH

2025 Top 5 Documentation and Revenue Tips in Community Health Centers – 2025 CMS Updates

NACHC 2025
Documentation and Coding Webinar Series

January 14, 2025

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS®

Disclaimer

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Deputy Director of Health Center Finance Training

Health Center Operations & Governance, NACHC

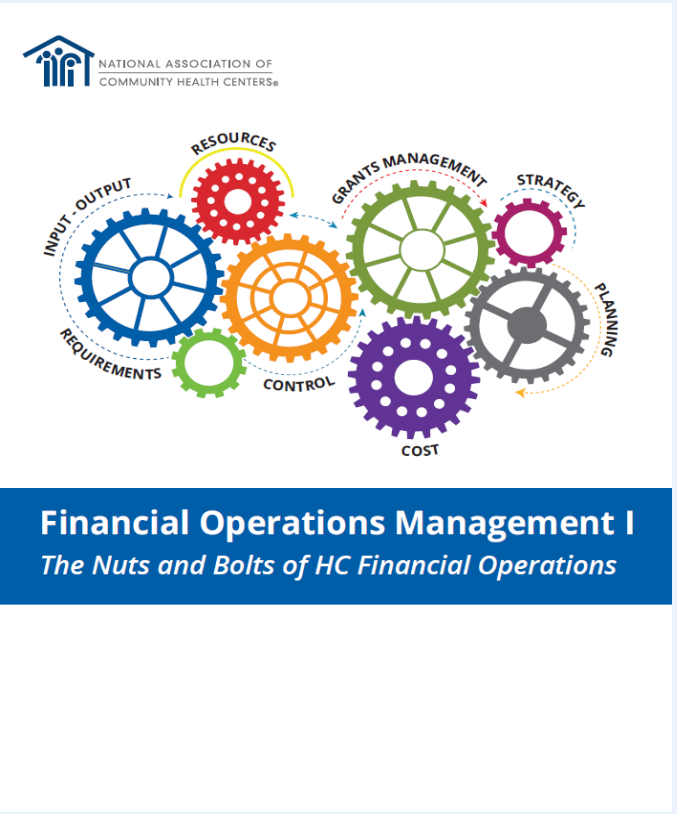
Housekeeping

Attendance is required for CEU eligibility

It’s important to us that you stay engaged.

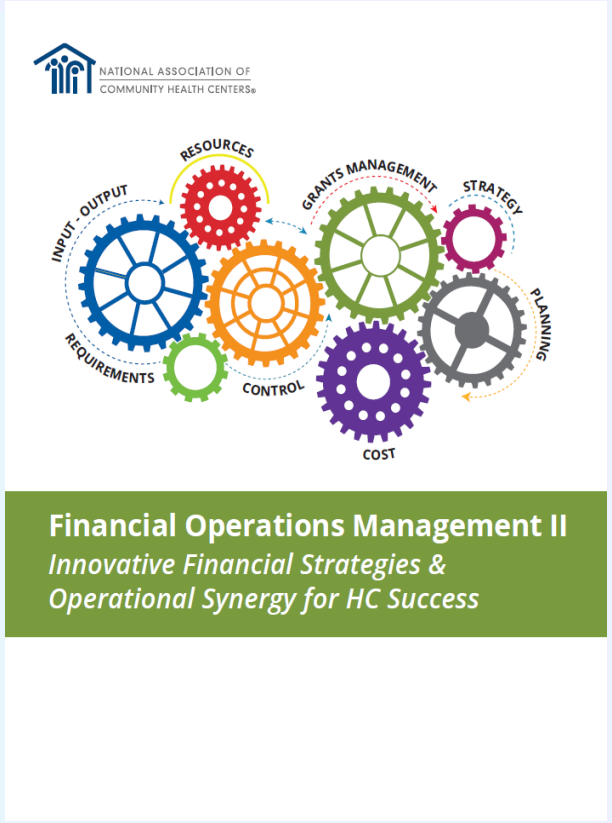
Use the Q&A tab for questions

Don’t Miss These NACHC Finance Trainings!



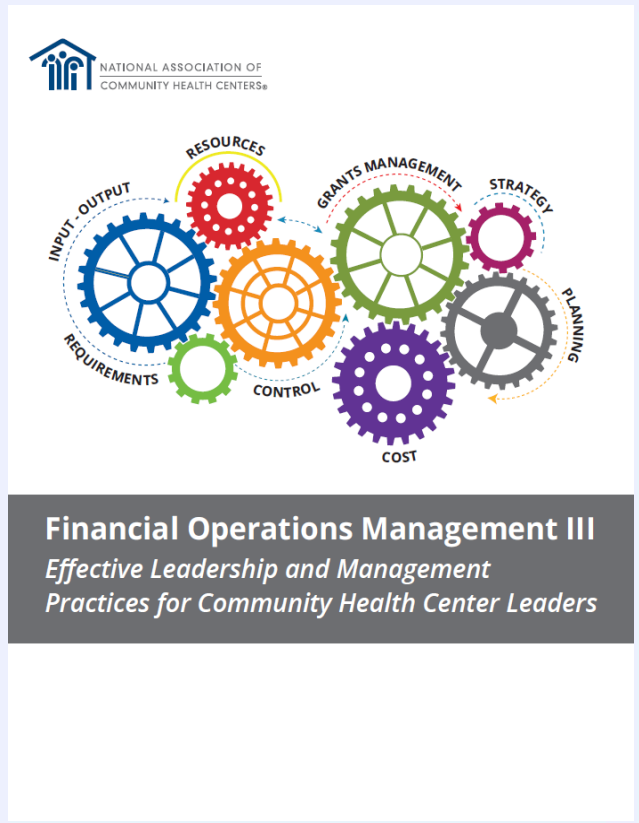
Financial Operations Management I

The Nuts and Bolts of HC Financial Operations



Financial Operations Management II

Innovative Financial Strategies & Operational Synergy for HC Success

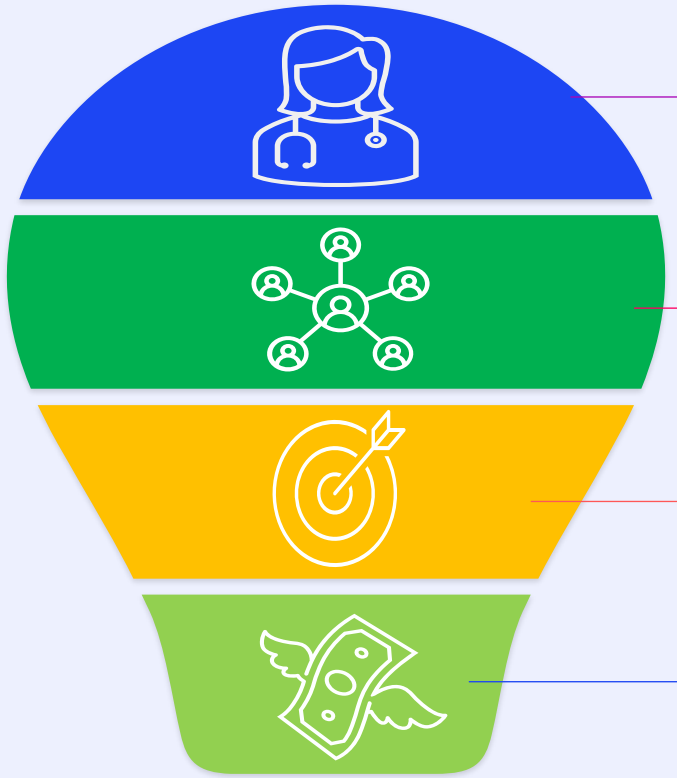


Financial Operations Management III

Effective Leadership and Management Practices for Community Health Center Leaders

Click on the training Brochure above for more detail

Target Audience



01 Clinical Providers

02 Facility Leadership

03 Professional Coders

04 Medical Billers

AMA's CPT

HCPCS-II

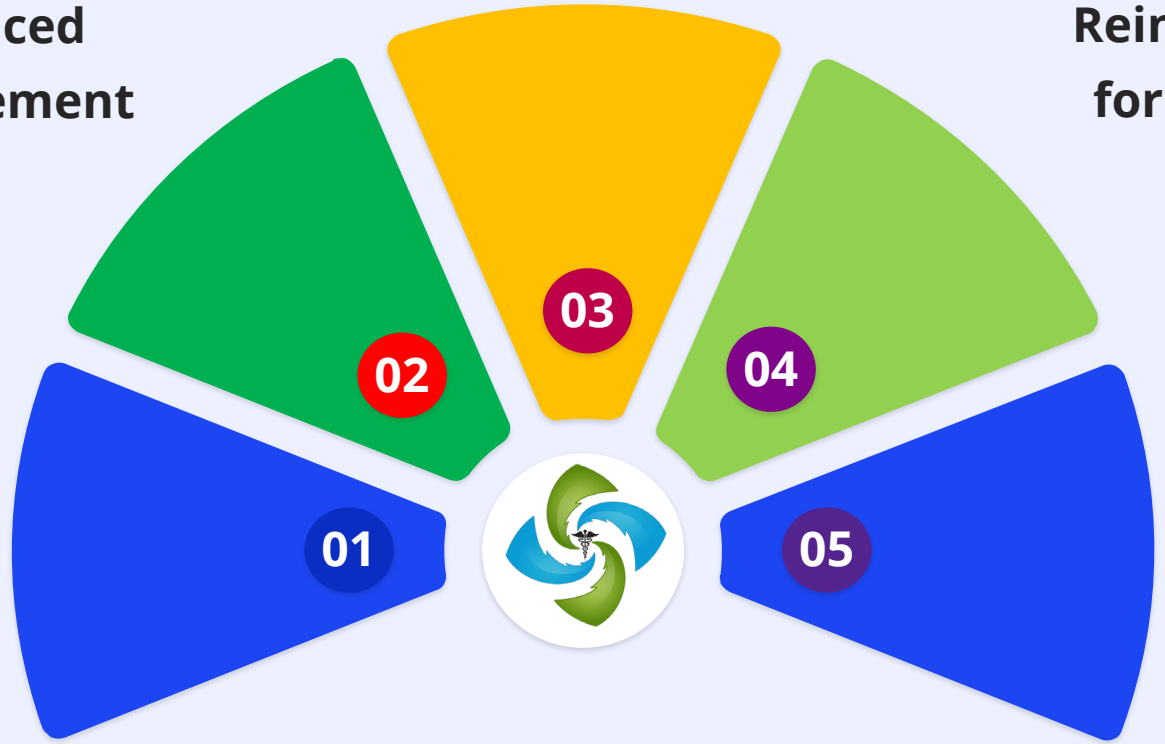
ICD-10-CM

Target Issues

Review of CMS' Global Surgery Payment Accuracy Initiative

Updates on Care Coordination Services and Advanced Primary Care Management

Reimbursement Changes for Preventive Vaccines



2025 Telehealth and Virtual Communication Services

Billing for Dental Services "*inextricably linked*" to Medical Services

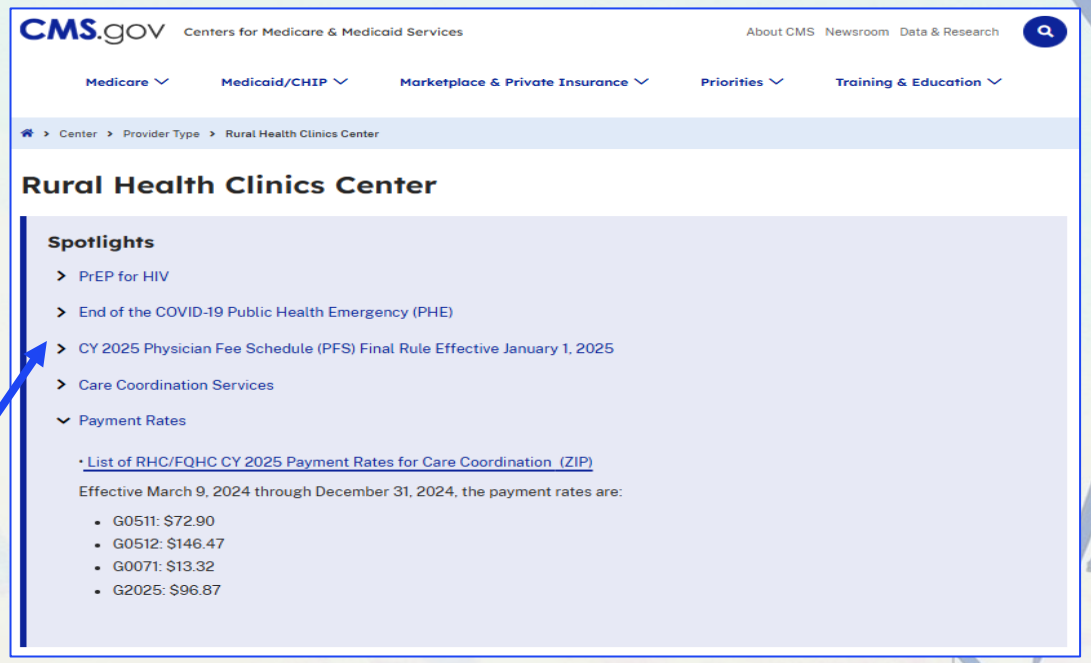
Training Objectives

Attendees will gain a better understanding on how various insurance companies want new or revised 2025 services that community health centers report on ***fee-for-service claims versus daily encounter rate claims***.

Revenue cycle staff will ***gain actionable recommendations*** on how to improve their clinical documentation through exposure to the HIPAA-mandated code sets including the CPT, HCPCS-II, and ICD-10-CM manuals while maintaining a focus on patient care.

Managers and coders will ***identify revenue opportunities and/or compliance risks*** that will impact their usage of new codes and payment updates.

CY2025 Physician Fee Schedule Final Rules for FQHC Billing - Quick Glance



Perform a more detailed review of the proposed rules, public comments, and final rule decisions from the CY2025 CMS Physician Fee Schedule from a few different sources including your MACs!

Check often for updates to CMS' general educational materials via CMS' Medicare Learning Network (MLN)

Newsroom Homepage > Fact Sheets > Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule

Fact Sheets Nov 01, 2024

Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule

Medicare Parts A & B

The Medicare Learning Network®

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MLN Publications & Multimedia

Filter on title or topic to get free educational resources for health care providers.

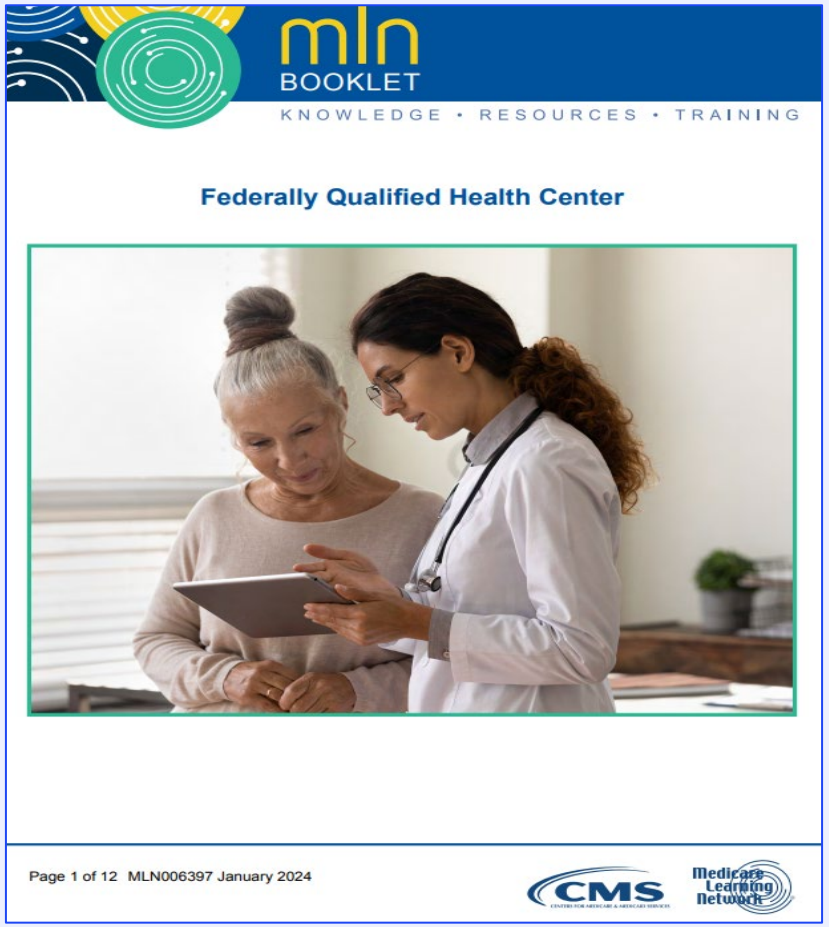
Showing 1–10 of 105 entries

Show Entries: 10 per page

Filter On:

Date	Topic	Title	Format
2024-12	Preventive Services	Medicare Preventive Services	Educational Tool
2024-12	Rural Health	Information for Critical Access Hospitals	Booklet
2024-12	Provider-Supplier Enrollment	Medicare Provider Enrollment	Educational Tool
2024-12	Provider-Specific	Intravenous Immune Globulin Items & Services	Fact Sheet
2024-12	Payment Policy	Medicare Payment Systems	Educational Tool
2024-11	Payment Policy	Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier	Fact Sheet
2024-11	Rural Health	Rural Emergency Hospitals	Fact Sheet
2024-11	Provider-Specific	Global Surgery	Booklet
2024-11	Preventive Services	Medicare Wellness Visits	Educational Tool

Community Health Centers
Basics



Also - go to www.CMS.gov >
Training & Education> Find Your Provider Type> Facilities > Outpatient Facilities > RHC/FQHC and bookmark it to check for periodic updates and access to wonderful resources all in one place!

Check often for updates to CMS' RHC and FQHC Claims (Ch.9) and Benefits Policy (Ch. 13) Manuals

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

Table of Contents
(Rev. 12070, 06-07-23)

Transmittals for Chapter 9

Although CMS groups RHC and FQHC in these 2 documents, be aware that the rules are not always the same.

Ch. 9 discusses the All-Inclusive Rate (AIR) and Prospective Payment System (PPS) billing systems.

Ch. 13 discusses staffing requirements, same day multiple visits, and global billing, and more.

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Table of Contents
(Rev. 12832; Issued: 09-12-24)

Transmittals for Chapter 13

Tips #1 – Telehealth and VCS

New AMA CPT® codes for audio/video telehealth services and CMS updates for coding and billing for telehealth and Virtual Communication Services (VCS).

Telehealth vs.
Virtual Communication Services (VCS)

Telehealth services are usually pre-scheduled and can be audio only under certain circumstances, such as many mental health visits.

1. Telehealth visits may not be pre-scheduled if a VCS service transitions to a full and immediate telehealth visit - in which case the VCS is not billed.

VCS are usually patient-initiated where patients are reaching out to see if they need to come in for an immediate visit or can they be taken care of virtually as long as they are unrelated to a visit in the last 7 days and does not result in an immediate appointment.

1. ***Virtual check-in*** services via technology-based interactive services ***OR***
2. ***Remote assessment of recorded video and/or images*** not originating from a visit in the last 7 days.

2025 Medicare Billing Thoughts for 2025
Until 3-31-25 when future updates go into effect

Medicare Billing 2025 Updates

On December 20, 2024, Congress ***extended the COVID-era Medicare telehealth flexibilities until 3-31-25*** that expanded the geographic requirements and eligible practitioners for FQHC services that were due to expire 12-31-24.

Expect upcoming clarifications in the new 2025 Congress.

FQHC Medical Telehealth

Report code **G2025** ***for all non-mental health telehealth services*** if on the most recent CMS-approved list to get paid via special payment rule ***flat fee ~$95 split 80/20***.

+

FQHC Mental/Behavioral Telehealth

List the ***CPT/HCPCS-II codes performed and add a modifier*** (ex. -93/-95) identifying audio-only or audio/video, etc. generating your PPS rate split 80/20.

+

Brief *patient initiated* "virtual check-in"

Expect to continue using the ***RHC/FQHC-specific code G0071***.

Which FQHC telehealth services are covered by Medicare in 2025?

- Expect payer variations in which services can be reimbursed using telehealth using this CMS link updated around December 11, 2024.
- Use ***Q3014*** with revenue code 0780 ***(flat fee of $31.01 for originating site facility fee)*** if other providers elsewhere are doing telehealth but you are ***using YOUR office's exam room*** and audio/video resources and maybe a nurse.

Non-Medicare payers may have different ways to for you to bill telehealth compared to Medicare

- Other non-Medicare telehealth options include the set of ***new 2025 CPT E/M telehealth codes 98000-90815*** that will likely get assigned FFS payment rates that could differ by payer.

- Some carriers ***may instead pay*** you the same for ***telehealth as if performed in person*** (ex. 99213 or 90832). Billing rules could ask you to ***add a modifier -93/-95*** (*or other*) to the service to indicate that the service was ***done via audio/video or audio-only***.

- Other commercial non-Medicare coding options include telephone assessments performed ***by non-physician Qualified Healthcare Professionals using codes 99866-98968***.

- ***Medicaid payers may want code T1014*** to be reported by the number of minutes the service(s) lasted in the units claim box.

Non-Medicare payers may have different ways to bill virtual communications services

- **Other current non-Medicare options for these *patient-initiated services* include the following codes that should be *compared to new 2025 code 90816*.**
  - **G2012** = Brief communication technology-based service, ***5-10 minutes*** of medical discussion for a ***"virtual check-in"*** for an E/M-eligible provider, ***not originating from a visit in the last 7 days*** and which ***does not result in an immediate appointment***.
  - **G2250 =** Remote assessment of ***recorded video and/or images*** of an established patient including interpretation and ***follow-up within 24 business hours not related to a recent visit in 7 days nor leading to an immediate appointment***.
  - **G2251-G2252 =** ***Brief virtual check-in*** by an E/M-eligible provider on an established patient unrelated to a recent visit in 7 days nor leading to an immediate appointment, ***5-10 minutes or 11-20 minutes***.

CMS resources for FQHC Telehealth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New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE20016 Revised | Related Change Request (CR) Number: N/A
Article Release Date: May 12, 2023 | Effective Date: N/A
Related CR Transmittal Number: N/A | Implementation Date: N/A

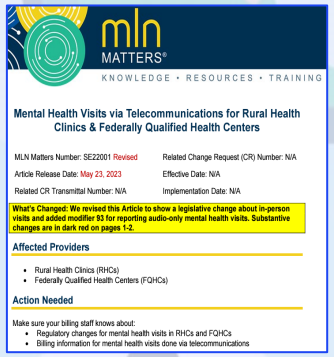
What's Changed: We updated this Article to show the impact of the end of the COVID-19 public health emergency (PHE). You'll find substantive content updates in dark red on pages 1-4.

Affected Providers
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

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 CMS made several changes to RHC and FQHC requirements and payments. The COVID-19 PHE ended on May 11, 2023. View Infectious diseases for a list of waivers and flexibilities that were in place during the PHE.

Also, view the latest COVID-19 information for RHCs and FQHCs.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Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

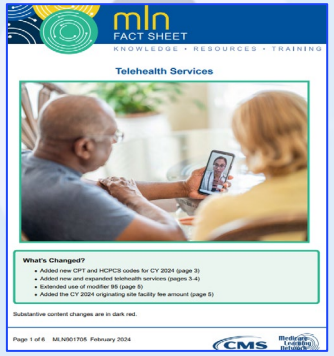
MLN Matters Number: SE22001 Revised | Related Change Request (CR) Number: N/A
Article Release Date: May 23, 2023 | Effective Date: N/A
Related CR Transmittal Number: N/A | Implementation Date: N/A

What's Changed: We revised this Article to show a legislative change about in-person visits and added modifier 93 for reporting audio-only mental health visits. Substantive changes are in dark red on pages 1-2.

Affected Providers
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

Action Needed

Make sure your billing staff knows about:
- Regulatory changes for mental health visits in RHCs and FQHCs
- Billing information for mental health visits done via telecommunications


mln FACT SHEET
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Telehealth Services

What's Changed?
- Added new CPT and HCPCS codes for CY 2024 (page 3)
- Added new and expanded telehealth services (pages 3-4)
- Extended use of modifier 95 (page 5)
- Added the CY 2024 originating site facility fee amount (page 5)

Substantive content changes are in dark red.

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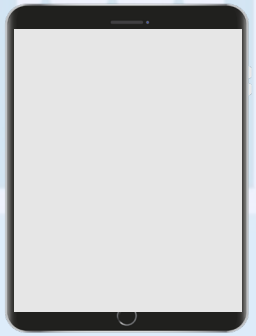
- Get the **CMS Med Learn Matters #SE20016** for ***FQHC-specific telehealth info*** (*last updated May 2023*) for updates, revenue codes, modifiers, and other great billing info.
- For updates on reporting ***mental health telehealth in FQHC*** please this **Med Learn Matters SE#22001** document *(updated May 2023)*
- For the general **CMS Telehealth Fact Sheet** which ***is not focused on FQHC*** check out this document *(last update April 2024).*



Telehealth and VCS
Billing Action Items

1.) Ensure that providers are documenting their location as well as the patient's location ***(ex. POS 02 or 10 on a CMS1500)*** in addition to the total time of the face-to-face visit and if done via audio-only, why the visit does not include video.

2.) Confirm the 2025 telehealth billing rules for non-Medicare payers and ***make sure your EHR/billing system/clearinghouse understand*** the differences.

3.) ***Expect likely telehealth changes at the beginning of 2025*** effective around 3-31-25 include reporting medical services using the actual CPT/HCPCS-II code performed as well as payment parity that would generate the PPS rate, rather than a flat ~$95 payment.

Tips #2 - Care Management

Updates to Care Coordination Services for CHCs including revisions to G0511 for General Care Management billing and the addition of new 2025 Advanced Primary Care Management codes.

Care Management Services
Documentation for Clinical Providers

The 2025 AMA Professional Edition ZERO CHANGES and 2+ pages of text on care management documentation guidelines. *Providers must be familiar with these guidelines* rather than how we get paid!

AMA CPT Guidelines

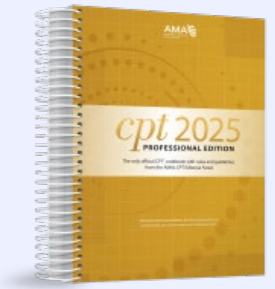
"management and support services provided ***by clinical staff***, under the direction of a physician or other qualified health care professional....(that) include"

"Establishing, implementing, revising, or monitoring the care plan

Coordinating the care of other professionals and agencies

Educating the patient or caregiver about the patient's condition, care plan, and prognosis"

“General Care Management”
Coding for Providers Managing Care Plans



TIPS: Develop templates in your EHR, track monthly time, document care plan updates and *get credit for the clinical work you do in between patient visits*. Consider external care managers to help with the workload.

Get patient verbal/written consent to be their ONLY care manager

Perform an “Initiating Visit” within 1 year prior to first billing General Care Management.

Chronic Care Management

99487-99491, +99439

+

Principal Care Management

99424-99427

Behavioral Health Integration (BHI)
99484

OR

Psychiatric Collaborative Care Model (Psych CoCM)

99492-99494

Monthly Chronic Pain Management

See G3002 and +G3003 for consideration with commercial and non-Medicare payers.

Many more related monthly Care Management options for RHC/FQHC were added by CMS in 2024!

All of these Care Management codes can be reported with G0511 to Medicare by FQHC until 7-1-25

Physician Fee Schedule Code	Description
G0323	General Behavioral Health Integration (BHI)
99487	Complex CCM (over 60 minutes of care management per month)
99490	Basic CCM (20 minutes of care management)
99491	30 minutes or more of CCM furnished by a physician or other qualified health professional
99424	30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners
99426	30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner
G3002	Chronic pain management first 30 minutes
G3003	Chronic Pain Management (each additional 15 minutes)
99453	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment**
99454	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial: device(s) supply with daily recording(s) or programmed alert**
99457	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes**
99458	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes**
99091	**Collection and interpretation of physiologic data (e.g. Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or oth (when applicable) requiring a minimum of 30 minutes of time, each 30 days**
98975	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment**
98976	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respira**
98977	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor muscu**
98980	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes**
98981	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive comm 20 minutes**
G0019	**Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit**
G0022	**Community health integration services, each additional 30 minutes per calendar month**
G0023	**Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month,**
G0024	**Principal Illness Navigation services, additional 30 minutes per calendar month**

Care management for BHI led by a CP, CSW, MHC, LMFT w/ a prescriber

General Care Management

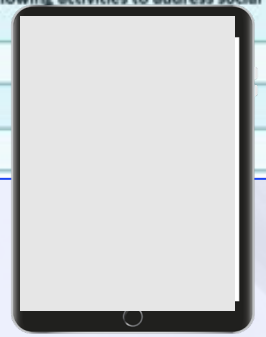
Remote Physiologic Monitoring (RPM)

Remote Treatment Management (RTM)

Remote Therapeutic Monitoring (RTM)

Community Health Integration

Principle Illness Navigation



For Medicare, G0511 can continue to be used 1 or more times per month ending on 6-30-25

NOTE that term "*general care management*" is used in the definition of G0511 rather than naming each of the 20+ options.

Transitional Care Management and the Psychiatric Collaborative Care Model are NOT included though they are in the CPT Care Management section.

G0511 = Rural Health Clinic or Federally Qualified Health Center only, ***general care management*** services 20 minutes or more of clinical staff time for chronic care management services directed by RHC or FQHC practitioner (MD, NP, PA, or CNM), per calendar month.

- "**General care management" =** principal/chronic care management, monthly chronic pain management, assorted remote monitoring services, community health integration, principal illness navigation, various time-based add-on codes, OR behavioral health integration.
- Payment is made via a special payment rate rather than the PPS rate at the average of what CMS pays FFS providers for all general care management services until 6-30-25 **~$72.90.**

Effective 7-1-25 we MUST use the individual CPT/HCPCS-II codes and G0511/G0512 should be removed from coverage!

You may use either code G0511/2 or the actual CPT/HCPCS-II codes from now until the end of June 2025 to Medicare

- ***If you already bill*** commercial and/or Medicaid carriers for Care Management services ***using the CPT/HCPCS-II codes*** – it seems as though that would be a logical option on January 1, 2025.

- This would allow you to **also report the *"…additional (XX) minutes"*** codes to be paid and patients know what they are being charged for.
  - Be very careful to charge the patient's coinsurance correctly based on your choice!

- The reimbursement from Medicare if using the actual CPT/HCPCS-II code(s) will be ***paid at the non-facility physician fee schedule*** (i.e. fee-for-service) for each code range via a special payment rate ***rather*** than the PPS rate.

Or consider the OPTION to use the new 2025 Advanced Primary Care Management (APCM) Services

Advanced Primary Care Management (APCM)
Monthly Service Options

2025 NEW APCM codes

Per CMS – "…***incorporates elements of several*** existing care management and communication technology-based services ***into a bundle*** that reflects the essential elements of the delivery of ***advanced primary care*** including principal care management, transitional care management, and chronic care management."

G0556 ~$15

Persons with one chronic condition.

G0557 ~$50

Persons with two or more chronic conditions.

G0558 ~$110

Persons with two chronic conditions **AND** a status as a dual eligible Medicare and Medicaid patient.

CLICK HERE to see CMS' APCM Billing Requirements?

Care Management Action Items

1.) Confirm if your current EHR/IT infrastructure allows time-based care management services to be ***captured and reported by individual CPT/HCPCS-II codes*** that covers a wide swath of services provided in between patient visits.

2.) Determine if CMS includes the following services in APCM payments to see if they can be ***billed in the same month***:

* Transitional Care Management,
* Virtual Communication Services,
* PCM/CCM services
* (*RPM and RTM should be separately billable*)

3.) Verify that you meet the APCM requirements from the link on the previous slide PRIOR to reporting these codes and check often for updates to the CMS Claims and Benefits manuals for details and clarifications that could differ from FFS providers.

4.) Determine Medicaid/commercial billing policies on the APCM codes.

Tips #3 – Global Surgery Payment Accuracy

Updates on how to report post-operative visits in your CHC for surgical procedures done outside of your CHC and properly using CPT® modifiers -54, -55, and/or -56 based on CMS' "Strategies for Improving Global Surgery Payment Accuracy."

Medicare global billing rules
do not apply to RHC/FQHC services

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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(Rev. 230, 12-09-16)

40.4 - Global Billing
(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

Surgical procedures furnished in a RHC or FQHC by a RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, the charges for the procedure go on the claim with the visit. Payment is included in the AIR when the procedure is furnished in a RHC, and payment is included in the PPS methodology when furnished in a FQHC. The Medicare global billing requirements do not apply to RHCs and FQHCs, and global billing codes are not accepted for RHC or FQHC billing or payment.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If a RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.

How does this issue impact the possible need for an E/M to require a modifier -25 to get reimbursed for a visit and a procedure in a FQHC?

Billing for surgeries done on Medicare patients OUTSIDE of your office performed by YOUR provider

Pre-operative

Your provider determines the need for the surgery

Report the E/M documented if done in the RHC/FQHC (modifiers -25/-57 are not needed)

Intra-operative

Your provider does surgery outside of your RHC/FQHC

Report the ***procedure code with a modifier -54*** to get FFS payment *that removes the payment for any office-based post-operative care*.

Post-operative

Your provider does RHC/FQHC-based f/u care on a procedure they performed that "typically" adds +10 or +90 days of post-op

Report each necessary visit as an E/M with a supporting aftercare (Zxx.xx) ICD-10-CM code.

Check out the possibility of needing new 2025 HCPCS-II code G0559! Stay tuned...

Billing for surgeries done on Medicare patients OUTSIDE of your office performed by a non-RHC/FQHC provider

Pre-operative

Outside provider determines need for surgery and performs the procedure

When they bill the procedure code, it likely includes their E/M *done the day of or the day before* the "major" surgery depending on the number of post-op days found via RBRVS or they may need to use modifier -56 on the surgery.

Intra-operative

Outside provider does surgery

If the surgeon is planning to have the patient get post-op care from us THEY should add modifier -54 (*and -56?)* to identify they are doing the surgical case only. This should remove the post-op care from THEIR payment.

Post-operative

RHC/FQHC to provide post-op care

Report each necessary visit as an E/M with a supporting aftercare (Zxx.xx) ICD-10-CM code. If they improperly reported the services without the -54 modifier ***then they have already been paid*** for the follow-up care.

Be sure to ***have a transfer of care plan in place with the surgeon*** and ask how they billed the procedure before billing for post-op care!

Billing for global surgical care on NON-Medicare patients whose payers use a form of the CMS traditional Global Package

Pre-operative

Your provider determines the need for the surgery

Only report the E/M on the day of if and only if, modifiers -25/-57 apply.

Intra-operative

Your provider does surgery outside of your RHC/FQHC

If performing ALL services, report the service as is and you should be paid for pre- and post-op services in the payment for the procedure(s) itself!

Post-operative

Your provider does all follow-up care for a procedure that "typically" adds +10 or +90 days of post-op $0???

You have already been paid for post-op care. Look to modifiers -24/-79 if performing unrelated E/M or procedural services for however long the post-op period lasts.

Global Surgery
Self-Study & Exercises

mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Global Surgery

CMS Medicare Learning Network

Review the recent updates made to the CMS Global Surgery MLN document but realize it does NOT discuss our unique RHC/FQHC nuances described in the Benefit Policy Manual section 40.4.

This document will help give you guidance for those non-Medicare payers who follow CMS' Global Surgical rules although they could use a different number of days for pre-/post-op care (ex. 15/30/60 days).

Tips #4 – Preventive Vaccines

Reimbursement changes to Medicare preventive services billing to speed up payments for vaccine administrations and vaccine product codes including additions to CMS' "**Drugs Covered as Additional Preventive Services**."

Starting July 1, 2025, you can get paid at the time of service for preventive influenza, pneumococcal, COVID, and Hep B vaccines and their administration

Prior to this change, we had delayed reimbursement, basically at the end of the year via the cost report, for key vaccines and their administrations causing cash flow challenges and administrative burdens

- These claims will initially pay 95% of the Average Wholesale Price for the vaccine product itself. We still expect annual reconciliation on an annual basis to make up the difference.
- Several vaccine administrations will be paid via a special payment rule and the following codes rather than traditional CPT vaccine admin codes:
  - G0008 (flu) = ~$33.71
  - G0009 (pneumo) = ~$33.71
  - G0010 (Hep B) = ~$33.71
  - 90840 (COVID-19) = ~$44.95

Preventive Vaccines Action Items

1.) Communicate this key change to your management and financial staff that begins July 1, 2025 to ensure a proper budgetary process that will cover vaccine expenses in a more timely manner.

2.) Check with your Medicaid carriers who had similar policies to confirm they will adopt this new change and if it is on the same timeframe.

3.) If your health center had delayed-invoicing arrangements with vaccine manufacturers, be prepared to make adjustments as needed well in advance of July 1,2025.

4.) If COVID-19, Hep B, flu, or pneumo vaccines are provided as a part of a qualifying visit at a patient's home investigate using code M0201 if the visit was solely to provide once or more of these vaccines, among other requirements.

Tips #5 – Dental Services

Clarifying which dental services that are linked to covered medical services can be billed separately from a medical visit and usage of a new HCPCS-II modifier.

Dental services are expanding in community health but CMS reimbursement issues have made it difficult

Medicare is not allowed, by statute, to pay for many dental services, especially routine treatments and cleanings deemed not medically necessary.

Examples include reporting CDT code D7140 (*tooth extraction*) + K03.2 (*erosion of teeth*)

- The list of services that are "inextricably linked" has been expanded to include a "dental or oral examination performed as a part of a comprehensive work-up prior to and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with":
  - Bone marrow, hematopoietic stem cell, and organ transplants,
  - chimeric antigen receptor T-cell therapy when treating cancer,
  - cardiac valve replacements,
  - valvuloplasty procedures,
  - chemotherapy when used in the treatment for cancer,
  - antiresorptive therapy when treating cancer,
  - **Patients preparing to receive dialysis for ESRD (ADDED in 2025!)**

Dental Action Items

1.) Reach out to your clinical providers to identify which dental services that are linked to covered medical services can be billed separately by community health centers in 2025 IN ADDITION to a medical/mental health visit using ***HCPCS-II modifier –KX defined as "Specific required documentation on file."***

2.) See how/if this impacts commercial insurance and/or Medicaid coverage of similar services and/or if the –KX modifier is necessary.

3.) Look for confirmation in a 2025 update to the CMS Benefits Policy Manual Chapter 13 Section 40.3

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