Critical Access Hospital and
Rural Health Clinic Conference

Focusing on the Quadruple Aim

Rural Health Clinic Billing

May 2, 2017

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AGENDA

- Rural Health Clinic Overview
- Rural Health Clinic Services
- Preventive Services in the RHC
- Non-RHC Services/Non-Covered Services
- Payment for Services
- Filing an RHC Claim
- RHC HCPCS Reporting Requirements
- Additional RHC Billing Issues
- Recent Events

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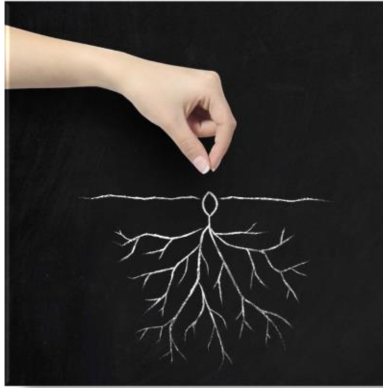

Rural Health Clinic Overview

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RHC Overview

What is an RHC?

RHC certification is a designation from the Centers for Medicare & Medicaid Services (CMS) to clinics providing primary care in certain rural, underserved areas, which provides an alternative, cost-based reimbursement system for treating Medicare and Medicaid beneficiaries.

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RHC Overview

How Are RHCs Paid?

RHCs are paid a flat rate for each *face-to-face encounter* based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs (i.e., cost report) occurring at the end of the fiscal year.

RHC Overview

Cost-based reimbursement is determined on the average cost per visit. A visit is defined as a medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker and a patient.

In general, if there is no "visit," there is no RHC payment (exceptions for flu/pneumo vaccines).

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RHC Overview

What Is Different About RHC Billing?

RHC services are billed and reimbursed by Medicare (and Medicaid in some states) under an all-inclusive payment rate regardless of the type of practitioner (physician vs. midlevel) or the complexity of services performed (99212 vs. 99215, E/M vs. surgical procedure).

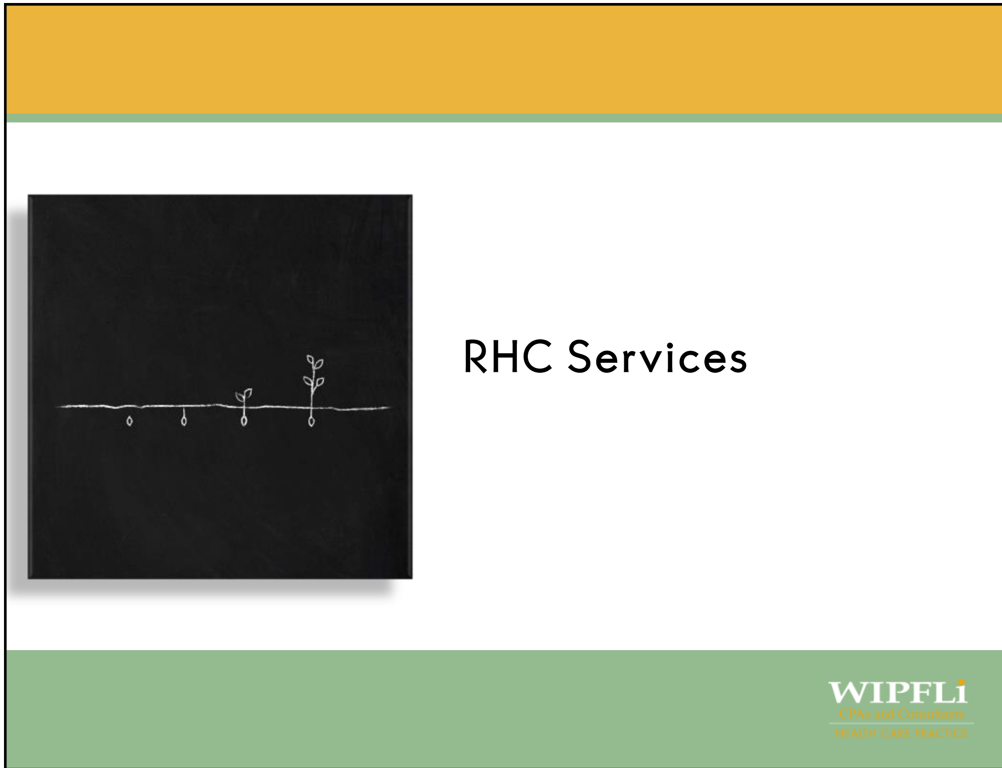
RHC services are billed to Medicare on the UB-04 claim form instead of the CMS 1500 form often used for billing physician services.

CPT/HCPCS codes are now reported for Medicare RHC billing purposes effective April 1, 2016 (more about this later).

RHC Overview

There are two types of RHCs; cost reporting and billing for some services are slightly different for each:

- Independent RHCs submit an RHC cost report to one of five regional fiscal intermediaries (transitioning to MAC).
- Provider-based RHCs submit an RHC cost report as a subset of the host provider (usually a hospital).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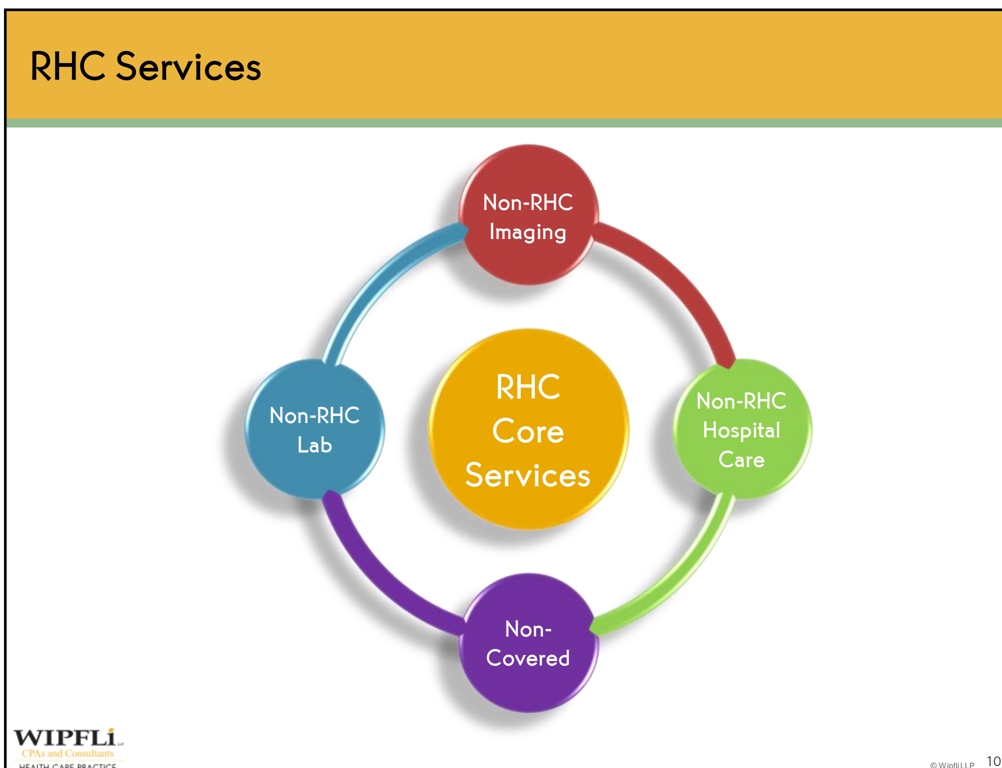
RHC Services
Non-RHC Imaging
Non-RHC Hospital Care
Non-Covered
Non-RHC Lab
RHC Core Services
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RHC Services

RHC Billing Differences (Core Services)

Service	Independent	Provider-Based
RHC services (face-to-face encounter in RHC site of service).	Billed to Independent RHC Regional Fiscal Intermediary - RHC provider number on Form UB-04.	Billed to host Provider Fiscal Intermediary - RHC provider number on Form UB-04.

RHC Services

RHC Billing Differences (Non-RHC Services)

Service	Independent	Provider-Based
Laboratory (excluding the draw procedure, e.g., CPT 36415).	Billed to Part B carrier - Existing group number on Form 1500.	Billed on hospital O/P claim type (14x, 13x, or 85x) on Form UB-04.
Other Diagnostic/Radiology - Professional component.	May be billed with encounter. If read by non-RHC provider, they will bill the carrier.	May be billed with encounter. If read by hospital radiologist, bill the carrier.
Other Diagnostic/Radiology - Technical component.	Billed to Part B carrier - Existing group number on Form 1500.	Billed on hospital O/P claim type (13x or 85x) on Form UB-04.
Non-RHC Professional Services (I/P, ER, other O/P services).	Billed to Part B carrier - Existing group number on Form 1500.	Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for O/P pro fees).

RHC Services

- Physician services
- Services of nonphysician practitioners (NPPs), which include physician assistants, nurse practitioners, and certified nurse midwives (does not include clinical nurse specialists)
- Services and supplies incident to physicians and NPPs
- Visiting nurse services to the homebound
- Clinical psychologist and clinical social worker services
- Services and supplies incident to clinical psychologist and clinical social workers
- Physician services for beneficiaries in Part A stay in SNF (including hospital swing bed) separately billable effective 1/1/05

RHC: Physician Services

- Physician services = Professional services performed by a physician for a patient:
  - Diagnosis, therapy, surgery, consultation, and interpretation of tests (EKG, x-rays)
- Services performed at the clinic are payable only to the RHC:
  - Include RHC or patient's place of residence or implied place of residence (SNF, NF, or swing bed)
- Payment made under all-inclusive rate

Note: Bill the carrier (or FI/MAC) for physician services furnished to beneficiaries in a place of service other than RHC

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RHC: Incident to Services

Services and supplies are furnished incident to physician services:

- Furnished as an incidental, integral part of professional services
- Commonly rendered either without charge or otherwise chargeable
  - Cannot bill carrier or intermediary separately!
  - Costs are included in the cost report as part of the all-inclusive encounter rate
- Commonly furnished in a physician's office
- Furnished by a clinic employee (staff)
- Includes services of clinic staff (e.g., nurse, therapist, technician, or other aide):
  - Example: Medicare-covered drug administration (see PM A-01-49 CR1600 4/5/01)
- Supplies such as bandages and tongue depressors are included in the office visit as packaged services

RHC: NP, PA, and CNM

Payment allowed for services furnished by NPPs in all areas and settings permitted under state licensure laws:

- Payable if no other facility or provider charges
- No separate payment made for ordering or referring services
- NP, PA, and CNM services provided in RHC follow same guidelines as outlined for physician services above (Reimbursed at same rates as physician – no reduction based on type of provider!)
- Payment made under all-inclusive rate

RHC: Visiting Nurse Services

- Covered if service area considered a shortage of home health agencies
- Services rendered to homebound patients
- Patient furnished part-time/intermittent nursing care by RN, LPN, or licensed vocational nurse
- Needs to be an employee of RHC
- Services furnished under written POT:
  - Reviewed once every 62 days by supervising physician of RHC

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RHC: Treatment Plans or Home Care Plans

See CMS Publ. 100-02, Chapter 13, Section 110.2

Except for comprehensive care plans that are a component of Chronic Care Management (CCM) services, treatment plans and home care oversight provided by RHC physicians to RHC patients are considered part of the RHC visit and are not a separately billable service.

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Preventive Services in the RHC

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Preventive Services in the RHC

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

- All preventive services furnished on the same day as another medical visit constitute a single billable visit, except for initial preventive physical examination (IPPE).
- If an IPPE visit occurs on the same day as another billable visit, two visits may be billed; i.e. "Eligible for Same Day Billing."
- All of the preventive visits listed may be billed as stand-alone visit if no other service is furnished on the same day; i.e. "Paid at the AIR."
- Copayment and deductible is waived by the ACA for the IPPE and annual wellness visit (AWV), and for Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force with a grade of A or B.

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Preventive Services in the RHC

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Initial Preventive Physical Exam (IPPE)	G0402	Initial preventive physical examination; face-to-face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment.	Yes	Yes	Waived

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Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Annual Wellness Visit (AWV)	G0438	Annual wellness visit, including PPPS, first visit	Yes	No	Waived
Annual Wellness Visit	G0439	Annual wellness visit, including PPPS, subsequent visit	Yes	No	Waived

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Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes	No	Waived
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	Yes	No	Not Waived

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Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Glaucoma Screening	G0117	Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist	Yes	No	Not Waived
Glaucoma Screening	G0118	Glaucoma screening for high-risk patient furnished under the direct supervision of an optometrist or ophthalmologist	Yes	No	Not Waived

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Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Screening Pap Test	Q0091	Obtaining screen pap smear	Yes	No	Waived
Alcohol Screening and Behavioral Counseling	G0442	Annual alcohol screen; 15 minutes	Yes	No	Waived
	G0443	Brief alcohol misuse counsel	Yes	No	Waived

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Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Depression Screening	G0444	Depression screen annual	Yes	No	Waived
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling	G0445	High intensity behavioral counseling STD; 30 min	Yes	No	Waived

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Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Intensive Behavioral Therapy for Cardio-vascular Disease	G0446	Intensive behavioral therapy for cardiovascular disease	Yes	No	Waived
Intensive Behavioral Therapy for Obesity	G0447	Behavioral counseling for obesity; 15 min	Yes	No	Waived

Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Smoking and Tobacco Cessation Counseling	99406* (*G0436 discontinued 10/1/2016)	Tobacco-use counseling; 3-10 min	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99407* (*G0437 discontinued 10/1/2016)	Tobacco-use counseling; >10 min	Yes	No	Waived

Preventive Services in the RHC

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Lung Cancer Screening with Low Dose Computed Tomography	G0296	Visit to determine LDCT eligibility	Yes	No	Waived

Preventive Services in the RHC

See Medicare Learning Matters MM7079

Effective for dates of service on or after January 1, 2011, Medicare beneficiaries receive an annual wellness visit (AWV), with a personalized prevention plan service (PPPS). The two HCPCS codes:

- G0438 – Annual wellness visit, includes PPPS, first visit
- G0439 – Annual wellness visit, includes PPPS, subsequent visit

Preventive Services in the RHC

See Medicare Learning Matters MM7079

- G0438/G0439 are paid under the RHC all-inclusive rate.
- G0438 (initial visit) is a once-in-a-lifetime benefit; cannot be billed within 12 months after effective date of Medicare coverage (should be preceded by IPPE).
- G0438 cannot be submitted within 12 months of IPPE (Welcome to Medicare Visit, G0402) or G0439 (AWV, subsequent visit).

Preventive Services in the RHC

See Medicare Learning Matters SE1039

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the Initial Preventive Physical Examination (IPPE) or "Welcome to Medicare Visit."

To ensure coinsurance and deductible are not applied, detailed HCPCS coding must be provided for preventive services.

The ACA also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

Professional component of covered preventive service billed as RHC encounter on TOB 71x using 052x revenue code along with the HCPCS code of G0402.

Preventive Services in the RHC

Pneumococcal and Influenza Vaccines

See CMS Publ. 100-02, Chapter 13, Section 210.1.1

Pneumococcal and influenza vaccines and their administration are paid at 100 percent of reasonable cost. When an RHC practitioner (physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the cost of the vaccines and administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should not be reported on an RHC claim when billing for RHC services, and the beneficiary pays no Part B deductible or coinsurance for these services.

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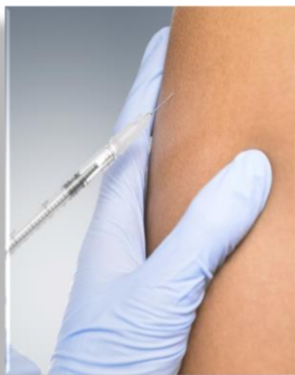
Preventive Services in the RHC

Hepatitis Vaccines

See CMS Publ. 100-02, Chapter 13, Section 210.1.2



Hepatitis vaccines and their administration are included in the RHC visit and are not separately billable. The cost of the vaccines and administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the RHC provides.

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Preventive Services in the RHC

Promote Medicare preventive services

- How many Medicare beneficiaries are currently considered "active" patients in your RHC?
- How many of your patients will become newly eligible for Medicare this year and qualify for the "Welcome to Medicare - IPPE" visit?
- What percentage of your Medicare patients receive the Annual Wellness Visit every year?

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Preventive Services in the RHC

Promote Medicare preventive services (Continued)

- What percentage of your Medicare patients receive annual flu vaccines and the pneumococcal vaccine?
- How frequently do your Medicare patients have an RHC encounter on an annual basis (low, high, average)?
- What is the age breakdown of your Medicare patients? Are there unique preventive services that may apply to certain age categories?
- Is the utilization of Medicare preventive services increasing year-over-year?

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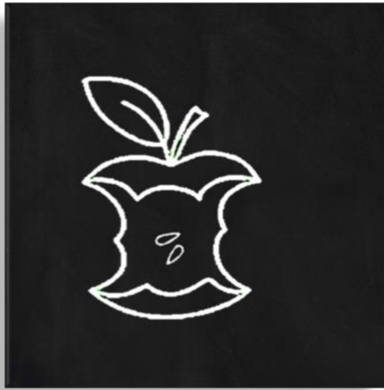

Non-RHC Services

Non-Covered Services

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Non-RHC Services

- DME
- Ambulance services
- Diagnostic tests such as X-ray and EKGs
- Lab test (although required for certification, must be able to perform six required tests in RHC)
- Screening mammography services
- Prosthetic devices
- Services provided to hospital patients (except those in a swing bed)

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Non-RHC Services - Lab

Required Lab Services That Must be Furnished as an RHC

- Chemical examinations of urine
- Hemoglobin
- Blood sugar
- Examination of stool specimens
- Pregnancy tests
- Primary culturing for transmittal to a certified laboratory
- Clinic must furnish these basic [CLIA waived] tests; however, they are billed as non-RHC services

Non-RHC Services - Lab

Lab performed by a CAH

- Medicare Improvements for Patients and Providers Act of 2008 allows cost-based reimbursement for all laboratory services provided by any provider type (i.e., SNF, RHC, or other physician clinic) that is operated by the CAH regardless of where the lab specimen is collected (i.e., patient does not have to be physically present in the CAH at the time the specimens are collected).
- Went into effect for service dates on or after July 1, 2009.

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Non-RHC Services - Lab

Billing Lab Services Performed *in* an RHC

- Independent RHC:
  - Bill all lab services (including the six basic required tests) to Part B carrier on CMS 1500
  - Excluding the lab draw procedure (CPT 36415)

Non-RHC Services - Lab

Billing Lab Services Performed *in* an RHC

Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see Section 1861(aa)(2)(G) of the Act and for FQHCs see Section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead, and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.

MLN Matters Number MM8504, November 22, 2013

Non-RHC Services - Lab

Billing Lab Services Performed *in* an RHC

- Provider-based RHC operated by a CAH:
  - For CAH lab services with dates of service beginning July 1, 2009, use 85X bill type to receive cost reimbursement for lab services

Non-RHC Services - Lab

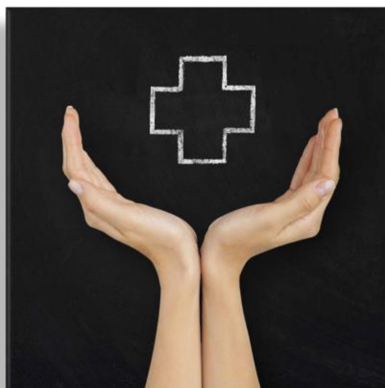
Billing Lab Services Performed *in* an RHC

- Provider-based RHC operated by a PPS hospital:
  - Bill all lab services (including the six basic required tests for RHC COP) performed in RHC as reference lab to FI on Form UB-04 using hospital billing number
    - ~ Again, bill under hospital main provider number (not RHC number!)
    - ~ Bill type 14X
    - ~ Revenue code 030X
    - ~ CPT code required field
    - ~ Fee schedule reimbursement

Services Not Covered

Services never paid by Medicare include:

- General exclusions from Medicare (e.g., dental, cosmetic surgery, routine services)
- Not reasonable and necessary for:
  - Diagnosis
  - Treatment of illness or injury
  - Improved functionality of malformed limb
  - Experimental services



Payment for Services

Payment Calculations

- Payments for covered RHC services by physician, PA, NP, CNM, CP, CSW, and visiting nurse are under an all-inclusive rate for each visit
- Each provider's interim rate is based on the all-inclusive rate per visit (determined based on the cost report)
- Established by your Medicare Administrative Contractor:
  - Determined by dividing total allowable cost by the number of total visits for RHC services
  - Rate may be adjusted during reporting period

Payment Calculations

- The upper payment limit for RHC for 1/1/17 through 12/31/17 is $82.30 per visit (based on the Medicare Economic Index, MEI, 1.2 percent increase over the 2016 rate of $81.32)
  - However, no upper payment limit for RHCs that are provider-based to a hospital with less than 50 beds

Charges to Beneficiaries

Part B Deductible

- The $183 Part B annual deductible applies to services covered under the RHC benefit for 2017 (increased from $166)

Part B Coinsurance

- If the item or service is covered under the RHC benefit, the beneficiary is responsible for 20% of the customary charge
- If the service is not covered under the RHC benefit and is covered under Part B, the beneficiary is responsible for 20% of Medicare-approved charge (MFS)

Payment Calculations

RHC Payment Examples

- Customary charge for 99213 is $120
- Assume Medicare fee schedule allowable is $70
- Medicare encounter rate is $160:
  - Limited to $80 for independent RHC
  - No limit for provider-based RHC - Available beds < 50
- Deductibles have been met already

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Payment Calculations

Comparison Between RHCs and Part B Payment Example

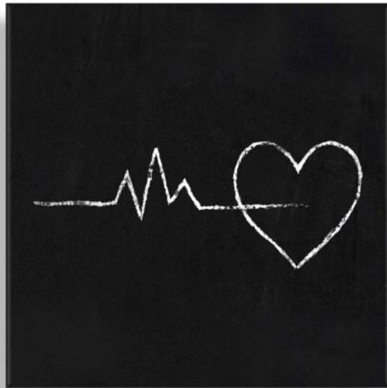
Description	RHC Amount (Independent)	RHC Amount (Provider-Based)	Part B Amount
Customary Charge	$120.00	$120.00	$120.00
Patient Copay	24.00	24.00	14.00
Medicare Pays	64.00	128.00	56.00
Total Payment	88.00	152.00	70.00
Contractual Adjustment	32.00	(32.00)	50.00

Payment Calculations

Does it matter how we code the visit if we get paid the same rate?

- Patient payment is affected
  - Medicare considers overcoding a violation of the fraud and abuse regulations because of the additional reimbursement
  - Medicare considers undercoding a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic

Conclusion: Yes, it Matters!



Filing an RHC Claim

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Filing an RHC Claim

- UB-04 (CMS Form 1450)
- Bill type 71x
- CPT/HCPCS required beginning April 1, 2016
- Separate RHC billing number (for each RHC)
- Only RHC services on RHC billing number
- Bill all non-RHC ancillary services SEPARATELY!
  - Independent - To Part B carrier using existing group number
  - Provider-based - Through the hospital provider number on 13x, 85x, or 14x type of bill (A-00-36 7/28/00)
- Non-RHC professional services billed to Part B carrier utilizing existing group number (or to FI/MAC under CAH Method II billing)

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Filing an RHC Claim

RHC Bill Types (UB-04 claim form, 71X):

- 710 Claim with only non-covered charges
- 711 Original claim
- 715 Late charge – adjustment to prior claim
- 717 Replacement claim – adjustment to prior claim
- 718 Void/cancel previous claim

Filing an RHC Claim

Traditional RHC Revenue Codes - Effective July 1, 2006:

- 0521 Clinic visit at RHC/FQHC
- 0522 Home visit by RHC/FQHC
- 0524 Visit by RHC/FQHC practitioner in Part A stay SNF
- 0525 Visit by RHC/FQHC practitioner in a NF or ICF or residential facility
- 0527 RHC/FQHC visiting nurse (must have special designation)
- 0528 RHC/FQHC visit other locations (i.e., scene of an accident)
- 0780 Telehealth services (Note: not an RHC service)
- 0900 Mental health visits
- Sometimes referred to as place of service with respect to RHC/FQHCs

Filing an RHC Claim

Beginning April 1, 2016, all revenue codes are valid except for:

- 002x – 024x
- 029x
- 045x
- 054x
- 056x
- 060x
- 065x
- 067x – 072x
- 080x – 088x
- 093x
- 096x – 310x

A complete list of revenue codes can be found in a National Uniform Billing Committee publication.

Filing an RHC Claim

Commonly Used Additional RHC Revenue Codes (> 4/01/16):

- 0250 - Pharmacy (does not need HCPCS)
- 0300 - Venipuncture
- 0636 - Injection/Immunization
- 0780 - Telehealth
- 0900 - Behavioral health

Healthcare Common Procedure Coding System Requirement for Rural Health Clinics

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RHC HCPCS Reporting Requirements

Purpose of RHC HCPCS Reporting Requirements

- Compliance with national coding standards and requirements.
- Collect data on RHC services to better inform policies.
- Increase accuracy of RHC claims processing.

Centers for Medicare and Medicaid Services

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Rollout Timeline

July 15, 2015: Physician Fee Schedule (PFS) Proposed Rule published (80 FR 41943)

Nov. 16, 2015: PFS Final Rule published (80 FR 71088)

Feb. 1, 2016: Billing instructions in Medicare Learning Network (MLN) 9269 published; MLN 9269 reissued on 2/10/16, 2/29/16, and 3/24/16

Apr. 1, 2016: RHCs are required to report HCPCS coding; Qualifying Visit List (QVL) used; hold on claims for billable encounters not on the QVL

May 9, 2016: Additional billing instructions in Medicare Learning Network (MLN) SE1611 published; SE1611 reissued on 8/02/16

Centers for Medicare and Medicaid Services

Rollout Timeline

Oct. 1, 2016: RHCs instructed to use “CG” modifier to replace use of QVL; held claims for billable encounters not on QVL to be submitted and paid

Oct. 14, 2016: CMS releases Frequently Asked Questions (FAQs) for rural health clinic billing

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf

Dec. 22, 2016: NARHC hosts “RHC Technical Assistance Call” explaining HCPCS Reporting and use of “CG” modifier

Centers for Medicare and Medicaid Services

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HCPCS Reporting Requirement Examples

Example 1: Patient comes to the RHC for a medical visit and venipuncture.

Example 2: Patient comes to the RHC for medical and preventive health services.

Example 3: Patient comes to the RHC for a medical visit and simple wound repair.

Example 4: Patient comes to the RHC for a medical visit and a behavioral health visit.

Centers for Medicare and Medicaid Services

Disclaimer

This presentation contains information on HCPCS reporting for RHCs. It is not a legal document. Participants are encouraged to review the specific statutes, regulations, and other materials regarding billing requirements.

This presentation contains billing and payment examples. The UB-O4 sample, HCPCS codes, revenue codes, and the associated charges used in the slides are for illustrative purposes only and should not be used as a guideline for billing or setting rates.

The examples use the following fictional charges for illustrative purposes only:

- 99213 = $140.00
- 90834 = $160.00
- G0101 = $80.00
- 12002 = $200.00
- G0117 = $100.00
- 36415 = $6.00
- 69200 = $150.00

Centers for Medicare and Medicaid Services

New RHC HCPCS Reporting

Qualifying Visit Line (Revenue code 052x or 0900)

- Report charges for all services furnished during the encounter minus charges for preventive services.
- Attach "CG" modifier on the Qualifying Visit Line (including preventive services).
- Charges for the qualifying visit represent the amount that will be used to access coinsurance and deductible.

Additional Service Line(s)

- Report each additional service furnished with the most appropriate revenue code with charges $0.01 or greater.

Some charges are displayed twice

- On the line with the qualifying visit and on the service line for the specific service.

Centers for Medicare and Medicaid Services

Example 1 – Medicare UB-04

Patient comes to the RHC for a medical visit and venipuncture on
October 1, 2016

Example is for illustrative purposes only

UB-O4 LINE ITEM ILLUSTRATION

FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$146.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$152.00*

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Example 2 – Medicare UB-04

Patient comes to the RHC for a
medical visit and preventive health services on
October 1, 2016
Example is for illustrative purposes only

UB-O4 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$146.00
0521	Breast/pelvic	G0101	10/01/2016	1	$ 80.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$232.00*

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Example 3 – Medicare UB-04

Patient comes to the RHC for a
medical visit and simple wound repair
October 1, 2016
Example is for illustrative purposes only

UB-O4 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$346.00
0521	Wound repair	12002	10/01/2016	1	$200.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$552.00*

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Example 4 – Medicare UB-04

Patient comes to the RHC for a
medical visit and behavioral health visit
October 1, 2016
Example is for illustrative purposes only

UB-O4 LINE ITEM ILLUSTRATION

FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$140.00
0900	BH session	90834 CG	10/01/2016	1	$160.00
001	*TOTAL CHARGE*				*$300.00*

Additional Billing Items

Line Item Messages (remits)

- CO 97 – Contractual obligation, No CG modifier.
- CARC 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- RARC M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

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Additional Billing Items

Modifier CG

- Beginning on October 1, 2016, MACs require modifier CG on RHC claims:
  - Report modifier CG on one revenue code 52X or 900 service line, which includes all charges subject to coinsurance and deductibles
  - This modifier indicates which service line should receive the all-inclusive rate and be subject to deductibles and coinsurance
  - Additional service lines should be reported with charges greater or equal to $0.01
  - Additional service lines are for informational purposes only

Additional Billing Items

Additional Modifiers

- Beginning on October 1, 2016, MACs accept modifier 25 or 59 when a patient, subsequent to the initial visit, suffers an illness or injury that was not present during the earlier visit and requires additional diagnosis or treatment on the same day

Additional Billing Items

Influenza and Pneumonia Injections

- Services to Medicare patients continue to be paid on the Medicare cost report and should not be included on RHC claim forms

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Additional RHC Billing Issues

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Additional RHC Billing Issues

RHC Billing Tips

- Always include unit/visit number with visit revenue code (e.g., 521 revenue code)
- CPT/HCPCS codes required beginning April 1, 2016
- Always code to most specific detail code available
- Use only ICD-10 to describe diagnosis

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Additional RHC Billing Issues

RHC Billing Tips

- NPI - Show appropriate identifier (assigned to the provider)
- Always include revenue code 001, total charges
- Can combine non-visit charges with visit charges:
  - Usually within 30 days
  - Bundle all charges with visit revenue code
- Should list actual charge on claim form—not reimbursement rate!

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Additional RHC Billing Issues

Mental Health Visit – Revenue Code 900

- Mental Health Visits Do Not Include
  - Initial psychiatric visits
  - Psychiatric testing
  - Psychiatric consultations
- These services are not subject to limitation and should be billed using 52X revenue code

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Additional RHC Billing Issues

Mental Health Visit – 521 or 900 revenue code?

Service	CPT Code	Rev Code
Diagnostic (no medical)	90791	521
Diagnostic (w/medical eval.)	90792	521
Psychotherapy (30 min)	90832	900
Psychotherapy (45 min)	90834	900
Psychotherapy (60 min)	90837	900
Psychotherapy with E&M	+90833/36/38	521
Psychotherapy for crisis	90839 (+90840)	0900
Family psychotherapy	90846/47/49	N/A
Group psychotherapy	90853	N/A
Other (pharmaceutical mgmt)	E&M codes	521

"+" means add-on service to primary service or procedure

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Additional RHC Billing Issues

Home Health Visits

As a condition for payment, the Affordable Care Act (ACA) mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she or an allowed NPP has had a face-to-face encounter with the patient.

- Must occur within 30 days of start of care unless seen within 90 days.
- Documentation must be present with starts of care on or after 1/01/11.
- Certifying physician can "hand off" care.
- Face-to-face encounter could be through telehealth in approved site.

(Refer to MLN Matters SE1038 for more details.)

Additional RHC Billing Issues

Hospice Care

The general requirement for hospice care is that if the patient is terminally ill (defined as life expectancy of 6 months or less), they can elect to receive hospice benefit. When doing this, the beneficiary gives up the right to receive any other care from a Medicare provider (including RHC/FQHCs).

However, if the beneficiary does need Medicare services for a condition completely unrelated, they should be able to bill for that service as an RHC service.

Use condition code 07: Treatment of Non-terminal Condition for Hospice Patient. The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.

Additional RHC Billing Issues

Special Billing - Telehealth Services

Telehealth services (originating site) are non-RHC services. Originating site will receive separate payment.
Coinsurance and deductible apply.

RHC (originating site)

- This is the only service that may be included on an RHC bill (bill type 71X) with another RHC service (e.g., Rev. Code 521)
- Bill Telehealth service under Rev. Code 0780 with HCPCS Q3014
- Requires HCPCS code Q3014 (Reimbursement ~ $25.00)

Additional RHC Billing Issues

Special Billing - Telehealth Services

Telehealth services include:

- Office Visits
- Annual Wellness Visit (2015)
- Consults
- Individual Psychotherapy
- Psychiatric Diagnostic Interview Exam
- Pharmacological Management
- Neurobehavioral Status Exam
- Individual Medical Nutrition Therapy
- Individual Health Behavior and Assessment and Intervention (effective January 1, 2010)

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Additional RHC Billing Issues

Special Billing - Telehealth Services

Physician service (distant site):

- Bill as if the patient was with you "face-to-face"
- Payment made based on current fee schedule for service provided as if the patient was with provider

Additional RHC Billing Issues

Transitional Care Management Services (TCM)

TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

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Additional RHC Billing Issues

Special Billing - Other Diagnostic Services

Example billing for EKGs:

- Part B service:
  - Bill technical component of EKG using 93005 (EKG) to Part B carrier or hospital FI
- RHC (professional) service:
  - Follow normal RHC billing if attending physician is also interpreting test; charge added (bundled) with office visit
  - Revenue code 52x
  - Paid as RHC encounter

Additional RHC Billing Issues

Special Billing - Multiple Visits

Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day at a single location constitute a single visit.

Exception: When one of the following conditions exist:

- After the first encounter, the patient suffers illness or injury requiring additional treatment.
- The patient has a medical visit and a clinical psychologist or clinical social worker visit.

Additional RHC Billing Issues

Special Billing – Non-Covered Services

Option 1:

- Entire episode not covered:
  - Not required unless requested by patient
  - Use condition code 20 - If patient disagrees and wants Medicare to decide
  - Use condition code 21 - Patient wants denial for other insurance coverage
- Bill Type 710
- Charges listed as non-covered

Additional RHC Billing Issues

Special Billing – Non-Covered Services

Option 2:

- Bill entire non-covered service to Part B on CMS 1500 claim form
- Will result in a better “cross-over” to supplemental plans
- Think preventive services in this scenario

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Recent Events

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Recent Events

Advanced Care Planning (ACP)

Effective January 1, 2016, Advanced Care Planning (ACP) became a stand-alone billable visit in an RHC.

Per the 2016 Physician Fee Schedule Final Rule:

- RHCs furnish Medicare Part B services and are paid in accordance with the RHC all-inclusive rate system. Beginning on January 1, 2016, ACP will be a stand-alone billable visit in an RHC when furnished by an RHC practitioner and all other program requirements are met. If furnished on the same day as another billable visit, only one visit will be paid. Coinsurance and deductibles will be applied for ACP when furnished in an RHC. Coinsurance and deductibles will be waived when ACP is furnished as part of an AWV. Additional information on RHC billing of ACP will be available in sub-regulatory guidance.

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Recent Events

Advanced Care Planning (ACP) (continued)

- CPT code 99497 - Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate; and
- An add-on CPT code 99498 - Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure).
- Refer to *RHC Technical Assistance Call* on January 19, 2016.

Recent Events

Chronic Care Management (CCM)

Effective January 1, 2016, RHCs are able to bill for Chronic Care Management (CCM) services when all CCM requirements are met.

See MLN Matters MM9234

RHCs can bill for CCM services when an RHC practitioner furnishes a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and initiates the CCM service as part of this visit.

Coinsurance and deductibles would apply as applicable to RHC claims. RHCs would continue to be required to meet the RHC Conditions of Participation and any additional RHC payment requirements.

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Recent Events

CCM
CHRONIC CARE MANAGEMENT

Chronic Care Management (CCM) (continued)

RHCs cannot bill for CCM services for a beneficiary during the same service period as billing for transitional care management or any other program that provides additional payment for care management services (outside of the RHC AIR) for the same beneficiary.

The CCM payment rate is based on the Medicare Physician Fee Schedule national average. The 2016 rate for CCM services in RHCs was $40.82; the 2017 rate is approximately $41.00.

Recent Events

CCM
CHRONIC CARE MANAGEMENT

Chronic Care Management (CCM) (continued)

Effective January 1, 2017, the RHC physician, NP, or PA responsible for the patient's care can now fulfill the general supervision requirements of the "incident to" rules. This means that any auxiliary staff performing CCM services no longer have to be located on site.

Refer to *RHC Technical Assistance Call* on January 19, 2016, for additional information.

Recent Events

Chronic Care Management (CCM) (continued)

- RHCs can only bill 99490 (20 minutes) and are not eligible to bill the two other CCM CPT codes added by CMS in 2017 (CPT codes 99487 and 99489).
- Several additional changes were made to the CCM Scope of Service Requirements for 2017.
- Refer to the December 2016 MLN Fact Sheet on Chronic Care Management Services.

Resources

CMS Online Manuals:

- Pub 100-4, Chapter 3, Section 30 - Inpatient Part A Hospital Manual
- Pub 100-4, Chapter 4, Section 250 - Part B Hospital (including Inpatient Hospital Part B and OPPS)
- Pub 100-4, Chapter 6, Section 20 - SNF Inpatient Part A Billing
- Pub 100-4, Chapter 9 - RHC/FQHC Manual
- Pub 100-4, Chapter 16, Sections 30.3 and 40.3.1
- Laboratory Services from Independent Labs, Physicians & Providers

Other:

- Medicare Prescription Drug Improvement & Modernization Act of 2003
- Medicare Improvements for Patients and Providers Act of 2008
- CMS Quick Reference Information: Preventive Services https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- United Government Services CAH Training Manual (available in PDF at) Noridian Administrative Services LLC www.noridianmedicare.com

Questions?

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Thank you!

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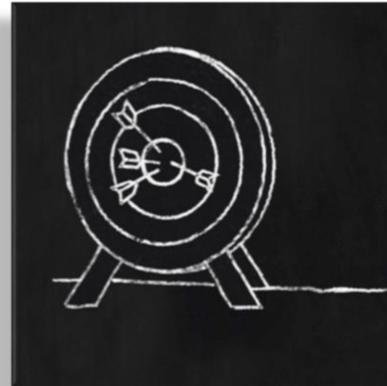

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