




Rural Health Clinic Billing – Two of Four Presented by Healthcare Business Specialists Sponsored by Azalea Health and ChartSpan January 22, 2020



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[RHC Information Exchange Group on Facebook](#)
 • "A place to share and find information on RHCs."

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2020 Dates

Nashville 11/5
 Somerset, KY 11/12
 Alabama, 11/18

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RHC Update Seminar – Clanton, Alabama
Agenda and Topics Outline
January 16, 2020

Healthcare Business Specialists, Azalea Health, and ChartSpan are providing a free seminar for RHCs at Clanton-Cashelton Center - Alabama Power Company, 2030 7th St N Clanton, AL 36045. To reserve your seat, visit us at www.chartspan.com.

Time	Subject Matter
9:00 AM to 9:30 AM	Registration and Check-in
9:30 AM to 10:00 AM	Costly Errors in RHCs
10:00 AM to 10:30 AM	Panel Discussion: RHCs in the Future
10:30 AM to 11:00 AM	Q&A Session
11:00 AM to 11:30 AM	Break
11:30 AM to 12:00 PM	Panel Discussion: RHCs in the Future
12:00 PM to 12:30 PM	Lunch
12:30 PM to 1:00 PM	Panel Discussion: RHCs in the Future
1:00 PM to 1:30 PM	Panel Discussion: RHCs in the Future
1:30 PM to 2:00 PM	Panel Discussion: RHCs in the Future
2:00 PM to 2:30 PM	Panel Discussion: RHCs in the Future
2:30 PM to 3:00 PM	Panel Discussion: RHCs in the Future

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HBS
 Healthcare Business Specialists

- We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.
- We prepare Program evaluations of RHCs.
- We help clinics startup as RHCs.
- Emergency Preparedness for RHCs.
- We prepare TennCare Quarterly Reports

• What does Healthcare Business Specialists do?
 • Listing of Services
<https://tinyurl.com/w63xpb9>

• Our Cost Reporting Brochure can be found at the following link:
[RHC Cost Report Brochure](#)

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RHC Information Exchange Group on Facebook

Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs

<https://www.facebook.com/groups/1503414633296362/>

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WEBINAR

- On January 29th, from 2:00pm – 3:00pm EASTERN, we will be hosting the next Rural Health Clinic Technical Assistance webinar. This one-hour webinar will be a regulatory update presented by NARHC Director of Government Relations, Nathan Baugh. At the conclusion of the formal presentation, there will be time for questions and answers.
- Here is the link to the webinar:
<https://hrsseminar.adobeconnect.com/fru-rhcs/>
- You can either use the audio controls on your computer or dial in using the following phone number and access code:
- Dial-in: 888-790-3413
- Participant Code: 7023213

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WEBINAR

Please register for Cost Reporting for Rural Health Clinics - What is needed to file an accurate and timely cost report on Jan 30, 2020 3:00 PM EST at:
<https://attendee.gotowebinar.com/register/7460659588778612236>

After registering, you will receive a confirmation email containing information about joining the webinar.

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Questions or Comments?

Please type your questions in the Questions area of Go To Webinar. Additionally, we will open up the lines for questions at the end of the 45-minute webinar.

QUESTIONS

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DISCLAIMER

- Information is current as of 1/20/2020.
- We will supply general information. All situations are specific so refer to specific guidance as necessary.
- This session is being recorded.

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RHCs may be either

Independent Provider-based

FOR SALE

NP Practice For Sale

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Reimbursement Differences between

Independent **Provider-based**

Payment capped at \$86.31
Use Form 222
Owned by physicians, NPs, PAs, or even hospitals.

Payment capped at \$86.31 except for less than 50 beds
Use Form 2552, M-Series of the cost report
Owned by the hospital

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Payment Differences for RHCs

1. They are paid on a cost per visit basis.
2. They file Medicare Cost Reports
3. **Medicaid Rates are based upon cost.**
4. The cost per visit is not all-inclusive.
5. Some services are still paid fee for service
 - A. Lab (minus CPT 36415)
 - B. Technical Component
 - C. Hospital

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Independent vs. Provider Based RHC Billing

	Encounter for RHC Service(s)	CLIA Lab in RHC	Technical Component (Non-RHC Service)
Independent RHC	Bill to Part A on UB-04	Bill to Part B on CMS-1500	Bill to Part B on CMS-1500
Provider-Based RHC	Bill to Part A on UB-04	Billed to MAC by Parent Entity PPS Hospital: TOB 141/131 CAH: TOB 851	Billed to MAC by Parent Entity PPS Hospital: TOB 131 CAH: TOB 851

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Charges

All patients must be charged the same amount for services, though what the RHC collects can vary based on policies such as cash and same day payment discounts, sliding fee schedule, etc. Do not charge your Medicare rate to Medicare patients. Note: Some states use a T1015 code for Medicaid services and an RHC may be required to include the Medicaid rate as the charge to Medicaid.

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13. Charges may be established based upon:



- a. As a percentage of the Medicare Fee Schedule (150% to 200%)
- b. Based upon knowledge of the local community
- c. Purchasing a Fee Analyzer for your local area
- d. All of the above

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CHARGEMASTER MAINTENANCE

Yearly Review	Regulatory updates
	HCPCS and ICD-10 coding changes
Revenue Reliability	Updates to billing system
	Payor Changes
Pricing	Contract constraints
	Compare to highest paying fee schedule
	Medicare pays lesser of MPFS or charge
Compliance	Overarching governance and oversight of the Revenue Cycle functions

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RHCs – The Original Bundled Payment


RHCs are paid a bundled payment. Independent RHCs are paid a maximum of \$69.05 per visit (AIR). Provider-based RHCs will get more.



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14. The patient has an E & M service and also receives a trigger point injection during the same visit:



- a. The Trigger Point injection and administration is billed to Part B, fee for service.
- b. The Trigger Point injection and administration is billed incident to the E & M service

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What are the Medicare RHC Payment Rates?

Type	Cap	Payment
Independent RHC	86.31	\$69.05
Provider-based < 50 beds (2018) CAH	None Mean Cost= \$207	Mean Payment = \$166

Medicare pays 80% minus 2% sequestration

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Comparison of Total Medicare Payments

Type	Charge 99213	Copayment	Medicare	Total Payment
Independent	\$125	\$25* *No Par limits	\$69	\$94
Provider-based (less than 50 beds)	\$125	\$25* *No Par limits	\$166	\$191 NO LCC

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Strange new rules

1. Must bill Medicare on a UB-04
2. No limiting charges - collect 20% of charges
3. Collecting more than you charge.
3. Remittance Advices are strange. How to record contractual adjustments correctly.
4. What services to bill Part A? Part B???
5. How is Medicaid affected by this?
6. We get Negative Reimbursement?????
7. HCPCS Billing changed on April 1, 2016.
8. CG Modifier Added October 1, 2016



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Some things remain the Same

1. The \$198 Deductible is the same.
2. Continue Coding and charging the appropriate level of service.
3. Charges must be consistent across the board.
4. Continue using either the 95 or 97 CPT Documentation guidelines.
5. Preventive Services are the same.



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Four Categories of Services




RHC Services
Face to Face Encounters
Incident to services

Non-RHC Services

Medicare Non-covered services



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Medicare

Part A



Part B

Professional Services

Technical Components

Lab Diagnostic

Hospital


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What is a Rural Health Clinic Visit?



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The History of the RHC Visit

Date Began	Definition	Date Changed
3/1/1978	Face to Face, Med necessary, Physician, NP, PA	12/31/2015
1/1/2016	Added Chronic Care Management - No face to Face	3/31/2016
4/1/2016	Must Be on QVL to Bill. Procedures held until 10/1/2016	9/30/2016
10/1/2016	No more QVL. Now add CG modifier	Present

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ELIGIBLE PROVIDERS

- Physician - Doctor of medicine, osteopathy, dental, podiatry, or optometry
- Nurse Practitioner
- Physician Assistant
- Certified Nurse Midwives
- Visiting nurse services to the homebound
- Clinical Psychologist
- Clinical Social Worker


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Definition of a Visit per Chapter 13 of the RHC Manual

40 - RHC Visits (Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18) An RHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC practitioner are considered RHC visits.

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What is a visit in a rural health clinic?

Has Three Components	<ol style="list-style-type: none"> 1. Is a face to face encounter with a physician, nurse practitioner, PA, NP, or CNM, CP, or CSW. 2. There is a medically necessary service provided (should reach the level of a 99212) 3. Is provided by the appropriately trained provider within their scope of practice.
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COVERED MEDICARE PART B, BUT NOT RHC

DSMT and MNT:

- Can be billed when incident to face-to-face

Nurse only visits:

- Injections
- Dressing Changes
- Blood pressure/Blood sugar monitoring



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Paid RHC Encounters are very limited

The definition of a rural health clinic encounter does not include:

1. Nurses
2. Physical Therapists
3. Dietitians
4. Nutritionists




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15. Dietitian and Nutritionist time counts toward the 20 minutes of Chronic Care Management time each month?

a. True
b. False



QUESTIONS

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99211 Visits (Nurse Only) are not Medicare RHC Visits

- Brief Established visits (99211's) do not meet the RHC guidelines. No history or judgment involved with this level of service. Do not bill Medicare a visit for these services.



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Where can you have an RHC Visit?

40.1 – Location (Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01-02-19) RHC or FQHC visits may take place in:

- the RHC or FQHC,
- the patient's residence (including an assisted living facility),
- a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
- the scene of an accident.

RHC and FQHC visits may not take place in:

- an inpatient or outpatient department of a hospital, including a CAH, or
- a facility which has specific requirements that preclude RHC or FQHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).

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Qualified services provided to a RHC or FQHC patient are considered RHC or FQHC services if:

- the practitioner is compensated by the RHC or FQHC for the services provided;
- the cost of the service is included in the RHC or FQHC cost report; and;
- other requirements for furnishing services are met.

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Where can a RHC visit occur?


In Three Locations	1. In the certified rural health clinic (0521)
	2. In the patient's home <ul style="list-style-type: none"> A. home (0522) B. SNF (Part A) (0524) C. ICF/NF (Not Part A) (0525) D. Assisted Living Facility (0522)
	3. Scene of an accident (0528)
	4. Telehealth (0780) Originating site only
	5. Behavioral Health (0900)

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16. What Place of Service Code should an RHC use when billing services on a UB-04?

a. 72
b. 11
c. The Revenue Code serves as the Place of Service Code on the UB-04



QUESTIONS


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Revenue Codes

0521	Clinic visit by a member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to member in a covered Part A stay at a SNF
0525	Visit by RHC practitioner to member in a non-Part A SNF, NF, ICF, or other residential facility
0527	RHC visiting nursing services to a member's home in a Home Health Shortage Area
0528	Visit by RHC practitioner to another non-RHC site (i.e. scene of an accident)
0900	Mental health visit

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Other Common Revenue Codes in RHCs

- 0250** Pharmacy – drug with no J-code
- 0300** Venipuncture
- 0636** Drugs with detailed HCPCS J-code
- 0780** Telemedicine originating site


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SERVICES PAID ON FEE SCHEDULE

Few services are reported on the UB-04 RHC claim, but paid based on the Medicare Physician Fee Schedule.

- Chronic Care Management:**
 - 99490, 99487 & 99489 are all billed as G0511 (effective 1/1/2018)
 - Initiating CCM code of G0506 not billable in RHC
 - Paid at National Average blended rate of \$67.03
- Telehealth Originating site only (can't bill as distant site provider):**
 - Paid at the National Average rate of \$26.15
 - Revenue Code 0780
 - HCPCS Code Q3014

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Claim Form, Bill Types & Place of Service

- RHC services are billed on a CMS-1450 (also known as a UB-04 form)
- RHCs should use Place of Service (POS) code **72**
- These are the common bill types (TOBs) used on RHC claims:

- 711** Original Claim
- 710** Non payment/zero claim
- 717** Adjustment Claim
- 718** Cancelled Claim

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Negative Reimbursement


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Negative reimbursement occurs when the cost of the visit is greater than the provider encounter rate and the billed amount is applied to the patient's Medicare deductible.

Total billed amount	\$115.00
Provider All-inclusive reimbursement rate	\$75.00
Amount applied to deductible	\$115.00
Beneficiary's responsibility	\$115.00
Medicare reimbursement	-\$40.00


Because the Medicare Deductible is now \$198 the withholds for Independent RHCs could be as high as \$112. (\$198 - \$86)

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17. When posting a negative reimbursement claim an RHC should always:



- Ensure that the Patient Balance remains correct after posting.
- To Post the withhold to the patient balance.
- Include the negative reimbursement on the Credit Balance Report.



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Negative Reimbursement

The key to posting negative reimbursement is to balance to Beneficiary Responsibility

Activity	Debit	Credit
Charge Patient	AR \$115	Sales/Rev \$115
Record Negative Payment from Medicare	Medicare Contractual Adjustment \$40	Bank Balance \$40

Notice: The Patient Balance is not affected by the Medicare Withhold

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Medicare Advantage Plans

Part A
Hospital Insurance

Part B
Medical Insurance

Part D
Prescription Drug Coverage

Vision • Hearing • Dental
Health & Wellness Programs
(additional services that may be covered)

Medicare Advantage

https://www.modernhealthcare.com/article/20180210/NEWS/180219989?fbclid=IwAR0MkzSTlwRI_rNk-irYTA94T33XeQf5GzWAsrnpBifhTwL_4Q7ZXtqvcc

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Medicare Advantage Plans

When a beneficiary enrolls in a Medicare Advantage (MA) plan, they are no longer classified as a Medicare patient for cost reporting purposes. These individuals are effectively treated as privately insured individuals.


MA plans must show that they have an "adequate" provider network in each market they serve. In an underserved area, it may be difficult for the MA plan to meet the market adequacy requirement if an existing RHC is not part of the network.

If an RHC is a contracted provider within a MA network, the RHC is obligated to follow whatever is established in the contract. Payment could be cost-based, fee-for-service, or even capitation plan.

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Its All about that Visit (QVL)



<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf>

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18. In order for an E and M code to qualify to be paid at the AIR the HCPCS code must be found on the QVL?



a. True

b. False

QUESTIONS

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Questions, Comments, Thank You






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