RURAL HEALTH CLINIC MEDICARE BILLING 201

December 7, 2023

Webinar Series

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What will we discuss on this webinar?

- Recap of the RHC Medicare reimbursement methodology and claim format
- 2024 Medicare Deductibles and Coinsurance Amounts
- Reimbursement Examples including Negative Remits
- Advanced Billing Topics:
  - Care Management Services
  - Telemedicine
  - Incident-to Billing Definitions
  - RHC Modifier Use
  - Medicare Secondary Billing
  - Condition Codes
  - Occurrence Codes
- Q & A

RECAP OF REIMBURSEMENT METHODOLOGY AND CLAIM FORMAT

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Cost-based Reimbursement Methodology

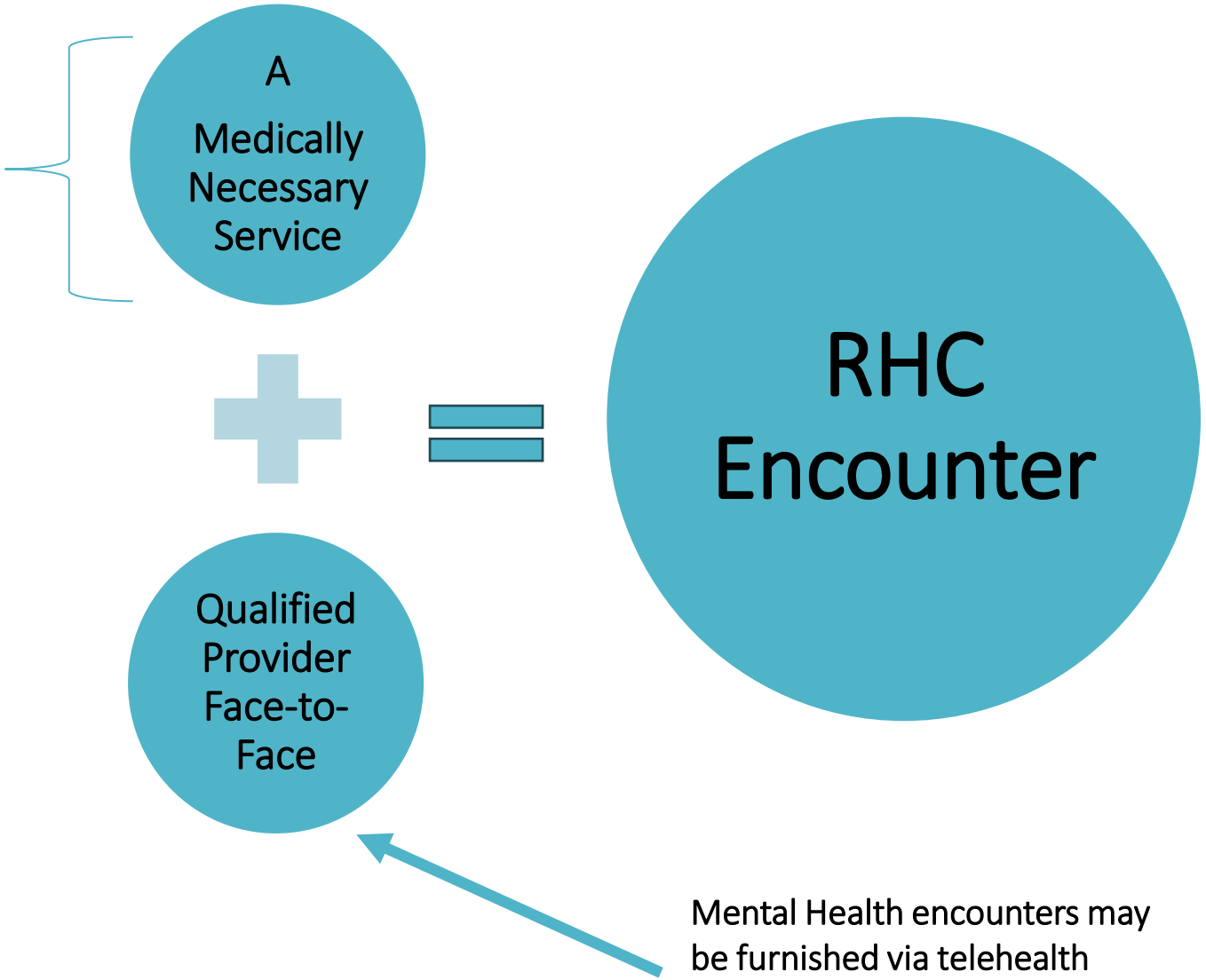
Part B medical offices are reimbursed at an allowable fee schedule amount, the Medicare Physician Fee Schedule (MPFS), for each reportable CPT/HCPCS code.

New RHCs will need to start thinking differently about how they are paid for performing services in the RHC setting.

RHCs are reimbursed per encounter based on a cost report calculation that is made every year. RHCs are paid each year based on what it actually costs them to provide care on a per encounter basis. The lesser or the actual cost or the current year's upper payment limit is used as the payment rate for the next year. That amount becomes the all-inclusive rate or AIR for all qualifying RHC services. The rate is calculated on the

Total Allowable Costs ÷ Total Qualifying Visits = All-Inclusive Rate (AIR)

Medicare LCD/NCD Covered Services



Mental Health encounters may be furnished via telehealth beginning 2022 are considered face to face.

Reimbursement for an encounter is based off the All-Inclusive Rate which is calculated each year on the cost report.

CMS reimburses 80% of the AIR after the deductible is met and there is an additional patient responsibility amount/coinsurance which is 20% of the total charges.

Deductibles and Coinsurance

- The Part B deductible for the calendar year applies to RHC services.
- If a patient does not have Part B Medicare, RHC services are not covered.
- Once the deductible has been met, the Medicare contractor pays 80% of the AIR and the patient responsibility is 20% of the total charges.
- The RHC is responsible for collecting any unmet deductible directly from the patient but is NOT allowed to keep the difference between the deductible and the full AIR. This will result in a negative take-back on the remit.
- Additional slides will have examples.

Says who?

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-X

§ 405.2410 Application of Part B deductible and coinsurance.

CROSS REFERENCE

Link to an amendment published at 88 FR 82176, Nov. 22, 2023.

(a) *Application of deductible.*

(1) Medicare payment for RHC services begins only after the beneficiary has incurred the deductible.

(2) Medicare payment for services covered under the FQHC benefit is not subject to the usual Part B deductible.

(b) *Application of coinsurance.* Except for preventive services for which Medicare pays 100 percent under § 410.152(l) of this chapter, a beneficiary's responsibility is either of the following:

(1) For RHCs that are authorized to bill on the basis of the reasonable cost system—

(i) A coinsurance amount that does not exceed 20 percent of the RHC's reasonable customary charge for the covered service; and

(ii)

New Deductibles and Coinsurance Amounts

Medicare Part B Deductible

2024 Medicare Deductible is **$240.** This is an increase of $14.00 over $226 for 2023.

This will be patient responsibility if the patient does not have a Medicap plan or secondary that covers the Part B Deductible.

The $240 deductible is applied to total charges of RHC services. An RHC is responsible for collecting the full deductible if charges equal or exceed $240.

The RHC is only allowed to keep the AIR payment. This is what creates the negative remittance advices.

When posting be careful to leave the correct patient responsibility on the patient account. You must be able to adjust the takeback while leaving the correct patient account balance.

Medicare Part A Deductible

For inpatient services, the Part A deductible for 2024 is $1,632. This is an increase of $32 over$1,600 for 2023. This does not apply to any RHC services.

https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles?mod=anlink%2F

Examples of RHC Medicare Reimbursement
(Deductible has been met)
RHC AIR is $126

Example 1

Date of Service	Description	CPT Code	Charge Amount
1/15/2024	OV Est Level 4	99214	125.00
1/15/2024	Inj Admn	96372	20.00
1/15/2024	Rocephin	J0696	50.00
	Total Charges		195.00

Payment

Medicare Reimbursement	100.80	80% of $126 AIR
Patient Coinsurance	39.00	20% of $195
Total Reimbursement	139.80	

Example 2

Date of Service	Description	CPT Code	Charge Amount
1/15/2024	OV Est Level 4	99214	75.00
1/15/2024	Inj Admn	96372	20.00
1/15/2024	Rocephin	J0696	20.00
	Total Charges		115.00

Payment

Medicare Reimbursement	100.80	80% of $126 AIR
Patient Coinsurance	23.00	20% of $115
Total Reimbursement	123.80	

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Examples of RHC Medicare Reimbursement Resulting in Negative Remit
(Deductible has NOT been met)

RHC AIR is $126 **Full Deductible = $240**

Example 1

Date of Service	Description	CPT Code	Charge Amount
1/15/2024	OV Est Level 4	99214	155.00
1/15/2024	Inj Admn	96372	30.00
1/15/2024	Rocephin	J0696	55.00
	Total Charges		240.00

Payment		
Deductible	240.00	Total Charges Collected Against Deductible
Patient Coinsurance	-	No Coinsurance Due until after deductible is met
Medicare Reimbursement	126.00	Full AIR
Negative Remit (Take Back)	(114.00)	Recoupment of excess between Deductible and AIR

The burden to collect the unmet deductible of $240 is on the RHC. However, you can only keep the AIR amount of $126

Example 2

Date of Service	Description	CPT Code	Charge Amount
1/15/2024	OV Est Level 4	99214	125.00
1/15/2024	Inj Admn	96372	20.00
1/15/2024	Rocephin	J0696	50.00
	Total Charges		195.00

Payment		
Deductible	195.00	Total Charges Collected Against Deductible
Patient Coinsurance	-	No Coinsurance Due until after deductible is met
Medicare Reimbursement	126.00	Full AIR
Negative Remit (Take Back)	(69.00)	Recoupment of excess between Deductible and AIR

The burden to collect the total charges against the Part B deductible is on the RHC. The RHC will receive the AIR.

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Posting negative remits

- Make sure that you leave the full deductible amount on the account as patient responsibility. Do not write off part of the patient responsibility to balance cash.
- Be cautious of auto-posting features.
- It may be necessary to set up a new adjustment category or set up a clearing account to reconcile the negative take-backs.
- The negative remit amount should be a debit to revenue and a credit to cash or another offsetting account.
- Make sure that your RCM partner or billing company understands this.
- Collect something upfront from traditional Medicare patients with no Medigap plan or other secondary.

SAMPLE RHC 837I CLAIM FORM (UB-04 OR 1450)

RECAP OF CLAIM FORMAT, BASIC CODING AND SPLIT-BILLING

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1	2	3a PAT. CNTL #	4 TYPE OF BILL
ABC Rural Health Clinic 1234 Main Street My Town, KY 40000	Not Required	Unique Provider ID for Patient b. MED. REC. #	0711

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
999999999	07 01 23	07 01 23	

8 PATIENT NAME		9 PATIENT ADDRESS				
a John Doe		a 5678 Happy Place				
b		b Any Town	c KY	d 40000	e	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
01/01/1957	M			9	9		01					Used rarely as needed								

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a		Occurrence Codes used only situational (MSP)								Not used						a
b																b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	Used for MSP Claims					
	b						

Fields needed for MSP will be discussed on other slides

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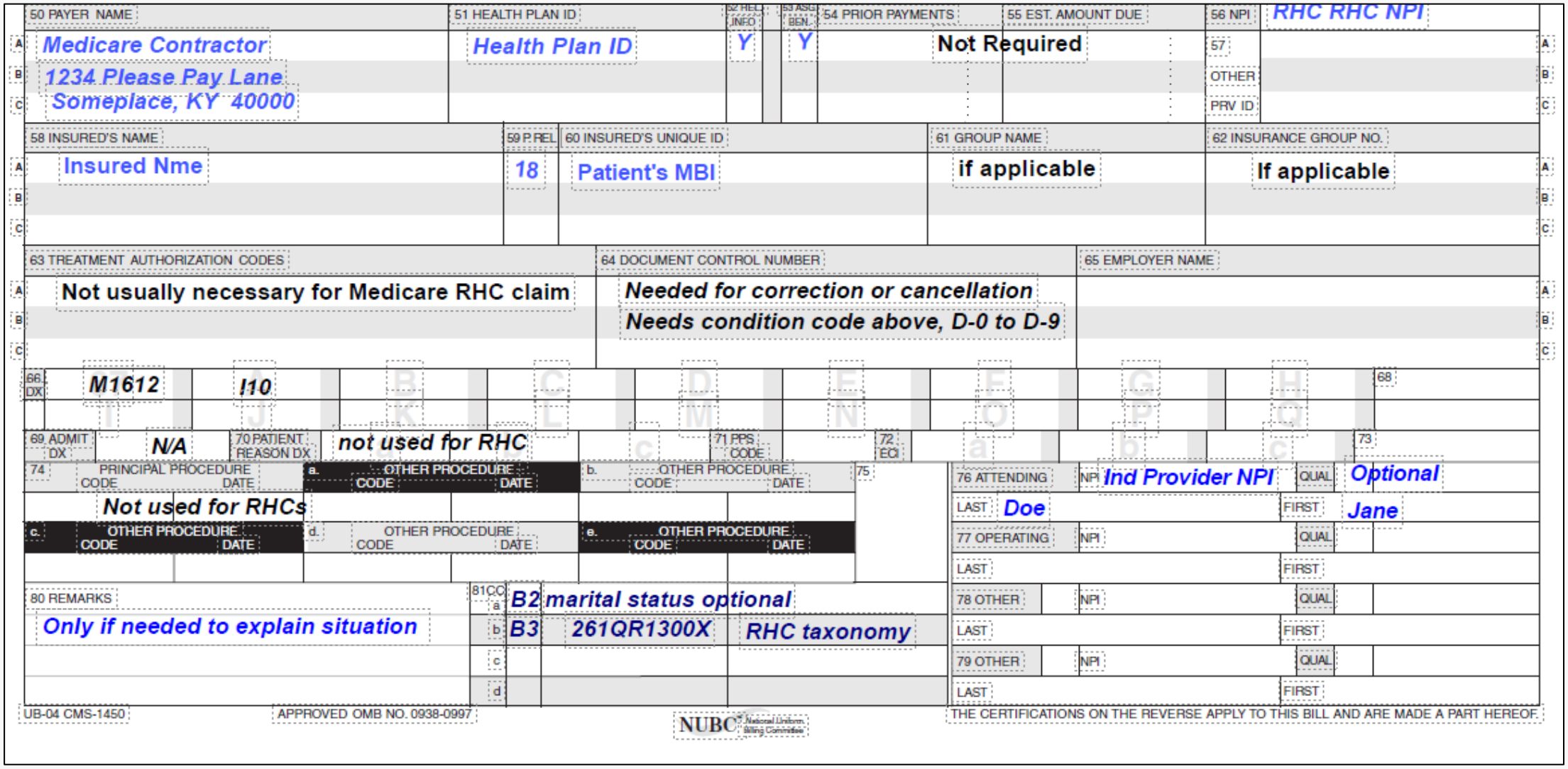
	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	RHC Encounter Clinic	99214 CG	07 01 23	1	225.00			1
2	0521	Injection Administration	96372	07 01 23	1	25.00			2
3	0636	Ketorolac tromethamine, per 15 mg	J1885	07 01 23	4	60.00			3
4									4
5									5
6									6
7									7



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Examples of Code Sets

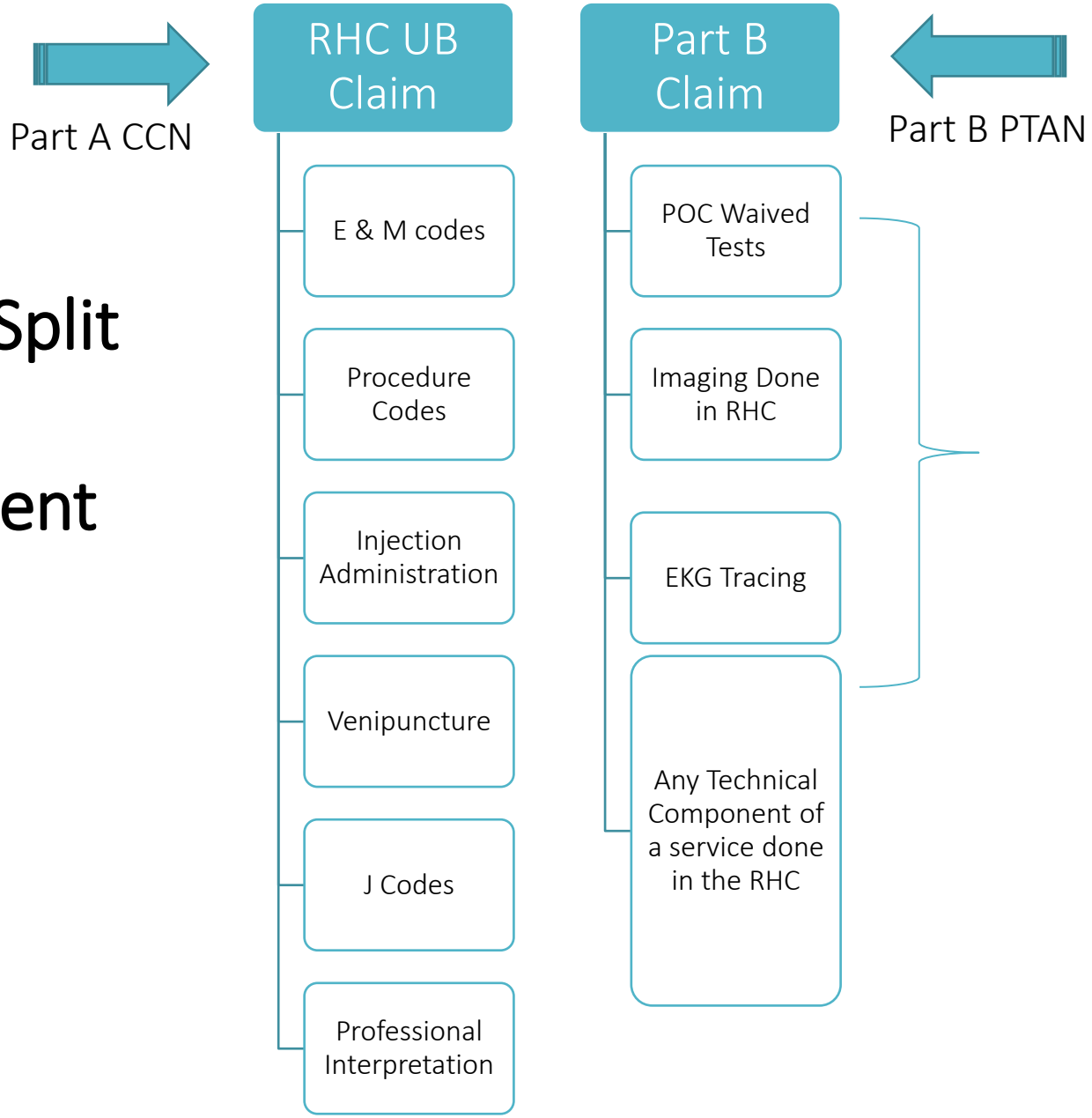
Code Set	Use	Examples
HCPCS Level 1 or CPT® Codes	To report evaluation & management services and procedures	99214 (E & M code); 17000 (Destroy pre-malignant lesion); 99495 (TCM); 81003 (urinalysis); 93005 (EKG tracing)
HCPCS Level 2 Codes	To report drugs, separately billable supplies, temporary codes, governmental payer codes and RHC specific codes	J0696 (Rocephin/250); G0238 (AWV), G0511 (RHC CCM); Q0911) Pap Smear Collection
Revenue Code (leading zero)	To report the type or location of the service. Used for all Part A facility types.	0521 (RHC Clinic); 0522 (RHC Home encounter); 0636 (J code drugs); 0300 (Venipuncture); 0900 (behavioral health
ICD-10-CM 3-7 characters	Used to a report signs, symptoms, diseases, conditions or the reason for the encounter (diagnosis codes)	I10 (Hypertension); J01.09 (acute sinusitis, unspecified; R05.3 (chronic cough); Z00.129 (routine child screening w/no abnormal find)
Condition Codes, Value Codes, & Occurrence Codes	Used to report supplemental information need to process claim.	Condition Code 07 for hospice patient being seen for non-hospice; Value Codes and Occurrence codes for MSP.

Main Revenue Codes for RHC Encounters

One of these revenue codes must be on the claim. Additional revenue codes can be used for drugs, venipunctures and supplies.

Location	Revenue Code	Comments
Within the RHC Certified Space	521 (Clinic)	Most common type of encounter
In the patient's home, assisted living or other residential setting	522 (Home, assisted living)	Must be a qualified RHC provider unless in a designated home health shortage area.
In a Part A skilled nursing facility or swingbed	524 (District part SNF or Swing bed)	Documentation must also be in RHC medical record
In a Part B nursing facility	525 (Nursing home)	Documentation must be in the RHC medical record and must include a treatment consent.
Other location (scene of an accident)	528 (Rarely used)	Qualified RHC provider provides a face-to-face encounter when responding to an accident.
Behavioral Health	900 (All)	Mental health services

Medicare Split Billing Independent RHC



- You should not bill professional procedures to Part B for increased reimbursement.
- You should NOT have a separate “treatment” room in your RHC.
- Do NOT include the six required tests on the RHC UB Medicare Claim.

Medicare Split Billing PBRHC

Pays AIR

RHC Part A
CCN
RHC NPI

RHC UB-04 Claim

- E & M codes
- Procedure Codes
- Injection Administration
- Venipuncture
- J Codes
- Professional Interpretation

Parent Hospital Claim

- POC Waived Tests
- Imaging Done in RHC
- EKG Tracing
- Any Technical Component of a service done in the RHC

Pays as an outpatient hospital claim

Hospital NPI,
Bill type 851 for CAH; 131 for PPS.

PBRHCs are NOT billed as departments of the hospital. CAH Method II billing does not apply to RHC professional services.

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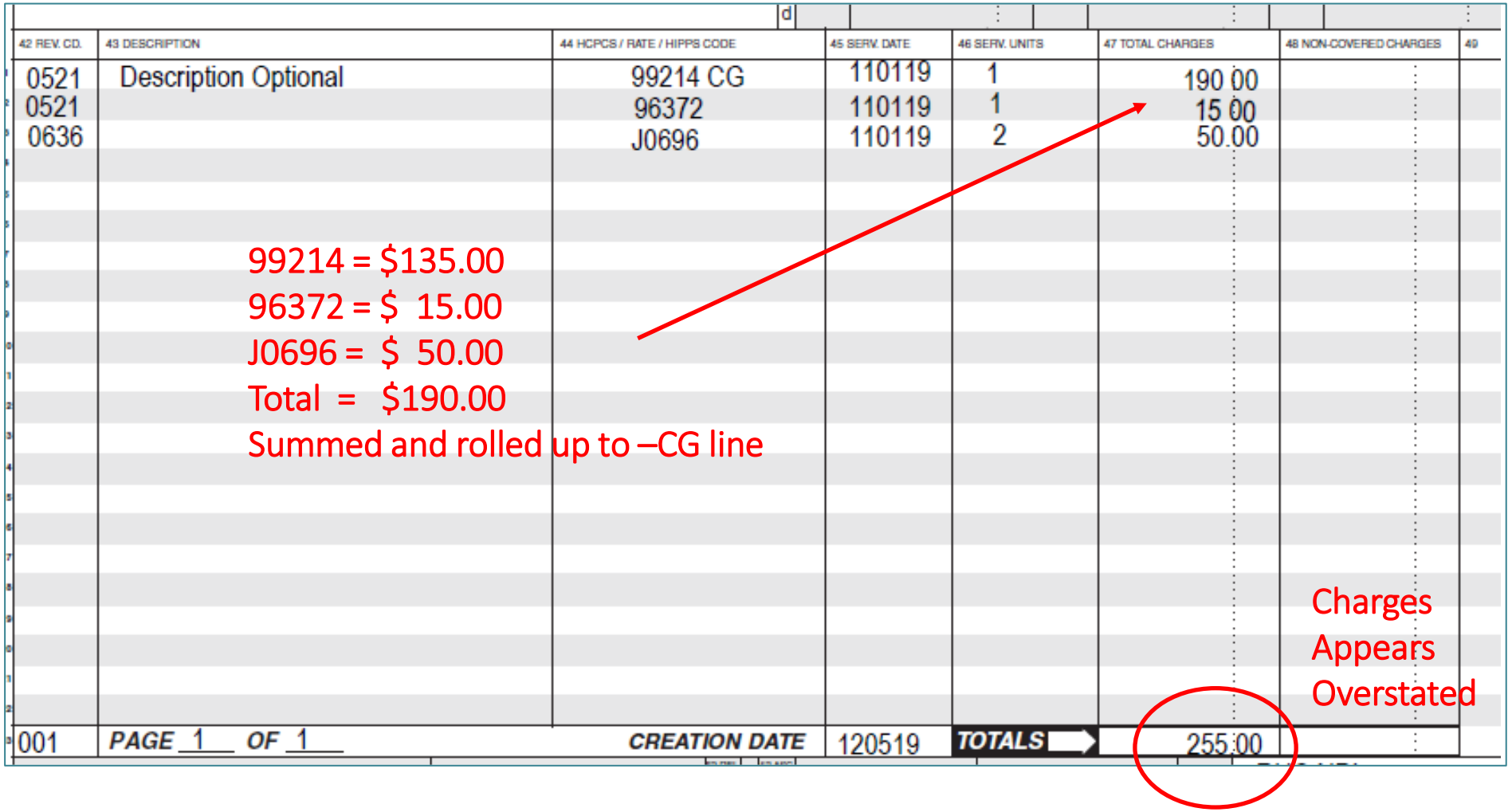
Caution:
Only One Hospital OP Claim per date of Service per patient. For RHCs who are on different systems, this can be challenging.

RHC Medicare Coding, Billing and Reimbursement Basics

-CG Modifier and Roll up of Charges

- RHCs also use a specific modifier on claims to indicate that a qualifying encounter has occurred. This modifier is –CG.
- All claims must include one –CG line. There are rare exceptions in which more than one line can be appended with the –CG modifier. An example would be whenever a medical encounter and a mental health encounter occurred on the same date of service for the same patient.
- The RHC Qualifying Visit List was published by CMS as a reference to which CPT/HCPCS® qualify as standalone encounters.
- All of the charges for RHC services performed at the encounter are reported by line item on the claim.
- However, all of the charges must be summed up to the –CG line. Only the –CG line processes.

Revenue Codes and CPT/HCPCS codes are listed for each line item.
The –CG Modifier is appended to the QVL code.
Only the –CG line will be processed.



RHC Encounter with Multiple Services

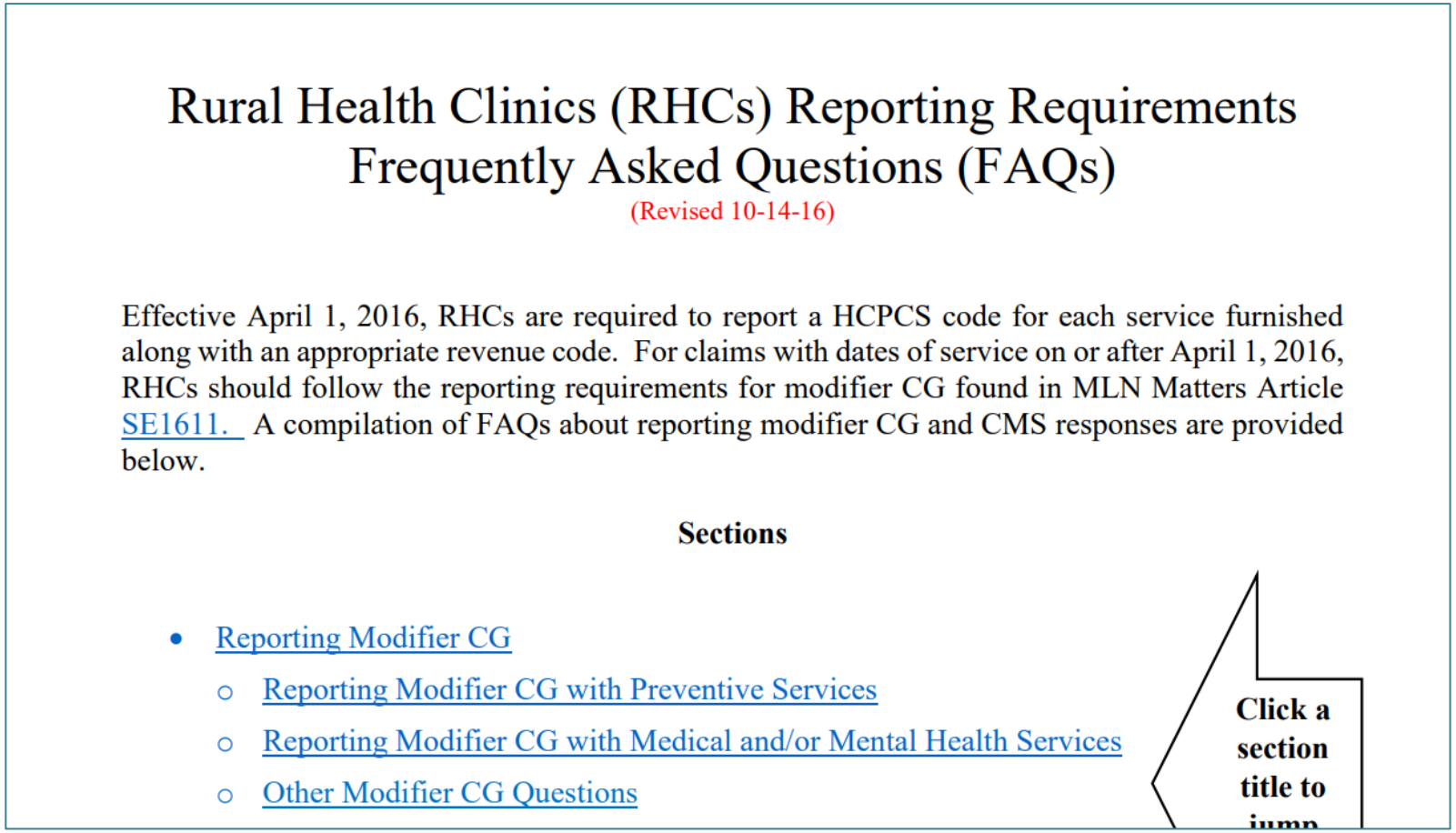
FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 **CG**	11/1/2022	1	250.00
0521	I & D Abscess	10160	11/1/2022	1	150.00
0001	Total Charge				400.00

★ Charges are rolled up or summed to the –CG line. Only this line is processed. Deductible and coinsurance amounts are calculated from this line only.

Provider performed an E & M service ($100) and an in-office procedure ($150.00) during the same visit. The supplies and local anesthesia would be integral to the procedure. The patient would be responsible for a $50.00 co-insurance payment. The total 001 line appears overstated.

The –CG line is the “encounter” line. Everything is calculated from it.

-CG Modifier FAQ Document



Rural Health Clinics (RHCs) Reporting Requirements
Frequently Asked Questions (FAQs)

(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

Sections

- Reporting Modifier CG
  - Reporting Modifier CG with Preventive Services
  - Reporting Modifier CG with Medical and/or Mental Health Services
  - Other Modifier CG Questions

Click a section title to jump

https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/rhc-reporting-faqs.pdf

Do you need the –CG Modifier?

YES OR NO	Reporting this type of service
YES	On the qualifying visit/roll up line reporting an RHC encounter with a face to face with the provider.
YES	On both the medical QV line and the mental health QV line when both occur on the same day in person. (Two –CG lines on claim exception, lines do not roll up, pays 2 AIR)
YES	On a mental health encounter when performed by telehealth. Other modifiers required also.
YES	On the medical visit QV line when performed with a qualified preventive service. The preventive service is not rolled up to the –CG line. No –CG is appended to the preventive service.
NO	On any service which does NOT pay the AIR; any service which pays a consolidated fee schedule amount; Examples: care management, medical telehealth, virtual communication services.
YES	When a preventive service is the ONLY service performed. If more than one preventive service is performed, then the –CG should be appended to the primary service.
NO	On a second unrelated, unscheduled visit on the same day as an earlier planned service. Modifier -59 is appended to the second encounter.
	On Medicare Advantage claims WHEN the billing instructions required a –CG modifier.

RHC Encounter: Medical Visit and Mental Health Visit on Same Date of Service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV New	99204 CG	11/01/2021	1	175.00
0900	Psych Eval	90791 CG	11/01/2021	1	200.00
0001	Total Charge				375.00

The physician performed an sick visit ($175) and the behavioral health provider performed a psych eval ($200) on the same date of service. Both services would be reported separately with the –CG modifier. Total RHC services would be $375.00. The patient would be responsible for a $75.00 coinsurance.

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RHC Encounter: IPPE and Sick Visit on same date of service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2022	1	150.00
0521	IPPE	G0402	11/01/2022	1	200.00
0001	Total Charge				350.00

The physician performed IPPE ($200) and an E & M ($150) for a problem visit on the same date of service. **The office visit for the problem visit is listed first with the -CG modifier**. The patient has no cost share for the IPPE service because the deductible and co-insurance is waived. The co-insurance amount due for the sick visit is $30.00. **No roll-up. The RHC will receive two AIR payments for this visit.**

You should track all preventive services for cost-reporting purposes.

Sick Visit with AWV

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Sick Visit	99213 CG	11/01/2022	1	100.00
0521	**AWV-Subsequent**	G0439	11/01/2022	1	150.00
0001	Total Charge				250.00

- ***-CG goes on the E & M for the follow-up of chronic conditions***
- ***AWV is reported on a separate line and NOT rolled up because there is no coinsurance and deductible on the preventive service.***
- ***It may be the best medical management decision to do both services even if not separately reimbursed.***
- ***The AIR is paid. Only one AIR is paid.***
- ***The patient coinsurance is $20 for the 99213.***

Other Modifiers

- RHC claims to traditional Medicare will **not** typically use Modifier -25 or Modifier -59.
- Do NOT report -25 or -59 with the –CG modifier.
- Educate coders and providers on the use of RHC modifiers. Modifier use on Medicare claims does **NOT** follow conventional coding.
- -25 and -59 can create erroneous overpayments.
- -59 is only used to report the second unrelated RHC encounter that occurs on the same date of service. This visit is unrelated to the first visit and is unscheduled or not anticipated.
- Claim example on another slide.

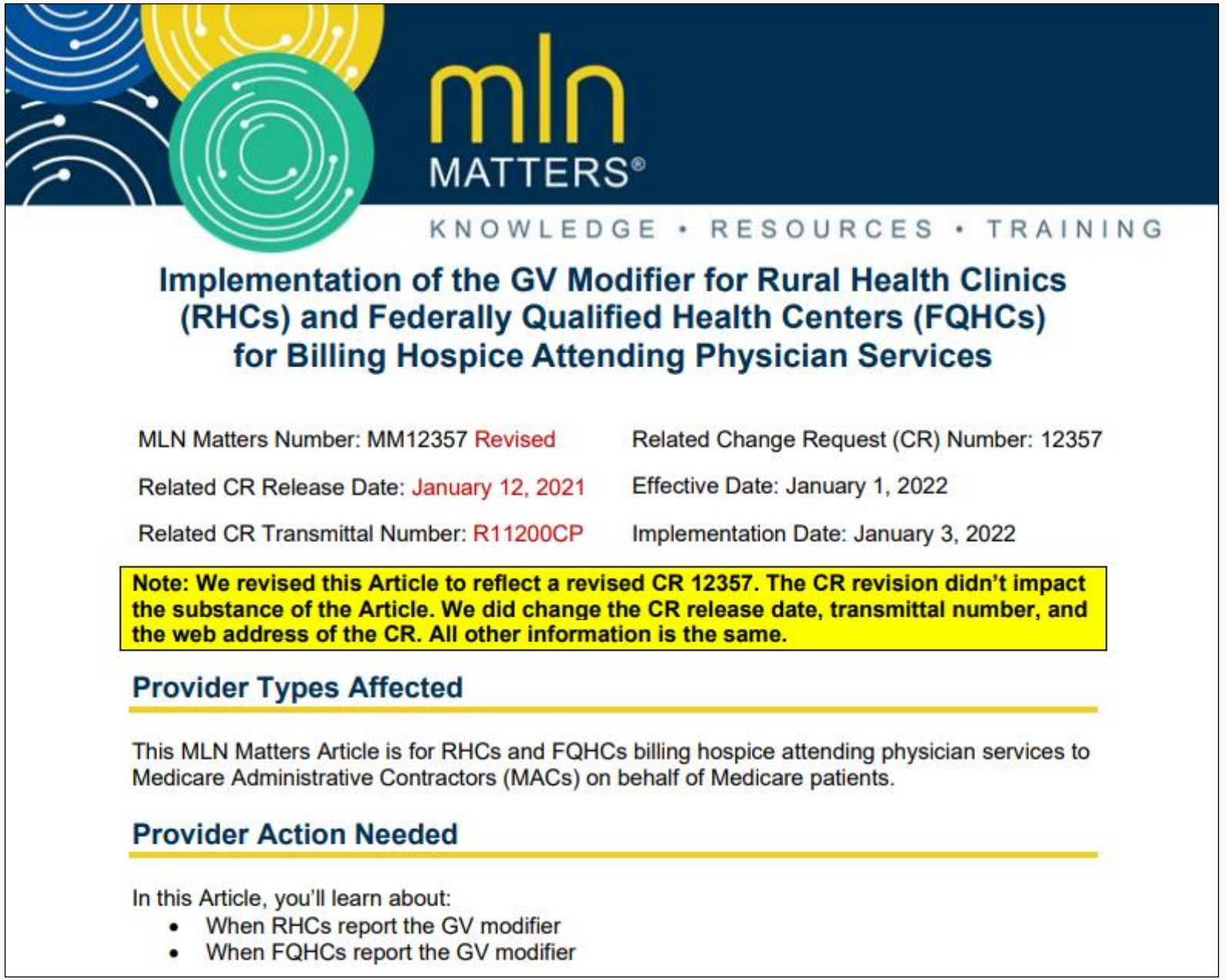
Billing Services to Hospice Patients in the RHC

Hospice Services by RHC Provider

- The 2022 final rule allowed RHC providers who are also the ***attending hospice physician*** to bill hospice professional services as RHC encounters.
- RHC claims will be appended with both the –CG modifier and the new –GV modifier. Appropriate revenue codes are used to reflect the location of the encounter.

Services not related to Hospice Admission

- Non-hospice related services provided by regular RHC practitioners would be billed as they currently are with the 07 condition code and –GW modifier with a non-hospice diagnosis.
- Coinsurance and deductible amounts apply.



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Incident-to Services
Incident-to-Physician Billing

- **Incident-to** means professional services provided subsequent to or related to a current or previous encounter. This would include nursing services, use of supplies, administration of medications, etc. These services are incident-to or included in the reimbursement for the original RHC encounter. These are benefits but are not separately reportable or reimbursable.
  - Examples: Nurse visit for a blood pressure check; an injection only service, an uncomplicated bandage change or suture removal.

- **Billing incident to a physician** means that the NP or PA is billing under the physician's NPI for continuation of a treatment plan which the physician initiated. The patient is established with an established problem for which the mid-level provider is not exercising any independent medical decision-making. The physician provider must be present in the suite. For RHC providers, there is no benefit for billing incident-to a physician since all providers are reimbursed the same AIR. All providers should be billed under their own NPIs, be enrolled with payers and be working at the top of their license to optimize the RHC model.

TRADITIONAL MEDICARE IMMUNIZATIONS IN THE RHC

- Flu, Pneumococcal, and COVID Vaccines are NEVER reported on the UB-04 Claim, not even at .01. NEVER. This is one of the most common billing errors reported by the MACs. If you need to track them to reconcile them to your logs, use a code that is set not to be billed in your system.
- Hep B is included as incident-to the encounter. It is reported on the claim, but no additional reimbursement is received.
- Tetanus given when treating an acute injury can be include on the RHC claim. Routine tetanus is Part D benefit.
- All other adult immunizations are Part D benefits.
- If you use a 3rd party vaccine management vendor or a 3rd party vaccine biller, please let your cost report preparer know.

SERVICES BILLED ON THE UB-04 WHICH DO NOT REQUIRE A FACE-TO-FACE

WITH EXAMPLES

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Exceptions to the Face-to-Face Encounter Requirement

- Care Management and Care Coordination Services (G0511)
  - Chronic Care Management
  - Principal Care Management
  - Chronic Pain Care Management
  - BHI
  - CHI and PCN
- Psychiatric Coordination of Care (G0512)
- Virtual Communication Services(G0071)
- Medical Distant Site Telehealth (G2025)
- Intensive Outpatient Programs (new for 2024)

These services are NOT reimbursed at the AIR. They are reimbursed at a composite FFS amount with RHC specific HCPCS Codes. These allowable amount are updated annually.

No –CG Modifier if the service does not reimburse at the AIR.

RHC Rates for Non-encounter services

HCPCS CODE	Description	2023	2024
G0511	Chronic Care Management, Principal Care Management; Chronic Pain Care Management; Remote Patient Monitoring, CHI and PNI	$77.94	$72.98
G0512	Psychiatric Coordination of Care Management	$146.73	-reduction in fee schedule factor
G0071	Virtual Communication Services	$13.22	
G2025	Distant Site Medical Telehealth through 12/31/24	$98.27	

Example of CCM Billing

CCM Reported Alone

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	CCM	G0511	02/01/2021	1	75.00
0001	Total Charge				75.00

The –CG Modifier is NOT appended to G0511 because the service is paid under fee-for-service reimbursement. Deductibles and co-insurance apply. **The 2023 rate for G0511 is $77.24. For 2024, $72.98. New guidance for billing multiple units of G0511 expected in 2024.**

The patient's coinsurance will be 20% of the allowable.

Example of CCM Billed with an Encounter

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213-CG	02/28/2021	1	100.00
0521	CCM	G0511	02/28/2021	1	75.00
0001	Total Charge				175.00

If CCM is billed with another RHC service, the charge for CCM is NOT added to the first line. The –CG modifier is only added on the first line. The clinic will receive the RHC all-inclusive rate for the office visit/encounter and the current fee schedule amount for the CCM. The coinsurance will be $20.00 for the office visit plus 20% of the allowable for G0511. It is important to explain to the patient the value of the CCM when enrolling them.

TELEMEDICINE BILLING FOR 2024

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RHC Distant Site Medical Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	05/15/2022	1	100.00
0001	Total Charge				100.00

Optional

Effective January 1, 2023, the payment rate for distant site medical telehealth services is $98.27. The 2024 rate for G2025 will be decreased as a result of a reduction in the conversion factor. G2025 is reported on the UB-04 claim.

Add the -CS Modifier if G2025 is reporting a preventive service that would not be subject to deductible and coinsurance. CMS has corrected the denials for the –CS modifiers

No –CG Modifier since this does not reimburse at the AIR. Not an encounter.

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

MLN Matters Number: SE20016 Revised

Related Change Request (CR) Number: N/A

Article Release Date: January 13, 2022

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

Beginning July 1, 2020, you should no longer put the CG modifier on claims with HCPCS code G2025.

Table 1. RHC Claims for Telehealth Services from January 27 – June 30, 2020

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

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

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

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CMS Telemedicine Codes
https://www.cms.gov/medicare/coverage/telehealth/list-services

LIST OF MEDICARE TELEHEALTH SERVICES		effective January 1, 2023 - updated May 9, 2023	
Code	Short Descriptor	Can Audio-only Interaction Meet the Requirements	Medicare Payment Limitations
99202	Office/outpatient visit new		
99203	Office/outpatient visit new		
99204	Office/outpatient visit new		
99205	Office/outpatient visit new		
99211	Office/outpatient visit est		
99212	Office/outpatient visit est		
99213	Office/outpatient visit est		
99214	Office/outpatient visit est		
99215	Office/outpatient visit est		

Cannot be audio only

This list is not RHC-specific. It is for all provider types.

CMS Telemedicine Codes
https://www.cms.gov/medicare/coverage/telehealth/list-services

LIST OF MEDICARE TELEHEALTH SERVICES		effective January 1, 2023 - updated May 9, 2023	
Code	Short Descriptor	Can Audio-only Interaction Meet the Requirements	Medicare Payment Limitations
G0427	Inpt/ed teleconsult70	Yes	
G0438	Ppps, initial visit	Yes	
G0439	Ppps, subseq visit	Yes	
G0442	Annual alcohol screen 15 min	Yes	
G0443	Brief alcohol misuse counsel	Yes	
G0444	Depression screen annual	Yes	
G0445	High inten beh couns std 30m	Yes	
G0446	Intens behave ther cardio dx	Yes	
G0447	Behavior counsel obesity 15m	Yes	
G0459	Telehealth inpt pharm mgmt	Yes	
G0506	Comp asses care plan ccm svc	Yes	

Can be audio only

This list is not RHC-specific. It is for all provider types.

Mental Health Telehealth Example

These visits are different from telehealth services provided during the Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See MLN Matters Article SE20016 for information on billing G2025 for professional telehealth distant site services other than mental health visits during the PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 Revised on 05/05/2022 : -CG now required
- Is an encounter; pays at the AIR.

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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 5, 2022
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Note: We revised this Article to show that RHCs must include modifier CG on claims for mental health visits via telecommunications. This change is in dark red font on page 2. All other information is the same.

MEDICARE SECONDARY PAYER CLAIMS

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

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(Rev. 11874, 02-23-23)

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10.1.1 - Right of Providers to Charge Beneficiary Who Has Received Primary Payment from a GHP

10.1.2 - Right of Physicians and Other Suppliers to Charge Beneficiary Who Has Received Primary Payment from a GHP

10.1.3 - Payment When *a* Proper Claim is Not Filed

10.2 - Situations in Which MSP Billing Applies

10.3 – Provider, Physician, and Other Supplier Responsibility When a Request is Received *f*rom an Insurance Company or Attorney

10.4 – Provider, Physician, and Other Supplier Responsibility When Duplicate Payments Are Received

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c03.pdf

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50 - Summary of MSP Data Elements for *the* Form CMS-1450 (UB-*04*)

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

The following table identifies the data elements that are submitted on bills to communicate the status of the primary payer and payment where Medicare is the secondary payer. See Medicare Claims Processing Manual *100-04*, Chapter 25, "Completing and Processing *the Form CMS -1450* Data Set," for a crosswalk to the electronic data elements or segment names.

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https://www.ngsmedicare.com/documents/20124/121705/2426_0923_msp_billing_examples_508.pdf/1c4967ef-09e2-05ef-1385-e1c285f278c1?t=1694717480362

MSP Condition Codes

These codes communicate the circumstance (condition)which created the MSP Claim.

Examples of these condition codes include but are not limited to:

Condition Code	Circumstance
02	Employment Related
06	ESRD Beneficiary
77	Full Payment expected from Primary

MSP Occurrence Codes

These codes communicate the primary payer and the date of the admission/event. Examples include but are not limited to:

Occurrence Code	Details
01	Medical is primary and date of admission
02	No fault and date of admission
03	Liability and date of admission
04	WC and date of admission

Value Codes

Value Codes and Amounts

12- Working Aged Beneficiary/Spouse Group Health Plan	Working Aged
13-ESRD Beneficiary in a Medicare Coordination Period with an Employer Health Plan	ESRD
14-No-fault, including auto/other.	No-Fault
15-Workers' Compensation Six zeros in the amount field indicates a request for a conditional Medicare payment.	WC
16-PHS, Other Federal Agency	Other Federal Agency, VA
41-Black Lung Six zeros in the amount field indicates a request for a conditional Medicare payment.	Black Lung
42-Veterans Affairs	VA
43-Disabled Beneficiary Under Age 65 with GHP	Disability
44-Amount Provider Agreed to Accept from Primary Payer as Payment in Full	All MSP Provisions
47- Any Liability Insurance	Liability Provisions

Questions/Discussion

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