# RHC Billing Test Lunch and Learn
# Healthcare Business Specialists
# December 13, 2023

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# MEET OUR TEAM

Healthcare Business Specialists offers a variety of services designed to assist physician practices and RHCs in providing better primary medical services to underserved, rural residents by enhancing Medicare and Medicaid Reimbursement and staying compliant with Rural Health Clinic program requirements.

Through cost reporting preparation, program evaluations, RHC startups and conversions, Emergency Preparedness Compliance, CHOWs, RHC terminations, and feasibility studies, Healthcare Business Specialists is equipped to serve all your RHC needs.

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# HBS Services

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## SERVICES

RHC COST REPORTING


RHC PROGRAM EVALUATIONS


RHC STARTUPS & CONVERSIONS


EMERGENCY PREPAREDNESS COMPLIANCE

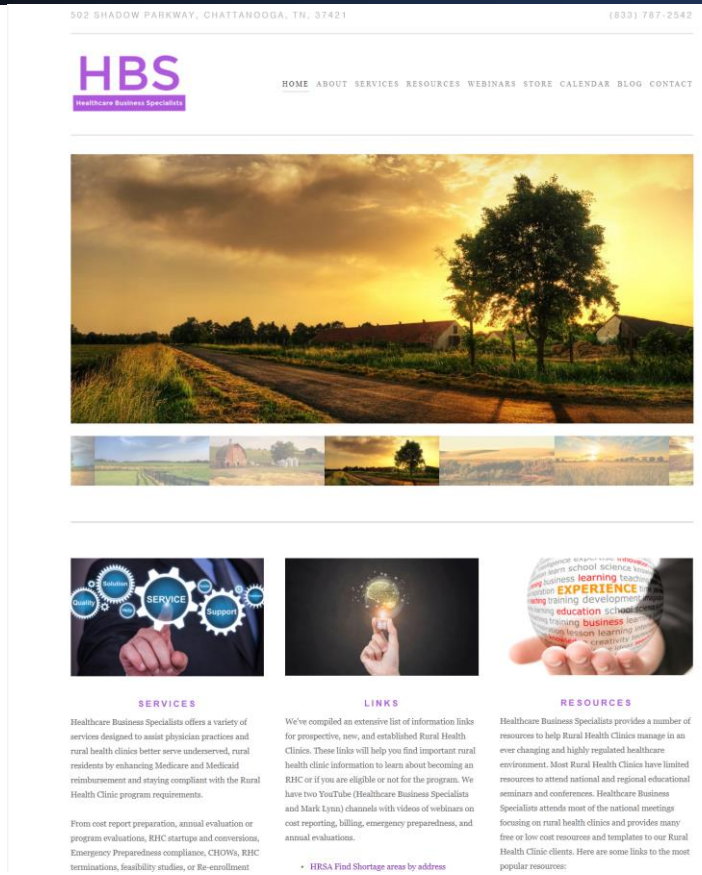
TENNCARE QUARTERLY REPORTING

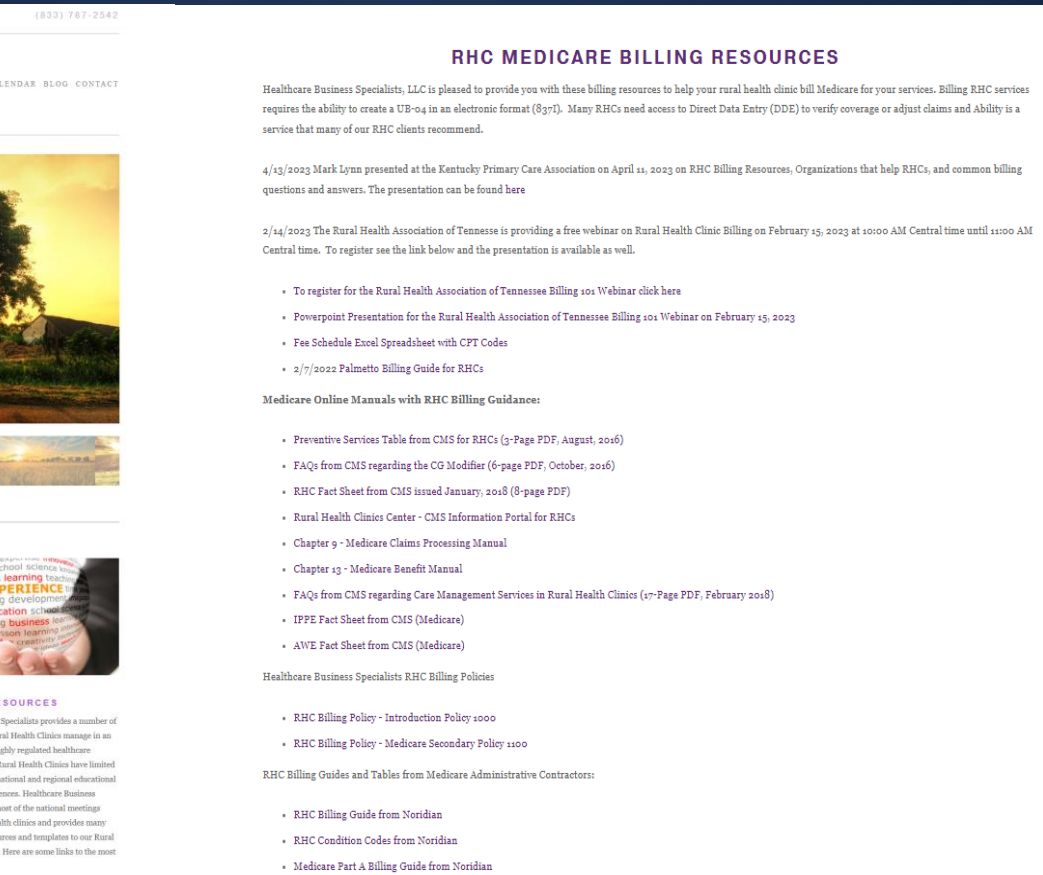
FOR MORE INFORMATION: 833-787-2542 | www.ruralhealthclinic.com


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/

# Healthcare Business Specialists Website



## RHC MEDICARE BILLING RESOURCES

Healthcare Business Specialists, LLC is pleased to provide you with these billing resources to help your rural health clinic bill Medicare for your services. Billing RHC services requires the ability to create a UB-04 in an electronic format (837I). Many RHCs need access to Direct Data Entry (DDE) to verify coverage or adjust claims and Ability is a service that many of our RHC clients recommend.

4/13/2023 Mark Lynn presented at the Kentucky Primary Care Association on April 11, 2023 on RHC Billing Resources, Organizations that help RHCs, and common billing questions and answers. The presentation can be found here

2/14/2023 The Rural Health Association of Tennesse is providing a free webinar on Rural Health Clinic Billing on February 15, 2023 at 10:00 AM Central time until 11:00 AM Central time. To register see the link below and the presentation is available as well.

- To register for the Rural Health Association of Tennessee Billing 101 Webinar click here
- Powerpoint Presentation for the Rural Health Association of Tennessee Billing 101 Webinar on February 15, 2023
- Fee Schedule Excel Spreadsheet with CPT Codes
- 2/7/2022 Palmetto Billing Guide for RHCs

**Medicare Online Manuals with RHC Billing Guidance:**

- Preventive Services Table from CMS for RHCs (3-Page PDF, August, 2016)
- FAQs from CMS regarding the CG Modifier (6-page PDF, October, 2016)
- RHC Fact Sheet from CMS issued January, 2018 (8-page PDF)
- Rural Health Clinics Center - CMS Information Portal for RHCs
- Chapter 9 - Medicare Claims Processing Manual
- Chapter 13 - Medicare Benefit Manual
- FAQs from CMS regarding Care Management Services in Rural Health Clinics (17-Page PDF, February 2018)
- IPPE Fact Sheet from CMS (Medicare)
- AWE Fact Sheet from CMS (Medicare)

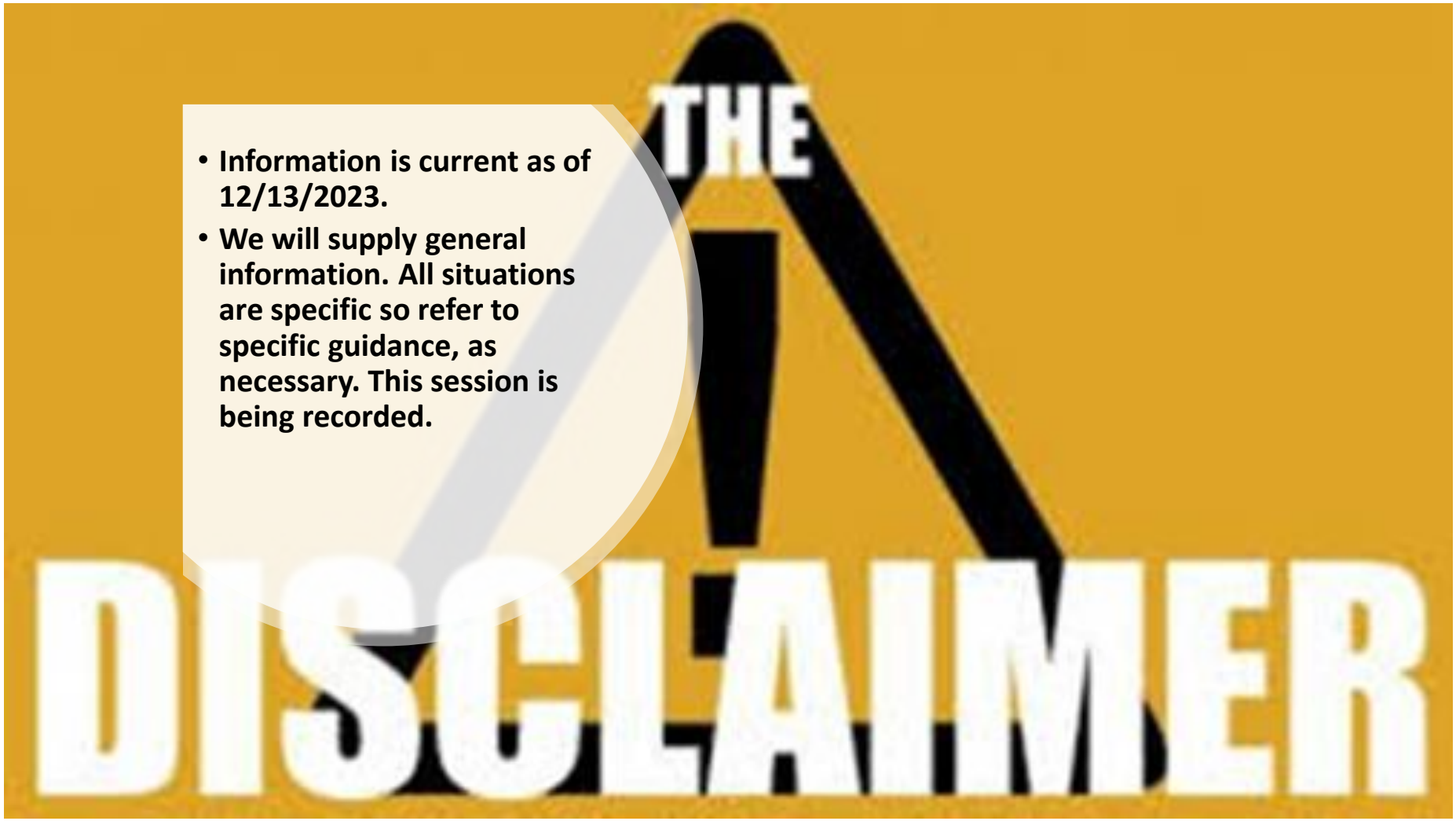
Healthcare Business Specialists RHC Billing Policies

- RHC Billing Policy - Introduction Policy 1000
- RHC Billing Policy - Medicare Secondary Policy 1100

RHC Billing Guides and Tables from Medicare Administrative Contractors:

- RHC Billing Guide from Noridian
- RHC Condition Codes from Noridian
- Medicare Part A Billing Guide from Noridian

http://www.ruralhealthclinic.com/




- **Information is current as of 12/13/2023.**
- **We will supply general information. All situations are specific so refer to specific guidance, as necessary. This session is being recorded.**

# Pre-Test

## Check your progress!

# 1. Billing and Coding are the same thing.

A. True

B. False

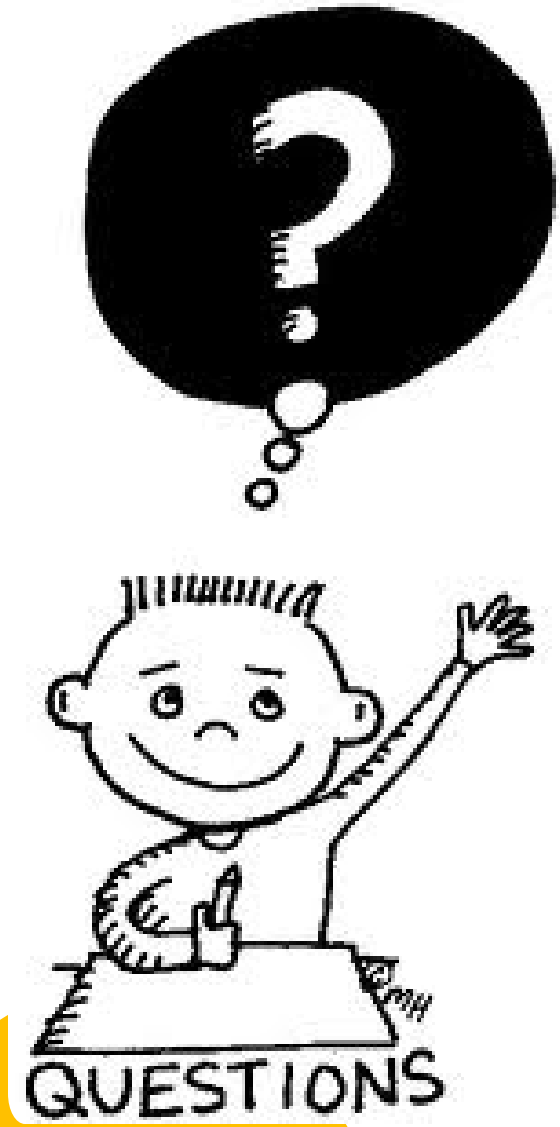
# Billing and Coding are not the same thing

| Description | Coding | Billing |
|---|---|---|
| Creator | AMA | CMS |
| Types of Codes<br>*ICD-10-CM (AMA/AHA/CMS/ NCHS) Why did you perform the service? Do you have current coding guidelines?* | CPT Codes – Current Procedural Terminology (What did you do) | HCPCS II Codes<br>Healthcare Common Procedure Coding System (What you did and what supplies were used) |
| Definition | It was designed to describe medical, surgical, and diagnostic services accurately. It is also used as a form of uniform communication among physicians, coders, patients, accreditation organizations, and those who pay for administrative, financial, and analytical purposes about certain medical procedures and services. | is a set of health care procedure codes based on CPT. It was designed to provide a standardized coding system in order to describe specific items and services that are provided when health care is delivered. It is a necessary form of coding for anyone who carries Medicare, Medicaid, and other health insurance programs in order to ensure that insurance claims are processed efficiently. |
| Example: | An RHC provides a 99213 via telehealth. The CPT Code is 99213. | The 99213 converts to a G2025 when billed to Medicare plus any required modifiers (CG/95/FQ) |
| Responsibility | Physicians, NPs, PAs, providers, Coders | Billers, Office Manager, CFO, Administrator |

# Billing and Coding Crosswalk Cheat Sheet

| Service | Example Coding CPT | Example Billing HCPCS | Payment | Cost Report Visit? | Allowable Medicare Cost? | Notes |
|---|---|---|---|---|---|---|
| Medicaid Visit (in some states) | 99213 (QVL) | T1015 | AIR | Yes | Yes | Only count 1 visit on your RHC Cost Report |
| Telehealth Visit | 99213 | G2025 | $98.27 | No | No | Medicaid may pay AIR |
| Mental Telehealth Visit (starting in 2022) | 90834 | 90834 CG 95 | AIR | Yes | Yes | Keep records on the costs of two different types of telehealth visits |
| Virtual Communication Services (G0071) | 99421 | G0071 | $23.72 | No | No | Exclude cost on cost report. |
| Chronic Care Management | 99484 | G0511 | 77.94 | No | No | Exclude cost on cost report. |

Note: The CPT Code column is not an all-inclusive list of CPT codes.




2. Rural Health Clinic Status directly impacts payments from the following:

A. Medicare

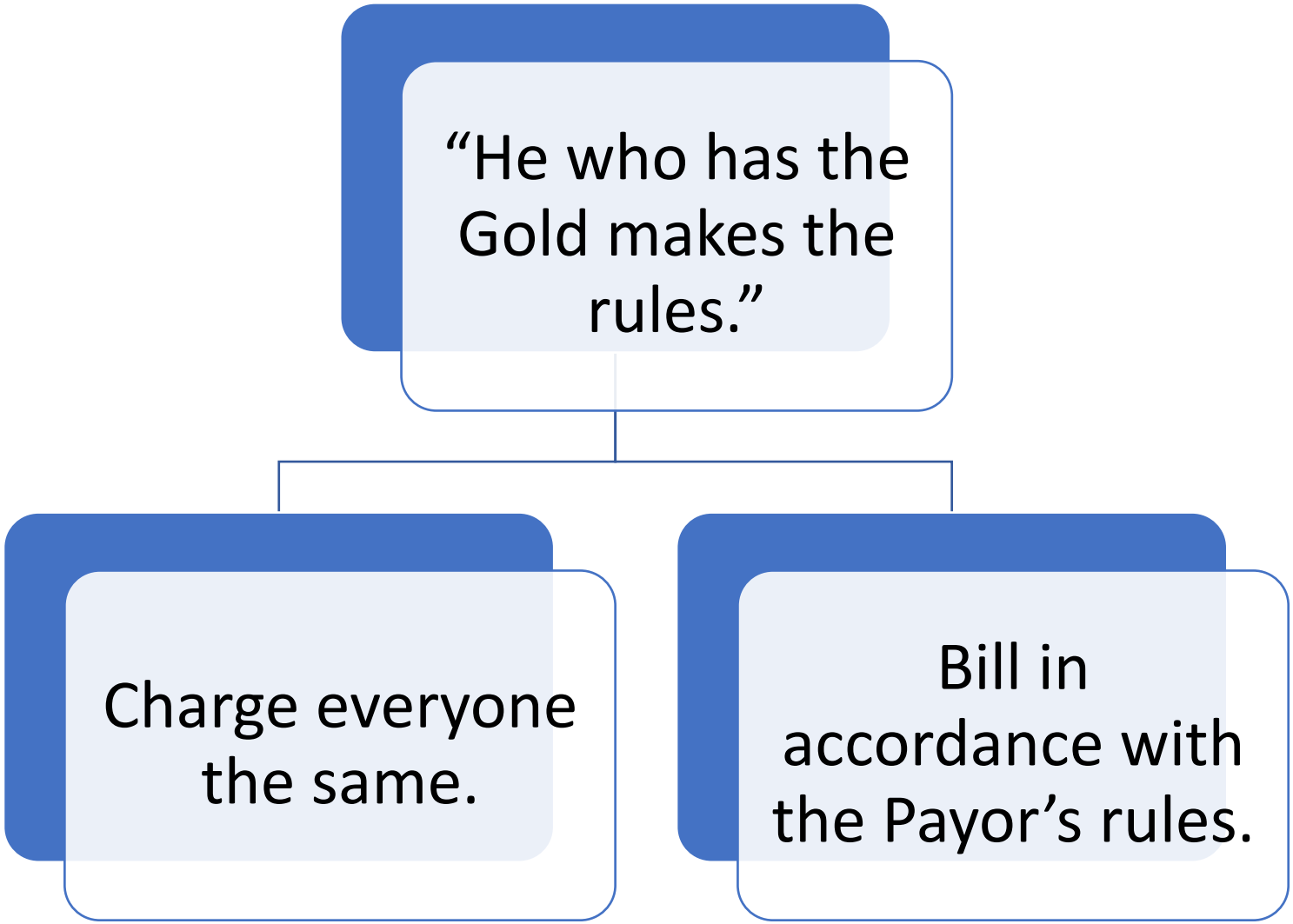
B. Medicaid

C. All Payers

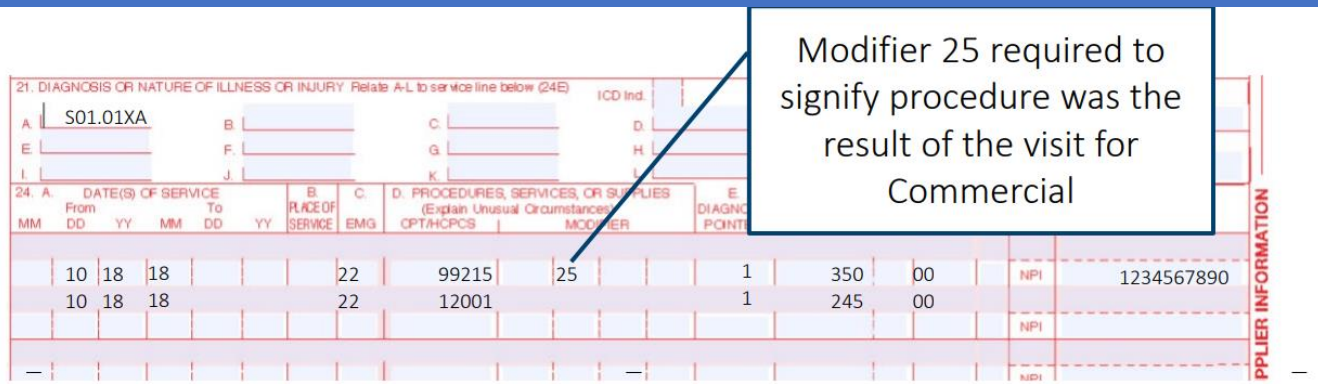
D. Medicare and Medicaid

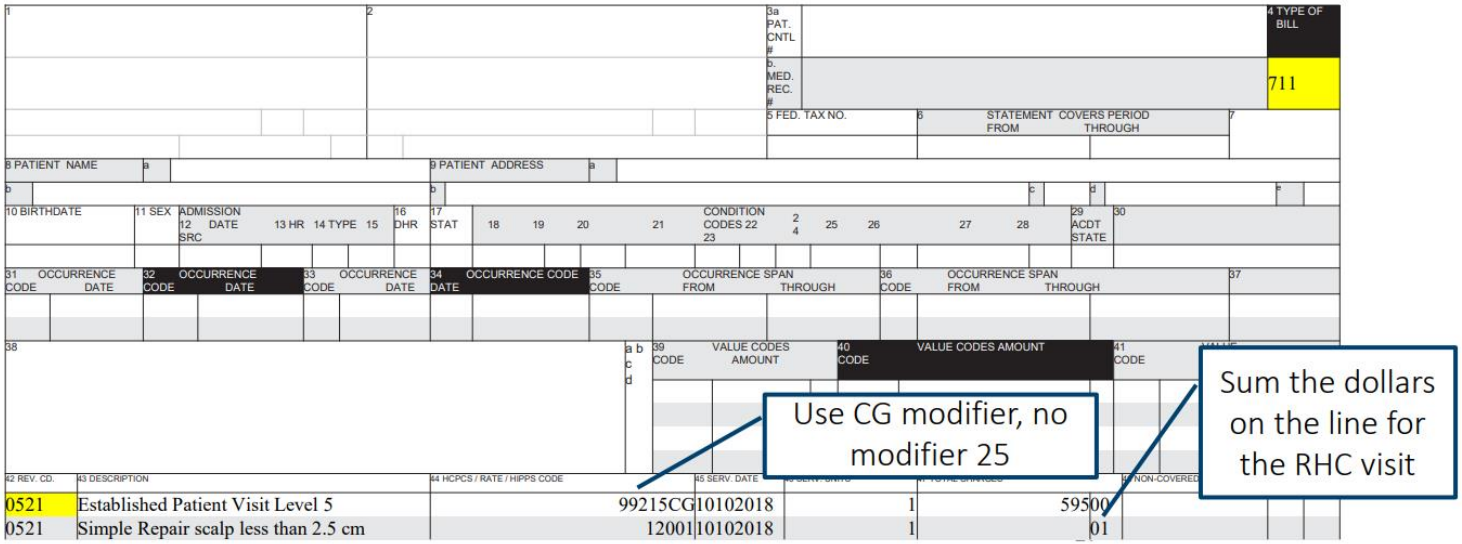
RHC Status only affects reimbursement from Medicare and Medicaid. Most Medicare Advantage plans do not recognize RHC status, but some do. Reach out to them and ask.

# The Golden Rule



# The Difference between Commercial and RHC Billing
# Modifier 25 and 59 are rarely used in RHC Medicare Billing



# Subject: Incident to

**Question: If the service is not on eligible visit list (QVL), then what?**

**Answer: First the QVL is not definitive, so the service may still qualify for AIR payment. If it does qualify for AIR payment hold the charges and bill them incident to within a medically reasonable amount of time (30 days).**

3. RHCs bill Medicare RHC claims for RHC covered services using the following Claim Form?

A. 1500

B. UB-04

RHCs use the Form CMS-1450 (UB-04) or 837 Institutional to bill Medicare for RHC Services

- **https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/837i-formcms-1450-icn006926.pdf**


**https://www.nubc.org/**

# National Uniform Billing Committee (NUBC) Codes

- The 837I and CMS-1450 also require codes maintained by the NUBC including:
- ● Condition codes
- ● Occurrence codes
- ● Occurrence span codes
- ● Value codes
- ● Revenue codes
- ● Type of bill
- ● Discharge status
- ● Point of origin
- ● Type of visit
- More information is available to subscribers of the NUBC Official UB-04 Data Specifications Manual. To subscribe go to the NUBC website.

# National Uniform Billing Committee
# https://www.nubc.org/

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National Uniform Billing Committee

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## Welcome to the Website of the National Uniform Billing Committee

### Your official source for news and information on the NUBC

Our goal is to achieve administrative simplification as outlined in the Heath Insurance Portability and Accountability Act of 1996. We actively engage the health care community in the discussion of the issues.

You can access the UB-04 billing information adopted by the NUBC by subscribing to the Official UB-04 Data Specifications Manual. This manual, copyrighted by the American Hospital Association, is the only official source of UB Data. No other publication — governmental or private/commercial — can be considered authoritative.

Learn More

### Announcements

**NUBC Public Meeting August 8th and 9th**
Jul 6, 2023
NUBC August 2023 Agenda

**NUBC Letter to Optum on Revenue Code 0761**
Jul 6, 2023
NUBC Letter to Optum on Revenue Code 0761

### Become a Subscriber

Receive updates on the latest deliberations and manual instructions.


### UB-04 Licensing

Access the Official UB-04 Data File containing the complete set of codes.


### Upcoming Events

Independent RHCs use the Form CMS-1500 (837P) to bill Medicare for Labs, technical components, and hospital services.

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/837p-cms-1500.pdf

mln FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

## Medicare Billing: 837P & Form CMS-1500

# 4. RHCs should charge:

A. Only the RHC reimbursement rate to Medicare and Medicaid

B. All payors using the same chargemaster

C. All payors the same chargemaster except indigent patients

D. Using a sliding fee schedule

# Charge Example

I recommend 150 to 200 percent of the Medicare Fee Schedule.

For example, 150% = $130  (85.59 *1.5) and 200% = $170 (85.59*2). I would split the difference and charge $150.

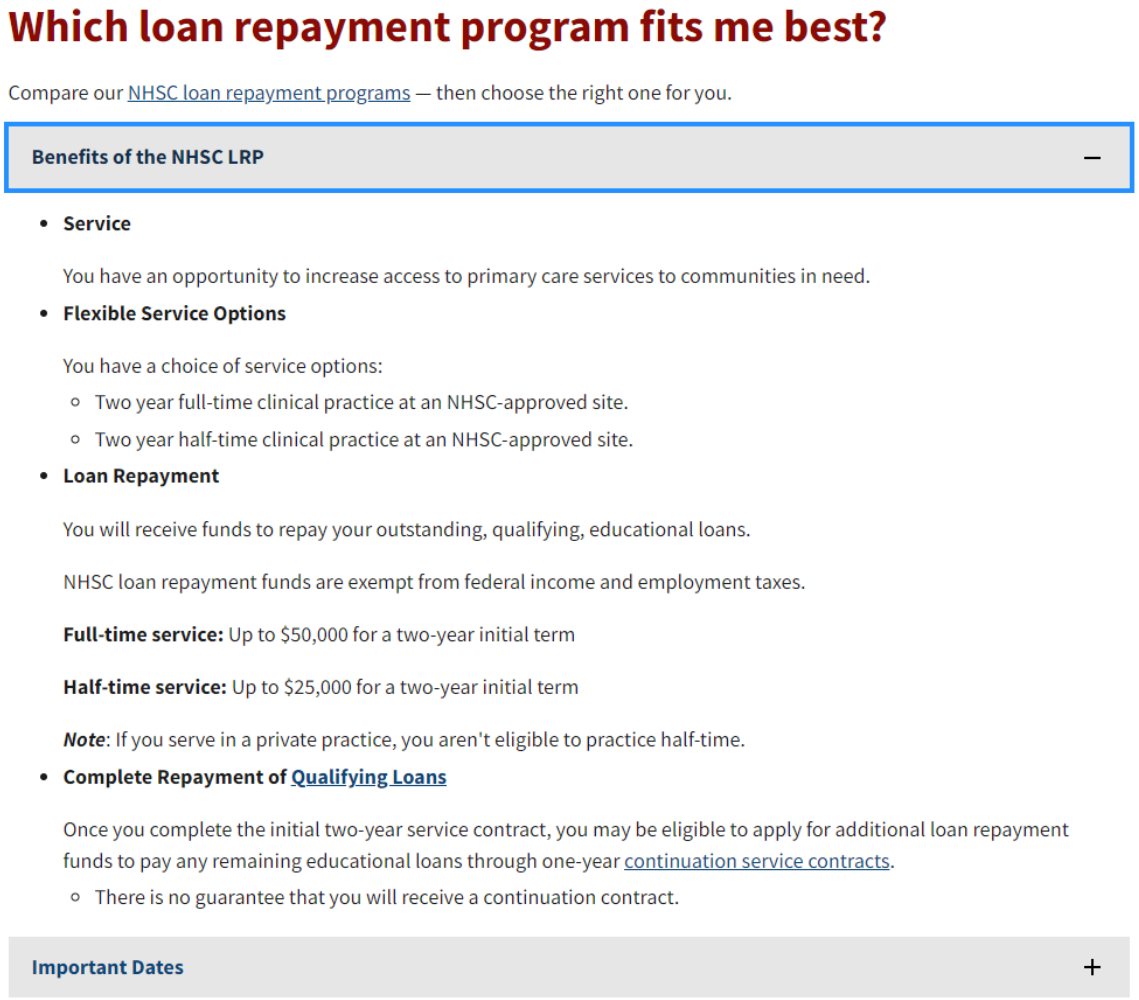
https://www.palmettogba.com/palmetto/fees_front.nsf/fee_main?OpenForm

| | | | |
|---|---|---|---|
| **Effective Date:** | 01/01/2022 | **Locality:** | 35 |
| **State:** | Tennessee | **Modifier:** | |
| **Procedure Code** | 99213 | | |

| Fees | Non-Facility | Facility | OPPS Cap Non-Facility | OPPS Cap Facility | Reduced Therapy |
|---|---|---|---|---|---|
| **Participating Amount:** | $85.59 | $63.67 | $0.00 | $0.00 | $37.96 |
| **Non-Participating Amount:** | $81.31 | $60.49 | $0.00 | $0.00 | $0.00 |
| **Limiting Charge Amount:** | $93.51 | $69.56 | $0.00 | $0.00 | $0.00 |

**RHCs can have a sliding fee schedule**

# RHCs do qualify for loan repayment for providers from NHSC – Sliding Fee Schedule Required



## Which loan repayment program fits me best?

Compare our NHSC loan repayment programs — then choose the right one for you.

**Benefits of the NHSC LRP** −

- **Service**

  You have an opportunity to increase access to primary care services to communities in need.
- **Flexible Service Options**

  You have a choice of service options:
  - Two year full-time clinical practice at an NHSC-approved site.
  - Two year half-time clinical practice at an NHSC-approved site.
- **Loan Repayment**

  You will receive funds to repay your outstanding, qualifying, educational loans.

  NHSC loan repayment funds are exempt from federal income and employment taxes.

  **Full-time service:** Up to $50,000 for a two-year initial term

  **Half-time service:** Up to $25,000 for a two-year initial term

  ***Note***: If you serve in a private practice, you aren't eligible to practice half-time.
- **Complete Repayment of Qualifying Loans**

  Once you complete the initial two-year service contract, you may be eligible to apply for additional loan repayment funds to pay any remaining educational loans through one-year continuation service contracts.
  - There is no guarantee that you will receive a continuation contract.

**Important Dates** +

- https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program

# 5. RHCs are paid an All-Inclusive Rate which pays for all Medicare services provided to the patient while at the RHC?

A. True

B. False

# The All-Inclusive Rate does not cover the following:

- Lab services (services except Venipuncture – CPT 36415)
- Technical components
- Hospital services
- Telehealth (except Mental Health Services starting in 2022)
- Chronic Care Management
- Principal Care Management

**Note: The six required lab services are not covered under the RHC benefit.**

# Types of Services Provided in an RHC

| UB-04 | 1500 | Cost Report |
|---|---|---|
| **Part of the All-Inclusive Rate (AIR) Calculation** | **Not Part of the All-Inclusive Rate Calculation** | **Pass-though Costs paid above the AIR** |
| Office Visits | Laboratory Services (except 36415) | Influenza Vaccinations |
| Incident-to Services | Hospital Services & Chronic Care Management | Pneumococcal Vaccinations |
| Mental Health Telehealth Visits | Telehealth Visits (medical, not mental health) | Covid-19 Vaccinations & MABS |
| Lab Draws (36415) | Private Practice Time (Non-RHC hours) | Bad Debts |
| Radiology Services (Professional Portion) | Radiology Services (Technical Portion) | Graduate Medical Education |

6. How much will Medicare Pay the RHC for a 99214 with a charge of $200 if the clinic has an AIR of $126 (the National Statutory Limit)

A. 200

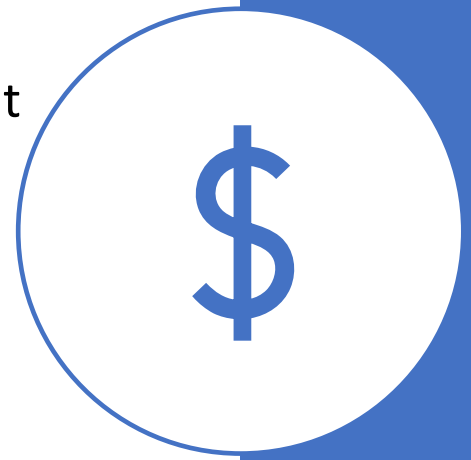
B. 126

C. 99

D. 139

# Answer: $99

- Medicare pays 80% of the AIR minus a 2% sequestration (78.4%).
- The AIR is $126 X .784 = $98.78 is the exact amount Medicare will pay.
- The RHC can collect $40 from the patient which is calculated at $200 X 20%. (Limiting charges do not apply)
- The RHC will collect in total $139 from Medicare and the patient and the balance ($61) will be written off as a Medicare contractual adjustment. (you can not balance bill Medicare patients)



# Posting the Medicare Payment

| Charge | Copay (20% of Charge) | Medicare Interim Rate | Sequester | Medicare Payment |
|---|---|---|---|---|
| 200 | 40 | 126 | 2% | 99 |

## How to Post Patient Charge to AR

| Account | Debit | Credit |
|---|---|---|
| Charges | | 200 |
| Patient Receivable | 200 | |

## How to Post Medicare Payment

| Account | Debit | Credit |
|---|---|---|
| Contractual Adjustments | 61 | |
| Medicare Payable/Cash | 99 | |
| Patient Receivable | | 160 |

**Patient will owe $40**

7. To Bill Medicare RHCs must always have a Face-to-Face encounter.

A. True

B. False

Examples of Medicare Services that do not require a Face-to-Face Encounter:

Telehealth Service

Chronic Care Management

Principal Care Management

# What is a Face-to-Face Encounter

**40 - RHC and FQHC Visits**

***(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)***

An RHC or FQHC 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. *However, effective January 1, 2022, a mental health visit is a face-to-face encounter or an encounter furnished using*

*interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder.* A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

**Source: Chapter 13 Medicare Benefits Manual**

# Requirements for RHCs to bill a Face-to Face Encounter

- Must be Face-to-Face with a provider (MD/DO/NP/PA/CSW/CP)
- Must be medically necessary
- Must be within the scope of practice of the provider
- Must require the skill of a that provider
- Should be on the QVL

# 8. For an RHC to bill an encounter to Medicare and receive the All-Inclusive Rate the encounter must be located on the published Qualifying Visit List (QVL) ?

A. True

B. False

The published Qualifying Visit List is no longer updated!!!

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

## Rural Health Clinic Qualifying Visit List (RHC QVL)

*(8-01-16)*

The RHC QVL is intended as guidance for RHCs beginning to report HCPCS codes. It consists of frequently reported Healthcare Common Procedure Coding System (HCPCS) codes that qualify as a face-to-face visit between the patient and an RHC practitioner and it is not an all-inclusive list of stand-alone billable visits for RHCs. More information on what is considered a RHC visit is included in the "RHC Visits" section of this guidance.

In this update to the QVL, *HCPCS code G0490 has been added as a stand-alone billable visit effective October 1, 2016 and HCPCS codes G0436 and G0437 have been replaced with CPT codes 99406 and 99407 effective October 1, 2016.* See the table below and accompanying footnotes for more information. The billable visits shown in black below are both effective and payable as stand-alone services beginning with dates of service on or after April 1, 2016. The billable visits shown in red below are effective for dates of service on or after April 1, 2016, for claims and adjustments received on or after October 1, 2016. RHCs should hold claims solely for these billable visits (shown in red) until October 1, when RHCs can bill these claims for payment *with the CG modifier (explained below)*. For dates of service on or after October 1, 2016, a medically-necessary service not on the current QVL can be billed as a stand-alone billable visit if the service meets Medicare coverage requirements, is within the scope of the RHC benefit, and is not furnished incident to a physician's service.

NOTE: The use of a HCPCS code from the below QVL does not guarantee payment of the claim. All of the conditions for coverage and payment must be met for payment to be made. RHCs must retain adequate documentation of a patient's condition and the services furnished as part of the patient's medical record, which, along with the claim, may be subject to review by CMS, its contractors, or other oversight authorities.

**HCPCS Reporting Requirements**

For dates of service on or after April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with revenue code on their Medicare claims. Services furnished through March 31, 2016, are not required to be reported with HCPCS code and should be billed under the previous guidelines.

From April 1, 2016 through September 30, 2016, all charges for a visit must be reported on the service line with the qualifying visit HCPCS code, minus any charges for preventive services using revenue code 052x for medical services and/or revenue code 0900 for mental health services. RHCs are allowed to report additional 052x or 0900 revenue code lines. Beginning on October 1, 2016, the Medicare administrative contractors (MACs) will accept modifier CG (policy criteria applied) on RHC claims and adjustments. RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line, which includes all charges subject to coinsurance and deductible for the visit. Modifier CG should only be used to indicate which revenue code 052x and/or 0900 service line should receive the all-inclusive rate (AIR) and be subject to coinsurance and deductible. Each additional service furnished during the visit should be reported with charges greater to or equal to $0.01. The additional service lines are for informational purposes only. MACs will package/bundle the additional service lines, which do not receive the

9. An RHC must include a CG modifier on all claims for RHC covered services.

A. True

B. False

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

(Revised 10-14-16)

**Q7.** Is modifier CG reported with the initial preventive physical examination (IPPE) when it is billed alone or with other billable services on a claim?

**A7.** No. Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service.

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

10. The MSP payer questionnaire questions must be asked

A. Every visit

B. Annually

C. Every 90 days

# Medicare Secondary Payor Rules

Medicare Secondary Payer MLN Booklet

## Gathering Accurate Data

You must determine if Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter before submitting a Medicare claim. Ask patients about other coverage. Questions you ask help update patient insurance information and verify the patient's CWF record is correct and current.

CMS developed tools, including an MSP model questionnaire, Admissions Questions to Ask Medicare Beneficiaries, to help providers identify the correct primary claims payers for all patient hospital services provided. CMS electronic tools help identify and verify MSP situations. Get more information in Medicare Secondary Payer Manual, Chapter 3, Section 20 or contact your MAC.

Providers must keep completed MSP questionnaire copies and other MSP information for 10 years after the service date. You may keep hard copy files, optical images, microfilms, or microfiches. When storing these files online, keep negative and positive question responses.

- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf

# Medicare Secondary Payor Requirements

If you're an institutional provider, you should:

- Ask patients to update their insurance profiles at each visit. The updates include MSP information, like GHP information or NGHP coverage resulting from an injury or illness, before providing services.
- Incorporate patient responses to MSP questions and eligibility verification from the HETS 271 response transaction in your health records.
- Review or administer the MSP questions each time you treat or admit the patient.
- Identify all known primary payers to Medicare on the claim.
- Submit claims to the appropriate primary payer first.
- Submit MSP information to the MAC using proper claim condition, occurrence, and value codes (for providers using Form CMS-1450 or its electronic equivalent).
- Submit an explanation of benefits or remittance advice from any other insurers with all appropriate MSP information to the MAC on the hard copy claim. Provide the necessary information in the appropriate fields, loops, and segments required to process an 837I electronic MSP claim.
- Provide updated information to government agencies as appropriate.

**https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf**

# Medicare Secondary Fact Sheet

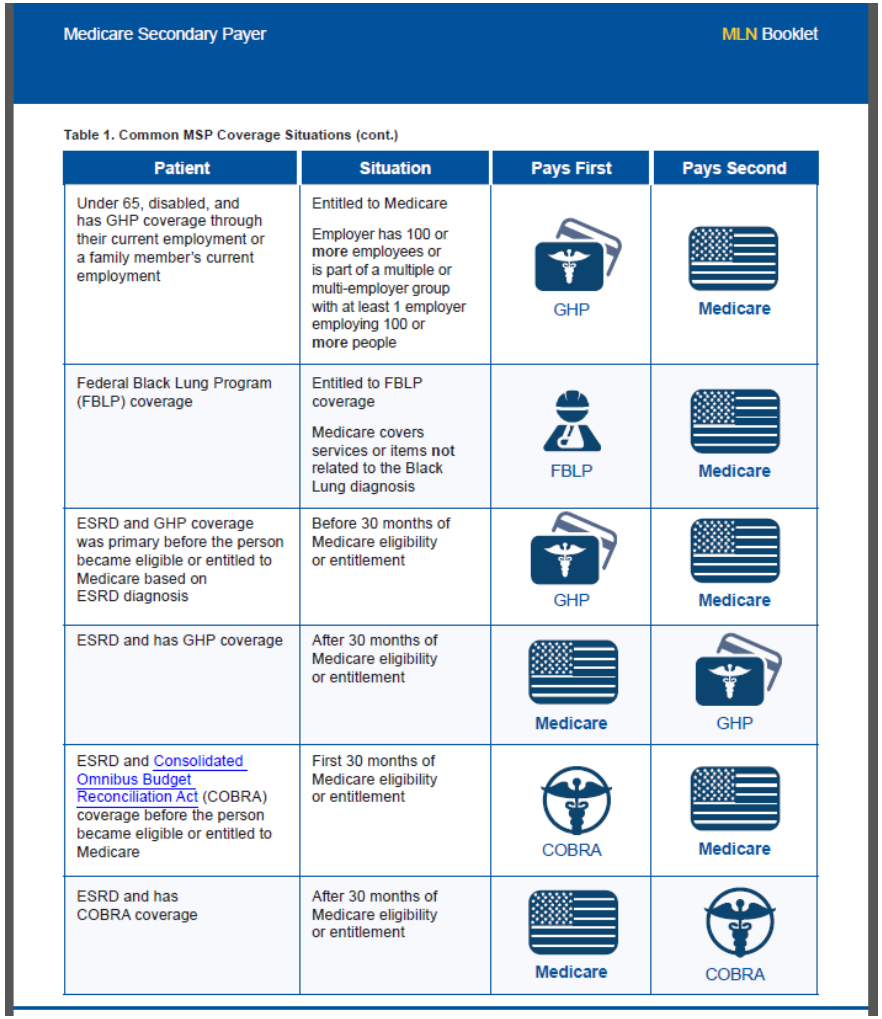




Table 1. Common MSP Coverage Situations (cont.)

| Patient | Situation | Pays First | Pays Second |
|---|---|---|---|
| Under 65, disabled, and has GHP coverage through their current employment or a family member's current employment | Entitled to Medicare<br>Employer has 100 or more employees or is part of a multiple or multi-employer group with at least 1 employer employing 100 or more people | GHP | Medicare |
| Federal Black Lung Program (FBLP) coverage | Entitled to FBLP coverage<br>Medicare covers services or items not related to the Black Lung diagnosis | FBLP | Medicare |
| ESRD and GHP coverage was primary before the person became eligible or entitled to Medicare based on ESRD diagnosis | Before 30 months of Medicare eligibility or entitlement | GHP | Medicare |
| ESRD and has GHP coverage | After 30 months of Medicare eligibility or entitlement | Medicare | GHP |
| ESRD and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage before the person became eligible or entitled to Medicare | First 30 months of Medicare eligibility or entitlement | COBRA | Medicare |
| ESRD and has COBRA coverage | After 30 months of Medicare eligibility or entitlement | Medicare | COBRA |

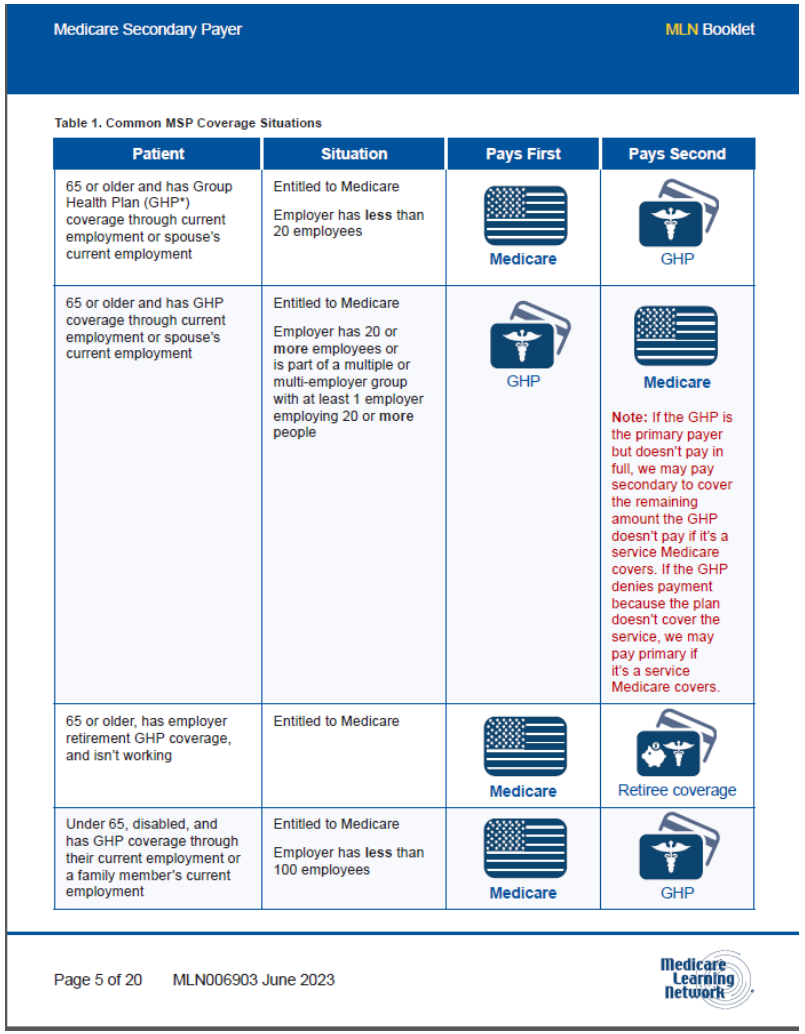




Table 1. Common MSP Coverage Situations

| Patient | Situation | Pays First | Pays Second |
|---|---|---|---|
| 65 or older and has Group Health Plan (GHP*) coverage through current employment or spouse's current employment | Entitled to Medicare<br>Employer has less than 20 employees | Medicare | GHP |
| 65 or older and has GHP coverage through current employment or spouse's current employment | Entitled to Medicare<br>Employer has 20 or more employees or is part of a multiple or multi-employer group with at least 1 employer employing 20 or more people | GHP | Medicare<br>**Note:** If the GHP is the primary payer but doesn't pay in full, we may pay secondary to cover the remaining amount the GHP doesn't pay if it's a service Medicare covers. If the GHP denies payment because the plan doesn't cover the service, we may pay primary if it's a service Medicare covers. |
| 65 or older, has employer retirement GHP coverage, and isn't working | Entitled to Medicare | Medicare | Retiree coverage |
| Under 65, disabled, and has GHP coverage through their current employment or a family member's current employment | Entitled to Medicare<br>Employer has less than 100 employees | Medicare | GHP |

# Medicare Secondary Payer Questionnaire

- https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer

**https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/providerservices/downloads/pro_othertool.pdf**

**20.2.1 - Admission Questions to Ask Medicare Beneficiaries**

***(Rev.)***

The following *questionnaire contains* questions *that can be used* to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers *may use this* as a guide to help identify other payers that may be primary to Medicare. *This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.*

**Part I**

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: *MM/DD/CCYY*

**BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.**

___ No.

2. Are the services to be paid by a government program such as a research grant?

___ Yes; Government Program will pay primary benefits for these services

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___ Yes.

**DVA IS PRIMARY FOR THESE SERVICES.**

___ No.

4. Was the illness/injury due to a work related accident/condition?

___ Yes; Date of injury/illness: *MM/DD/CCYY*

Name and address of WC plan:

_____

Policy or identification number: _____

Name and address of your employer:

_____

**WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.**

___ No. **GO TO PART II.**

11. CPT Category II Codes can not be included on the UB-04.

A. True

B. False

# Answer from the NARHC Forum on Category II CPT Codes

- Contributor: Patty Harper, InQuiseek Consulting

- Cat II codes cannot be reported on institutional UB claims. The codes must be reported through a registry-either through CMS or a 3rd party. The codes can be reported on the 1500 format for states which use the 837P for RHC Medicaid claims.

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940 Ratcliff Street
Shreveport, LA 71104

# 12. What Place of Service Code should an RHC use when billing Medicare?

A. 72

B. 11

C. The Revenue Code serves as the Place of Service Code on the UB-04

# Revenue Codes can be found in Chapter 9 Medicare Claims Processing Manual

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf

**Revenue Codes, FL42**
The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge.

For FQHC claims with dates of service on or after January 1, 2010, FQHCs may report additional revenue codes when describing services rendered during an encounter. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in the following table:

| Code | Description |
|---|---|
| 0521 | Clinic visit by member to RHC/FQHC |
| 0522 | Home visit by RHC/FQHC practitioner |
| 0524 | Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF |
| 0525 | Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility |
| 0527 | RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area |
| 0528 | Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident) |
| 0519 | Clinic, Other Clinic (only for the FQHC supplemental payment) |
| 0900 | Mental Health Treatment/Services |

13. An RHC treats a patient on January 1, 2023 and charges $226. The RHCs AIR is $126. When the bill is submitted to Medicare how much does Medicare pay?

A. 0

B. $100

C ($100)

D. $25.20

# Negative Reimbursement

**Rural Health Clinics (RHC)**

For Rural Health Clinics (RHCs), negative reimbursement is encountered 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.

| **Example** | 2023 | |
|---|---|---|
| Total billed amount | $226 | $115.00 |
| Provider all-inclusive reimbursement rate | $126 | $75.00 |
| Amount applied to deductible | $226 | $115.00 |
| Beneficiary's responsibility | $226 | $115.00 |
| Medicare reimbursement | -$100 | -$40.00 |

When posting it is important to balance to the patient responsibility per the EOB.
The variance is Medicare contractual and is an adjustment (not collectable from the patient).

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

A. Ensure that the Patient Balance remains correct after posting.

B. Post the withhold to the patient balance.

C. Include the negative reimbursement on the Credit Balance Report.

# HOW TO POST NEGATIVE REIMBURSEMENT & MEDICARE CLAIMS

| Account | Debit | Credit |
|---|---|---|
| Charges | | 226 |
| Patient Receivable | 226 | |

| Account | Debit | Credit |
|---|---|---|
| Contractual Adjustments | 100 | |
| Medicare Payable/Cash | | 100 |

Patient still owes $226.

15. An RHC patient receives an EKG. How is it billed.

A. CPT Code 93000 to Part B on the 1500 fee for service.

B. CPT Code 93000 on the UB-04 as an RHC service.

C CPT 93005 to Part B fee for service and CPT 93010 on the UB-04 for the professional read.

D. Recorded in a log and placed on the cost report at the end of the year.

# EKG Billing

| CPT | Description | How to bill |
|---|---|---|
| 93000 | Global interpretation and technical component | Do not bill this way in an RHC. |
| 93005 | Technical Component | Bill to Part B – Paid on 1500 for Independent and use UB-04 and hospital outpatient provider number |
| 93010 | Interpretation | Bill on UB-04 (incident to – No visit) |

# Subject: Radiology

How do we split the Chest x-rays on RHC?

Answer: The technical component is split billed to Medicare as a non-RHC service. The professional portion is included on the UB-04 as an RHC service and is “paid” incident to.

16. How many CPT Code G0447s can be billed annually per patient?

A. 12

B. 22

C. 24

D. 34

# Up to 22 visits per year for Weight Loss paid at the AIR

Telehealth Eligible

Print

## Intensive Behavioral Therapy (IBT) for Obesity (NCD 210.12)

Select another service

### HCPCS & CPT Codes

**G0447 —** Face-to-face behavioral counseling for obesity, 15 minutes

**G0473 —** Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes

**What's Changed?**

- No changes from the last quarter

### ICD-10 Codes

- Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45

**Note:** Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 webpage. Find your MAC's website for more information.

### Medicare Covers

Patients with Medicare Part B and obesity when:

- Obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared)
- Competent and alert when counseling is delivered
- Qualified primary care physician or other primary care practitioner conducts counseling in a primary care setting

### Frequency

We pay up to 22 visits billed with codes G0447 and G0473, combined, in a 12-month period:

- **First month:** 1 face-to-face visit every week
- **Months 2–6:** 1 face-to-face visit every other week
- **Months 7–12:** 1 face-to-face visit every month if patient meets certain requirements

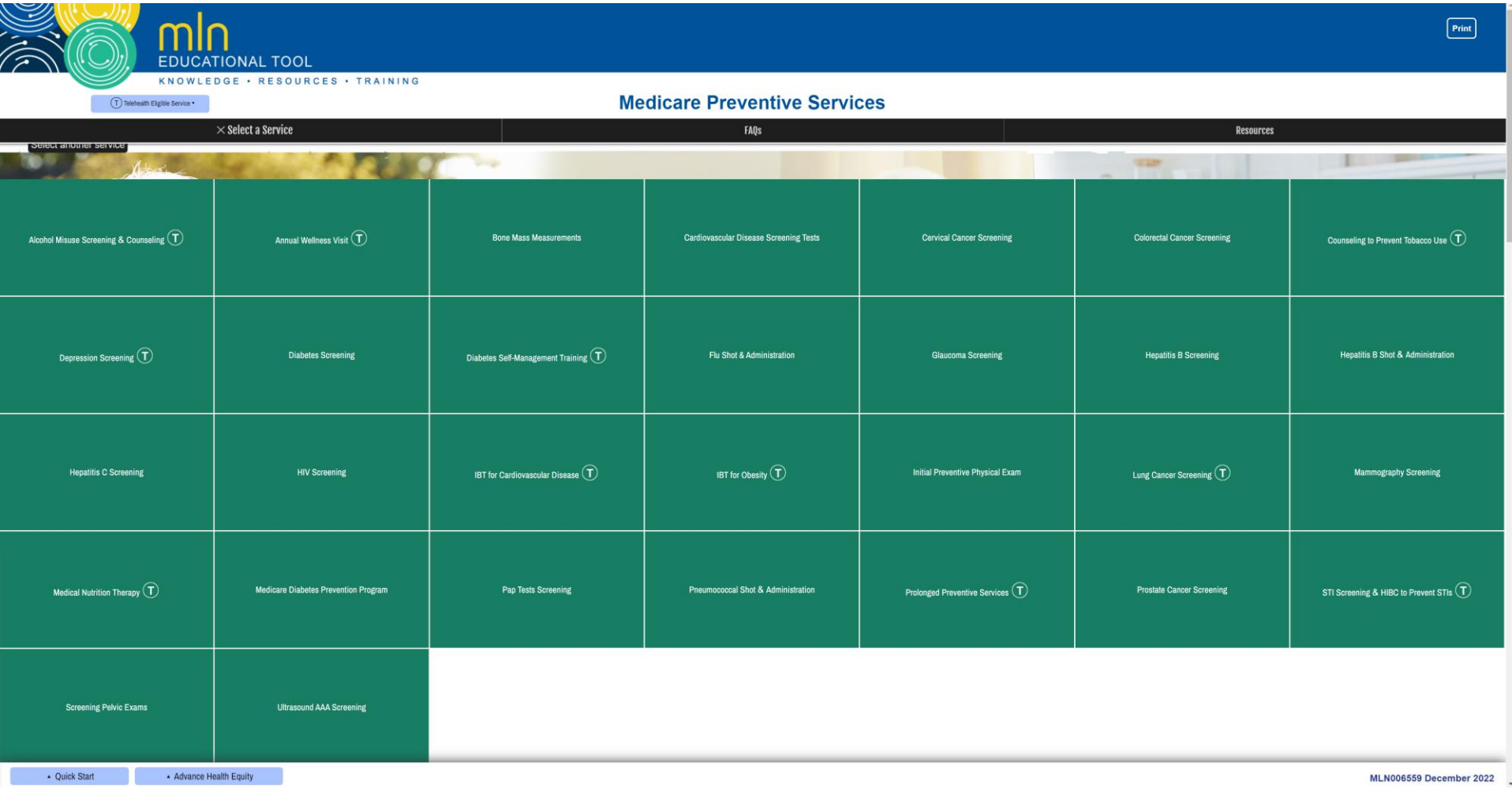
**Note:** See FAQ on how to check eligibility.

### Patient Pays

- No copayment, coinsurance, or deductible

### Other Notes

- Obesity reassessment and weight loss determination required at 6-month visit
- If the patient loses at least 3 kg during the first 6 months, they're eligible for additional face-to-face visits occurring once a month for months 7–12
- Patients who don't achieve a weight loss of at least 3 kg during the first 6 months, reassess their readiness to change and BMI after an additional 6-month period




https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

## Rural Health Clinic (RHC) Preventive Services Chart

*(Rev. 08-10-16)*

RHCs are paid an all-inclusive rate (AIR) for qualified primary and preventive health services. Except for the initial preventive physical examination (IPPE), all preventive services furnished on the same day as another medical visit constitute a single billable visit. If an IPPE visit occurs on the same day as another billable visit, two visits may be billed. All of the preventive services listed below may be billed as a stand-alone visit if no other service is furnished on the same day. The beneficiary copayment and deductible is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force with a grade or A or B.

Additional information on RHC policy for preventive services is available in the Medicare Benefit Policy Manual, Chapter 13 (http://go.cms.gov/14BSdPN). Additional information on payment and claims processing for RHC preventive services is available in the Medicare Claims Processing Manual, Chapter 9 (http://go.cms.gov/1DFvBcO), and Chapter 18 (http://go.cms.gov/1w5l6cX). The table below lists preventive services with their associated HCPCS (Healthcare Common Procedure Coding System) code and descriptor, whether they are eligible to be paid based on the RHC's AIR when billed without another covered visit, which preventive services can be billed separately when another visit is billed on the same day, and which preventive services have the co-insurance and deductible waived.

**Table 1: RHC Preventive Services**

| Service | HCPCS Code | Short Descriptor | Paid at the AIR | Eligible for Same Day Billing | Coinsurance /Deductible | CMS Pub 100-04 |
|---|---|---|---|---|---|---|
| IPPE | G0402 | Initial preventive exam | Yes | Yes | Waived | Ch. 9 §150<br><br>Ch. 18 §80 |

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

17. A patient receives an Annual Wellness Exam and an Evaluation and Management (E & M) on the same day how is billed and paid?

A. The AWE is billed to fee for service on a 1500 and the E and M is billed on the UB-04.

B. The AWE and E and M is billed on the UB-04 and only one AIR is paid.

C. The AWE and E & M are billed on the UB-04 and two AIRs are paid by Medicare.

D. Both are billed to Medicare Part B on a 1500 and both services are paid as long as modifier 25 is added.

18. The physician treats an E & M telehealth patient from his home after RHC hours. How is this billed and paid by Medicare.

A. Bill on the UB-04 to Medicare Part A with the G2025 CPT Code which pays $95.37 in 2024.

B. Bill on the 1500 to Part B with a 95 modifier and be paid fee for service for the service

C. After hours telehealth can not be billed at all.

D. After hours telehealth can not be billed but can be included as an allowable expense on the cost report.

19. The physician treats a mental health patient from the RHC during RHC hours (audiovisual). How is this billed and paid by Medicare.

A. Bill on the UB-04 to Medicare Part A with the 9XXXX CPT Code, and CG and 95 modifier which pays the AIR and is an allowable cost on the cost report.

B. Bill on the 1500 to Part B with a 95 modifier and be paid fee for service for the service and the cost is excluded from the cost report.

C. Bill on the UB-04 to Medicare Part A with G2025 CPT Code which pays $95.37 in 2024.

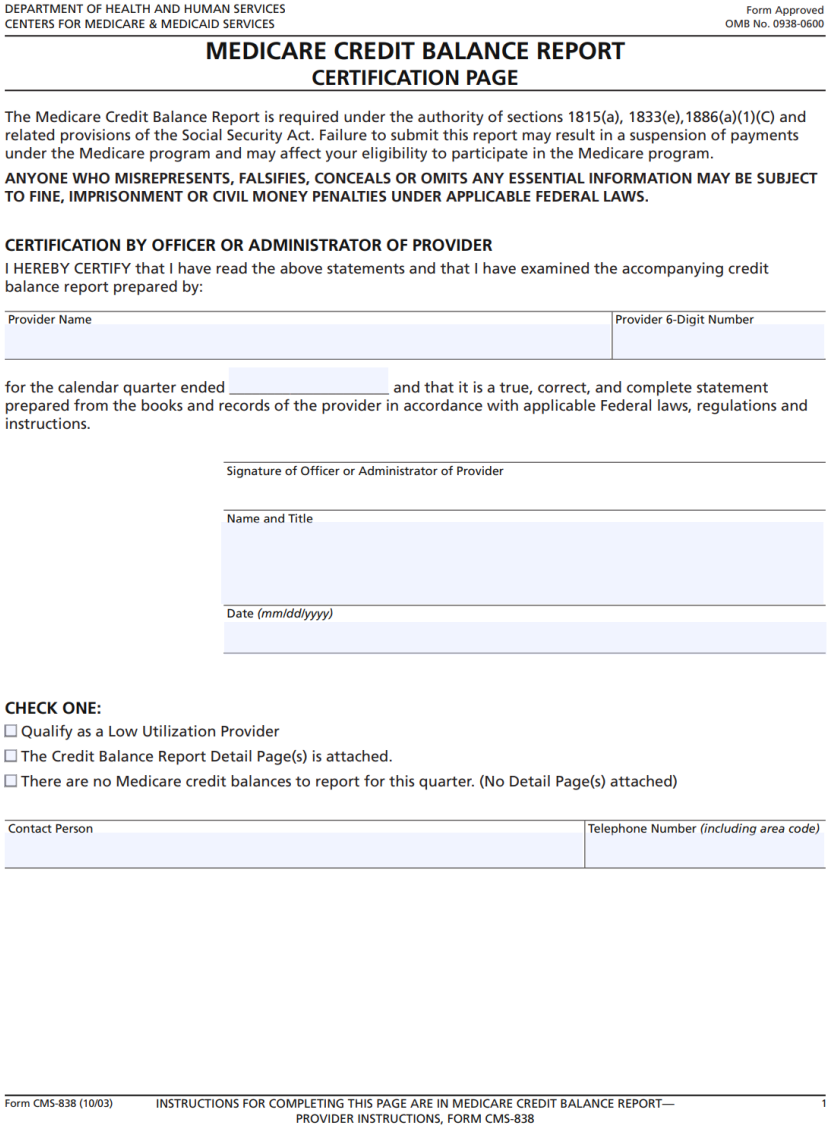
D. Bill on the UB-04 to Medicare Part A with the 9XXXX CPT Code, and CG and 95 modifier which pays the AIR and is **not** an allowable cost on the cost report.


## 20. How often does an RHC have to complete a Form 838 Credit Balance Report?

- A. Weekly
- B. Monthly
- C. Quarterly
- D. Annually

The Medicare Credit Balance Report must be completed Quarterly or your payments will be cut off.

**https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms838.pdf**



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0600

## MEDICARE CREDIT BALANCE REPORT
### CERTIFICATION PAGE

The Medicare Credit Balance Report is required under the authority of sections 1815(a), 1833(e),1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

**ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.**

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER**

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by:

| Provider Name | Provider 6-Digit Number |
|---|---|
| | |

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

Signature of Officer or Administrator of Provider

Name and Title

Date *(mm/dd/yyyy)*

**CHECK ONE:**

- ☐ Qualify as a Low Utilization Provider
- ☐ The Credit Balance Report Detail Page(s) is attached.
- ☐ There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached)

| Contact Person | Telephone Number *(including area code)* |
|---|---|
| | |

Form CMS-838 (10/03) INSTRUCTIONS FOR COMPLETING THIS PAGE ARE IN MEDICARE CREDIT BALANCE REPORT— PROVIDER INSTRUCTIONS, FORM CMS-838 1


Thank You!

Mark Lynn, Healthcare Business Specialists

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