Basic Billing Requirements for All RHCs

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Please Note…

- The content of this presentation is current as of today. Healthcare rules and regulations, and payer guidelines change frequently. You should always do your own research as to current guidelines and regulations as they are subject to change.
- This presentation covers the RHC billing regulations as they relate to traditional Medicare. The guidance included will focus on guidelines outlined by CMS.

Session Objectives:

- Establish the fundamental billing requirements for billing as a Rural Health Clinic
- Review the billing and payment differences between provider-based and independent RHCs
- Determine the appropriate way to bill for RHC services, non-RHC services, and incident-to services according to current CMS guidance

RHC Visit = RHC Encounter

"A 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 services are rendered."

CMS Internet Only Manual 100-02, Chapter 13

What is *NOT* a RHC Encounter?

Visits only for medication refills

Visits only for lab results

Visits only for injections (i.e. allergy)

Suture removal or dressing change without an additional face-to-face visit

Visits billed using CPT code 99211 (nursing visit)

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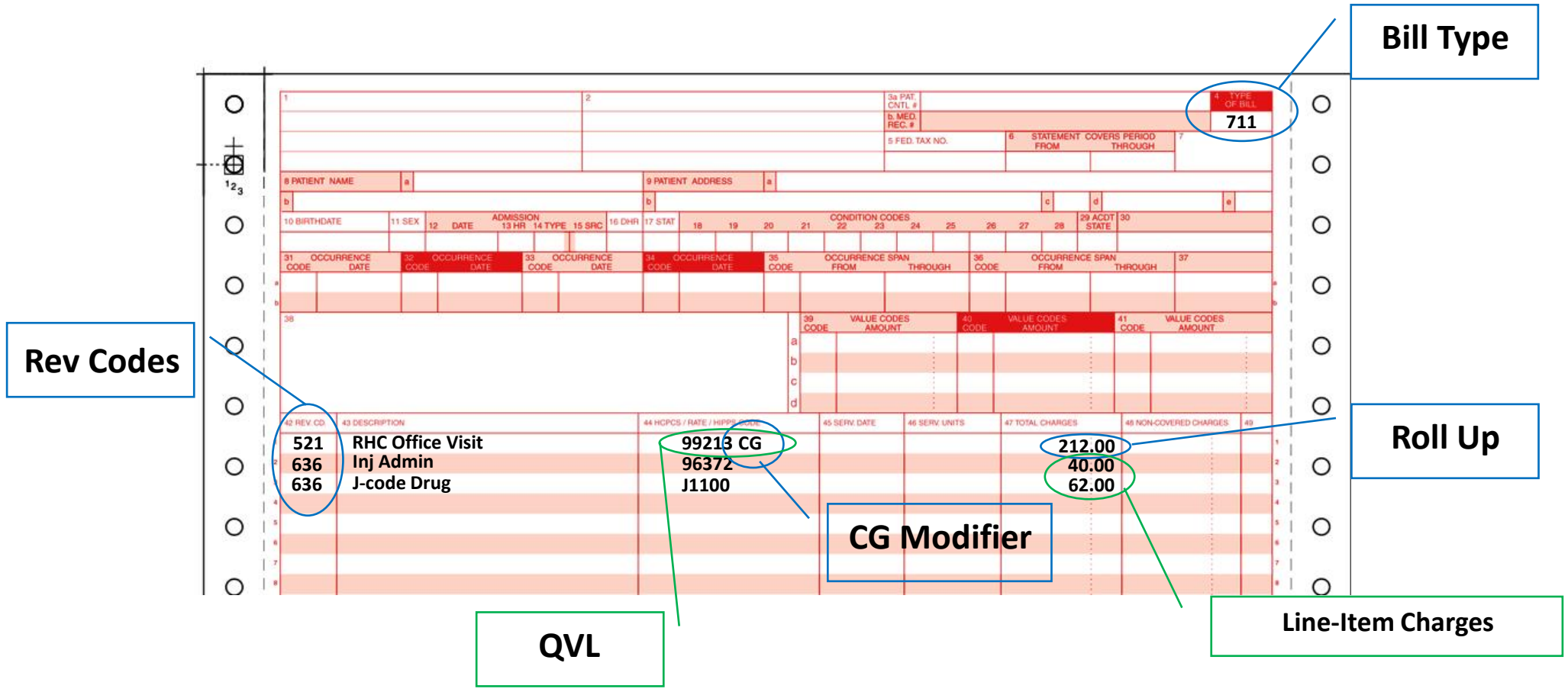
What goes on the RHC claim?



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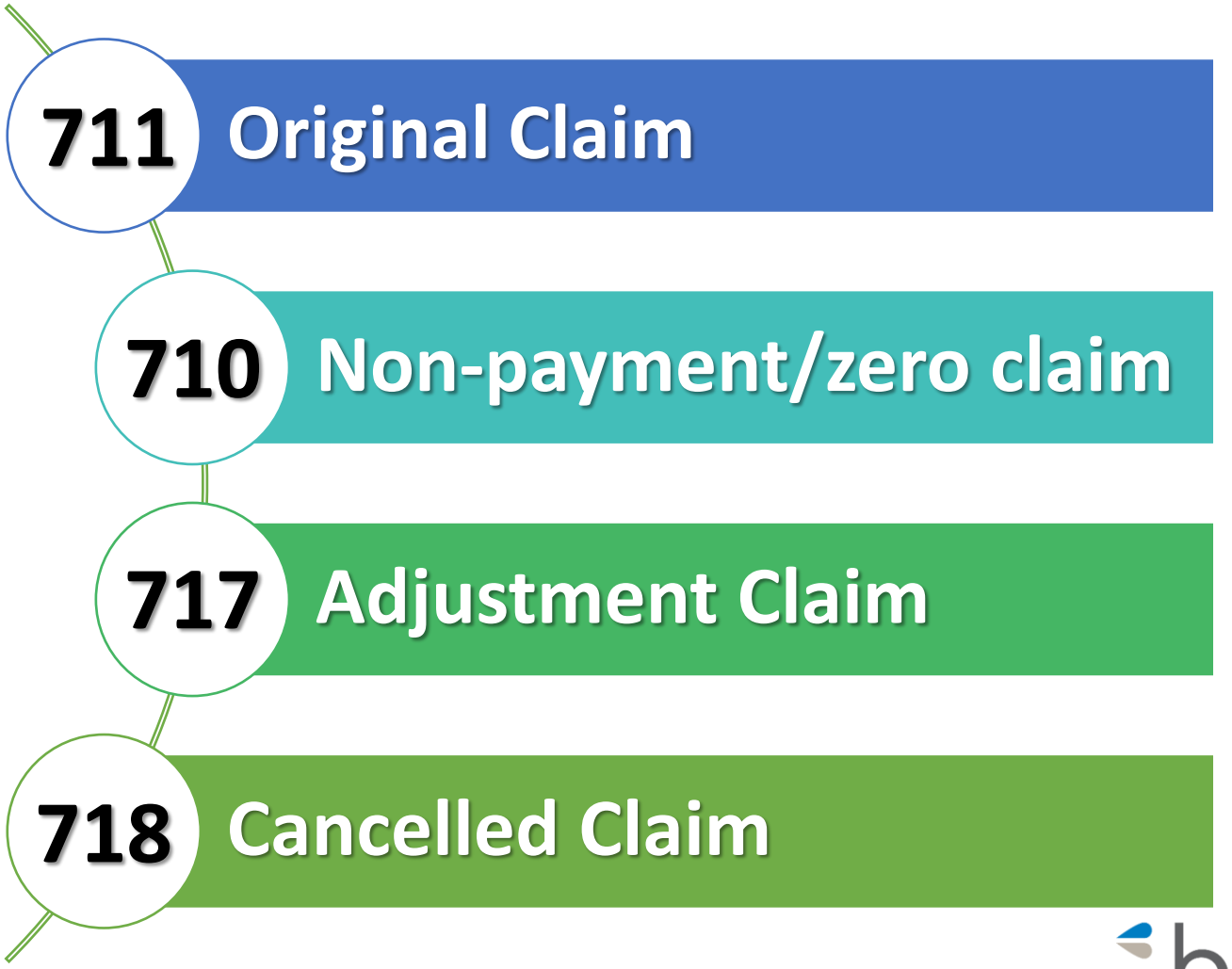
Claim Form & Bill Types

- RHC services are billed on a UB-04
- The electronic form is the 837i
- These are the common bill types (TOBs) used on RHC claims:



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

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

Qualifying Visit List (QVL)

- Last updated **August 1st, 2016**

QVL consists of "frequently reported HCPCS codes that qualify as a face-to-face visit between the patient and an RHC practitioner…"

"…NOT an all-inclusive list of stand-alone billable visits for RHCs." *(Still very comprehensive.)*

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

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QVL and CG Modifier

- Every RHC claim must have a Qualifying Visit Line identifying the primary reason for the patient encounter
- Modifier CG should be attached to identify the qualifying visit
  - Modifier CG signals to Medicare which line to use when calculating applicable coinsurance and deductible
- There are specific instances when two CG modifiers may be reported on the same claim

Multiple Visits on the Same Day – Exceptions

- Exceptions are for the following circumstances ***only***:

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. In this situation only, the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits.

The patient has a qualified medical visit and a qualified mental health visit on the same day (2 billable visits).

The patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits).

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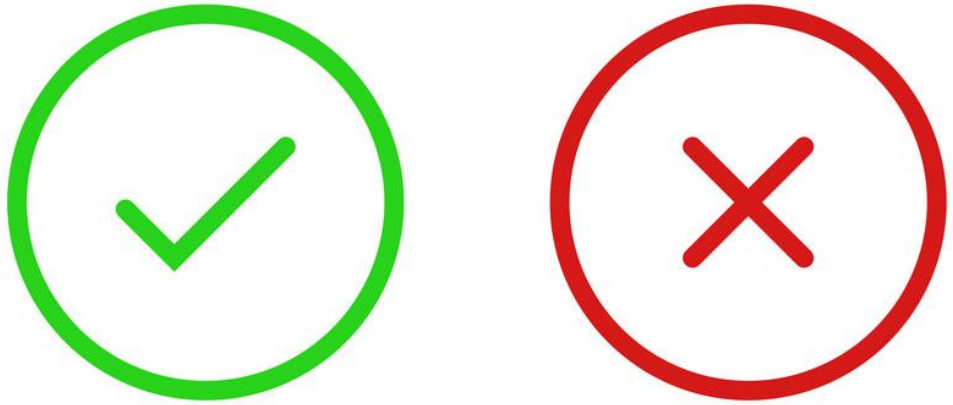
Charges for RHC Services

- RHCs should report appropriate codes for all services provided during the RHC visit, and their associated charges
  - RHCs have the option to report additional line items with actual charges or a $0.01 charge
  - This determination is largely based on the functionality of your billing system
- Charges for all services provided during the visit should be “rolled up” to the qualifying visit line/CG modifier line
  - Exception: charges for qualifying preventive health services
- Total Charges for the entire claim are reported on line 0001
  - Payment not adjudicated based on 0001 total

Medicare Payment for RHC Services

Medicare pays RHCs their all-inclusive rate (AIR) for RHC services



TRUE or FALSE

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RHC Medicare Payment

- Actual payment from Medicare is 80% of your AIR, less 2% sequestration
  - Comes out to 78.4% of your RHC AIR
  - Exception for qualifying preventive services – paid at 100% of AIR
  - Any applicable deductible must be met before Medicare will make payments
- The amount you are paid by Medicare, has nothing to do with what you charge.
  - What IS impacted by your charge amounts, is the patient's coinsurance.

Coinsurance & Deductible

- Coinsurance is equal to 20% of the ***total charges*** submitted on the RHC claim.
  - It is ***not*** based on the Medicare allowable amount
  - Calculated from the qualifying visit line, as identified by the CG modifier
- Coinsurance and deductible are waived for qualified preventive health services
- The Part B deductible is applied to RHC services. Patients who only have Medicare Part A coverage are not covered.
- Deductibles owed by the patient can lead to negative reimbursements at the beginning of the year.

Claim Example #1

RHC Encounter – E/M Office Visit Only

- Scenario: RHC Provider completed a level-3 E/M office visit. Charge for the visit is $100.00. No additional work (incident-to or non-RHC services) were required.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/01/2022	1	$100.00
0001	Total Charge				$100.00

Claim Example #2

RHC Encounter – Procedure Only

- Scenario: RHC Provider completed a simple I&D in the office. Charge for the visit is $150.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	I&D Abscess	10160 CG	10/01/2022	1	$150.00
0001	Total Charge				$150.00

Claim Example #3

RHC Encounter – E/M Office Visit and Procedure

- Scenario: RHC Provider completed a level-3 E/M office visit and a simple I&D in the office. Charge for the E/M visit is $100.00 and for the procedure is $150.00. *RHC will receive only 1 AIR payment.*

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/01/2022	1	$250.00
0521	I&D Abscess	10160	10/01/2022	1	$150.00
0001	Total Charge				$400.00

Claim Example #4a

RHC Encounter – Reporting Additional Line-Item Charges

- Scenario: RHC Provider completed a level-4 E/M office visit and a gave the patient a Rocephin injection. E/M visit charge is $150.00, admin charge is $40.00 and charge for the drug is $32.00. ***Additional line-items reported as actual charges.***

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/01/2022	1	$222.00
0636	Inj Admin	96372	10/01/2022	1	$40.00
0636	Rocephin, 250 mg	J0696	10/01/2022	1	$32.00
0001	Total Charge				$294.00

Claim Example #4b

RHC Encounter – Reporting Additional Line-Item Charges

- Scenario: RHC Provider completed a level-4 E/M office visit and a gave the patient a Rocephin injection. E/M visit charge is $150.00, admin charge is $40.00 and charge for the drug is $32.00. ***Additional line-items reported with $0.01.***

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/01/2022	1	**$222.02**
0636	Inj Admin	96372	10/01/2022	1	**$0.01**
0636	Rocephin, 250 mg	J0696	10/01/2022	1	**$0.01**
0001	Total Charge				**$222.04**

Claim Example #5

RHC Encounter – Medical Visit & Subsequent Visit, Same Day

- Scenario: RHC Provider completed a level-4 office visit with a patient who has diabetes. Later in the day the patient fell and came back to the RHC to be seen. Charge for the first medical visit is $150.00 and for the subsequent visit is $100.00

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/01/2022	1	$150.00
0521	Office Visit – Established Pt III	99213 **CG 25**	10/01/2022	1	100.00
0001	Total Charge				$250.00

Claim Example #6

RHC Encounter – Medical Visit & Mental Health Visit (In-Person), Same Day

- Scenario: RHC Provider completed a level-3 office visit with a patient and a mental health provider in the same office completed a psychiatric diagnostic evaluation on the same day. Charge for the medical visit is $100.00 and for the mental health visit is $200.00

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/01/2022	1	$100.00
0900	Psych eval	90791 CG	10/01/2022	1	$200.00
0001	Total Charge				$300.00

Claim Example #7

RHC Encounter – IPPE, Medical Visit, & Mental Health Visit, Same Day

- Scenario: RHC Provider completed a patient's IPPE. While they were in the office, they were seen for their hypertension. The patient also saw a mental health provider who had a 30-minute psychotherapy session. Charge for IPPE is $195.00, for the medical visit is $150.00, and for the mental health visit is $220.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/01/2022	1	$150.00
0521	IPPE	G0402	10/01/2022	1	$195.00
0900	Psychotherapy, 30 m	90832 CG	10/01/2022	1	$220.00
0001	Total Charge				$565.00

RHC Mental Health Telehealth Visits

- Effective January 1, 2022 RHCs may provide mental health visits via telecommunications technology. These visits may be audio-video or audio only.
  - Audio only is acceptable in instances where the patient does not have access to audio-video technology or does not consent to the use of audio-only technology.
- There must be an in-person mental health visit 6 months prior to the mental health telehealth visit, and there must be at least one in-person mental health visit every 12 months while the patient is receiving mental health services via telehealth.
  - CMS will make limited exceptions to the in-person requirement on a case-by-case basis.

Billing and Reimbursement for RHC Mental Health Telehealth Visits

- Mental health telehealth visits will be reimbursed at a rate equivalent to an in-person visit (aka: the RHC's AIR)
- How you bill for these depends on the *type* of telehealth visit

Audio-Video:

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit payment code)	***95 (audio-video)*** CG (required)

Audio-Only:

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit payment code)	***FQ (audio only)*** CG (required)

Resource: MLN Matters #SE22001: https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf

Claim Example #8

RHC Encounter – Mental Health Visit, In-Person

- Scenario: RHC Provider completed psychiatric diagnostic evaluation with a patient. Charge for the visit is $200.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psychiatric diagnostic evaluation	90791 CG	10/01/2022	1	$200.00
0001	Total Charge				$200.00

Claim Example #9

RHC Encounter – Mental Health Visit, Telehealth

- Scenario: RHC Provider completed a mental health visits via audio-video technology. Charge for the visit is $200.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psychotherapy, 45 minutes	90834 **95,CG**	10/01/2022	1	$200.00
0001	Total Charge				$200.00

RHC as Distant Site for Telehealth, Medical

- **During the COVID public health emergency** CMS has allowed for several telehealth flexibilities for RHCs
- During the PHE, RHCs are authorized to serve as the distant site
  - Distant site = location of the provider during the encounter
  - Both patient and provider can be in any location (including their home) during the encounter
    - Must be during RHC hours
- The distant site service only qualifies for reimbursement if it is on the CMS list of approved telehealth services: https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip

RHC as Distant Site for Telehealth, Medical

- Qualifying RHC distant site services should be billed using the RHC-specific G-code G2025
  - For dates of service from 1/27/2020 – 6/30/2020:
    - Bill using G2025 with modifier CG and optional modifier 95
  - For dates of service on or after 7/1/2020:
    - Bill using G2025 and optional modifier 95 (CG modifier no longer required)
- Payment rate for G2025 is as follows:
  - DOS 2022: $97.24
- Keep up to date on RHC telehealth flexibilities here: https://www.cms.gov/files/document/se20016.pdf

Preventive Health Services

- When billing for preventive health services, DO NOT include charges for those services in the “roll up” to the qualifying visit line
- If the only service provided on a given date of service, Medicare pays for qualifying preventive health services at 100% of AIR
- If a preventive service is furnished on the same day as another billable visit, it is not separately payable. The RHC will only receive 1 AIR payment.
  - Exception: IPPE
- Coinsurance and deductible do not apply for qualifying preventive health services.
- **Resource:** Rural Health Clinic Preventive Services Chart https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

Claim Example #10

RHC Encounter – E/M Office Visit and IPPE

- Scenario: RHC Provider completed a level-4 E/M office visit. While in the office, the provider completed the patient's IPPE. Charge for the E/M visit is $150.00, and for the IPPE is $195.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/01/2022	1	$150.00
0521	IPPE	G0402	10/01/2022	1	$195.00
0001	Total Charge				$345.00

Note: Will receive 2 AIR payments for medical + IPPE on the same day.

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Claim Example #11

RHC Encounter – E/M Office Visit and AWV

- Scenario: RHC Provider completed a level-4 E/M office visit. While in the office, the provider completed the patient's AWV. Charge for the E/M visit is $150.00, and for the AWV is $175.00. **RHC is paid 1 AIR.**

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/01/2022	1	$150.00
0521	AWV - Subsequent	G0439	10/01/2022	1	$175.00
0001	Total Charge				$345.00

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Non-RHC Services

- RHCs may ***"furnish certain services that are beyond the scope of the RHC benefit".*** These are considered "Non-RHC Services"
- Non-RHC services are billed separately to the appropriate MAC under the payment rules specific to that service.
- All costs associated with non-RHC services (i.e. space, equipment, supplies, facility, overhead, personnel) should be removed from the cost report.
- "Non-RHC" does not mean "Non-Payable"
  - CAHs receive cost-based reimbursement
  - PPS hospitals and IRHCs reimbursed based on a fee schedule

Non-RHC Services Examples

- Medicare excluded services
- Technical component of RHC service (i.e., x-rays, EKGs)
- Laboratory services (yes, even the 6 required ones)
- Durable medical equipment (DME)
- Ambulance services
- Prosthetic devices
- Body braces
- Practitioner services at certain other Medicare facility
- Telehealth distant-site services
- Group services

Resource: CMS Benefit Policy Manual (100-02), Chapter 13, Section 60.1

Independent vs. Provider Based RHC Billing

	Encounter for RHC Service(s)	CLIA Lab in RHC	Technical Component (Non-RHC Service)	Professional Services - Hospital
Independent RHC	Bill to Part A on UB-04; RHC CCN	Bill to Part B on CMS-1500; Use RHC CCN	Bill to Part B on CMS-1500; Use RHC CCN	Part B on CMS-1500 Medicare Group
Provider-Based RHC	Bill to Part A on UB-04; RHC CCN	Billed by Parent Hospital on UB04; PPS Hospital: TOB 141/ 131 CAH: TOB 851	Billed by Parent Hospital on UB04; PPS Hospital: TOB 131 CAH: TOB 851	Part B on CMS-1500 Medicare Group

Claim Example #12

RHC Encounter – E/M Office Visit and EKG

- Scenario: RHC Provider completed a level-3 E/M office visit. While in the office, the provider also did an EKG. Charge for the E/M visit is $100.00, and for the professional fee for the EKG is $25.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/01/2022	1	$125.00
0521	EKG, interpretation and report	93010	10/01/2022	1	$25.00
0001	Total Charge				$150.00

Note: EKG interpretation and report only included when completed by RHC provider.

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Claim Example #12

RHC Encounter – E/M Office Visit and EKG

- In this scenario, the technical component of the EKG (a non-RHC service) is billed differently depending on whether the RHC is independent or provider-based:

Independent RHC	RHC will bill HCPCS code 93005 (EKG, tracing only) to Part B on CMS-1500. Fee schedule payment.
Provider-Based RHC	Parent entity will bill HCPCS code 93005 (EKG, tracing only) to MAC. Fee schedule payment (unless CAH – then payment at cost).

“Incident-to” Services

- “Incident to” – services and supplies that are integral, though incidental:
  - Commonly rendered without charge and included in the RHC payment;
  - Commonly furnished in an outpatient clinic setting
  - Furnished under the physician’s direct supervision; except for authorized care management services which may be furnished under general supervision; and
  - Furnished by RHC ancillary staff
- When services and supplies are furnished incident-to an RHC service, payment for the incident-to services are included in the RHC AIR
- An encounter that includes only incident to services is not a stand-alone billable visit

“Incident-to” Services

- The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit
- Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate time frame
  - Commonly referred to as the “30-Day Rule”
    - Hold claims and add incident-to services as rendered
  - Another billing option: submit an adjusted claim each time an incident-to service is provided (TOB 717)
- No additional payment from Medicare, only increased coinsurance

Claim Example #13

RHC Encounter with Incident to on Different Date

- Scenario: RHC Provider completed a level-3 E/M office visit and instructed the patient to come back weekly for allergy injections for the next four weeks. Charge for the E/M visit is $100.00, and for each allergy shot is $10.00. Date of service on claim is date of office visit.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/01/2022	1	$140.00
0636	Allergy Injection	95115	10/01/2022	4	$40.00
0001	Total Charge				$180.00

Influenza (G0008) & Pneumococcal (G0009)

- RHCs are reimbursed for flu and pneumococcal vaccines, and their administration, through the cost report.
- DO NOT report flu and pneumococcal vaccines, nor their administration on the RHC claim.
- You should have a mechanism in place for tracking vaccines (all payers) and their administration in order to accurately reconcile these on your cost report.
  - Keep a log with patient's name, DOB, insurance information, date of immunization, at a minimum.

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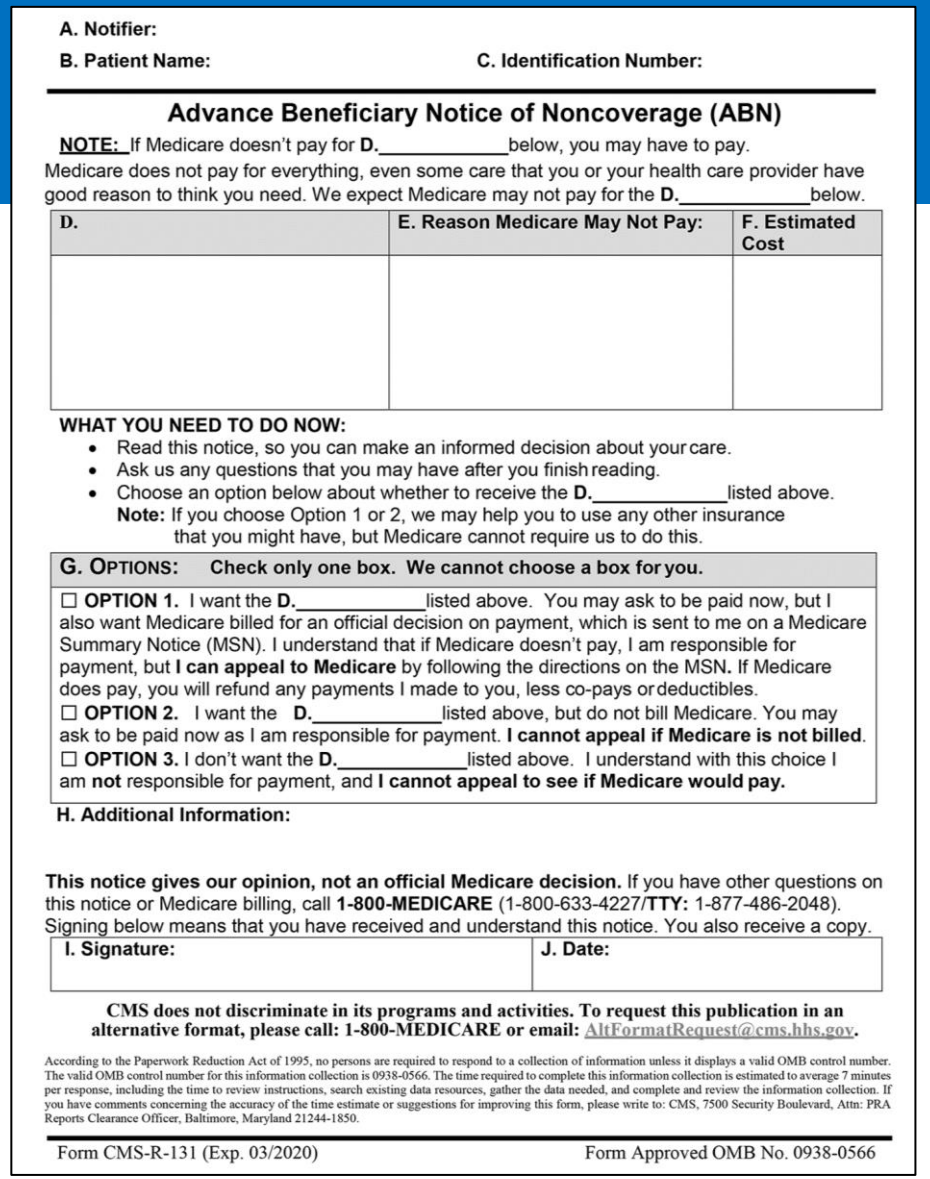
COVID-19 Vaccines

- RHCs are reimbursed for COVID-19 vaccines and their administration in the same manner as influenza and pneumococcal vaccines
- The cost for providing these vaccines will be included in the cost-report and reimbursed based on vaccine administration costs
- This applies for regular Medicare beneficiaries **AND** those with Medicare Advantage plans – this is for the COVID-19 vaccine only, not flu and pneumo

Non-Covered Services

- Non covered services are not considered medically-necessary, therefore not covered by the RHC benefit, nor any Medicare benefit
- The RHC should complete an Advance Beneficiary Notice of Non-Coverage (ABN) for all non covered services.
- Submit these charges using TOB 710
- Payment for charges associated with non covered services is the responsibility of the patient.



A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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ABN Requirements

- The ABN notifies Medicare beneficiaries that a particular service is non covered, or that Medicare may deny payment for a particular service. In these cases, the patient is responsible for the charges.
- The ABN should be given to patients ***before*** they receive the service.
  - If it is given to them after they receive the service, it is not valid, and the RHC may by liable for any amounts Medicare does not pay. You may not bill the patient for those services.
- The ABN must include a ***reasonable estimate*** for the cost of the service to be provided.
  - "Reasonable estimate" is defined as within $100 or 25% of the total cost, whichever is greater.

Helpful Resources

- CMS Benefit Policy Manual, Chapter 13: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- CMS Claims Processing Manual, Chapter 9: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
- CMS Rural Health Clinic Center: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center
- NARHC Website: www.narhc.org
  - Forum: https://www.narhc.org/discussionforums/DiscussionDefault.asp
  - News: https://www.narhc.org/narhc/News1.asp
- Facebook Group: Rural Health Clinics Information Exchange

Questions?

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Contact me!

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