National Association of Rural Health Clinics

Billing Overview

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CRHCP Code: 998-40

RHC Services

- An RHC Encounter is defined as a medically-necessary, face-to face (one-on-one) medical or mental health visit, or a qualified preventative health visit, with a RHC practitioner during which time one or more RHC services are rendered.

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf

Claim Submission Information

- Claims are submitted on a UB-04
- RHC Claims billed to Part A.

Revenue Codes

- 0521- Clinic Visit
- 0522- Home Visit
- 0524- Part A SNF Visit
- 0525- SNF, NF or Residential facility (Non Part A) Visit
- 0528- Scene of an Accident
- 0780- Telehealth
- 0900- Mental Health Service

Additional Revenue Codes

0250 – Pharmacy (Does not need the HCPCS)

0300 – Venipuncture

0636 – Injection/Immunization

Bill Types

- RHC claims typically have 4 types of bills:
  - *710- Non payment/ Zero Claim*
  - *711- Original Claim*
  - *717- Adjustment Claim (Replacement of prior claim)*
  - *718- Cancelled Claim (Void/Cancel Prior claim)*

RHC Billing Requirements

- Beginning October 1, 2016, RHCs shall add modifier CG to the line with all the charges subject to coinsurance and deductible. (SE1611) **Exception is the Initial Preventative physical Exam (IPPE)**
- RHCs are required to bill the appropriate HCPCS code for each line along with the correct revenue code on each line.

Qualified Visit List

- The list provided to clinics in April 2016 was not an all inclusive list. It was merely a guide to provide you with examples of additional procedure codes. It does not mean that if it is not on there that you can’t bill it.

Claim Examples

When a claim is for an office visit only then you would have the 0521 revenue code, with a CG modifier placed at the end of the procedure code

0521	Freestanding Clinic-Rura	99214CG		121316	1	21700	

Claim Example

0521	Office Visit	99213CG25		275.00 (175.00)
0521	Procedure	12001		100.00

Claim Example

0521	Office Visit	99213CG25		$195.00 ($175.00)
0636	Toradol	J1885		$20.00

Procedures

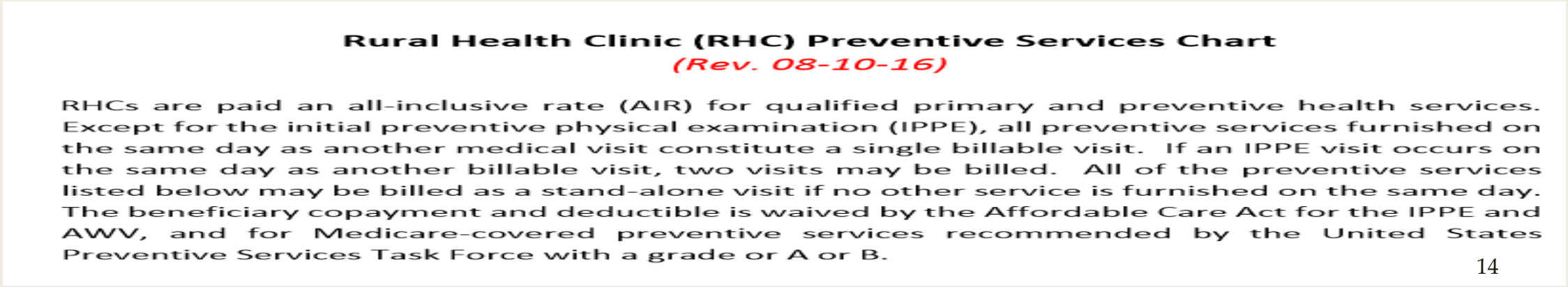
- EKGs: 93000 vs 93005, 93010 (93005 should be billed to Part B and 93010 should be billed to Part A)
- X-rays (Technical goes to Part B, Professional Part A)
- Ensure that both split charges equal your full charge. (93000 $100.00= 93005 $50.00, 93010 $50.00)

Claim Example

0521	Office Visit	99213CG		$225.00 ($175.00)
0521	EKG	93010		$50.00

Preventive Services

- Preventive services can be stand alone visits or billed with another visit.
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf



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.

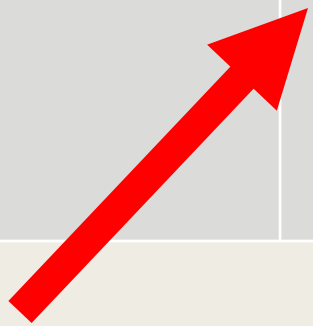
Deductible/Coins Waived

Table 1: Approved Preventive Health Services with Coinsurance and Deductible Waived

HCPCS/CPT Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
99406	Tobacco-use counsel 3-10 min
99407	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

Initial Preventive Exam

Procedure Code	Description	Paid at the AIR	Eligible for Same Day Billing	Coins/Deductible Applied
G0402	Initial Preventive Exam	Yes	Yes	Waived



Annual Wellness Visit

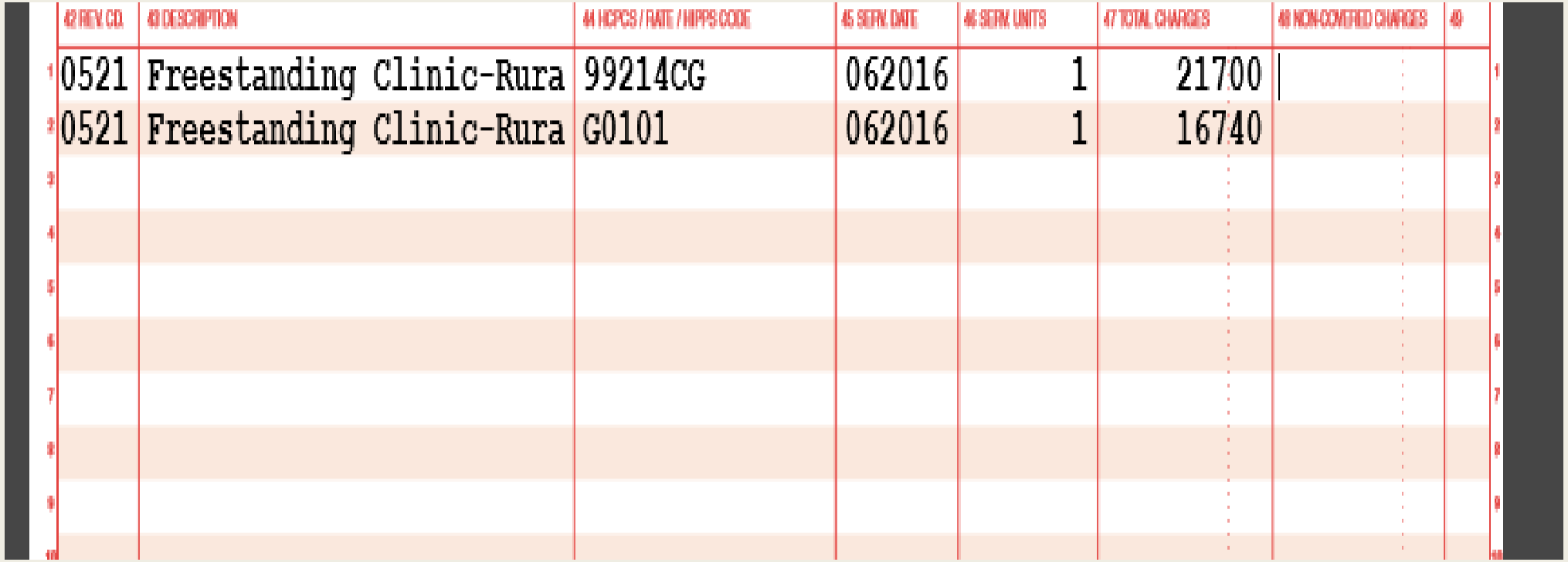
Procedure Code	Description	Paid at the AIR	Eligible for Same Day Billing	Coins/Deductible Applied
G0438	Initial Visit	Yes	No	Waived
G0439	Subsequent	Yes	No	Waived

Screenings

Procedure Code	Description	Paid at the AIR	Eligible for Same Day	Coins/Deduct Applied
G0101	CA Screening. Pelvic/Breast	Yes	No	Waived
Q0091	Obtaining Pap	Yes	No	Waived

Claim Examples

- Preventative services with an Office visit.



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	Freestanding Clinic-Rura	99214CG	062016	1	21700		
0521	Freestanding Clinic-Rura	G0101	062016	1	16740		

Two Visits on the Same Day

When the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, the subsequent medical service should be billed using revenue code 052x and modifier 59. Beginning on October 1, 2016, RHCs can also report modifier 25 to indicate the subsequent visit was distinct or independent from an earlier visit furnished on the same day. When modifier 59 or modifier 25 is reported, RHCs will receive the AIR for an additional visit. This is the only circumstance in which modifier 59 or modifier 25 should be used.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf

Claim Example

0521	Office Visit	99213CG25 or 59		175.00
0521	Office visit	99215CG		250.00

Influenza and Pneumonia Vaccines

- Should be put on your Shot Log and submitted as part of your cost report. Do not submit on a claim.

Patient Name	***Health Insurance Number***	***Date of Service***
Donald Duck	123456789A	10/15/2017
Daisy Duck	987654321A	10/15/2017

Hospice Services

- Can treat a patient for Non-Hospice Diagnosis
- If treating for Non-Hospice Diagnosis then 07 condition code must be applied to the claim
- If provider is treating for Hospice related diagnosis then claim should be billed to hospice company or adjusted. Claim **cannot** be billed to Part B.

Non RHC Services

- Hospital Visits- Billed to Part B
- DME- Must have a DME Provider number
- Part D Drugs- www.mytransactrx.com

Ancillary Services Billed as nonRHC

- Labs
  - *ALL Labs, to include the 6 basic required labs*
- EKG Tracing
- X-ray Technical Component

Medicare reg on nonRHC service billing, Labs, TCs & EKG tracing, etc: CMS Internet-Only Manual, Publication 100-04, Ch 9, Sec 90;

LABS REQUIRED TO BE PERFORMED IN RHC

- Blood Glucose testing
- Dip-stick UA
- Hemoglobin or Hematocrit
- Pregnancy Test
- Hemoccult test
- Transfer of cultures to certified lab

- Any other tests can be performed per the RHC CLIA certificate issued.

Provider Based RHC
Hospital OP Provider Number

- All labs, to include the 6 basic required labs;
  - *Remember, venipuncture is part of the office visit bundled services*
- X-ray TC;
- EKG tracing;
- Holter Monitor TCs
- Billed to MAC on HCFA UB04 Form, just as if provided at the hospital setting
- Paid the Medicare Pt B rates

Independent RHC
Part B Provider Number

- All labs, to include the 6 basic required labs
  - *Remember, venipuncture is part of the office visit bundled services*
- X-ray TC;
- EKG tracing;
- Holter Monitor TCs
- Billed to MAC on HCFA 1500 Form
- Paid on the Medicare Pt B fee schedule

“Incident to” Services

- Direct supervision by provider required
  - Must be in clinic, not in same room
  - being in the hosp when attached to clinic is NOT “incident to”
  - Exception is the Chronic Care Management services
- Part of provider’s services previously ordered
  - integral, though incidental
  - covered as part of an otherwise billable encounter
  - I.e. dressing change, injection, suture removal, blood pressure monitoring

Medicare (Medicaid if State requires) services should be billed under the provider that performed the service unless it is an “incident to” service

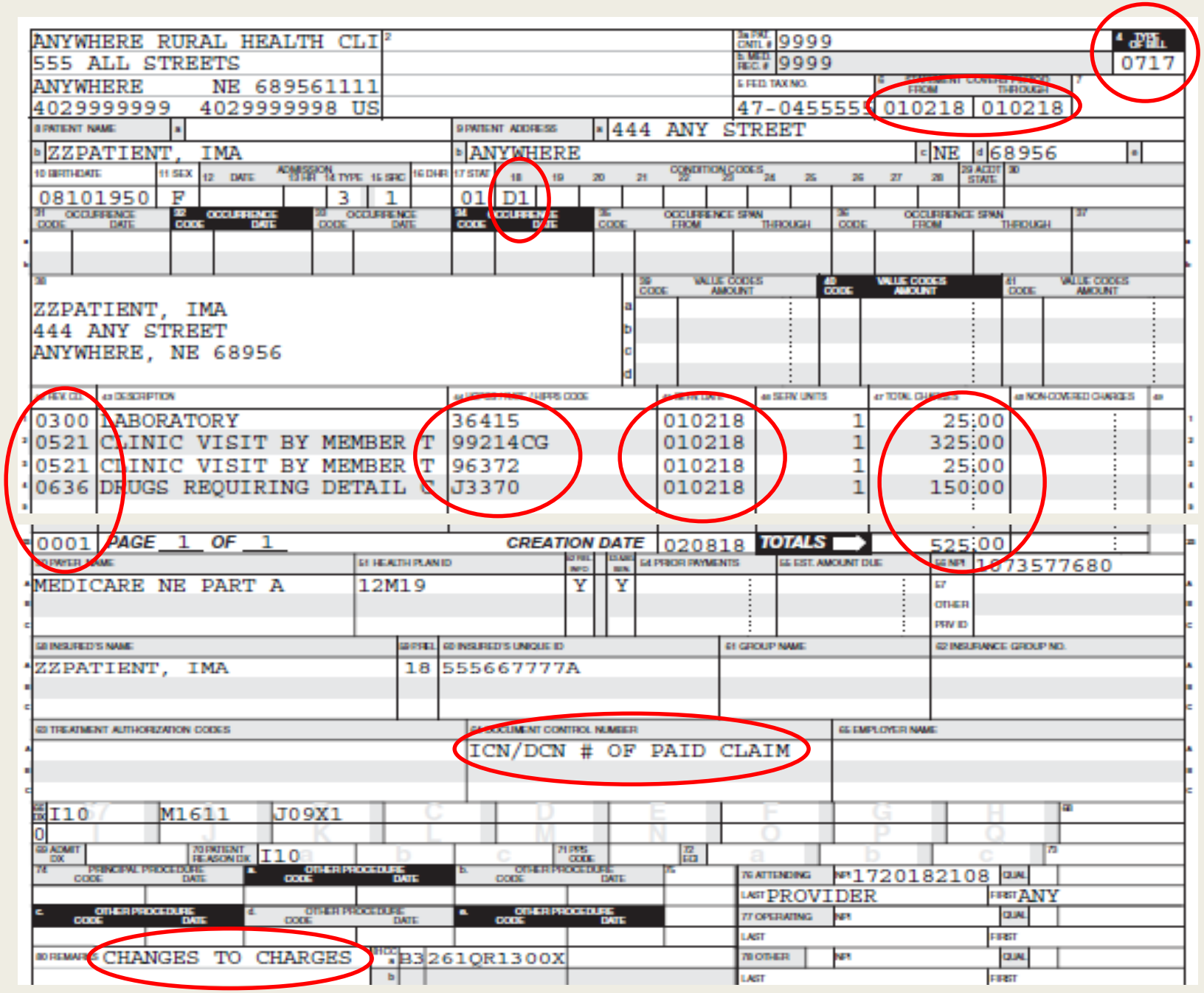
Services Rendered on non-visit days—"Incident To" Services

- Can be combined on claim with a visit within 30 days pre or post
- "incident to" service for plan of treatment established
- NEVER considered a separate visit
- List only the date of the visit as date of service
- Charges should reflect all services bundled (CG line)
  - *Added charges detail will be on subsequent lines of UB*
- When added, the added reimb is the 20% copay of the added charges
- Adjustments OK—717 Type of Bill; CC=D1; ICN# in FL 64, remarks "changes in charges"
- Otherwise, the costs are shown on your cost report and claimed indirectly

CMS 100-02, Ch 13, Sec 120

Adjustments

- TOB 717
- Claim must be in finalized status
- Adjustment will appear as a debit or credit on future remittance advice
- Encourage submitting electronically
  - *exceptions—denied charges & claims rejected as MSP*
- Do not send another 711 claim as will error as a duplicate
- Examples of Adjustments:
  - *Revenue code changes, Added Service Lines, Total charges changed, Primary payer incorrect*


ANYWHERE RURAL HEALTH CLI
555 ALL STREETS
ANYWHERE NE 689561111
4029999999 4029999998 US
9999
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0717
47-0455555
010218
010218
444 ANY STREET
ZZPATIENT, IMA
ANYWHERE
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68956
08101950
F
3
1
01
D1
ZZPATIENT, IMA
444 ANY STREET
ANYWHERE, NE 68956
0300 LABORATORY 36415 010218 1 25.00
0521 CLINIC VISIT BY MEMBER T 99214CG 010218 1 325.00
0521 CLINIC VISIT BY MEMBER T 96372 010218 1 25.00
0636 DRUGS REQUIRING DETAIL C J3370 010218 1 150.00
0001 PAGE 1 OF 1
CREATION DATE 020818
TOTALS 525.00
MEDICARE NE PART A
12M19
Y
Y
1073577680
ZZPATIENT, IMA
18
555667777A
ICN/DCN # OF PAID CLAIM
I10
M1611
J09X1
I10
1720182108
PROVIDER
ANY
CHANGES TO CHARGES
B3261QR1300X

Medicare Corporate Compliance

- Are we getting ABNs (Advanced Beneficiary Notices) when appropriate (must be CMS-R-131 03/2020)
  - *This would apply to any lab, EKG, x-ray that does not have a covered diagnosis. Cannot bill the patient if claim is denied as noncovered without the ABN.*
- Keep copy of ABN
- Are we asking the MSP (Medicare Secondary Payer) questions?
  - *These questions must be asked of the Medicare patient each time they come to the clinic for a visit.*

INTERNET WEBSITES OF INTEREST

www.narhc.org (National Association of RHCs)

www.cms.gov

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf *(Medicare Claims Processing Manual Ch 9 RHCs)*

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf *(RHC/FQHC Regs 1/18)*

Questions??

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