



Healthcare Common Procedure Coding System (HCPCS) Requirements for Rural Health Clinics (RHCs)

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Centers for Medicare and Medicaid Services

March 29, 2016

Objectives

- Review HCPCS reporting requirements.
- Discuss initial questions from the RHC community.
- Provide information to RHCs on reporting requirements.
- Answer outstanding questions.

Overview

- Corinne Axelrod
 - Introduction
 - Initial Questions
- Simone Dennis
 - HCPCS Reporting Examples
 - FAQs
- Tracey Mackey
 - HCPCS Reporting Examples



Purpose of RHC HCPCS Reporting Requirements

- Compliance with national coding standards and requirements.
- Collect data on RHC services to better inform policies.
- Increase accuracy of RHC claims processing.

Timeline

- July 15, 2015:** Physician Fee Schedule (PFS) Proposed Rule published (80 FR 41943)
- Nov. 16, 2015:** PFS Final Rule published (80 FR 71088)
- Feb. 1, 2016:** Medicare Learning Network (MLN) 9269 published
- Feb. 10, 2016:** MLN 9269 reissued
- Feb. 29, 2016:** MLN 9269 reissued
- Apr. 1, 2016:** RHCs are required to report HCPCS codes



Initial Questions

- Implementation Date
- Qualifying Visit List
- Appearance of Charges
- Crossover / Secondary Claims
- Other Questions

RHC Qualifying Visit List

- Posted on the “Spotlight” section of the RHC Center Page:
 - <https://www.cms.gov/center/provider-type/rural-health-clinics-center.html>
- Updated quarterly, as needed.
- Subscribe to the RHC Center Page to receive notifications.

RHC Visit

- Billable visits are medically-necessary, face-to-face medical or mental health visits, or qualified preventive health visits, with a RHC practitioner.
 - The RHC Qualifying Visit List consists of HCPCS codes that are stand-alone billable visits.

RHC HCPCS Reporting Examples

*Ex 1: Patient has a medical visit on March 31, 2016.**

*Ex 1a: Patient has a medical visit on April 1, 2016.**

Ex 2: Patient has medical and preventive health services.

Ex 3: Patient has preventive health services.

*Ex 4: Patient has two medical visits from the RHC qualifying visit list.**

*Ex 4a: Patient has two medical visits from the RHC qualifying visit list (additional lines reported with charges \geq \$0.01).**

*Ex 5: Patient has a mental health visit.**

Ex 6: Patient has a medical and mental health visit.

Ex 7: Patient has a medical visit (one qualifying visit and other medical services).

Ex 7a: Patient has a medical visit (one qualifying visit and other medical services with additional line reported with charges \geq \$0.01).

Ex 8: Patient has a medical visit in the morning and later in the day returns to the RHC for a new medical condition (modifier 59).

Ex 9: Patient has wound repair only.

Disclaimer

- This presentation contains information on HCPCS reporting for RHCS. It is not a legal document. Participants are encouraged to review the specific statutes, regulations, and other materials regarding billing requirements.
- This presentation contains billing and payment examples. The UB-O4 sample, HCPCS codes, revenue codes, and the associated charges used in the slides are for illustrative purposes only and should not be used as a guideline for billing or setting rates.
- The examples use the following fictional charges for illustrative purposes only:
 - 99213 = \$8.00
 - 90834 = \$8.00
 - G0101 = \$7.00
 - 12002 = \$7.00
 - G0117 = \$7.00
 - 36415 = \$5.00
 - 90863 = \$5.00
 - 69200 = \$5.00



Previous RHC Reporting Guidelines

For services furnished through *March 31, 2016*, RHCs are not required to report specific HCPCS codes when billing for RHC services.

Example 1 - Patient's Account

Patient has a medical visit on *March 31, 2016*.

| CHARGES TO THE PATIENT'S ACCOUNT | | | |
|----------------------------------|---------------------|-------|----------------|
| DATE OF SERVICE | REV. CODE | HCPCS | CHARGE |
| <i>03/31/2016</i> | 0521 | 99213 | \$8.00 |
| <i>03/31/2016</i> | 0300 | 36415 | \$5.00 |
| | | | |
| | CHARGE TOTAL | | \$13.00 |

Example 1 - UB-04 Claim

Patient has a medical visit on *March 31, 2016*.

| UB-04 CLAIM EXAMPLE | | | | | | | EXAMPLE RESULTS | |
|---------------------|--|--|--|--|--|--|-----------------|--------|
| | | | | | | | CLAIM COINS | \$2.60 |

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------------------|-------------------|----------------|-----------------|------------------------|----|
| 1 0521 | * | * | <i>03/31/2016</i> | * | \$13.00 | * | * |
| 2 0001 | * | * | * | * | \$13.00 | * | * |
| * | * | * | * | * | * | * | * |

COMMENTS

1 Paid at the AIR

2

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Example 1 - Coinsurance

Patient has a medical visit on *March 31, 2016*.

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - Office visit \$8.00 + Venipuncture \$5.00 = \$13.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$13.00 \times 0.20 = \2.60



RHC HCPCS Reporting

Effective *April 1, 2016*, RHCs, including RHCs exempt from electronic reporting under §424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes.

RHC HCPCS Reporting

- **Qualifying Visit Service Line (Revenue code 052x or 0900)**
 - Report charges for all services furnished during the encounter minus charges for preventive services.
 - Charges represent the amount that will be used to assess coinsurance and deductible.
- **Additional Service Line(s)**
 - Report each additional service furnished with the most appropriate revenue code with charges \$0.01 or greater.
- **Some charges are displayed twice**
 - On the line with the qualifying visit and on the service line for the specific service.

Example 1a – Patient’s Account

Patient has a medical visit on *April 1, 2016*.

| CHARGES TO THE PATIENT’S ACCOUNT | | | |
|----------------------------------|---------------------|-------|----------------|
| DATE OF SERVICE | REV. CODE | HCPCS | CHARGE |
| <i>04/01/2016</i> | 0521 | 99213 | \$8.00 |
| <i>04/01/2016</i> | 0300 | 36415 | \$5.00 |
| | | | |
| | CHARGE TOTAL | | \$13.00 |

Example 1a – UB-04 Claim

Patient has a medical visit on *April 1, 2016*.

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$2.60 |
|-------------|--------|

COMMENTS

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 0521 | * | 99213 | 04/01/2016 | 1 | \$13.00 | * | * |
| 2 0300 | * | 36415 | 04/01/2016 | 1 | \$5.00 | * | * |
| 3 0001 | * | * | * | * | \$18.00 | * | * |
| * | * | * | * | * | * | * | * |

- 1 Paid at the AIR
- 2 Medicare assigns CARC 97
- 3

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Example 1a - Reporting

Patient has a medical visit on *April 1, 2016*.

- Report the most appropriate HCPCS code from the qualifying visit list on the 0521 service line.
- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - Same as it is pre HCPCS reporting.
 - Office visit \$8.00 + Venipuncture \$5.00 = \$13.00

Example 1a – Additional Line(s)

Patient has a medical visit on *April 1, 2016*.

- Additional service(s) are reported with the most appropriate revenue code(s) and HCPCS code(s).
 - Payment for these lines are included in the all-inclusive rate (AIR) and will be assigned Claim Adjustment Reason Codes (CARC) 97.
 - CARC 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Example 1a – Coinsurance / Payment

Patient has a medical visit on *April 1, 2016*.

- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - The same as it is pre HCPCS reporting.
 - $\$13.00 \times 0.20 = \2.60
- Medicare pays 80% of the RHC AIR, subject to the payment limit.

Example 2 – Patient’s Account

Patient has medical and preventive health services.

| CHARGES TO THE PATIENT’S ACCOUNT | | | |
|----------------------------------|-----------|--|-----------------------|
| DATE OF SERVICE | REV. CODE | HCPCS | CHARGE |
| 04/01/2016 | 0521 | 99213 | \$8.00 |
| 04/01/2016 | 0521 | G0101 | \$7.00 |
| 04/01/2016 | 0300 | 36415 | \$5.00 |
| | | | |
| | | CHARGE TOTAL | \$20.00 |
| | | <i>CHARGE TOTAL (minus preventives)</i> | <i>\$13.00</i> |

Example 2 – UB-04 Claim

Patient has medical and preventive health services.

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$2.60 |
|-------------|--------|

| | 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|---|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 | 0521 | * | 99213 | 04/01/2016 | 1 | \$13.00 | * | * |
| 2 | 0521 | * | G0101 | 04/01/2016 | 1 | \$7.00 | * | * |
| 3 | 0300 | * | 36415 | 04/01/2016 | 1 | \$5.00 | * | * |
| 4 | 0001 | * | * | * | * | \$25.00 | * | * |
| | * | * | * | * | * | * | * | * |

COMMENTS

- 1 Paid at the AIR
- 2 Medicare assigns CARC 97
- 3 Medicare assigns CARC 97
- 4

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Example 2 - Coinsurance

Patient has medical and preventive health services.

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - Office visit \$8.00 + Venipuncture \$5.00 = \$13.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$13.00 \times 0.20 = \2.60

Example 3 – UB-04 Claim

Patient has preventive health services.

| UB-04 CLAIM EXAMPLE | | | | | | | | EXAMPLE RESULTS | |
|---------------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|-----------------|-----------------|
| | | | | | | | | CLAIM COINS | \$0.00 |
| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 | COMMENTS | |
| 1 0521 | * | G0101 | 04/01/2016 | 1 | \$7.00 | * | * | 1 | Paid at the AIR |
| 2 0001 | * | * | * | * | \$7.00 | * | * | 2 | |
| 3 * | * | * | * | * | * | * | * | 3 | |

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Example 3 - Coinsurance

Patient has preventive health services.

- The charges for preventive services are reported on the 0521 service line and are not subject to coinsurance and deductible.
 - 0521 service line = \$7.00

Example 4 – Patient’s Account

Patient has two medical visits from the RHC qualifying visit list.

| CHARGES TO THE PATIENT’S ACCOUNT | | | |
|----------------------------------|-----------|---------------------|----------------|
| DATE OF SERVICE | REV. CODE | HCPCS | CHARGE |
| 04/01/2016 | 0521 | 99213 | \$8.00 |
| 04/01/2016 | 0521 | 12002 | \$7.00 |
| 04/01/2016 | 0300 | 36415 | \$5.00 |
| | | | |
| | | CHARGE TOTAL | \$20.00 |

Example 4 – UB-04 Claim

Patient has two medical visits from the RHC qualifying visit list.

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$4.00 |
|-------------|--------|

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 0521 | * | 99213 | 04/01/2016 | 1 | \$20.00 | * | * |
| 2 0521 | * | 12002 | 04/01/2016 | 1 | \$7.00 | * | * |
| 3 0300 | * | 36415 | 04/01/2016 | 1 | \$5.00 | * | * |
| 4 0001 | * | * | * | * | \$32.00 | * | * |
| * | * | * | * | * | * | * | * |

COMMENTS

- 1 Paid at the AIR
- 2 Medicare assigns CARC 97
- 3 Medicare assigns CARC 97
- 4

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Example 4 - Coinsurance

Patient has two medical visits from the RHC qualifying visit list.

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - Office visit \$8.00 + Wound Repair \$7.00 + Venipuncture \$5.00 = \$20.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$20.00 \times 0.20 = \4.00



Example 4a – Charges \geq \$0.01

All other services furnished during the visit are reported with a charge greater to or equal to *\$0.01*.

Example 4a – UB-04 Claim

Ex 4a: Patient has two medical visits from the RHC qualifying visit list (*additional lines reported with charges ≥\$0.01*).

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$4.00 |
|-------------|--------|

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 0521 | * | 99213 | 04/01/2016 | 1 | \$20.00 | * | * |
| 2 0521 | * | 12002 | 04/01/2016 | 1 | <i>\$0.01</i> | * | * |
| 3 0300 | * | 36415 | 04/01/2016 | 1 | <i>\$0.01</i> | * | * |
| 4 0001 | * | * | * | * | <i>\$20.02</i> | * | * |
| * | * | * | * | * | * | * | * |

COMMENTS

- 1 Paid at the AIR
- 2 Medicare assigns CARC 97
- 3 Medicare assigns CARC 97
- 4

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Example 4a - Coinsurance

Ex 4a: Patient has two medical visits from the RHC qualifying visit list (*additional lines reported with charges \geq \$0.01*).

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - Office visit \$8.00 + Wound Repair \$7.00 + Venipuncture \$5.00 = \$20.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$20.00 \times 0.20 = \4.00
- The charges reported on the subsequent lines do not impact the coinsurance.

Example 5 – Patient’s Account

Patient has a mental health visit.

| CHARGES TO THE PATIENT’S ACCOUNT | | | |
|----------------------------------|-----------|---------------------|----------------|
| DATE OF SERVICE | REV. CODE | HCPCS | CHARGE |
| 04/01/2016 | 0900 | 90834 | \$8.00 |
| 04/01/2016 | 0900 | 90863 | \$5.00 |
| | | | |
| | | CHARGE TOTAL | \$13.00 |

Example 5 – UB-04 Claim

Patient has a mental health visit.

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$2.60 |
|-------------|--------|

| | 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|---|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 | 0900 | * | 90834 | 04/01/2016 | 1 | \$13.00 | * | * |
| 2 | 0900 | * | 90863 | 04/01/2016 | 1 | \$5.00 | * | * |
| 3 | 0001 | * | * | * | * | \$18.00 | * | * |
| | * | * | * | * | * | * | * | * |

COMMENTS

- 1 Paid at the AIR
- 2 Medicare assigns CARC 97
- 3

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Example 5 - Coinsurance

Patient has a mental health visit.

- Charges subject to coinsurance and deductible are reported on the 0900 service line.
 - Psychotherapy \$8.00 + Med. Management \$5.00 = \$13.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$13.00 \times 0.20 = \2.60

Example 6 – UB-04 Claim

Patient has a medical and mental health visit.

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$5.20 |
|-------------|--------|

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 0521 | * | 99213 | 04/01/2016 | 1 | \$13.00 | * | * |
| 2 0300 | * | 36415 | 04/01/2016 | 1 | \$5.00 | * | * |
| 3 0900 | * | 90834 | 04/01/2016 | 1 | \$13.00 | * | * |
| 4 0900 | * | 90863 | 04/01/2016 | 1 | \$5.00 | * | * |
| 5 0001 | * | * | * | * | \$36.00 | * | * |

COMMENTS

- 1 Paid at the AIR
- 2 Medicare assigns CARC 97
- 3 Paid at the AIR
- 4 Medicare assigns CARC 97
- 5

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Example 6 - Coinsurance

Patient has a medical and mental health visit.

- Charges for medical services subject to coinsurance and deductible are reported on the 0521 service line.
 - Office visit \$8.00 + Venipuncture \$5.00 = \$13.00
- Charges for mental health services subject to coinsurance and deductible are reported on the 0900 service line.
 - Psychotherapy \$8.00 + Med. Management \$5.00 = \$13.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $(\$13.00 + \$13.00) \times 0.20 = \$5.20$

Example 7 – UB-04

Patient has a medical visit (one qualifying visit and other medical services).

| UB-04 CLAIM EXAMPLE | | | | | | EXAMPLE RESULTS | |
|---------------------|--|--|--|--|--|-----------------|--------|
| | | | | | | CLAIM COINS | \$2.60 |

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 | COMMENTS |
|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|----------------------------|
| 1 0521 | * | 99213 | 04/01/2016 | 1 | \$13.00 | * | * | 1 Paid at the AIR |
| 2 0521 | * | 69200 | 04/01/2016 | 1 | \$5.00 | * | * | 2 Medicare assigns CARC 97 |
| 3 0001 | * | * | * | * | \$18.00 | * | * | 3 |

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Example 7 - Coinsurance

Patient has a medical visit (one qualifying visit and other medical services).

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - Office visit \$8.00 + Foreign Body Removal \$5.00 = \$13.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$13.00 \times 0.20 = \2.60

Example 7a - Charges \geq \$0.01

All other services furnished during the visit are reported with a charge greater to or equal to *\$0.01*.

Example 7a – UB-04

Patient has a medical visit (one qualifying visit and other medical services with **additional line reported with charges \geq \$0.01**).

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$4.80 |
|-------------|--------|

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 0521 | * | 99213 | 04/01/2016 | 1 | \$13.00 | * | * |
| 2 0521 | * | 69200 | 04/01/2016 | 1 | \$0.01 | * | * |
| 0001 | * | * | * | * | \$13.01 | * | * |
| * | * | * | * | * | * | * | * |

COMMENTS

- 1 Paid at the AIR
- 2 Medicare assigns CARC 97

* Field intentionally left blank

Example 7a - Coinsurance

Patient has a medical visit (one qualifying visit and other medical services with *additional line reported with charges \geq \$0.01*).

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - Office visit \$8.00 + Foreign Body Removal \$5.00 = \$13.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$13.00 \times 0.20 = \2.60
- The charges reported on the subsequent lines do not impact the coinsurance.

Modifier 59

- Reported when the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day.
- *Modifier 59* signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day.
 - This is the only circumstance in which modifier 59 should be used.

Example 8 – UB-04 Claim

Patient has a medical visit in the morning and later in the day returns to the RHC for a new medical condition (modifier 59).

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$3.00 |
|-------------|--------|

| 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 0521 | * | G0117 | 04/01/2016 | 1 | \$7.00 | * | * |
| 2 0521 | * | 99213 59 | 04/01/2016 | 1 | \$8.00 | * | * |
| 0001 | * | * | * | * | \$15.00 | * | * |

COMMENTS

- 1 Paid at the AIR
- 2 Paid at the AIR

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Example 8 - Coinsurance

Patient has a medical visit in the morning and later in the day returns to the RHC for a new medical condition (modifier 59).

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - 0521 service line = \$7.00
- Charges for subsequent services subject to coinsurance and deductible are reported on an additional 0521 service line with modifier 59.
 - Subsequent 0521 service line = \$8.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $(\$7.00 + \$8.00) \times 0.20 = \$3.00$

Example 9 – UB-04 Claim

Patient has wound repair only.

UB-04 CLAIM EXAMPLE

EXAMPLE RESULTS

| | |
|-------------|--------|
| CLAIM COINS | \$1.40 |
|-------------|--------|

| | 42 Rev. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGE | 48 NON-COVERED CHARGES | 49 |
|---|-------------|----------------|------------------------------|---------------|----------------|-----------------|------------------------|----|
| 1 | 0521 | * | 12002 | 04/01/2016 | 1 | \$7.00 | * | * |
| 2 | 0001 | * | * | * | * | \$7.00 | * | * |
| | * | * | * | * | * | * | * | * |

COMMENTS

1 Paid at the AIR

2

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Note: CMS updated the RHC Qualifying Visit List on 3/24/16 with additional medically-necessary services. RHC held claim and claim was received after 10/01/2016.

Example 9 - Coinsurance

Patient has wound repair only.

- Charges subject to coinsurance and deductible are reported on the 0521 service line.
 - 0521 service line = \$7.00
- Coinsurance (20 percent of charges reported on the qualifying visit line)
 - $\$7.00 \times 0.20 = \1.40



Frequently Asked Questions



Frequently Asked Questions

Q: For services furnished through March 31, but billed after April 1, should those claims follow the new reporting requirements?

A: The reporting requirements are effective for dates of service on or after April 1, 2016. Claims for services furnished before April 1 should be billed under the previous guidelines with no HCPCS codes.



Frequently Asked Questions

Q: Can CMS delay the April 1, 2016 implementation of the reporting requirements?

A: Medicare changes are already in place. A delay is not possible.



Frequently Asked Questions

Q: Are services not on the RHC qualifying billable visit list payable as a stand-alone service?

A: Medicare covered services not on the RHC qualifying visit list are allowable but not payable as a stand-alone service. CMS will update the qualifying visit list quarterly, as needed.



Frequently Asked Questions

Q: Should charges for all services furnished be reported on the qualifying visit service line?

A: Yes. The charges for the visit should be reported on the qualifying visit line minus charges for preventive services. Charges represent the amount that will be used to assess coinsurance and deductible. Additional service line(s) should be reported for each additional service rendered with charges greater to or equal to \$0.01.



Frequently Asked Questions

Q: What charges are represented on the total line (0001 revenue code) and are some charges displayed twice?

A: Total line (0001 revenue code) is the sum of all of the charges reported on the claim. Some charges are displayed twice, once on the qualifying visit service line and on the line for the specific service.



Frequently Asked Questions

Q: Does Medicare pay based upon the charges reported on the qualifying visit line or the total charges (0001 revenue line) on the claim?

A: Medicare does not pay or adjudicate the total line (0001 revenue line). Payment is based on the qualifying visit line.



Frequently Asked Questions

Q: Should claims to Medicare as the secondary payer follow the new reporting requirements?

A: Yes. All claims to Medicare should follow the new reporting requirements.

Frequently Asked Questions

Q: What revenue codes are reported on RHC claims?

A: RHCs should report the most appropriate revenue code for the services being performed. The qualifying visit line should be reported with revenue code 052x or 0900. For additional lines RHCs can report services using all valid revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. A complete list of revenue codes can be found in a National Uniform Billing Committee publication.

Questions?

- Billing or MA Questions: Contact your MAC
- RHC Payment Policies:
Corinne.Axelrod@cms.hhs.gov or
Simone.Dennis@cms.hhs.gov
- RHC Claims Processing:
Tracey.Mackey@cms.hhs.gov