RHC BILLING 101

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WHAT IS AN RHC?

- A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement.
- RHCs are required to be staffed at least 50% of the time with a midlevel practitioner (PA, NP, CNM, PhD, CSW, or LCSW).
- Must be 51% Primary Care Services

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TWO DIFFERENT TYPES OF RHC

- Independent RHC
  - Professional billing is submitted under the CLINIC Part A number.
  - Technical billing is submitted under individual provider or group Medicare part B number.

- Provider Based RHC
  - Professional billing is submitted under the CLINIC Part A number.
  - Technical billing is submitted under Hospital billing number.

RHC LOCATIONS

- The clinic (office)
- Home visit (the home of the patient)
- Nursing Home/Skilled nursing facility
- Scene of an accident

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RHC Providers

- Physicians
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwifes (CNM)
- Clinical Psychologists
- Clinical Social Workers (CSW or LCSW)

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What is an RHC encounter?

- Medically necessary, face to face medical or mental health visit between the patient and a physician, NP, PA, CNM, CP, LCSW or CSW during which a qualified RHC service is provided.

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RHC Services

- Physician services (MD or DO)
- Services and supplies incident to the services of a physician
- Nurse Practitioners, Physician Assistants, Certified Nurse-Midwife, Clinical Psychologist, and Clinic Social Worker services
- Services and supplies incident to the services of a NP, PA, CNM, CP, LCSW and CSW
- Visiting nurse services to the homebound in an area where CMS has certified that there is a shortage of Home Health Agencies.

Services that do not meet the requirements

- Review Lab tests/results only
- Dressing change
- Refill of prescriptions
- Administration of injection only or allergy shot
- Completion of claim forms
- Care plan oversight
- 99211 is NOT an RHC encounter. If the provider is billing this level they are most likely under coding

NON-RHC SERVICES

- Laboratory services
- Diagnostic testing (technical component)
- X-ray & EKG (technical component)
- Professional services done in the hospital
- Part D Drugs(www.mytransactrx.com) & self administered drugs
- DME – must have DME provider number

Medicare & Medicare Advantage

RHC Billing

BILLING GUIDELINES

- All billing is subject to CMS guidelines.
- Verify that your credentialing/enrollments are correct and current.
- Verify that the NPPES website has current information and that the clinic NPI has the correct taxonomy codes including Rural Health Clinic, 261QR1300X.
- Midlevel providers need to have their own Medicare Part B billing numbers.
- Know your carriers and if the midlevel needs to bill under the supervising physician or if they can be credentialed as a provider.

BILLING GUIDELINES continued

- A patient must have Medicare part B coverage in order to bill for RHC services (Part A covers inpatient hospital and other nursing facilities, not RHC services)

- If the patient has a Medicare Advantage plan, then that plan is billed in place of regular Medicare (ie. Aetna Medicare, Humana Medicare, UHC Medicare Solutions, etc.)

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BILLING GUIDELINES continued

- Commingling is being paid twice from Medicare for the same service(s) and is considered fraud. You cannot bill Medicare part B for RHC services.

- Since RHCs are billing incident-to services and the professional component of certain tests to Medicare Part A along with an RHC visit, you cannot bill the same services to Medicare Part B to receive a second payment (examples are J code drugs, blood draws, x-ray readings)

- Procedures and surgeries are considered RHC visits and billed on the UB04 to Medicare part A, bundled with E&M and incident-to if performed on the same day

RHC Encounter Billing

- File on the UB04 claim form
- Submit claim to Medicare part A
- Type of bill:
  - 710 Claim for non-covered charges to get rejection to bill patient or secondary insurance
  - 711 for RHC original claim
  - 717 for adjusted (must include the ICN/DCN from original claim)
  - 718 for voided (must include the ICN/DCN from original claim)

RHC Encounter Billing continued

- Revenue Codes for the RHC encounter:
  - 0521 Clinic visit at RHC by qualified provider
  - 0522 Home visit by RHC provider
  - 0524 Visit by RHC provider to a Part A SNF bed
  - 0525 Visit by RHC provider to a SNF, NF or other residential facility (non-Part A)
  - 0527 Visiting Nurse service in home health shortage area
  - 0528 Visit by RHC provider to other non-RHC site (scene of accident)
  - 0780 Telehealth originating site facility fee (CPT code Q3014)
  - 0900 Mental Health Services

RHC Encounter Billing continued

- Some examples of other revenue codes for incident to services:
  - 0300 Blood draw (36415)
  - 0320 X-ray professional component (reading)
  - 0412 Respiratory Services (94640, etc)
  - 0636 J code drugs (J1885, J0696, etc)
  - 0521 Admin of drug (96372) – or use the same rev code as the RHC visit, see previous page

RHC Encounter Billing continued

- Bundle all CPT CHARGES that have coinsurance/deductible due into the first line on the UB04 and include the charges for the first CPT line, add the modifier CG to this line

- The other lines can have their regular fee schedule charge or $0.01, but cannot be $0.00. Also, there will be no CG modifier on these subsequent lines

For example below: 99213-$80.00, 36415-$3.00, 10060-$120.00

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/ Deductible applied
052x	99213CG	5/1/2016	1	$203.00	80% of AIR	Yes
052x	10060	5/1/2016	1	$120.00	Included in AIR	No
0300	36415	5/1/2016	1	$3.00	Included in AIR	No

RHC Encounter Billing continued

For example below: 12001 – $150.00 , 99213–$80.00, 36415–$3.00, 96372 – $40.00, J1040 – $10.00, 94640 – $20.00

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/ Deductible applied
052x	12001CG	5/1/2016	1	$303.00	80% of AIR	Yes
052x	99213	5/1/2016	1	$80.00	Included in AIR	No
0300	36415	5/1/2016	1	$3.00	Included in AIR	No
052x	96372	5/1/2016	1	$40.00	Included in AIR	No
0636	J1040	5/1/2016	1	$10.00	Included in AIR	No
0412	94640	5/1/2016	1	$20.00	Included in AIR	No

RHC Encounter Billing continued

Since Medicare waives the coinsurance or deductible on wellness visits, they are an exception to the bundling rule. These charges must go on their own line and not bundled with any other CPT charges on the same claim (examples: G0438, G0439, G0402, G0101, etc).

For examples below: 99213-$80.00, 36415-$3.00, 10060-$120.00, G0439-$150.00

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/Deductible applied
052x	G0439CG	5/1/2016	1	$150.00	100% of AIR	No

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/Deductible applied
052x	99213CG	5/1/2016	1	$203.00	80% of AIR	Yes
052x	10060	5/1/2016	1	$120.00	Included in AIR	No
0300	36415	5/1/2016	1	$3.00	Included in AIR	No
052x	G0439	5/1/2016	1	$150.00	Included in 99213 AIR	No

No CG modifier

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RHC Encounter Billing continued

You can add other incident to CPT such as injections, allergy shots, blood draw (36415), that are not billable on their own to a visit within 30 days to increase the 20% coinsurance, but you still only get one RHC Rate for the face to face visit.

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/ Deductible applied
052x	99213CG	5/1/2016	1	$203.00	80% of AIR	Yes
052x	10060	5/1/2016	1	$120.00	Included in AIR	No
0300	36415	5/1/2016	1	$3.00	Included in AIR	No

The 36415 is from a different date (4/26/2016), but you use the visit date for the claim.

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RHC Encounter Billing continued

- After deductible is met, coinsurance is 20% of the total charge of professional services rendered, NOT 20% of the Medicare allowed amount
- Only one medical encounter per day is paid at the AIR, however, you can bill both a mental health visit and a medical visit on the same day and get paid for both
- Two AIRs can be paid on one day, in the rare case where a patient comes in for a sick visit, then returns for a DIFFERENT reason like an accident, add modifier 25 or 59

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/ Deductible applied
052x	99213 CG	5/1/2016	1	$200.00	80% of AIR	Yes
052x	12001 59	5/1/2016	1	$120.00	Second AIR paid at 80%	No

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WELCOME TO MEDICARE Exam – IPPE (G0402)

- This is payable once per lifetime
- The service must be rendered within twelve months of the patient becoming eligible for Medicare or if they are enrolled in Medicare and they have NOT had their welcome visit.
- The coinsurance or deductible are not applicable to this service
- The IPPE is the only Medicare preventative service that is eligible to be paid in addition to other services on the same day (ie. 99213, 12001, etc)

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ANNUAL WELLNESS VISIT

- Annual wellness is NOT a physical
- Medicare DOES NOT pay for the wellness exam, i.e., 99397
- G0438/G0439
  Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

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ANNUAL WELLNESS VISIT

- The initial annual wellness visit (AWV) includes taking the patient's history; compiling a list of the patient's current providers; taking the patient's vital signs, including height and weight; reviewing the patient's risk factor for depression; identifying any cognitive impairment; reviewing the patient's functional ability and level of safety (based on observation or screening questions); setting up a written patient screening schedule; compiling a list of risk factors, and furnishing personalized health services and referrals, as necessary.

- Subsequent annual wellness visits (AWV) include updating the patient's medical and family history, updating the current provider list, obtaining the patient's vital signs and weight, identifying cognitive impairment, updating the screening schedule, updating the risk factors list, and providing personalized health advice to the patient.

Chronic Care Management

(Reference: MLN matters MM10843)

- CCM Services is at least 20 minutes of care management services directed by an RHC provider, per calendar month
  - G0511 (replaces 99490, 99487, 99484) – $62.28 – 2018 payment rate
  - Initiating Visit: E/M, Annual Wellness Visit or IPPE furnished by physician, NP, PA, CNM has occurred no more than one-year prior to commencing care coordination services
  - Beneficiary Consent obtained – can be written or verbal, must be documented in the medical record
  - Patient Eligibility: Patient must have:
    - Option A: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, OR
    - Option B: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.
  - RHC face to face requirement waived
  - General supervision requirements apply instead of direct supervision requirements
  - Paid once per month, coinsurance and deductible apply
  - Cannot be billed during TCM or home health care supervision services

Psychiatric Chronic Care Management (G012)

- Psychiatric CCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment. It includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving. The primary care team regularly reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care, as needed.

- Patients with mental health, behavioral health, or psychiatric conditions, including substance use disorders, who are being treated by an RHC or FQHC practitioner may be eligible for psychiatric CoCM services, as determined by the RHC or FQHC *primary care practitioner.*

- Psychiatric CoCM services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for psychiatric CoCM as for CCM and BHI services, as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of psychiatric CoCM services.

- The behavioral health care manager is a designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs.

- The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant is not required to be on site or to have direct contact with the patient and does not prescribe medications or furnish treatment to the beneficiary directly.

- Paid at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services)

Advanced Care Planning

- Explanation and discussion of advanced directives by the physician or other qualified health professional.
- 99497 for the first 30 minutes
- 99498 for additional 30 minutes
- There are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limits. When the service is billed multiple times for a given beneficiary, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.
- Deductible and copay apply except when furnished as part of the AWV

Virtual Communications Services (G0071)

- Effective January 1, 2019, RHCs receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR payment when the requirements for these services are met. Coinsurance and deductibles apply to RHC claims.
- At least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC practitioner to a patient that has had a billable visit in the RHC within the previous year.
- The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and does not lead to an RHC service within the next 24 hours or at the soonest available appointment.
- If the discussion between the patient and the RHC practitioner is related to a billable visit furnished by the RHC or FQHC within the previous 7 days or within the next 24 hours or at the soonest available appointment, the cost of the RHC or FQHC practitioner's time would be included in the RHC AIR or the FQHC PPS payment and is not separately billable.
- Paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services)

BILLING AND PAYMENT

- HCPCS code G0071 (Virtual Communication Services)
  - New Virtual Communications G-code for use by RHCs and FQHCs only
- Payment rate set at the average of the PFS national non-facility payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services)

BILLING AND PAYMENT

- RHC would be able to bill the Virtual Communications G-code either alone or with other payable services
- The payment rate for the Virtual Communications G-code would be updated annually based on the PFS amounts

BILLING AND PAYMENT

- G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)

BILLING AND PAYMENT

- G2010 (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment)

BILLING AND PAYMENT

- Coinsurance and deductibles apply to RHC claims for G0071
- Face-to-face billing requirements are waived

BILLING AND PAYMENT

- Coinsurance and deductibles apply to RHC claims for G0071
- Face-to-face billing requirements are waived

- **Fact Sheets, FAQs, Benefit Policy Manual**
  - **https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html**

RHC Vaccine Billing

- Hepatitis B vaccine (for patients at high or intermediate risk) – bill on UB04 on it's own line so coinsurance or deductible will not be applied by Medicare, do not bundle charges with other service lines

- Vaccines directly related to the **treatment of an injury or direct exposure to a disease or condition** – bill on UB04, charges bundled with a visit

- Other vaccines are covered under Medicare part D, you can use a third party service to bill these services (example: www.mytransactrx.com)

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RHC Vaccine Billing continued

These injections are covered under the RHC program

- Influenza virus vaccine (Q2035, Q2036, 90686, 90756, etc)
- Pneumococcal pneumonia vaccine/Includes Prevnar 13 (90732, 90670)

Billing for influenza and pneumonia vaccines

- Regular Medicare services are NOT to be billed on a claim – A log needs to be kept for these injections and they are submitted with the cost report
  - Date of service
  - Patient name
  - Patient Medicare Number
  - Vaccine type
- Medicare Advantage plans are to be billed on a HCFA 1500 with the administration code. Use Medicare billing CPT codes for Flu/pneumo. (G and Q code series)

Non-RHC Billing

The following services are billed to Medicare part B using the group Medicare part B number (IRHC) or the hospital number (PBRHC)

1. LABORATORY

   RHCs must be able to perform the follow 6 CLIA waived lab tests, but they are billed as non-RHC services

   - Chemical examination of urine by stick or tablet method or both (ie. 81002)
   - Hemoglobin or hematocrit (ie. 83026)
   - Blood sugar (ie. 82962)
   - Examination of stool specimens for occult blood (ie 82270)
   - Pregnancy tests (ie. 81025)
   - Primary culturing for transmittal to a certified laboratory

2. DIAGNOTICS TESTS, EKGs, RADIOLOGY – technical portion only billed to part B

3. PROFESSIONAL SERVICES DONE IN THE HOSPITAL

FINANCIAL INFORMATION

RHC Payments/copays/deductibles

- Regular Medicare
  - Will pay 80% of the RHC encounter rate after the patient's deductible is met
  - The patient/secondary insurance will be responsible for 20% of the CHARGE after the deductible is met
- Medicare Advantage Plans
  - Will pay RHC rate minus any copays/deductibles
  - The patient/secondary insurance usually owes a flat copay amount (ie $25.00) if there is no deductible

Financial examples

CPT codes 99213 ($50.00), 96372 ($30.00), J1885($20.00), 81002($15.00)

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/Deductible applied
0521	99213CG	5/2/2017	1	$100.00	80% of AIR	Yes
0521	96372	5/2/2017	1	$30.00	Included in AIR	No
0636	J1885	5/2/2017	4	$20.00	Included in AIR	No

- Regular Medicare will pay 80% of RHC rate, patient will owe 20% of the $100 or $20.00, after deductible met
- Medicare Advantage will pay RHC rate minus coinsurance, patient will owe their contracted coinsurance/deductible

CMS1500 (FFS billing to part B) – 81002

- Regular Medicare will pay according to the part B fee schedule, patient may owe 20% of Medicare ALLOWED amount depending on the lab, some are coinsurance waived
- Medicare Advantage will pay according to their fee schedule minus any coinsurance due

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Financial examples continued

CPT codes 99213 ($80.00), 10060 ($200.00), 85610 ($15.00), G0439 ($150.00)

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/Deductible applied
0521	99213CG	5/2/2017	1	$280.00	80% of AIR	Yes
0521	10060	5/2/2017	1	$200.00	Included in AIR	No
0521	G0439	5/2/2017	1	$150.00	Included in 99213 AIR	No

- Medicare will pay 80% of the RHC rate, patient will owe 20% coinsurance on the $280.00 for total due $56.00, if deductible is met
- Medicare Advantage will pay RHC minus coinsurance or deductible

CMS1500 (FFS billing to part B) – 85610 QW

- Regular Medicare will pay according to the part B fee schedule, patient may owe 20% of Medicare ALLOWED amount depending on the lab, some are coinsurance waived
- Medicare Advantage will pay according to their fee schedule minus any coinsurance due

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Financial examples continued

CPT codes G0439 ($150.00), G0101 ($50.00)

Revenue Code	HCPCS	Service Dates	Units	Total Charges	Payment	Coinsurance/Deductible applied
0521	G0439CG	5/2/2017	1	$150.00	100% of AIR	No
0521	G0101	5/2/2017	1	$50.00	Included in AIR	No

- Medicare will pay 100% of the RHC rate once, not for both
- Medicare Advantage will pay 100% of RHC rate as long as the clinic's contract with the insurance does not state different

CPT codes G0008, 90688 (influenza) and G0009, 90732 (pneumonia), etc.

- Medicare not billed, put on log, paid with cost report settlement
- Medicare Advantage billed on CMS1500 paid at contracted rate, usually no copay due

How Medicare handles deductibles

UB04 claim with total charges $200.00

- Patient has $147.00 deductible due
- RHC rate is $80.44

Medicare ERA will show as follows:

- Deductible due $147.00
- Copayment due $10.60 (200.00-147.00) x 20%
- Medicare payment NEGATIVE $77.16,

  Medicare takes $77.16 back from the clinic since the clinic "will be" paid $157.60 from the secondary insurance or patient and is only allowed $80.44 (RHC rate)

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MEDICARE SECONDARY PAYER

- Collect patient health insurance or coverage information at EACH patient visit.

- Tools can be found on the CMS website:
  - http://www.cms.gov/manuals/downloads/msp105c03.pdf

- Bill the primary payer before billing Medicare, add value codes to MSP claims (ie. 12- primary paid for pt age over 65, 43-primary paid for pt under age 65, 44 - primary allowed amount, etc)

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MEDICARE BAD DEBT

- RHCs are allowed to claim bad debts in accordance with 42 CFR 413.80. RHCs may claim unpaid deductible. The RHC must establish that reasonable efforts were made to collect these co-insurance amounts in order to receive payment for bad debts. If the RHC coinsurance or deductible is waived, the clinic may not claim bad debt amounts for which it assumed the beneficiary's liability.
- Reasonable attempts must be made to attempt to collect the bad debt. Trail to show statements/billing in a routine pattern for 120 days.
- Only services rendered during RHC effectiveness qualify to be written off for Medicare Bad Debt.
- Medicare Bad Debt is reported in the year it was written off.
- Any denials by Medicaid as secondary payer as long as claim was actually billed and denied
- Documented charity write-offs

OTHER REPORTS

OTHER REPORTS

- Credit Balance Reports
  - Due 30 days after the end of each fiscal quarter
  - Report over-payments from Medicare
  - No payments will be made if you do not complete this report
- CMS billing audit reports
  - CMS may ask for 25 patients specific billing for a date of service and the office notes to support the billing.
  - An adjudicator reviews and decides if the service was a medical necessity.
  - Monies can be taken back by Medicare. There is an appeal process through the adjudicator.

COMMERCIAL BILLING

- You will submit your commercial, workers comp, and auto claims as you always have. These are submitted on 1500 claim forms.
- You will bill your self pay services as you always have through your statement services.
- You may still turn accounts over to collections
  - Have a process
  - Have policy

RHC Resources

- Chapter 13 of the "Medicare Benefit Policy Manual" (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf on the CMS website

- Chapter 9 of the "Medicare Claims Processing Manual" (Publication 100-04)located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf on the CMS website

- National Association of Rural Health Clinics (http://narhc.org)

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QUESTIONS /ANSWERS

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