

WHAT IS A RHC?

 A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.

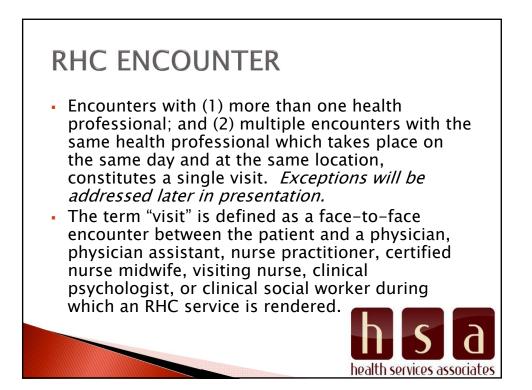




RHC LOCATIONS

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



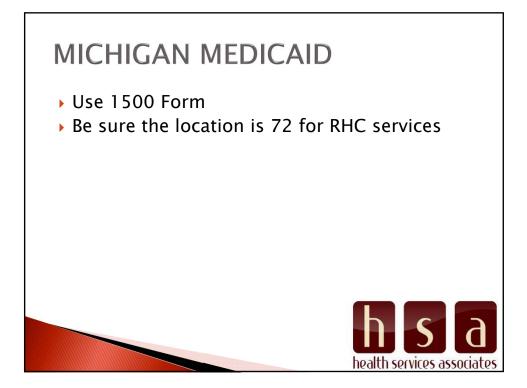


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COMMERCIAL AND MEDICAID RHC BILLING



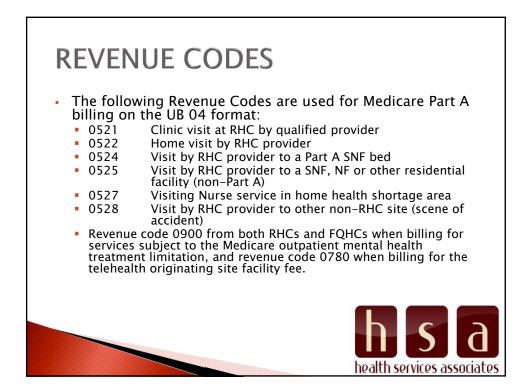




BILLING GUIDELINES

- All billing is subject to CMS guidelines.
- Be certain that your credentialing/enrollment processes are correct and current.
- Be sure that each provider's NPI numbers are attached to the services rendered and that the NPPES website has current information.
- Be sure that the clinic NPI number has the correct taxonomy codes including Rural Health Clinic.
- 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





COMINGLING

 Commingling is being paid twice from Medicare for the same service(s) and is considered fraud.

 Since you are billing incident-to-services with the professional component to Medicare Part A as an RHC you cannot bill the same incident-to-services to Medicare Part B to receive a second payment





MEDICARE PART A BILLING

- File in the UB 04 format
- Type of bill 711 for RHC and 771 for FQHC
 - Enter actual charges, NOT THE ENCOUNTER RATE.
 The charges must be rolled into 1 line item with the correct revenue code EXCEPT for G0402, G0438, G0439
- Co-insurance/deductible is based on the total charge of professional services rendered.
- Bill only one Medicare encounter per day for services rendered in the clinic
- Must have a medically-necessary diagnosis
- A mental health visit AND an RHC encounter are payable on the same day.
- Timely filing limits have changed to one year from the date of service.



BILLING OFFICE VISITS

Established Patient

- New Patient
- Independent RHC submits the encounter under the CLINIC Medicare Part A number on the UB form
- Provider Based RHC submits the encounter under the CLINIC Medicare Part A number on the UB form



LABORATORY

- All Independent RHC lab services are billed to Medicare Part B using the clinic Medicare Part B number and filed in the 1500 claim format.
- This includes venipuncture.
- Use CLIA waived modifiers QW on Part B claims.
- All Provider Based RHC lab services are billed to Medicare Part A using the hospital Medicare Part A number and filed in the UB 04 format.

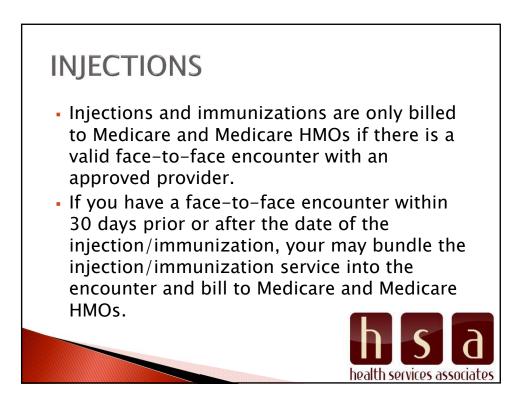


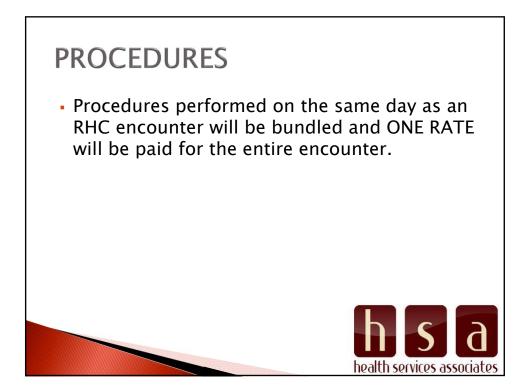
MEDICARE EKG

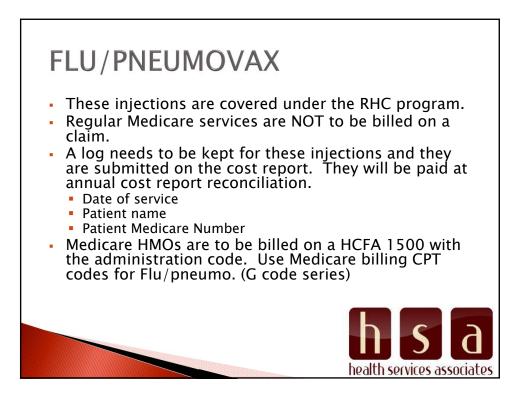
- The professional component (interp and report) 93010 is bundled into the RHC encounter and billed inclusive on the UB form to Medicare Part A for both Independent and Provider Based RHC.
- The technical component 93005 is billed as fee for service to Medicare Part B 1500 claim format using the clinic Medicare Part B number for the Independent RHC and to Medicare Part A UB 04 claim format using the hospital Medicare Part A for the Provider Based RHC.



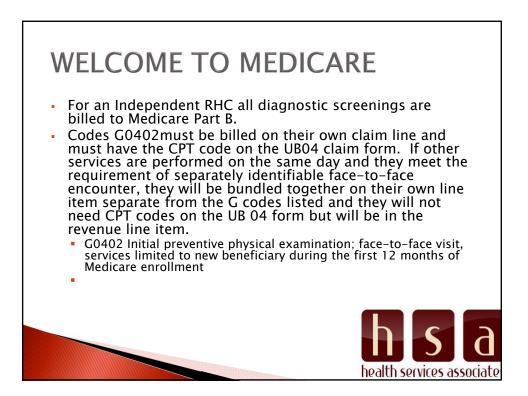
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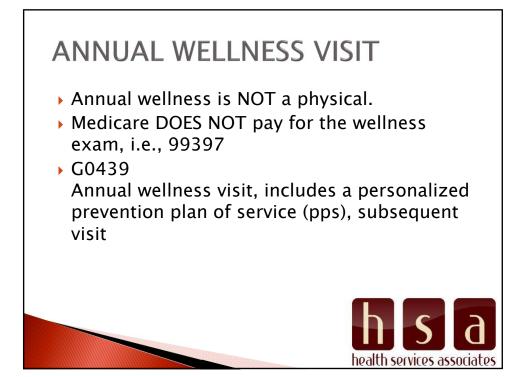


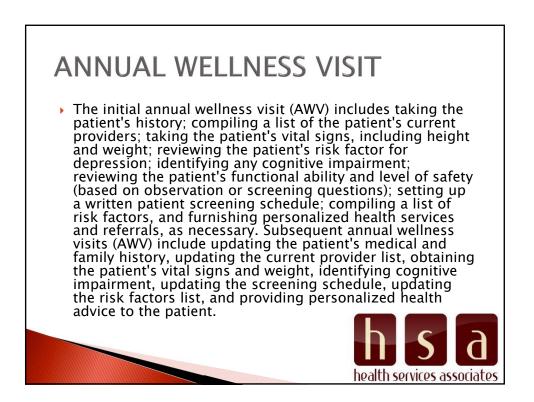




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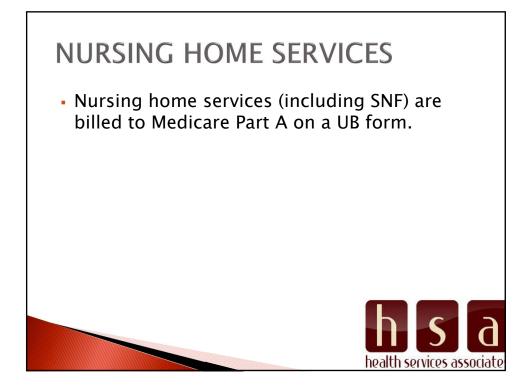


ANNUAL WELLNESS VISIT

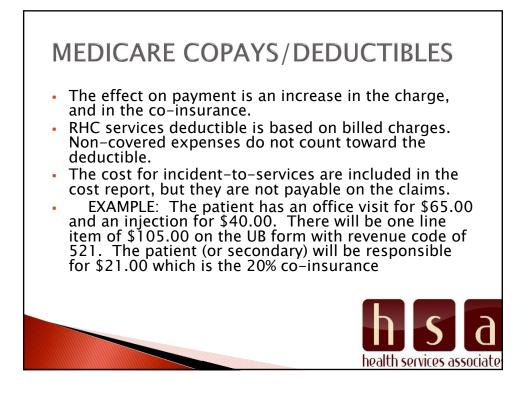
- G0438 Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
- G0439 Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
- G0438, G0439 must be billed on their own claim line and must have the CPT code on the UB04 claim form. If other services are performed on the same day and they meet the requirement of separately identifiable face-toface encounter, they will be bundled together on their own line item separate from the G codes listed and they will not need CPT codes on the UB 04 form but will be in the revenue line item.

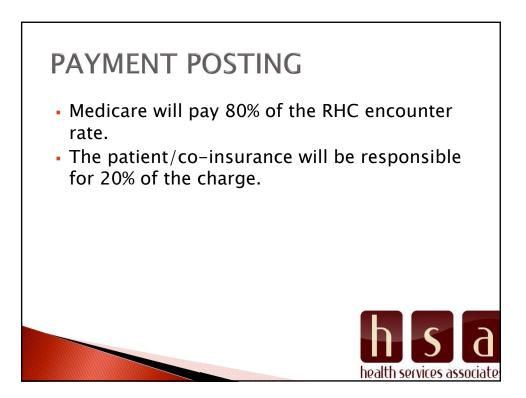


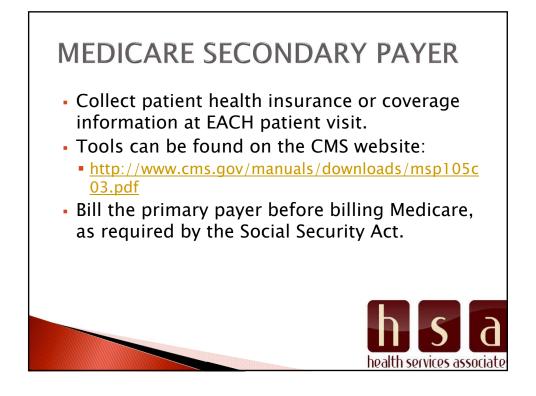


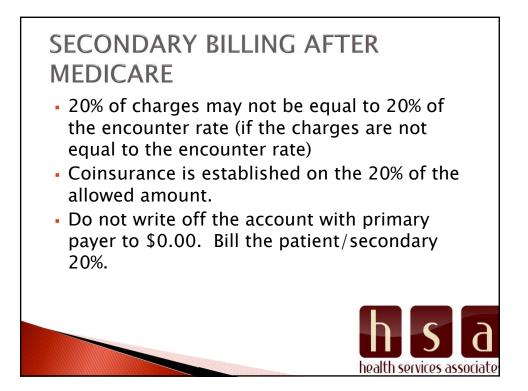












MEDICARE BAD DEBT

- 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 coinsurance amounts in order to receive payment for bad debts. If the RHC co-insurance 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

- 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



