Rural Health Clinics—Technical Assistance Call

RHC Billing RHC and nonRHC Services

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Health Care Consulting & Management

OBJECTIVES

- ✓ Understand the billing of the various revenue codes
- ✓ Understand how to bill preventive services and how the RHC is paid
- ✓ Understand how the changes in billing affect the RHC

RHC MEDICARE BENEFIT POLICY

- Medicare Benefit Policy Manual Ch 13 – RHC and FQHC Services Rev 166 issued 1/1/13, effective 3/1/13
- MM8504 issued 11/22/13 updates effective 1/1/14

What is a Visit?

- Face-to-Face with the Provider
  - Physician, PA, NP, CNM
  - Clinical Social Worker or Clinical Psychologist
    - NPP, at least 1 must be a W-2 employee of the RHC
- Medically necessary
  - Does it require the skills of a Provider?
- Payer Class
  - All payer classes are counted in the total visit count
- Place of Service
  - Clinic, Home, NH, SNF/SW B, Scene of Accident
- Level of Service
  - All levels apply, to include procedures
    - To include all services "incident to"

Medicare Part A Revenue Codes

- 521 Office visit in clinic
- 522 Home visit
- 524 Visit to a Part A SNF or SW patient
  Only prof service as labs, drugs, x-ray TC, EKG tracing gets billed to the SNF.
- 525 Visit to a Pt in a SNF, NF, ICF MR, AL
  Patient not on a Part A SNF Stay
- 527 Visiting Nurse Service in a HHA shortage
- 528 Visit at other site, I.e. scene of accident
- 780 Telehealth site fee
- 900 Mental Health Services
  - *All drugs & supplies, are bundled with the visit code charges in the Revenue Codes shown above*

CPT PROCEDURE CODES

- All Procedure Codes that are normally performed in a physician's clinic are applicable in the RHC
- Coding in the RHC is no different than any clinic
- If your coder is also your biller, the knowledge of what service to bill to which payer is imperative
- Some CPT codes will have to be "split" billed, i.e. EKG, x-ray prof & tech comp
- **The difference is how the RHC gets paid**

RHC Covered Services

- ✓ Physician services
- ✓ NP, PA & CNM services
- ✓ Services & Supplies incident to provider service
- ✓ Diabetes self-management training services and medical nutrition therapy services for diabetic patients provided by registered dietitians or nutritional professionals
  - ✓ not separately billable for RHCs but indirectly paid
- ✓ Visiting nurse services in non HHA area
- ✓ Clinical psychologist & clinical social worker
- ✓ CP & CSW supplies & services "incident to"

NonCovered as RHC Services (Covered if Billed to Correct Payer)

- Hospital patient services
- Lab tests (except venipuncture which is part of visit)
- Part D Drugs & Self administrable drugs
- DME
- Ambulance services
- Technical components of diagnostic tests
  - i.e. x-rays & EKG, Holter Monitoring
- Technical components of screening services
  - i.e. screening paps/pelvic, PSA
- Prosthetic devices
- Braces
- Hospice Services (see also Sec 200)

CMS Pub. 100-02. Ch 13, Sec 60 & 60.1

Medicare Covered But Non-billable Services

- Nurse service w/o face-to-face visit or "incident to" visit
  - I.e. allergy injection, hormone injection, dressing change
  - Provider MUST be present to have "incident to"
  - CMS Manual 100-02 Chapter 13 Section 110.2
- Telephone services
  - CMS Manual 100-02 Chapter 13 Section 100 & 120
- Prescription services
  - CMS Manual 100-02 Chapter 13 Section 100 & 120

EXAMPLES OF NO MEDICAL NECESSITY

- Routine INR visit for lab
- Simple suture removal
- Dressing change
- Results of normal tests
- Blood pressure monitoring
- B12 injection
- Allergy Injection
- Prescription service only

E & M CODING

Definitions:

- Preventive CPT codes
  - CPT codes for physical exams based on age
  - Use when patient has no significant complaints or follow up of ailments
  - Medicare does not pay for Preventive physical CPT codes with the exception of the Introduction to Medicare Physical, paps, pelvic, annual wellness visit, PSA, etc. (those listed in the Medicare beneficiary booklet)

MODIFIER -25

- Significant, separately identifiable E/M service by same provider on the same day of a procedure or other service.
  - Append to E/M code , I.e. 99214-25 (*in system only)*
- Use Modifier 25 when one of the following criteria is met:
  - Visit for a problem **unrelated** to the procedure
  - Visit for a new problem or a problem that has changed significantly and requires re-evaluation before performing the procedure.
  - Visit for the same problem in different sites; one treated surgically and one treated medically.

Medicare Part A Billing RHC Services

- UB 04 form or 837i electronic format
- Bill Type 711
- Revenue Codes (NO CPT CODES ON CLAIM)
  - Exception when billing preventive services
- Sent to Medicare Administrative Contractor (MAC)
- Claims for all RHC visits
  - Office, Skilled Nursing Home, Swing Bed, Nursing Home, Home, Scene of an accident
- Actual charges billed
- Billed under the provider that saw the patient

Medicare RHC Provider Number

- RHC office visit services
  - **Excludes** all labs, x-ray TC & EKG Tracing, any TC
  - **Includes** venipuncture effective 1/1/14
- Billed to the FI/MAC, UB04 Form or electronic
- Paid on the clinic's "all inclusive rate"
- All Medicare coverage rules apply
  - Reasonable & necessary
  - Allowed preventive is covered, I.e. pap, PSA

Medicare Part B Provider Number (IRHC)

- All labs, x-ray TC, EKG tracing, any technical components
- All hospital services (IP, OP, ER, OBS)
- Billed to MAC, HCFA 1500 Form
  - Form change 1/1/14 to Form version 02/12
  - Must use by 4/1/14 (MM 8509)
- Paid on the Medicare Pt B fee schedule

Medicare Part B Provider Number (PBRHC)

- All hospital services (IP, OP, ER, OBS)*
- Billed to MAC, HCFA 1500 Form
- Paid on the Medicare existing fee schedule

* The only exception is if the CAH is Method II reimbursement, then the OP, ER & OBS professional component is part of the hospital's claim.

PBRHC - Hospital OP Provider Number

- ALL Laboratory performed in the RHC, including 6 basic tests
  - Billed using 141 bill type for PPS Hospitals
    - As new info in SE1412 allows with no modifier L1
  - CAH 851 bill type
    - For any facility owned by CAH or CAH employee performing
    - If IRHC sends to CAH, then it is a 141 TOB "reference lab"
- Technical Component
  - X-ray
  - EKG
  - Holter Monitor
  - All TC's Billed using 131 bill type for PPS Hosp
  - All TC's Billed using 851 bill type for CAH
- Paid on the Medicare Pt B Fee Schedule

PPS LAB BILLING, MLN SE1412

Condition	Claims with Dates of Service on or after January 1, 2014, and received Prior to July 1, 2014	Claims with Dates of Service on or after January 1, 2014 Received on or after July 1, 2014
(1) Non-patient (referred) specimen;	TOB 14x	TOB 14x without the new modifier
(2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service;	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014
(3) A hospital conducts outpatient lab tests that are clinically **unrelated** to other hospital outpatient services furnished the same day	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014

State Medicaid RHC/nonRHC Billing

- Each State Medicaid is specific as to their State requirements—50 states, 50 plans
- May use either the 1500 or UB04
  - Managed Care Plans have choice as well
- Coverage is specific to each state
- Most States require both RHC and nonRHC Medicaid provider numbers
- Paid on the RHC rate or a PPS rate

Private Pay or Private Insurance

- Billed as in fee-for-service clinic
- Billed on the 1500 claim form
- No changes in reimbursement
- All discounts given should be based on finances of patients
  - i.e. sliding fee scales can be developed to as high as 400% of poverty guidelines per Federal Regulations

Medicare Advantage (MA)

Two types of plans

- PFFS – Private Fee for Service
  - Send Claims on UB04 with Medicare Rate letter
- Regional/PPO Plans
  - Must provide service to the entire region per CMS
  - Send Claims on UB04; you negotiate payment

When patients switch to MA, they are on your "Private" section of your visit counts

You may want to keep them separate as they will count as Medicare patients if you need to figure the % of Medicare utilization.

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

- Can be combined on claim with a visit
- "incident to" service for plan of treatment
- NEVER considered a separate visit
- Visit should be within 30-days pre or post
- List only the date of the visit as DOS
- Charges should reflect all services bundled
- Adjustments OK—717 Type of Bill; CC=D1; remarks "changes in charges"
- Otherwise, the costs are shown on your cost report and claimed indirectly

"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"
- 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, etc.
- When added, the additional reimb is the 20% copay
- Otherwise, if not on a claim, all costs are part of your cost report and are included in your rate

CMS 100-02, Ch 13, Sec 110.1 110.2

MEDICARE INJECTIONS

- Injections with an Office Visit
  - Charge All CPT codes in system
  - Bundle all charges and submit claim to RHC MCR
  - If it is a Pt D drug, it must be sent to Pt D plan or Patient
- Injections only—nurse service
  - Charge in system
  - Either DO NOT bill (write off) as there is no f-t-f visit
  - OR can be bundled with a visit within 30 days pre or post nursing service and submitted with that f-t-f visit
  - If injectable is a Part D drug it MUST not be a part of the RHC claim as it is only billable to the patient or to Part D

PART D - INJECTIONS

- Injectable/Vaccine as a Part D drug – 1/1/08
  - The injectable/vaccine is payable only through Pt D
    - i.e. TDAP; Zostavax; Gardisil; Varivax
  - If injectable/vaccine is obtained at the clinic level, then the patient is to pay for the injectable/vaccine and the administration privately and then they have to submit that claim to their Part D company to be reimbursed for the services.

Clinics can link to: www.mytrnsactrx.com and bill the Pt D drug and receive payment to include administration of the drug and site will show the copay amount due from patient.

(MLN Vaccine Payments under Medicare Pt D ICN 908764)

Laboratory Services

- Lab Services are nonRHC services
  - Exception: Venipuncture is part of the bundled OV services
  - All lab tests, to include the 6 basic required tests, are billable to Medicare Pt B or IRHCs or billed by the parent facility (hosp or CAH) for PBRHCs
  - If a waived test—the claim will show a QW modifier
- Venipuncture
  - When part of visit, bundle the veni charge with OV
  - When "incident to" on a day without an OV, can add to a previous OV or do an adjustment of the claim, or adjust off
  - Is never to be sent to Pt B for payment
  - PB—if only the veni, then it must be incident to the visit
    - perhaps send more patients to parent facility for tests

EKG SERVICES

- Coded using the tracing only for the TC & the interpretation only if provider interprets.
  - EKG Tracing only = 93005
  - EKG Interpretation and report = 93010
- Interp is billed with the office visit and included in the total charges that are submitted to Medicare Rural Health
- Tracing only: IRHC bills to Medicare Pt B; PBRHC bills using the hospital OP provider number
- IF "preventive service" MUST use the appropriate G-code

How Do We Bill: OV & Hospital Admit same day for same ailment

Medicare: In calls to MACs—(depends on medical necessity)– but generally, if for same ailment, are not allowing both services to be billed; thus bill the Admit (services must take place in the hospital—face-to-face), if not, bill the OV

Medicaid: State Specific

Private/Commercial: Bill the hospital admit

For all payers make sure you are "accumulating" all services to set the level of admit.

HOSPITAL/CLINIC PROCEDURES

- No global charges for Medicare in the RHC
- Each visit in the clinic is a billable visit
- Code the hosp surgical procedure with -54 (surgical procedure only) and bill to Part B
- Bill the pre and post visits as RHC visits as it is the RHC facility billing the services, not a specific provider
- If not your provider doing procedure, verify with the provider that the -54 was billed

CMS Manual 100-02 Chapter 13 Section 40.4

Medicare Maternity Care in the RHC

- Visits would be medically reasonable and necessary and billed as an RHC visit with 711 TOB and 521 revenue code.
- Delivery only would be billed as a hospital nonRHC service; each post partum visit is a billable visit

More Than One Visit Per Day

- Only allowed if a different illness or injury
  - If same diagnosis, accumulate to set E & M level
- If seen by physician and then the mental health provider both are billable—2 visits
- If have IPPE and an ailment visit, it is 2 visits
- If IPPE, ailment and mental health visit, is 3 visits
- If seen in clinic, then admitted (MAC determines)
- If seen by two different specialties, only 1 visit billable

CMS Manual 100-02 Chapter 13 Section 40.3

Behavioral Health Services

- Clinical Psychologist (PhD)
- Clinical Social Worker (CSW masters level)
- Use 900 revenue code to bill therapeutic behavioral health
- The first visit to determine services by a physician/PA/NP is an RHC visit, then behavioral health services apply
- Reimbursement in 2014 is paid at 80/20
- Make sure the CP and CSW have credentials

Flu & Pneumonia Injections

- Keep a log of injections, or have your computer track
- Medicare paid on your Medicare Cost Report
- Flu payable once per season; pneumo once lifetime
- Medicaid is paid only if in your State benefits at time of service
- Keep track of vaccine and supply costs
- Determine average nursing hours per week
- Determine average provider hours per week
- Generally allow 10 minutes per injection on Cost Report, but do a time study
- NO Medicare Advantage on log
- **LOGS MUST BE LEGIBLE**

Preventive Services

- Allowed Medicare Preventive Services are billed through the Rural Health Clinic on the UB04
- Technical Components, labs, EKG tracing are billed on the nonRHC side, either through the Hospital OP provider number (PBRHC) or to MCR Pt B (IRHC) use correct G-codes
- Each preventive service MUST be on a separate line on the UB with the G-code
- http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance/Deductible	CMS Pub 100-04
Initial Preventive Physical Examination (IPPE)	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	Yes	Yes	Waived	Ch 9 §150 Ch 18 §80
Diabetes Self-Management Training (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	No	No	Not Waived	Ch 9 §181 Ch 18 §120
Medical Nutrition Therapy (MNT)	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	No	No	Waived	Ch 9 §182
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	No	No	Waived	
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	No	No	Waived	
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	Yes	No	Waived	Ch 18 §140
	G0439	Annual wellness visit, including PPPS, subsequent visit	Yes	No	Waived	
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes	No	Waived	Ch 18 §40
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	Yes	No	Not Waived	Ch 18 §50
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	Yes	No	Not Waived	Ch 18 §70
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist	Yes	No	Not Waived	

RURAL HEALTH CLINIC
123 ANY STREET
ANYWHERE NE 666661234
3333333333 3333333334

3333
3333
0711
47-0607118 011012 011012

PATIENT, IMA
123 AVENUE
SMALLTOWN NE 66666

08101940 F 3 1 01

PATIENT, IMA
123 AVENUE
SMALLTOWN, NE 66666

0521	CLINIC VISIT BY MEMBER T	G0402	011012	1	250.00	

0001 PAGE 1 OF 1 CREATION DATE 041512 TOTAL 250.00

CAHABA GBA OGBA Y Y 1760521926

PATIENT, IMA 18 555555555A

V700
V700

1780629626
PHYSICIAN SOLO

IPPE
B2S
B2261QR1300X

RURAL HEALTH CLINIC
123 ANY STREET
ANYWHERE NE 666661234
3333333333 3333333334

3333
3333
0711

47-0607118 011012 011012

123 AVENUE

PATIENT, IMA
SMALLTOWN NE 66666

08101940 F 3 1 01

PATIENT, IMA
123 AVENUE
SMALLTOWN, NE 66666

0521	CLINIC VISIT BY MEMBER T		011012	1	132.50
0521	CLINIC VISIT BY MEMBER T	G0438	011012	1	125.00

0001 PAGE 1 OF 1 CREATION DATE 041512 TO RJS 257.50

CAHABA GBA OGBA Y Y 1760521926

PATIENT, IMA 18 555555555A

25001 4011 V700

25001

178062962 6

PHYSICIAN SOLO

RHC OV & PREVENTIVE SERVICE AWV B2S B2261QR1300X

RURAL HEALTH CLINIC
123 ANY STREET
ANYWHERE NE 666661234
3333333333 3333333334

3333
3333
0711

47-0607118 011012 011012

PATIENT, IMA
123 AVENUE
SMALLTOWN NE 66666

08101940 F 3 1 01

PATIENT, IMA
123 AVENUE
SMALLTOWN, NE 66666

0521	CLINIC VISIT BY MEMBER T	G0101	011012	1	75.00
0521	CLINIC VISIT BY MEMBER T	G0438	011012	1	125.00
0521	CLINIC VISIT BY MEMBER T	Q0091	011012	1	25.00

0001 PAGE 1 OF 1 CREATION DATE 041512 TO PAY 225.00

CAHABA GBA OGBA Y Y 1760521926

PATIENT, IMA 18 555555555A

V762 V700

V762

1780629626
PHYSICIAN SOLO

B2S
B2261QR1300X

Preventive Services

Preventive Services Quick Reference Guide:

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf

IPPE Quick Reference Guide:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

Annual Wellness Visit Quick Reference Guide:

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

More Preventive Service info:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

HOW TO BILL: WELL WOMAN EXAM

- **How does a RHC bill for a "Well Woman Exam"?**
- Medicare **does not** have a "Well Woman Exam" as a covered preventive service, CPT codes 99381-99387.
- Each component of the "Well Woman Exam" billed on separate line items.
  - i.e. G0438 for the initial Annual Wellness Visit (covered once in a lifetime) or
  - G0439 if it is a subsequent Annual Wellness Visit (covered annually).
  - Screening Pap Tests Q0091and Screening Pelvic Examinations G0101 covered every 24 months for low risk.
  - Each of these Codes, if the beneficiary is eligible, would be billed on a separate 052x revenue code line.

For more information on Medicare's Preventive Services, please see the "Medicare Preventive Services Quick Reference Chart"

Suggest ABN for Preventive Services

For any preventive service that has a frequency limitation, it is encouraged to have an ABN signed in case the service is performed at the incorrect timing, if no ABN, the clinic cannot charge the patient if Medicare does not pay.

Services to a Hospice Patient

- When seen for the hospice condition
  - Is not payable to the clinic and must be coordinated with the Hospice Entity
  - Any TC is billed to the Hospice Co, if required
  - *Can only be payable if seen outside the RHC hours as an nonRHC service, if employer allows*
- When seen for a condition other than the reason for being on hospice
  - Bill the MAC/FI as an RHC visit, RC 521
  - Use Condition Code 07
  - Use diagnosis for ailment not the hospice DX

Medicare Benefits Policy Manual 13, Sec. 200
Update: MM8504

Telehealth Site Fee Services

- Bill to RHC FI
- Revenue Code 780
- Does not require a Face-to-Face visit the same day
- Q3014 code is paid separately from all-inclusive rate at the Medicare Phys Fee Schedule
- Bill for transmission fee
- **REQUIRED** to put the Q code on the claim
- RHCs **are not** allowed to be the provider

BILLING NONCOVERED CHARGES

- If **all** charges are noncovered, send 710 TOB with all charges as noncovered and condition code 21.
- If only some of the charges are noncovered, per CMS Internet-Only Manual, Publication 100-4, Ch 1, Sec 60.4.3. This section of the manual states, "... all of a bundled service must be billed as noncovered, or none of it. Therefore, as long as part of a bundled service is certain to be covered or medically necessary, billing the entire bundled service as covered is appropriate."

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, Service unit decrease or increase, Total charges changed, Primary payer incorrect

MEDICARE SECONDARY BILLING

- When claim billed on 1500 on separate line items--roll everything into one line. Even though the primary may pay each line item separately, you still need to send the claim to Medicare according to Medicare billing regulations.
- If clinic has a contractual obligation with the other insurance and if they paid less than the contractual amount and less than the total charges of the claim, you would use the 44 value code to indicate the contractual amount.
- Another value code to indicate what type of policy the primary is and what they actually paid is required.

Medicare Corporate Compliance

- All practices that accept Medicare & Medicaid dollars are required to have a Clinic Corporate Compliance Policy
- Hosp/Clinic Corporate Compliance Policy
- HIPAA Policies in place
- Do we have consents signed?
- Are we getting ABNs (Advanced Beneficiary Notices) when appropriate (must be CMS-R-131 03/11)
- Keep copy of ABN
- Are we asking the MSP (Medicare Secondary Payer) questions at every visit?

INTERNET WEBSITES OF INTEREST

www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf

http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

www.cms.gov/Outreach-and-Education/Medicare-Learning -Network-MLN/MLNProducts/downloads//MPS_QRI_ IPPE001a.pdf

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ /AWV_Chart_ICN905706.pdf

www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf

Make sure you are a part of your MAC listserve for updated info!

Internet Websites of Interest

www.narhc.org (NARHC)

www.cms.gov

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf *(RHC Benefit Manual)*

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf *(RHC CMS Claims Manual)*

www.wpsmedicare.com

www.cahabagba.com

www.noridianmedicare.com

www.novitas-solutions.com

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Questions ?

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