

Billing for RHC and Non-RHC Services

Rural Health Clinic Technical Assistance Series Call

September 18, 2014, 3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, participants will be in a listen only mode until the question and answer portion. If at that time you'd like to ask a question press Star 1. Today's conference is also being recorded. If you have any objections, please disconnect at this time. I'd now like to turn the call over to your host today to Mr. Bill Finerfrock. Sir, you may begin.

Bill Finerfrock: Thanks, operator. I want to welcome all of our participants. As she said my name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'll be the moderator for today's call. Today's topic is billing for RHC and non-RHC services and our speaker is Janet Lytton from Rural Health Development in Cambridge, Nebraska. Janet's going to talk to us about various RHC billing issues and then we'll open up the lines for your questions at the end. The technical assistance series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy in conjunction with the National Organization of State Offices of Rural Health and the National Association of Rural Health Clinics.

The purpose of the series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call is the 59th in the series which began in late 2004. During that time, over 15,000 combined participants have listened in on these calls. As you know there's no charge to participate and we encourage you to refer others who might benefit from this information to sign up and receive announcements regarding dates, topics and speaker presentations. If they're interested you can go to HRSA.gov/ruralhealth -- one word -- [/policy/DONFCALL/index.html](http://policy/DONFCALL/index.html). During the Q&A period we request that callers please provide their name and city and state prior to asking your question. In the future if you have ideas for topics or submit questions you can send them to info, that's INFO@narhc and put RHC question or RHC topic in the subject line.

Today's call will last approximately one hour. If we get some questions and we have to go over, we do have an ability to extend the time. But at this point I'd like to turn the control of the meeting over to Janet Lytton. Janet welcome and thank you and we look forward to hearing your presentation.

Janet Lytton: Thank you, Bill, and thank you everybody for being on the call. This is a great opportunity to answer a lot of our billing questions for both our rural health clinic services and our non-rural health clinic services. Today I am going to talk about

how we need to understand the billing of various revenue codes, how we are going to understand how to bill preventive services and how the RHC is paid and to understand how the changes in billing affect our rural health clinic.

Every one of us need to be aware of our rural health clinic Medicare benefit policies. Each of you can get on the internet and get the information off of the CMS Website located at the Medicare Benefit Policy Manual Chapter 13 of the RHC and FQHC services. It's revision 166 and it was issued 1-1 of 2013 which was effective 3-1 of '13. It may be updated at this point and they update it as new regulations come through. Also you need to be aware of and review the (Medlearn Matters), the MM8504 which was issued 11-22 of 2013 which also gave us updates effective 1-1 of '14. There have been some other updates that we have recently received and I'm going to talk about those throughout the presentation and I will let you know those when we get there.

Slide Number 4, what is a visit? This seems like it should be very easy to explain. However, we still get questions on it. It must be a face-to-face visit with a provider. That provider must be a physician, a physician assistant, a nurse practitioner, or a certified nurse midwife, a clinical social worker or clinical psychologist. Of the nurse practitioner and the PA, at least one of those mid level practitioners must be an employee of the rural health clinic. There was a change that allows us now to contract with those practitioners. However one must still be an employee within our clinic. There must be a medical necessity. Does it require the skills of a provider to see that patient? That makes it a visit or not a visit.

Payer classes, all of the different payer classes from the commercial to the Medicare, the Medicaid are all counted in the total visit counts. Places of services, we've got our clinic service. We have home services. We have nursing home. We have skilled nursing home, swing bed and at the scene of an accident. Those are our different places of services for rural health clinic services. The levels of services, those levels do not change when we become a rural health clinic. We still have all the applicable levels from the 99201 to the 99215. All of those different E/M levels to include any procedures that can be performed within the clinic setting are applicable as rural health clinic services. All of these services will also include any services that are incident to those practitioners' services.

Slide Number 5. Our Medicare Part A revenue codes that we bill through are billed on the UBO4 which requires revenue codes to be billed. We have the 521 is an office visit in the clinic. A 522 is a home visit, 524 is a visit to a Part A skilled nursing facility or a swing bed patient within a hospital. Only the professional services are billed by the rural health clinic. Any of the labs performed in the clinic, any supplies, any drugs, those all have to be billed to the nursing home for payment if they're on a Part A stay. The 525 revenue code is for any regular

resident in a skilled nursing home, a nursing facility, an intermediate care facility, a mental rehab facility or an assisted living. Any of those patients or residents in those facilities is a 525. 527 we have very few of those revenue codes ever used because those are visiting nurse services in a home health agency shortage area. There are very few of those across the United States but there may be some. I don't know which places but there may be some. 528 is for visits at any other site. For instance, a scene of an accident. Maybe somebody fell at Walmart and the practitioner went to Walmart. That would be the scene of an accident. Tele-health service fees, it's the site fee only, is a 780 revenue code. And our mental health services are - is a 900 revenue code. So with that said all of our CPT procedure codes that we bill with is a part of those revenue codes. Any CPT codes or procedure codes that are normally performed in a physician's clinic are applicable within a rural health clinic.

You need to make sure that your coding doesn't change from a fee for service to a rural health clinic. The only thing that has changed is how we are submitting our claims and how we bill it and get paid. The coding does not change. If your coder happens to also be your biller make sure that they understand the rural health clinic regulations and what to bill to what payer. Within our rural health clinic we have certain services. For instance an EKG, an X-ray, each one of those services have a professional component and a technical component. The professional component is part of our rural health clinic claim and the technical component is part that we send to Part B to get paid or if you're provider based your hospital would send those technical components in order to be paid through the Medicare physician fee schedule. The only difference in our clinics from a fee for service to a rural health clinic is how we're getting paid.

Slide 7. Our rural health clinic covered services we have our physician services, our nurse practitioner, PA and certified nurse midwife services and any supplies and services incident to those provider's services. We also have covered diabetes self management training services and medical nutrition therapy services for diabetic patients provided by registered dietitians or nutritional professionals. I want to tell you those are covered services. However, they are not separately billable within the rural health clinic to either Part A or Part B as these are not allowed providers within that list of providers that I gave you through our regulations. The cost for those services is a part of our cost so we are getting paid for those services indirectly through our cost report and on our cost settlements.

Visiting nurse services for non-home health agency areas are a covered service. Clinical psychologist and clinic social worker and any of the supplies and services incident to those practitioners. Covered as rural health clinic services or non-covered by rural health clinic, I mean when they're non-covered that doesn't mean we don't get paid at all but we need to know which payer to bill them to in order

to receive payment for those services. For instance we have our hospital patient services, our lab tests. Lab is not considered a rural health clinic service. As of January 1 of this year the venipuncture is now part of our office visit bundled services. So we cannot send that portion of the lab to Medicare Part B or bill through the hospital in order to get additional payment for that. That's part of our visit.

Any Part D drugs that we have within our clinic need to be billed to Part D companies or billed to the patient. Any DME items goes to the (D Merck) carriers. Ambulance services are not billable by the rural health clinic. Technical components of diagnostic tests, for instance the X-rays and the EKG, the Holter monitoring, all those technical components of those codes are billed either to Part B or they're billed by the hospital provider outpatient provider number. The technical component of screening services is the same thing. That gets billed to Part B for our independents or it gets billed through the hospital on the outpatient provider numbers. Prosthetic devices and braces and hospice services we're going to discuss that later, and it is section 200 of our policy benefit manual. But we need to be aware of the new - the changes on hospice for us as well.

We have Medicare covered but non-billable services. This means if we have this happen within our clinic that we cannot bill it to anybody. We can't bill it to Medicare. We cannot bill it to the patient. And those are services like your nursing services. Without a face to face visit they're considered an "incident to" service. The expenses for those services go into our cost report and we are disclosing that at the end of the year when we do our cost report and it is shown within our rate being paid. That would also be like allergy injections, hormone injections, dressing changes. The provider must be present in the clinic for anyone to have an "incident to" service. We are not allowed to perform medical services for any patient to include rooming the patient as a rural health clinic unless we have a provider within our clinic. Telephone services are not billable services and prescription services only are not rural health clinic or billable services.

Some examples when we talk about medical necessity that CMS has given us that is deemed as no medical necessity because it's typically not required that the provider give that information or do those services for those patients. These services could most likely be done by an RN or by a telephone call. For instance a routine INR visit for a lab. As long as it's a routine and you have the parameters on the increase or decrease of the medication used in that INR then it can be a - it is not a medical necessity to see a provider. A simple suture removal, a dressing change, if there happens to be an issue with that wound when that nurse is doing that dressing change and brings a provider in to see that patient then we have a visit. But a simple suture removal does not constitute a medical necessity for a provider to see those patients. Results of normal lab tests, blood pressure

monitoring, a B12 injection that has been ordered for the next month or the next six months. The patient comes in and gets the B12 injection and then goes on their way. That's an "incident to" service. It's not separately billable. Allergy injections and prescription services only.

Slide Number 11, E/M coding. Make sure you know your definitions. Your preventive CPT codes--remember Medicare does not pay for the preventive CPT code, the 993XX code. It does not pay for physicals. It pays for the parts and pieces as on the preventive service guide but it does not pay for a physical. You use the preventive codes when there are no other significant complaints or there's no follow up of ailments. So if you have a patient, and it could be a Medicare patient, coming into your clinic and wants a physical, if there is nothing wrong with that patient then that patient will be paying that bill because Medicare does not pay for annual physicals. They only pay for the services that they have on their (Medicare) preventive list and physicals are not one of them.

The next Slide, 12, modifier 25. Make sure that if you are doing a procedure and if there is a separately identifiable E/M code attached to that procedure that CPT code requires a 25 modifier in order to tell Medicare that that service is separately identifiable other than and in addition to that procedure. That E/M code is not an automatic add on to a procedure code. There must be documentation to support your E/M level as well as your procedure code that was performed.

Slide 13, our Medicare Part A billing for our rural health clinic services is done on the UB04 or the 837I electronic format. Most of our claims are sent in electronic so we're going to look at the 835I format. We always bill a 711 type of bill. We bill revenue codes. Those revenue codes do not require any CPT codes on the claim. Many of us when we put the CPT codes on the claim on a Medicare claim that's what gets us in trouble. That's when if that CPT code does not match or is a conflict with the revenue code that we have used, the 52X revenue code, it's going to get errored out or rejected and then we're sitting there with a claim that's not going to get paid.

We send our claims to the Medicare administrative contractor or MAC. Many of us we - all across the United States there's 15 different MACs that are used. We used to have only two or three. Now we have 15. So you've got to be careful on how you submit your claims in the format that your MAC wants it sent in. However what I'm giving you today are CMS guidelines and I haven't seen a MAC yet that doesn't want it the way that CMS is requiring.

Claims for all of our rural health clinic visits at all of our places of service are sent on our UB forms as rural health clinic visits. Each day, each visit, is a claim. Do not do from and through on your statement dates for visits. Actual charges are

billed within our rural health clinic. Our charge master for our private pay patients becomes the charge master for our Medicare patients unlike in a fee for service clinic that we're working with the Medicare physician fee schedule. We get the opportunity to set our fees where we need them to be, within reason, for our Medicare patients and our Medicare clientele.

When we bill Medicare we bill Medicare under the provider that saw those patients. So if you have physician's assistants or nurse practitioners that are you are billing those claims under the supervising physician, you need to get the PAs or the nurse practitioners credentialed so that you're sending those claims under those practitioners and not the physician.

Slide 14. The Medicare rural health clinic provider number is for our rural health clinic office visit services. It excludes our labs, our x-ray technical component, our EKG tracings, any technical component. Holter monitoring is another one that has technical components. It includes our venipunctures as of January 1 of 2014. Those venipunctures are an add-on to our office visit service of the day. We bill to the FI or the MAC/fiscal intermediary. We use the UB04 form or the electronic format. We are paid by the clinics all inclusive rate. You can hear it called an encounter rate, all inclusive rate--but we are paid 80% of that rate from Medicare and the patient owes you 20% of the allowed charges, which is the charges we submitted, or their supplemental insurance will also pay that 20% co-pay.

All the Medicare coverage rules apply for our rural health clinic. We do not have a separate set of rules. Everything is based on reasonable and necessary from the reasonable and necessary charges that we charge from the medical necessity of our physicians and our PAs and nurse practitioners' visits. Everything goes under reasonable and necessary. All of the allowed preventive services, for instance the pap, the PSAs, the breast exams, the annual wellness visits, all of those preventive services are rural health clinic services. Yes I understand we have had a challenge on getting some of those paid and I'm going to get into that much deeper in just a little bit.

Next Slide 15. We bill Medicare Part B provider number for our independent rural health clinics for all the labs, the x-ray technical components, the EKG tracings and any other technical component. All of our hospital services to include our inpatient, outpatient, ER and observation bed will be billed to the MAC on the 1500 form and remember that form changed as of January of 2014 to the 2012 version of the 1500 form. That had to be used by April 1 of this year and that was in (Medlearn Matters) MM8509. We are paid on the Medicare fee schedule for any of those services that we bill to Part B.

Next Slide, 16. Our Medicare Part B provider number for our provider based rural health clinic is all of our hospital services, the inpatient, outpatient, ER and observation bed with the exception of our critical access hospitals that bill method II. If it's a method II critical access hospital they will do the professional billing for any outpatient service. So that's the only caveat on that one. Other Provider Based RHCs bill to the MAC on the 1500 form. They are paid on the Medicare existing fee schedule.

Next Slide 9. Our provider based rural health clinics hospital outpatient provider number. The provider based clinics will send all of our their labs performed in the rural health clinic to include the six basic lab tests using the hospital's outpatient provider number to get paid for those services. It is billed using a 141 bill type for our PPS hospitals and it is billed with an 851 type of bill for our critical access hospitals. Those bill types also include the technical components for x-rays, EKGs, Holter monitoring, any technical component using the 131 for the PPS hospitals and the 851 for the critical access hospitals. These are also paid on the Medicare fee schedule.

There was a (Medlearn Matters) SE1412 that came out earlier this year which has to do with your lab billing and it is stating just as I said it's a 141. When we draw those lab tests in our clinic and transfer them to the hospital for the hospital to do that test that patient is not in the hospital and is considered a referral lab with no patient there. It's a 141 type of bill. And with the critical access hospital, it's an 851 type of bill. But I wanted to bring that new regulation up for you.

Slide 19. The state Medicaid and rural health clinic and non-rural health clinic numbers. I am not going to go through Medicaid at this point. There's 50 different states. There's 50 different plans. So it is very difficult to talk on a national basis on the Medicaid side. Medicaid can use either the 1500 form or the UB04 form. Managed care plans have their choice as well. Coverages are different within each state because the federal government allowed the states to set their own parameters for the rural health clinic services applicable within each of their states.

Most states do require a rural health clinic and a non-rural health clinic Medicaid provider number. Many states are paid on a PPS rate. What the PPS rate, perspective payment system rate, means is that at the end of the year you will have no cost settlements back to you typically and you are paid with that rate set from the very beginning. They usually change every year per the Medicare economic index.

Next Slide, 20. Private pay and private insurance that did not change when we moved from a fee for service to a rural health clinic. We bill just as we always

have on a 1500 form. No changes in what we get paid. All the discounts that are given to private pay you need to pay attention because when you give discounts it's supposed to apply across the board regardless of payer class. If you have a sliding fee scale developed, the federal government allows you to set your sliding fee scale up to a 400% of poverty and then going forward you can change. You can have as many increments as you want. That's a whole other presentation. However, I would encourage you to use a sliding fee scale. You are not required to use a sliding fee scale. You are required to use a sliding fee scale if you have National Health Service Corps employees in your building and then it is required.

Slide 21, Medicare Advantage plans. I think most of us would like to see those go away because they can be a pain in order to get paid. However we have to deal with them sometimes on a daily basis. We have the private-fee-for-service companies. Those particular companies and plans are required to pay the rural health clinic our rates. It's not supposed to have changed. However, those companies need to have a copy of your rate letter on file so that they know what to even pay you. Any regional or PPO plans within your area that you - that your patients have, you must negotiate a rate or a payment style with each of those in order to be paid. You could be considered out of network if you do not. So pay attention to the different types of plans.

When those patients switch to a Medicare Advantage plan they are basically giving up their traditional Medicare plan for a private plan. And in your Medicare visit counts those are not counted as Medicare visits because Medicare is not paying for those services. It's a private company that they moved to the private sector of the plans. The only time that you count those patients as Medicare patients is for instance if you were wanting to meet meaningful use in your electronic record. Those numbers of patients that have Medicare Advantage plans would count toward the numbers of your Medicare patients within your clinic. So make sure that you keep track of those plans and you know how they want those claims submitted. They can be a 1500 form. They can be a UB04 form. Just you've got to sometimes call those customer service places.

Services rendered on non-visit days those are "incident to" services. They can be combined with a claim with a visit, a face to face visit, typically within a 30-day period whether it's 30 days before or 30 days after that "incident to" service. Those "incident to" services which are nursing services are never billed as a separate visit to Medicare. They are never billed to Medicare Part B. They have to either be put with a face to face visit within that 30 day before or after or you have to adjust them off. When you submit a claim with "incident to" services bundled in with that face to face visit that happened on a different date, the date on the claim used is the face to face service date. You do not do from and through dates.

You just note in your billing system that those services are billed with that face to face visit.

You can do adjustments which is a 717 type of bill. You would use a condition code of a D1 and in the remarks section you would put “changes in charges”. Otherwise the cost for those “incident to” services are shown in your expenses within your cost report and it is referred to as claimed indirectly. That does not mean you're going to get paid for any additional for those services on your cost report. It just means that those expenses are in your cost report. If you are an independent rural health clinic and already at the capped rate you're not going to see another dime. If you are a provider based and you have no cap on your expenses it may increase your rate accordingly depending on how many dollars that would be.

Next Slide, 23. “Incident to” services require direct supervision by a provider. Direct supervision does not mean in the same room. It means in the clinic. Being in the hospital when the clinic is attached, does not meet “incident to”. They must be in those four walls of the rural health clinic. Those “incident to” services are part of the provider's services that had been previously ordered and they are covered as part of that service or another billable service but they are not separately billable. I cannot stress that enough. That could include dressing changes, injections, suture removals, any of those type of services that our nursing staff is providing and not necessarily the provider.

When added to a visit the only additional reimbursement that the clinic will receive is the 20% of that added charge in our reimbursement. Otherwise again, if it's not on the claim all of those costs are on our cost report and are included in our rate. Again, if we are an independent and already at the cap you're not going to see any difference.

Medicare injections, injections with an office visit, Slide 24. Charge all of our CPT codes in your system. We bundle all of our charges and submit our claim to rural health clinic Medicare. If that injection that we just gave is a Part D drug it is not to be bundled in our office visit. Part D is a different payer. Those drugs need to be billed to Part D. The injection only, the nursing service you charge it in your system. You either do not bill it and you have to adjust it off if there was no face to face or again you bundle it with a face to face visit. Maybe they came in yesterday for flu like symptoms and they have to have a Rocephin shot for the next three days. Those three days of Rocephin shots can be put with that original office visit and submitted as one bundled service with the date of service of the office visit yesterday.

Slide 25, Part D injections. That's what I was just talking about. Make sure that you know what those are. Some of them are your DTAP, your ZOSTAVAX, your GARDASILs, your VARIVAX. Medicare does not pay for routine update of vaccinations for the Medicare patients. The only vaccine that they routinely cover is the flu shot annually and then the pneumonia shot which is supposed to be a lifetime but sometimes with high risk patients they will allow once every five years. There is a Part D payment mechanism online that you can investigate and sign up for if you choose to and it's www.mytransactrx.com. And this system will allow you to put in the patient name and their Medicare Part D plan and it will tell you what the co-payment is for that company is. It works with this Website and will send you your portion and then you will know what to charge the patient at the time of service.

Slide 26, laboratory services. Laboratory services are non-rural health clinic services. The exception is the venipuncture which is part of our bundled office visit service. All lab tests, to include those six basic lab tests, are billable to Medicare Part B for our independent clinics or they're billed by our parent facility if we are a provider based rural health clinic. If it is a waived test the claim will show a QW modifier on the claim. The venipuncture you can set your charge for the venipuncture, for instance maybe \$15. Then you will get paid the extra for that particular service of 20% which would be \$3, they will have a co-pay on that venipuncture unlike they ever did on the other by billing it as a lab. But since, I believe it's January, we are required to have that in our bundled service. It is very specific in our Medicare Benefit Policy Manual for rural health that that is part of our visit. This was also a question of (Teri Miller) out of Rocky Ford, Colorado and I'm hoping that that answered her question on that part of it.

Slide Number 27, our EKG services. They are coded with the tracing only, the technical component--the tracing only is the 93005 and the interpretation and report is 93010. The tracing only is sent to either Medicare Part B for our independents or it is sent through the hospital outpatient provider number for our provider base. The interpretation and report, if it interpreted by our rural health clinic providers, is part of our office visit of that day. The interpretation and report when the patient is not seen is not a billable service because we had no face to face service. Remember if we have the preventive services and there is a preventive EKG when the patient turns 65 and they're on Medicare make sure if you're billing that EKG that you have the specific preventive G codes associated with those services in order to get paid correctly. If you do not you will not get paid correctly.

Slide 28, how do we bill an office visit, a hospital admit the same day for the same ailment? That is going to depend. I have called Medicare payers, the MACs and it depends on medical necessity. That was the main answer that I received.

Generally if the patient is in your clinic and you are seeing that patient in your clinic and then you are referring them directly to the hospital for an admit you will bill the admit and not the visit in the clinic. If the patient is in the clinic in the morning and they go home and then in the afternoon or evening that illness has exacerbated and then they're admitted later for that particular reason then you may have two visits in the same day. Remember the rural health is billed to Part A. The inpatient service or the admission, maybe it's admit to observation, is billed to the Part B side because that's a hospital service. Medicaid is all state specific. So know your Medicaid rules. Private pay and commercial most generally they will only allow the one visit and it would be the hospital admit that they would be using for the code. Make sure that if you do have a clinic visit and a hospital visit and they go directly from the clinic to the hospital that you're accumulating all of that information to be on the hospital admit. It could very well increase the level of care for that hospital admit when you're doing that inpatient work.

Next slide is Slide 28, hospital and clinic procedures. Remember within our rural health clinic we have no global services, no global charges for Medicare in our rural health clinic. Each visit in the clinic is a billable visit in the clinic. When we code out a procedure we code it as the procedure only. If we have our providers performing services or surgical procedures in the hospital we will bill out the procedure with a 54 modifier and when they come to the clinic to see us for follow up each visit at the clinic is a billable visit. Then we have our visiting docs. In many of our rural areas we don't have the surgeon at our facilities. So those surgeons are coming into our hospital, doing those surgery procedures and then those patients if they come to us for follow up on that surgical procedure we, as the rural health clinic, are required to contact that surgeon's office and find out if he billed - he or she billed, for that procedure only. If they did not append that 54 modifier we are not allowed to bill for that visit in our clinic if it is only for the follow up of that surgical procedure. They have put the burden up on the rural health clinic to assure that the prior provider billed with the 54 modifier. So it can be difficult.

Slide 30. The maternity care, Medicare maternity care in our rural health clinic and we're seeing more of that all the time because of some of the disability claims that are out there. Each visit for that OB Medicare patient in your clinic is a visit, is a rural health clinic visit. You would bill it with the 521 revenue code and send it on and you would receive your 80% of your rate and the 20% co-pay from the commercial or the co-pay insurance company or the patient. When that patient delivers and they deliver at the hospital you will bill a delivery only service at that point to Medicare Part B. So it is possible. There was a question by (Denise Houser) of Oregon and this was her question.

Slide 31, more than one visit per day. Sometimes that happens. We don't have it happen very often but Medicare CMS has given us some parameters that we do have depending on what we have done during the day. It is allowed if it is a different illness or injury. Perhaps we saw that patient in our clinic in the morning for flu like symptoms. They went home and fell and cut their head. We have two visits in that day. If they're seen by the physician for a medical reason and then they are seen by the mental health provider we have two billable visits. If they - it happens to be a Medicare patient within their first year of qualifying for Medicare and they have an IPPE exam and they have an ailment visit on the same day with the E/M code that is two billable visits. And I'm going to say how to do that in just a minute.

If they have an IPPE exam, an ailment visit and a mental health visit on the same day you have the potential of three visits on that day. If they are in the clinic - seen in the clinic and then admitted -- we just talked about that. It depends on your MAC. It depends on the circumstances. Remember if they're admitted to the hospital there must be face to face contact in that hospital in order for a provider to bill hospital services. If they are seen by two different specialties that's one visit in our clinic a day. One visit. So if they see a podiatrist in your clinic and then they happen to go to a cardiologist in your clinic that's one visit. One visit. You can combine all of the documentation to set the level but you've got one visit.

Behavior Health Services, clinical psychologists which is a Ph.D, or clinical social worker which is a master's level clinical social worker we use the 900 revenue code to bill therapeutic behavioral health. The first visit that our providers have determined that they require these mental health services is a rural health clinic visit. The visits thereafter of the clinical psychologist or clinical social worker are considered mental health services and billed with the 900 revenue code. This year for 2014 there is no difference in mental health service payments or as a rural health clinic regular medical visit. It's an 80/20 split. It's finally even keel with all of our other Medicare visits. What you need to do on your clinic side is make sure that your mental health providers have the correct credentials in order to see our Medicare patients and we get paid. That's the whole kicker. They have to have the credentials in order for to comply with Medicare guidelines.

Slide 33, our flu and pneumonia injections. Our flu and pneumonia injections are only billed through our cost report. We give them a log and that's when we get paid through our cost report. So it's by cost, keep your information and go from there.

Our preventive services, Slide 34. Allowed preventive services are billed through our rural health clinic. The technical components will be split out. The labs will

be split out. The EKG tracings will be split out. Know your rules. Each preventive service must be on a separate line in order to get paid correctly. Check your clearinghouse if they are scrubbing out codes or billing it differently than you submit because I've just had that happen a week ago. So make sure that you know.

Slide Number 35, this is the list that just came out on I believe it was August 18 that shows the standalone services that we are allowed to have on our claim as the only service and receive an all inclusive rate or an encounter rate for those services. So know those services as well. Not everything can stand alone, only what Medicare has deemed can stand alone. Our biggest issue was our G0101. So make sure that you know the rules.

The next slide happens to be an example of submitting a claim using the G code and the charge. This is a clean claim that would be sent. This happens to be going to (Cahaba) I believe. So that's an example.

The next one is an example of two different services. The top one, the first service on Slide 37 is an ailment visit. So we've got the ailment visit and we've also done a preventive service on the same day. The preventive services always require a CPT code, always. The rural health clinic visit itself does not require any CPT code.

The second - the example on Slide 38 are three different codes. I will say that right now the Q0091 has been a huge issue. I have found on the CMS Web site they have told us two different ways of doing the billing of that. One of them gets paid and one of them gets our claim rejected. The one that gets paid is in the preventive service manual and it is sent as a lab gathering - specimen gathering, to Medicare Part B or it is billed through the hospital outpatient provider number. Those claims are getting paid. If they're on a rural health clinic claim which it also shows us in one area of the CMS manual that to do it that way is they are not getting paid and they are making our claims hang up. So I know which way I would do it.

So also the next Slide 39, are some great preventive service guides. Don't be without them. Print them for your billers. Print them for your providers because many times they don't know what's covered as preventive services as well. So how do we bill a well woman exam? You bill all the parts and pieces to that exam. You do not bill the 99381 to 87. Those do not apply. You would bill, for instance, an annual wellness visit you could bill the gathering of the pap test, which is the Q0091. You could bill the G0101. It's all of the parts and pieces to those services that you bill for the annual well woman exam. The CMS preventive service manual, billing manual, is manual 100-04, Chapter 18, section 30. That's

the manual that tells us to send that Q0091 to Medicare Part B or through the hospital outpatient provider number.

Slide 41, I would suggest getting an ABN for all of your preventive services that your patients are requesting because many of them are frequency driven and if they have received a duplicate service within the wrong - too soon of a frequency you will get stuck with that. You will not get paid for it and you cannot bill that patient unless you have given them an ABN.

Services for a hospice patient, the only services that we can bill as a rural health clinic are the hospice patients that we see for a diagnostic reason other than the hospice diagnosis. Medicare views a rural health clinic as not being able to see that patient for their hospice diagnosis. We cannot get paid for the hospice diagnosis as a visit. When we have a patient that comes in for a non-hospice diagnosis that's on hospice we bill with a 07 condition code and Medicare will pay it. For the hospice diagnosis they look for us to reach out to the hospice company for the reimbursement of our rural health clinic claim.

The tele-health site fee on Slide 43. That is a 780 revenue code. We are only allowed to bill the distant site fee that the patient is at. We cannot bill the provider service. We are required to put the Q3014 on our claim so that Medicare knows that this was the site that the patient was at to see another provider. Now I want to alert you that I have seen there are companies out there now that are cropping up doing tele-health site services and they are wanting the clinic to bill both the profession - the provider part of it and the site fee part of it with the different codes and having a contract with those tele-health companies. As a rural health clinic you cannot bill the professional provider side of that. It cannot be a part of your rural health clinic. You can have an agreement with that company that you do their billing for them for that service but you will not get paid for that through your rural health clinic.

Billing non-covered services. Many times we have services that patients think that should be covered that are truly not covered and we need to send those to Medicare on a 710 type of bill. We put the service on our service line item and we have a condition code of a 21 on the claim which tells Medicare that we know this isn't covered but we need a denial and we need a remittance advice for that. And that will give us our denial. There is a part in the CMS manuals that states as we bill a bundled service if any portion of that bundled service is non-covered as long as we have covered services for that day the whole service is a covered Medicare service. And I've given you the look up on the internet only manual to look at that if you choose so. Adjustments are always done with a 717 type of bill and you must have a condition code on those claims in order to have those claims adjust correctly.

Medicare secondary payer, Slide 46, if the bill - if the claim was originally billed on a 1500 form you must switch that claim to a UB04 form on the one line item just like Medicare requires and use the different value codes in order to tell Medicare what the commercial payer paid or whoever the other company was that paid. Each Medicare payer usually has a Medicare secondary payer cheat sheet on their Web site. I would suggest looking that cheat sheet up and having one in your billing department.

Slide 47, I always talk about Medicare corporate compliance. As a clinic receiving Medicare and Medicaid dollars we are required to have a Medicare corporate compliance plan. Make sure that we have it. Do we get our HIPAA policies and our information to the people. Are we getting our consents signed? Are we getting our advanced beneficiary notices? Are we getting our Medicare secondary payer questions asked? Those Medicare secondary payer questions are required every time a patient comes into the clinic. I cannot stress that enough. Last week CMS came out and said there are going to be many audits and MACS are doing audits on have we asked those Medicare secondary payer questions. It is required at every visit--every visit.

Now on Slide 48 these are all of the internet Web sites that I have used to prepare my program and on 49 is also additional Web sites that I've used to create this program. Know your CMS Web site. It is very, very important. There is so much information out there that I swear to God I'm on there every day of the week including weekends. So please know your sites. Be a part of your listservs. Be a part of the National Association of Rural Health Clinics as a member and on the listserv. They do tremendous work on behalf of every one of our rural health clinics. Be a part of your listserv of your MAC, for who's your payer, for your state. Be a part of those lists serves. Now, if you have any questions I would be happy to answer them.

- Bill Finerfrock: Hey, Operator? Do you want to open up the lines and give the instructions for folks who want to ask questions? We're going to obviously go over. We'll try to get to as many questions as time allows. So, Operator?
- Coordinator: Yes, and thank you. At this time if you would like to ask a question please press Star 1 and record your name. Once again, at this time, to ask a question please press Star 1. One moment for questions.
- Bill Finerfrock: While we're waiting for people to line up, we did get a couple others emailed in. Janet, this comes from (Yvonne Gould). If a patient has an office visit and gets a (TDAP) at the time of service, does the charge get bundled in the office visit? Or is the patient responsible for this? Is this covered under the Part D plan?

Janet Lytton: It is covered under Part D. I will tell you that I just heard last week that one Medicare payer has put out an LCD, that's a local coverage determination, that they are covering the (DTAP) through Medicare. So, you have to know your Medicare payer's view on that in order to know which direction to go.

Typically if you are looking at the CMS Web site it will tell you that it is a Part D drug billable to the Part D company or to the patient themselves.

Bill Finerfrock: Okay. Do we have questions from some callers, Operator?

Coordinator: Yes, sir, we do. The first question we have comes from (Tammy). Your line is open.

Bill Finerfrock: (Tammy), please ask your question and let us know where you're calling from.

(Tammy): This is (Tammy) and I'm calling from St. Luke Medical Clinic in Marion, Kansas. And mine is on the (TDAP) also. I had read that Medicare would cover that if it was an accident. That's...

Janet Lytton: Typically what Medicare says on their - in their manuals is they only cover the Tetanus portion of it and not the (TDAP). That's why I'm saying there are a few payers out there that have local coverage determinations that they will pay it. So that's why I say, know your Medicare payer. Call and ask them.

I know at this point WPS does not cover the (TDAP) or - as a covered service. And it is Part D only.

(Tammy): Thank you.

Bill Finerfrock: Next question?

Coordinator: Next question is from (Donna). Your line is open. I'm sorry, it's from (Linda).

Bill Finerfrock: All right, (Linda).

(Linda): Hi. Could you just clarify again the preventative services when there's no ailment? And also, the from and through date field.

Janet Lytton: Preventative services do not have to have - there is no ailment for preventative services. If you print off the quick reference guide that Medicare puts out for preventative services, it lists every preventative service for Medicare patients. To include the CPT codes. To include the ICD-9 diagnosis codes if certain ones

apply. Who is covered. How often they are covered. And how much the beneficiary has to pay. So, there is no ailment on a preventative Medicare service.

(Linda): And also the from and through date on the claims. Our claims won't go through without those.

Janet Lytton: No, you have to have a from and through date on the claim. Like, if they had a visit today it would be from today, through today. It's one visit, one day.

(Linda): Okay. Thank you.

Janet Lytton: You're welcome.

Coordinator: Thank you. The next question is from (Donna). Your line is open.

Janet Lytton: Hi (Donna).

(Donna): Hi. This is (Donna), Parris Family Medical Center, Parris, Illinois. And my question is I just really want to know again the site to get all these slides copied so I can have all the information again?

Bill Finerfrock: Send an email to info, I-N-F-O, @ N-A-R-H-C. We will send you the link.

(Donna): @ N-A...

Bill Finerfrock: R-H-C.org -- info@narhc.org. And we will send you the link to the slides. And just so everyone knows, a recording of this call will be made, a transcript, and a link to the slides. I can't tell you exactly when that will be up. That will be up on the Federal Office of Rural Health Policy's Web site. I gave you their Web address earlier. So if you missed something and want to go back or you have a colleague who wants to listen, it will be available for listening at a later date.

Coordinator: Thank you. The next question is from (Ken). Your line is open.

(Donna): Hi (Ken).

(Ken Peppin): Yes, thank you. (Ken Peppin) from Baraga County Memorial Hospital in the Upper Peninsula of Michigan. We had problems using the modifier 25 on a UB form. We get a front end rejection that won't allow us to do that. Is that a case for everyone? Or is it just our system?

Janet Lytton: You don't - no modifiers on our rural health clinic billing. It's a bundled service so you have no 25 modifier on your claim. You should have only one line on your claim.

(Ken Peppin): Okay. That's what I thought. But I thought you had mentioned earlier to use a modifier 25 and we were just thinking how do you do that?

Janet Lytton: You need to have the modifier 25 in your system because what you have in your system must match what you bill. So if Medicare did an audit, they would look in your system. What do you have in your system? If you have the modifier 25 in there and your documentation in the chart would show that you've had applicable separate (E&M) code, as well as a procedure.

(Ken Peppin): Okay. So is that how we're going to get paid for our - we're also not getting paid if we have a wellness exam and then the, you know, an IPPE or whatever exam, and then we have an illness exam. We're only getting paid for the first one, not the - the second line is not being paid. Is there - is that the case as well? We should append that with a 25 even though it doesn't print on the (UB04)?

Janet Lytton: No. You shouldn't need that for - if it's an IPPE exam and an (ailment) exam, you should get two per diems for that day. Now, there have been issues in the Medicare payers' systems. And I can't really answer why. But that should pay two visit per diems for that particular visit.

(Ken Peppin): Okay. So we're just going to continue trying until we get that fixed, I guess then. I appreciate it. Thanks for your help.

Janet Lytton: Call your payer and ask them how they want you to submit that claim. It should be exactly like I have on that example. But...

(Ken Peppin): Okay.

Janet Lytton: So check it.

(Ken Peppin): Great. Okay. Thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: Next question? Operator?

Coordinator: Yes. The next question is from (Christina). Your line is open.

(Christina): Hello. (Christina), Family & Internal Medicine, Lebanon, Kentucky. I had a question about the MSP questionnaire. We are asking the questions, we're an electronic health record, do - if we were audited, I guess my question is do we have to actually have the questions listed in our computer and checked off patient responses? Or can we just put on the patient's chart MSP was verified? Or do you have to have the actual questionnaire in our computer?

Coordinator: I would say as long as you've got it marked that you've asked those questions. But I would say be ready for an auditor to say, okay, ask me those questions. What are those questions. Typically I see in an electronic system those - basically there's six or seven questions in there. And then to at least prompt that person not to just say, "Has anything changed since your last visit? Is this a Medicare secondary?"

That's not asking the questions. You need to ask the questions.

(Christina): But if we were to be audited, that's what I'm saying, we are asking the actual five or six questions. But when we put it in our system we're just, for example, saying the MSP was verified. So if we're audited, how is - is that going to suffice if we don't actually have the questions listed in our computer system? (Unintelligible)...

Janet Lytton: I think it would suffice because you said that there was - that it was verified. Typically, if a clinic is a paper - still paper-based, there is a short form, which I call it a short form, of those seven questions.

(Christina): Right.

Janet Lytton: And then at the side it is basically a date that it has - of the visit, and then who asked the questions. You're doing the same thing with that - marking that box.

(Christina): Okay. Well, it's not actually a box. We're just literally just typing in "MSP verified". Now, electronically it will acknowledge who the user was, what time that...

Janet Lytton: You should be fine. You should be fine.

(Christina): Okay. And one more quick question. You were saying about if the patient was seen, I understand you only have one visit per date. But if you see a patient in the morning and then they come back in the afternoon, because of a cut (unintelligible). On the UB form, is that all bundled into one line, or do we list that as two separate lines?

Janet Lytton: It depends on your Medicare payer. Some - I know that WPS payer, they do have you process the first claim. And once it is paid you process the second claim. And then there's another payer that does a line item with two units, and with the remarks of "seen a second time because of". So it's all across the board. Know how your payer wants them sent.

(Christina): Okay. Thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: We had a couple questions that were emailed in to me. One is: I was wondering about billing patients for non-covered services such as refraction non-covered by Medicare. Is it okay if we notify the patients that the services are not covered and we bill them directly?

Janet Lytton: It is - if it is a non-covered service by Medicare, you are required to bill the patient.

Bill Finerfrock: You would have to have them do an (ABN) too, correct?

Janet Lytton: If it is non-covered statutorily by Medicare, it does not require an (ABN). I suggest giving the (ABN) just for PR reasons to the patient so that they understand that this is going to be their bill. But an (ABN) is only required on the services that potentially are covered by Medicare.

Bill Finerfrock: But I think it's a good policy to just always do it so the patient doesn't come back and say, "Well, I didn't know that. If I had known that wasn't going to be covered I wouldn't have asked you to provide the service."

Janet Lytton: Yes. That's why I say good PR.

Bill Finerfrock: Okay. Also, a person has: Regarding billing, secondary insurances -- this is from (Clara Ecstrom) -- with a Medicare EOB I get a lot of denials because the EOMB records back with the (RAC) code 521. And when I bill Blue Cross and Blue Shield, send in the claim with the actual CPT code, the denials are that the EOMB is not attached. And if it is, the EOMB doesn't match. Then I call and explain that we're a rural health clinic. I just want to know if there's some way I can prevent this from happening. Any advice?

Janet Lytton: Not - there is - actually, the first - the 1500 claim has it all listed out. And then when we bill Medicare secondary it requires the one-line item. Yes, it's got to be in the formats that Medicare requires. So we bill a one-line item. There are certain

value codes to be used. Other than that, I don't know. And make sure your place of service is, you know, like on your 1500 form is rural health clinic.

Bill Finerfrock: Okay. Operator, how many questions do we have in the queue?

Coordinator: Sixteen.

Bill Finerfrock: Oh. We'll try to get to a few more. We're probably going to have to cut it off around 4:30 our time Eastern. If there are questions that we don't get to, perhaps we can - Janet, if you'd be willing to give out your email and then we can perhaps have folks email those questions to you.

Janet Lytton: I think my email is on Slide Number 49.

Coordinator: Were you ready for the next question on the phone?

Bill Finerfrock: Okay.

Coordinator: From (Tristan). Your line is open.

Bill Finerfrock: Go ahead, (Tristan).

(Tristan): Hello. Family Practice Clinic in Emmetsburg, Iowa. My question is on bundling with a non-face-to-face visit to a face-to-face visit. How does that work? Do we just hold that encounter from the face-to-face visit and then attach like the other non-face-to-face visit? Say they're coming in for Rocephin for like three days after that, do we put it on that initial face-to-face visit? Or how do we put that to make them all one?

Janet Lytton: (Tristan), it's entirely an administrative process. You can either hold that initial claim for those Rocephin shots. Or perhaps the last time at the last injection, maybe they see the provider to make sure that the injectable is doing what it's supposed to be doing. It could be either way.

I will say don't beat yourselves up by trying to get every little "incident to" service put to a face-to-face visit. It is an administrative nightmare if you do that. I would only do that for the more expensive injectables and those types of services. So tracking can be a nightmare.

(Tristan): Okay. Thank you.

Coordinator: (Connie), your line is open.

(Connie): Yes. We are in the process of converting...

Bill Finerfrock: Where are you from?

(Connie): Hello?

Bill Finerfrock: Yes, where are you from?

(Connie): Corning.

Bill Finerfrock: And that's up in where?

(Connie): California.

Bill Finerfrock: Okay. Thank you. And what was your question?

(Connie): Yes. We're in the process - we've been a freestanding independent clinic and we're in the process of converting over to a provider-based clinic. My first question is we've had - in the past we've had a significant private patient population as well as Medicare/Medicaid. And on Slide 30 - or 20, I'm sorry. The billing for the private insurance, we've always used those guidelines for billing whatever the contact is with the private insurance company on a 1500 claim form.

And some of the insurances have allowed for a patient to come in for an injection only. And we were allowed to bill for the administration and the cost of that supply.

Janet Lytton: And that's...

(Connie): But we carved it out. We didn't count - I mean, that was counted as a non-face-to-face injection-only visit. But we were told by the new entity that no, you can't do any injection-only, that's not allowed in rural health. Although this is private sectors. I just wanted to clarify on that because we were following the guidelines of the insurance companies.

Janet Lytton: There is no difference. When you become from independent to provider based, you are still going to have those injection-only services. It does not require a provider to see a patient for every injection that is given.

For instance, if there's an order in the chart for a B12 shot for the next six months - that's just an example and I don't even know if it happens. But if there is, each time that comes - that patient comes in, it is not required to see a provider. There is no medical necessity to see a provider for just the injection. You've already got

the order. So you're always - I don't know a clinic that doesn't have "incident to" services happen.

(Connie): Okay. But with the private, we were actually billing for the administration and the vaccine...

Janet Lytton: You can do that with a commercial company or a private pay person. Medicare...

Bill Finerfrock: Those policies you were referring only apply to Medicare or potentially Medicaid. What you do with your commercial payments is up to whatever the policies for that commercial payer are.

Janet Lytton: That's right.

(Connie): Okay. That's what my understanding - I just wanted to clarify that. And then the second part comes with the required lab, the Part B. We've all - we've did time studies. We've carved out our staff time. The cost of any supplies and taken that out of the cost report.

Now, with provider-based, I'm understanding that will go - the Part being required will go through the hospital lab provider, whatever...

Janet Lytton: That's correct.

(Connie): But we still have to carve that out, don't we, and keep track of the time?

Janet Lytton: The auditors, the hospital auditors, will do all of that behind the scenes.

(Connie): Okay.

Janet Lytton: And they will ask you if they need any additional information.

(Connie): Okay. I just want to make sure we're doing it right. Okay. That's - thank you.

Janet Lytton: Yes, you're welcome.

Bill Finerfrock: Next question?

Coordinator: Thank you. Family Medical Center of Hart County, your line is open.

(Ramona): Yes, ma'am. Did I understand you to say that the Q0091 is not a billable RHC service? That it has to be sent to the Part B?

Bill Finerfrock: I'm sorry, can you tell us where you're from?

(Ramona): Yes. This is (Ramona) and I'm from the Family Medical Center in Munfordville, Kentucky.

Bill Finerfrock: Thank you.

Janet Lytton: You will find on the CMS Web site two different interpretations on how to build a Q0091. In the preventative service manual, it views it as a technical component and it is billed to the Part B side or through your hospital, depending on if you're provider-based or independent.

In the rural health clinic, other billing area on how-to's, it will say to add it to your rural health clinic claim. Anybody that I have seen add it to their claim, it gets the claim hung up and does not pay correctly. So that's what I'm saying. We need more clarification. We need manuals to state the same thing. And if it were me, I would be billing it on the technical component site to get it paid.

(Ramona): All right. And one other thing. On the hospital admit from the office, do we not charge (E&M) code that day, just the hospital admit?

Janet Lytton: It depends. If they're in - you're sending them directly to the hospital and if your provider is doing the services in the hospital for the admit, then you're doing the hospital admission only. A clinic service for the same thing that they're admitted, you do not have two different - two separate visits. You've got one or the other.

(Ramona): Okay. But to do the hospital admit they would have to be face-to-face at the hospital, right?

Janet Lytton: Yes, that's correct.

(Ramona): Okay.

Janet Lytton: Yes.

(Ramona): All right, thank you.

Janet Lytton: You're welcome.

Coordinator: (Susan), your line is open.

(Susan): Hi. This is (Susan). I'm calling from Plymouth Rural Health Center in Plymouth, California. And my question goes back to Slide Number 35. And there's a column titled Eligible for Same Day Billing. Could you explain what that means?

Janet Lytton: You know what? I don't even know what that column means. For same day billing - I don't know that answer. I do know that the ones that are in the column that is the G0402, the - and that's one of them for same day billing, that's the IPPE. And all I know is that the other ones that - in that other column paid at the AIR can be standalone claims. I have looked to find out what that column means. Bill, do you know what that column means?

Bill Finerfrock: I believe that what - and keep in mind, this is a document that was prepared by CMS, not any of us. But I believe what that means is that those are the - that is a service if you can bill - even though you had another billable visit on that same day. So let's say the patient came in, in the morning for the IPPE and came back later in the day for a medical problem, you can bill two visits, those two visits on the same day.

If the patient came in for the annual wellness or one of the screening exams, let's say, pelvic exam, and then came back later in the day, I believe what CMS is saying, or in conjunction with that, you can't generate two claims for that.

Janet Lytton: Okay, and that makes sense.

Bill Finerfrock: I believe that that's referring to the same day.

Janet Lytton: Okay. Okay, because none of those other codes, if they're put with an ailment visit do you get a separate payment for. So...

Bill Finerfrock: Right.

Janet Lytton: And so you're probably right, then.

(Susan): Okay. That helps. That makes sense. Thank you.

Bill Finerfrock: Next question, Operator?

Coordinator: (Tina), your line is open.

(Tina): Hi. This is (Tina) from Gunderson Tri-County Hospital and Clinics in Whitehall, Wisconsin. And I do have a couple of questions. I guess the first question is I am trying to understand - I am the clinic coordinator here. I am trying to understand the preventive medical codes 99397, 99387 versus the Medicare annual wellness.

I guess I'm wondering, the G code for the Medicare annual wellness, are those meant to take place of the preventive medical codes for physicals for Medicare patients? Or are those Medicare annual wellness visits a different type of service?

Our physicians at our clinic, that is - they are in their notes dictating that they're seen as a 69-year-old patient for preventative medicine visit and follow-up of medical problems. And very rarely are they ever indicating that it's an annual - Medicare annual wellness visit.

And I'm not certain if we are - you know, if it's a matter of education for the providers that they're not - on their end that they're not doing it correctly. And I have to code as they - you know, as they're presenting it in their notes. And I certainly want to be accurate with my coding. I just want to understand the differences.

Janet Lytton: What you need to do is get on the preventative guidelines and pull off - there's a quick reference guide to annual wellness visit. There's a quick reference guide for the IPPE exam. And you will see on that quick reference guide that those are not annual physicals.

Medicare is very, very specific. They do not pay for an annual physical. They only pay for what's on that preventative list. So if you're billing out that 993XX code, you are billing incorrectly. Because unless they - if that's what they had, that's patient payable only.

(Tina): Okay. And I believe that that's what they had. I will pull that information off, so I do think that I have some of that already. And they really are doing it as a preventive annual medical visit.

Janet Lytton: And it all comes down to documentation. If that chart was audited and CMS sees "here for annual physical" or "here for preventative physical", that's going to throw it out immediately. Therefore, annual visit will not - yes...

Bill Finerfrock: The terminology and the wording that you use, I think what Janet's saying, is critically important because of how an auditor is going to use that. And that's why the documents she referred you to are important. Also, the - CMS will create the G codes because of the unique way in which Medicare wants to handle certain claims. So, for example, the annual wellness visit has its own specific code compared to an annual physical or something else, too.

Because as you'll note on that document that she had on Slide Number 35, coinsurance and the deductible is waived for the patient. And so that's the way

that Medicare knows that specific service and they're going to pay you full AIR as opposed to the "take out for the beneficiary co-pay".

(Tina): Okay.

Bill Finerfrock: So it's very important that you understand the documentation requirements, that you code it correctly, and you use the proper Medicare G codes as opposed to a CPT code that may be similar, but is going to result in the claim getting rejected.

Janet Lytton: That's right, Bill. And also, once we bill with a G code, that G code hits the common working file. So that anybody that has access to CMS patient eligibility system - for that patient can get on their access to the information on the common working file to see if they are eligible for that next preventative code as well.

(Tina): Okay. So I just want to - I'm sorry if I'm repeating myself. But I do want to reiterate this. So if a doctor is saying in their note that the patient is presenting for a preventative medicine annual visit, I cannot bill the G code. But if they indicate that they are presenting for a Medicare annual wellness visit, and that Medicare annual wellness visit that they are doing also does include a full physical exam. And the types of things that are - would be in a physical, that can be billed with a G code?

Janet Lytton: If they've hit all the bullets of that annual wellness visit on that quick reference guide, then they can. But they're not charging for the physical at that point. The physical is only patient payable.

(Tina): Right. Okay, and I understand that. Okay, do you have time for one more question?

Bill Finerfrock: I apologize. We're going to need to move on. There's a ton of other questions. And if you wanted to communicate with Janet directly via email, I think that that might be the best way. But...

(Tina): Okay. That's fine.

Bill Finerfrock: Operator, how many more questions do we have in the queue?

(Tina): Nine.

Bill Finerfrock: Okay. I think we're only going to be able to get to about two or three and then we're going to have to cut it off. So let's try about three more and then we're going to have to call it for a day.

Coordinator: Thank you. (Carla), your line is open.

(Carla): Yes. I'm trying to find out if the podiatrist is covered under rural health...

Bill Finerfrock: (Unintelligible).

Janet Lytton: A podiatrist, if they are within the rural health clinic and one of your providers, their services are rural health clinic services. But again, it must meet the Medicare guidelines for those podiatry services.

Bill Finerfrock: Yes. Remember, if a podiatrist is not a fully recognized - not everything that a podiatrist does...

Janet Lytton: Is allowable.

Bill Finerfrock: Not all is going to be recognized as Medicare.

Janet Lytton: That's right.

(Carla): Okay. Thank you.

Janet Lytton: You're welcome.

Coordinator: (Tricia Tier), your line is open. (Tricia), your line is open. Please check your mute button.

(Tricia Tier): Hi. This is (Tricia Tier) from Mercy Cadillac in Michigan.

Bill Finerfrock: Hi (Tricia).

(Tricia Tier): My question - I'm hoping you can kind of circle back to the diabetic education and medical nutrition therapy. What I need to know is we have a registered dietician and from what I understand we can bill these services only if they are bundled in with an eligible face-to-face visit. Is that correct?

Janet Lytton: Correct.

(Tricia Tier): Okay. So we could take the services from the registered dietician, bundle them with the services from one of our eligible RHC providers within 30 days?

Janet Lytton: Exactly.

Bill Finerfrock: The reimbursement you are going to collect then is the portion of the co-pay, the 20% of the allowable. But it - and this is an area where there's also a lot of confusion. All of those costs for that dietician, the space, the whatever supplies, are allowable costs on your cost report. So you are getting paid for that, even in your encounter rate because it's reflected.

So if you took those - let's say your encounter rate is \$78. You took those costs out, maybe your encounter rate would only be \$75. So you are getting reimbursed for it. What you're billing them for is the 20% of the allowable that you can collect from the patient.

(Tricia Tier): Right. The only thing I wanted to verify for sure was if it was a service that had to be completely carved out. Or if it was one that could be included and we could bundle...

Janet Lytton: It is not a carve-out service because it is allowable within the rural health clinic. It is just not separate billable.

(Tricia Tier): Perfect. Thank you so much.

Janet Lytton: You're welcome.

Bill Finerfrock: Next question?

Coordinator: (Lori), your line is open.

(Lori): Yes. My question is...

Bill Finerfrock: Where are you at, (Lori)?

(Lori): I'm from Regional Family Health in Manchester, Iowa, by the way. And my question, Slide 29, in regards to global billing. Right now what we're doing is we do a procedure with a global period. We've been told that we cannot have total charges that exceed what we would charge if we billed the whole global period. For example...

Janet Lytton: That's correct.

(Lori): Okay. So we do have to reduce the charges for the follow-up visits in our rural health clinic, correct? We can't just bill what we normally bill?

Janet Lytton: No. What you would do is you would reduce your charges for the procedure on the hospital side or in your clinic side. And then you would bill the appropriate

(E&M) level for the follow-up visits. So just the opposite way that you're doing it.

(Lori): So I've got...

Janet Lytton: If you've got two (E&M) codes after the fact for follow-up. And let's say each one of them is \$75. So that's \$150. And if your procedure happens to be \$500, take off \$150 off of that \$500 would be \$350. And that would be the charge for the procedure to begin with if you're billing...

(Lori): Okay. So we shouldn't be reducing our charges in the rural health clinic for the follow up?

Janet Lytton: No.

(Lori): Okay. Thank you.

Janet Lytton: Yes.

Coordinator: (Clara Ecstrom), your line is open.

Bill Finerfrock: And I believe, Operator, this is the last question from what we agreed to?

(Clara Ecstrom): Okay. This is (Clara Ecstrom). I'm calling from Fort Brad California, North Cost Family Health Center. And my question is about Slide 31. If seen by two different specialties only one billable visit. And my question is, is when you were talking about that you stated that you could combine those. And I was just wondering how.

Janet Lytton: You would combine the documentation for both providers and to set a level of care. So if you have one provider seeing them for one ailment and you have another specialty seeing them for another ailment, perhaps that would increase perhaps from a 99213 up to a 99214, or perhaps even a 99215 -- whatever the case may be.

But even though it's two separate specialties, with the exception of a medical visit and a mental health visit, if it's two medical specialties, it's considered one visit.

(Clara Ecstrom): Okay. I do understand that. And I was just wondering - so, we would increase the charge on the UB, the charge amount, the billed amount?

Janet Lytton: Yes. It would - you would increase the level of care. Maybe you - like again, the 99213 to a 99214, or a 99215, whatever the case may be...

(Clara Ecstrom): And we bill with the provider? Excuse me, would we bill with the provider that the patient saw first that day? Like if they saw a medical provider and then they saw the ophthalmologist, for example?

Janet Lytton: Well, remember, some ophthalmology services are not covered by Medicare.

(Clara Ecstrom): Okay. I do understand that. I was the one who asked about the refractions. So thank you, that does answer my question.

Janet Lytton: Okay. You're welcome.

Bill Finerfrock: I think we're going to have to wrap it up here. My apologies to all those who weren't able to get their questions in. As Janet noted, her email address is on the last slide and she graciously agreed to try and answer your questions if you want to email her directly. I'd like to thank Janet for participating and spending so much time with us today to help you out with your billing for RHC and non-RHC services.

Please encourage others who may be interested in this series to participate. It is free of charge. As I said, it is being supported by the Federal Office of Rural Health Policy, the National Organization of State Office of Rural Health, and the National Association of Rural Health Clinics.

For those of you also who didn't get a chance to answer your questions, on - or anybody else. On September 30, we are going to have a rural health clinic technical assistance call. It's called Ask the Experts. And the entire phone call will be devoted to questions from the audience. And we have put together a panel of rural health clinic consultants who are familiar with billing, coding, cost reporting, quality assurance, survey and certification.

So if you have any questions, if you didn't get your question answered today, if you come up with additional questions or you want additional clarification, we will be scheduling a call for September 30. We will be getting out information on that to you shortly with regard to the specific times and the call-in number.

I also want to take this opportunity to remind everybody that we have an upcoming National Association of Rural Health Clinics conference. It will be in Reno, Nevada, on October 22 to the 24th. Janet will be a speaker there, along with many other experts covering a range of - again, covering survey and certification, cost reporting, billing, and many, many more.

If you want information on that conference in more detail, you can contact Rhondi Davis at the national office and she'll be glad to help you. Her email is rdavis, that's R-D-A-V-I-S @narhc.org, and she can get you more information. If you sign up in the next seven days you can continue to get a discounted rate for attendance. And I believe we still have a few hotel rooms available.

Again, I want to thank everybody for participating and I look forward to your participation in our future calls. Thank you.

Janet Lytton: Thank you, Bill.

Coordinator: Thank you. This does conclude the conference. You may disconnect at this time.

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