

RHC HCPCS Reporting

Rural Health Clinic Technical Assistance Series Webinar December 22, 2016 2:00 – 3:00 pm ET

Coordinator: Welcome and thank you for standing by. All participants will be able to listen-only until the question and answer portion of today's conference. To ask a question please press Star 1. Today's conference is being recorded. If you have any objections please disconnect at this time. I would now like to turn the conference over to Mr. Bill Finerfrock. Sir, you may begin.

Bill Finerfrock: Thank you operator and I want to welcome everyone to today's Rural Health Clinic Technical Assistance call on RHC billing issues. 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. The series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy and is done in conjunction with the National Association of Rural Health Clinics. We're supported by a cooperative agreement and as you can see or you will see on your screen or you may see -- I don't know if we've got it up there today -- the Federal Office of Rural Health Policy does support this initiative.

The purpose of the series is to provide RHC staff with valuable technical assistance at our agency specific information. Today's call is a 73rd in the series which began in 2004 and over that time more than 18,000 people have participated in this teleconference call series. As you know there is no charge to participate and we encourage you to refer others who might benefit from the information to sign up. To receive announcements regarding dates, topics

and speaker presentations. To do that they can go to www.hrsa.gov/ruralhealth/policy/confcall/index.html.

During the Q&A period today which will occur at the end of our presentation we ask that the callers please identify yourselves by name, city and state or you can also type your question if you're following along on line as part of the Webinar into the chat box located on your screen. In the future if you have questions or suggestions for topics you can send those to info that's I-N-F-O@narhc.org input R-A-C-A-T-A question or R-A-C-T-A topic into the subject line. We a couple of things. One, if you are listening online you may get some change to the - if we get a lot of feedback through that our administrator may have to turn that down. You can always listen over your phone and still watch online may be a preferable option. Also I just want to remind folks at the end of the slide there will be a few questions. We ask you to fill out with regard to the presentation and to the R-A-C-T-A series so if you could take the opportunity to respond to those I'd appreciate it.

I'm really pleased that we have two great folks today who are going to talk to you about some of the RAC billing issues and then answer some questions at the end. We have Charles James with us who is the President of North American Healthcare Management Services Rural Health Clinic consulting firm who's worked with NARHC for a number of years is also happens to be a member of the board of directors and is quite knowledgeable.

Joining him is Shannon Chambers who is the Director of Provider Solutions with the South Carolina Office of Rural Health. Shannon too has been a great asset for the World Health Clinics Community not just in South Carolina but she's been a speaker at some of our national meetings and really comes with a wealth of knowledge with regard to RHC billing. So at this point you don't want to hear any more from me. I'm going to turn it over to Charles. I think

you're going to start off and we look forward to your presentation and then the Q&A at the end. Thanks.

Shannon Chambers: Actually this is Shannon I'm going to go ahead and start off first.

Bill Finerfrock: All right.

Shannon Chambers: So...

Bill Finerfrock: (Unintelligible) first Shannon.

Shannon Chambers: Reporting services - beginning April 1 of 2016 RHCs were required to report the appropriate HCPCS code for each service line along with the revenue code on their Medicare claim. RHC qualify medical visits are typically your evaluation and management type services and/or screenings for certain preventative services.

So HCPCS reporting only of course is going to be for our Medicare RHC claims only. Again you will see here as we discussed for our HCPCS reporting our qualifying visit list, our CG modifiers and all of the RHC billing requirements did change April 1. This of course does not affect your commercial or your state Medicaid RHC billing requirements. For your revenue codes the qualifying visit line or QVL must include the total charges for all services provided during the encounter or visit. RHCs can report incident to services using all valid revenue codes except for the ones you see listed. And we're going to go into detail a little bit about those in the next few slides. RHCs should report the most appropriate revenue code for the service being performed and you can find that on the MLN of 9269.

All right so here's your revenue codes. The following revenue codes are used on your UB04 claims, your 0521 ones for your clinic visit at your RHC by an RHC provider, your 0522 for your home visit by your RHC provider, 0524 for your part A SNF bed again RHC provider 0525 non-SNF bed nursing facility or other residential facility your non-Part A claims and 0527 visiting nurse service and your home health shortage area. And probably the least used one would be the 0528 your visit by an RHC provider to other non-RHC sites meaning scene of an accident.

Additional revenue codes that were used effective April 1 for us were the 0250 for your pharmacy. And as you will see you do not need to include your HCPCS code there, 0300 for your venipuncture. We actually had a lot of claims that denied because people were using the 0521 for venipuncture so make sure you're using the 0300, your 0636 for your injections and immunizations, your 0780 for your telehealth, your 0900 for your behavioral health services. So of course, effective October 1 of 2016 they changed the requirements for us. And beginning on October 1 you shall add the modifiers CG to the line with all the charges subject to the coinsurance or deductible or your qualifying visit line. This actually became for any services that were received by Medicare after 10-1-16 effective date. So if you filed claims on September 30 and they did not make it out of your clearinghouse and over to Medicare until 10-1 you're required to have a CG modifier on those claims.

All right so here's your little differences between what happened with us April 1 and then a few months later back on October 1. So April 1 we were required to do line item billing with your HCPCS reporting implemented with your qualifying visit list. The original qualifying visit list lacked various types of procedure codes. Nathan and Bill did a great job allowing us to submit those codes so that they could get those over to CMS to review. And a CG modifier was announced in place of continually updating the QVLs.

October 1 did again require the CG modifier for those claims. The CG modifier is required for all claims submitted after 10-1-2016. And your CG modifier of course will affect any claim for date of service retroactive back to 4-1 of 2016 including the procedure only visit claims that you held from April 1 all the way until October 1. So your CG modifier again RHCs should report modifiers CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face to face visit. The qualifying visit list or QVL can be used as a guideline to determine which HCPCS codes constitute RHC encounters. And Charles is going to go through some great examples with you in just a minute. And you're frequently asked questions this is a great resource for you. And again I know these slides will go out or have already gone out and a great resource for frequently asked questions. And with that I'm going to go ahead and turn it on over to Charles.

Charles James: Excellent. Thank you very much Shannon. I was just taking a second to try to reply to the venipuncture question over there on the chat and we'll see how this comes through. I just posted the language relative to venipuncture and why venipuncture is bundled into our visit. So if I get to the correct arrows on our slides one thing I wanted to point out are some of the line item messages that you all will get on your claims. Now I realize that what, we have 350 people on the call and clearly we're going to have folks from across different MAC or Medicare payers on here so the way some of your claims get adjudicated could be a little different for MAC.

But generally speaking your line items that are service detailed at least on the remits I have reviewed the service details errors out or adjusts or is processed with the CEO 97 message which is a contractual obligation and indicates there was no CG modifier on that particular line item. So a lot of you are seeing that CO 97 if you submitted incorrect claims without the CG modifier on it but a

lot of us are also seeing that CO 97 on our service detail reporting lines. The initial guidance we got from Medicare indicated that we would get CARC 97 or RARC - my display just went. There we go, went a little crazy on me there. Sorry about that. I lost my screen for a second. So we had expected CARC or RARC messages to appear on those additional line items. So any of these three messages you may see applied to the line items that are not the qualifying visit line.

So let's jump in to a few of these claim examples. On a fairly straightforward line item here -- and I've tried to keep our dollar amounts consistent on the various services that we're representing -- so this is just regular old 99T13 for \$100. No additional detail line items were going to report on this. So in effect the difference on this claim for -- from April 1 or 10-1 on April 1 we had to get our -- and I'm not going to draw. That normally slows me down here.

April 1 we had to have the 99213 on the claim. And additional service detail lines applied at that time. We didn't need the CG modifier here until October 1 and you see this is a pretty straightforward claim. We have \$100 detail line. Medicare is going to pay us 80% of our all-inclusive rate. The patient is going to be responsible for 20% of the charge on this line. So other than the CG modifier this should have been a fairly straightforward claim to have gotten paid after the deadline.

Now one thing that has tripped a lot of us up was how we report the service detail line when ultimately the revenue attached to the line is just going to get adjusted off so that we would run into this problem that if we just post it straight service detail lines as their full charge amount we would overstate our revenue, we would overstate adjustments and we would overstate accounts receivable.

And so many of us answer to hospital CFO types. We ourselves are a billing agency so we certainly don't like any inflation of revenue or artificial inflation of revenue adjustments in AR. So Medicare CMS and their guidance has said that our service detail line items can report – be reported as long as they are greater than zero. So we can report our line items as 1 cent which helps eliminate some of that artificial inflation of revenue and or adjustments, et cetera, until that claim adjudicates.

So I've drawn these examples up as if we were doing what I call the alternate method of billing here which indicates that we're using a penny for our line items. So we would have our qualifying visit line with revenue code 521. We're now reporting our 99213 with the CG modifier amended on there. We've got a claim that's after April 1. Perhaps we're submitting this date on 10-5, hopefully we didn't wait that long. But you can see on our Toradol injection we implicitly have a \$30 charge for the Toradol. We've bundled that \$30 up with the qualifying visit line and we've used a penny to report that service detail line so that our total charge amount comes out with the bundled amounts as a penny. Our total charge is \$130.02. We would otherwise have inflated this claim by \$30 if we just posted straight line items on that 636.

And you can see our injection code is 636 on there as opposed to other revenue codes we may find. 636 you can use for injections. We're not going to address the administration here on injections. I think that's for another day's conversation. So this is...

Shannon Chambers: Hey Charles...

Charles James: Yes?

Shannon Chambers: So I'm going to actually stop you for just a quick second as we had a good question emailed in. And the question states that they were confused on the use of the CG modifier when more than one line was billed. They are told each line is listed separate with appropriate dollar amount next to the CPT and then the total of the CPTs are bundled on the first line. When Medicare was paying the claim they were using the total billed amount instead of what Line 1 is. Therefore they're overpaying each RHC claim that are more than one line. So I know here we pulled several remits here and your total charge actually does show on your remit. But if you actually look through for your qualifying visit line that's where the 20% is being pulled from. And you had the same thing is that correct Charles?

Charles James: I pulled several examples for that where we had just one line item or multiple line items and indeed that coinsurance is pulling correctly from the qualifying visit line. The total, the amount allowed is showing up but that allowed amount should not be affecting your payment. So in – so at the end of the day your claim should process with coinsurance and deductible based on the qualifying visit line. The CG modifier is going to be on the qualifying visit line which is the primary reason for the visit. But our total charge which is generally irrelevant for anything other than it's going to show up on the remittance advice.

But none of your other numbers on the claim should be associated with that total bill charge other than the arithmetic should add up. So we would add the additional penny to the line item because we're bundling those line items up into that qualifying visit line. So ultimately that's where the penny is reflected. And I guess we could have some arguments on how best to reflect that penny but ultimately the objective is not to duplicate that Toradol injection line.

Now if we have – so, you know, we have a number of different scenarios we could present on here. We tried to cherry pick some of those that seemed to be getting the most questions or presented the most difficult billing scenario. So one thing that really froze the whole conversation or makes following the line items difficult is the fact that if we have preventive services we're going to report the CG modifier on the preventive visit that is our - excuse me on the preventive service line item that is our primary reason for the visit. So we could quibble about the details of that but so for – and we have a couple examples to show for that. But if somebody shows up with an annual wellness visit and we're going to do a Pap then the annual wellness visit is really the primary reason for the visit and will put that on the CG modifier.

So preventive services if they're the only service on there we should get the CG modifier on the line item that's the primary preventive visit. So, you know, we can come up with multiple different scenarios for preventive visits. One of the questions that seems to come up a lot is a visit like this. Now this I did not do the penny on this example because I want to illustrate how the numbers work.

So Shannon here in a second is going to talk about preventive services. But our - the whole complexity of these claims arrive because of our preventive visits. If we have a preventive visit and a sick visit on the same day we have to remove the dollars for the preventive visit from the qualifying line item so that those preventive services are not included in the coinsurance. So on this visit right here say we have obviously a female shows up, we have a 99213 but we're also going to do a Pap on this person. So this is not just a well woman exam. This is a sick visit with a pap. Now Shannon's going to talk in his second about standalone encounters versus same-day billing but in effect on this one we've done a venipuncture as well. The venipuncture we have bundled up into our qualifying visit line of 99213 for \$120. So the \$120 on the

qualifying visit line represents the \$100 charge for the office visit and the \$20 charge for the venipuncture. I posted in the chat box why that venipuncture gets bundled these days.

I have excluded the \$75 for the breast and the pelvic exam from the qualifying visit line. The reason I've done that is because it is a standalone visit. And if it's done at the same time as another visit we only get one encounter. So we've had to remove the \$75 from our qualifying visit line in order that this claim would process with only the sick portion applied to coinsurance and deductibles. I know it's a very complicated claim for us to get our heads around but in the fact we're removing the preventive visit from the qualifying visit line so that patients aren't charged coinsurance on their qualifying visit. I'm sure we'll have some additional questions about that type of service.

One of the big services that comes up and if somebody can point me to where this is in writing that would be great but the big question is bundled services different dates. So in the FAQ for our CG modifier is this text -- I don't have the citation on there but it is from the FAQ -- we can combine incident to services from different dates of service as long as they're furnished in the medically reasonable timeframe. I obviously just paraphrased that but our incident to services should not be. So the line items for our incident to services should not get a CG modifier but we can report services from different dates with one visit as long as they happen within a reasonably appropriate timeframe. The reasonably appropriate timeframe that we generally recognize is 30 days before or after the visit. So in this example I don't have dates listed here but let's use the example the office visit happened on April 2.

One week before or one week after -- let's say one week before on March 20 - - this patient had had an allergy injection. The patient came back in on April

2. Now we can bundle the allergy injection with our office visit. This is the part that I'm not sure where it's in writing but we all generally agree out there that the – even though they happen on different dates we should report the date of the encounter even though the allergy injection happen on a separate date. We don't want to span our dates of service on rural health clinic claims because if we span that date of service and there may be a hospitalization or some other service in there in-between the patient that service would kick out because it – Medicare would think the patient was at our facility for that for that full week.

So we don't want to span our dates of service. We want to use the date of the visit on this claim. We have everything bundled up into the qualifying visit line. We have a \$115 visit to reflect \$15 of an allergy injection. And then we can see on this how when we don't use that penny reporting mechanism that we overstate our total charge by the amount of the service line. But again \$115 will be used to process the patient coinsurance and deductible.

Now this is actually the same representation of the same allergy injection with the penny reporting mechanism. So you can see here what we do is we eliminate the extra revenue from our system by using that penny mechanism otherwise our line items are reported in exactly the same manner.

Shannon Chambers: Hey Charles so that actually is another one of the questions that came to us via email before the call. They have of course to bundle the 36415 venipuncture with the visits. The question was what do we do about outside lab orders where we do a courtesy draw? How do we bill for the venipuncture when there is no follow-up for that? So this would be a great way the appropriate way for you to do that again the 30 days billing before or during.

Charles James: Thirty days before or after. So if that patient comes in for a venipuncture -- and this doesn't matter if you're provider-based or independent -- the patient comes in for a venipuncture, you send the sample off to the lab, you don't have anything other than the venipuncture. The patient is never seen so we don't have a visit within a medically reasonable timeframe to attach the venipuncture. So the venipuncture what I recommend is you post that on your system and write it off get rid of it. It's nothing that's ever going to pay and that "goes on your cost report."

All that means is that goes into your revenue and your charge amounts for your Medicare patients. It's not going to result in a payment for you at all. But those standalone venipunctures that never have a visit to associate with them ultimately you're not going to be able to bill unless there's a visit 30 days or before or after to bundle that with. Behavioral health gets pretty straightforward treatment on here. We have a 0900 revenue code. Behavioral health sessions be sure that you look at the qualifying visit lines for behavioral health.

Qualifying business lines are not really suggestions and a guideline but at the same time there are some assessment codes on there that some folks try to bill that are not qualifying visits. So you want to be sure and look at the qualifying visits for behavioral health. And again those are a guideline but still pretty relevant so fairly straightforward claim. CG modifier gets on the behavioral health qualifying visit. We have \$120 visit and of course the patient's going to be responsible for a 20% co-pay of that.

Now we start to get into sick visit, subsequent day visits, et cetera. One of our reasons we can have separate visits is if we have a sick or clinic visit on the same day as a behavioral health visit. So we don't need to do anything different other than patients come in and seeing a nurse practitioner or doc,

you've had a sick visit and they've come over and they've seen our LCSW for a therapy visit. I'm not sure that 90834 is a therapy visit but all the same behavioral health session we have two line items with CG modifiers. We'll get to encounters out of this claim because this is one of the instances where Medicare will pay two encounters. Shannon?

Shannon Chambers: All right, so we're going to get into our preventive Medicare standalone encounters. So we've detailed out some of the Medicare standalone encounters for you. And for the description at the top is it going to pay your rate. Again is it same day billing and then of course coinsurance and deductible waived.

We got a lot of questions actually about this through the emails prior to our call. And one of the questions that we had was in regards to Tdap. And billing for a Tdap. And the question we received was that they would like to know how to bill for the Tdap?

They were told it was a Part B vaccine and will not be covered unless it's just tetanus. Can you help me with this? We are a small enough clinic. We would not be able to carry just the tetanus vaccine and realistically use it more for the pertussis aspect. So part of this is going to come back to immunization. You know, if you're doing it for immunization it really can be covered through their Medicare Part D plans. If it is for an injury for the tetanus, then that's going to be bundled with the claim just like the Toradol injection that Charles went over with you before.

The other part of the questions that we received was and relates to diabetes and medical nutrition therapy billing and a provider-based RHC for Medicare patients. While those two are actually not listed on the Medicare standalone encounters if you are seeing a patient for a diabetes encounter to go over

whether it's nutrition or there's hemoglobin or their new medication that would stand and suffice for an actual visit of services. As you will see again flip to the next screen here and these are your additional Medicare preventative services and standalone encounters. And so Charles I'm actually going to throw one right back at you.

We have had a lot of questions off of the NARHC listserv lately regarding the preventative service lines and so I'll go ahead and read that question for you. It is "I'm wondering if anyone else is having issues with Medicare replacement plans denying annual physicals these being billed with the actual 99396 and 99397 not the G codes because they are not on the RHC qualified visit list." Do you want to discuss that?

Charles James: Certainly. So this – that actually dovetails nicely with a couple different issues on here. So the 9938 9939 codes are routine visits right? So Medicare does not pay those routine visits. And I think according to the question the Medicare replacement plans were stating if those 9938X or 9939X codes are not on the qualifying visit line then even the Medicare replacement plan was not going to pay them as encounter. So the fairly simple solution would be that any of those 9938s that you're performing instead of just making those routine visits you would actually need to make sure and do the visit but those could and should be billed as annual wellness visits so that instead of using the 9938 or 39X codes we use G0438 for the initial annual wellness visit or G0439 for the subsequent annual wellness visit or of course the Welcome to Medicare visit is a different code as well.

But the replacement plans now of course if you're billing the annual wellness visit we need to do the annual wellness visit. And there's a set list of criteria for the annual wellness visit that need to be complete. As an asterisk many of us want our RNs to do the annual wellness visit which is fine but then is not

payable as an RHC visit. So we still have to have a qualified provider provide that annual wellness visit, qualified RHC provider. And as long as that RHC provider provides the annual wellness visit then it's a billable encounter. If the RN provides an annual wellness visit it's not a billable encounter.

I had at one of the recent gigs I did a question where somebody insisted we were having an argument about that. And the docs were just insistent that they didn't need to do the annual wellness visits. But unfortunately in order to get them paid they needed. That's the only way to have that happen. So 9938, 9939 should be annual wellness visits assuming that you're doing the whole deal on the annual wellness visit.

Now on one brief note on this screen right here on alcohol screening for example and on the – these other visits here where we have a duration stated you really need to timestamp those in your visit note to ensure that you've met the various duration requirements.

So for example obesity we would need to timestamp, you know, 201 to 216 that that lasted the full 15 minutes. I've seen folks have to pay those back when they didn't have the timestamps on those. So a brief note on that. And then note here too that the smoking cessation codes have changed effective 10-1- to a 99 format from the old G04 codes on those so be aware of that. We do have a couple of these back on this last slide prostate and glaucoma that do not have coinsurance waived so prostate and glaucoma screenings have coinsurance applied to those.

Shannon Chambers: So Charles I did see on the chat box that it looks like one of the questions that came across is someone's asking if the patients already have their annual wellness visits how would they bill for their physical.

Charles James: That's a good question. I don't know of a way they would do that. That would be outside of Medicare's payment schedule. So unless somebody differs with me if they've already – I don't know why you would want to have another...

Shannon Chambers: And I agree completely...

Charles James: ...you haven't...

Shannon Chambers: ...with you.

Charles James: If you've had the annual wellness visit I could think of maybe a DOT or an FAA physical but I would think that would be fairly exceptional. But regardless...

Shannon Chambers: And I...

Charles James: ...I would think the patient would have to pay for it.

Shannon Chambers: I agree. I think that would be patient responsibility if they've already had their annual wellness visit for the year and now they're coming back in for a physical unless some kind of major change has happened where you're doing an extreme, you know, like a 99215 visit to capture something, you know, a stroke or something like that. I don't see why...

Charles James: Right.

Shannon Chambers: ...you would have two within the same year.

Charles James: Right. And you then if it was a stroke you still have medical necessity right? So...

Shannon Chambers: Correct for that visit.

Charles James: Yes. So in the same vein as those standalone encounters here's a frequent question we get. You know, what do we do with the breast and pelvic exam and the Pap collection when they're billed together but we may not have another visit? Now either of these could be billed as standalone visits so the breast and pelvic exam by itself, the Pap collection by itself could be billed as standalone visits which of course then either one would get the CG modifier. In this case I attached the CG modifier to the breast and the pelvic exam and we would get one encounter out of this visit.

Each of these would be paid as encounters by themselves. When standalone encounters rendered with another visit either preventive or a sick visit you're still going to get one encounter. The only visit handled differently than that other than some of our subsequent day stuff is the Welcome to Medicare visit.

Procedure only, there was a lot of confusion about procedure only claims because the qualifying visit list came out in June or July whatever that was. And that was the first thing that we noticed was not on the initial qualifying visit list were minor surgical procedures or perhaps some OB services and things that maybe we wouldn't have thought of initially. So this was the whole reason for the CG modifiers. Instead of updating the qualifying visit list constantly we, remember CMS implemented use of the CG modifier to indicate the reason for the visit. So instead of perpetual QVL updates here's what we've got. So a lot of - oh, my - I'm not sure what just happened to my slide there. We went all the way to the beginning. Let me get back to the correct example here.

Experiencing technical difficulties right? So here's our procedure only code. All you do is take the minor surgical procedure and amend the CG modifier to it so not a complicated claim. Many of us have thought for a long time that we have to have an E&M code on this for some reason. We do not.

Qualified RHC provider hands and eyes on the patient medically necessary visit and you have an encounter. Now of course we have the qualifying visit list as our guideline but a pretty straightforward claim with our procedure only. We were not able to submit this claim until after October 1 because A the 11/100 or comparable procedure were not on the qualifying visit list and B we weren't able to use the CG modifier for those. So many of us had to hold these claims from sometime in the summer or from 10-1, excuse me April 1 all the way through to October 1 when that modifier was implemented but that's how that claim looks.

Shannon Chambers: So Charles we did have another - sorry...

Charles James: Yes please.

Shannon Chambers: So we did have another question emailed in about the procedure only claim. The lady indicated that she's receiving rejections on her Medicare RHC claims for procedures that of course they held until 10-1 stating that the revenue code and HCPCS are an invalid combination. They stated that they're actually a part of WPS and the claims are rejecting because we're sending CPT codes with the 521 revenue code and WPS had told them to use other revenue codes that actually when I did the research for this claim actually are not appropriate revenue codes for RHC. The only problem unfortunately with this question is it doesn't state if they were actually using the CG modifier.

Charles James: Right.

Shannon Chambers: So I just want to be clear that for procedures where you actually did one of the procedures that are on the original qualifying visit list you are putting a CG modifier on that claim. The other thing to make sure is making sure that your clearinghouse is actually letting that claim go through with the CG modifier...

Charles James: Right.

Shannon Chambers: ...because we did have a clinic here that the clearinghouse was stripping that CG modifier off.

Charles James: Yes. Yes and I think on the example we looked at Shannon the revenue codes that were being suggested were inpatient or observation revenue codes is that correct?

Shannon Chambers: Correct, they were as inpatient observation revenue codes.

Charles James: Yes so to us when we looked at the least the text of the question our first question was assuming we had a clean claim with the CG modifier on it assuming that was the case then the necessity for the inpatient or observation revenue code was probably a processing error. And I would get a hold of the MAC with that. But it was difficult to tell because we weren't 100% certain that there was a CG modifier on it.

And so just from a kind of - historical perspective goes back to October 1 on a lot of the questions we've had, you know, we've had a lot of a, you know, "Hey, you know, Cahaba's not processing these," or "Hey, you know, these claims aren't paying this way." And a lot of the questions that we've seen many - I shouldn't say a lot. Many of the questions we've seen when you drill

down to it the CG modifier was not on the claim correctly. And I have a feeling that that is what happened with that particular procedure only visit. If it was...

Shannon Chambers: Thanks.

Charles James: ...processed correctly so now on the Welcome to Medicare visit the Welcome to Medicare visit creates some additional confusion because for some reason we don't have to have according to the FAQ don't have to have the CG modifier on the claim. So Welcome to Medicare only we seem to get the CG modifier waived for that but I believe it will process with the CG modifier on it either way. But again strictly according to the FAQ we don't have to have it on there. Now that said for all of your preventive services make sure - and forget Cg modifiers. Make sure that you all are tracking your preventive service charge amounts because those can go on your cost report.

And I don't want to open up a cost reporting discussion but make sure you have the ability to track's visits. And actually back to the venipuncture question where if you're just going to - you just have venipuncture's that ultimately you're not going to get paid I ultimately believe very strongly that regardless of whether or not the line item is going to be paid it should really be entered on your practice management system so at the very least you can mine the data for cost reporting purposes or your practice management system matches the services that were rendered as documented in the note and everything ties together nicely.

A couple more claim examples here, this is a sick visit and a Welcome to Medicare visit. This is following the instructions strictly by the FAQ and not using the CG modifier on the Welcome to Medicare visit. As we mentioned a second ago here is our key word here, same day billing. When we have an

encounter and a Welcome to Medicare visit on the same day, same day billing is only applicable to the Welcome to Medicare visit. So the only preventive visit that will get a sick visit and a preventive visit will get two encounters out of those two visits together is this right here. And of course we would know that the only coinsurance would be applied to the 99213 on that particular visit.

Here's the well woman exam that we talked about. So instead of billing that out as a 9938X or 9939X that the - I think one of those is children -- I'm not sure. So maybe the 38 is incorrect for well woman but same difference. 993 is so routine visit codes. We would do a subsequent annual wellness visit that would get our CG modifier. That would be the exam portion. And of course then our breast and our pelvic exam and our Pap collection would be ultimately for information only on this claim. But once again our baseline is to we report all services as rendered and regardless of whether or not it's going to affect payment.

Now the other topic we're not touching today is of course quality payments. What - I'm sure we can all imagine why we need to start reporting HCPCS detail and service detail line items so that we can start capturing data. And this is only Charles James speaking but I assume that that's for a future applicable in quality payment programs over all but the first step is to capture the data. So my point is don't shortchange yourself. If you're your providing preventive services get those reported because that's going to roll into larger context of quality payment measures which is a whole different presentation. But we at...

Shannon Chambers: Charles?

Charles James: Pardon me. Go ahead Shannon.

Shannon Chambers: What I was going to say, one of the questions that you're getting on this example here is they're asking if the charges are rolling up on the first line for this example. And one more clarification before you answer is regarding the cost report for the preventative services...

Charles James: Yes?

Shannon Chambers: ...they – that'll be pulled off of course for their PS &R. It does not mean that you - not from your actual interning billing records just to clarify.

Charles James: Right got it. Thank you. But no so we – I didn't roll the charges up into the qualifying visit because on this there would be no coinsurance or deductible amount. I suppose there's an argument for doing so but according to the FAQ and according to the guidance I've looked at this would be the appropriate way to report multiple preventive services and especially when you get full credit for those. So no, on preventive visits there is no need to bundle services up because we won't have a coinsurance or deductible on those.

Shannon Chambers: Perfect, thank you.

Charles James: I imagine someone was out there listening on this call 356 of us have had some corrected claims that we've wanted to deal with. And there's been...

Shannon Chambers: Yes you've been asked to go in very good detail on this as people are still having lots of questions about how to get their corrected claims back out so lots, lots of conversation on the Q&A chat box regarding this.

Charles James: Sweet because that is where the money is right? So first of all many of us got caught up. I would have to say North American did as well. We had

communicated internally that ten - that our 10-1 deadline was a submission date threshold not a date of service threshold. So even though I had put it in bold and caps and red on the emails all over the place you still had some batches from late September that we did not get the CG modifier on. So of course the first indication of those is when those claims start kicking back to you as CO97s and rejecting without payment. So you cannot just turn around and resubmit your incorrect claim with corrected information on it. You cannot just turn around and resubmit that as a new claim.

You have to let the initial claim reject and then you need to file a corrected claim, not a new original claim. Though most of us unless those of you that are correcting these claims don't ever have to deal with types of bill and the types of bill drive on our UB04 -- it's up in Field 4, 5 up in the top right-hand corner of the claim -- many of us would never have to deal with those. But a 711 as a new claim a 717 is a corrected claim.

So on any claims that did not get the CG modifier applied correctly the first thing to do is and your practice management software and there are a variety of mechanisms that you can use to get the claim there if your practice management software is insufficient you need to be able to amend the type of bill to 717 to indicate a corrected claim.

We need a condition code in field - excuse me I'm having trouble reading my UB04 here.. In field 18 we need the condition code and there's been a lot of information about this out there. The condition code that we have used at North American across payers has been D as in dog 9, D as in Dog 9 which indicates other change or other charge change I believe. But we've used condition code D9. We did not put anything in the description up in D9.

In Field 44 we added the CG modifier to our charge amount and then critically we need the ICN number from the original rejection. If you don't have the ICN number on there the claim will reject. Your corrected claim will reject. It won't know what claim you're correcting.

Type of bill 717 critical. It's not a new claim. It's a corrected claim. Condition code D9 D as in Dog 9 get your CG modifier on there. Make sure you get your ICN number from the rejection. That goes in Field 64 which is a document control field. Let's see yes, Field 64 yes document control number was Field 64 on the UB. And then in Field 80 in the remarks we want to put added the CG modifier.

So that is the way to get your claims corrected. Now of course if it's something other than just adding the CG modifier and you need to add line items you may use a different condition code on there but the D9 is other charge change. I may be mashing that charge change up, other change effectively. But of course you would need to match your claims to any of the claims examples that we just reviewed.

But otherwise these five steps are all required for correcting your claims that have been either erroneously or erroneously rejected or more likely did not have the CG modifier on them at the outset of the submission date 10-1 and beyond. That's what we've primarily seen. And just for the record particularly during the National Association Conference in Reno there was a lot of scuttlebutt going around that for example particular payers were not processing even corrected claims. And universally we found that they were CG modifier issues with those claims when we were having folk state that.

Again we're in active billing operation here in North America and across multiple payers. And universally we're getting our claims paid cleanly using

the processes we just reviewed. But we're getting our corrected claims paid across payers as well. I'm looking at three examples right here across payers and this is valid guidance across the payers from our experience.

Another big question is Modifier 59 or 25. Now I think I'm getting the questions that Shannon and I dealt with together conflated with another conversation I've had. But Modifier 59 and Modifier 25 particularly Modifier 25 we're not really using according to its pure definition. So we've distorted the Modifier 25 meaning a little bit relative to rural health clinics. We know in a non-rural health clinic environment of course that Modifier 25 is separately identifiable procedure which is barely distinguishable from Modifier 59 which means a separate procedure or service. And coding minds better than mine can look up the precise language of those.

Regardless the 59 or the 25 are used only in event of subsequent visits. So we've got a modifier 25 or 59 what represent the primary reason for the subsequent visit, okay? So our initial visit will need the CG modifier. Our subsequent visit will get either the 25 or the 59 modifier. They are virtually interchangeable for these purposes. If you look at the FAQ some of the language on the answers for the FAQ is actually a little difficult to follow but what its saying is do I need a Modifier 59 on my initial visit for the day? No, we need the CG modifier on there.

Now the FAQ asks, "Do I need the CG modifier in the subsequent visit?" No on the subsequent visit we need the 25 or the 59. Now I've seen many folks apply this Modifier 59 to an office visit and a surgical procedure that happened at the same visit which would be totally incorrect. The 59, this Modifier 59 this will result in two payments, two encounter payments and it indicates patient came in at some point in the morning or earlier in the day and

then came back later with a subsequent illness or injury that we're treating separately from the visit from, you know, earlier in the day.

So the subsequent visit does not mean the CG modifier. The subsequent visit gets 25 or the 59 modifier. We will not put CG modifiers on both line items for subsequent visits. We will not do that. We will not put a 59 or 25 modifier on an additional line item that happened at the same visit. You'll get to encounters.

Bill Finerfrock: Charles were getting up close on our hour here...

Charles James: Yes.

Bill Finerfrock: ...and we haven't even had time for Q&A. So...

Charles James: Yes.

Bill Finerfrock: ...if Wakina or folks at RSP can we extend beyond 2 o'clock...

Wakina Scott: Yes.

((Crosstalk))

Bill Finerfrock: ...or 3 o'clock?

Wakina Scott: Yes we can.

Charles James: I'm sorry I had in my head we were going to 2:30.

Bill Finerfrock: So Charles and Shannon can you stick around for a little while longer?

Charles James: Of course absolutely.

Bill Finerfrock: Are you okay to stay?

Shannon Chambers: Of course.

Bill Finerfrock: Okay. Well thanks for all of your great insight and perspective. I know there's been a lot of commentary and questions on this chat box. We're going to try to get to some of those. Here's the contact information on your screen for Charles and for Shannon if you want to follow up with them. Operator do you want to give the instructions if folks want to ask a question through the phone line?

Coordinator: Yes thank you. If you would like to ask a question please press Star 1 and you will be prompted to record your first in your last name. Please unmute your phone when recording your name and to withdraw your question press Star 2. One moment please.

Bill Finerfrock: And I know that folks have been asking stuff along the line in the chat room but I'm really going to ask if you would – and I know people have been going back and forth and it's a little hard to figure out what may or may not been asked. So if you have a question that you already put in the chat box I would ask that you restate the question now and we'll start taking question also out of the chat box rather than trying to go back up through figure out what has or hasn't been answered. So you have the option now of adding a question to the chat box or asking the question through the phone line. So operator do we have any phone questions?

Coordinator: Yes we do have a phone question. One moment.

Bill Finerfrock: Okay. We'll take our first question. And remember in both...

Coordinator: (Nicole) your line is open.

((Crosstalk))

Bill Finerfrock: If you could let us know who you are and where you're calling from.

(Nicole Nickbauer): I am (Nicole Nickbauer) and I am from South Dakota.

Bill Finerfrock: Okay (Nicole).

(Nicole Nickbauer): And my question is we have many people come in for their office visits like to refill their medications and stuff and then they also have the lesion removal or a joint injection at the same time. My - our understanding is we are to put the CG on the office visit code and do not put anything on the procedure code but we do have to include it on the claim. Is there any separate reimbursement for that or do we just get - still get the premium?

Shannon Chambers: So it won't be a separate reimbursement it will be 20% off of the total charge line meaning that if you had a \$100 office visit and then a \$100 for your injection or your joint injection then the coinsurance is going to process off of that \$200 for the patient responsibility versus you not putting any charge amount on that joint injection.

(Nicole Nickbauer): But then we do not - are we to still report the medication like the J code or do we leave that off because that's not on the qualifying visit list?

Shannon Chambers: You can still - go ahead.

Charles James: No please Shannon.

Shannon Chambers: I was going to say you can still report the actual medications...

(Nicole Nickbauer): Okay.

Shannon Chambers: ...that you're injecting even though those aren't necessarily on the qualifying visit list. That's still part of the procedure that you're actually doing so I would encourage you to include those because again the cost of that total charge is what you're getting the coinsurance, either patient responsibility or secondary picking up.

(Nicole Nickbauer): Okay thank you.

Charles James: Let me also say I think there's still some confusion about the QVL and the Qualified Visit List. And I think Charles or Shannon touched on it. That was an original concept of CMS to try and, you know, identify what they thought were qualified visit list. And it became quite apparent early on that that was going to be unmanageable and would never be fully complete. So while that's a guide it is not an absolute. And just because something's not on there doesn't mean that a visit or some other service. The key for rural health clinics as long as it's a medically necessary service that it would be covered by Medicare that is appropriate for a physician's office that is provided by a physician PA nurse practitioner or other recognized provider in a face to face visit is a billable RHC service or visit. So don't be – get too hung up on that qualified visit list.

Bill Finerfrock: Right.

Charles James: If there are things that aren't on there that doesn't mean that it's not a billable visit as RHC.

(Nicole Nickbauer): Okay.

Bill Finerfrock: Back in the old days of Riverbed which some of us may remember they had really great encounter definition that one of their primary folks would always harp on and it was always, you know, hands and eyes on the patient. Qualified provider hands and eyes on the patient medically necessary encounter. You know, that's our guideline.

(Nicole Nickbauer): Okay thank you.

(Nathan Bah): All right so there's been a number of questions on the chat Q&A and if you could print that out. There's a couple of things. First to get the chat Q&A you can check you can download the presentation once it's posted online and the chat Q&A will still be there. The second thing that I will make sure to do is at the end of this we will make sure to copy the chat Q&A and post it as well in the transcript. So yes for those of you who want the chat Q&A to be saved we will have that it'll be in both the transcript and in the presentation once it is posted and we will also have it saved in a Word file.

And so with that we have a number of questions online. And I'm not entirely sure where it started because it keeps reloading for me so I'm just going to pick one and start there. (Michelle) asked, "Per conversation with NGS rep all RHC claims will deny until the January quarterly update." Does anyone have an answer on that Shannon or Charles?

Charles James: Call back. See if you get the same answer again and then let us know. No I mean that I've never heard of it. Bill do you know what that is talking about?

Bill Finerfrock: No I - actually Shannon had texted me during this to say that that come up. We're going to have to check on it. This is the first we've heard about a problem with NGS. But if you would send an email to me at info@narhc.org and attach if you have a formal anything you can send from NGS indicating that that's what they're doing we can look into it and find out what's going on. But we're not aware of any reason why they should be holding claim.

(Nathan Bah): Yes. This is (Nathan Bah). If you can send me an email with that I can try to look into it. So feel free to reach out to any of us and hopefully - we had a similar issue with Cahaba where they were...

Charles James: Yes.

(Nathan Bah): ...not paying all claims and so there was some confusion there. So maybe that's going on - same thing that's going on with NGS but we're going to need more details of what they're saying and what's going on.

Charles James: And that should not - ultimately it should not be the case. There's not January threshold for claims that anyone knows about.

Bill Finerfrock: Operator do we have any more questions from the phone?

Coordinator: We do. We have a question from (Beth). Your line is open.

Bill Finerfrock: Go ahead (Beth).

(Beth): Hi. I would like to know if we add a modifier CG on the IPPE exam is that going to be a problem. Will it still process?

Charles James: It should.

Bill Finerfrock: (Beth) where are you from?

(Beth): (Barda), Illinois.

Bill Finerfrock: Okay.

Charles James: Will hey (Beth) you're just not too far down the road from me so hello from just up the road. Yes I don't believe that should be problematic. I think that claim would...

Bill Finerfrock: Yes. It should process even with the CG modifier.

Charles James: Yes.

Bill Finerfrock: It shouldn't be a problem.

(Beth): Okay.

Shannon Chambers: We've had them processed both ways.

(Beth): Yes because when we very first started we were told to put a CG modifier on it. But then today you're saying that we don't need a CG modifier on the IPPE.

Charles James: Well the Medicare...

Bill Finerfrock: You don't need it to get it paid but it will pay. It will process if you put it on. It will process if you don't put it on for the IPPE only.

((Crosstalk))

Shannon Chambers: Correct.

(Beth): Okay.

Shannon Chambers: Correct.

(Beth): All right. Thank you.

Coordinator: Another question, one moment. (Teresa) your line is open.

Bill Finerfrock: Please identify your name and where you're calling from?

(Teresa Greer): (Teresa Greer) Louisiana.

Bill Finerfrock: Go ahead (Teresa).

(Teresa Greer): Okay. We have a diabetic foot care done in our clinic. And we are having - we are submitting a claim for GEO245 with a CG modifier with a 521 revenue code. And every time we do we get - they reject in the DDE system saying that for bill type 71X 73X 74X or 75X G0245 through GEO247 is present. The associated revenue code must be 940. But the 940s are not a revenue code that you can get paid - you know, it's not reimbursable revenue line.

Shannon Chambers: Which MAC are you using?

(Teresa Greer): Which - oh, Novita's.

Man: Can't find the question.

Charles James: And this is on foot care as well.

(Teresa Greer): Right.

Charles James: Now I assume these foot care patients have diabetes that you're putting on there?

(Teresa Greer): They do, they do.

Charles James: Yes.

(Teresa Greer): its diabetic patients.

Shannon Chambers: And that's the only thing that you are doing that day or is that in addition to an office visit?

(Teresa Greer): That's the only thing we're doing that day. It's on the qualifying list. They just will not let it go through.

((Crosstalk))

Charles James: And that is on the QVL?

(Teresa Greer): Pardon?

Charles James: And that is on the qualifying visit list?

(Teresa Greer): Yes. It's on the qualifying visit list. It's on the very last page G0245, G0246 and G0247.

Charles James: Well yes it...

Bill Finerfrock: I don't know that we can explain why they're not turning it – why they are rejecting it. If you want to again send that to you can send it to either Shannon or Charles...

Charles James: Yes.

Bill Finerfrock: ...or if you want to send it to us here at NARHC we can try to look into it and see what we can find out.

Charles James: Have you tried to wrap with that? Have you tried bumping it up?

(Teresa Greer): We have tried.

Charles James: Did you talk to anybody about it?

(Teresa Greer): We've tried calling Novitas but whenever we talk to them they tell us to put the 940 on there. And of course when we put the 940 on there it rejects ...

Charles James: It rejects as well.

(Teresa Greer): ...because we don't have a...

Charles James: Yes.

(Teresa Greer): ...revenue line that is qualifying to pay.

Charles James: Right and...

Shannon Chambers: I think you need to bump that to a - into a tier 2 person as it is on the qualifying visit list but I'll be glad to help you if you want to email me.

Charles James: Yes. And you're right there's no way that'll pay with a 940 on it.

(Teresa Greer): Right.

Charles James: So...

(Teresa Greer): Right, okay. So I can email you and you'll help me?

Charles James: Sure.

Shannon Chambers: Yes ma'am.

Charles James: Yes just copy us both.

(Teresa Greer): All right thank you.

Bill Finerfrock: And then take a question from the list serve or from the chat box?

(Nathan Bah): And I apologize where I don't think we'll be able to get to most of these questions and it's not going to be in any order. However I did notice one question. Charles can you speak to the Cahaba situation and what happened there, just go over that?

Charles James: As far as I guess I'm not sure which part we want to talk about, just that some of the information that they were given out? I'm not sure what the...

Shannon Chambers: So I think that part of it is Cahaba wasn't giving out...

((Crosstalk))

Shannon Chambers: ...information back all the way down to their customer service reps.

Charles James: Right, right, right, right.

Shannon Chambers: We also had that problem as well.

Charles James: Right so that's right. And so when we were calling Cahaba we were sometimes getting contradictory information on specifically when we were calling about how to correct claims. So that we would call the customer service reps. For example one of the items that came up was well we have a January decision to make and we'll let you know in January what to do with these claims. While none of that was accurate and I think they were just having inconsistent information on the part of the customer service reps within Cahaba.

But I can tell you now at least within our shop that the corrected claim information that I showed you applies directly to Cahaba and getting those corrected claims paid with Cahaba. There's no other kind of data threshold or mystery information the corrected claim information should operative. Does that address that question? I'm not sure.

Bill Finerfrock: I don't - it was again it was one that was written in so we don't necessarily know. We had another question that says occasionally we have a doctor who

after examining the patient refers the patient to another physician. How do we bill that wi- and it's on the same day. So you have a patient that comes into the rural health clinic. The doctor sees the patient there, refers the patient to another physician, goes to the other physician and is seen by that other physician on the same day. Is there any difference – should – is there any problem or any question as to how they would build that as a rural health clinic visit?

Charles James: So that is how Medicare typically defines multiple visits. And if they're seeing multiple providers for the same problem on the same day that's one visit.

Bill Finerfrock: So who gets - so you is it just a question of who gets their claim in first?

Charles James: Yes.

Bill Finerfrock: They get paid and the other provider doesn't get paid?

Charles James: They - that would be considered one encounter. We would – I would think put both encounters on the claims so you'd have a total charge. I don't know how from an E&M or a documentation perspective that may work but ultimately you're going to get one encounter out of that.

Bill Finerfrock: No. But this patient is going it appears that...

Shannon Chambers: I don't...

((Crosstalk))

Bill Finerfrock: ...going to another provider completely separate from the clinic. In other words it's not...

Charles James: Oh.

Bill Finerfrock: ...just another provider within the RHC...

Charles James: Oh I'm sorry.

Bill Finerfrock: That's the way I took the question.

Shannon Chambers: That's how I took it as well. And to me that's two separate visits. It's...

Charles James: Yes.

Shannon Chambers: ...the RHC gets a visit for whatever they're treating the patient for and then whatever condition they're referring that patient to the other clinic for then that's what that other clinic would be billing for as well.

Charles James: Right. Yes I'm sorry.

((Crosstalk))

Bill Finerfrock: There shouldn't be any problem with that RHC claim getting paid because it's referring - I mean if you're your point Charles if you're referring it to another provider within the RHC then you still only get one visit.

Charles James: Correct.

Bill Finerfrock: They're not going to let you ping-pong back and forth, you know, doctor. PA, PA nurse practitioner doctor, you know, whatever one visit one patient, same medical problem one visit a day okay? Do we have any calls on the phone?

Coordinator: Yes. We do have one more caller. One moment.

Bill Finerfrock: Okay.

Coordinator: (Sherry Dykes) your line is open.

(Sherry Dykes): Hello.

Charles James: Yes?

Bill Finerfrock: Hi.

Charles James: Fire away.

Bill Finerfrock: Where you from (Sherry)?

(Sherry Dykes): Hi. I'm from Vandalia, Illinois. I have a question. I'm - we're with Cahaba and I am trying to get some claims paid. They keep returning to provider. And what it is, is a G0101 code. I'm putting the CG modifier on it with the 82270 which is the hemocult slide billing that as .01 cents and they're all being denied return to provider with the reason code something to do with the revenue code.

Charles James: Your lab services should not be on those claims.

(Sherry Dykes): The 82270?

Charles James: Correct. I think it's your lab services throwing that claim.

(Sherry Dykes): Okay.

Charles James: Those – are you provider based?

(Sherry Dykes): Yes.

Charles James: So those will be billed under the hospital PTAN?

(Sherry Dykes): Okay no. No I'm sorry we're individual.

Charles James: So that those are going to get billed under your Part B...

(Sherry Dykes): Okay yes.

Charles James: ...group or individual fee-for-service numbers.

(Sherry Dykes): Okay.

Charles James: And it's the lab on that claim that's throwing it would be my bet.

(Sherry Dykes): Okay. That's what I thought. But when I called Cahaba she told me it was the revenue code on the G code. I didn't think that was...

Shannon Chambers: And I would also on that G code I would also make sure that you check your individual ICD9 or excuse me, ICD-10 code as the actual edit that still is coming back from Cahaba is showing ICD-9 codes so make sure it's either

Z12.4 or somewhere around there depending on what's going on with that patient.

(Sherry Dykes): Oh, okay. I'll check the code then. Okay that's all I have. Thank you.

Shannon Chambers: Thank you.

Charles James: You know, one thing I keep seeing here on the chat box as well as the listserv and Shannon maybe I don't have any great suggestion for this is are the folks that are saying, "Hey I've got D9 on my code, you know, I've got 717, I've got D9 in here. Everything is laid out the way you say it should be but they're still rejecting the claims." So Shannon do you have any advice for...

Shannon Chambers: The only thing that I was going to say is if they're using actual like DDE. DDE did not like D9. DDE wanted OT...

Charles James: Okay.

Shannon Chambers: ...as another code. So I don't know if that's - I've been trying to scroll back through some of the questions. That may be part of the problem is that wants OT which is just another, you know, additional thing that you added on.

Charles James: Right.

Shannon Chambers: So that might be something else as well.

Charles James: I think I see a continuing question out there from (Louise Birkhead) about that. And it looks like maybe that was a DDE error. So you folks out there you said what OT is the (unintelligible) code?

Shannon Chambers: OT, correct. And that normally goes on Page 3 just to be even clearer. I did see one more question, come cross and we also had this question emailed and I apologize that we hadn't gotten to it yet. It was regarding a physician performing chemical peels in the office...

Charles James: Yes.

Shannon Chambers: ...as well as doing an office visit. And the question was of course the chemical peel is a non-covered service and how should they bill that? So I'll give you my take and then Charles I'll let you ring in as well. If the 99214 is unrelated to the chemical peel than I would be billing the 99214 of course with my CG. The chemical bill peel being that it is noncovered really could do an ABN. And that claim is really going to in effect be split billed where that patient is responsible for that chemical peel and then the 99214 would go on to Medicare to process.

Charles James: And, you know, we can think of some occasions where we may need a non-covered rejection but of course that wouldn't apply to the chemical peel.

Shannon Chambers: Correct.

Charles James: So yes I, you know, anytime you have those cosmetic services like that they're just going to be totally excluded from the claim as opposed to trying to submit that on that rural health clinic claim somehow.

Bill Finerfrock: We have another question from the chat room.

(Nathan Bah): If you have two different specialties in the same clinic and the patient is seen by the two the different specialties for two different issues on the same days are - would that be considered one visit or two?

Bill Finerfrock: So that's two different problems, two different specialists, two different providers within an RHC.

Charles James: And...

Shannon Chambers: And are you saying different days?

Bill Finerfrock: No it's all the same day.

Charles James: Same day.

((Crosstalk))

Bill Finerfrock: You know, so I don't – we don't have the clinical example but basically there's two different – let's say it was a mental health provider and a family physician. So they came in for a medical problem with the family physician and went to see the psychologist clinical social worker in the RHC. So...

Charles James: So Bill your example is easy two encounters.

Bill Finerfrock: Right. Now...

((Crosstalk))

Charles James: Sick visit mental health provider on the same day easy, no problem.

((Crosstalk))

Shannon Chambers: What if part of the problem question is coming in there is in regards to if its two different providers how are they billing that out? And a lot of times you're going to have to let one go through. And then the second one will process later and you may have to supply the documentation to show the two different visits or that's what we've had so Charles?

Charles James: Yes. Well and I think the - where I think the question arises is maybe we've got a family practice doc and maybe we have a cardiologist in the rural health clinic for example on something that would not be as clear-cut between behavioral health and family practice. So I think that then if they go from a family practice to a cardiologist for example since you're in the same rural health clinic I don't know that you're going to get any subsequent visits out of that. I mean am I correct typically it's what different specialty, different tax ID number. Am I saying that right Shannon?

Shannon Chambers: You've got it right. I agree with you that if it's if they're under the same information, same tax ID number same then it's still to me is one visit.

Charles James: Yes.

Shannon Chambers: But if it's actual, you know, behavioral health that's totally different because again that's a behavioral health service and it appears like you answer that perfectly because the lady did say it was cardiology and family medicine on the same day.

Charles James: Okay good, good.

(Nathan Bah): So the next question our Medicare Advantage plans required to follow the CG rules?

Charles James: I think the short answer is no. I think they can follow what rules they put into place. Some will recognize a rural health clinic encounter, others won't. I think as one of our questions indicated a couple of those replacement plans were requiring that clinic to follow our existing billing guidelines. So Shannon you may answer for your neck of the woods but for our neck of the woods here in the Midwest what we see is just kind of all over the map depending on the Medicare replacement plan and ultimately you've got to contact each one.

Shannon Chambers: Correct. The only one that - yes I agree with you. In addition I'm going to add in one little thing is that Humana actually has a benefit for their Medicare Advantage if you have Humana where they actually do cover different things for theirs. They don't want - they do not want the actual CG modifier but as we were talking about the physicals earlier today they actually will cover the physical. So if Humana is kicking back and trying to recoup for your physicals you need to reach back out to them because that's an additional benefit for just Humana patients.

Bill Finerfrock: Yes. I think the general rule of thumb people need to keep in mind is that when an individual enrolls in a Medicare Advantage plan they're effectively distant rolling from regular Medicare and are agreeing to be subjected to the rules and policies of the Medicare Advantage plan. Within the Medicare Advantage term there are multiple different types of plans so you also have to be cognizant of what type of plan. Is it a traditional managed care plan, is it a PPO, is it a private fee for service product?

And then lastly are you a contracted provider or are you a non-contracted provider? If you're a contracted provider you're subjecting yourself you have voluntarily agreed to accept the terms and conditions of the contract you signed. If you're a non-contracted provider there's certain requirements the plan has to make with respect to you as a non-contracted provider. If it's a fee-

for-service plan there are different requirements and if it's a PPO or if it's a managed care capitated plan. So it's really difficult to make a generalization with regard to Medicare Advantage because there are different requirements with respect to the patient and it will also depend on the type of Medicare Advantage plan you're talking about.

Shannon Chambers: Very well said.

(Nathan Bah): So here's another question. (Sheila) was actually one of the first questions. She wants to know how to bill co-management services within the RAC? She says it's her understanding that RAC providers cannot bill for global surgery code and she uses 66984 as an example. The visit qualifies as face to face so she is wondering if you have any guidance and how to build a charge and she says with the 54 modifier.

Charles James: So generally speaking anything with a global billing period rendered outside of the rural health clinic the global billing period will follow that patient to the rural health clinic, A. B, if the service originates in a rural health clinic we don't have a global billing period. Today is a global billing period. No that brings up some fairly complicated issues about charging more into rural health and non-rural health for these types of services that I don't think this is a great forum for.

Shannon Chambers: Yes and I just pulled up that code with it being the 66984 which is a cataract removal so I don't think we're doing that within our rural health clinics.

Charles James: I would think that that that would be extremely rare. But on the face of it let's say you did you'd just get an encounter out of that one encoder out of that.

And then any follow-up services to that would have to be documented as medically necessary. Do you agree with that Shannon?

Shannon Chambers: I do.

Charles James: But even so it would be...

((Crosstalk))

Bill Finerfrock: I'm sorry go ahead.

Charles James: I just going to say I am skeptical about cataracts in a rural health clinic but...

Bill Finerfrock: Okay.

Charles James: ...aside from that...

Bill Finerfrock: Operator anybody on the phone?

Coordinator: I'm showing no further questions.

Bill Finerfrock: Okay. Why don't we – we're coming up almost on 3:30. Why don't we - you've got one more from the stat?

(Nathan Bah): We'll take this last question from (Joan). She says, "In Florida FCSO issued a document indicating effective January 1, 2017 the new influenza CP2 code is 90674. Is this covered at the RHC since it is not an approved code on the qualifying visit list?"

Charles James: Well if that's a flu immunization is that what we said that's a flu immunization?

Shannon Chambers: Yes.

Charles James: So that's going to go on our cost report anyway and we would never have any counterclaim that has an influenza injection on it.

Bill Finerfrock: But I think I'm to the larger point of the fact that the code is not on the QVL. I think I'm going to go back to a comment I made earlier. The QVL concept was something that CMS had thought would be a good way to do this. They realized new codes would be added that they would constantly be in a position of having to update it. So they've basically scrapped it. They will not be updating the QVL. It is a guide but it is not an absolute.

So the fact that a code is not on the QVL does not mean that it would not be an allowable or appropriate code for a billable visit in the RHC. Again if you look at the code just don't look at the numbers. Is it a medically necessary service? Is it required to have a face to face encounter between the physician, the PA, the NP or other provider and the patient? And for that level and skill of training of that individual and is it a service that's otherwise covered by Medicare? If it meets those tests regardless of whether or not it's on this QVL list on it should be a billable visit for the RHC.

The influenza is different, flu and pneumonia they're reported on your cost reports through a log and those are paid at 100% through your cost report at - as an end of your reconciliation. So but again on the QVL it is a guide. It is not an absolute.

I think we'll have to end it here. I want to thank Charles and Shannon for their tremendous amount of time and insight and perspective they provided us today. It's extremely helpful. On your screen is information if you want to join the new information where you can go either to any RHC's Web site or to the Office of Rural Health Policy's Web site to sign up.

There are also questions that were posted for our survey. If you could take a few seconds and fill those out we'd appreciate it. It helps us know for future opportunities. We have not scheduled the next call you but we hope to do that and it'll be sometime after the New Year.

And I want to just go ahead and wish everyone a very happy holiday season. If you're traveling during the holidays please travel safely and we look forward to chatting with you next year. Thanks everybody for your time and attention today and we'll call it a day. Thank you very much.

Charles James: Have a great holiday everybody.

Shannon Chambers: Thank you.

Coordinator: Thank you for your participation. You may disconnect at this time.

END