

Healthcare Common Procedure Coding System (HCPCS) Requirements for RHCs

**Rural Health Clinic Technical Assistance Series Webinar
March 29, 2016
1:30 pm ET**

Coordinator: Welcome and thank you for standing by. At this time all participants are in listen only mode until the question and answer portion of today's conference.

If you would like to ask a question today please press star followed by the number one on your touchtone phone. You will then be prompted to record your first and last name.

The conference is being recorded. If you have any objections you may disconnect at this time.

Now I will turn the call over to your host, Mr. Bill Finerfrock. Thank you sir, you may begin.

Bill Finerfrock: Thank you operator and I want to welcome all of our participants and our speakers. My name is Bill Finerfrock and I am the Executive Director of the National Association of Rural Health Clinics and I will be the moderator for today's call.

Today's topic is RHC CPT Reporting Requirements. This series is sponsored by the Health Resources and Services Administration, Federal Office of Rural Health Policy and is done in conjunction with the National Association of Rural Health Clinics.

We are supported by a cooperative agreement and as you can see on your screen through the Federal Office Rural Health Policy and that allows us to bring you these calls free of charge.

The purpose of this series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call is the 71st in the series which began in late 2004. During that time there have been over 18,000 combined participants on the Bi-monthly National Teleconferences now being also done as Webinars.

As you know there is no charge to participate in the series and we encourage you to refer others who might benefit from the information to sign up and receive announcements regarding dates, topics and speaker presentation. The Web address and the Web link will be at the end of this presentation so I won't read it to you at this point.

During the Q&A period we ask that the callers please provide their name and city and state location before asking your question or you have the option to type your question if you are on line in the Chat Room which should be on the left hand side of your screen.

In the future you can email questions to info@narhc.org and put RHCTA questions in the subject line. All questions and answers will be posted in the RHC Conference Call Series Website and on the NARHC Website which is www.narhc.org.

We are pleased today to have some great folks from CMS. We have been working with them quite a bit over the last few months on this initiative. We have Corinne Axelrod, Tracey Mackey and Simone Dennis with CMS who are going to do the CMS portion and then we are pleased to have Monique

Funcanbusch with BKD Consulting. Monique worked with FQHCs as they went through a similar process a few years ago and we have asked her to provide some insight and perspective with regard to how this all rolled out for the FQHCs.

So at this point I would like to turn the meeting over to Captain Corinne Axelrod, Tracey Mackey and Simone Dennis for their portion of the presentation. It is all yours folks.

Captain Corinne Axelrod: Okay, thanks Bill, and thank you everybody for being on the call today. What we want to do today is to review the HCPCS reporting requirements, then discuss some of the initial questions that we have gotten from the RHC community. We are going to provide information to RHCs on reporting requirements, and then answer your outstanding questions.

I will be doing the introductory remarks and will go over some of the initial questions that we have gotten. Simone will then be going through the examples. I hope you have all had an opportunity to download the slides or have them with you to look at as she goes through them, and she will be going over the slides and the Frequently Asked Questions. Tracey will also be going over some of the examples, and Simone and Tracey and I will then answer any questions you may have.

The purpose of the RHC HCPCS reporting requirements are really three-fold - first is compliance with National Coding Standards and Requirements, also to collect data on RHC services to better inform policies, and to increase the accuracy of RHC claims processing.

The next slide - slide five - has a timeline. We first proposed this in the Physician Fee Schedule that was published on July 15th of 2015, and then

finalized in the final Physician Fee Schedule Rule that was published on November 16th of 2015.

In February we released a Medicare Learning Network, MLN Article No. 9269, that we then revised a couple of times because we were made aware of an error in it and then we had some questions, so we added a little more material. We found out that in fact it was actually just reissued on March 24th - the system sort of automatically generated a reissue because there was a slight change in it.

In any case, the more detailed billing instructions were published in February, and since then we have gotten some initial questions, and the first question is regarding the implementation date. Many people have asked us if we could delay implementation of the new billing requirements.

We would be happy to do so if we could, but changes to the claims processing system used for RHC claims generally take several months and it depends on a lot of different steps that are not all in our control, so even if we wanted to, we would not be able to reprogram the system to postpone implementation.

The new HCPCS reporting requirements will start for services furnished on or after April 1st. We hope that today's session will clarify the billing requirements and answer as many of your questions as possible so that you will all be able to bill correctly starting on April 1st. We will work with you to the extent possible if any issues come up once you start billing under the new billing requirements, but again, the billing requirements are effective April 1st.

We also have gotten quite a few questions about the Qualifying Visit List. When we published the MLN Matter Article in February that outlined the new

billing requirements, we included a list of HCPCS codes of services that would qualify as standalone billable visits in a RHC.

We got feedback from people who felt that the list was not reflective of the complete scope of services that are typically furnished in an RHC. Our intention was not to change the services that are furnished in RHCs or the RHC payment, so we decided to look at the list and see where we could expand it to reflect the RHC services that are being provided.

We looked at the data that we have on RHC billing, which is limited because coding has not been required, and based on our data, which is, again, limited, the original list that we published included about 96% of all RHC services. We then looked at the remaining 4%, and based on that, we have added more HCPCS codes to the list.

The new list is posted on our website under the title “RHC Qualifying Visit List” and the link is on slide seven. The codes that have been added are in red italics and are effective on April 1st. If you are billing one of the newly added codes along with another billable visit, you would just add the code to the claim and go ahead and submit it. However, if one of these newly added codes is the only billable service, you will have to hold the claim because the claims processing system won’t allow payment on it until October 1st.

Again, we expect that these added codes will comprise a very small portion of your RHC billing and will hopefully be only a short-term inconvenience. I want to remind everybody that the definition of a RHC visit, which is on slide eight, has not changed. Services that are considered incident to services are still incident to services and will not be added to the list of standalone billable visits. If any adjustments need to be made to the list, we will do so on a quarterly basis.

We do not expect to make many changes to the list but sometimes a code changes or a new service is authorized. If there is a code that you believe should be on the list but currently is not on the list, please send us an email or you can send Bill and Nathan an email. We can't promise that any other codes will be added to the list but we will consider any requests that we get.

When we get a request, we will review it with our Medical Officers to determine whether to add it to the list or not. I know that Nathan has been compiling a list for us and we will look at that and see if we can add any of the codes to the list in time for the October 1st effective date. We don't have exact dates on the cutoff but we think that any codes that we get by the end of this week we should be able to review and hopefully get on the list for October, but again it will just depend on the code itself and the timing of other aspects of the system that are not in our control.

Another issue that has come up for people is the appearance of charges. Some people have expressed concern to us that the way the charges appear on the claim will sometimes look like the patient is being charged twice for the same service. There are other claims processing systems that are set up like this and it has not been a problem, although there probably are some patients that will ask you about this and you may have to just explain to them that they are not being billed twice on all of those line items.

We have also heard that some people are concerned that the way the charges appear, the secondary or crossover claims may be rejected. These reporting requirements are similar to the requirements that FQHC's had beginning in 2011 when they were paid under the all-inclusive rate, and it was not a problem, so we don't expect any problems on this, but we do have with us today Brian Pabst who is a Technical Advisor for the Coordination of Benefits

team here at CMS, and he will be happy to answer any questions you may have on this.

We know there may be some other questions that you have, and once Simone and Tracey go through the rest of the slides, hopefully we will have answered most of them, if not all of them, but again we will happy to answer any other questions that come up.

So at this time I am going to turn this over to Simone and I think we are on slide nine at this point. Simone.

Simone Dennis: Yes, thank you Corinne. We are on slide nine. So this presentation includes 12 examples. Some of these examples are similar to the examples in MLN 9269. Examples 1A, 4A, and 7A relate to the example of the same number but include slightly different information.

During this call we will be reviewing the five examples in red. Example 1 and example 1A compare the current reporting requirements to the new reporting requirements. Example 4 and 4A review reporting two qualifying visits and ways to report the charges on the additional service lines.

Lastly, example five reviews reporting mental health visits -- we include also examples in the presentation so that participants can review additional reporting scenarios at a later time. We will post this presentation to the RHC Center Page. I encourage participants to have the RHC Center Page Book marked on their browsers. We update it frequently. For those who have not visited the page it can be easily found by clicking the link in this presentation or searching RHC Center on any browser. It is usually the first result that appears.

So moving to slide 10 - before we review the examples we want participants to be aware that this presentation is not a legal document. Participants are encouraged to review other sources for a comprehensive guide on policy and billing requirements.

The presentation contains billing and payment examples using the UB-04 Claim Form - HCPCS's coding, revenue coding and charges which are for illustrative purposes only. Lastly we included a fictional chart list for all the charges used in these examples.

Slide 11 - before we discuss the new reporting requirements let's discuss reporting for services furnished today. For services furnished through March 31st, RHC's are not required to report specific HCPCS's code when billing for RHC services.

Slide 12 - example one, on March 31st a patient receives a medical visit. Slide 12 shows the charges to the patient's account for the services received during the visit. The \$8 for the office visit plus the \$5 for venipuncture equals \$13 which is highlighted in yellow.

Slide 13 - shows an excerpt of the UB-04 claim. Charges subject to coinsurance and deductible are reported on the 0521 service line. Therefore on the claim the RHC reports \$13 for the charges on the 0521 service line. The \$13 reported matches the chart's total from the previous slide. Please see the \$13 highlighted in yellow.

Now let's take a look at the information in teal on the right side of the claim. We include an example results in comment section which is not part of the claim form. Let's first take a look at the example result section. Coinsurance

is 20% of the \$13 reported which equals \$2.60. Next the comment sections shows that line one would receive the all-inclusive rate or AIR.

Slide 14 discusses coinsurance and breaks down the calculations. Charges subject to coinsurance and deductible are reported on the 0521 service line. In this example that equals \$13. Coinsurance is 20% of the charges are put on the qualifying visit line. In this example that equals \$2.60.

So slide 15 - beginning on April 1 all RHC's are required to report HCPCS codes along with revenue codes on Medicare Claims for RHC services.

Slide 16 is an overview of the reporting requirement. The qualifying visit service line is reported with revenue code 052X for Medical Services or 0900 for Mental Health Services. On the qualifying visit service line report all charges for services furnished on the counter minus charges for preventive services. The charges represent the amount that will be used to assess coinsurance and deductible.

For additional service lines, report each service furnished with the most appropriate revenue code and with charges equal to a penny or greater. Note some charges are displayed twice - once with the qualifying visit and on the line for the specific service.

Slide 17 - so this is example 1A. We are going to review the same example again. The only difference that the patient comes to the RHC on April 1 - slide 17 shows the charges to the patient's account for the office visit and venipuncture - the \$8 for the office visit plus \$5 for the venipuncture equals \$13 which is highlighted in yellow.

Slide 18 for example 1A shows a claim. Charges subject to coinsurance and deductible are reported on the 0521 service line therefore on the claim the RHC reports \$13 for the charges on the 0521 service line. This is highlighted in yellow. The \$13 reported matches the charge total from the previous slide. The RHC reports each additional service furnished and in this case venipuncture with the most appropriate revenue code and charges.

Now let's take a look at the information on the right side of the claim. Looking at the example result section, coinsurance is 20% of the \$13 reported, which equals \$2.60. Next, the comment section shows that line one is paid at the all-inclusive rate. Line two is an assigned claim adjustment reason code, or CARC 97, by Medicare.

So on slide 19 we have an overview of what we just discussed from example 1A. The RHC reports the most appropriate HCPCS code from the qualifying visit list on the 0521 service line - in this case it is an office visit HCPCS code 99213. Charges subject to coinsurance and deductible are reported on the 0521 service line which is the same as it is today. Like in example one, that equals to \$13.

Slide 20 - additional services are reported with the most appropriate revenue code and HCPCS codes. Payment for these lines are included in the all-inclusive rate and will be assigned claim adjustment reason code, or CARC 97. CARC 97 means the benefit for this service is included in the payment for another service or procedure that has already been adjudicated.

In this example, the additional service furnished, venipuncture HCPCS code 36415, is reported with the most appropriate revenue coding charges. The venipuncture service line would receive CARC 97.

Slide 21 - coinsurance is 20% of charges reported on the qualifying visit line, which is the same as it is today. Like in example one, that equals to \$2.60 - Medicare pays 80% of the RHC AIR subject to the payment limit.

So that concludes the discussion of example 1 and example 1A. Examples 2 and 3 review the reporting requirements when the patient comes in for preventive services. Both examples are similar to the ones in MLN 9269. Note the charges subject to coinsurance and deductible are reported on the qualifying visit service line. When preventive services and medical service are furnished, the charges for preventive services should be carved out.

Now we are going to move ahead to example 4 which is on slide 27. In this example a patient has two medical visits from the RHC qualifying visit list. This slide shows the charges to the patient's account for the medical visits. The office visit charges of \$8, plus the wound repair charge of \$7, plus the venipuncture of \$5, equals \$20, which is highlighted in yellow.

Slide 28 - on the UB-04 Claim the RHC reports the charges subject to coinsurance and deductible on the 0521 service line. In this case the \$20 from the previous slide is reported on the qualifying visit service line. Please see the \$20 highlighted in yellow. The RHC reports each additional service furnished and in this case wound repair and venipuncture with the most appropriate revenue codes and charges.

Next let's take a look at the information in teal on the right side of the claim. The coinsurance is 20% of the \$20 reported, which equals to \$4. Line one is paid the all-inclusive rate. Line 2 and 3 are assigned CARC 97 by Medicare.

The key takeaway from this example is how to report two services from the qualifying visit list furnished on the same day. The charges for the visit are

rolled into the office visit or E/M codes. The HCPCS code for the other medical service is also reported with its charge.

Slide 29 - this slide reviews the coinsurance portion of example 4. Again, the charges subject to coinsurance and deductible are reported on the 0521 service line. In this example the charges add to \$20. Coinsurance is 20% of the charges, which equals to \$4.

Example 4A is the same scenario. I am going to turn it over to Tracey who is going to discuss a different way of reporting the charges for the additional service line.

Tracey Mackey: Example 4A is very similar to 4, the difference being that the additional services are reported with a penny. On your first service line 0521 with the E&M 99213, \$20 is reported to show the charges that are subject to deductible and coinsurance. The additional procedure, 12002, is reported with a penny as this charge has already been taken care in the E&M line. The venipuncture 36415 is also reported with a penny.

Highlighted in yellow you will see the \$20 that is subject to coinsurance, which equals \$4. This line will also receive the AIR. Service lines 2 and 3 will receive CARC 97 and are not subject to payment. Your total line is the sum of all the charges on the claim and in this example is \$20.02.

Slide 32 is just a summary. It shows that the office visit is \$8, the wound care is \$7, the venipuncture is \$5 which equals a total of \$20, again highlighted in yellow. The coinsurance is subject to - is 20% of the \$20 which equals \$4. The subsequent lines do not impact the coinsurance at all.

Simone Dennis: Thank you Tracey. So two points from example 4 - first is that the example shows how to report two medical visits from the RHC Qualifying Visit List - charges for the visit should be rolled into the E&M code. Secondly, the RHC cannot report zero charges on the additional line but the RHC can report charges greater than or equal to a penny.

Next we are going to discuss mental health visits using example five. So slide 33 - the patient comes to the RHC for a mental health visit. Slide 33 shows the charges to the patient's account for the mental health visit. The psychotherapy charge of \$8, plus the medication management charge of \$5, equals \$13, which is highlighted in yellow.

On slide 34 we have UB-04 claim. The RHC reports the charge that is subject to coinsurance and deductible on the 0900 service line. In this case, the \$13 from the previous slide is reported on the qualifying visit service line is highlighted in yellow. The RHC reports each additional service furnished, in this case medication management, with the most appropriate revenue code and charges.

Next let's take a look at the information in teal on the right side of the claim. The coinsurance is 20% of the \$13 reported which equals \$2.60. Line one is paid at the all-inclusive rate. Line 2 would be assigned CARC 97 by Medicare.

So slide 35 is just a summary of the coinsurance portion of example five. Again, the charges subject to coinsurance and deductible are reported on the 0900 service line. In this example the charges add the \$13. Coinsurance is 20% of that which equals to \$2.60. So that ends the discussion of example five.

So the next example will not be discussed during the presentation but here is a quick overview of what they review. Example six reviews billing for a medical and mental health visit. Example seven reviews reporting of qualifying visit and other medical services - example eight reviews reporting Modifier 59, example nine reviews reporting a medically necessary service recently added to the RHC qualifying visit list.

Now we are going to move ahead to the FAQ section in slide 48. So the next slide reviews some of the frequently asked questions we have received in response to the reporting requirement.

Slide 49 addresses billing for services furnished before April 1 but billed after April 1. These claims should be billed under the previous reporting guidelines with no HCPCS coding.

Slide 50 - this addresses whether we can delay the implementation. As clearly noted these changes are already in place and a delay is not possible.

Slide 51 discusses services not on the RHC qualifying visit list. In general Medicare covered medical and mental health and preventive services not on the list are allowable but not payable as standalone services.

Slide 52 - this slide reviews what charges should be reported on the qualifying visit service line. All charges subject to coinsurance and deductible should be reported on the qualifying visit service line.

Slide 53 - this slide discusses the total line which is a sum of all the charges reported on the claim. In slide 54, a follow-up to that Medicare does not pay or adjudicate the total line. Payment is based on the qualifying visit service line.

Slide 55 - this pertains to MSP Claims. All claims to Medicare should follow the reporting requirements.

Slide 56 - this slide addresses revenue codes. RHC's should report the most appropriate revenue code for the service being performed. A complete list of revenue codes can be found in a NUBC publication.

And slide 57 - this concludes our presentation portion of this call.

In summary, we reviewed the HCPCS reporting requirement, we discussed the initial questions from the RHC community, and we provided information about the reporting requirements.

I am going to pass the call back to Bill. Thank you everyone for listening.

Bill Finerfrock: Thanks. I appreciate it. At this point we will now go to Monique Funkenbusch who will talk about some of the experience with the FQHC community and provide some insight there and then at the end of that we will open it up for the Q&A portion of the call. Monique, you are up.

Monique Funkenbusch: Thanks a lot Bill. Now that Corinne and the rest of the CMS representatives have explained the details that are associated with the transition that is set for this Friday I am going to take just a few minutes to highlight a few lessons learned, as Bill mentioned that were part of the Federally Qualified Health Centers or FQHC's detailed billing (unintelligible) which is somewhat similar to what you guys will be involved in on Friday.

Their actual transition occurred back on January 1, 2011 so you can imagine we have a few good lessons learned from that transition from them.

This transition helps to highlight some of the importance of establishing an accurate and current fee schedule or charge structure for your particular clinic. Best practice really for any practice, physician clinic or Rural Health Clinic really is to evaluate or update your fee schedule on an annual basis.

Claims processing considerations that you will want to think through would tie into staff training. That is a big component that FQHC's learned right off the bat is that they were very much lacking in that particular area for their billing staff. So do your staff and the billing department really understand your payment policies or internal payment policies? Do they also understand the CMS regulations as part of this change? so You need to make sure your staff truly understand all the guidelines, even more so now with this latest change that is occurring.

An example includes, proper billing or claims submission processes for preventive services, or multiple services that might be rendered by your providers in Rural Health Clinics to the same patient on the same day. How are we really submitting our claims? Are they accurate, are we making sure they are going through cleanly the first time through?

A few other things to consider as part of this transition are impacts to your reporting of claims and payment processing - so reporting as it relates to your AR data as well as perhaps your encounter volume - how is your practice management system actually tabulating or extracting that data? If it is skewed they (unintelligible) with this new transition or is it inaccurate? A lot of discussion really needs to be focused on how your practice management system is going to facilitate this transition.

So have you had these conversations with your vendors - with the FQHCs' implementation it was very evident many FQHCs really hadn't had that initial conversation and our vendors sometimes aren't always up to speed on the latest CMS regulation changes so it is up to you, the customer, to insure your vendors understand the significance of this change and how to implement that change in your own facility, especially since a lot of you are on different versions and different systems altogether.

I know that a lot of you will probably have some questions about what specific changes or specific technical issues have come about from the FQHC implementation and I will have to say that I cannot answer that specifically. There are many different issues, many different topic areas when it comes to technical setup so I really have to focus you towards communicating directly with your own individual vendors even though the Rural Health Clinic a couple of hours away from you that you may be friends with from a leadership standpoint may have the same vendor but it may be separate versions of the PMS that you are on so it may not be an apples to apples comparison.

So again, the importance here is that you have your own individual conversations with your specific vendor contact.

Additionally when it comes to staff training, are we making sure that our staff understand how to accommodate that crosswalk of appropriate revenue codes to all of the CPT codes that we may be listing related to the UB-04 detailed billing we are now going to be presented with. This will be another barrier. That was a major challenge for a lot of our FQHC billing staff in understanding that linkage or that crosswalk.

So make sure that is another item you add to your billing staff training list to tackle especially since there is such a significant volume of revenue codes. M

make sure your staff really understand how to correctly map to the specific CPT codes, those specific services your providers are rendering for that particular patient on that day.

And I think the CMS folks also mentioned the National Uniform Billing Committee document that you can reference to look up those revenue codes, but again just make sure you crosswalk those carefully. And then the next step to that is to make sure that information is also incorporated into your practice management system. So ,again, further conversation with your vendors about that capability and that functionality is necessary.

Another piece regarding the reporting aspect I mentioned, are your encounter volumes being calculated or extracted correctly out of our systems? Does this have an impact to you, perhaps nor your provider compensation plans or quality reporting pieces? Let's make sure we take a peek at that aspect as well.

The other note I would like to make relates to denial management. So again, one extra item to add to the list from a billing staff training perspective is making sure we are working through all of the denials for the multiple revenue or service line items versus just simply submitting an E&M Code and leaving the detail off of the claim.

To further explain this, when the FQHCs went through their transition, because it didn't for them appear to make any type of reimbursement difference if they got a rejection based off of some of the HCPCS codes that they had listed. They were frustrated enough to the point where they simply decided to focus on the E&M code, the 99212 as an example, and submitted that through on the claims versus listing all of the appropriate revenue code line items and HCPCS codes that were actually rendered for that service for that patient on that day.

So that is something you should really focus on not allowing your staff to do. Again, it is focusing on making sure we are properly listing all of the HCPCS codes that were truly identified from the chart documentation - the services our providers actually rendered to that patient on that day.

On the next slide we have just a few key points. Again, most of you on the call can probably relate to this fact - most providers either didn't receive proper coding training in their medical programs, residency programs or even once they joined your facility, so oftentimes we find that we are having to educate our providers about proper coding practices. This detailed billing transition is going to emphasize the need for this training with your providers even more so.

We have to make sure we are focusing on our providers in improving the chart documentation process, as well as the accuracy of their coding practices and I would be interested to have a poll at some point just to get a sense of how many of you actually conduct any internal or external chart audits or reviews of your chart documentation for your providers.

In most cases with Rural Health Clinics it tends to fall off the radar to a certain degree so it is not a prime focus, however, especially with this change coming about, it is even more important we conduct those audits. A best practice scenario from a coding or chart audit review would be on a quarterly basis if at all possible. Realistically speaking at a minimum you really need to have the chart audits occur at least once on an annual basis.

A lot of folks will also recommend (AAPC or AHIMA) that you also utilize an external source to conduct those chart audits to have an unbiased opinion, someone who is a little bit more experienced at looking at all provider types or

even just a variety of Rural Health Clinics so they bring to the table a different level of expertise than say your own internal coder or someone who has coding experience but isn't a certified coder. This is something to definitely consider as part of this transition.

The other piece is something the CMS folks had actually listed as one of their FAQ's as it relates to Modifier 59. A lot of times our providers are not following proper coding documentation simply from a modifier standpoint, as well as from an under-coding perspective but use of Modifier 59 is going to become a little bit more pressing with this change and you will have to make sure the Modifier 59 is truly justified and again as they noted in their slide you need to append that Modifier 59 to indicate any type of procedure or service that was truly distinct or independent from the other services performed on the same day for that particular patient.

So an example, similar to what is outlined by the MACs as part of the "same day" guidance for this detailed billing transition, would be the provider treats a patient for an ear infection in the morning at the appointment but then the patient comes back in to be seen by the provider later in the afternoon with a sprained ankle so again very distinct and separate services or procedures that are being rendered to the patient. To further clarify, please note that two distinct services relate to procedures and not your typical E&M visits. Additionally, modifier-59 should only be used if no other more appropriate code is available to describe the given procedures/scenario.

Another key point related to that coding practices section relates to your EHR, your electronic health records capabilities similar to our comments on the practice management side - we need to make sure we are having similar discussion with our EHR vendors about that, making sure that our EHR actually has current HCPCS CPT codes all listed within the system so our

providers can more accurately and correctly code for the services they are rendering at the Rural Health Clinic.

The second bullet point mentions keeping current with CMS updates and guidance that are to be released. You can really attest to this, even in the past couple of weeks we have had even newer information released related to those qualifying visits. So as things start to evolve, we will begin to see a lot more additional information coming out from CMS that will be helpful for our billing staff and our providers to really be aware of, as well as the impact it may have to our practice management system and/or EHR.

Be sure to go out to the CMS Website on a routine basis just in case you happen to not receive the latest notification - all of the latest information is to be posted out to the cms.gov Website.

The last few bullet points hopefully are some bullet points you may have addressed in prior weeks, especially since we are down to the wire here with Friday just around the corner as part of the implementation, What we learned from the FQHC side is if at all possible, we really want to perform some type of internal testing of the detailed billing on claims prior to the actual transition. So if you can work with your Practice Management System vendors to really make sure you are getting the claims processed accurately, start with a small bundle versus mass submissions to ensure that at least those first few are getting submitted correctly before you send the masses through and then have to make additional corrections and rework those claims.

On an ongoing basis for the next several months you may want to continue to monitor those claims and any remittance advices you receive to ensure your correct payments are being received and also to monitor the data accuracy that is going to be relayed through that information exchange.

But in summary I think the key points here as takeaways are to make sure you are speaking directly with your Practice Management System and EHR vendors. Secondly making sure your billing staff are appropriately trained and ramped up for this transition and thirdly making sure your providers understand the transition that is occurring and help them get ramped up on the proper coding practices and guidelines and the importance of that as part of the detailed billing transition for your Rural Health Clinic.

With that I want to thank all of you for your time in listening to this Webinar today and hopefully it provides a lot of helpful information as you get prepared for your transition this Friday. I am going to hand it off to you, Bill.

Bill Finerfrock: Great, thanks Monique. At this point we are going to start the Q&A portion of today's presentation. There are a lot of questions. There are a lot of comments coming in on the Chat Box and we are not going to address the comments. Please, you know, everyone is able to see those - I think there is obviously some frustration out there with regard to some of the things that are occurring here. There have been previous phone calls on this. This is not the first time that we did a presentation. We did one a few months - weeks ago with CMS Staff. I know CMS had discussion on this on an Open Door Forum but we are going to do the best that we can to try and get through as many of the questions as we can if you want to put them in to the Chat Box or I would encourage you also to use the phone line portion. Operator, would you give the instructions if someone would like to ask their question verbally?

Coordinator: Certainly, thank you. If you would like to ask your question over the audio lines please press star, followed by the number one. You will be prompted to record your first and last name. Please do check that your phone is unmuted when recording your name so that I am able to hear it and introduce you.

Bill Finerfrock: While we are waiting for folks to get lined up in the audio queue we did take note of a couple of questions. I wanted to kind of start off with one or two here. We have had a lot of concern expressed about how the secondaries will handle these claims, particularly where the total amount and the charges don't match up with a particular CPT code that may be in that Qualifying Visit line that claims will get rejected on the secondary because the coinsurance would be more than the allowable for that charge. I don't know if this is something that Brian could address but what kind of communications have occurred with the Medicare Secondary Payers and is there concern that they will not properly or be able to adjudicate those secondary claims?

Brian Pabst: Yes, it is Brian Pabst with CMS. In terms of communications I know a lot of them have seen the Medlearn article that was put out there. The main thing that I am noticing that is different about this compared to how it is today is that of course we are including HCPCS codes or CPT-4 codes and honestly the industry for years said to me "Why don't RHC claims have those" and it would be a lot easier for them to work with. I think they will - hopefully they will understand that as the presentation today suggested with the 0521 being the line on which the coinsurance and the deductible applies for the non-mental health types of services that that is going to continue to be the case. The only different again is that there will be HCPCS codes or CPT-4 codes there whether or not today but be assured if we start seeing examples of trading partners who are not accepting your claims because of the reasons that has been expressed we will get right on that with you. I do that all the time with the FQHC claims. Understand that there are differences - the FQHC claims had a G-code which someone had said is not really being widely received even after all of this time, and that that code was requiring that the 99212 for example be bundled in to that code so it is a different concept this

time around so we are “hoping” and we put that it quotes that it won’t be the impact that it was with the FQHC claims initially.

Bill Finerfrock: Okay.

Brian Pabst: But I am the contact here at CMS if there is ever any concerns or examples that need to be analyzed or if they are not being processed when we cross them over.

Bill Finerfrock: Can you give us your email address. Is that something, you are able to do that - folks can have...

Brian Pabst: Sure, sure, I will probably get bombarded but that is okay. It is Brian with an I, dot P-A-B-S-T – like the beer, brian.pabst@cms.hhs.gov.

Bill Finerfrock: Great, thank you.

Brian Pabst: (Unintelligible).

Bill Finerfrock: We had another, folks are wondering whether the Medicare Advantage Plan will be subjecting claims to the MA Plans to the similar - to this requirement. I don’t know that there is anybody that can speak to that but is there - can you speak to that - can someone there speak to that?

Corinne Axelrod: Bill we don’t have anybody here from the MA Plans but generally we really can’t speak for them so people would just...

Bill Finerfrock: Yes, they - that is what I figured. I just wanted to put it out there. The MA Plans are essentially private insurance companies that offer a product to beneficiaries who essentially dis-enroll from the Medicare Program, enroll in

that Medicare Advantage Plan and they establish their own coding and reporting requirements and are not subject to the coding and billing requirements other than services have to be covered but they can do their own coding and billing as I understand it.

Okay, there was some questions and I think this gets to the qualifying visit list about osteopathic manipulation which a number of RHC's have osteopaths. I know we have received a number of recommendations for inclusion of some of those osteopathic codes and that is something that we would submit to CMS for their consideration for some of those DO specific claims.

There was also a question on a couple of the slides back where you listed .01 as a claim charge. When do you use the .01 as a claims charge versus the actual charge? Do you remember those slides?

Tracey Mackey: Hi, this is Tracey Mackey. So the .01 example is just another way to show it. The charges that are being reported on the Qualifying Visit List are what the payment and how the claim is adjudicated based on. The coinsurance and deductible is based on the charges reported on the Qualifying Visit List and the AIR payment is also applied there.

The additional lines are really informational only so we are not as concerned with those charges and we know some of the RHC's were concerned about doubling the charges. So that is just another way to show the additional services if you don't want to put all of the charges on there again they can do with a penny.

Bill Finerfrock: Right, so there - yes, there has to be some dollar amount, some actual dollar amount, at least a penny there. So you could either put the actual charge or you could put a penny on to that charge line and it doesn't make any

difference for the processing of the claim. It would help address the concern of the disagreement between what is in the 0521 Qualifying Visit Line and what is in that 001 line - it would diminish the differential between those two. Folks are more comfortable putting a penny on that line rather than the actual charge on that line, correct?

Tracey Mackey: That is correct.

Bill Finerfrock: Okay, all right, operator, do we have any calls from the phone?

Coordinator: Let's see we do have several questions and am I remembering it correctly, you would like them to say their name and their city and state?

Bill Finerfrock: Name and where they are from, yes.

Coordinator: Okay, thank you. The first party is (Kathy Conway). Your line is open.

Bill Finerfrock: Go ahead (Kathy).

(Kathy Conway): Hello, I am (Kathy Conway) (unintelligible). I had a really quick question. The slide says for services furnished through March 31st RHC's are not required to report any specific HCPCS's but my question is will you all accept them? It is going to be difficult for our software to be able to handle both so we have to rebill.

Tracey Mackey: So (Kathy) thank you so much for that question. Prior - the changes are effective based on dates of service so prior to the system is set up to bill using the mechanism that you do today. So if you were to bill out those detailed lines with multiple five 2X lines your claim would get kicked out.

(Kathy Conway): Okay, that is what I needed to know, thank you.

Coordinator: Thank you. The next party is (Kristy Knudsen). Please give your city and state.

(Kristy Knudsen): I am calling from Audubon, Iowa and my question is...

Bill Finerfrock: Hey (Kristy).

(Kristy Knudsen): Hi, do we go ahead and use the appropriate - when you say appropriate revenue code select for drug codes we would use a 636 or a 250 - is that what I am understanding?

Tracey Mackey: Absolutely correct. You - I mean the system will accept the 52X Revenue Code of all the service lines. We have opened it up where you can bill any of the approved NUBC revenue codes. There is a small group of exceptions that are not - that cannot be used on RHC claims but if you were billing like a drug you would use 636. If you were billing venipuncture you would use 0300 and if you look on slide 56 the list of exclusions are there.

(Kristy Knudsen): Okay, thank you very much.

Tracey Mackey: Thank you.

Bill Finerfrock: We will take another one from the phone and then we will go to some of the Chat Box questions.

Coordinator: Thank you, (Becky) from (Bora) County Memorial Hospital. Can you give us your last name and your city and state please.

(Patricia): Yes, this is (Patricia), Bay Wisconsin.

Coordinator: Thank you, go ahead.

(Patricia): The question that I have is on the modifiers. Can we use all modifiers for example (XE25GY)?

Tracey Mackey: (Becky) hi, this is Tracey Mackey. Yes, you can use any valid modifier. The system will accept up to five modifiers per service line.

(Patricia): Okay, the follow up question is we sometime charge all fracture care if you know there is follow up visits for fracture care. Currently we don't bill those, the follow up visits. It is all included in the fracture, initial fracture care. If we were to dispense an item, a supply, could we then revert to billing that service since it is medically necessary so we would also get reimbursed for the supply that is being dispensed?

Captain Corinne Axelrod: This is Corinne and we just want to reiterate that our intention here is not to change the way that RHCs bill for services or pay for services, and that services and supplies that have been incident to would continue to be considered incident to services, so we would advise to not do anything different in terms of your billing - it is really just the way that your claims are processed.

(Patricia): Thank you.

Bill Finerfrock: All right, so now we are going to go to the - some of the questions on the Chat. Some of them are falling off so I am going to do my best to remember this but these do with (Kathy) who asked are these - the way the RHCs are

billing now is that HCPCS compliant? So do the CMS folks want to address that?

Corinne Axelrod: We are looking at each other right now.

Brian Pabst: To the best we know, yes.

Corinne Axelrod: So to the best that we know, yes.

Bill Finerfrock: Okay, all right, I just wanted to get that in there. Now a lot of these questions are falling off. (Mimi Veer) was confused on Example 4 and 4A. She was - do we want to address the penny versus the?

Corinne Axelrod: Can you give us a little more detail exactly what was confusing?

Bill Finerfrock: (Unintelligible). No, I think the (unintelligible) is what I had addressed on the - why some examples had a penny and some had the charges. I think you have went over that fairly quickly and there seemed to be some confusion as to what point you were trying to make with that.

Corinne Axelrod: Yes, it is and, again it is just an option. We are not advising people to do that but it will process as long as there is one cent or more on the claim. The claim will process, so it is not a policy, it is just that that is another way that you can submit your claim in order for it to be paid.

Bill Finerfrock: Okay, some folks - none of this to be clear effect the billing for the non-RHC Claims so if you have a non-RHC service that you would be currently billing on a 1500 that will continue. This is only what is effecting claims under the UB-04 process, nothing to do with anything you do on your 1500, for non-RHC services.

Corinne Axelrod: Yes, that's correct.

Nathan Baugh: And just to be clear, the slides that were posted on the link, they were updated at the last minute, so as soon as this call is over we'll make sure that the slides that were used on this presentation are the same slides that were available on the link, so apologies for that. But know that the updated slides, the slides that you just saw will be available at that exact same URL.

Operator? Do you want to take some calls and questions from the phone?

Coordinator: Certainly sir; one moment just getting a name. (Cynthia Yong) your line is open.

(Cynthia Yong): Hi. This is (Cynthia). I'm calling from Shawnard, Texas, and the question we have is, are the (Remetinfed) devices or the EOBs going to be looking any different when our payments come back to us, as when we do live preventive care office visit, or are they still going to look the same?

Tracey Mackey: This is Tracey. Your Remits will still look the same. You will have some different messages on there, like for instance CARC 97 on the claim, and I think the remittance shows 115 or M15 I'm sorry, I can't remember that one off of the top of my head. But it's to further explain the additional lines and that there's no payment for those and the payment is included in another line.

(Cynthia Yong): Okay. So, when we do like a preventive care, which will be with no co-insurance for deductible applied with an office visit, how are they going to be broken down to know which part goes to which part of the payment?

Tracey Mackey: That will look very similar because what you do today for the preventives is you report the 52X lines with all your charges and then you carve out the preventive on another line, and those lines the coinsurance and deductible are not applied, so that is very similar to what you're doing today.

(Cynthia Yong): Okay. And, are we going to be using a 771 revenue code for the preventive care, or we change it to a 521?

Tracey Mackey: That's at your discretion. There may be some edits that are not related to RHC claims. Let's say certain preventives have to be billed with the 771 or a certain revenue code, but we did not put any edits in for RHCs to limit the type of revenue code. So, if you wanted to report every line with a 52X that's okay in terms of RHCs, as long as there's not existing local edits at your MAC that prevent you from filling those things with the 52X.

(Cynthia Yong): Okay. Thank you very much.

Bill Finerfrock: We'll take some questions that were submitted on the chat line. (Joni) asks was it stated under the RHC should hold claims that have the added billable code or should those be billed and CMS will hold them in a suspense status?

Tracey Mackey: This is Tracey Mackey. We're asking that the RHC hold those claims. And, it's only if it's one of those new codes only. If you're billing for something that's on the list already, additional with one of those medically necessary services, there's no need to hold. But, if you're billing one of the new codes that are effective April 1 that are being implemented October 1, we ask that you hold those claims.

Man: Right. And, those are easily distinguishable between the codes that are in black were the ones that were already on the qualifying visit list, and the

codes that are in red are the ones that were recently added and that you would have to wait on. (Theresa) asks, would modifier XE for a separate encounter be a better modifier than modifier 59?

Corinne Axelrod: We're not familiar with that modifier, so we would suggest sticking with modifier 59 unless there's some reason that we're not aware of to use a different modifier.

Bill Finerfrock: I wasn't either but it was on the questions, so I thought well maybe I don't know everything. But, apparently I'm with you.

Woman: Okay.

Bill Finerfrock: The next question is do you report your total charge on the first one? For example, is the office visit \$100 and the injection is \$25, does the \$125 go on the first line? And, I'm just going to add to that, if you had multiple procedure codes that are qualifying visits, so let's say I performed two qualifying visits that are just procedures with no E&M, which one of those would be the one that the co-insurance is calculated off of? Do they roll it up in that situation?

Simone Dennis: This is Simone. I do not understand the beginning part of your question, but towards the end where you were asking me about multiple services, multiple of those red ones that we recently added, I think in most cases a RHC would report one of those codes. However, we need to take a look at the scenario more closely.

Man: Okay.

Simone Dennis: So those charges would just be reported on that line.

Man: So you're saying that if you have two procedure codes or the codes that are in red, then you would suggest only reporting one of them?

Woman: No.

Man: Yes. I'm not sure. Let's say I had multiple lacerations. I had a laceration of the hand and a laceration of the thigh, those would be two separate services that would have two different codes for those, that would roll up into a single AI and still do the calculation on the qualifying visit for the charges for those, correct?

Woman: So, in your scenario when there's two different lacerations, so use different codes that's still going to be SV paid as you said the all-inclusive rate one payment. So, I thought your initial question was really whether really the code that's being paid on is the one that has to be on the first line if the sequence matters? Is that what you were asking, or?

Man: Yes. Does the sequence matter?

Tracey Mackey: So, what happens is, and I guess we should get away from this being first line second line because when the claim comes in the system will sort the lines. So, what may be the first line may end up being the last line. We might need to take this back and look at it a little more. My initial thing would be to put it on the, I don't know, we'll take this back and ...

Man: All right. So, we'll have some further communication with the community on this.

Man: But to the basic question was do you report the total charges on the first line, and the example they gave is an office visit at \$100 and an injection of \$25, does the \$125 go on that first line, the answer to that would be yes.

Tracey Mackey: If it's an E&M we can say, if it's an E&M and a procedure you would report the charges on the E&M. But, I think you're asking what if it's two procedures? And, that's what we need to look into.

Man: Okay. All right. Operator, questions from the phone?

Coordinator: Certainly, next we have a question from (Louise Compton). Please give your city and state. (Louise Compton)? Can you check your mute button ma'am?

(Louise Compton): Okay. My question was about the ones that we're not going to send in until October the 1st, so I think they clarified that, that they are the ones in red, the new ones, is that correct?

Man: Yes.

(Louise Compton): Okay. Sounds good.

Coordinator: Thank you.

(Louise Compton): Thank you.

Coordinator: (Tammy Hickok) please give your city and state.

(Tammy Hickok): Jenson, Iowa.

Coordinator: Go ahead with your question.

(Tammy Hickok): I too have a question regarding those procedures that were added on, more so regarding timely filing of secondary. So, a CMS recommendation is that we're holding a procedure only claim for six months, if that patient has a secondary; six months may not be within their timely filing recommendations. What are you proposing we do with those?

Corinne Axelrod: That's actually something that we have not looked into, so we'll have to look into that. I'm not sure really what we can do about it because as we explained earlier there's nothing we can do to make our system pay for this earlier. We'll have to look into that and see if there's anything that we can do to assist if that occurs. So thank you for bringing that up.

Bill Finerfrock: I want to make sure, so if I understood the question too as we're trying to get an answer to this, you're suggesting that you would have a problem with timely filing on a secondary if you held a Medicare claim for six months?

(Tammy Hickok): I'm simply asking. I don't know what all of the timely filing is for the secondary, but there are a lot of different secondaries.

Bill Finerfrock: Well if you have, I would think and this is, you know, me but you have a year to do timely filing on a Medicare claim. And, I would think that the secondary would be obligated to fulfill their obligation on the secondary in a timeline that is consistent with what Medicare's timely filing is.

So, it would seem to me a little bit incongruous if you could have a year timely filing on a Medicare claim, secondary the beneficiary has the contact with would somehow be able to disregard the one-year timely filing they had on the Medicare claim. You don't know that that will be a problem, you're just speculating?

(Tammy Hickok): I am just questioning, correct.

Bill Finerfrock: Okay. All right. Operator? Another question?

Coordinator: Okay. (Crystal Embry). Please give your city and state.

(Crystal Embry): South Haven, Michigan.

Coordinator: And your question ma'am?

(Crystal Embry): Actually, I had two questions; the first one is our lab, we're a hospital based, we're a hospital health center, so our labs get billed out under the hospital with the 141 bill type. So, am I still going to do that or am I going to include them on the actual claim? I'm not going to separate them anymore?

Tracey Mackey: This is Tracey. You would still do that. RHCs are paid for professional services only, and the only exception would be the venipuncture, so you would continue to bill the technical service on your 14X or whatever you do today.

(Crystal Embry): Okay. And, then the other question is, so I have a patient that has an E/M level let's say for hypertension or something and then they do the Depo, which we know is not covered by Medicare, but I need to it rejected to bill the secondary, do I separate that claim, put it as a 710 with that ...

Tracey Mackey: Condition code 21?

(Crystal Embry): Well condition code 21 and then that ZO modifier that says it's two separate identifiable visits?

Tracey Mackey: I'm not familiar with the GO modifier, but if you wanted to bill for a denial, you would do that on a separate claim, which are condition code 21.

(Crystal Embry): Okay. Thank you.

Coordinator: Thank you. And, I apologize ...

Bill Finerfrock: We'll take a chat line question here before we go back over to ...

Man: Just had a couple of questions on how the EOB will look to the patient, will the patient see charges for only the qualifying line or the total claim, the 001 line? Does someone from CMS know?

Corinne Axelrod: Give us one second; we're reviewing some information.

Bill Finerfrock: If it's going to take more than 30 seconds, (Nathan) said he could sing.

Nathan Baugh: Nobody wants that. Nobody wants that.

Bill Finerfrock: That was your incentive to get the answer fast because we don't think you want to hear Nathan sing.

Corinne Axelrod: Well why don't we go on and if we can come up with an answer before the call is over we'll do that; otherwise, we'll have to get back to you on that.

Bill Finerfrock: Okay. So Operator can we take a question on the phone?

Coordinator: Certainly. (Tina Yonkers) please state your city and state and go ahead with your question.

(Tina Yonkers): Johnstown, Pennsylvania. We are a hospital-based RHC and currently we bill our claims on a UB and we do not show a modifier for our qualifying visits. My question is on hospital-based clinics for a regular hospital we use a G0463 code and CMS changed all the H6 codes, and the nine codes to the new codes on UBs, would we use the G0463 on our billing the RHCs or would we use the 99 codes that we currently use on our 1500s for our UB billing?

Woman: Hi. If we understand your question correctly, we would recommend you using one of the qualifying visits on the RHC qualifying visit list.

(Tina Yonkers): Okay. So, I should use one of the 99 codes on the qualifying visit list?

Woman: Yes. That's correct.

(Tina Yonkers): Okay. Thank you so much.

Coordinator: Thank you. Next is (Christina Hamilton), your city and state please?

(Christina Hamilton): Lebanon, Kentucky. I have a question about revenue codes. We're an independent rural health clinic. The only ones we've really used are the 0521 and the 05, the nursing home codes. And, on that national Web site, the UB Web site it charges you to get that revenue code list. So, my question is like I know the one for the venipuncture and the pharmaceutical but like the professional fees for like the x-ray that we bill on the UB, what revenue code would be appropriate for those?

Tracey Mackey: This is Tracey Mackey. So things like x-rays, again those are technical services and you would not be billing those on your RHC claims.

(Christina Hamilton): But we bill the reading like the technical piece will go to our professional claim but the reading of the x-ray, which is a professional fee just like an EKG, the technical component goes to our Part B on ...

Tracey Mackey: The interpretation?

(Christina Hamilton): Right.

Tracey Mackey: We're just taking a look at our revenue code list; just give us a second please?

(Christina Hamilton): Okay. And one more quick question while you're looking for that, on the form locator 43 for the description on the UB, that doesn't have to be filled out, correct?

Tracey Mackey: No. That does not have to be filled out. You would only put the actual CPT code.

(Christina Hamilton): Okay.

Tracey Mackey: And I am not seeing a revenue code. If you want to send me an email, I can follow up with you through email.

(Christina Hamilton): Okay. What's your email address?

Tracey Mackey: In the packet, it's Tracey.mackey@cms@hcs.gov, if you look on page 57, or it might be two slides down on 55 depending on the version you're using.

(Christine Hamilton): Okay. Thank you.

Coordinator: Ready for the next question?

Bill Finerfrock: Let us take one real quick from the chat line.

Coordinator: Thank you.

Man: There's still a bit of confusion about the October 1 hold/waiting period, so if we could have someone from CMS go over just line by line what to hold, what can bill, be billed on April 1, and just go over that again? I think we need some clarification on that.

Corinne Axelrod: Okay. This is Corinne and I'll start and then Simone and Tracey can jump in. The codes that are listed on the MLN Article that was originally published and is on our Web site, those codes are, I'm not sure if this is the correct term or not, but they're hard coded in, so those are billable codes starting on April 1st.

The codes that we added in response to the feedback that we got, and Nathan mentioned those are in red, those codes require a change in our claims processing system that is not going to be in effect until October 1st. So what we're saying is that starting April 1st, those codes, the newly added codes, are billable visits.

However, the system will not be able to process them until October 1st, so because of that, if those are the only codes on a claim, you need to hold the claim. If you have a claim that already has a standalone billable visit on it, then you can process it, you can submit it because it will be processed. But if it is the only code, if one of the newly added codes is the only code on the

claim, the system will not pay on it, so that's why we're asking you to hold those until October 1st.

I also just want to remind everybody that we know that the data we have is not the best data, it's not the most complete. But it's probably in the ballpark, and the data that we have showed that about 96 percent of all the services that RHCs are billing are already on the list, and those are all services that will be paid starting on April 1st. So we know it's inconvenient and we apologize for that but there's really not much we can do about it. But it really should just be a few codes that between April 1st and October 1st you're going to have to hold if there's no other billable visit.

Bill Finerfrock: And again maybe Brian there still seems to be somewhat from looking at the traffic on the chat room people who are really concerned about this timely filing and the secondaries being able to meet. Brian, I don't know whether in your interactions with the secondaries you know what their timely filing or when they're timely filing kicks in? Do you know anything about how the secondaries handle timely filing of claims and whether or not this delay will cause a problem on timely filing for secondaries?

Brian Pabst: We can definitely look into that. But most of the time there's no issues but there are some occasional situations where somebody has like a 90-day timely filing limit and of course Medicare, like you said before, is a year. We've had cases where we've had to ask the payers to make an exception to their own rules. Just like we're able to override timely filing under Medicare sometimes, they can too if we are able to get to them and explain the situation. Hopefully, that won't be an issue but if it is seen I'll be glad to work with the situation and try to have that addressed by the other insurance.

Bill Finerfrock: Okay. And, Corinne to your point in terms of the small percentage of claims, I think for a lot of RHCs you're right but there have been some folks who've indicated that they have, in one case for example, a podiatrist who would only be doing procedure-only claims and that's 100 percent of the work he does in their RHC, which would mean that 100 percent of his claims, even though it may only be a relative, you know, percentage of the RHC claims would be held.

And so, there are specific circumstances under which this delay could cause some problems just so you're aware that in the grand scheme of things you may be right, but there are circumstances where it could be a significant hardship.

Corinne Axelrod: Yes. Thanks Bill. I think that is a good point that, we tend to look at kind of the average, and there are always some that bill more of certain codes than others. If there are any RHCs that are having a problem with that, please have them contact us and we'll see if there's anything that we can do to work with their MAC in order to help out with this situations. Again, we don't expect that it would be many, but I think you're probably right that there probably are a few that this would impact a little bit more than a little.

Bill Finerfrock: Okay. Operator some questions from the phone.

Coordinator: Yes. Thank you. (Sheila Long) your city and state please? (Sheila) do you have your mute button on?

(Sheila Long): El Campo, Texas.

Coordinator: Go ahead with your question ma'am.

(Sheila Long): I was concerned about the charge for like the penny that we're putting in there. Is that because we received an encounter rate?

Tracey Mackey: Hi. This is Tracey. Yes. So you're paid on a per diem, you know, we only pay one line on the claim because there's only one payment, but part of the new requirements is to report as we want to see all of the services, and the system will not accept charges equal to zero. So, we report those services, something has to be reported in the charge field. We're not expecting you to use the penny, but we have heard feedback that some people have concerns about putting the actual charge because some of the charges are doubled. So that's just a suggestion to put a penny so the charges won't be doubled.

(Sheila Long): Okay. Very good. Thank you.

Coordinator: Thank you. (Christy Sumner), your city and state please? Miss (Sumner) please check your mute button. Go ahead with your city and state ma'am.

(Christie Sumner): Red Fox, Kentucky.

Coordinator: All right, and your question?

(Christie Sumner): It was a follow up with the last question. If we start using that penny just because of the concerns about the double rates, is that going to be kicked back out or is that something that they are going to discourage in the future?

Tracey Mackey: This is Tracey. We have no plans to discourage it in the future.

(Christie Sumner): Okay.

Tracey Mackey: We're okay with accepting the penny on those additional lines.

(Christie Sumner): Okay. Thank you.

Coordinator: Next, we go to (Lee Ann Latham). Your line is open.

(Lee Ann Latham): Hi, Ottawa, Iowa. My question, I'm not quite understanding as far as procedure only visits or CPT codes that are not on the qualifying list yet. If we do that such as osteopathic notes manipulations or any other code that's not yet a qualifying visit and there's no (unintelligible) how we are to bill for those? I've had this come up on a previous call and I thought I understood folks talking about billing some sort of equivalent, what would be equivalent in an E&M for those non-qualifying procedure codes.

Corinne Axelrod: This is Corinne. So, a couple of points. First, and I know this is obvious, but people should only bill for codes that they are actually using and doing. So, if you're not furnishing an E&M service then you should not use an E&M code just to get paid for service that's not on the list. I know it sounds very obvious but we just want to be really clear on that.

If the service is not on the list of qualifying visits, then you should assume that it's not a standalone billable visit. Whether or not it will be added or not we don't know because, as I mentioned earlier, we will review any codes that we get that people are asking to be put on the list, we will review those with our Medical Officers and determine whether or not it is appropriate to add it on or not.

So just because you submit a code doesn't mean that it's going to get on the list. There's no change in what is a billable visit before April 1st and after April 1st, so a lot of procedures are not standalone billable visits, some are some aren't. But again if it's not on the list, then it is not a standalone billable

visit. If it is furnished on the same day standalone billable visit it would go on the claim.

If it's the only service furnished and there's no billable visit then it's not going to be payable. So this is really again no different than under the current system.

(Lee Ann Latham): So in osteopathic manipulation that is a billable visit you just don't know if it's going to be added yet?

Corinne Axelrod: I don't actually have the list in front of me but I don't know that that's on the current list.

Bill Finerfrock: Yes it's not currently on the list but we received a number of requests from folks that various osteopathic codes be added, and in the list that we are compiling to send over to CMS are a number of those osteopathic codes on the list. Again, I think, you know, as Corinne said whether or not they add it is up to CMS. There is no guarantee.

To your point, if it is a service, I'm not a clinician, if it is a service that is recognized and covered service by Medicare and it's a service that can be provided in a rural health clinic, then it seems that it might be reasonable to think that it would be added to the list, but we'll have to wait and see once CMS has a chance to take a look at it.

We'll be sending in the list of codes that we've compiled here within the next day in order for an opportunity hopefully for CMS to review those and get them added to the list so that they are operational on October 1.

Bill Finerfrock: A quick question from (Shannon Dickerfield) who wants to know if claims will reject if a description is in Field 43? Someone from CMS want to take that? I think she's talking 43 on the UB04 field, 44 on the UB04 form.

Woman: We're looking right now.

Woman: I'm sorry. She's asking if the claim will be rejected if the description is left blank?

Bill Finerfrock: Yes. If there is a description in Field 43 or not.

Woman: That's not required.

Bill Finerfrock: So either if there's text there or if there's no text there it won't affect the claim.

Woman: Right. And, I think some of the software like TCH and things like that, I'm not even sure if they have that description field. This is on the paper format of the UB04.

Bill Finerfrock: Operator? Do we have calls online, on the phone?

Coordinator: Mm-hmm. (Sherry Planton). Your city and state please and go ahead with your question?

(Sherry Planton): Jerseyville, Illinois. My question, I have a couple of questions this is the same for whether it's free standing or provider based or hospital based rural health clinic, it's in effect for everyone, correct?

Woman: Yes. Okay.

(Sherry Planton): And, in looking at the list of everything that is in red, I'm looking at the medical services that they have out on the link on the Web site, those are the ones that we cannot bill until October 1st? We have to hold the entire claim in order to bill that?

Corinne Axelrod: You would only hold the entire claim if that's the only service being billed on that day.

(Sherry Planton): Okay. So if there's an office visit and a lesion removal then that can all be billed?

Corinne Axelrod: Correct. Yes.

Bill Finerfrock: Correct. Yep.

(Sherry Planton): Okay, then if we like carve out some of it's rural health, some of it goes to Medicare Part B, we're not changing any of that? Our carve out is going to stay the same and our rural health billing is going to stay the same?

Tracey Mackey: That's correct. You would continue to bill your professional services on the UB04 and the RHC claims and your technical services would go on your 1500 form if you're independent. If you're hospital based it may go on a 13X or a 14X bill type.

(Sherry Planton): Okay. All right. Thank you very much.

Coordinator: Thank you. (Laura Williams)? Did you want to take one from the Web site?

Bill Finerfrock: Yes Operator. Sorry.

Coordinator: That's all right. Go ahead.

Bill Finerfrock: Go ahead (Laura).

(Laura Williams): Hi. My name is (Laura). I'm calling from Silver Springs, Texas. I have a question. If we have a patient come in only for say an I&D, CPT code 10060, normally would not bill an RHC visit with that. We only bill that procedure to Part B? We do not bill it on a UB as an RHC visit? So this doesn't affect, we don't have to hold that claim?

Woman: The only claims that you would hold are the ones that are on the list in red.

(Laura Williams): This one is, the 10060 is on that list and red, but normally that would for us go on a 1500 and we would bill it to Part B only. We do not bill it with an RHC visit.

Bill Finerfrock: I think you're, well go ahead Corinne. How do you want to answer that question?

Corinne Axelrod: You go ahead Bill.

Bill Finerfrock: Well I'm not sure that what you're doing is correct billing.

(Laura Williams): Okay.

Bill Finerfrock: Because what it sounds like is that what you may be doing is commingling of doing an RHC encounter and providing FC service in conjunction with that. Now, you haven't gone into details, but if you are simultaneously providing a

rural health clinic service and a non-RHC service on the same patient, that would ...

(Laura Williams): No. We're not doing an RHC service on the patient like they are only here that day for the injection and when we have a separate room, you know, not part of the RHC that we do that in.

Bill Finerfrock: Right, the space has been carved out.

(Laura Williams): Right. Yes.

Bill Finerfrock: The personnel have been carved out. All right yes in that case then we're not talking about an RHC claim at all. You're talking about just a 1500 claim that occurs whether it's in separate space in that building or five miles down the road.

(Laura Williams): So it doesn't matter that it's in red on that list?

Bill Finerfrock: No ...

(Laura Williams): Okay.

Bill Finerfrock: ... because you're not doing that as a rural health clinic service. Like I said, you could be at a clinic five miles down the road they're not an RHC.

(Laura Williams): Okay.

Bill Finerfrock: The way you framed the question made it sound like you were doing co-mingling.

(Laura Williams): Sorry. Okay. I understand what you're saying.

Bill Finerfrock: Was that your reaction Corinne?

Corinne Axelrod: Yes, it's a good time to just remind everybody that you are not allowed to bill Part B for RHC services while you're operating as an RHC, and that if you do have space that is carved out, you need to be very clear about the space that's carved out, when it's carved out and all of the costs with it. So, if the service is an RHC service furnished in the RHC, it cannot be billed to Part B even if it's not on our list of qualifying visits.

(Laura Williams): Thank you.

Corinne Axelrod: Thank you.

Bill Finerfrock: Operator? How many calls do we have on the line? Questions I mean?

Coordinator: You have 18.

Bill Finerfrock: We're up on 3:00. I know we've taken a lot of time from the folks at CMS. Are you guys able to stick around and answer a few more questions, or do we need to stop now?

Corinne Axelrod: I think we can take a few more.

Bill Finerfrock: Okay, we're not going to get to all 18. I apologize but if you want to send an email directly, I think were your emails are at the very beginning on the first slide?

Woman: Our emails are on Slide 57.

Bill Finerfrock: Yes, there it's up on the screen now. So, if we can't get to your question, either email the folks at CMS or if you wanted to email them to either me or to Nathan here at NARHC, we'll try and get those answered as well. But Operator we'll take a couple more questions from the phone.

Coordinator: Thank you. (Joy Mulbert) your city and state?

(Joy Mulbert): (Unintelligible), Michigan.

Coordinator: Go ahead with your question.

(Joy Mulbert): We are wondering what the actual rural health clinic reimbursement is? Do you know if it's 100 percent of your all-inclusive rate, or is it only 80 percent? We're getting conflicting answers from CMS.

Corinne Axelrod: Medicare pays 80 percent of the all-inclusive rate, except for the preventive services that are paid at 100 percent.

Bill Finerfrock: And, your all-inclusive rate if you're an independent or a hospital with fewer than 50 beds is at the cap your cap bed the RHC rate, if you are in a provider based with fewer than 50 beds, then you get the full cost-based rate. But again, only 80 percent of that but you would get 80 percent of your full rate versus 80 percent of the cap rate if you're above the cap. If that doesn't confuse matters royally for you?

Does that help?

(Joy Mulbert): Yes it does. Thank you.

Bill Finerfrock: Okay. Next question Operator?

Coordinator: Yes we have a question from Tracey. I did not get a last name. If you can, give your full name and city and state? Tracey?

Bill Finerfrock: Go ahead Tracey.

(Tracey Cook): (Tracey Cook), Paoli, Indiana.

Bill Finerfrock: How can we help you?

(Tracey Cook): We see OB patients and would we bill for those when they come in for a visit?

Corinne Axelrod: I believe that's on the list that Nathan has been compiling. OB visits are on there, but in any case we're going to take a look at all of the codes that people have asked about. We'll review that with our Medical Officers and then add any appropriate ones onto the list.

(Tracey Cook): Okay. Thank you.

Coordinator: Thank you. (Lori Mynard) your city and state and go ahead with your question.

(Lori Mynard): I'm calling from Pender, Nebraska. And I guess I just, I understand why you guys can't add the codes until October, but has there been any thought to maybe postponing the go-live of April 1st back to October since we have identified such a large group of codes and then not run into the secondary payer issues?

Corinne Axelrod: Well, first I would say that we have not identified a large group of codes, and that for the vast majority of rural health clinics, the vast majority of codes are already on the list. We don't know if there will be a problem with secondary payers, there may be with some, but we really don't know that yet. But as I said when we began, we would be happy to postpone the effective date if we could just so that people would have more time. But the system requires several months to make changes, and so it's not possible for us to delay implementation. The start date is April 1st and there's just nothing that we can do about that.

(Lori Mynard): Okay. And, I jumped on the call late. I must have missed that at the beginning. Then, my only other question is, and I've listened to some other calls and my understanding, and I know you guys were kind of, it was asked earlier but it's kind of what the EOBs going to look like to the patient, and how, if there are any suggestions on how we kind of explain to the patients either a penny charge or what appears to be kind of inflated prices by the double pricing on there. You know, for Medicare patients traditionally are a little harder to understand their EOBs anyway, and I'm just kind of concerned about that.

Tracey Mackey: So, this is Tracey. I'm glad you came back with that question. We were able to look that up. So, the EOB will list all of the services on the claim. And as for the charges there is something on the EOB that says that this is a Medicare approved amount. This may be less than what your provider actually charged, so it states that on there.

(Lori Mynard): But, I think and maybe I'm wrong, but I'm thinking it's going to appear like we're inflating our charges or looking like we're double billing to the patient.

Tracey Mackey: I think another thing is, it asks, you know, did you go to this facility? Did you receive all of these services? So, all of the services will be listed. And again,

in that column it says that the provider's charges, or it says the facility. The facilities charges may be more than what Medicare paid.

Corinne Axelrod: We recognize that and in some cases you may have to really explain to the patient about the way that their EOB looks. I mean a lot of patients are not going to look at it but there's always some that will and will question it. And especially initially you may have to do a little bit of explanation.

I know the FQHCs were worried about this as well when we transitioned them to their new payment system. I don't think it turned out to be as much of a problem as what they were afraid it might be, but certainly we acknowledge that there will be some patients that will ask you about it, and that it will require a little bit more explanation. We don't have any particular script or information to recommend, and I don't know if other RHCs may have some suggestions on that.

(Lori Mynard): So, if I just understand it correctly; so the line item, you know, with the 521 on it and with the E&M code, if we have like a \$100 office call and a \$200, it's going to have a \$3 charge on it? And then the subsequent line below it will have the \$200 procedure line? So I mean to the patient it's going to look like we're double billing it isn't it, or am I not understanding how that EOB is going to look?

Corinne Axelrod: I think you're correct that it might look like that and we did identify that one of the issues we've been hearing about is the appearance of the EOB, and again I think for some patients you'll just have to explain that you're not overcharging them. You're not overcharging Medicare. It's just that that's the way that it looks.

(Lori Mynard): And I think that supports the argument from what I understand of changing that to the penny so it doesn't look quite as ...

Bill Finerfrock: Yes that's the psychological or visual reaction if it's a penny people won't have the same reaction as if it was a \$200 charge and they thought you were double billing, so that will help them address that visual.

(Lori Mynard): Right. That's kind of the motivating factor for me to really think about changing that over to the penny is just from the patient's EOB standpoint to go that extra step, so okay thank you.

Coordinator: Okay. Thank you. Next we have ...

Bill Finerfrock: Go ahead.

Coordinator: ... okay, (Evette Martin).

(Evette Martin): Yes. This is (Evette Martin), Salem, Kentucky.

Coordinator: Go ahead ma'am.

Bill Finerfrock: Go ahead.

(Evette Martin): Okay. My question it's still along the remit side but it's more with the provider remits. I know a few comments have been made about how it would look, and I'm not understanding because our remits when we get them right now they're more focused of the overall claim. They only give us that total claim information. They don't give us detailed line information. Is the new remit going to give us detailed line information?

Tracey Mackey: Yes, this is Tracey. It's my understanding that the remit is in two parts; you have a summary and then you also have the detailed lines. So the detailed line will definitely give all of the detailed lines on the remit, and then again there's a summary also.

(Evette Martin): Okay. So, with this transition they're going to look more like a Part B remit versus a Part A remit? I guess that's how we sort of differentiate them here.

Tracey Mackey: I can't say that it's going to look like a Part B for providers doing it on the 1500, but it would look like more like any other outpatient that bills on a UB04.

(Evette Martin): Okay. Yes. With us being the provider base that's really the only that we see as this rural health clinic total so okay, but they should have detailed claims a little bit more?

Tracey Mackey: Yes, you will have the summary but you also get the detail.

(Evette Martin): Okay. Thank you.

Bill Finerfrock: Operator? Let's take two more calls from the line and I think we'll have used up, overstayed our welcome with the folks from CMS.

Coordinator: All right. Thank you. (Alan Vandreal) please give your city and state and go ahead with your question.

(Alan Vandreal): I'm from Smith Center, Kansas. I'm back on the remittance advice again. I'm confused about how that exactly is going to appear and how we're supposed to deal with it, because if I understand it right, the first line of the claim will

have the qualifying service with a total on it that would actually be the sum of all of the lines on the claim? Am I stating that correctly?

Bill Finerfrock: That's correct.

(Alan Vandreal): Okay. So, if you've got ...

((Crosstalk))

Bill Finerfrock: Unless you have a preventive service.

Corinne Axelrod: That's minus any approved preventive services.

(Alan Vandreal): Okay. All right. Well, let's leave aside the issue of preventive services for the moment, but let's say there's an E&M code that has, as somebody used as an example earlier, \$100 and there's a procedure code below that that has a \$200 charge. So you've got a \$100 line item, you've got a \$200 line item; you're supposed to adjust the price on the E&M, the qualifying code line to be all of those. So you would have that as, in this example \$300.

The claim total then would be the \$300 plus the \$200, which would be \$500 for the claim total. And when you get a remittance advice back somehow you've got to separate. All of that \$500 is going to show in virtually any practice management system is going to show as revenue, and somehow you're going to have to make contractual adjustments to back that total down to what the actual claim is, but it isn't going to work. The math isn't going to work out, and I'm confused about how we're supposed to deal with those scenarios. Can you help me with that?

Tracey Mackey: This is Tracey. I don't know if I can tell you exactly how you have to deal with it in your practice, but your remit will show that those charges for those subsequent lines have been backed out and that the payment is included in another line. And so, you're right you're going to have to do some math to kind of back those charges back out.

(Alan Vandreal): But you can't claim those contractual adjustments. That's not a contractual adjustment. That's a claim adjustment. I mean it's not the same as if we bill something at one rate and it's paid at a different rate. This is a whole; I've never seen a claim where you have services that are effectively double-counted when you add the revenue all together and then somehow you have to come back to being able to show the payment for the amount of the claim, which doesn't match the total on the claim. You see what I'm saying?

Tracey Mackey: Well I'm not sure that we can, oh (Bill go ahead).

Bill Finerfrock: Well I was just going to say I mean I want to hear the answer if you have one, but I think there are two things; one is the FQHCs have dealt with this, I mean they have the same type of a situation where you're going to have that over billing. And, we were told that, you know, the secondaries were never able to figure that out.

The other option is what they had suggested in one of the examples is instead of putting the actual charge there, you put a penny and then that virtually eliminates that difference between the top line and the bottom line where you're noting rightly that there's the discrepancy so that would be the way to work around if you will instead of putting the actual charge, you put a penny in for each of those subsequent lines on the claim and your 0521 qualifying visit line is still the total upon which the co-insurance is going to be calculated.

(Alan Vandreal): Yes. I understand that, but I have two concerns about using that methodology too. Number one that means that every claim is going to have to be manually tweaked in order to put that one penny because you're going to have a price for that procedure loaded in your charge master in your practice management system for billing other payers and so forth. So you're going to have to adjust that price manually on every single claim that's got that line item on it.

And secondly, what that does is it means that you're actually billing out a claim with different prices on it for the same service. And Medicare has preached for years, and years, and years that you must bill all payers, all patients the same rate. You can do an adjustment, but you can't bill them at a different rate. And now they're saying you can bill them at a one-penny rate for a service that you're going to bill to another payer at potentially several hundred dollars.

Corinne Axelrod: If we could just clarify that we are not saying that they would be billed at a different rate, because we're not paying off of that line. It's just a way to get the claim through the claims processing system, but I just want to be clear that we're not suggesting or saying that the patient would actually be billed at a different rate.

I'm not sure that we can answer your question other than what we've already said, so I'm not sure what else we can say right now. I think you certainly have raised some important points, and we will look into it. But I'm not sure we have any other answers for you right now.

(Alan Vandreal): About four days from now we have to figure out how to process these claims.

Coordinator: One more question sir.

(Alan Vandreal): Thank you.

Bill Finerfrock: Okay go ahead Operator this'll have to be the last question.

Coordinator: All right. It will come from (Tish Hollingsworth) please give your city and state and ask your question. Thank you.

(Tish Hollingsworth): Thank you. This is (Tish Hollingsworth) from Topeka, Kansas. And I guess one question that I have submitted to Corinne and also another individual at CMS is would you consider taking off and doing away with the all-inclusive lines if we just need to report all of the individual items? You know, we currently pull out the preventive services. Your examples look like you're able to process individual lines. And it seems like consideration should be given to maybe getting rid of the all-inclusive line and a lot of these issues could potentially go away. Is that something you've considered?

Tracey Mackey: Hi Tish. This is Tracey. And I think I responded to your email. So, RHCs and FQHCs are paid a per diem payment, and they are billed on a UB-04 so we have to require HCPCS and we need them detailed on the lines, but unfortunately we can't unbundle the bundle. But at the same time because of reporting issues, you have to report the detailed services on the line and the system will not accept charges, you know, at zero so it presents this problem. But, you know, I don't know how we could do away with the air payment because by law we have to pay an air payment.

(Tish Hollingsworth): Okay. Then the other concern that I think and someone else maybe asked the question earlier would be that you're going by dates of service right? So that in our world we would have to be able to handle this two ways for claims that were prior to April 1st, and then also claims after April 1st?

Tracey Mackey: That's correct because we have to account for adjustments prior to under the old reporting system so that's why a date of service is used in the system. So if someone wanted to go back and do an adjustment for a claim that was submitted March 1st, we have to do that based on dates of service so the claim would not hit edits.

(Tish Hollingsworth): Okay. Thank you.

Bill Finerfrock: All right. I want to thank everyone for all of the time you've taken today; Corinne Axelrod, Tracey Mackey, Simone Dennis, Brian Pabst from CMS and (Monique Funkenbush) with BKD consulting. This is obviously representing challenges. I think all of us might have things that we would've, could've, should've done differently if we were designing it, but this is what we have. And I think, you know, this is the second call that we've done on this.

We had over 800 people on the call today, which I think is indicative of the significance of the change that's occurring here. I think CMS has gotten information out. I've seen folks who've said, you know, this is the first time hearing of this, you know, three days prior to it going live. I don't know if you are a member of the national association or rural health clinics. We've been certainly putting information out about this from the beginning, sharing information.

If you are not on the rural health care technical assistance list serve, I would encourage you to do that. If you go to the NARC Web site, if you're not on the list serve, you can find out how to get there and get that information. If you're not, if you hopefully belong to some other association I don't know

how you're getting information but this certainly wasn't the first time that we've done anything or others have done things on this topic.

We have to deal with it. I think as the outset CMS made the point; they are not trying to come up with new reasons to deny claims, to reduce RHC payments. I do think that collecting information about what is going on, what kinds of services RHCs are providing has validity and has value, not only for CMS but for us as an RHC community.

We will continue to do what we can to try and make this work as smoothly and as efficiently as possible. If you encounter problems, you have the emails for the folks at CMS. You have our emails, please let us know, we can try and get together. I think up until this point when we brought things to CMS's attention, they've done the best that they can to try and be responsive.

Some things they can't change as much as they might like to as well, but where we have an opportunity to make some changes, I think there's a willingness to try and look at options. Again, I want to thank everybody for participating in today's call. We will have another RHC call probably in another month or so. We haven't decided on the topic. We will put information out on that on the rural health clinic technical assistance.

I want to thank the federal office of rural health policy for allowing us to have this additional call on this topic. Again, given the number of people who are on I think is an indication of the significance of the subject matter. So without further dragging this out, if you haven't before you log off you'll see up on your screen a poll. How helpful was today's RHC Webinar? And then any suggestions for future RHC Webinars or topics, and any other comments you'd care to make.

This will help us make sure we continue to provide programming that meets your needs moving forward. Again, thank you everyone for participating and have a great rest of your day. Thank you.

Coordinator: This does conclude today's conference. Thank you all for your participation. Participants may disconnect at this time.

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