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**RHC Billing**  
**Session 2**  
**December 5, 2018**



**H B S**

Healthcare Business Specialists



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**[RHC Information Exchange Group on Facebook](#)**

***• "A place to share and find information on RHCs."***



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## **Rural Health Clinic Information Exchange Group on Facebook**

**Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs**

**<https://www.facebook.com/groups/1503414633296362/>**



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## Questions or Comments?

**Raise your hand button and I will call on you to ask your question or comment.**





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# Technical Assistance Webinar

The next RHC Technical Assistance webinar has been scheduled for Tuesday December 18<sup>th</sup> at 2:30pm (EASTERN).

We are pleased to announce that Corinne Axelrod and Susan Janeczko, PharmD, JD, from CMS will be our presenters. Susan and Corinne will be talking about the new RHC service expansion that was recently finalized and scheduled to take effect on January 1, 2019.

They will also be available to answer your questions about Medicare payment policy and RHC services.

Below is the call-in/log-in information for this webinar.

**Start/end time:** 2:30-3:30pm ET

**Conference number:** 888-810-6807

**Participant passcode:** 5566903

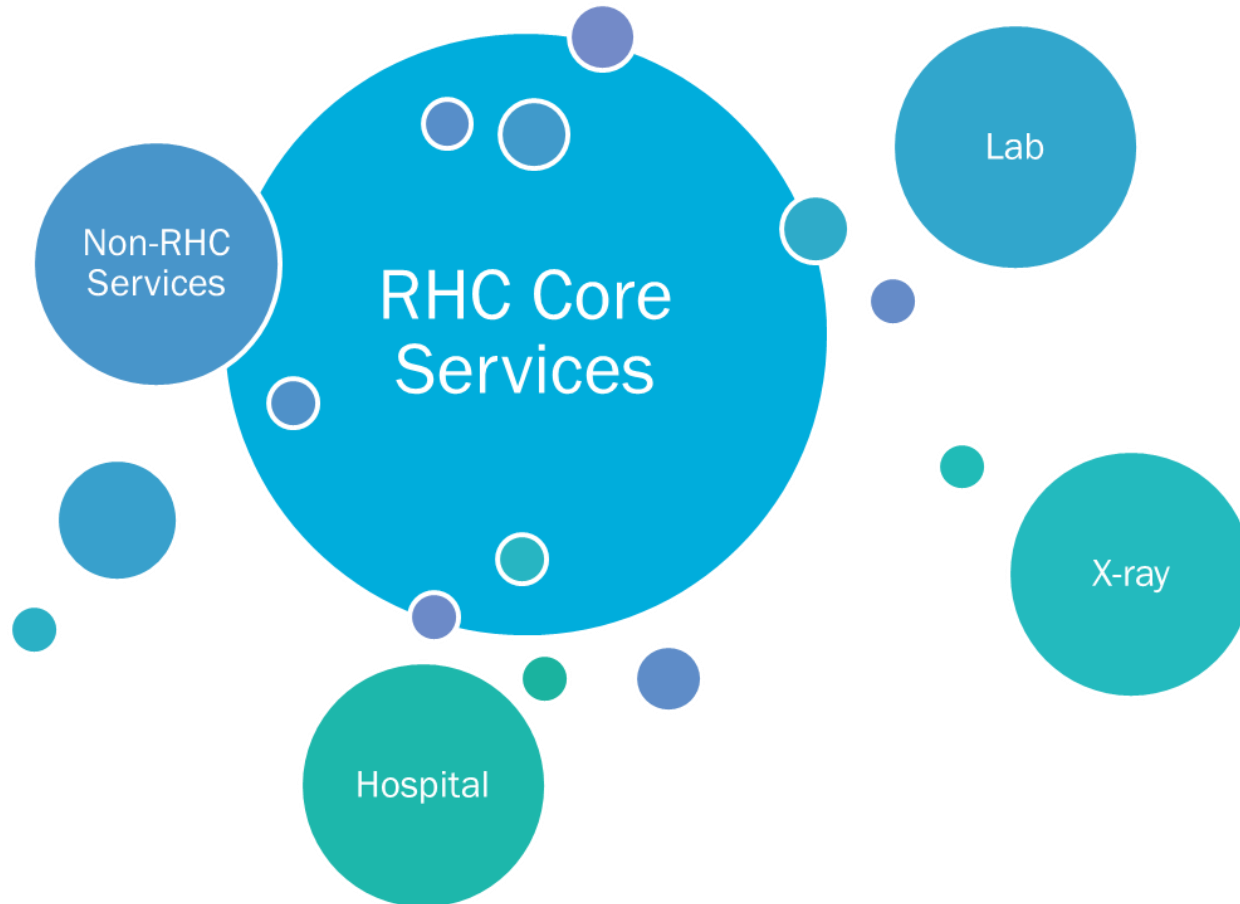
**Webinar URL:** : <https://hrsaseminar.adobeconnect.com/rhctadec18/>



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# Billing for RHC and Non-RHC services



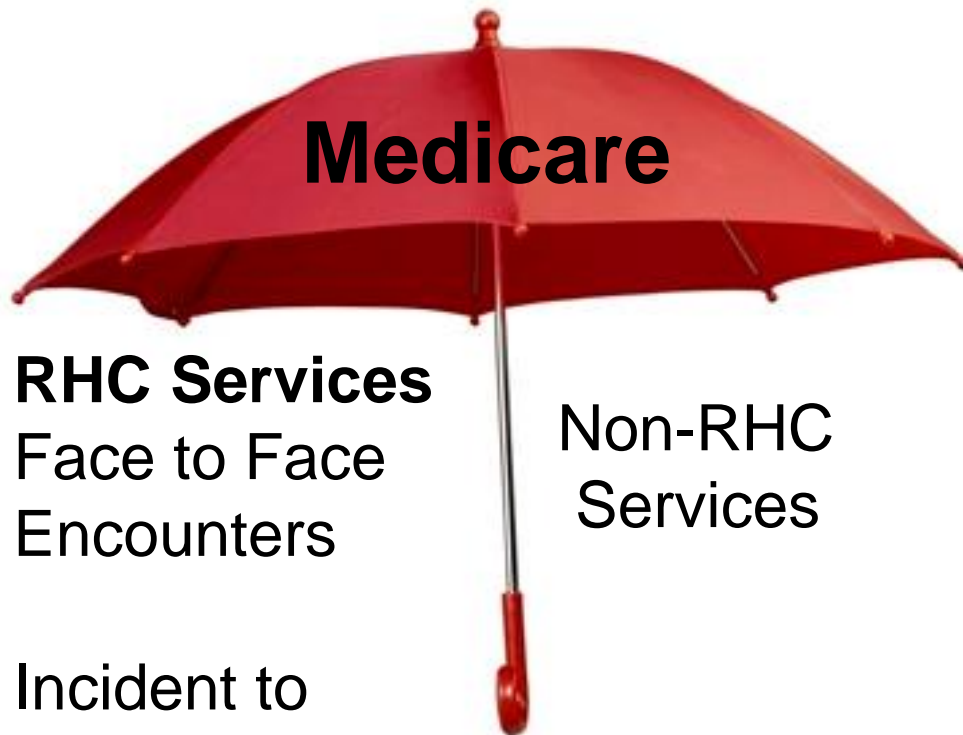




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# Four Categories of Services



**Medicare**

**RHC Services**

Face to Face  
Encounters

Incident to  
services

Non-RHC  
Services



**Medicare  
Non-covered  
services**



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# Medicare

**Part A**

**Part B**

**Professional  
Services**

**Technical  
Components**

**Lab  
Diagnostic**

**Hospital**





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# What is a Rural Health Clinic Visit?





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## The History of the RHC Visit

<b>Date Began</b>	<b>Definition</b>	<b>Date Changed</b>
3/1/1978	Face to Face, Med necessary, Physician, NP, PA	12/31/2015
1/1/2016	Added Chronic Care Management - No face to Face	3/31/2016
4/1/2016	Must Be on QVL to Bill. Procedures held until 10/1/2016	9/30/2016
10/1/2016	No more QVL. Now add CG modifier	Present



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## **Definition of a Visit per Chapter 13 of the RHC Manual**

**40 - RHC and FQHC Visits (Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17) A RHC visit is defined as a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a **face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW** during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be a RHC visit. Services furnished must be within the practitioner's state scope of practice.**



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## What is a visit in a rural health clinic?

Has  
Three  
Components

1. Is a face to face encounter with a physician, nurse practitioner, PA, NP, or CNM, CP, or CSW.
2. There is a medically necessary service provided (should reach the level of a 99212)
3. Is provided by the appropriately trained provider within their scope of practice.



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# **Paid RHC Encounters are very limited**

**The definition of a rural health clinic encounter does not include:**

- 1. Nurses**
- 2. Physical Therapists**
- 3. Dietitians**
- 4. Nutritionists**





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# **Paid RHC Encounters are very limited**

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# **99211 Visits (Nurse Only) are not Medicare RHC Visits**

- Brief Established visits (99211's) do not meet the RHC guidelines. No history or judgment involved with this level of service. Do not bill Medicare a visit for these services.





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# Where can you have an RHC Visit?

**40.1 - Location (Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16) A RHC visit may take place:**

- 1. in the RHC,**
- 2. the patient's residence,**
- 3. an assisted living facility,**
- 4. a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1) or the scene of an accident.**

**RHC visits may not take place in either of the following:**

- an inpatient or outpatient department of a hospital, including a CAH, or**
- a facility which has specific requirements that preclude RHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).**



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## Where can a RHC visit occur?

In  
Three  
Locations

1. In the certified rural health clinic (0521)
2. In the patient's home
  - A. home (0522)
  - B. SNF (Part A) (0524)
  - C. ICF/NF (Not Part A) (0525)
  - D. Assisted Living Facility (0522)
3. Scene of an accident (0528)
4. Telehealth (0780) Originating site only
5. Behavioral Health (0900)

Note: Do not use POS 72 on any Medicare Claim



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## Revenue Codes

**0521**

Clinic visit by a member to RHC

**0522**

Home visit by RHC practitioner

**0524**

Visit by RHC practitioner to member in a covered Part A stay at a SNF

**0525**

Visit by RHC practitioner to member in a non-Part A SNF, NF, ICF, or other residential facility

**0527**

RHC visiting nursing services to a member's home in a Home Health Shortage Area

**0528**

Visit by RHC practitioner to another non-RHC site (i.e. scene of an accident)

**0900**

Mental health visit



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## Other Common Revenue Codes in RHCs

**0250**

Pharmacy – drug with no J-code

**0300**

Venipuncture

**0636**

Drugs with detailed HCPCS J-code

**0780**

Telemedicine originating site



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# Claim Form, Bill Types & Place of Service

- RHC services are billed on a CMS-1450 (also known as a UB-04 form)
- RHCs should use Place of Service (POS) code **72**
- These are the common bill types (TOBs) used on RHC claims:

**711** Original Claim

**710** Non payment/zero claim

**717** Adjustment Claim

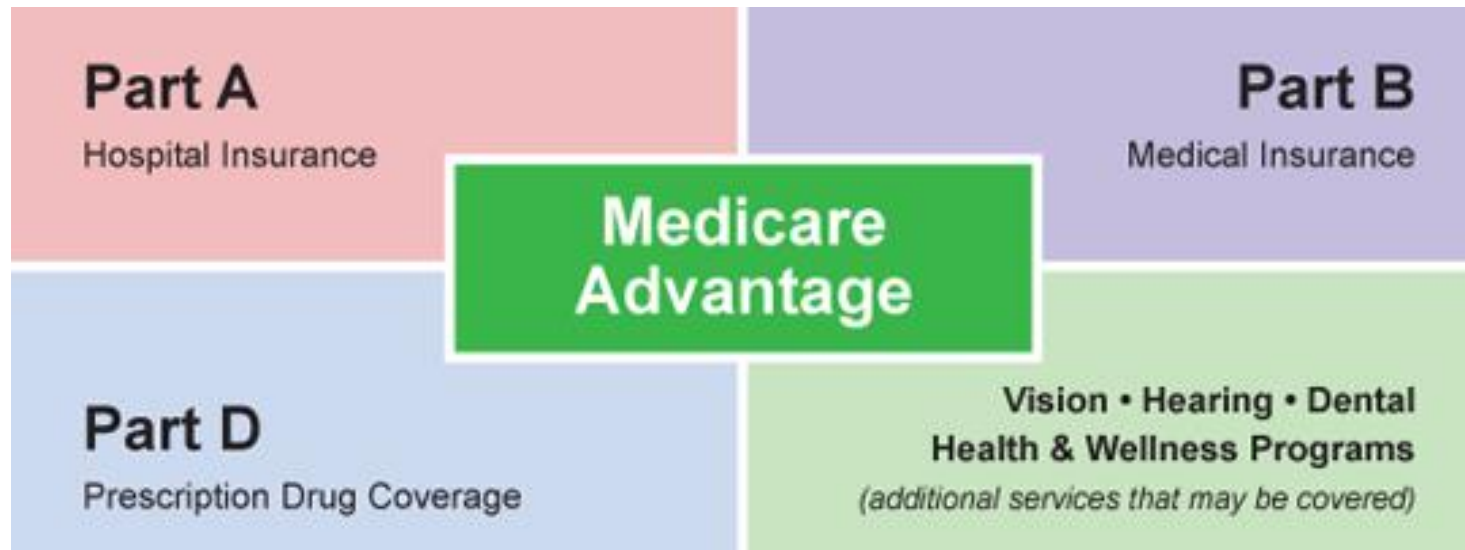
**718** Cancelled Claim



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# Medicare Advantage Plans



[https://www.modernhealthcare.com/article/20180210/NEWS/180219989?fbclid=IwAR0MkzSTlwRI\\_rNk-irYTA94T33XeQf5GzWAsrnpBifhITwL\\_4Q7ZXtqvcg](https://www.modernhealthcare.com/article/20180210/NEWS/180219989?fbclid=IwAR0MkzSTlwRI_rNk-irYTA94T33XeQf5GzWAsrnpBifhITwL_4Q7ZXtqvcg)



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# Medicare Advantage Plans

**When a beneficiary enrolls in a Medicare Advantage (MA) plan, they are no longer classified as a Medicare patient for cost reporting purposes. These individuals are effectively treated as privately insured individuals.**

**MA plans must show that they have an "adequate" provider network in each market they serve. In an underserved area, it may be difficult for the MA plan to meet the market adequacy requirement if an existing RHC is not part of the network.**

**If an RHC is a contracted provider within a MA network, the RHC is obligated to follow whatever is established in the contract. Payment could be cost-based, fee-for-service, or even capitation.**

**plan.**

<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf> (see page 25)





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# Non-RHC Services



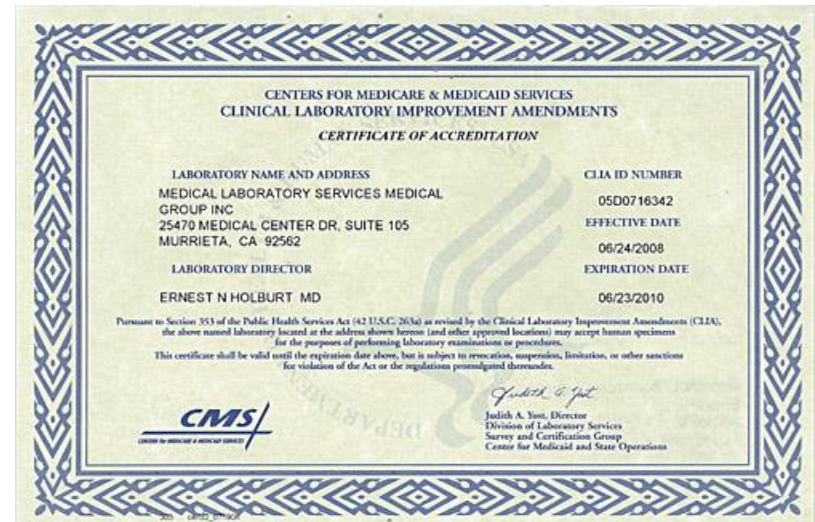
Ancillary Care Services



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# Laboratory services are **not** covered under the RHC benefit

All Laboratory services are **not** included under the RHC benefit including the six required laboratory tests.





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## **What are the six laboratory tests required for Rural Health Clinic certification?**

- 1. Chemical examinations of urine by stick or tablet method or both**
- 2. Hemoglobin or hematocrit**
- 3. Blood sugar**
- 4. Examination of stool specimens for occult blood**
- 5. Pregnancy tests**
- 6. Primary culturing for transmittal to a certified laboratory (No CPT code available)**

**Reference: [CMS Publication 100-04, Chapter 9, Section 130](#)**



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# Venipuncture – Lab Draw (36415)

**Effective 1/1/2014, Venipuncture is covered by Part A and is included in the billing to Part A on the UB-04 Form. You can continue to charge for the service. It will increase the co-pay from the patient. MLM 8504.**





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## Laboratory Services

[CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 60.1](#)

- Venipuncture is included in AIR and is not separately billable
- Laboratory services are not an RHC benefit and not included in AIR
  - Provider-based RHCs bill under parent provider to on UB-04 or 837I equivalent
  - Independent RHCs submit claim on CMS-1500 Claim Form or 837P equivalent



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## **Independent RHC – Laboratory services**

<b>SERVICES</b>	<b>BILL TYPE</b>	<b>CLAIM FORM</b>	<b>PAYMENT</b>
<b>Laboratory Except 36415</b>	<b>NA</b>	<b>1500</b>	<b>Fee for Service</b>



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## **Provider-based RHC Laboratory services are paid as follows in a PPS Hospital**

<b>SERVICES</b>	<b>BILL TYPE</b>	<b>CLAIM FORM</b>	<b>PAYMENT</b>
<b>Laboratory Use the Hospital Outpatient Provider Number</b>	<b>131/141</b>	<b>UB-04</b>	<b>Cost</b>



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## **Provider-based RHC Laboratory services are paid as follows in a CAH**

<b>SERVICES</b>	<b>BILL TYPE</b>	<b>CLAIM FORM</b>	<b>PAYMENT</b>
<b>Laboratory Use the Hospital Outpatient Provider Number</b>	<b>851</b>	<b>UB-04</b>	<b>Cost</b>



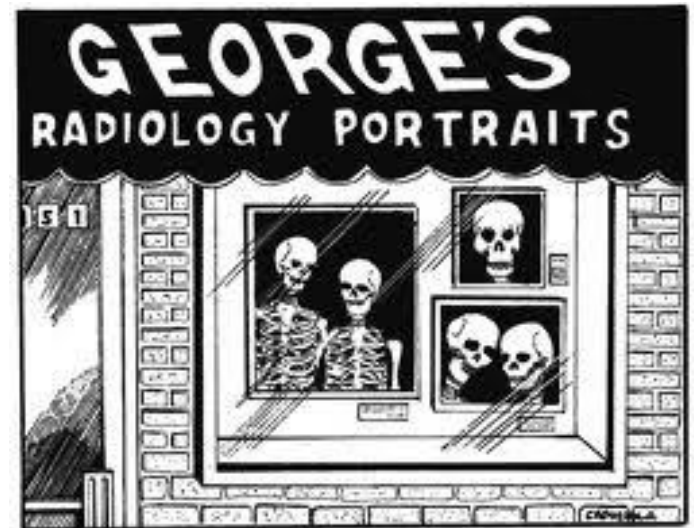


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## **Diagnostic Tests are not covered under the RHC Benefit**

**Technical components were excluded under Public Law 95-10 establishing RHCs.**





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## **RHC Independent - Diagnostic Tests - Technical Component Only**

<b>SERVICES</b>	<b>BILL TYPE</b>	<b>CLAIM FORM</b>	<b>PAYMENT</b>
<b>Radiology, EKG</b>	<b>NA</b>	<b>1500</b>	<b>Fee for service</b>



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## **RHC Provider-based - Diagnostic Tests - Technical Component Only – PPS**

<b>SERVICES</b>	<b>BILL TYPE</b>	<b>CLAIM FORM</b>	<b>PAYMENT</b>
<b>Radiology, EKG</b>	<b>131</b>	<b>UB-04</b>	<b>Fee for service</b>



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## **RHC Provider-based - Diagnostic Tests - Technical Component Only – CAH**

<b>SERVICES</b>	<b>BILL TYPE</b>	<b>CLAIM FORM</b>	<b>PAYMENT</b>
<b>Radiology, EKG</b>	<b>851</b>	<b>UB-04</b>	<b>Fee for service</b>



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## **Diagnostic Tests – Professional Components**

**Professional components are covered under the RHC benefit and are included on the UB-04 and billed to the RHC MAC. (they must be billed with a face to face encounter)**





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## **RHCs (Ind/Prov) -What happens to the professional component of Radiology?**

<b>SERVICES</b>	<b>BILL TYPE</b>	<b>CLAIM FORM</b>	<b>PAYMENT</b>
<b>Radiology, EKG</b>	<b>711</b>	<b>UB-04</b>	<b>Incident to. No visit</b>



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## How to Bill EKGs

<b>Modifier</b>	<b>Description</b>	<b>How to bill</b>
93000	Global interpretation and technical component	Do not bill this way in a RHC.
93005	Technical Component	Bill to Part B – Paid on 1500 for Independent and use UB-04 and hospital outpatient provider number
93010	Interpretation	Bill on UB-04 (incident to – No visit)



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## **Hospital Services are not covered under the RHC Benefit**

**Hospital services for independent and provider-based RHCs are billed on the 1500 form and paid fee for service.**







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## **Can we bill a Hospital Admission and an Office Visit on the same day?**

We asked CMS this question and their response was to bill it to the MAC and let them decide if it is payable or not. Most are paid; however, some do get rejected if the patient becomes observation instead of a hospital admission.



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**Flu and Pnu shots are paid very well  
in the RHC setting . Use a log on  
the cost report. Do NOT Bill!!!!**

**Average payment was \$250 for  
pnuemococal. (Cost is \$125)**

**Average payment was \$40 for  
influenza in 2017. (Cost is 11)**

**Place Patient Name, HIC Number,  
and Date of Injection on a Log.**





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# Ancillary Services and Incident to Billing





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## The Basics

Description	Type	Payment
E and M – Face to Face	RHC – Face to Face	AIR
Shots, Allergy shots, 99211s	RHC – Incident to or Ancillary services	Part of AIR. No extra payment from Medicare
Flu and Pnu	RHC – Do not bill	Paid extra money on cost report
Lab	Non-RHC	FFS
Diagnostic Tests	Non-RHC	FFS
Hospital Services	Non-RHC	FFS



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# Incident to





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# Incident to Per TA Session

- Direct supervision by provider required
  - Must be in clinic, not in same room
  - being in the hosp when attached to clinic is NOT “incident to”
  - Exception is the Chronic Care Management services
- Part of provider’s services previously ordered
  - integral, though incidental
  - covered as part of an otherwise billable encounter
  - I.e. dressing change, injection, suture removal, blood pressure monitoring

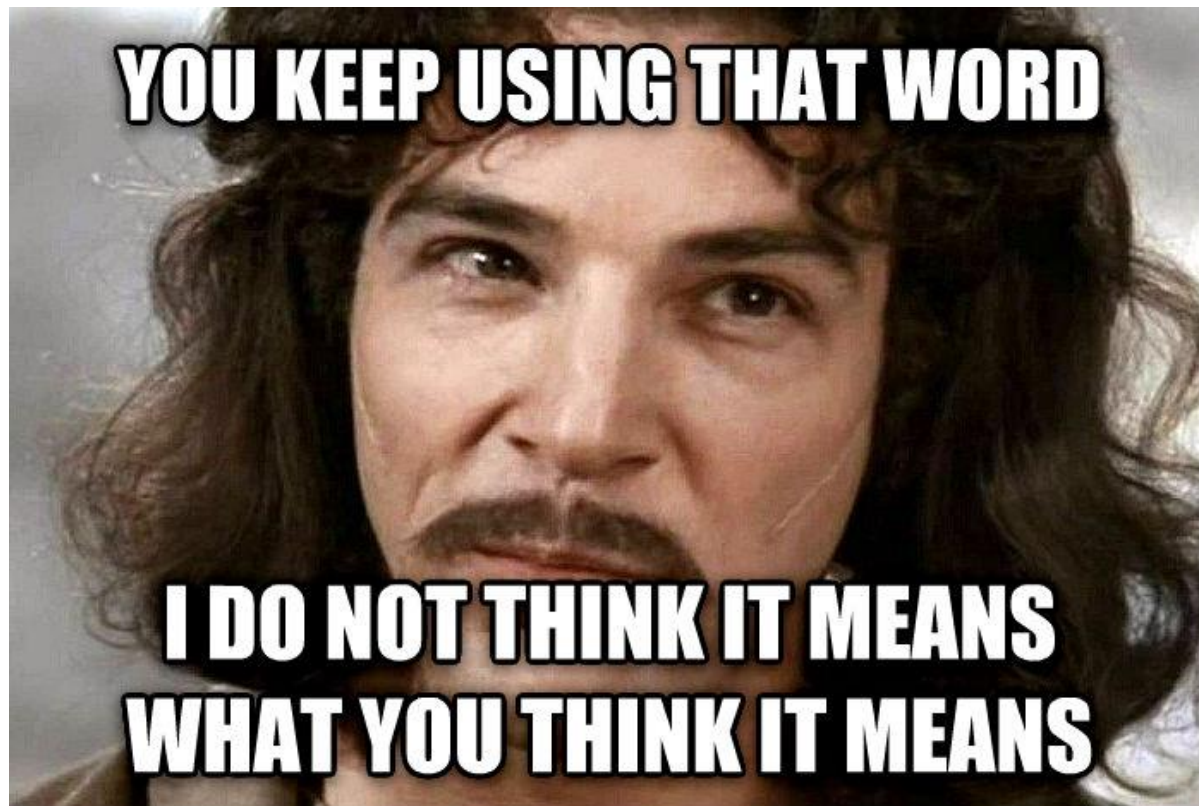
Medicare (Medicaid if State requires) services should be billed under the provider that performed the service unless it is an “incident to” service



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**Sometimes the words don't really  
mean what they say**





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## **120 - Services and Supplies Furnished “Incident to” Physician’s Services**

“Incident to” refers to services and supplies that are an integral, though incidental, part of the physician’s professional service and are:

- Commonly **rendered without charge** and included in the RHC payment;
- Commonly furnished in an outpatient clinic setting;
- Furnished **under the physician’s direct supervision**; except for authorized care management services which may be furnished under general supervision; and
- Furnished by RHC auxiliary personnel.





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## **120.3 - Payment for Incident to Services**

**Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with an RHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.**



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## **140 - Services and Supplies Furnished Incident to NP, PA, and CNM Services**

NOTE: The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service **only if such a person is permitted to exercise such supervision under the written policies governing the RHC**. Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.



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# Incident to Billing in RHCs

## The Options

#	Description
1	Include the charges with a face to face visit within 30 days by: A. Holding claims B. Adjusting claims
2.	Writing the service off and not bill.
3.	Set up non-rhc hours and perform during that time. A. Must treat everyone the same (Non-Medicare) B. Must exclude cost and visits from cost report. C. Avoid commingling issues



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## **The 30 Day Rule – Incident to**

- **Incident to services can be combined with claims with visits within 30 days. List only the date of the visit.**



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# **Change of Charges**

## **For Incident to billing**

- 1. Use Bill Type 0717**
- 2. Use Condition Code D1 in FL 18-28**
- 3. Place DCN in FL64 (Document Control Number)**
- 4. In Remarks indicate “Change of Charges”**



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## Non-RHC Hours – What you have heard?

- 1. Your going to jail.**
- 2. Its complicated**
- 3. Cost Report Nightmare**
- 4. AIR will go down.**





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## **Non-RHC Hours - Reality**



- 1. No one is going to jail**
- 2. Not that hard**
- 3. Cost Report is designed for it.**
- 4. AIR will not go down if done correctly**



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## **Keys to making it work**

- 1. Treat everyone the same**
- 2. Keep up with Non-RHC visits**
- 3. Place a sign on the door indicating times**
- 4. Notify your Cost Report Person.**







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## What services can be done during Non-RHC Hours

<b>99214</b>	<b>Trigger Point Injections</b>
<b>99215</b>	<b>Procedures</b>
<b>36415</b>	<b>Allergy Shots</b>
<b>AWE</b>	<b>Nurse Only Visits</b>
<b>IPPE</b>	<b>TCM</b>



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## 100 – Commingling

Commingling refers to the sharing of RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- **Selectively choosing a higher or lower reimbursement rate for the services.**



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## **No Magic Part B Room – Treatment Room**

RHC practitioners may not furnish or separately bill for RHC covered professional services as a Part B provider in the RHC, or **in an area outside of the certified RHC space such as a treatment room adjacent to the RHC**, during RHC hours of operation. If an RHC practitioner furnishes an RHC service at the RHC during RHC hours, the service must be billed as an RHC service. **The service cannot be carved out of the cost report and billed to Part B.**



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## **Costs must be properly allocated**

If an RHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC space must be clearly defined. If the RHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.



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## **Sharing Services - Commingling**

RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC and non-RHC usage to avoid duplicate reimbursement.



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Questions, Thank You



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