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RHC Billing – Session 4

www.ruralhealthclinic.com

Spring, 2018

HBS

Healthcare Business Specialists

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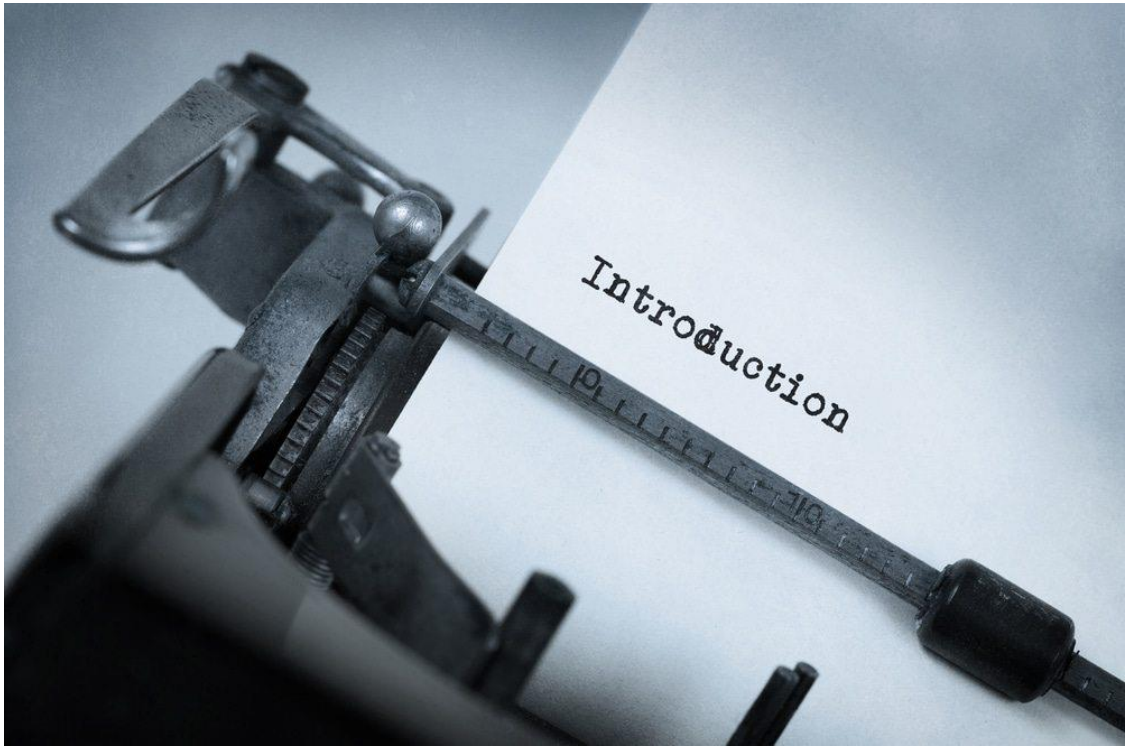
Introduction and Administrative



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Like Healthcare Business Specialists on Facebook for more RHC information

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RHC Information Exchange Group on Facebook

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

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Rural 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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https://www.youtube.com/channel/UCXW4pkwNzDXVTMFrFwMy2_A

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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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Disclaimer

1. **Information is current as of 3/8/2018.**
2. **Medicaid is different in each state. We will not be able to answer state specific questions in many states.**
3. **I am not young enough to know everything, nor am I an expert in all areas of RHCs.**

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Filing a Claim – Completing the UB-O4

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Description	Links
Chapter 9 - Medicare Claims Processing Manual Updated 12/31/2015 (38 Page PDF)	**https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf**
Care Management Services in RHCs FAQ Updated February, 2018 (17 Page PDF)	**https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf**

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Billing Resources at RuralHealthClinic.com

http://www.ruralhealthclinic.com/rhc-billing

RHC MEDICARE BILLING RESOURCES

Healthcare Business Specialists, LLC is pleased to provide you with these billing resources to help your rural health clinic bill Medicare for your services. Billing RHC services requires the ability to create a UB-04 in an electronic format (837I). Many clinics that are new to RHC billing rely on outside help to bill for services. We have worked with AMS Software out of Raleigh, North Carolina who has been working with RHCs on billing since 1989. Many RHCs need access to Direct Data Entry (DDE) to verify coverage or adjust claims. Many of our clients use Ability to connect to Direct Data Entry.

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Healthcare Business Specialists Beginning Billing for Independent Rural Health Clinics Webinar Series in February, 2018

In February, 2018, Healthcare Business Specialists, LLC conducted a series of webinars on RHC billing for Independent RHCs. We have provided the information from the webinars including PDFs of the slides and links to the recording of the presentations on Youtube:

- RHC Billing Webinar Session 1 Presentation (PDF)
- RHC Billing Webinar Session 2 Presentation (PDF)
- RHC Billing Webinar Session 3 Presentation (PDF)

The Youtube Recording of the sessions are below:

- RHC Billing Recording of Webinar Session 1
- RHC Billing Recording of Webinar Session 2
- RHC Billing Recording of Webinar Session 3

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Medicare Online Manuals with RHC Billing Guidance:

- Preventive Services Table from CMS for RHCs (3-Page PDF, August, 2016)
- FAQs from CMS regarding the CG Modifier (6-page PDF, October, 2016)
- RHC Fact Sheet from CMS (7 page PDF, January, 2017)
- Rural Health Clinics Center - CMS Information Portal for RHCs
- Chapter 9 - Medicare Claims Processing Manual
- Chapter 13 - Medicare Benefit Manual
- FAQs from CMS regarding Care Management Services in Rural Health Clinics (17-Page PDF, February 2018)

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RHC Billing Guides and Tables from Medicare Administrative Contractors:

- RHC Billing Guide from Noridian
- RHC Condition Codes from Noridian
- Medicare Part A Billing Guide from Noridian

Healthcare Business Specialists RHC Billing Policies

- **RHC Billing Policy - Introduction Policy 1000**
- **RHC Billing Policy - Medicare Secondary Policy 1100**

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HCPCS Codes for All Inclusive Rate (AIR) Reimbursement General Guidelines for RHCs

Number	Description or Guideline
1	A payable encounter (visit) should (not must) be included on the QVL. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf
2	Report appropriate HCPCS code for each service line.
3	Include the appropriate revenue code for all HCPCS code
4	HCPCS Code 36415 Venipuncture is included in the AIR.
5	Include CG Modifier as required.
6	Claim Adjustment Codes can be found at Washington Publishing Company: http://www.x12.org/codes/claim-adjustment-reason-codes

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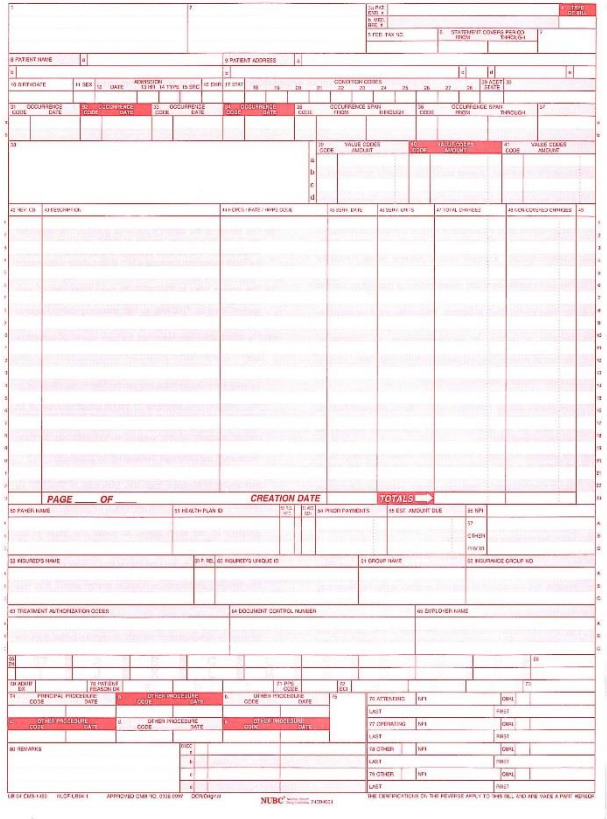
Completing the UB-04

There are 81 Form locators.
You must complete 28 and
The others are conditional and may be left blank. Don't over think it.



Completion of the CMS-1450 (UB-04)
Claim Form: [UB-04 Claim Sample]

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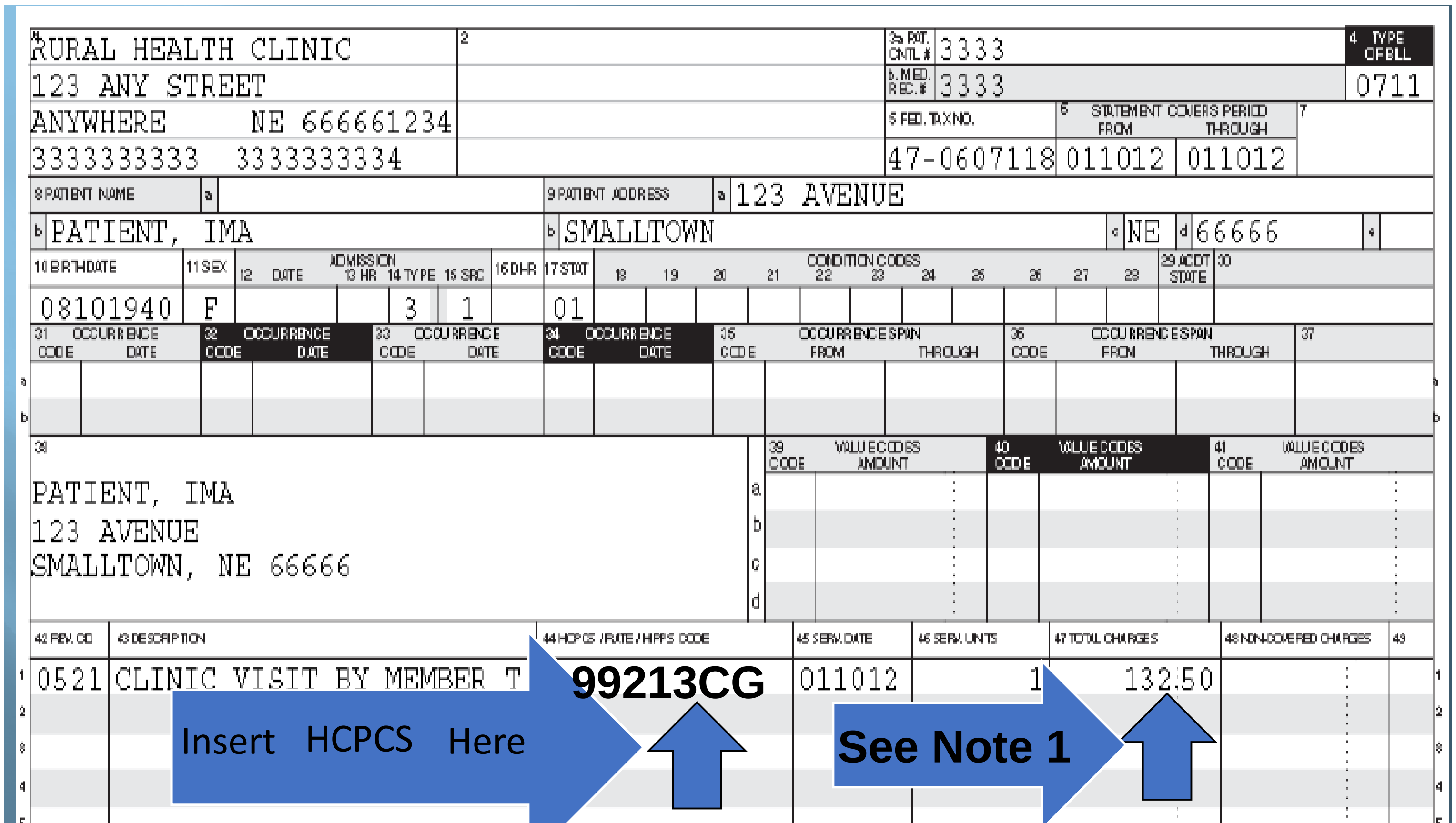
Simple example of a patient with a only a 99213


RURAL HEALTH CLINIC
123 ANY STREET
ANYWHERE NE 666661234
3333333333 3333333334

3a PAT. CNTL # 3333
b. MED. REC. # 3333
4 TYPE OF BILL 0711
5 FED. TAX NO. 47-0607118
6 STATEMENT COVERS PERIOD FROM 011012 THROUGH 011012

8 PATIENT NAME b PATIENT, IMA
9 PATIENT ADDRESS a 123 AVENUE b SMALLTOWN c NE d 66666

10 BIRTHDATE 08101940 | 11 SEX F | 14 TYPE 3 | 15 SRC 1 | 17 STAT 01

38
PATIENT, IMA
123 AVENUE
SMALLTOWN, NE 66666

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	CLINIC VISIT BY MEMBER T	99213CG	011012	1	132.50		

Note 1: Total charges for all services provided during the encounter, minus any charges for the approved preventive service"

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Direct Data Entry (DDE) Into the Fiscal Intermediary Standard System (FISS)

Direct Data Entry (DDE) is a method of claim submission with full editing, claim correction, claim status inquiry and beneficiary eligibility inquiry (HIQA) directly into/from the Fiscal Intermediary Standard System (FISS).

EDI Enrollment
Contract with a Vendor
Request DDE Access from Novitas Solutions
Reference Materials
Resetting Passwords Using CDS
EDI Enrollment

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UB-04 Fact Sheet

This Fact Sheet covers basic Information about the UB-04.
8-page PDF updated August, 2014

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

National Uniform Billing Committee (NUBC) Codes

The 837I and CMS-1450 also require the use of codes maintained by the NUBC. Examples of codes maintained by the NUBC include:

- Condition codes;
- Occurrence codes;
- Occurrence Span codes;
- Value codes; and
- Revenue codes.

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Noridian RHC Billing Guide

Noridian (an RHC MAC) has a great tool to help you with RHC Billing. The document is in table format and is extremely helpful summarizing information.

https://med.noridianmedicare.com/web/jea/provider-types/rhc/rhc-billing-guide

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Resources for Completing the UB-04

Completing the UB-04 for RHCs – Chapter 9 **Medicare Claims Processing Manual**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

All institutional claims submitted on behalf of Medicare patients must be in the CMS-1450 (UB-04) claim format.
The CMS Claims Processing Manual, Pub 100-04, Chapter 25 * contains general instructions for completing the CMS-1450 for Billing.

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Completing the UB-04

Please visit the NUBC * for data elements and codes included on the CMS-1450 and used in the 837I transaction standard.

Electronic Claim Submission

CMS requires providers to submit their claims electronically. Please see the CMS Claims Processing Manual, Pub 100-04, Chapter 24, §90 * concerning the mandatory requirement for electronic claims submission.

* National Uniform Billing Committee

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Completing the UB-04 (FL 1-3b)

Form Locator	Required?	Description	Comments
1	Y	Name of Facility Name, Street, City, Zipcode, Phone, Fax	Do not use P.O. Box Number.
2	N	Where payments are sent	
3a	Y	Patient control number	RHC Patient Account Number
3b	N	Medical Record Number	Use situationally

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Completing the UB-04 FL 4-6

Form Locator	Required?	Description	Comments
4	Y	Bill Type	Use 0711 is most cases Use 0710 for a denial Use 0717 for an adjustment Use 0718 to cancel a claim
5	Y	Federal Tax ID Number	Must agree with the 855A
6	Y	Statement from and through date	Use the date of the office visit only

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RHC Bill Types

Type	Description
0711	Admit to discharge
0717	Adjustment
0718	Cancel
0710	No payment

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Completing the UB-04 FL 7-13

Form Locator	Required?	Description	Comments
7	N	Not Used	
8	Y	Patient Name	Must agree exactly to the patient's Medicare card
9	Y	Patient Address	
10	Y	Patient Birthday	
11	Y	Patient Sex	
12	N	Admission Date	NA for Outpatient claims
13	N	Admission Hour	NA for Outpatient claims

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Completing the UB-04 FL 14-15

Form Locator	Required?	Description	Comments
14	Y	Admission Type	This is new – RHCs will most like use the following: 2 = urgent **3 = elective (most common)** 9 = information not available
15	Y	Source	Typical responses for RHCs **1= nonhealthcare point of origin (home-most common)** 5 = from ICF, SNF or ALF 9 = information not available

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5010 Requirements for RHC Billing
General Guidelines

FL 14 Type = 1 Emergency; 2 Urgent; 3 Elective; 4 newborn; 5 trauma center; 9 unavailable. *RHC typically uses 2 or 3.*

FL 15 Source = 1 non-healthcare point of origin; 5 transfer from ICF, SNF or ALF; 9 info not available. *RHC usually uses 1*.

FL 17 Status = 01 discharged to home or self-care (routine discharge); 02 discharged to hospital; 03 discharged to a SNF; 04 discharged to a facility with custodial care. *RHC typically uses 01.*

No admission date is required, only the statement covers dates.

Each claim must have FL 52 REL. INFO (release of information) and FL 53 ASG.BEN (assignment of benefits) marked. *RHC typically responds Y (yes) and Y (yes).*

Claims are paid based on the NPI # (FL 56).

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Completing the UB-04 FL 16-28

Form Locator	Required?	Description	Comments
16	N	Discharge Hour	Do not use on OP Claim
17	Y	Status (where discharged to)	Typical Responses for RHCs 01=discharge to home or self care 03=discharge to SNF 04=discharge to custodial care fac.
18-28	N	Condition Codes (rarely used with RHCs except for secondary payer, denials, and Hospice.	Typical Responses for RHCs 07=hospice patient for nonhospice DX 21=claim sent for denial purposes. See Cahaba reference guide for secondary billing codes at the end of this document

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Condition Codes UB-04 FL 16-28

Condition Codes The provider enters the corresponding code to describe any of the following conditions or events that apply to this billing period. National Uniform Billing Committee (NUBC) assigned payers only codes are not submitted by providers. Payer only codes may be viewed in the CMS IOM Publication 100-4, Chapter 1; Section 190 – Payer Only Codes Utilized by Medicare at:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

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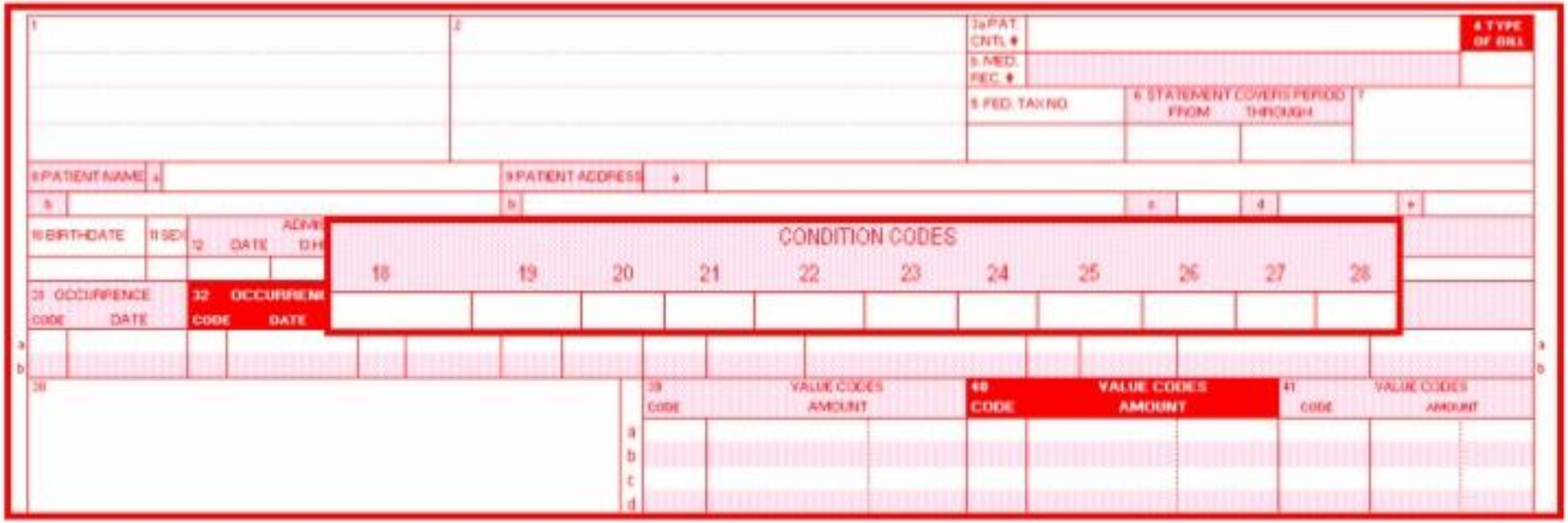
Form Locators 18–28

Condition Codes



Condition Code Examples

Code	Description
02	Condition is employment-related
07	Treatment of non-terminal condition for hospice
08	Beneficiary would not provide information concerning other coverage
20	Beneficiary requested billing
21	Billing for denial notice

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Completing the UB-04 FL 29-36

Form Locator	Required?	Description	Comments
29	N	Accident state	Not used
30	N	Not used	
31-34	N	Occurrence Code & Date	Situational but normally not used unless related to MSP
35-36	N	Occurrence Span Codes	Typically not used in RHCs

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Occurrence Codes – Used in MSP Something happens for a period of time

Description 01 Accident/Medical Coverage - Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury
02 No-Fault Insurance Involved-including auto accident/other - Date of an accident, including auto or other, where State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).

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Occurrence Span and Value Codes

Occurrence Span codes – The condition or occurrence is only for a period of time. These are the dates the code is appropriate.

Value Codes When reporting numeric values that do not represent dollars and cents, put whole numbers to the left of the dollar/cents delimiter and tenths to the right of the delimiter. (how much did the primary pay)

Occurrence Code Examples

Accident/Medical Codes:

- 01 - Accident/Medical Coverage
- 02 - No-Fault Insurance Involved – Including Auto Accident/Other
- 03 - Accident/Tort Liability
- 04 - Accident - Employment Related
- 05 - Accident/No Medical or Liability Coverage
- 06 - Crime Victim

Medical Condition Codes:

- 09 - Start of Infertility Treatment Cycle
- 10 - Last Menstrual Period
- 11 - Onset of Symptoms/Illness

(Extracted from CMS Manual https://www.cms.gov/transmittals/downloads)

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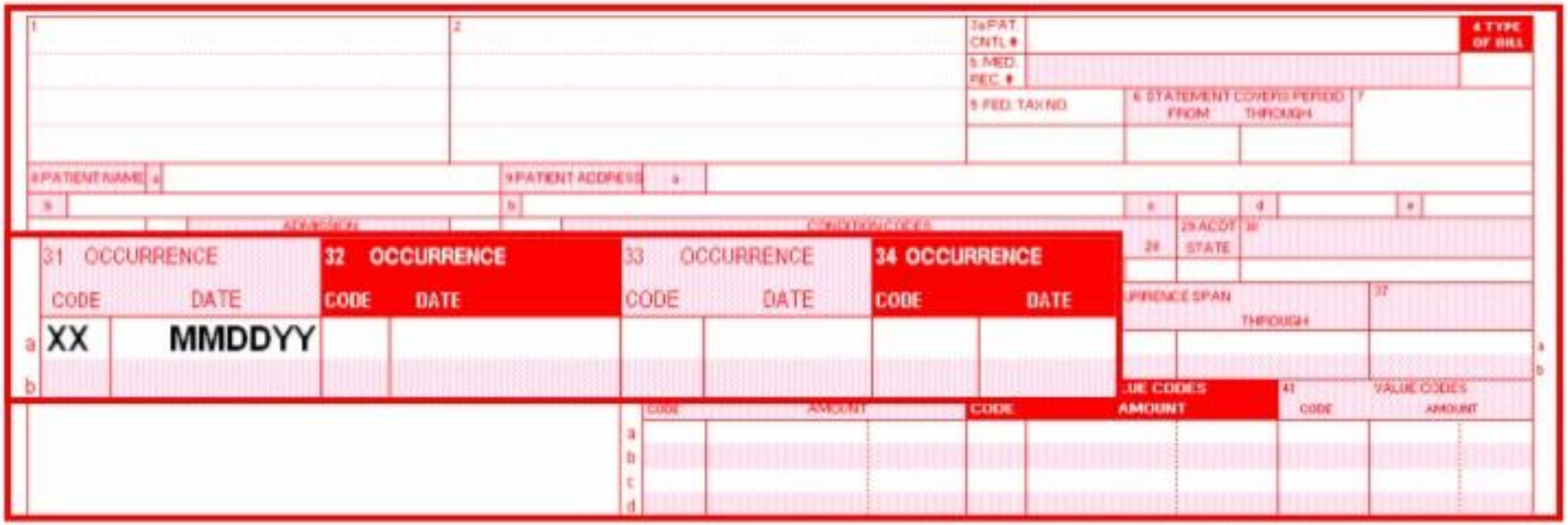
Form Locators 31–34

Occurrence Codes and Dates



Value Codes and Amounts

Value Codes

01 - Most Common Semiprivate Room Rate
02 - Hospital Has No Semiprivate Rooms
03 - Reserved for National Assignment
04 - Inpatient Professional Component Charges That Are Combined Billed
05 - Professional Component Included in Charges and Also Billed Separately to Carrier
06 - Medicare Blood Deductible
07 - Reserved for National Assignment
08 - Medicare Lifetime Reserve Amount in the First Calendar Year
09 - Medicare Coinsurance Reserve Amount in the First Calendar Year
10 - Medicare Lifetime Reserve Amount in the Second Calendar Year
11 - Medicare Coinsurance Reserve Amount in the Second Calendar Year
12 - Working Aged Beneficiary/Spouse with EGHP
13 - ESRD Beneficiary in the Medicare Coordination Period with an EGHP

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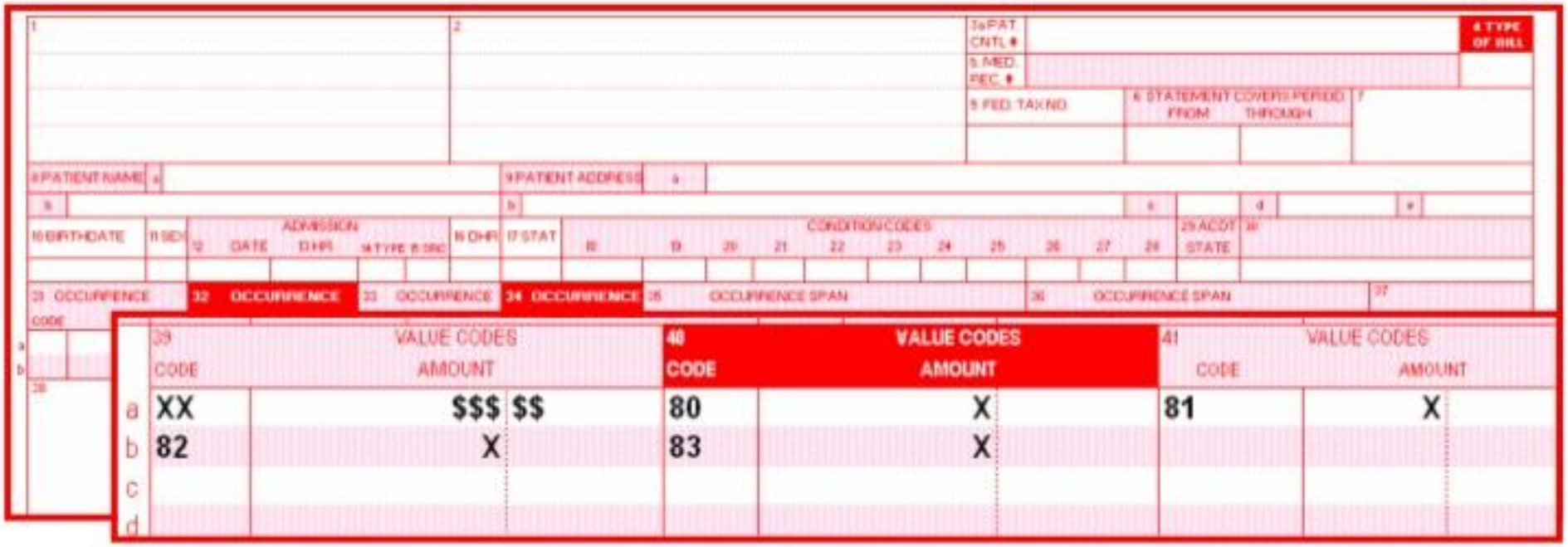
Form Locators 39–41

Value Codes and Amounts



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Completing the UB-04 FL 42

Form Locator	Required?	Description	Comments
42	Y	Revenue Code	0521 = office visit, Preventive 0522 = home, 0524 = SNF or SW paid by Part A 0525 = Nursing Home visit, 0900 =Behavioral health, 0780 = Telehealth site fee, 001 = Total charges at bottom

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RHC Revenue Codes FL- 42

Code	Description
0521	Clinic visit by member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at the Skilled Nursing Facility (SNF)
0525	Visit by RHC practitioner to a member in a SNF (not in a covered Part A stay) or Nursing Facility (NF) or Intermediate Care Facility for Mental Retardation (ICF MR) or other residential facility
0780	Telemedicine origination
0900	Behavioral Health

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Revenue Codes for Ancillary Services

Revenue Code	Revenue Center
0300	Laboratory
0320	Radiology
0636	Injections - Serums
0730	EKG

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Completing the UB-04 FL 43-46

Form Locator	Required?	Description	Comments
43	N	Description	Most systems default to a description of "clinic visit"
44	Y	HCPCS/Rate/HIPPS Code	HCPCS codes are required for RHC claims effective 4/1/2016.
45	Y	Service Date	Will be the same as the from an through date in FL 6
46	Y	Service Units	Will be a unit of 1 regardless of number of services performed,

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Completing the UB-04 FL 47-49

Form Locator	Required?	Description	Comments
47	Y	Total Charges	All services performed that day to include office visit, procedures, additional supplies, injections, and drugs that are bundled into the first line minus co-payments.
48	N	NonCovered Charges	Rarely used unless sending for a denial.
49	N	Not Used	

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Completing the UB-04 FL 50-52

Form Locator	Required?	Description	Comments
50	Y	Payer Name	Typically, Medicare, CahabaGBA, WPS, etc.
51	Y	Health Plan ID	National Health Plan Identifier or the number Medicare has assigned
52	Y	Release of Information	Usually "Y" – Yes, patient signed statement for data release, could be "I" – Informed consent to release data regulated by statue.

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Completing the UB-04 FL 53-56

Form Locator	Required?	Description	Comments
53	Y	Assignment of Benefits	"Y" – Payment to provider is authorized "N" – Payment to provider is not authorized
54	N	Prior Payments	Left Blank for RHC claim
55	N	Est. Amount Due from Patient	
56	Y	NPI of Billing Provider	RHC NPI Number

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Completing the UB-04 FL 57-60

Form Locator	Required?	Description	Comments
57	N	Provider ID of Second and Third Payers	If you want the claim to crossover to Medicaid or secondary payers, this must be completed.
58	Y	Insured's Name	
59	Y	Patient Relationship to Insured	Typically 18 (self)
60	Y	Insured's Unique Identification	

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Completing the UB-04 FL 50-52

Form Locator	Required?	Description	Comments
61	N	Insured Group Name	
62	N	Insurance Group Number	
63	N	Treatment Authorization Code	May be required for HMO or PPO claims when preauthorization is required
64	N	Document Control Number	Required for any adjustment or cancel claims, Condition Code, D0 – D9, most used in RHC . D1 = change to charges; D5 cancel to correct HICN (Medicare number); D9 = any other change

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Completing the UB-04 FL 65-68

Form Locator	Required?	Description	Comments
65	N	Employer Name	
66	N	Diagnosis and Procedure Code Qualifier	The qualifier that denotes the version of International Classification of Diseases (ICD) reported.
67	Y	Principal Diagnosis Code and Present on Admission Indicator (ICD-9-CM code)	Some V-codes are appropriate as primary codes; list as many as provider addressed and also those that were considered in the treatment of the patient
68	N	Not Used	

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Completing the UB-04 FL 69-75

Form Locator	Required?	Description	Comments
69	N	Admission Diagnosis	Not required for outpatient claims
70	N	Patient Reason Diagnosis	Not required for RHCs
71-73	N	Not Used	
74	N	Principal Procedure Codes and Dates	Not used in RHCs
75	N	Not Used	

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5010 Requirements for RHC Billing
General Guidelines (2)

FL 70 Patient reason for visit – diagnosis code

The taxonomy code for the RHC listed in FL 81CC is code B3 (in first small box) 261QR1300X (matches 855A).

The Name of the Facility with the correct 9 digit zip code, the Tax ID, the NPI and the taxonomy code MUST match exactly or it will error out and not pass edits.

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Completing the UB-04 FL 76-80

Form Locator	Required?	Description	Comments
76	Y	Attending Provider NPI, Last Name, First Name	May also have another Qualifier number in "Qual": could include State license number, 1G = Provider UPIN, G2 = Provider Commercial Number
77-79	N	Other Providers	Not used with RHC claim
80	N	Remarks	Use only if need additional information to the payer. Must have a remark if claim is adjusted, canceled, or two visits on the same day.

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Completing the UB-04 FL 81CC

Form Locator	Required?	Description	Comments
81CCa	N	Code-Code Field	This will show if there is a marital status for the patient, ie B2 for single. This is not required.
81CCb	Y	Code-Code Field	This is the Taxonomy code for the facility. RHC = B3 (noting taxonomy code) 261QR1300X (taxonomy code)

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Chapter 9 Section 80 - Telehealth Services

RHCs may bill the Telehealth originating site facility fee on a RHC claim under revenue code 0780 and HCPCS code Q3014.. RHCs are not authorized to serve as distant practitioners for Telehealth services.

For more information on Telehealth services please see Pub 100-04, chapter 12, section 190: http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c12.pdf

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Care Management Services in RHCs

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Q1. What are care management services?

A1. Care management services in RHCs and FQHCs include the following services:

- Transitional care management (TCM)
- Chronic care management (CCM)
- General behavioral health integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)

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Transition Care Management in RHCs

TCM: For TCM services furnished on or after January 1, 2013, TCM services are billed by adding CPT code 99495 (14 day discharge, moderate complexity) or CPT code 99496 (7 day discharge, high complexity) to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit is paid.

2018 payment (CPT code 99495 or 99496) - Same as payment for an RHC or FQHC visit

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CCM Services in RHCs in 2018
G0511 Pays $62.28

For CCM services furnished on or after January 1, 2018, CCM services are billed by adding the general care management HCPCS code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

2018 payment (HCPCS code G0511) – $62.28

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G0512 Psyhiatric CoCM pays $145.08

Psychiatric CoCM: For psychiatric CoCM services furnished on or after January 1, 2018, psychiatric CoCM services can be billed by adding the psychiatric CoCM G code, G0512, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services).

2018 payment (HCPCS code G0512) – $145.08

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Q13. Do coinsurance and deductibles apply to care management services?

A13. Coinsurance and deductibles apply to all care management services in RHCs, and coinsurance applies to all care management services in FQHCs.

Q14. If a patient cannot afford the copayment but would benefit from this service, can the copayment be waived?

A14. The coinsurance for care management services cannot be waived, however, many RHCs and FQHCs offer financial assistance for patients who qualify.

Q15. How is coinsurance determined for care management services?

A15. Coinsurance is 20% of submitted charges.

Q16. Are care management services required to be billed on a claim with an RHC or FQHC visit?

A16. Care management services can be billed either alone or on a claim with an RHC or FQHC billable visit.

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Q23. What revenue code should be used for care management services?

A23. Care management services should be reported with revenue code 052x.

Q24. Can care management costs such as software or management oversight be included on the cost report?

A24. Yes. Any cost incurred as a result of the provision of RHC and FQHC services, including care management, is a reportable cost and must be included in the Medicare cost report. These costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

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Experienced Knowledge

Questions, Thank You

H B S

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