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Independent RHC Billing – Introduction

Session 3

December 6, 2018

HBS

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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Disclaimer

1. **Information is current as of 12/6/2018.**
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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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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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.

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)
- RHC Billing Webinar Session 4 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
- RHC Billing Recording of Webinar Session 4

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 issued January, 2018 (8-page PDF)
- 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)

Healthcare Business Specialists RHC Billing Policies

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

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

- Palmetto JJ Contract Handout for Part A on November 9, 2017

Chronic Care Management Information: Below are links to information presented August 1st, 2017 on the new CCM guidelines for RHCs effective January 1, 2018 by CMS:

- Chronic Care Management Med-Learn Matters MM1075 (7-page PDF)
- Presentation [PDF, 364KB]
- Transcript [PDF, 195KB]
- Audio Recording [ZIP, 18MB]

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https://med.noridianmedicare.com/web/jfa/provider-

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Healthcare Solutions

Jurisdiction F - Part A
Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

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JF Part A / Browse by Provider Type / Rural Health Clinic (RHC)

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Vulnerability

BROWSE BY PROVIDER TYPE

- Acute Inpatient Prospective Payment System (PPS) Hospital
- Ambulance
- Critical Access Hospital (CAH)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- End Stage Renal Disease (ESRD)
- Federally Qualified Health Center (FQHC)
- Inpatient Psychiatric Facility (IPF)
- Inpatient Rehabilitation Facility (IRF)
- Laboratory
- Locum Tenens and Reciprocal Billing
- Long Term Care Hospital (LTCH)
- Mental Health
- Nonphysician Practitioner (NPP)
- Outpatient Prospective Payment System (OPPS)
- Outpatient Therapy
- Provider Based Facilities
- **Rural Health Clinic (RHC)**
- Skilled Nursing Facility (SNF)
- Sleep Medicine

Educational Resources

CG Modifier: RHC Reporting

Rural Health Clinic (RHC)

RHC visits are medically necessary face-to-face encounters between the patient and a physician, NP, PA, CNM, CP, or CSW during which a RHC service is furnished. In certain limited situations, RHC visits may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient.

Access the below RHC related information from this page.

- Nonphysician Practitioners
- RHC Billing Guide
- RHC Care Management Services
- RHC Venipuncture Policy
- RHC Visiting Nurse Services

Resources

- CMS Care Management
- CMS Medicare Learning Network (MLN) Matters Special Edition (SE)1611 - RHC HCPCS Reporting Requirement and Billing Updates
- CMS Rural Health Clinic (RHC) Center

Last Updated May 21, 2018

Related Articles

The below are topic specific articles which have been published to "Latest Updates" and sent out in Noridian emails within the past two years. Exclusions to this include time sensitive related announcements such as: Noridian and CMS educational events, Ask-the-Contractor Teleconferences and claims processing downtime.

Handling of Claims Inappropriately Assigned Reason Code 32404		Feb 20, 2018
RHC and FQHC Medicare Benefit Policy Manual Chapter 13 Update - Revised	CR10350	Jan 11, 2018
Care Coordination Services and Payment for RHCs and FQHCs - Revised	CR10175	Nov 14, 2017
RHC AIR Payment Limit Update for CY 2018	CR10333	Nov 14, 2017
Rural Health Clinics (RHC) Billing Update		May 15, 2017
FQHC and RHC Educational Resources Updated		Jan 12, 2017

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Its All about that Visit (QVL)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

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Visits - The RHC Qualifying Visit List (QVL)

The RHC Qualifying Visit List for a list of HCPCS codes that are defined as qualifying visits, which corresponds with the following guidance on service level information. CMS will no longer update this list. It is more of a guideline as to what is payable as a visit.

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Goodbye QVL – We hardly knew you.

On October 1, 2016 – CMS replaced the QVL listing with the CG Modifier.

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Multiple Visits on One Day

- In general, encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day count as a single RHC visit and will only receive one AIR payment.
- "This applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit."
  - **Resource:** CMS IOM 100-02, Chapter 13, Section 40.3
- However, there are a few ***specific*** exceptions…

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Multiple Visits on the Same Day – Exceptions

- Exceptions are for the following circumstances ***only***:

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC). In this situation only, the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits.

The patient has a qualified medical visit and a qualified mental health visit on the same day (2 billable visits).

The patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits).

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RHC CG Modifier – 10/1/2016

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MLN 9269 – What You Need to Know

Effective April 1, 2016, All RHCs are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes.

Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met.

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Description	Links
Last Version of SE1611 on Billing using QVL and CG Modifier Effective 10/1/2016	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf
FAQs for the CG Modifier	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf

Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

Sections

Click a section title to jump ahead

Reporting Modifier CG

Q1. When should modifier CG be reported?

A1. RHCs should report modifier CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit. This line should have the bundled charges for all services that are subject to coinsurance and the deductible (e.g., charges for all services furnished during the visit minus the charges for preventive services for which the coinsurance and/or deductible are waived).

If only preventive services are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the medically necessary face-to-face visit and the bundled charges.

Q2. Should claims for dates of service on or after April 1, 2016 be billed with modifier CG?

A2. Yes. These claims should follow the reporting requirements for modifier CG. Claims that have already been paid do not need to be resubmitted with modifier CG.

Q3. Is modifier CG used to report the line subject to coinsurance and deductible?

A3. Not necessarily. Coinsurance and deductible will be applied to the line reported with modifier CG as applicable. However, coinsurance and deductible will not be applied when modifier CG is reported with approved preventive services paid at 100 percent.

Q4. Should modifier CG be reported if there is only one service furnished as part of the billable visit?

A4. Yes. Modifier CG should be reported with the medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit.

Reporting Modifier CG with Preventive Services

Q5. Should modifier CG be reported if only preventive services are furnished during the visit?

A5. Yes. If only preventive services for which the coinsurance and/or deductible are waived are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the visit and the bundled charges.

Q6. If a medical service and a preventive service are furnished on the same day, should modifier CG be reported with both services?

A6. No. Modifier CG should be reported only with the medical service HCPCS code that represents the primary reason for the medically necessary face-to-face visit when medical and preventive services are furnished on the same day.

Q7. Is modifier CG reported with the initial preventive physical examination (IPPE) when it is billed alone or with other billable services on a claim?

A7. No. Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service.

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CG Modifier FAQ Summary

FAQ #	Question	CG Modifier
Q1	Use when bundling charges, the primary reason for the face-to-face encounter	Yes
Q2	Use for dates of service on or after April 1, 2016	Yes
Q3	Use to report the line subject to coinsurance and deductible	Not Necessarily
Q4	Use when only one service is provided	Yes
Q5	Use when preventive service only	Yes
Q6	Use when a medical service and preventive service is furnished on the same day	No

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CG Modifier FAQ Summary (2)

FAQ #	Question	CG Modifier
Q7	Use for IPPE	No
Q8	How often should CG modifier be used?	1 - 052x 1 - 0900
Q9	Use when medical service and mental health service are furnished	Yes, 2 CGs (see Q8)
Q10	Use for Chronic Care Management services	No
Q11	Use for medically-necessary visits in Skilled Nursing Facility	Yes

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FAQ #	Question	CG Modifier
Q12	Is there still a QVL?	Yes, sorta – it is a guide
Q13	Is CG used for two E and Ms on the same day for different diagnosis?	No – use 59 on the 2nd visit.
Q14	Do you put the CG and the 59 (or 25) on the same line. IE 99213CG59	NO, just 59 (see Q13)
Q15	Do you use modifier 59 or 25 for bundled services with the subsequent visit?	No
Q16	Should RHCs continue to bundle services using the April 1, 2016 guidelines	Yes

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FAQ #	Question	CG Modifier
Q17	Should RHCs report the CG Modifier with incident to services	No
Q18	Can RHCs continue to bill incident to (the 30 day rule?	Yes
Q19	What Revenue Codes are valid?	All are valid except a list provided.
Q20	Does the order of claim lines matter?	No
Q21	Do MSP claims use the CG Modifier?	Yes

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FAQ #	Question	CG Modifier
Q22	Will secondary payers accept the CG modifier?	Hopefully
Q23	Should RHCs use more than one UB-04?	No
Q24	Does Medicare use total charges to compute co-pays?	No.
Q25	Does this affect Part B – technical comps.	No
Q26	Does the affect flu and pnu?	No

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FAQ #	Question	CG Modifier
Q27	Does CG affect lab billing?	No.
Q28	How will the EOB appear to the patient?	Some may look like the claim was inflated.
Q29	How to get additional information?	https://www.cms.gov/center/provider-type/rural-health-clinics-center.html

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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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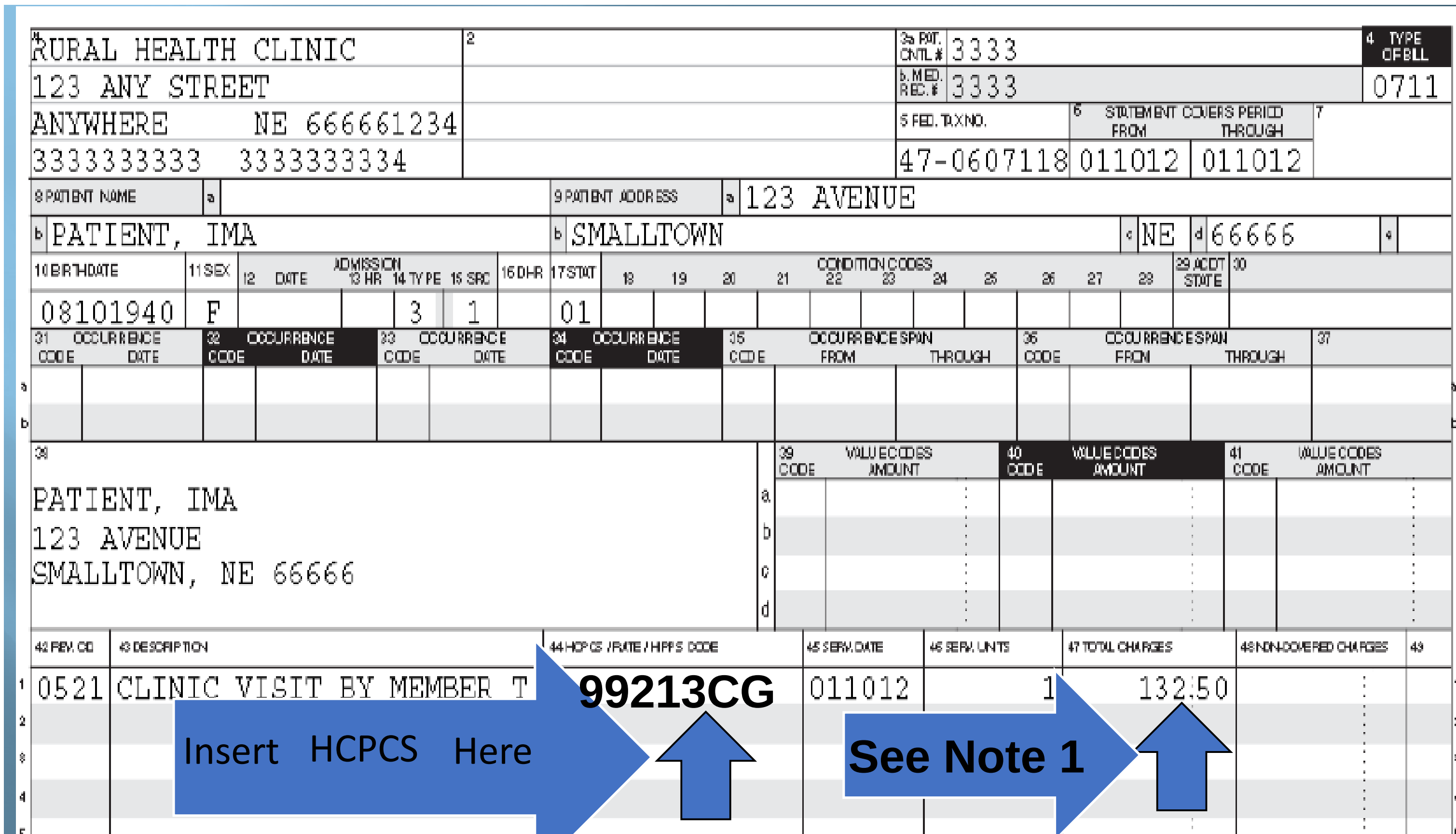
Simple example of a patient with a only a 99213



1 RURAL HEALTH CLINIC
123 ANY STREET
ANYWHERE NE 666661234
3333333333 3333333334

2

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
7

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

10 BIRTHDATE 08101940
11 SEX F
ADMISSION 12 DATE 13 HR 14 TYPE 3 15 SRC 1
16 DHR
17 STAT 01
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38
PATIENT, IMA
123 AVENUE
SMALLTOWN, NE 66666

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

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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RHC Encounter – E/M Office Visit Only

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/25/2018	1	$100.00
0001	Total Charge				$100.00

- **Coinsurance = 20% of $100.00**
- **Coinsurance is $20.00**

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Incident To Services (within 30 days of E & M) (Allergy Shots, B-12s, Venipuncture)

Medical Services and Incident to Services

Services and supplies furnished incident to a RHC visit are considered RHC services. They are included in the payment of a qualifying visit and are not separately billable. The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. Payment for these service lines is included in the AIR and the service lines will receive CARC 97 for the covered lines not receiving the AIR payment on RHC claims.

Example 6:

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016[2]	1	$XX.XX[3]	AIR	Yes
0300	36415	04/01/2016[2]	1	$XX.XX[3]	Included in the AIR	No

[1]HCPCS code from the RHC Qualifying Visit List
[2]Any date of service on or after 04/01/2016
[3]Enter charge amount

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Incident To Services Example (99213 charge is $100)

42 Rev Code	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Payment	Coinsurance/ Deductible Applied
0521	99213CG	04/01/2018	1	$120.00	All-inclusive rate (AIR)	Yes
0300	36415	04/01/2018	1	$20.00	Included in AIR	No

Description	**Amount**
An independent RHC at the cost cap would receive from Medicare	$64.52
A co-pay on the E & M visit could be collected of:	$24.00
Total Collections would be:	$88.52

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Bundling Under April 1, 2016 HCPCS Coding Guidelines

The visit is coded as a 99214. Patient receives ancillary services which could occur on the same day of the visit or within 30 days of the visit. (incident to).

CPT Code	Service	Charge RHC	Reported RHC
CPT 99214CG	Established Visit – (1) Copays computed on this line	150	210
CPT 96372	Injection Code	40	40
CPT 36415	Venipuncture	10	10
CPT J3301	Triaminolone acet..	10	10
Totals		210	270

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Bundling using .01 for the Ancillary Services

The clinic may elect to only show .01 as the charge for the ancillary services if it chooses. Depending on the billing and software that you use. Either way is approved by CMS.

		Charge	Reported
CPT Code	Service	RHC	RHC
CPT 99214CG	Established Visit – (1) Copays computed on this line	150	210
CPT 96372	Injection Code	40	0.01
CPT 36415	Venipuncture	10	0.01
CPT J3301	Triaminolone acetonide	10	0.01
Totals		210	210.03

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RHC Encounter – E/M Office Visit and Injection

- Scenario: RHC Provider completed a level-4 E/M office visit and a gave the patient a Rocephin injection. Charge for the E/M visit is $150.00, for the administration is $12.00 and for the drug is $45.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/25/2018	1	$207.00
0521	Inj Admin	96372	10/25/2018	1	$12.00
0636	Rocephin, 250 mg	J0696	10/25/2018	1	$45.00
0001	Total Charge				$264.00

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RHC Encounter – E/M Office Visit and EKG

- Scenario: RHC Provider completed a level-3 E/M office visit. While in the office, the provider also did an EKG. Charge for the E/M visit is $100.00, and for the professional fee for the EKG is $25.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/25/2018	1	$125.00
0521	EKG, interpretation and report	93010	10/25/2018	1	$25.00
0001	Total Charge				$150.00

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Why is this so hard

Medicare is trying to patch
The software by using most
Of the old programming which
Bundled everything in Line 1
Of the UB-04.

CMS Programming the changes

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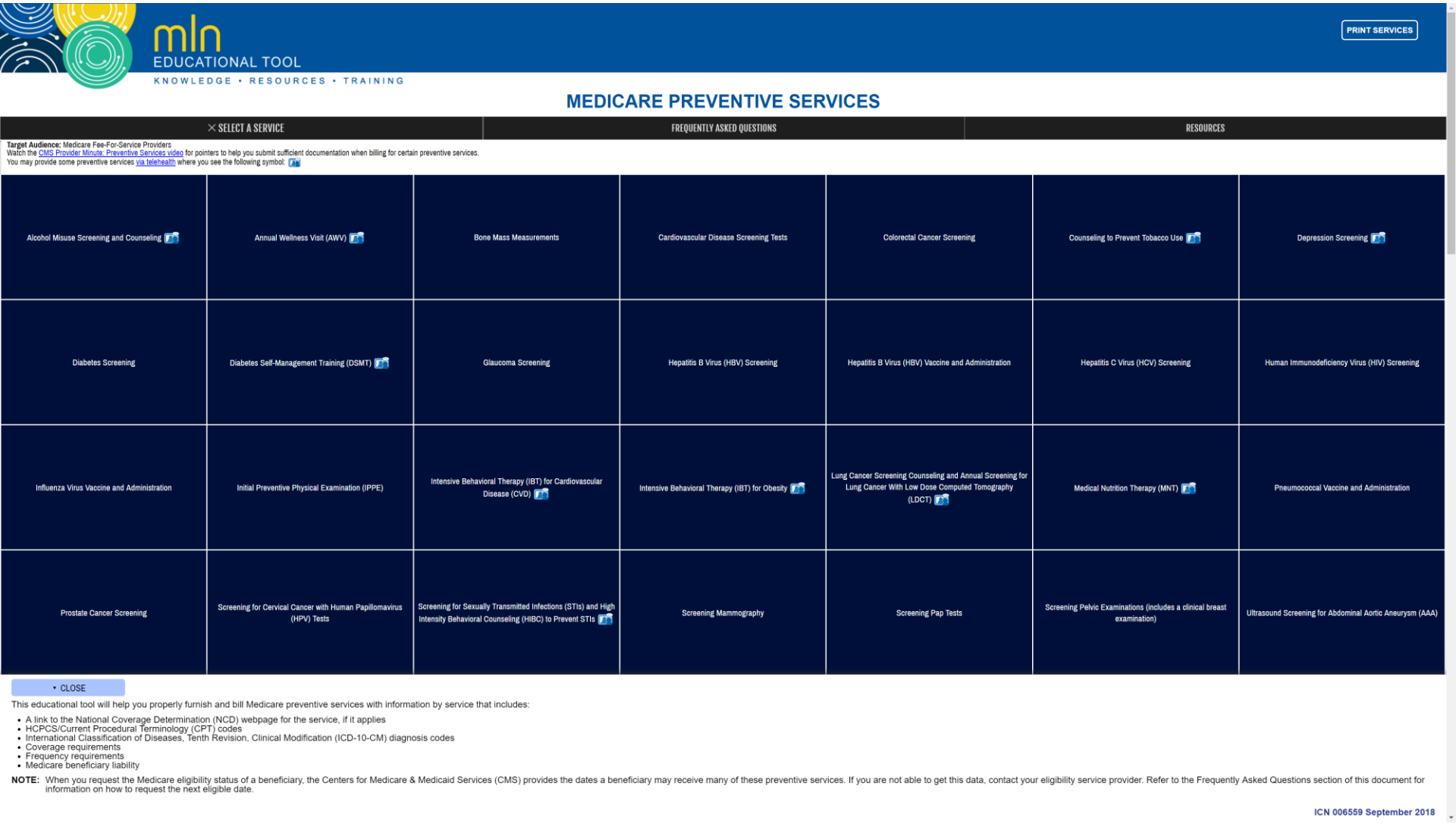
Preventive Services

The Most Profitable Patient in the World?



https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

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Intensive Behavioral Therapy (IBT) for Obesity (NCD 210.12)

PRINT THIS SERVICE

HCPCS/CPT Codes

G0447 – Face-to-face behavioral counseling for obesity, 15 minutes
G0473 – Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes

What's Changed?
- No 2018 fourth quarter changes

ICD-10 Codes

Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, or Z68.45

NOTE: Additional ICD-10 codes may apply. See the CMS ICD-10 webpage for individual Change Requests (CRs) and the specific ICD-10-CM codes Medicare covers for this service, and contact your Medicare Administrative Contractor (MAC) for guidance.

Who Is Covered

Medicare beneficiaries when all of the following are true:
- Obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared)
- Competent and alert at the time counseling is provided
- Counseling furnished by a qualified primary care physician or other primary care practitioner in a primary care setting

Frequency

Medicare will pay for up to 22 visits billed with the codes G0447 and G0473, combined, in a 12-month period:
- First month: one face-to-face visit every week
- Months 2–6: one face-to-face visit every other week
- Months 7–12: one face-to-face visit every month if certain requirements are met

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Other Notes

- At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed.
- To be eligible for additional face-to-face visits occurring once a month for months 7–12, Medicare beneficiaries must have lost at least 3 kg during the first 6 months.
- For Medicare beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

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Preventive Health Services

- When billing for preventive health services, DO NOT include charges for those services in the "roll up" to the qualifying visit line
- Medicare pays for qualifying preventive health services at 100%
- Coinsurance and deductible do not apply for qualifying preventive health services.
- **Resource:** United States Preventive Services Task Force (Grade A or B)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

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Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
AWV	G0438	Ppps, initial visit	Yes	No	Waived	Ch. 18 §140
	G0439	Ppps, subseq visit	Yes	No	Waived	
Screening Pelvic Exam	G0101	Ca screen; pelvic/breast exam	Yes	No	Waived	Ch. 18 §40
Prostate Cancer Screening	G0102	Prostate ca screening; dre	Yes	No	Not Waived	Ch. 18 §50
Glaucoma Screening	G0117	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	Ch. 18 §70
	G0118	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	
Screening Pap Test	Q0091	Obtaining screen pap smear	Yes	No	Waived	Ch. 18 §30
Alcohol Screening and Behavioral Counseling	G0442	Annual alcohol screen 15 min	Yes	No	Waived	Ch. 18 §180
	G0443	Brief alcohol misuse counsel	Yes	No	Waived	
Screening for Depression	G0444	Depression screen annual	Yes	No	Waived	Ch. 18 §190

Rural Health Clinic (RHC) Preventive Services Chart

(Rev. 08-10-16)

RHCs are paid an all-inclusive rate (AIR) for qualified primary and preventive health services. Except for the initial preventive physical examination (IPPE), all preventive services furnished on the same day as another medical visit constitute a single billable visit. If an IPPE visit occurs on the same day as another billable visit, two visits may be billed. All of the preventive services listed below may be billed as a stand-alone visit if no other service is furnished on the same day. The beneficiary copayment and deductible is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force with a grade or A or B.

Additional information on RHC policy for preventive services is available in the Medicare Benefit Policy Manual, Chapter 13 (http://go.cms.gov/14BSdPN). Additional information on payment and claims processing for RHC preventive services is available in the Medicare Claims Processing Manual, Chapter 9 (http://go.cms.gov/1DFvBcO), and Chapter 18 (http://go.cms.gov/1w5l6cX). The table below lists preventive services with their associated HCPCS (Healthcare Common Procedure Coding System) code and descriptor, whether they are eligible to be paid based on the RHC's AIR when billed without another covered visit, which preventive services can be billed separately when another visit is billed on the same day, and which preventive services have the co-insurance and deductible waived.

Table 1: RHC Preventive Services

Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
IPPE	G0402	Initial preventive exam	Yes	Yes	Waived	Ch. 9 §150 Ch. 18 §80

Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling	G0445	High inten beh couns std 30m	Yes	No	Waived	Ch. 18 §170
Intensive Behavioral Therapy for Cardiovascular Disease	G0446	Intens behave ther cardio dx	Yes	No	Waived	Ch. 18 §160
Intensive Behavioral Therapy for Obesity	G0447	Behavior counsel obesity 15m	Yes	No	Waived	Ch.18 §200
Smoking and Tobacco Cessation Counseling	*99406*[1]	*Behav chng smoking 3-10 min*	Yes	No	Waived	Ch. 18 §150
	99407[1]	*Behav chng smoking > 10 min*	Yes	No	Waived	
Lung Cancer Screening With Low Dose Computed Tomography	G0296	Visit to determ LDCT elig	Yes	No	Waived	Ch. 18 §220

[1] HCPCS code G0436 and G0437 will be discontinued effective 10/1/2016. CPT codes 99406 and 99407 are the remaining codes for tobacco cessation counseling.

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Hepatitis B Vaccine

Hepatitis B Vaccine (G0010)

- Not separately billable. Vaccine and administration can be included in line item for otherwise qualifying visit
- Coinsurance and deductible applies and will be based on the charges reported on the revenue code 052x and/or 0900 service line with modifier CG.

- Hepatitis B vaccine and its administration is included in RHC visit

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TransactRx

Generally, Medicare prescription drug plans (Part D) cover all commercially-available vaccines (like the shingles shot) needed to prevent illness. Except for vaccines covered under Medicare Part B, Medicare Part D plans cover all commercially available vaccines as long as the vaccine is reasonable and necessary to prevent illness.

https://www.transactrx.com/medicare-part-d-billing?fbclid=IwAR1rGBrksHSzJX_zpEQzm71twtySRG8cDwzokVPSd3fSmNTodd7X3k86Dq8

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Payment Comparison of Typical CCM Services

CPT	Description	FFS	Ind RHC	Prov RHC
99495	**TCM- 14 Days**	**156.27**	**65.75***	**128.85***
99496	**TCM – 7 days**	221.27	65.75*	128.85*
G0402	**IPPE (No Co-pay/Ded)**	159.73	83.45	164.36
G0438	**AWE – Initial (No Co-pay/Ded)**	164.46	83.45	164.36
G0439	**AWE – Subsequent (No Co-pay/Ded)**	111.36	83.45	164.36

*** Plus 20% of charges**

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Example of an E & M and a Preventive Visit

Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE.

Example 2:

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016[2]	1	$XX.XX[3]	AIR	Yes
052X	G0101	04/01/2016[2]	1	$XX.XX[3]	Included in the AIR	No

[1]HCPCS code from the RHC Qualifying Visit List
[2]Any date of service on or after 04/01/2016
[3]Enter charge amount

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An E & M Code & a Preventive Visit

42 Rev Code	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Payment	Coinsurance/ Deductible Applied
0521	99213CG	04/01/2016	1	$100.00	All-inclusive rate (AIR)	Yes
0521	G0101	04/01/2016	1	$125.00	Included in AIR	No

Description	**Amount**
An independent RHC at the cost cap would receive from Medicare	$64.52
A co-pay on the E & M visit could be collected of:	$20
A co-pay for the G0101 should be paid on the Cost Report of:	$25

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Two AIRs would be paid in this example

RHC Encounter – E/M Office Visit and Preventive

- Scenario: RHC Provider completed a level-4 E/M office visit. While in the office, the provider completed the patient's IPPE. Charge for the E/M visit is $150.00, and for the IPPE is $195.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	10/25/2018	1	$150.00
0521	IPPE	G0402	10/25/2018	1	$195.00
0001	Total Charge				$345.00

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Preventive Visit Only

Preventive Services

When a preventive health service is the only qualifying visit reported for the encounter, the payment and applicable coinsurance and/or deductible will be based upon the associated charges for this service line. Frequency edits will apply.

Example 3:

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied
052X	G0101	04/01/2016[1]	1	$XX.XX[2]	AIR	No[3]

[1]Any date of service on or after 04/01/2016
[2]Enter charge amount
[3]Coinsurance and deductible are waived when appropriate

The RHC will receive the full AIR minus sequestration.

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Preventive Visit Only

42 Rev Code	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Payment	Coinsurance/ Deductible Applied
0521	G0101CG	04/01/2018	1	$125.00	Included in AIR	No

Description	Amount
An independent RHC at the cost cap would receive from Medicare 83.45 (2018 UPL) – $1.67 (2% sequestration)	$81.78

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RHC Encounter – Mental Health Visit Only

- Scenario: RHC Provider completed psychiatric diagnostic evaluation with a patient. Charge for the visit is $200.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psychiatric diagnostic evaluation	90791 CG	10/25/2018	1	$200.00
0001	Total Charge				$200.00

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RHC Encounter – Procedure Only

- Scenario: RHC Provider completed a simple I&D in the office. Charge for the visit is $150.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	I&D Abscess	10160 CG	10/25/2018	1	$150.00
0001	Total Charge				$150.00

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Modifier 59 is Defined

Use when you have two separately identifiable E & M codes when a patient is treated on the same day for unrelated diagnosis. (ie. Hypertension in the morning and a fall in the afternoon)

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

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Modifier 59 – MLN - 9269

Modifier 59 is used when you have two qualified visits that occur on the same day. Both have revenue code 0521

Two (2) E and Ms use 59
One (1) E and M and one preventive – do not use
One (1) E and M and mental health - do not use

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Modifiers for RHCs (Red - do not place on UB-04)

Modifier	Description
25	Two E & Ms or an office visit and a procedure on one day and 1 AIR paid.
54	Procedure only to be paid. No global payment requested.
59	Two E and M visits on the same day and two AIRs are expected. 99213 9921459

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Definition of Modifier 25

Modifier 25 (significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service)

It is basically two E and M codes on the same
Day or an E and M code and a preventive

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Why is Modifier 25 important

1. **If you are only paid one visit from Medicare, but report two E & M codes, your cost report preparer is going to pick up both E & M codes unless your CPT frequency report identifies one of them with a Modifier 25.**
2. **This will cause you to over count your total visits and lower your cost per visit.**

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Modifier 25 – Use it - Don't Abuse it

- The E/M service must be significant. The problem must warrant physician work that is medically necessary. This can be defined as a problem that requires treatment with a prescription or a problem that would require the patient or family to return for another visit to address it. A minor problem or concern would not warrant the billing of an E/M- The E/M service must be separate. The problem must be distinct from the other E/M service provided (eg, preventive medicine) or the procedure being completed. Separate documentation for the E/M-25 problem is helpful in supporting the use of modifier 25 and especially important to support any necessary denial appeal.
- The E/M service must be provided on the same day as the other procedure or E/M service. This may be at the same encounter or a separate encounter on the same day.
- Modifier 25 should always be attached to the E/M code. If provided with a preventive medicine visit, it should be attached to the established office E/M code (99211–99215).
- The separately billed E/M service must meet documentation requirements for the code level selected. It will sometimes be based on time spent counseling and coordinating care for chronic problems.

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RHC Billing – No Globals – No Groups

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Procedures – Chapter 13 Updates

40.4 - Global Billing (Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16) Surgical procedures furnished in a RHC or FQHC by a RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, the charges for the procedure go on the claim with the visit. Payment is included in the AIR when the procedure is furnished in a RHC, and payment is included in the PPS methodology when furnished in a FQHC. The Medicare global billing requirements do not apply to RHCs and FQHCs, and global billing codes are not accepted for RHC or FQHC billing or payment.

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Procedures - Continued

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If a RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.

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RHC Encounter – E/M Office Visit and Procedure

- Scenario: RHC Provider completed a level-3 E/M office visit and a simple I&D in the office. Charge for the E/M visit is $100.00 and for the procedure is $150.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/25/2018	1	$250.00
0521	I&D Abscess	10160	10/25/2018	1	$150.00
0001	Total Charge				$400.00

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An E & M and a Procedure on the Same Day (99213 charge is $100)

42 Rev Code	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Payment	Coinsurance/ Deductible Applied
0521	99213CG	04/01/2018	1	$300.00	All-inclusive rate (AIR)	Yes
0521	12002	04/01/2018	1	$200.00	Included in AIR	No

Description	**Amount**
An independent RHC at the cost cap would receive from Medicare	$64.52
A co-pay on the E & M visit could be collected of:	$60.00
Total Collections would be:	$124.52

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Hospice

- RHC's can get paid for Hospice patient's if the payment relates to an Unrelated diagnosis.
- Input condition code 07 which indicates that the diagnosis has nothing to do with the terminal illness.

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RHC Encounter – Medical Visit & Mental Health Visit, Same Day

- Scenario: RHC Provider completed a level-3 office visit with a patient and a mental health provider in the same office completed a psychiatric diagnostic evaluation on the same day. Charge for the medical visit is $100.00 and for the mental health visit is $200.00

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	10/25/2018	1	$100.00
0900	Psych eval	90791 CG	10/25/2018	1	$200.00
0001	Total Charge				$300.00

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Questions, Thank You

H B S

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