HBS

Healthcare Business Specialists

Rural Health Clinic Billing – Four of Four

Presented by Healthcare Business Specialists

Sponsored by Azalea Health and ChartSpan

January 28, 2020

Azalea HEALTH

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Healthcare Business Specialists

Contact Information

Mark Lynn, CPA (Inactive), CRHCP
RHC Consultant
Healthcare Business Specialists
Suite 214, 502 Shadow Parkway
Chattanooga, Tennessee 37421
Phone: (423) 243-6185
marklynnrhc@gmail.com
www.ruralhealthclinic.com

Become a fan and Like us on Facebook for more RHC information

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Dani Gilbert, CPA, CRHCP
RHC Consultant
Healthcare Business Specialists
Suite 214, 502 Shadow Parkway
Chattanooga, Tennessee 37421
Phone: (833) 787-2542
dani.gilbert@outlook.com
www.ruralhealthclinic.com

RHC Information Exchange Group on Facebook

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

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Healthcare Business Specialists

Panelist

Louise Burkhead RH-CBS
Billing Staff
Trinity Medical Clinic LLC
731.434.0200

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Panelist

Cammie Jones, CPC
Commonwealth Health Management
151 N. Eagle Creek Drive, Suite 310
Lexington, KY 40509
Phone: (859) 263-4341
Fax: (859) 263-7441
Cell: (859) 771-7220
E-Mail: cjones@kymba.net

2020 Dates

Nashville 11/5
Somerset, KY 11/12
Alabama, 11/18

RHC Update Seminar – Clanton, Alabama

Agenda and Topics Outline

January 16, 2020

Healthcare Business Specialists, **Azalea Health**, and **ChartSpan** are providing a **free** seminar for RHCs at Clanton Conference Center - Alabama Power Company, 2030 7th St S. Clanton, AL 35045. To register go to our website at www.ruralhealthclinic.com

Time	Subject Matter
9:00 AM to 9:50AM Catch-Up Session for people new to RHCs	Welcome and Introductions. Robert (Rob) Boyles from the Alabama Department of Public Health Office of Primary Care and Rural Health will introduce the program. Mark Lynn will provide a Catch-Up session for people new to the Rural Health Clinic Program. We will go over the 9 Conditions of Participation for RHCs and some basic 101 information for people new to the program. If you have been an RHC for awhile you may want to just come at 10.
10:00 AM to 10:50AM Omnibus Burden Reduction and RHC Modernization Act	Mark Lynn, CPA, CRHCP will present information on the Omnibus Burden Reduction Regulations which reduces the compliance thresholds for Emergency Preparedness & Program Evaluations and the RHC Modernization Act which could increase the independent RHC cap to $115 per visit.
11:00 AM to 12:00AM RHC Billing Alabama Medicaid	Tori Nix, Provider Relations Supervisor, **DXC Technology** (Alabama Medicaid) will provide instructions for RHCs on how to bill for Medicaid services and answer questions about specific billing issues with Alabama Medicaid.
12:00 to 1:00 Lunch Provided by **Azalea Health** & **Chartspan**	Boxed Lunches Provided on site by **Azalea Health**, **ChartSpan**, and Healthcare Business Specialists- At 12:30 Davis Bayles will discuss Rural Health Services provided by **Azalea Health** including the new Telehealth offering.
1:00 PM to 1:50 PM Emerging Trends in Reimbursement	In this session, John Roddy of **ChartSpan** will discuss Chronic Care Management and how RHCs can utilize chronic care management to increase revenues and Alan Bragwell from Bragwell Services will discuss mental health services in RHCs
2:00 PM to 3:30 PM RHC Billing & Cost Reporting	Cost Reporting Updates, Electronic Filing of Cost Reports, what is needed to file cost reports. How to accumulate your information, Prevnar 13 and 23, Influenza and Pneumococcal and Medicare Bad Debts. Timing of settlements and critical deadline. Mark Lynn will provide an RHC Billing Update. Questions and Answers. What is a visit, bundled services, preventive services, incident to, procedure billing, no global billing, no groups, non-rhc services, commingling, **setting up non-RHC time, and other FAQs.**

Join our Facebook Group for more RHC Information: https://www.facebook.com/groups/1503414633296362/

502 Shadow Parkway, Suite 214, Chattanooga, Tennessee 37421
Telephone: (833) 787-2542, Fax: (800) 268-5055, Email: marklynnrhc@gmail.com
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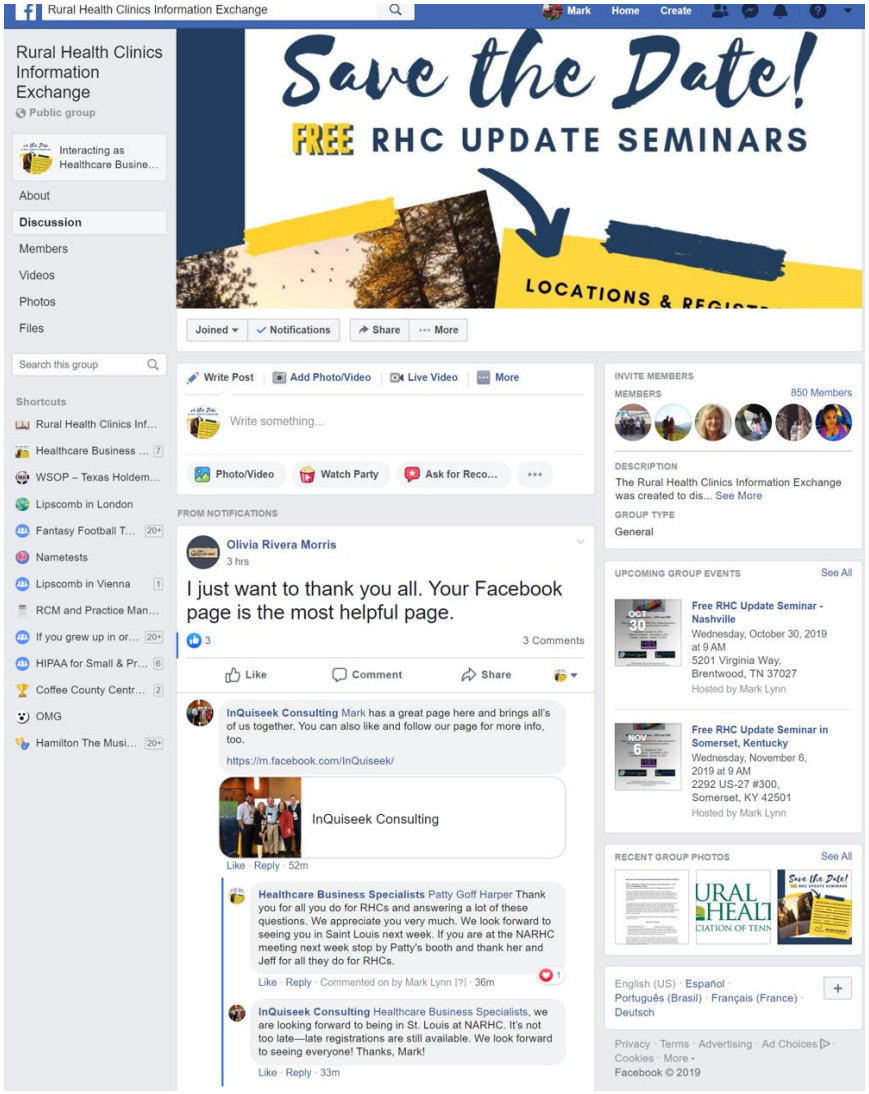
HBS

Healthcare Business Specialists

- What does Healthcare Business Specialists do?
- Listing of Services

https://tinyurl.com/w63xbp9

- We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.
- We prepare Program evaluations of RHCs.
- We help clinics startup as RHCs.
- Emergency Preparedness for RHCs.
- We prepare Tenncare Quarterly Reports
- Our Cost Reporting Brochure can be found at the following link:
- RHC Cost Report Brochure



RHC 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/

- On January 29th, from 2:00pm – 3:00pm EASTERN, we will be hosting the next Rural Health Clinic Technical Assistance webinar. This one-hour webinar will be a regulatory update presented by NARHC Director of Government Relations, Nathan Baugh. At the conclusion of the formal presentation, there will be time for questions and answers.
- Here is the link to the webinar:
- **https://hrsaseminar.adobeconnect.com/fru-rhcs/**
- You can either use the audio controls on your computer or dial in using the following phone number and access code:
- Dial-in: 888-790-3413
- Participant Code: 7023213

Please register for Cost Reporting for Rural Health Clinics - What is needed to file an accurate and timely cost report on Jan 30, 2020 3:00 PM EST at:

https://attendee.gotowebinar.com/register/7460659588778612236

After registering, you will receive a confirmation email containing information about joining the webinar.

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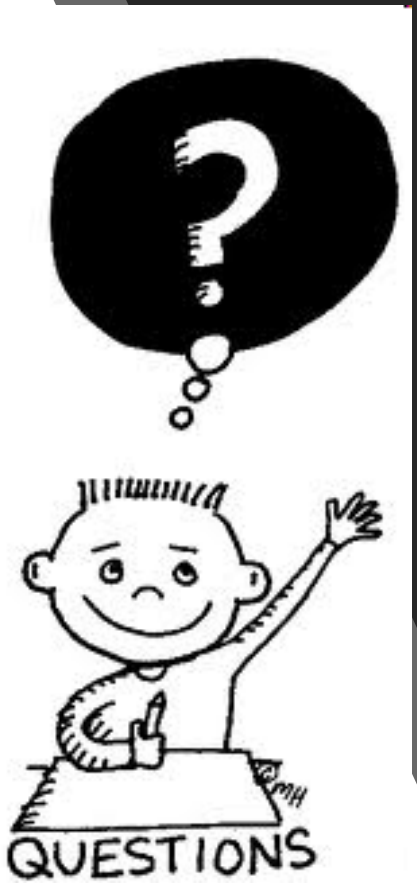
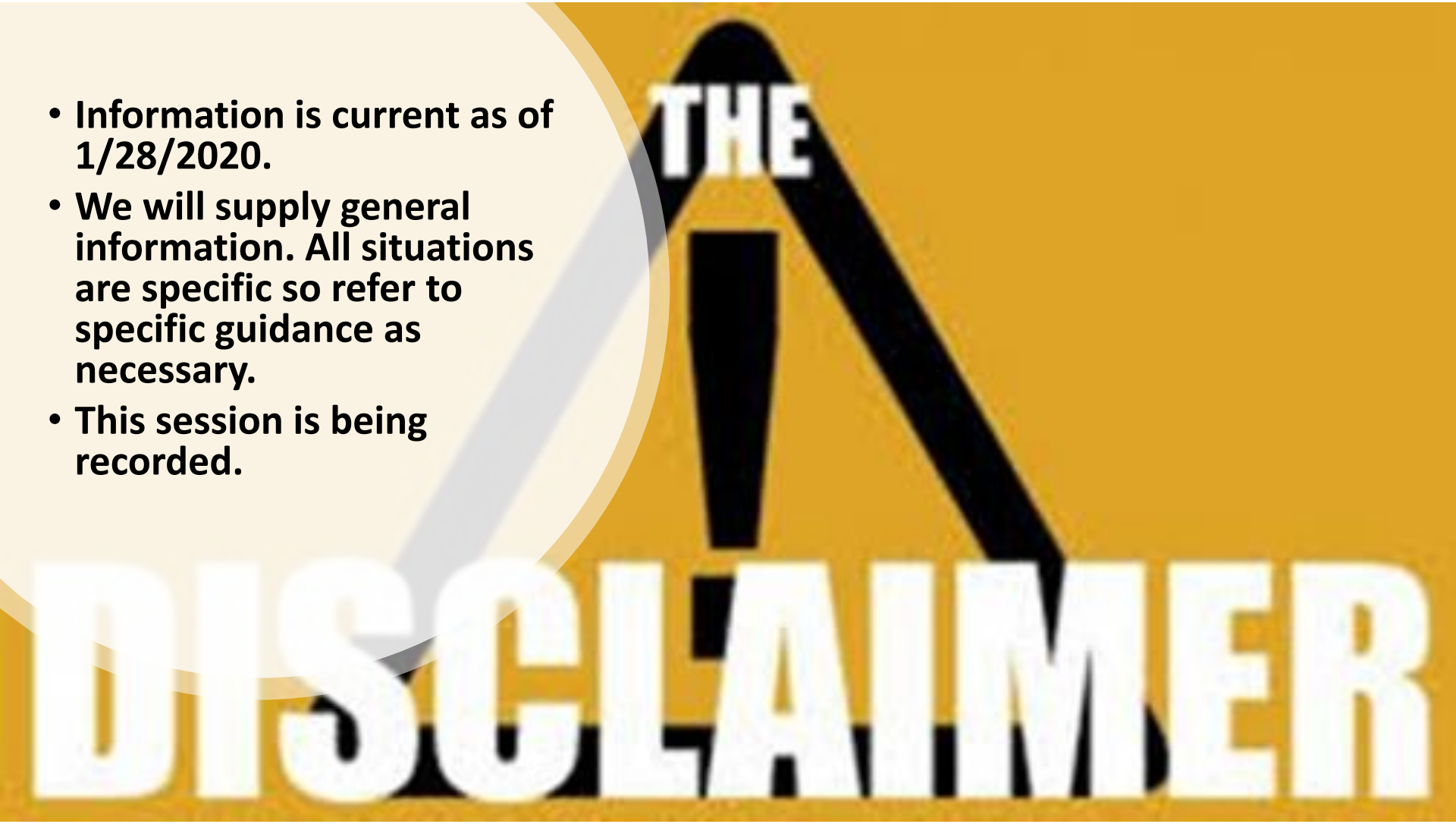


Questions or Comments?

Please type your questions in the Questions area of Go To Webinar. Additionally, we will open up the lines for questions at the end of the 45-minute webinar.

- Information is current as of 1/28/2020.
- We will supply general information. All situations are specific so refer to specific guidance as necessary.
- This session is being recorded.



Agenda

- Preventive Services
- Other Services
- Medicare Secondary Payer
- Common Billing Errors
- Completing the UB-04

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Experienced Knowledge

Preventive Services

The Most Profitable Patient in the World?

Preventive Services

When can CMS add new preventive services as Medicare benefits?

CMS may add coverage of preventive services through the National Coverage Determination (NCD) process if the service meets all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF)
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program

CMS may also add additional preventive services through statutory and regulatory authority.

How do I determine the last date a Medicare beneficiary got a preventive service so I know the beneficiary is eligible to get the next service and the service will not be denied due to frequency edits?

You have different options for accessing eligibility information. You may access the information through the CMS HIPAA Eligibility Transaction System (HETS) either directly or through your eligibility services vendor, through your Medicare Administrative Contractor (MAC) provider call center Interactive Voice Response (IVR) unit, or through the MAC provider web portal. Contact your eligibility service vendor or check with your MAC's eligibility services for more information.

https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List

25. Effective 2011, Medicare covers physicals.

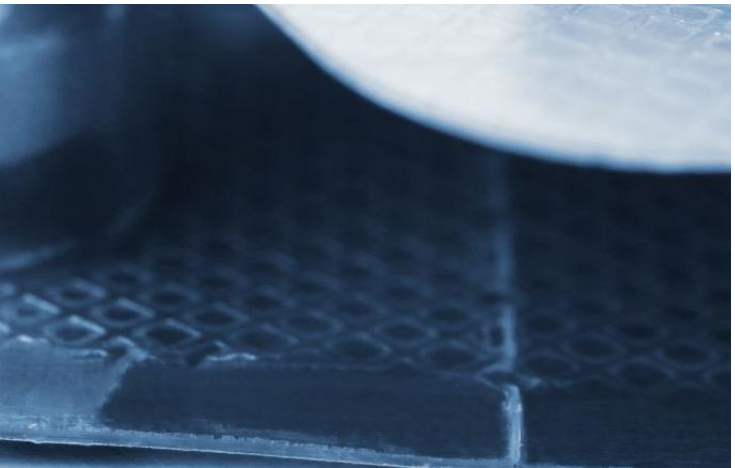
a. True

b. False

RHC Encounter: IPPE Only

Is the IPPE the same as a beneficiary's yearly physical?

No. The IPPE is not a routine physical that some older adults may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. CMS encourages providers to inform beneficiaries about the Annual Wellness Visit and perform such visits. **The Social Security Act (SSA) explicitly prohibits Medicare coverage for routine physical examinations.**



https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

INITIAL PREVENTIVE PHYSICAL EXAMINATION

Target Audience:
Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Medicare Coverage of Physical Exams—Know the Differences

Initial Preventive Physical Examination (IPPE)	Annual Wellness Visit (AWV)	Routine Physical Examination (See Section 90)
Review of medical and social health history, and preventive services education	Visit to develop or update a personalized prevention plan, and perform a health risk assessment	Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury
✔ Covered only once, within 12 months of Part B enrollment	✔ Covered once every 12 months	⊘ Not covered by Medicare; prohibited by statute
✔ Patient pays nothing (if provider accepts assignment)	✔ Patient pays nothing (if provider accepts assignment)	⊘ Patient pays 100% out-of-pocket

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES Medicare Learning Network

RHC Encounter: IPPE Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	1/28/2020	1	200.00
0001	Total Charge				200.00

The physician performed IPPE (Welcome to Medicare) service on this date of service. No –CG modifier is required. The patient has no cost share for this visit because the deductible and co-insurance is waived.

Medicare Annual Wellness Visit

KNOWLEDGE • RESOURCES • TRAINING

ANNUAL WELLNESS VISIT

Target Audience:
Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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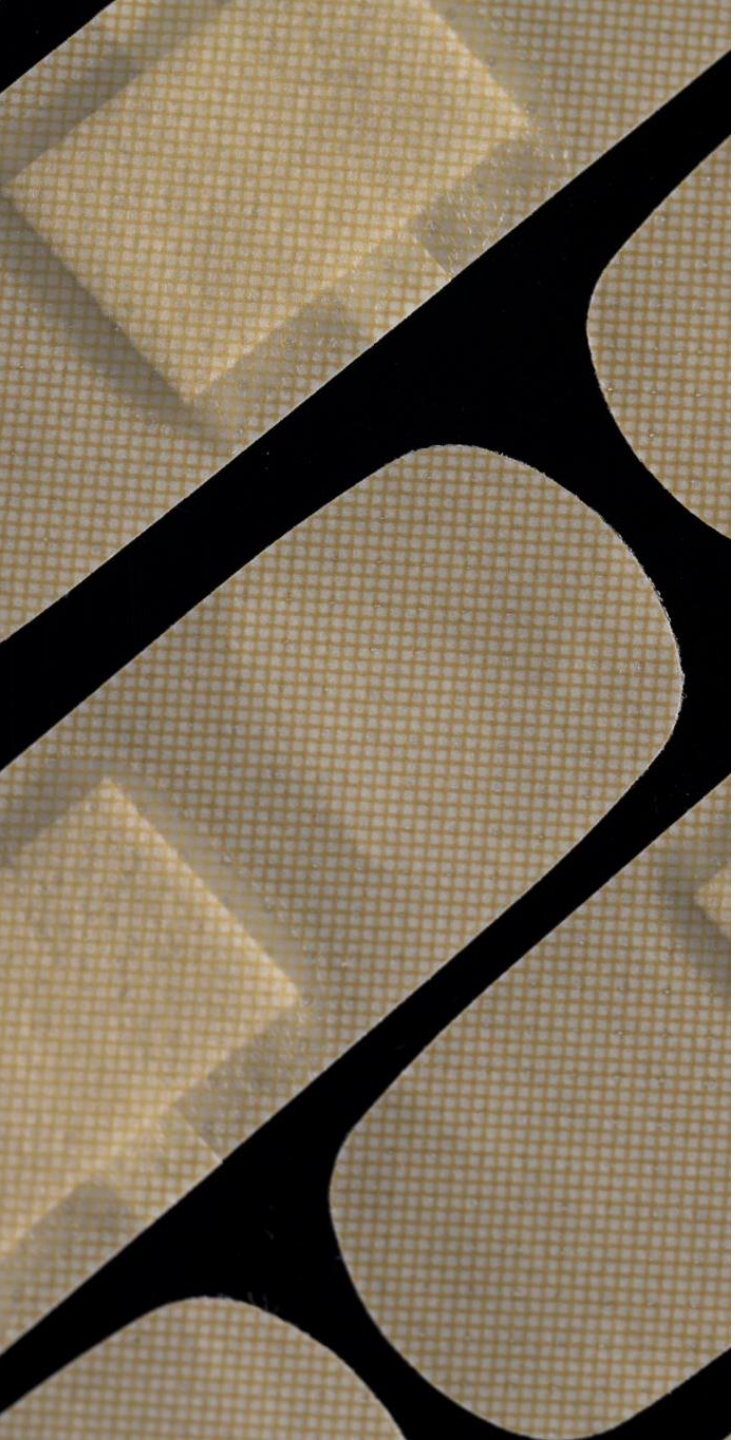
✔ Patient pays nothing (if provider accepts assignment)	✔ Patient pays nothing (if provider accepts assignment)	⊘ Patient pays 100% out-of-pocket

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

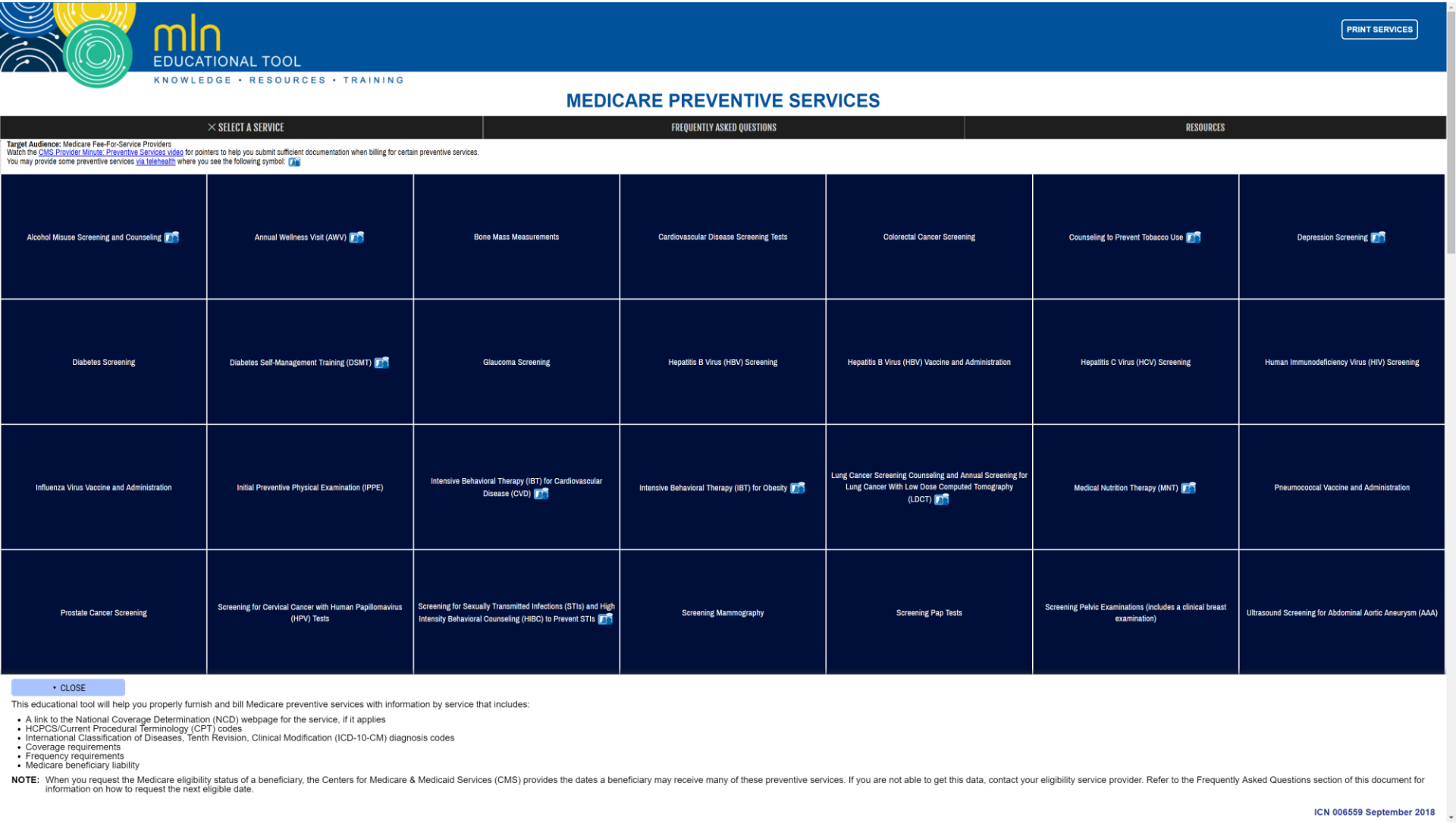


Medicare Annual Wellness Visit

- **Is NOT a routine physical exam.**
- **Must include certain components**
- **Is payable as a stand-alone RHC visit when it is the only service performed**
- **Is not payable as a separate service when performed on the same day of service as other medical or screening services.**

- ***Is the AWV the same as a beneficiary's yearly physical?***

- ***No. The AWV is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.***



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

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.

26. Most Medicare Preventive Services are not subject to co-pays and the Medicare deductible.

a. True

b. False

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

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

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.*

https://www.medicare.gov/Pubs/pdf/11420-Preventive-Services-Card.pdf

Are You Up-To-Date on Your Preventive Services?

Medicare covers a full range of preventive services to help keep you healthy and help find problems early, when treatment is most effective. Ask your doctor which of these services is right for you and use the space below to write down important information.

- ☐ One time "Welcome to Medicare" Preventive Visit—within the first 12 months you have Medicare Part B (Medical Insurance) _____
- ☐ Yearly "Wellness" Visit—get this visit 12 months after your "Welcome to Medicare" preventive visit or 12 months after your Part B effective date _____
- ☐ Abdominal Aortic Aneurysm Screening _____
- ☐ Alcohol Misuse Screening and Counseling _____
- ☐ Bone Mass Measurement (Bone Density Test) _____
- ☐ Cardiovascular Disease (Behavorial Therapy) _____
- ☐ Cardiovascular Screenings (cholesterol, lipids, triglycerides) _____
- ☐ Colorectal Cancer Screenings _____
- ☐ Depression Screening _____
- ☐ Diabetes Screening _____
- ☐ Diabetes Self-management Training _____
- ☐ Flu Shot _____
- ☐ Glaucoma Test _____
- ☐ Hepatitis B Screening _____
- ☐ Hepatitis C Screening _____
- ☐ HIV Screening _____
- ☐ Lung Cancer Screening _____
- ☐ Mammogram (screening for breast cancer) _____
- ☐ Medical Nutrition Therapy Services _____
- ☐ Medicare Diabetes Prevention Program _____
- ☐ Obesity Screening and Counseling _____
- ☐ Pap Test and Pelvic Exam (includes a breast exam) _____
- ☐ Pneumococcal Shots _____
- ☐ Prostate Cancer Screening _____
- ☐ Sexually Transmitted Infection Screening and Counseling _____
- ☐ Counseling to Prevent Tobacco Use and Tobacco-Caused Disease _____

Your "Guide to Medicare Preventive Services" has more information about these and other preventive services, including costs and conditions that may apply. Visit **Medicare.gov/publications**.

Paid for by the Department of Health & Human Services.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Product No. 11420
Revised September 2019

27. When Preventive services are provided on the same day as an E & M the charges are added to the E & M Code with the CG Modifier on the UB-04.

a. True

b. False

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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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Preventive Visit Only

42 Rev Code	44 HCPCS/RATES	45 SERV DATE	46 SERV UNITS	47 Total Charges	Payment	Coinsurance/ Deductible Applied
0521	G0101CG	04/01/2020	1	$125.00	Included in AIR	No

Description	Amount
An independent RHC at the cost cap would receive from Medicare 86.31	$86.31

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Experienced Knowledge

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	$69
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

RHC Encounter: "Woman Well Visit" AWV and Other Screenings

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	**AWV-Subsequent**	G0439 CG	1/01/2020	1	150.00
0521	Breast/Pelvic	G0101	1/01/2020	1	100.00
0521	Pap Smear	Q0091	1/01/2020	1	50.00
0001	Total Charge				300.00

The patient received a subsequent AWV along with other preventive services on the same date of service. The –CG is appended to the AWV. There is no cost share for this visit.

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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

Other Services

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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 – 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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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.

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**

- **Summary:**
  - **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**

28. When billing on the UB-04 RHCs should add modifier 25 to all the lines with incident to services listed.

a. True

b. False

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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.
59	Two E and M visits on the same day and two AIRs are expected. 99213 9921459

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 service that you do not get paid an RHC Visit.

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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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RHC Billing – No Globals – No Groups

Procedures – Chapter 13 Guidance

40.4 - Global Billing (Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18) Surgical procedures furnished in an RHC by an RHC practitioner are considered RHC 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 an RHC, The Medicare global billing requirements do not apply to RHCs, and global billing codes are not accepted for RHC billing or payment.

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Procedures - Continued

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

Three Day Payment Window

40.5 - 3-Day Payment Window (Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18) Medicare's 3-day payment window applies to outpatient services furnished by a hospital (or an entity that is wholly owned or wholly operated by the hospital). The statute requires that hospitals' bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with section 1886 of the Act. RHCs services are not subject to the Medicare 3- day payment window requirements.

For additional information on the 3 day payment window, see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM7502.pdf

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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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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	04/01/2020	1	$250.00	All-inclusive rate (AIR)	Yes
0521	12002	04/01/2020	1	$150.00	Included in AIR	No

Description	**Amount**
An independent RHC at the cost cap would receive from Medicare	$69.05
A co-pay on the E & M visit could be collected of:	$50.00
Total Collections would be:	$119.05

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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.

29. Home Care Plan Recertification is not billable to Medicare by a Rural Health Clinic.

a. True

b. False

c. Not as an Encounter but include some of the time in CCM.

110.2 - Treatment Plans or Home Care Plans

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Except for comprehensive care plans that are a component of authorized care management services (see section 230), treatment plans and home care oversight provided by RHC or FQHC physicians to RHC or FQHC patients are considered part of the RHC or FQHC visit and are not a separately billable service.

Home Care Plan Recertification

G0179 (**recertification**) and G0180 (**certification**) were created specifically for billing Medicare-covered **home health** services provided as part of a **home health care plan**, including **physicians**' contacts with the **home health** agency and review of patient status reports.

Because there is no face to face encounter, RHCs can not bill G0179 and G0180, but the time can counted towards CCM services.

How to Bill Medicare Railroad in an RHC

PALMETTO GBA
A CELERIAN GROUP COMPANY

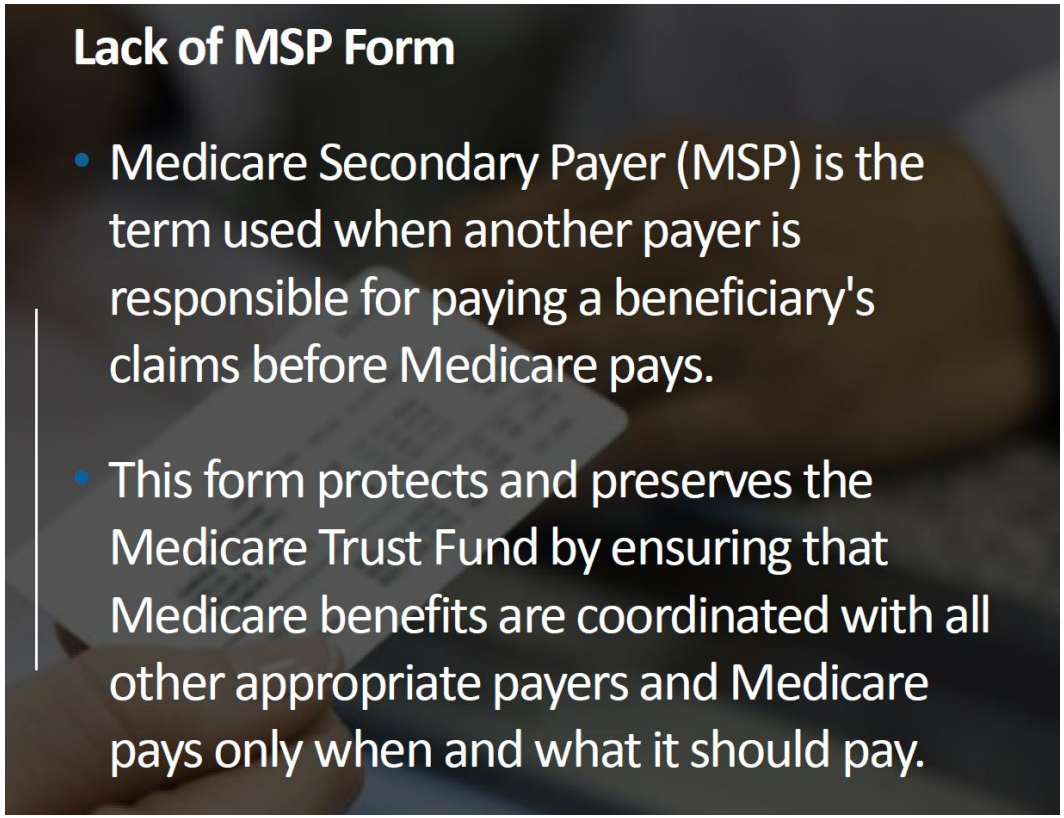
Railroad Medicare's
Quick Reference Guide

https://palmettogba.com/Palmetto/Providers.Nsf/files/Quick_Reference_Guide_for_Railroad_Medicare.pdf/$File/Quick_Reference_Guide_for_Railroad_Medicare.pdf

https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Railroad-Medicare~8NNQKB3563


Medicare
Secondary
Payer
Compliance

MSP Form Completed each visit



The official MSP Questionnaire (12 pages)

20.2.1 - Admission Questions to Ask Medicare Beneficiaries
(Rev. 53, Issued: 06-09-06, Effective: 09-11-06, Implementation: 09-11-06)

The following questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare. This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?

____ Yes; Date benefits began: MM/DD/CCYY

BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.

____ No.

2. Are the services to be paid by a government research program?

____ Yes.

GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

____ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

____ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

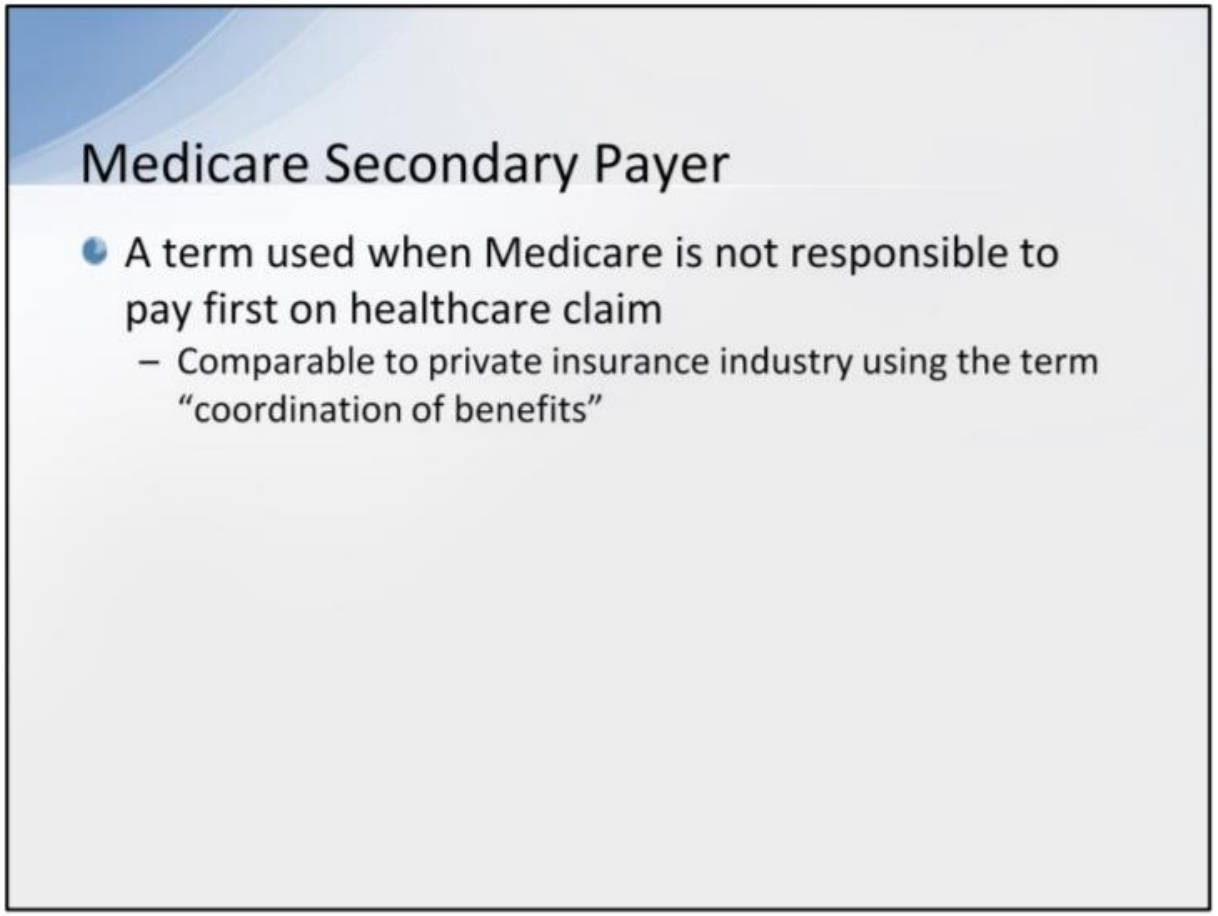
____ No.

4. Was the illness/injury due to a work-related accident/condition?

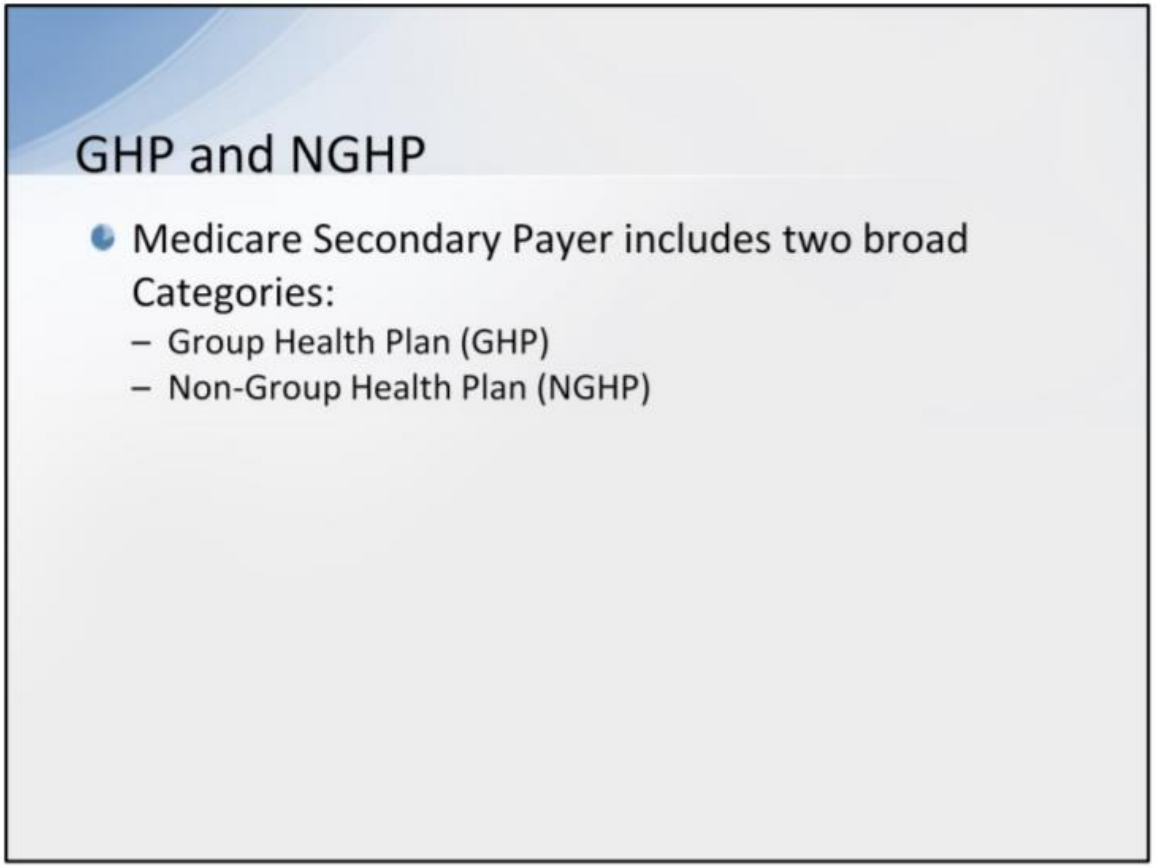
____ Yes; Date of injury/illness: MM/DD/CCYY

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/Downloads/CMS-Questionnaire.pdf

Medicare Secondary Payer Overview Slides from CMS



Medicare Secondary Payer (MSP) is a term used when Medicare is not responsible for paying first on a healthcare claim. The decision as to who is responsible for paying first on a claim and who pays second is known in the insurance industry as "coordination of benefits."



Medicare Secondary Payer provisions apply to two broad categories of insurance: Group Health Plan (GHP), and Non-Group Health Plan (NGHP).

What is a Group Health Plan?

- Health coverage sponsored by an employer or employee organization (such as a union) for a group of employees, and possibly for dependents and retirees as well

- Includes:
  - Self-insured plans
  - Government plans (Federal, State and local)
  - Employee organization plans
  - Union plans
  - Employee health and welfare funds

A Group Health Plan is health coverage sponsored by an employer or employee organization (such as a union) for a group of employees, and possibly for dependents and retirees as well. The term GHP includes self-insured plans, plans of government entities (Federal, State, and local), and employee organization plans such as union plans, employee health and welfare funds, or other employee organization plans. The term also includes "employee-pay-all" plans which receive no financial contributions from the employer. The term does not include self-employed persons.

30. Non-Group Health Plans will almost always pay primary and Medicare will pay secondary.

a. True

b. False

Non-Group Health Plan (NGHP) MSP

- Includes Liability insurance (including self-insurance), No-Fault insurance, and Workers' Compensation
- Liability insurance example
  - Medicare beneficiary injured in an auto accident
  - Beneficiary files a claim against the alleged responsible party and receives payment
  - Medicare is secondary to the Liability insurance payment

Non-Group Health Plan MSP encompasses three different types of insurance: Liability, No-Fault, and Workers' Compensation. By statute, Medicare is always a secondary payer to Liability insurance (including Self-insurance). An example of Liability insurance is where a Medicare beneficiary is injured in an auto accident. The beneficiary files a claim against the alleged responsible party and receives payment. Medicare is the secondary payer to the Liability insurance payment.

MEDICARE SECONDARY PAYER

Medicare as Secondary Payer MLN Booklet

The Medicare Secondary Payer (MSP) provisions protect the Medicare Trust Fund. Compliance with the MSP provisions contributes to the appropriate use of Medicare funds. This booklet provides an overview of the MSP provisions and outlines your responsibilities.

When "you" is used in this booklet, we are referring to providers, physicians, other suppliers, and billing staff, unless stated otherwise.

WHAT IS MSP?

The MSP provisions protect the Medicare Trust Fund by ensuring Medicare does not pay for items and services when other health insurance coverage is primary to Medicare. The MSP provisions apply when Medicare is not the primary or first payer of claims. In these cases, the MSP requirements provide the following benefits for you and the Medicare Program:

- **National program savings** – The Centers for Medicare & Medicaid Services (CMS) enforcement of the MSP provisions saved the Medicare Program roughly $8.5 billion in Fiscal Year (FY) 2018.
- **Increased provider, physician, and other supplier revenue** – If you bill a primary plan before billing Medicare, you may get more favorable reimbursement rates. Also, properly coordinated health coverage may expedite the payment process and reduce your administrative costs.
- **Avoidance of Medicare recovery efforts** – If you file claims correctly the first time, you prevent future Medicare recovery efforts on claims.

Stay Up to Date

To sign up for automatic updates, enter your email address in the "Receive Email Updates" box at the bottom of any CMS.gov webpage. Select the box for "Subscription Sign-up for Coordination of Benefits & Recovery (COB&R) Overview."

To get these benefits, you must access accurate, up-to-date information about your Medicare beneficiary's health insurance coverage. Medicare regulations require anyone submitting Medicare claims to determine whether Medicare is the primary payer for items or services provided to the beneficiary.

WHEN DOES MEDICARE PAY FIRST?

Primary payers have the responsibility to pay a claim first. Medicare pays first for beneficiaries in the absence of other primary insurance or coverage. Medicare may also pay first when the beneficiary has other insurance coverage, but a special condition exists.

Table 1 lists some common situations when a beneficiary has both Medicare and other health plan coverage and which entity pays first (primary payer) and pays second (secondary payer).

Definition of "Spouse"

"Spouse," under the MSP Working Aged provisions, includes both same-sex and opposite-sex marriages.

WHAT ARE YOUR RESPONSIBILITIES UNDER THE MSP PROVISIONS?

Part A Institutional Providers (for example, Hospitals)

Gather accurate MSP data to determine if Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for information such as group health coverage through employment or non-group health coverage resulting from an injury or illness.

Bill the primary payer before billing Medicare, as required by the Social Security Act.

Submit any MSP information on your Medicare claim using proper payment information, value codes, condition and occurrence codes, etc. (If submitting an electronic claim, provide the necessary fields, loops, and segments for Medicare to process an MSP claim.)

Table 1. Analysis of Common MSP Coverage Situations

Individual	Condition	Pays First	Pays Second
Is 65 or older, and covered by a Group Health Plan (GHP*) through current employment or spouse's current employment	The individual is entitled to Medicare The employer has less than 20 employees	 Medicare	 GHP
Is 65 or older, and covered by a GHP through current employment or spouse's current employment	The individual is entitled to Medicare The employer has 20 or more employees, or the employer is part of a multiple or multi-employer group with at least one employer employing 20 or more individuals	 GHP	 Medicare
Is 65 or older, has an employer retirement GHP, and is not working	The individual is entitled to Medicare	 Medicare	 Retiree Coverage
Is under 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has less than 100 employees	 Medicare	 GHP
Is under 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has 100 or more employees, or the employer is part of a multi-employer group with at least one employer employing 100 or more individuals	 GHP	 Medicare

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Has End-Stage Renal Disease (ESRD) and GHP coverage was the primary plan prior to the individual becoming eligible and entitled to Medicare based on ESRD	First 30 months of Medicare eligibility or entitlement	 GHP	 Medicare
Has ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage prior to becoming eligible or entitled to Medicare	First 30 months of Medicare eligibility or entitlement	 COBRA	 Medicare
Has ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury	The individual is entitled to Medicare	WC for health care items or services related to job-related illness or injury. See section titled, "When May Medicare Make a Conditional Payment?"  Workers' Compensation	 Medicare

How Do You Determine if Medicare Is the Secondary Payer (MSP)?

List of Common Situations When Medicare May Pay First or Second			
If the Individual...	**And this condition exists**	**Then this program pays first**	**And this program pays second**
Is age 65 or older and covered by a Group Health Plan (GHP) through current employment or spouse's current employment...	The employer has less than 20 employees...	Medicare	GHP
Is age 65 or older and covered by a GHP through current employment or spouse's current employment...	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals...	GHP	Medicare
Has an employer retirement plan and is age 65 or older...	The individual is entitled to Medicare...	Medicare	Retiree coverage
Is disabled and covered by a GHP through his or her own current employment, or through a family member's current employment...	The employer has less than 100 employees...	Medicare	GHP
Is disabled and covered by a GHP through his or her own current employment, or through a family member's current employment...	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	GHP	Medicare
Has End-Stage Renal Disease (ESRD) and GHP coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	GHP	Medicare
Has ESRD and GHP coverage...	After 30 months...	Medicare	GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	Medicare
Has ESRD and COBRA coverage...	After 30 months...	Medicare	COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury...	The individual is entitled to Medicare...	WC (for health) care items or services related to job-related illness or injury claims	Medicare
Was in an accident or other situation where no-fault or liability insurance is involved...	The individual is entitled to Medicare...	No-fault or liability insurance for accident or other situation-related health care services claimed or released	Medicare
Is age 65 or older OR disabled and covered by Medicare and COBRA...	The individual is entitled to Medicare...	Medicare	COBRA

http://www.ppsimpact.org/how-do-you-determine-if-medicare-is-the-secondary-payer-msp/?print=print

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf

Medicare Secondary Payer (MSP) Manual
Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

Table of Contents

(Rev. 125, 03-22-19)

20.2.1 - Model Admission Questions to Ask Medicare Beneficiaries
(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

The following model questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare. This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this model questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: MM/DD/CCYY

BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government research program?

___ Yes.

GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work-related accident/condition?

___ Yes; Date of injury/illness: MM/DD/CCYY

Name and address of workers' compensation plan (WC) plan:

_____

31. How long must an RHC keep evidence that the Medicare Secondary Payer form was completed?

a. One Year

b. Three Years

c. Five Years

d. Ten Years

PATIENT NAME_____

MEDICAL RECORD # _____

Medicare Secondary Payer Form

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? **Yes No**
2. Is illness covered by the Black Lung Program, Veterans Administration or research program? **Yes No**
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? **Yes No**
4. Is patient covered by a large group health plan through either the patient's employer or spouse's current employer and the plan is primary over Medicare? **Yes No**
5. Medicare Beneficiary's (Patient) Retirement Date_____
6. Is the patient entitled to Medicare based on Disability? **Yes No**

Registrar Notes:

A. If patient responds "no" to questions 1-4, Medicare is primary.
B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____

Address of Insurance Company _____

_____

Name of Policy Holder _____

Policy Number _____

Policy Holder's Employee Name _____

Policy Holder's Employer Address _____

Date of Accident (if applicable) _____

Patient's / Legal Representative's Signature: _____ Date: _____ Time: _____

http://www.ruralhealthclinic.com/s/2020-Medicare-Secondary-Payer-MSP-Questionnaire.pdf

https://static1.squarespace.com/static/53c5f79de4b0f4932a3942a8/t/5e2dee583ea0ef64f093d7b5/1580068441039/2020+Billing+Medicare_Secondary_Payer_Questionnaire+%282-Page%29.pdf

MEDICARE SECONDARY PAYER QUESTIONNAIRE

What is the Medicare Secondary Payer questionnaire?

MEDICARE SECONDARY PAYER	A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.
	Use: Completion required for any situation where another payer or insurer pays your medical bills before Medicare.

We ask that you complete this form with either a **"Y"** for yes or **"N"** for No, dates and address required where indicated.

Part I
Government Program Coverage:

1. Is the patient receiving Black Lung Benefits? _____
   Date benefits began: _____/_____/_____
2. Are services covered by a government program (research)? _____
3. Has Dept of Veteran Affairs agreed to pay for care? _____
4. Was illness due to work related accident/condition? _____
   If yes, name and address of workers compensation plan:
   _____
   _____
   _____

(Please note: If you answered "yes" to any questions, then that plan is primary to Medicare. If you answered "no" to all, then go to the next section).

Part II
Accident Related Injuries:

1. Was illness/injury due to non-work related accident? _____
   If "No", then go to the next section
   If "yes, date: _____/_____/_____
2. Was accident caused by automobile_____, non-automobile _____ or another party? _____
   If yes, provide name, address, phone, claim # of no-fault or liability insurer:
   _____
   _____
   _____

Part III
Reasons for Medicare Benefits:

1. Is beneficiary entitled to Medicare benefits based on
   Age: _____
   Disability: _____; if yes, go to **Part V**
   End Stage Renal Disease: _____, if yes, go to Part VI
2. Is beneficiary part of a Medicare HMO? _____
   If yes, then the HMO replaces Medicare.

Turn Over to Complete

C:\Documents and Settings\nkhorozova\Desktop\MEDICARE SECONDARY PAYER QUESTIONNAIRE.doc

Part IV
Employment Status:

1. Does patient have current employment status? _____
   if no, what was the Date of retirement? _____/_____/_____
   (**Office use only**: If yes, provide the named and address of employer on registration screens. If no, record the date of retirement on the occurrence code).
2. Does patient's spouse have current employment status? _____
   if no, what was the spouse's Date of retirement ? _____/_____/_____
   (**Office use only**: If yes, provide the named and address of spouse's employer on registration screens. If no, record the spouse's date of retirement on the occurrence code).
   If no to both questions, then Medicare is primary. If health insurance exists through employment and there are 20 or more employees, health insurance is primary.
   If unable to obtain retirement date, note why?
   _____

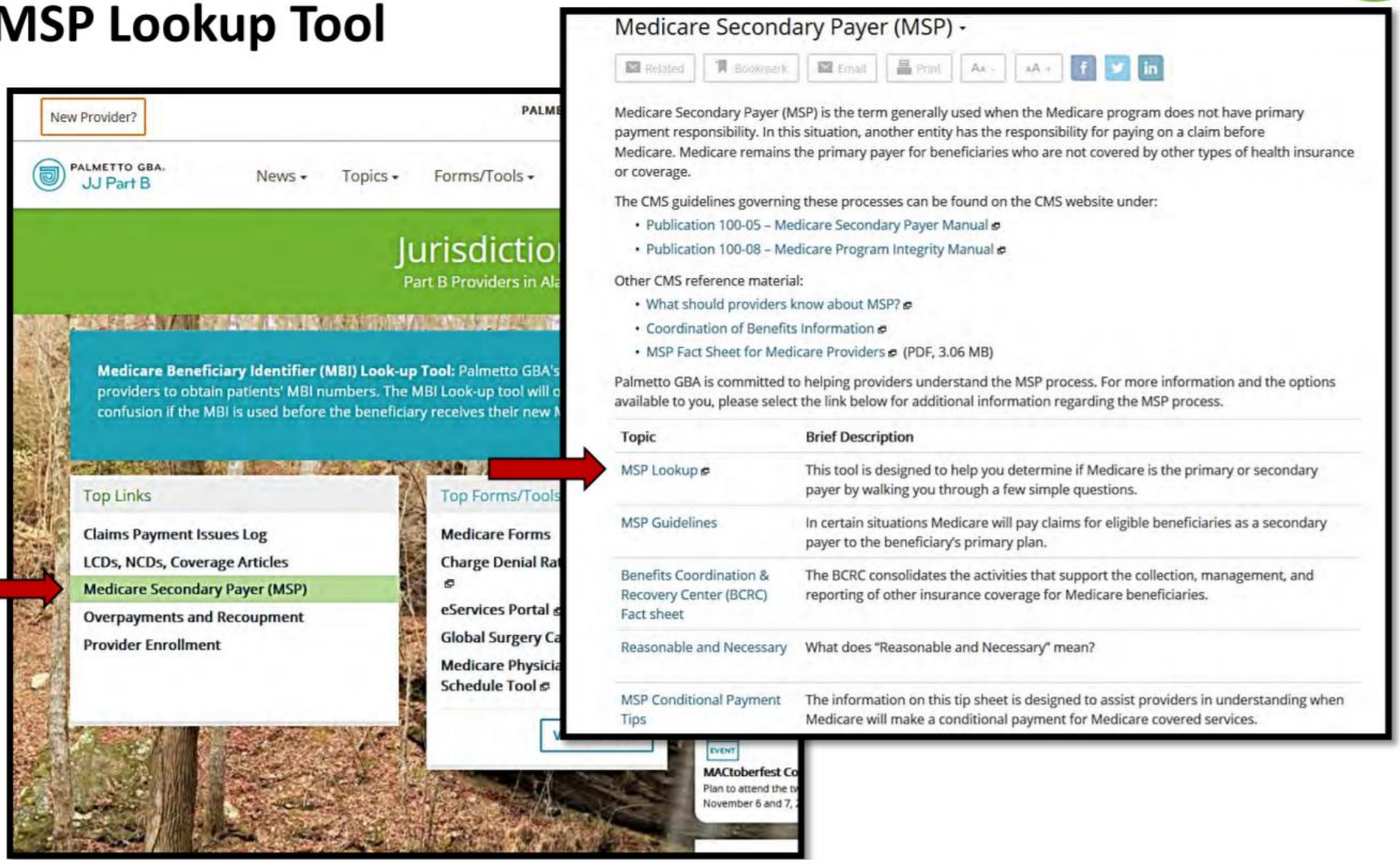
Part V
Disability:
Is patient RETIRED disability? _____
If yes, date of disability retirement _____/_____/_____
(Medicare is primary unless spouse employed with benefits)

If disability, does patient or spouse have current employment status? _____
(**Office use only**: If yes, provide the named and address of employer on registration screens. If no to employment questions, Medicare is primary. If health insurance exists, plan is primary).

Part VI
End Stage Renal Disease:
Does patient have current insurance coverage? _____
(**Office use only**: if yes, record information on insurance screens, that plan becomes primary).
Has patient received a kidney transplant? _____
If yes, date of transplant: _____/_____/_____
Has patient received dialysis? _____
If yes, date dialysis began: _____/_____/_____
If self dialysis, date of training: _____/_____/_____
Is patient within the 30 month coordination period? _____
If yes, insurance is primary until 30 months is up.
Was patient's initial entitlement to Medicare based on ago or disability? _____
(**Office use only** If yes, Medicare primary. In no, insurance coverage primary until 30 months is up).

Medicare Secondary Payer (MSP)

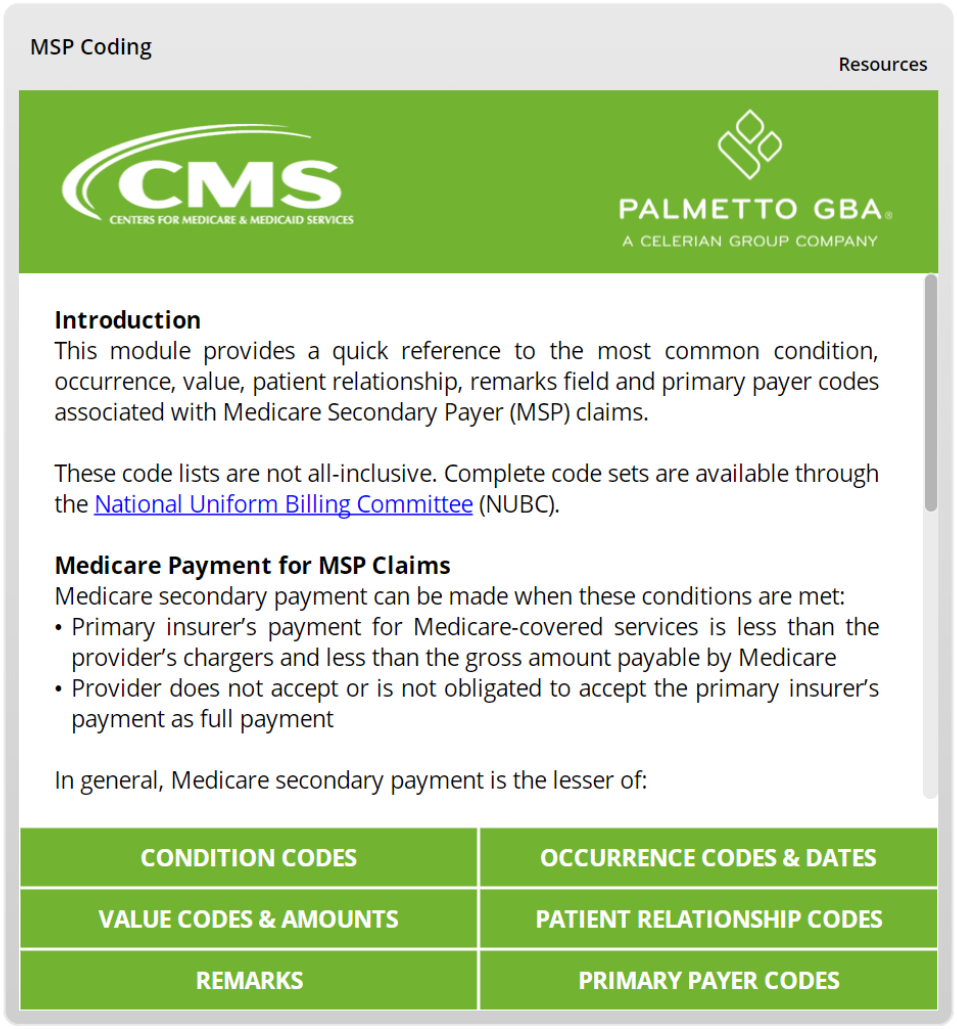
MSP Lookup Tool



MSP Claim Rejections

- The MSP type entered on an electronic claim must correspond to the information Medicare has on file or the claim will be rejected
- Rejected claims:
  - Do not have appeal rights
  - Must be submitted as a new claim

MSP Type	Description
12	Working Aged: age 65 or over, employer's group plan has at least 20 employees
13	End-Stage Renal Disease (ESRD): 30-month initial coordination period in which other insurer is primary
14	No-Fault Situations: Medicare is secondary if illness/injury results from a no fault liability.
15	Workers Compensation (WC) Situations
41	Black Lung Benefits
43	Disability: under age 65, person or spouse has active employment status and employer's group plan has at least 100 employees
47	Liability Situations: Medicare is secondary if illness/injury results from a liability situation



https://palmettogba.com/internet/elearn3.nsf/MSPCoding/story_html5.html

https://cgsmedicare.com/parta/claims/msp_billing.pdf

Medicare Secondary Payer BILLING & ADJUSTMENTS

Medicare Secondary Payer (MSP) Billing Codes
(UB-04 FL)

Refer to the Hospice Medicare Billing Codes Sheet at https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_medicare_billing_codes_sheet.pdf or the Home Health Medicare Billing Codes Sheet at https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf for additional billing information.

Condition Codes (FL18-28)	
Code	**Description**
02	Condition is employment related
05	Lien has been filed
06	ESRD patient in first 30 months of entitlement
08	Beneficiary would not provide information concerning other insurance coverage
09	Neither patient nor spouse is employed
10	Patient and/or spouse is employed but no GHP coverage exists
11	Disabled beneficiary but no GHP coverage
28	Patient and/or spouse's GHP is secondary
29	Disabled beneficiary and/or family member's GHP is secondary to Medicare
77	Provider accepts or is obligated/required due to a contractual agreement or law to accept payment by a primary payer as payment in full. No Medicare payment will be made.

Occurrence Codes (FL31-34)	
Code	**Description**
01	Accident/Med pay (use with VC 14 or 47)
02	No-fault insurance involved-including auto accident/other
03	Accident - liability (includes underinsured and uninsured) (use with VC 47)
04	Accident/employment related (use with VC 15)
06	Crime victim
18	Date of retirement patient/beneficiary (use with VC 12, 13, or 43)
19	Date of retirement spouse (use with VC 12, 13, or 43)
24	Date insurance denied
25	Date benefit terminated (use with VC 14 or 15)
33	First day of coordination period for ESRD beneficiaries covered by GHP (use with VC 13)
A3	Benefits exhausted (payer A) (use with VC 12, 13, or 43)

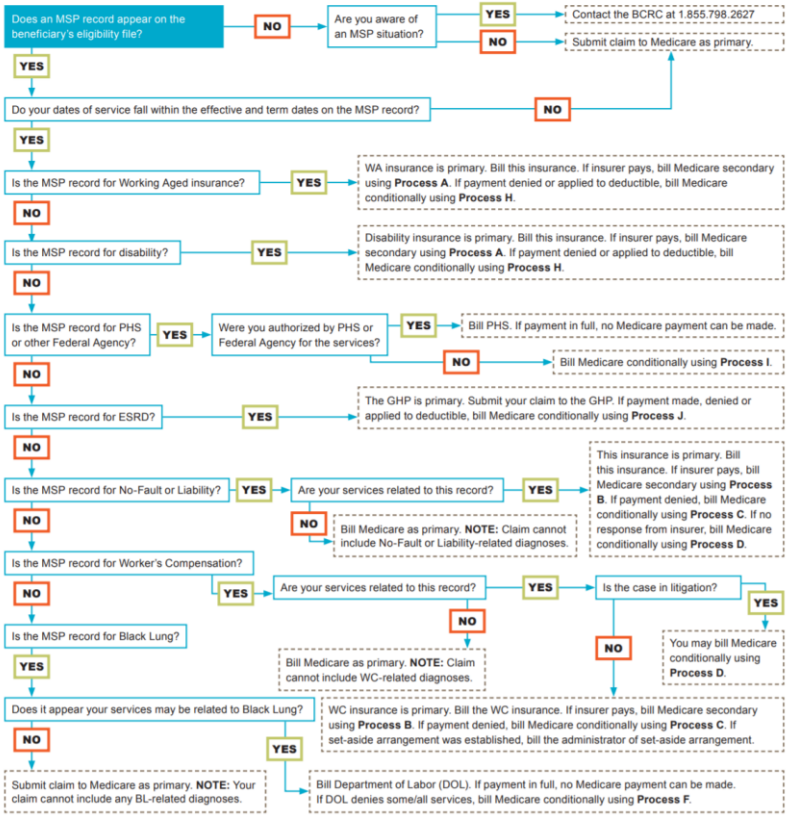
Description	Value Codes: FL39-41	Payer Codes: PAYER/FL 50	Remarks FL 80 MSP Explanation Codes*
Working aged beneficiary/spouse with GHP	12	A	BE, CD, FG, NB, PC
ESRD beneficiary in 30-month coordination period with GHP	13	B	BE, CD, FG, NB, PC
No-fault, including auto/other	14	D	BE, CD, DA, NB, PE
Workers' compensation	15	E	BE, DA, FG, NB
Public health service (PHS) or other federal agency (Ex: crime victim, drug trial)	16	F	
Black lung	41	H	BE, NB
Disabled beneficiary under age 65 with large group health plan (LGHP)	43	G	BE, CD, FG, NB, PC
Amount provider agreed to accept from primary payer when this amount is less than charges, but higher than payment received. (Enter the total amount you agreed to or are obligated to accept.) **NOTE:** Value Code 44 should not be reported with payer code 'C.'	44	Use appropriate Payer Code A-H or L	
Liability insurance	47	L	BE, DA, DP, LD PP
Conditional payment (payment denied or applied to deductible)**NOTE:** Do not submit value code 44 with Payer Code 'C.' (conditional payment).	Any of the above	C	BE, CD, DA, DP, FG, LD, NB, PC, PE, PP

* MSP Explanation Codes are used in conditional payment situations to assist CGS with claim processing. Refer to page 17 for the codes/descriptions, or the MSP Processes for applicable codes/descriptions.

Relationship Codes (REL/FL59)							
Code	**Description**	**Code**	**Description**	**Code**	**Description**	**Code**	**Description**
01	Spouse	17	Stepson/stepdaughter	23	Sponsored dependent	39	Organ donor
04	Grandfather/grandmother	18	Self	24	Dependent of minor dependent	40	Cadaver donor
05	Grandson/granddaughter	19	Child	29	Significant other	41	Injured plaintiff
07	Nephew/niece	20	Employee	32	Mother	43	Child where insured has no financial responsibility
10	Foster child	21	Unknown	33	Father	53	Life partner
15	Ward	22	Handicap dependent	36	Emancipated minor	G8	Other relationship

For a complete list of all UB-04 codes, go to the National Uniform Billing Committee website, http://www.nubc.org.

Medicare Secondary Payer BILLING & ADJUSTMENTS



NOTE: If the eligibility file lists multiple records, use chart for each record shown. If the eligibility file is incorrect, contact the Benefits Coordination & Recovery Center (BCRC) at 1.855.798.2627. For more information about MSP, see the *Medicare Secondary Payer Manual* (CMS Pub. 100-05) available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html.

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Revised January 22, 2019 • H-017-19

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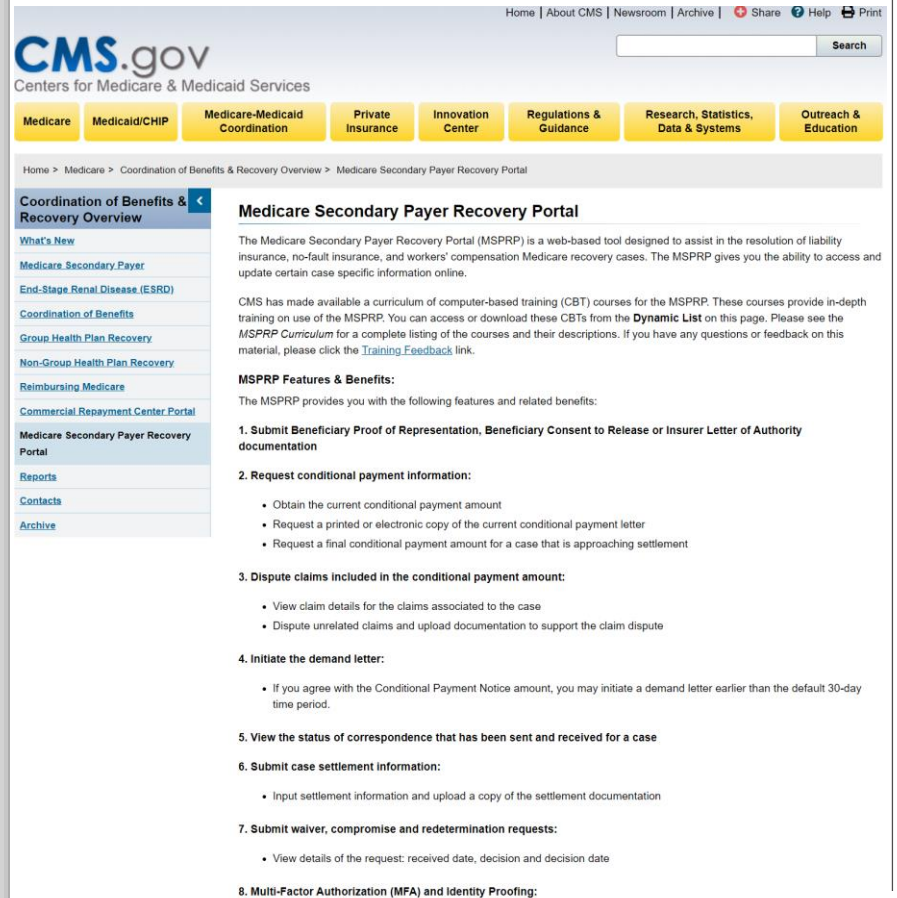
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/MSPRP/Medicare-Secondary-Payer-Recovery-Portal



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Centers for Medicare & Medicaid Services

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Coordination of Benefits & Recovery Overview

- What's New
- Medicare Secondary Payer
- End-Stage Renal Disease (ESRD)
- Coordination of Benefits
- Group Health Plan Recovery
- Non-Group Health Plan Recovery
- Reimbursing Medicare
- Commercial Repayment Center Portal
- **Medicare Secondary Payer Recovery Portal**
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Medicare Secondary Payer Recovery Portal

The Medicare Secondary Payer Recovery Portal (MSPRP) is a web-based tool designed to assist in the resolution of liability insurance, no-fault insurance, and workers' compensation Medicare recovery cases. The MSPRP gives you the ability to access and update certain case specific information online.

CMS has made available a curriculum of computer-based training (CBT) courses for the MSPRP. These courses provide in-depth training on use of the MSPRP. You can access or download these CBTs from the **Dynamic List** on this page. Please see the *MSPRP Curriculum* for a complete listing of the courses and their descriptions. If you have any questions or feedback on this material, please click the Training Feedback link.

MSPRP Features & Benefits:

The MSPRP provides you with the following features and related benefits:

1. Submit Beneficiary Proof of Representation, Beneficiary Consent to Release or Insurer Letter of Authority documentation

2. Request conditional payment information:

- Obtain the current conditional payment amount
- Request a printed or electronic copy of the current conditional payment letter
- Request a final conditional payment amount for a case that is approaching settlement

3. Dispute claims included in the conditional payment amount:

- View claim details for the claims associated to the case
- Dispute unrelated claims and upload documentation to support the claim dispute

4. Initiate the demand letter:

- If you agree with the Conditional Payment Notice amount, you may initiate a demand letter earlier than the default 30-day time period.

5. View the status of correspondence that has been sent and received for a case

6. Submit case settlement information:

- Input settlement information and upload a copy of the settlement documentation

7. Submit waiver, compromise and redetermination requests:

- View details of the request: received date, decision and decision date

8. Multi-Factor Authorization (MFA) and Identity Proofing:

- Request access to view unmasked claims data. Individuals requesting this access must complete the ID Proofing and MFA process.

Note: Only those actions that are applicable to the case will be available.

How to Access the MSPRP

Beneficiaries will access the MSPRP through the MyMedicare.Gov Web site. They will login to their MyMedicare account via the MyMedicare.gov Web site. This Web site can be accessed from the link: My Medicare.Gov. The beneficiary will enter their established Login ID and Password for that application in the Secure Sign In section of the web page. After they successfully login to the MyMedicare.Gov site and enter the MSP section, they can access the MSPRP in two different ways:

- Click the **[Case ID]** in the "Payment Details" box on the MyMedicare page of the case they would like to access.
- Click the **[Go to MSPRP]** button.

Insurers and attorneys will access the MSPRP using the following MSPRP Application link: https://www.cob.cms.hhs.gov/MSPRP/. Please note that registration must occur before access to the MSPRP is permitted. Additionally, you must complete the Identity Proofing and Multi-Factor Authentication process on the MSPRP if you wish to request access to unmasked claims data. See the MSPRP User Guide and the *Remote Identity Proofing (RIDP) - Multifactor Authentication (MFA) on the Medicare Secondary Payer Recovery Portal (MSPRP) Frequently Asked Questions*. The FAQ is available under the 'Reference Material' menu option of the MSPRP application.

MSPRP User Guide

The MSPRP User Guide was written to help you understand how to use the MSPRP. The User Guide is available under the 'Reference Material' menu option of the MSPRP application.

Assistance with MSPRP Issues

For problems related to registration and other technical issues, please contact the Benefits Coordination & Recovery Center (BCRC) EDI Department at 1-646-458-6740.

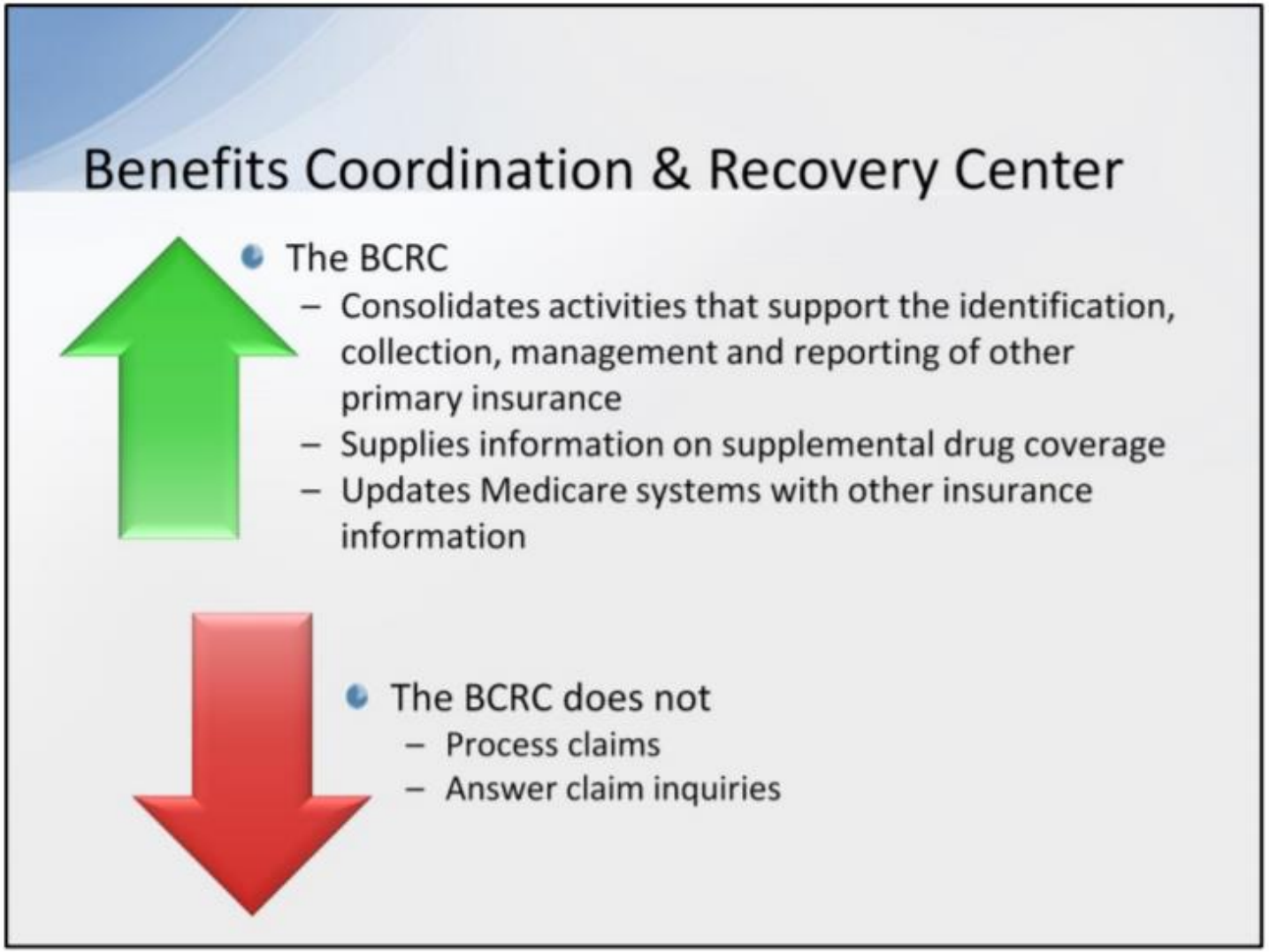
For questions related to a case or why an MSPRP option is unavailable (i.e., grayed out), please contact the BCRC at 1-855-798-2627.

Show entries: 5 per page | Filter On | Apply

Showing 1-10 of 21 entries

ID	Title	Type	Description
01	MSPRP Curriculum	PDF	A printable listing of the courses and their descriptions for the MSPRP CBT Curriculum.
02	Benefits of Using the MSPRP	PDF	This course explains the benefits of using the MSPRP and informs users what they will need to use the MSPRP.
03	Application Overview	PDF	This course will provide an overview of the MSPRP including general navigation guidelines. It will also include information on how to search for a case and the Case Information page.
04	Application Overview - Beneficiary	PDF	This course will provide an overview of the MSPRP including general navigation guidelines. It will also include information on how to search for a case and the Case Information page.
05	Corporate Registration	PDF	This course provides instruction on how to complete a New Registration on the MSPRP for a corporate account type and the steps that must be followed once the registration has been submitted. Note: This module is intended for those entities who will register for a corporate account. A corporate account indicates that the entity has an Employer Identification Number (EIN) and will be regularly submitting MSPRP requests.
06	Corporate Account Setup	PDF	This course will explain the Account Setup process for a Corporate account. It will describe the role of the Account Manager and explain how the Account Manager will complete the Account Setup and register themselves as the Account Manager. It will conclude with the steps to follow once the Account Setup has been completed. Note: This module is intended for those entities who will register for a corporate account. A corporate account indicates that the entity has an Employer Identification Number (EIN) and will be regularly submitting MSPRP requests.

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview



https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page

Coordination of Benefits & Recovery Overview

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Contacts

Note: Submit all payments, forms, documents and/or correspondence to the return mailing address indicated on recovery correspondence you have received. Otherwise, refer to the contact information provided on this page.

Benefits Coordination & Recovery Center (BCRC)

BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Note: For information on how the BCRC can assist you, please see the **Coordination of Benefits** page and the **Non-Group Health Plan Recovery** page.

Data Collections (Coordination of Benefits)

Please mail correspondence related to reporting a case, coordination of benefits, etc. to:

Medicare - Data Collections
P.O. Box 138897
Oklahoma City, OK 73113-8897

Fax:
1-405-869-3307

For Non-Group Health Plan (NGHP) Recovery initiated by the BCRC

The following addresses and fax are for information relative to NGHP Recoveries(e.g. all NGHP checks and inquiries including liability, no-fault, workers' compensation, Congressional, Freedom of Information Act (FOIA), Bankruptcy, Liquidation Notices and Qualified Independent Contractor (QIC)/ Administrative Law Judge (ALJ)):

Non-Group Health Plan (NGHP) Inquiries and Checks:
NGHP
P.O. Box 138832
Oklahoma City, OK 73113

Special Projects: (e.g. all Product Liability Case Inquiries and Special Project Checks)
Special Projects
P.O. Box 138868
Oklahoma City, OK 73113

Self-Calculated Conditional Payment Amount Option and fixed Percentage Option:
Self-Calculated Conditional Payment Amount/Fixed Percentage Option
P.O. Box 138880
Oklahoma City, OK 73113

Fax:
1-405-869-3309

MSP FAQs

April 30, 2019, Part A Medicare Secondary Payer (MSP) Pay Webcast: Questions & Answers

Bookmark Email Print Font - Font +

Question: Is there a specific form we need to have the patient fill out at each visit to comply with MSP guidelines?

Answer: CMS suggests that provider utilize the MSP Questionnaire. Go to the Centers for Medicare & Medicaid Services (CMS) Provider Services webpage and to Your Billing Responsibilities. The CMS Questionnaire is available at the bottom of the page.

Question: How do you bill a MSP claim electronically?

Answer: There is free electronic claims billing software (vendor software or PC-ACE Pro32) that can be downloaded from our website or the Direct Data Entry (DDE) system, unless you qualify for a waiver to submit paper claims. The DDE User's Guide and information on how to obtain access is available on our website under the topic EDI.

Question: Are you required to bill Medicare as secondary if the primary paid in full?

Answer: Providers are required to submit claims to Medicare for beneficiaries who have insurance primary to Medicare regardless of whether or not Medicare payment will be made.

Question: For lab reference claims on bill type 14X, that have a payer primary to Medicare and received Obligated to Accept as Payment in Full (OTAF), should providers file a claim to Medicare as secondary with Condition Code 77? If so, are the MSP Value Codes not required since an MSP is not required for Lab Reference account?

Answer: An MSP-Q is not required in a non-face-to-face reference lab. However, the claim should be submitted following MSP guidelines.

Question: Can an attorney tell no-fault insurance companies not to make payments for medical bills even if there is a primary insurance payer available?

Answer: No. Please refer attorneys to the attorney services page of the CMS.gov website so that they are aware of their obligations for MSP claims.

Question: If liability or no fault does not pay, are we required to bill Medicare by law if an attorney's office is waiting for us to file Medicare before paying?

Answer: You must bill the primary insurance prior to billing Medicare. Refer attorney to the above link so that they are aware of their obligations for MSP claims.

Question: If a patient completes a MSPQ and indicates an accident, but no liability (record) is available, and we contact them by phone and they indicated not liability available, do we bill Medicare as primary based on the patient's response. However, we later receive a payment for the accident. We also checked the Common Working File (CWF) and there is no open MSP on file. What should we do the payment we received?

Answer: Contact the Benefits Coordination & Recovery Center (BCRC) to report potential MSP situations or invalid MSP auxiliary files, or to have the appropriate record added to the patient's file. The BCRC Customer Call Center toll free number is 855–798–2627. If you received two primary payments, you should refund Medicare's payment in full. Submit a payment along with the disclosed overpayment, the appropriate MSP Voluntary Refund form must be submitted along with the primary insurer's EOBs.

https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~JM%20Part%20A~Articles~General~BCGJPQ8381?open

Common Billing Errors

https://palmettogba.com/palmetto/providers.nsf/MACtoberfest_2018_JJ_Medicare_Part_B_Billing_and_Clinical_Updates_Final.pdf

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Why We Need to Review RHC Billing

CERT Jurisdiction J
November 2017 Report

State	Project-ed Error Rate	Projected Im-proper Payment	Number of Claims Sampled	95% Confidence Interval	Proportion of Overall Error
Overall JJ	**10.1%**	**$1,511,029,383**	**2,163**	**7.4% - 12.7%**	**72.4%**
AL	16.1%	$732,558,643	512	7.1% - 25.0%	35.1%
TN	5.7%	$422,329,731	768	3.4% - 8.0%	20.2%
GA	6.1%	$356,141,009	883	4.1% - 8.1%	17.1%

Alabama has a 16.1% Projected Error Rate

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To Avoid Errors Document Timely

Timely

- Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

- The CMS IOM does not provide any specific period to reflect "as soon as practicable," however, WPS GHA medical directors would offer a reasonable time frame of 24-48 hrs.

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Provider Signature on Medical Record

Physician Authentication

- A provider may not submit a claim to Medicare until the documentation is completed. Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done.

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Consent to Treat

Signature

- 491.10 – Records System – Informed Consent
  - Name of the specific procedure(s)
  - Practitioner who is performing the procedure(s)
  - Statement that the procedure, benefits, material risks, and alternative therapies, was explained to the patient.
  - Signature of the patient or the patient's representative; and
  - Date and time the informed consent is signed by the patient.

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Use an ABN for Non-covered Services

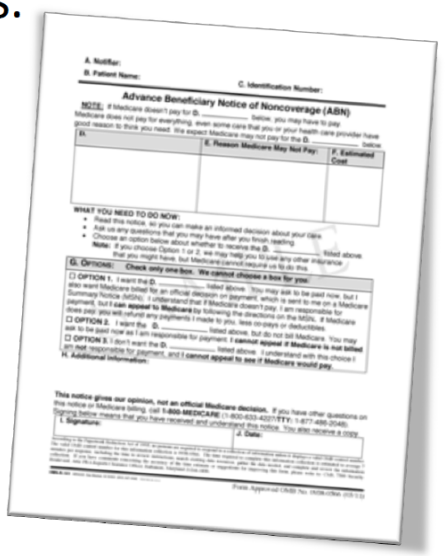
Lack of Advanced Beneficiary Notice (ABN)

An ABN is a written notice from Medicare (standard government form CMS-R-131), given to a patient before receiving certain items or services:

- Medicare may deny payment for that specific procedure
- Patient will be personally responsible

  for full payment if Medicare denies

  payment.



Advance Beneficiary Notice of Noncoverage (ABN)

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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.
- This is an unconventional use of -59 and is only used in this way, unique to RHC billing of multiple visits on the same date of service.
- Use of modifiers (-59, -25) other than the -CG modifier on Medicare claims with multiple services may trigger an incorrect overpayment.

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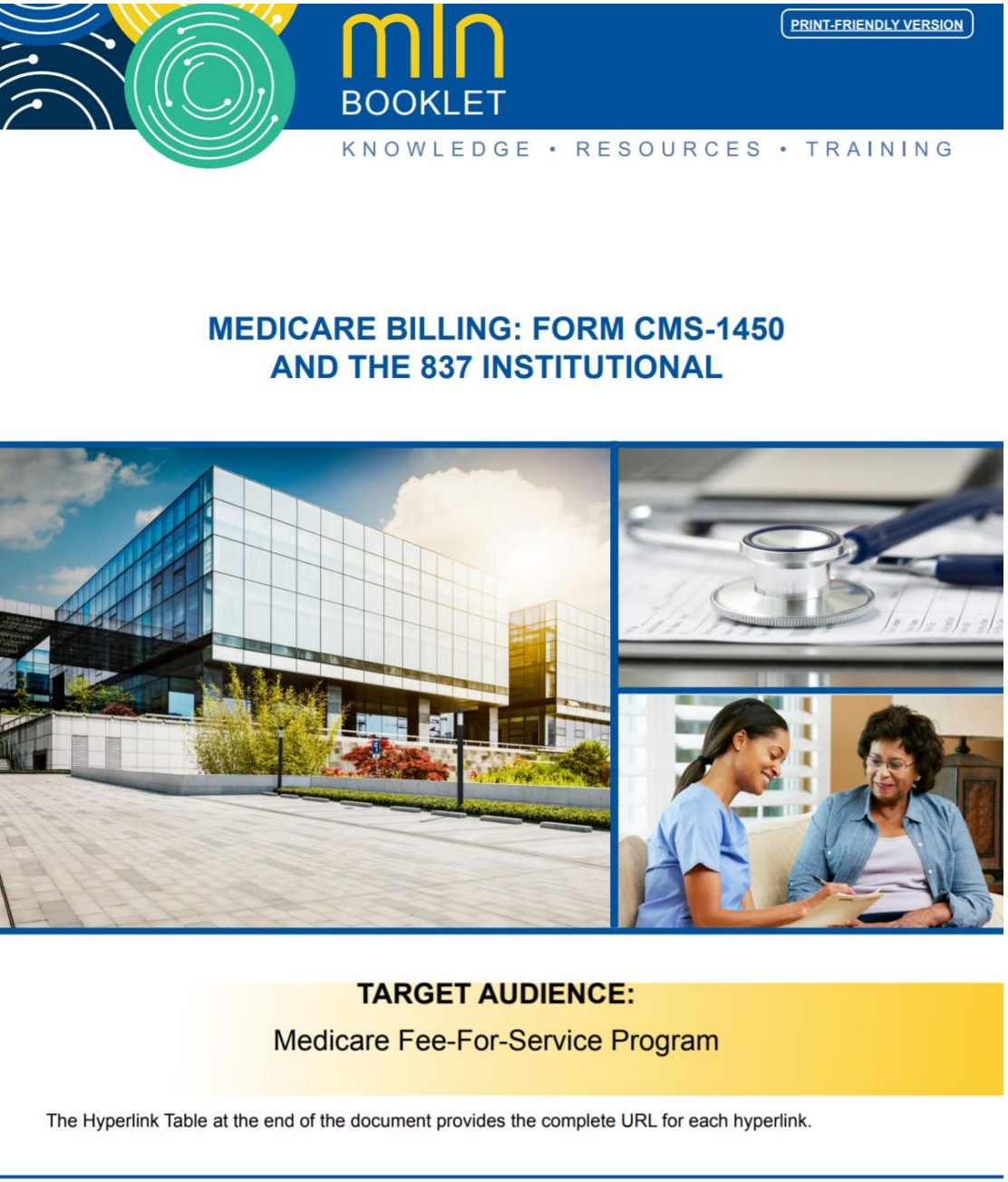
Filing a Claim – Completing the UB-O4

UB-04 Fact Sheet

This Fact Sheet covers basic Information about the UB-04. 11-page PDF updated June, 2018

file:///C:/Users/la_vi/Downloads/006926_2018-06_MedicareBillingFormCMS-1450andthe837I_Final.pdf



WHAT ARE THE 837I AND THE FORM CMS-1450?

The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically. The Form CMS-1450, also known as the UB-04, is the standard claim form to bill Medicare Administrative Contractors (MACs) when a paper claim is allowed. In addition to billing Medicare, the 837I and Form CMS-1450 may be suitable for billing various government and some private insurers.

Data elements in the Centers for Medicare & Medicaid Services (CMS) uniform electronic billing specifications are consistent with the hard copy data set to the extent that one processing system can handle both. CMS designates the form as the Form CMS-1450 and the form is referred to throughout this booklet as the CMS-1450.

Institutional providers include hospitals, Skilled Nursing Facilities (SNFs), End Stage Renal Disease (ESRD) providers, Home Health Agencies (HHAs), Hospice Organizations, Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services, Comprehensive Outpatient Rehabilitation Facilities (CORFs), Community Mental Health Centers (CMHCs), Critical Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), Histocompatibility Laboratories, Indian Health Service (IHS) Facilities, Organ Procurement Organizations, Religious Non-Medical Health Care Institutions (RNHCIs), and Rural Health Clinics (RHCs).

ANSI ASC X12N 837I

The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837I (Institutional) Version 5010A2 is the current electronic claim version. To learn more, visit the ASC X12 website.

- **ANSI =** American National Standards Institute
- **ASC =** Accredited Standards Committee
- **X12N =** Insurance section of ASC X12 for the health insurance industry's administrative transactions
- **837 =** Standard format for transmitting health care claims electronically
- **I =** Institutional version of the 837 electronic format
- **Version 5010A2 =** Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for institutional providers.

The National Uniform Billing Committee (NUBC) makes their UB-04 manual available through their website. This manual contains the updated specifications for the data elements and codes included on the CMS-1450 and used in the 837I transaction standard. MACs may include a crosswalk between the ASC X12N 837I and the CMS-1450 on their websites.

Direct Data Entry

The Direct Data Entry (DDE) system was designed as an integral part of the Fiscal Intermediary Standard System (FISS) to be used by all Medicare A providers. DDE will offer various tools to help providers obtain answers to many questions without contacting Medicare Part A via telephone or written inquiry. It will also provide another avenue for electronically submitting claims to the fiscal intermediary, which are listed below.

- **Key and send UB-04 claims**
- **Correct, adjust and cancel claims**
- **Inquire about the patient's eligibility**
- **Access the Revenue Code, HCPCS Code and ICD-9 Code inquiry tables**
- **Access the Reason Code and Adjustment Reason Code inquiry tables**

https://www.palmettogba.com/Palmetto/Providers.Nsf/files/EDI_Enroll_AB_DDE.pdf/$File/EDI_Enroll_AB_DDE.pdf

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/
Federally Qualified Health Centers

Table of Contents
(Rev. 3434, 12-31-15)

Chapter 9 of the RHC Manual has information on how to complete the UB-04 Form

https://www.cms.gov/media/136461

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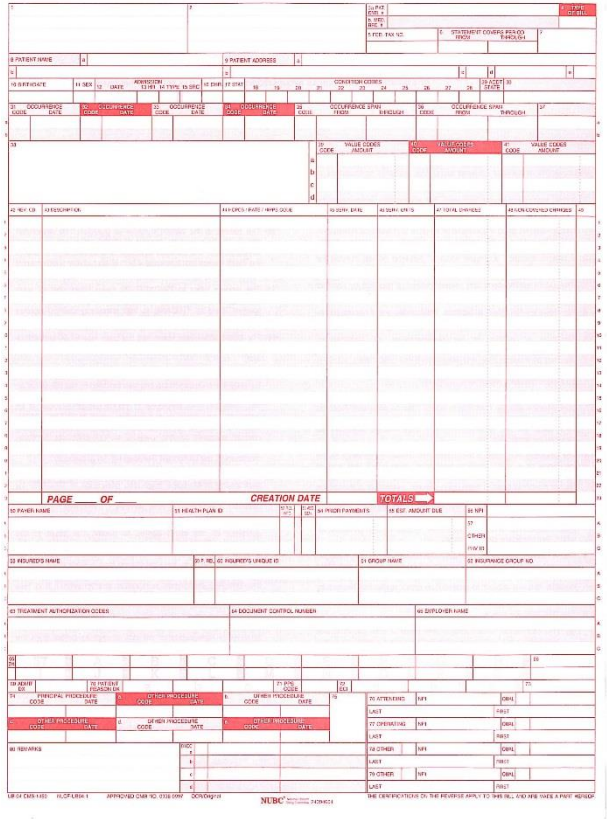
Completing the UB-04

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



Completing the UB-04

5010 Transition -RHC UB-04 Claims Requirements Cheatsheet
Source: HRSA Technical Assistance for RHCs presentation
February 2, 2012

This Cheatsheet is derived from Janet Lytton's excellent presentation sponsored by the NARHC. If you would like to contact Janet, her email is RHDconsultJL@hotmail.com.

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		
3a	Y	Patient control number	RHC created
3b	N	Medical Record Number	Use situationally
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
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
14	Y	Admission Type	This is new – RHCs will most like use the following: 2 = urgent 3 = elective (most common) 9 = information not available

https://static1.squarespace.com/static/53c5f79de4b0f4932a3942a8/t/5e2dfadb491d5b77519df3de/1580071643539/2017+5010+Transition+UB-04+Claims+Requirement+Cheatsheet.pdf

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Completing the UB-04

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.

To learn more about to learn more about electronic filing requirements, including the Electronic Data Interchange (EDI) enrollment form that must be completed prior to submitting Electronic Media Claims (EMCs) or other EDI transactions to Medicare, please refer to the CMS Claims Processing Manual Pub 100-04, Chapter 24 *.

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.***

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

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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RHC Bill Types Form Locator 4

Type	Description
711	Admit to discharge
717	Adjustment
718	Cancel
710	No payment

Source: 100-4, Chapter 9, Section 100

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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
300	Laboratory
320	Radiology
636	Injections - Serums
730	EKG

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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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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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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

32. Condition, Occurrence, and Value Codes are mainly used for reporting Medicare Secondary Payor information.

a. True

b. False

https://www.cgsmedicare.com/parta/pubs/news/2013/0213/cope21194.html#A

February 12, 2013 – Revised 10.01.15

Medicare Secondary Payer (MSP): Condition, Occurrence, Value, and Patien Relationship, and Remarks Field Codes

This article includes tables of some of the most common Condition, Occurrence, Value, Patient Relationship, and Remarks Field Codes associated with MSP claims. Please note: these code lists are not all-inclusive. Complete code sets are available through the National Uniform Billing Committee (NUBC website, www.nubc.org.

To navigate directly to a particular type of code, click on the type of code from the following list:

Condition Codes (ccs) (UB-04 FLs 18-28)

Code	Description
02	Condition is employment related
06	End-stage renal disease (ESRD) beneficiary in first 30 months of eligibility/entitlement covered by an employer group health plan (EGHP)
08	Beneficiary refused to provide information concerning other insurance coverage
09	Neither the beneficiary nor spouse is employed
10	Beneficiary and/or spouse is employed but no EGHP
11	Disabled beneficiary and/or family member is employed but no large group health plan (LGHP)
28	Beneficiary's and/or spouse's EGHP is secondary to Medicare. Beneficiary and/or spouse are employed and there is an EGHP that covers beneficiary but either: 1. EGHP is a single employer plan and employer has fewer than 20 full- and/or part-time employees 2. EGHP is a multi- or multiple-employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees
29	Disabled beneficiary and/or family member's LGHP is secondary to Medicare. Beneficiary and/or family member(s) are employed and there is a LGHP that covers beneficiary but either: 1. LGHP is a single employer plan and employer has fewer than 100 full- and/or part-time employees 2. LGHP is a multi-or multiple employer plan and all employers participating in plan have fewer than 100 full- and/or part-time employees
63	Services rendered to beneficiary in state or local custody (prisoner) meets requirements of 42 CFR 411.4(b) for payment
77	Provider accepts or is obligated/required, due to a contractual arrangement/law, to accept payment by primary payer as payment in full (and that amount has been received and no Medicare payment is due). MSP claim is being filed because claim is an inpatient claim or claim is an outpatient claim and the beneficiary has not yet met his/her annual Medicare Part B deductible.
D7	Change to make Medicare the secondary payer (report on adjustment when original claim was processed as a Medicare primary claim, conditional claim or was rejected for MSP).
D8	Change to make Medicare the primary payer (report on adjustment when original claim was processed as an MSP claim or as a conditional claim).
D9	Any other change (report on adjustment claim when original claim was rejected for MSP but Medicare is primary or when original claim was processed as an MSP or conditional claim and a change needs to be made to the claim such as a change in the MSP VC amount).

Occurrence Codes (OCs) and Dates (UB-04 FLs 31 – 34)

Code	Description
01	Accident/Medical Payment Coverage – Date of accident/injury for which there is medical payment coverage. Reported with VC 14 or VC 47. If filing for a Conditional Payment, report with Occurrence Code 24.
02	No-Fault Insurance (including automobile and other accidents) – Date of accident/injury for which the state has applicable No-Fault laws. Reported with VC 14 or 47. If filing for a Conditional Payment, report with Occurrence Code 24.
03	Accident/Tort Liability - Date of an accident/injury resulting from a third party's action that may involve a civil court action in an attempt to require payment by third party, other than No-Fault. Reported with VC 47.
04	Accident/Employment-Related - Date of an accident/injury related to beneficiary's employment. Reported with VC 15 or VC 41. If filing for a Conditional Payment, report with Occurrence Code 24.
05	Accident/No Medical Payment, No-Fault or Liability Coverage – Date of accident/injury for which there is no Medical Payment or other third-party liability coverage
06	Crime victim - Date on which a medical condition resulted from alleged criminal action committed by one or more parties
18	Date of retirement (beneficiary)
19	Date of retirement (spouse)
24*	Date Insurance denied - Date of receipt of a denial of coverage by a higher priority payer. This could be date of primary payer's Explanation of Benefit (EOB) statement, letter or other documentation. Date is required on all Conditional Payment claims.
25	Date Coverage No Longer Available – Date on which coverage, including Workers' Compensation benefits or No-Fault coverage, is no longer available to beneficiary
33	First day of MSP ESRD coordination period for ESRD beneficiaries covered by an EGHP

* Maintain documentation on file that supports the request for conditional payment from Medicare, such as the primary payer's EOB statement, denial/rejection letter, etc.

Value Codes (VCs) and Amounts (UB-04 FLs 39-41) When entering amounts for VCs (except for VC 44), the following applies:

- Enter the amount provider received from primary payer toward Medicare-covered charges on claim
- If requesting conditional payment, enter zeros (00.00)
- If no payment or reduced payment was received due to failure of filing a proper claim with primary payer, enter amount provider would have recei had it filed a proper claim with primary payer.

Code	Description
12	Working aged beneficiary/spouse with an EGHP (beneficiary over 65). Beneficiary must have Medicare Part A entitlement (enrolled in Part A) for this provision to apply. Primary Payer Code = A.
13	ESRD beneficiary with EGHP in MSP/ESRD 30-month coordination period. Primary Payer Code = B.
14	No-Fault including automobile/other. Examples: Personal injury protection (PIP) and medical payment coverage. Requires OC 01 or 02 with date of accident/injury. Primary Payer Code = D. If filing for a Conditional Payment, report with Occurrence Code 24.
15	Workers Compensation (WC). Requires CC 02 and OC 04 with date of accident/injury. Primary Payer Code = E. If filing for a Conditional Payment, report with Occurrence Code 24.
16	Public health services (PHS) or other federal agency. Conditional billing does not apply. Primary Payer Code = F.
41	Federal Black Lung (BL) Program. Primary Payer Code = H.
42	Veterans Administration (VA). Conditional billing does not apply. Primary Payer Code = I.
43	Disabled beneficiary under age 65 with an LGHP. Beneficiary must have Medicare Part A entitlement (enrolled in Part A) for this provision to apply. Primary Payer Code = G.
44	Amount provider was obligated/required to accept from a primary payer as payment in full due to contract/law when that amount is less than charges but higher than amount actually received. An MSP payment may be due. **Note:** When applicable, this VC is reported in addition to MSP VC.
47	Any Liability Insurance. Requires OC 02 with date of accident/injury. Primary Payer Code = L. If filing for a Conditional Payment, report with Occurrence Code 24

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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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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)

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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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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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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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Questions/Comments

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