RURAL HEALTH ASSOCIATION OF TENNESSEE

Rural Health Clinic Billing – 101
Healthcare Business Specialists
February 15, 2023

HBS
Healthcare Business Specialists

HBS
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CONTACT INFORMATION

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A Quick Summary

- Rural Health Center (RHC) is a CMS designation.
- RHCs may be independent (freestanding) or provider based.
- RHCs provides access to primary care in underserved areas
    - Medicaid required to recognize RHCs
    - Commercial payors make no distinction for RHCs
- Typical Provider Types in an RHC
    - Physicians - MDs and DOs
    - Advanced Practice Practitioners (NP, PA, CNM)
    - Clinical psychologist
    - Clinical Social Workers
- At least 51% of the services provided must be primary care services and can not be primarily a mental health provider
- At least 50% of the time, the clinic must be staffed with advanced practice practitioners (NP, PA, CNM)
- Medicare reimbursement is based on an all-inclusive rate (AIR)
- Each RHC must have their own NPI (National Provider Identifier) number
- Bill using the UB-04 format to Medicare for RHC covered services

Tenncare Summary RHC Payment Summary

RHCs bill MCOs according to the MCOs billing and payment guidance

Quarterly the RHC will submit a wrap report to Tenncare for the difference in their RHC rate and what the MCO paid on an interim basis

The Quarterly Wrap report is settled only on paid claims not based upon the date of service

Tenncare rates for RHCs entering the program post moriatum

Caseload Mix Averages - EAST		
	> 8,000	8,000 to 13,999
6/30/2017	$ 167.48	$ 124.05
6/30/2018	$ 169.49	$ 125.54
6/30/2019	$ 171.86	$ 127.30
6/30/2020	$ 174.44	$ 129.21
6/30/2021	$ 177.75	$ 131.66
6/30/2022	$ 180.24	$ 133.51
6/30/2023	$ 184.03	$ 136.31

Regional Average - EAST	
6/30/2021	$ 142.72
6/30/2022	$ 144.72
6/30/2022	$ 147.76

Regional Average - MIDDLE	
6/30/2021	$ 135.85
6/30/2022	$ 137.76
6/30/2022	$ 140.65

Caseload Mix Averages - MIDDLE		
	> 8,000	8,000 to 13,999
6/30/2017	$ 137.88	$ 151.94
6/30/2018	$ 139.54	$ 153.77
6/30/2019	$ 141.49	$ 155.92
6/30/2020	$ 143.61	$ 158.26
6/30/2021	$ 146.34	$ 161.27
6/30/2022	$ 148.39	$ 163.52
6/30/2023	$ 151.51	$ 166.95

Regional Average - WEST	
6/30/2021	$ 146.34
6/30/2022	$ 148.39
6/30/2022	$ 151.51

Caseload Mix Averages - WEST		
	> 8,000	8,000 to 13,999
6/30/2017	$ 143.51	$ 131.03
6/30/2018	$ 145.23	$ 132.60
6/30/2019	$ 147.26	$ 134.46
6/30/2020	$ 149.47	$ 136.47
6/30/2021	$ 152.31	$ 139.06
6/30/2022	$ 154.44	$ 141.01
6/30/2023	$ 157.68	$ 143.97

RHC Resources for Billing Information

Where to look and where to find help

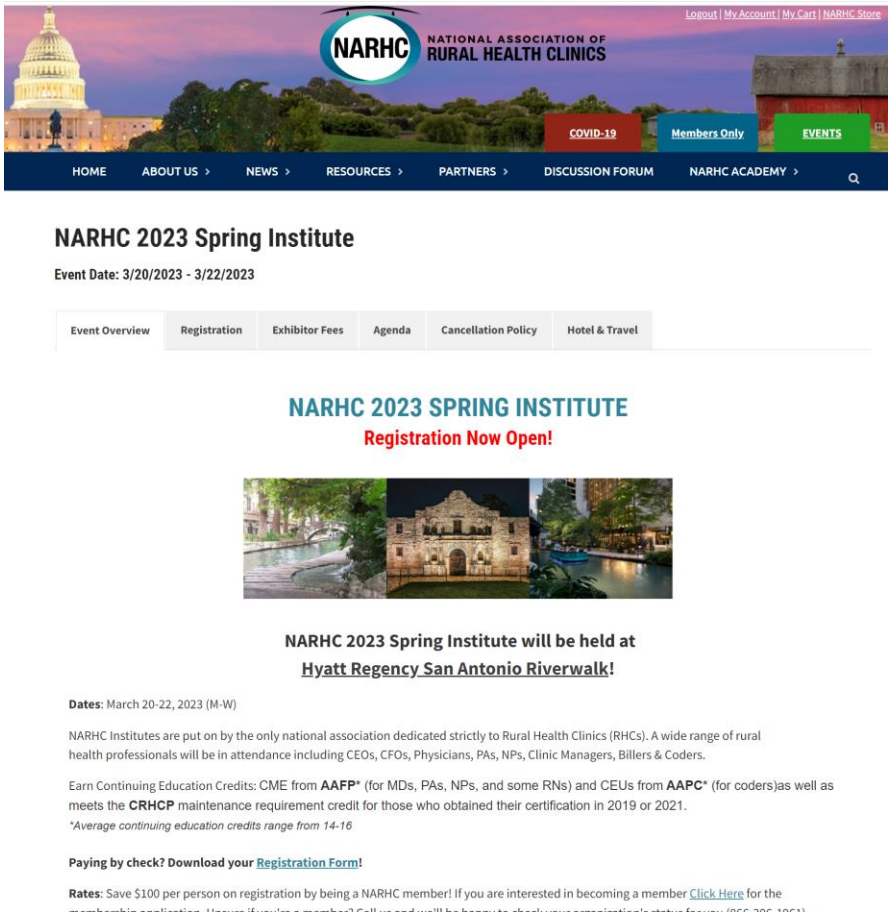
Where to Find Help

Name	Abbreviation	Type	Website
National Association of Rural Health Clinics	NARHC	Membership Organization	https://www.narhc.org/narhc/Default.asp
National Rural Health Association	NRHA	Membership Organization	https://www.ruralhealth.us/
Rural Health Association of Tennessee	RHAT	Membership Organization	https://www.tnruralhealth.org/
ArchProCoding	ARCH	Membership Organization	https://www.archprocoding.com/
Rural Health Information Hub	RHI HUB	Website	https://www.ruralhealthinfo.org/
National Rural Health Resource Center	NRC	Website	https://www.ruralcenter.org/
RHC Information Exchange	RHCIE	Facebook Group	https://www.facebook.com/groups/1503414633296362
RHC Billing Resources from HBS	HBS	Website	http://www.ruralhealthclinic.com/rhc-billing

National Association of RHCs

https://www.narhc.org/narhc/Default.asp

NARHC Spring Institute – March 20-23, 2023



https://www.narhc.org/assnfe/ev.asp?ID=464

https://www.narhc.org/assnfe/ev.asp?ID=394

Introduction to RHCs

Event Overview | Registration

Introduction to RHCs

The National Association of Rural Health Clinics is proud to announce the launch of a new orientation tool that will offer new employees of Rural Health Clinics the opportunity to learn the fundamentals of running an RHC as well as a brief history of the RHC program and how NARHC was formed.

This online course consists of 4 short modules created by Shannon Chambers, Director of Provider Solutions at the South Carolina Office of Rural Health, Teresa Treiber, Manager RHC Team for Spectrum Health Corporate in Michigan, and NARHC staff. The modules cover the basics of what it means to be a Rural Health Clinic and explores how RHCs differ from other types of clinician offices. This is a self-paced course consisting of approximately 1 hour of video content.

- **Cost**: NARHC Member FREE! We do ask that each individual person creates an account and registers for the course. Non-Member $50
  Not a current member? Click Here for a list of member benefits and to download a membership application. Unsure if you're a member? Call us and we'll be happy to check your status for you 866-306-1961.
- **Educational Learning Format**: On-Line. It is recommended that you use Chrome as your browser for all NARHC courses.
- **Length**: Approximately 60 minutes
- **Content**: Those going through this orientation tool will learn about the history of the RHC program and how the National Association of Rural Health Clinics came to be. In addition, they will be educated with a high-level overview of managing an RHC vs a Non-RHC, RHC basics, best practices for RHC managers and understanding the value of being a Rural Health Clinic.
- **Pre-requisites**: None
- **Who should take this course?** New employees and individuals that are new to rural health clinics

For a more thorough and in depth look at how to manage an RHC please consider taking our Certified Rural Health Clinic Professional Course (CRHCP). You can find more information on the CRHCP course Here.

Become a CRHCP

2022 Spring CRHCP Session

Event Date: 1/17/2022 - 4/4/2022

Event Overview | Registration | Cancellation Policy | Frequently Asked Questions

NARHC's Certified Rural Health Clinic Professional (CRHCP) Course

REGISTRATION CLOSES FEBRUARY 28th

NARHC is offering Directors, Clinic Administrators & other RHC leaders a unique full-spectrum course designed to teach you how to operate a successful Rural Health Clinic. Upon course completion & attainment of an 80% or higher exam score, you will earn a CRHCP certification.

- **Enrollment**: Begins January 2022. Download the PDF form **HERE** and return OR register online (above registration tab). As soon as your payment has been processed, you will receive an email notification with further instructions regarding the course.

- **Cost**: NARHC Member $450, Non-Member $600
  Course Workbook is available during registration at an additional fee:
  $35 Digital file $50 Spiral Bound Printed Workbook (includes digital file)

Member Rates: Save $100-$125 per person on registration by being a NARHC member! Not a current member? Click on the Join Today on the right-hand side of the page to fill out a

https://www.narhc.org/assnfe/ev.asp?MODE=&ID=451

Join NARHC DC Staff for Virtual Office Hours!

NARHC DC Staff continues host RHC Office Hours at 1 pm ET every other Wednesday via Zoom. We encourage anyone with RHC questions to join us!

We hope that this form of technical assistance will increase the dialogue between NARHC staff and the RHC community. Questions regarding HRSA COVID-19 programs, RHC policy, Medicare, RHC certification, and more are all acceptable!

Stop by the Zoom room anytime between 1 and 2 PM ET, and as always don't hesitate to contact us if you need assistance outside of this time.

The schedule for 2023 is as follows:

Wednesday, January 11
Wednesday, January 25
Wednesday, February 8
Wednesday, February 22
Wednesday, March 8
Wednesday, April 5

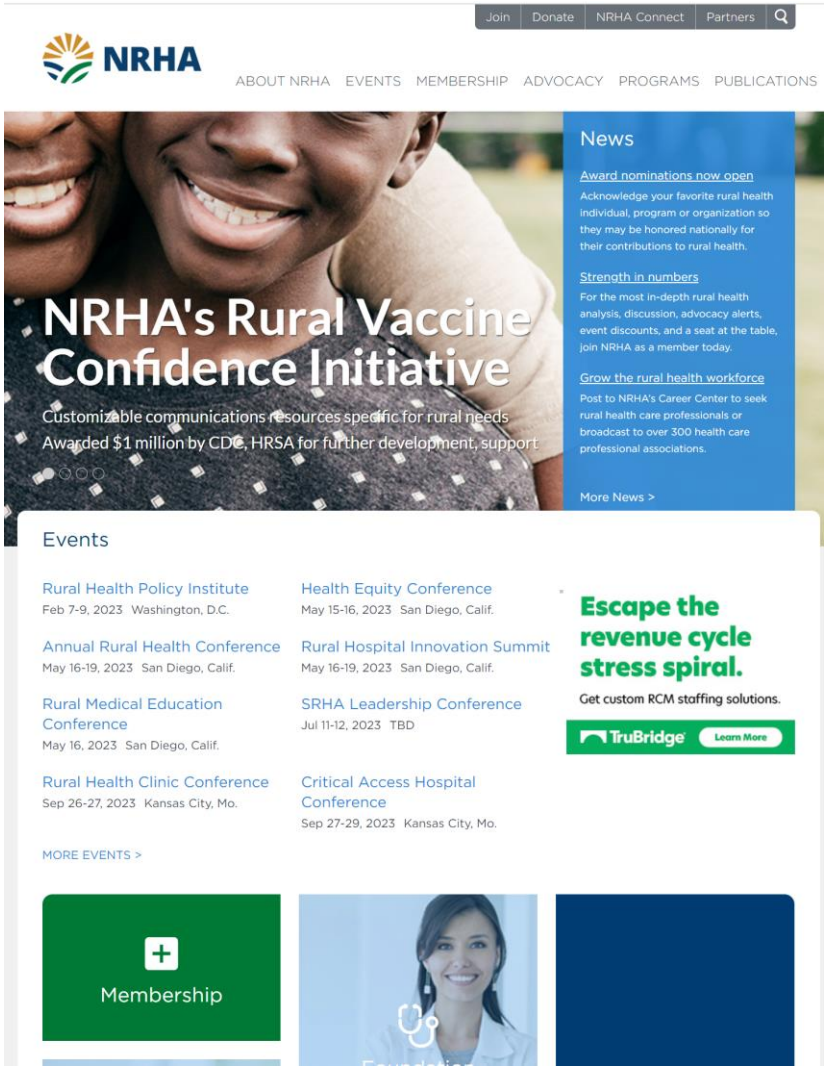
Join NARHC DC Staff for Virtual Office Hours!

- No registration is required, and RHCs can join using the below link or call-in information.
- **Zoom Webinar Information:**
https://us06web.zoom.us/s/81747173194

Audio Conference Details:
Attendees without computer access or computer audio can use the dial-in information below:

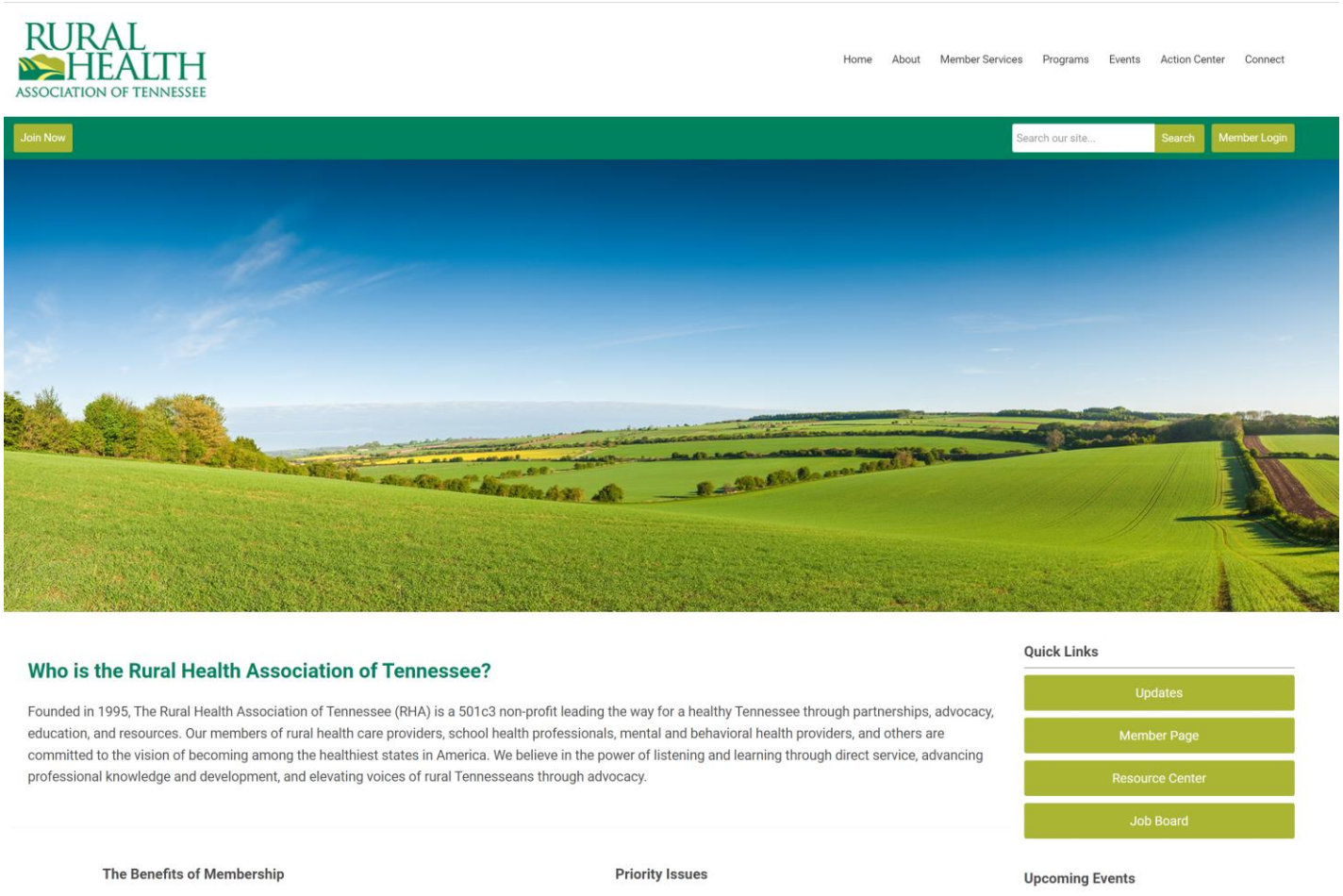
- Dial-in Toll-Free #: +1 301-715-8592 PIN: 817 4717 3194#
- Meeting ID: 817 4717 319
- We hope to see you there!
-

National Rural Health Association



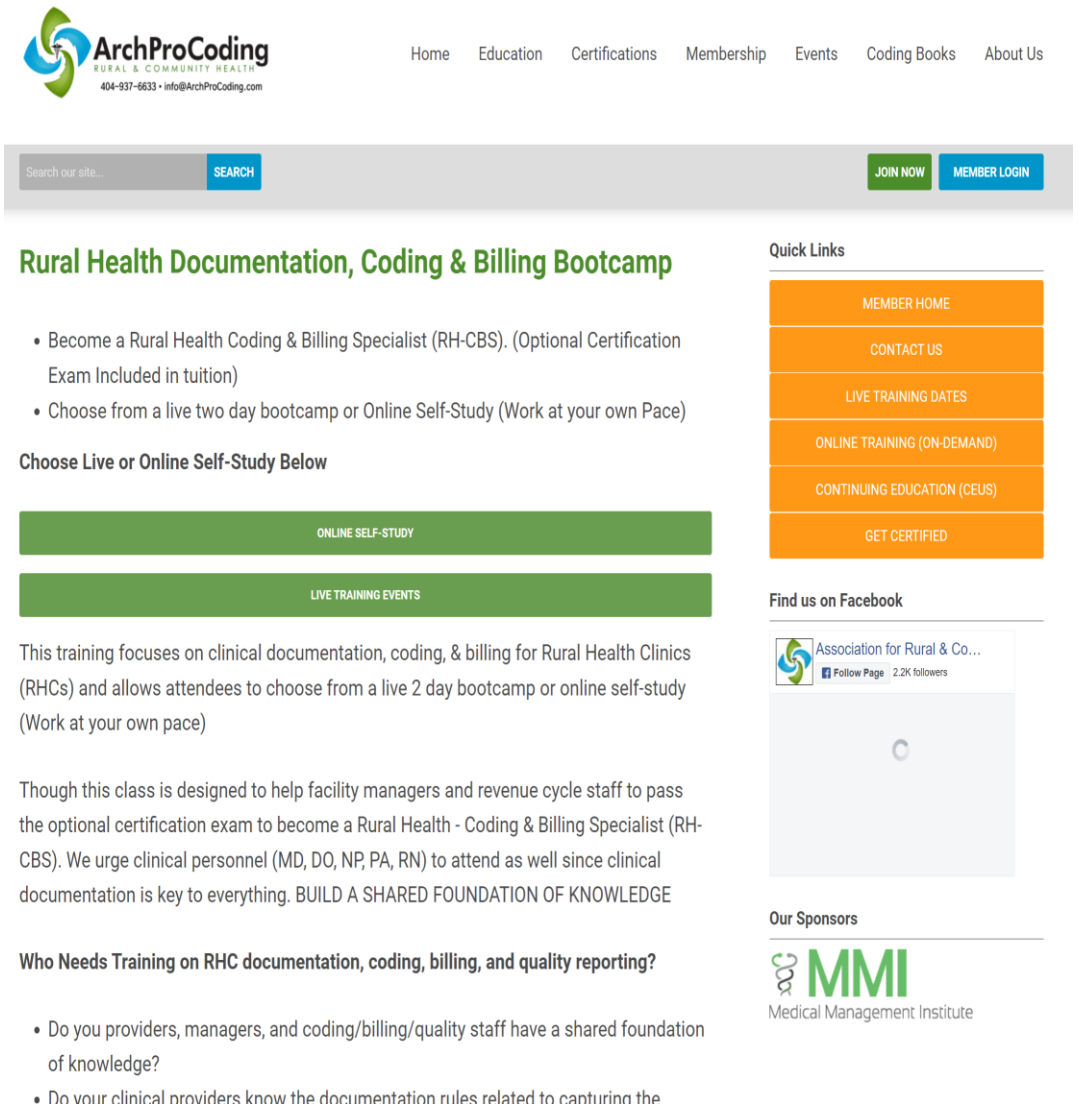
- https://www.ruralhealth.us/

Rural Health Association of Tennessee



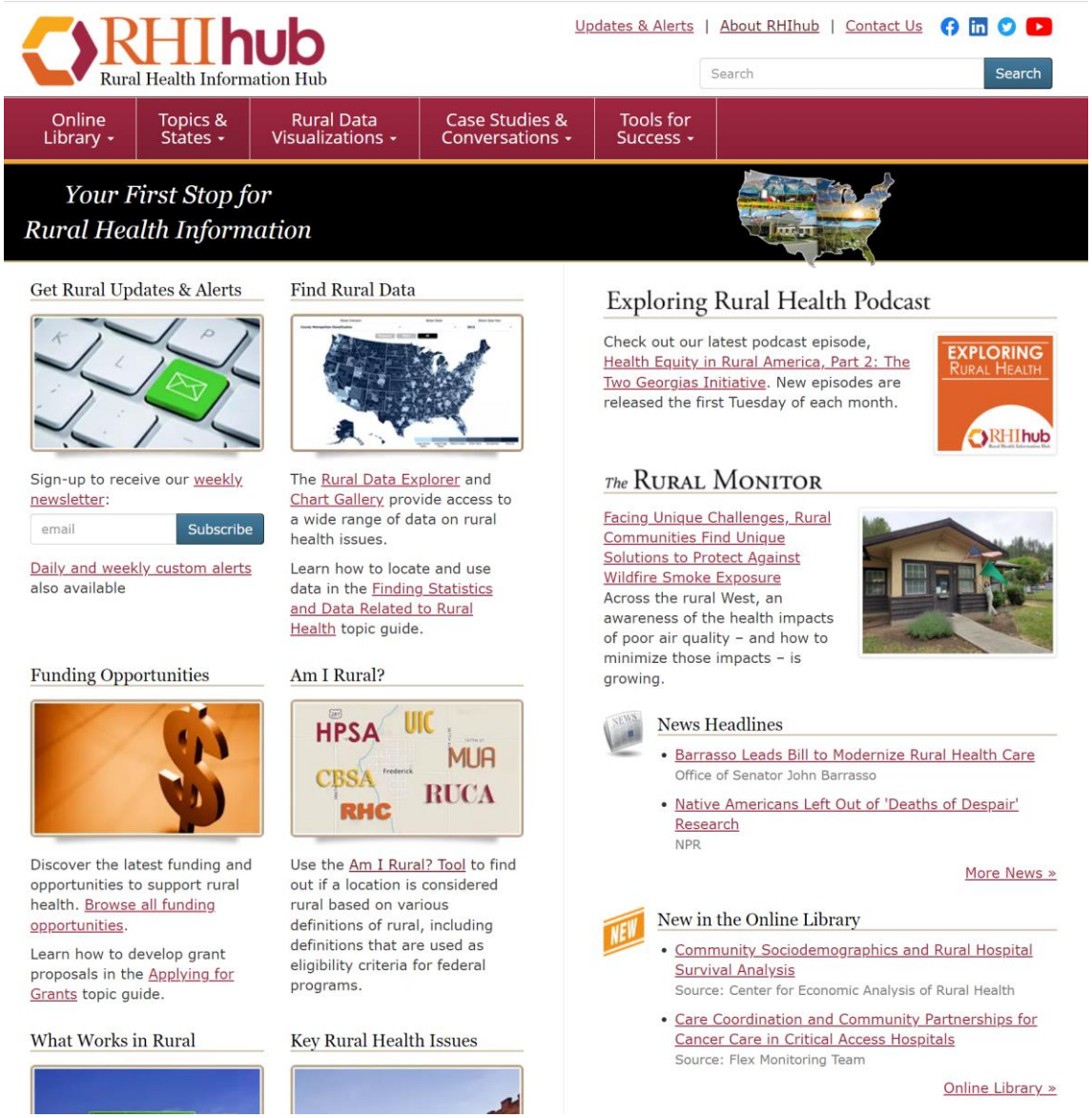
https://www.tnruralhealth.org/

[Become a RH-CBS https://www.archprocoding.com/](https://www.archprocoding.com/)



Rural Health Information Hub

- https://www.ruralhealthinfo.org/topics/rural-health-clinics



National Rural Health Resource Center

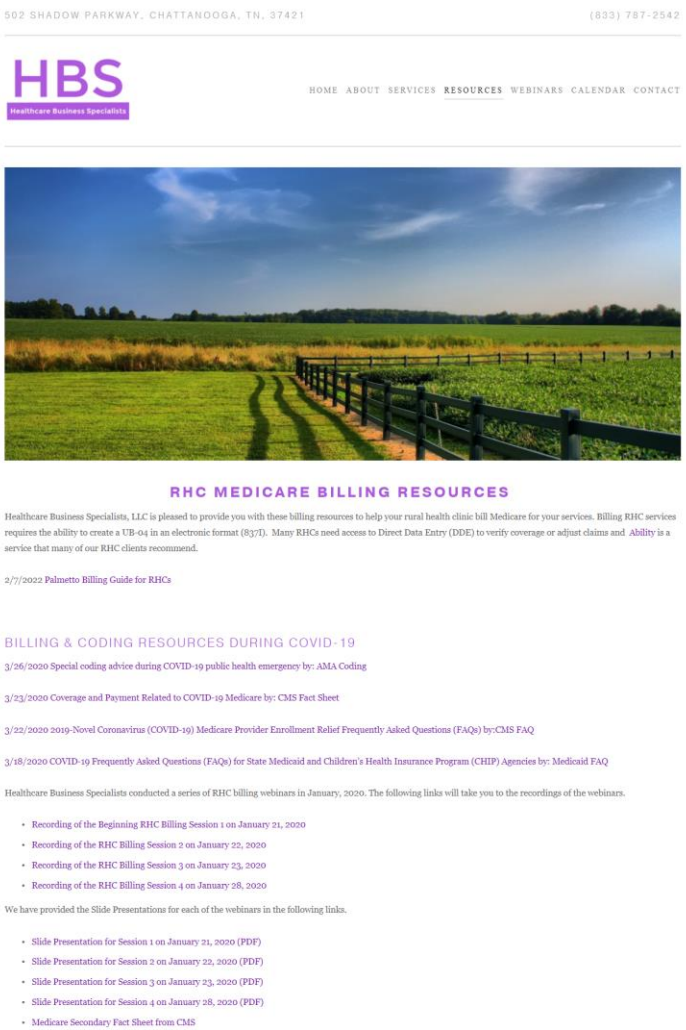
- https://www.ruralcenter.org/

Rural Health Clinics Information Exchange Facebook Group

- The Facebook Group has 4,100 members.
- Conferences, Seminars, and Webinar announcements.
- Updates of RHC information.
- You can ask questions to the group.

https://www.facebook.com/groups/1503414633296362

RHC Billing Resources from HBS



502 SHADOW PARKWAY, CHATTANOOGA, TN, 37421 (833) 787-2542

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RHC MEDICARE BILLING RESOURCES

Healthcare Business Specialists, LLC is pleased to provide you with these billing resources to help your rural health clinic bill Medicare for your services. Billing RHC services requires the ability to create a UB-04 in an electronic format (837I). Many RHCs need access to Direct Data Entry (DDE) to verify coverage or adjust claims and Ability is a service that many of our RHC clients recommend.

2/7/2022 Palmetto Billing Guide for RHCs

BILLING & CODING RESOURCES DURING COVID-19

3/26/2020 Special coding advice during COVID-19 public health emergency by: AMA Coding

3/23/2020 Coverage and Payment Related to COVID-19 Medicare by: CMS Fact Sheet

3/22/2020 2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs) by:CMS FAQ

3/18/2020 COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies by: Medicaid FAQ

Healthcare Business Specialists conducted a series of RHC billing webinars in January, 2020. The following links will take you to the recordings of the webinars.

- Recording of the Beginning RHC Billing Session 1 on January 21, 2020
- Recording of the RHC Billing Session 2 on January 22, 2020
- Recording of the RHC Billing Session 3 on January 23, 2020
- Recording of the RHC Billing Session 4 on January 28, 2020

We have provided the Slide Presentations for each of the webinars in the following links.

- Slide Presentation for Session 1 on January 21, 2020 (PDF)
- Slide Presentation for Session 2 on January 22, 2020 (PDF)
- Slide Presentation for Session 3 on January 23, 2020 (PDF)
- Slide Presentation for Session 4 on January 28, 2020 (PDF)
- Medicare Secondary Fact Sheet from CMS

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

Recordings of Previous Billing Webinars

Description	Date	Presenter	Recording	Presentation
RHC Billing 101 – Building Blocks	2/7/2022	Mark Lynn – Healthcare Business Specialists	Recording of the webinar	Powerpoint Presentation for the webinar (PDF)
RHC Billing 201 – The Basics of Medicare billing for independent and provider-based RHCs	2/22/2022	Amanda Dennison – Blue & Co.	Recording of the webinar	RHC Billing 201 Slide Presentation from Amanda Dennison from Blue & Co.
RHC Billing 301 – Completion of the UB-04 Form, Form Locator Values,	2/25/2022	Douglas Swords – Azalea Health	Recording of the webinar	Slide Presentation by Douglas Swords of Azalea Health
RHC Billing 401 – Advanced Subjects - Preventive Services, Mental Health Services, Billing Examples, Telehealth, Covid,	3/1/2022	Charles James, Jr. – North American	Recording of the webinar	Advanced Billing Presentation by Charles James of North American HMS (PDF)

Reference Materials

CMS RHC Billing Guidance

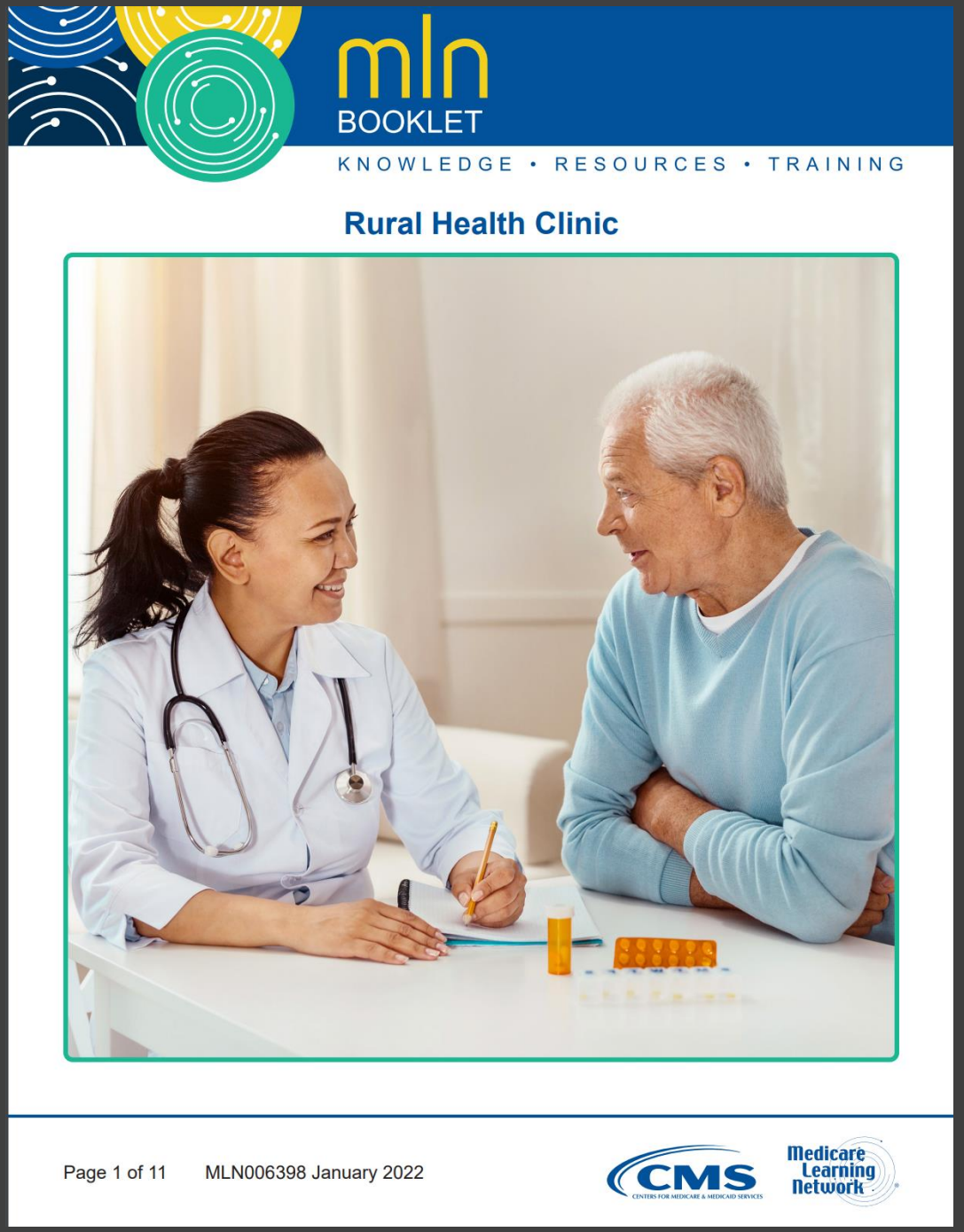
Name	Source	Description	Website
RHC Fact Sheet	CMS Updated January 2022	Brief Introduction to the RHC Program (11-page PDF)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf
Medicare Claims Processing Manual, Chapter 9	CMS Updated January, 202	Provides guidance on how to complete each field of the UB-04 (41-page PDF)	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf
Medicare Benefit Policy Manual, Chapter 13	CMS Updated April 26, 2021	Outlines covered services, visits, payment policies, etc. (57-page PDF)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
Medicare Benefit Policy Manual, Chapter 13 (2023 Updates only)	CMS Updated January 26, 2023	Updates Chapter 13 with new payment policies (31-page PDF)	https://www.cms.gov/files/document/r11803BP.pdf#page=6
CMS Rural Health Clinics Center	CMS Updated 11/7/2022	Website with updated RHC Information	https://www.ruralhealthinfo.org/

What is a rural health clinic?

RHC Fact Sheet

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

Last Update: January 2022



How to prepare RHC (UB-04) claims in Medicare Claims Processing Manual, Chapter 9

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

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(Rev. 11200, 01-12-22)

Transmittals for Chapter 9

10 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) General Information
- 10.1 - RHC General Information
- 10.2 - FQHC General Information

20 - RHC and FQHC All-Inclusive Rate (AIR) Payment System
- 20.1 - Per Visit Payment and Exceptions under the AIR
- 20.2 - Payment Limit under the AIR

30 - FQHC Prospective Payment System (PPS) Payment System
- 30.1 - Per-Diem Payment and Exceptions under the PPS
- 30.2 - Adjustments under the PPS

40 - Deductible and Coinsurance
- 40.1 - Part B Deductible
- 40.2 - Part B Coinsurance

50 - General Requirements for RHC and FQHC Claims

60 - Billing and Payment Requirements for RHCs and FQHCs
- 60.1 - Billing Guidelines for RHC and FQHC Claims under the AIR System
- 60.2 - Billing for FQHC Claims Paid under the PPS
- 60.3 - Payments for FQHC PPS Claims
- 60.4 - Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans
- 60.5 - PPS Payments to FQHCs under Contract with MA Plans
- *60.6 - RHCs and FQHCs for Billing Hospice Attending Physician Services*

70 - General Billing Requirements for Preventive Services
- 70.1 - RHCs Billing Approved Preventive Services
- 70.2 - FQHCs Billing Approved Preventive Services under the AIR
- 70.3 - FQHCs Billing Approved Preventive Services under the PPS
- 70.4 - Vaccines
- 70.5 - Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf

Chapter 9 – Field Locator Descriptions

For services that do not qualify as a billable visit, the usual charges for the services are added to those of the qualified visit. RHCs/FQHCs use the date of the visit as the single date on the line item. If there is no is billable visit associated with the services, then no claim is filed.

Service Units, FL 46
The RHC/FQHC enters the number of units for each type of service. Units represent visits, which are paid based on the AIR or the FQHC PPS, no matter how many services are delivered. Only one visit is billed per day unless the patient leaves and later returns with a different illness or injury suffered later on the same day.

Total Charges, FL 47
The RHC/FQHC enters the total charge for the service described on each revenue code line.

Payer Name, FL 50
The RHC/FQHC identifies the appropriate payer(s) for the claim.

National Provider Identifier (NPI) – Billing Provider, FL 56
The RHC/FQHC enters its own NPI. When more than one encounter/visits is reported on the same claim i.e., medical and mental health visits, please choose the NPI of the provider that furnished the majority of the services.

Principal Diagnosis Code, FL 67
The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

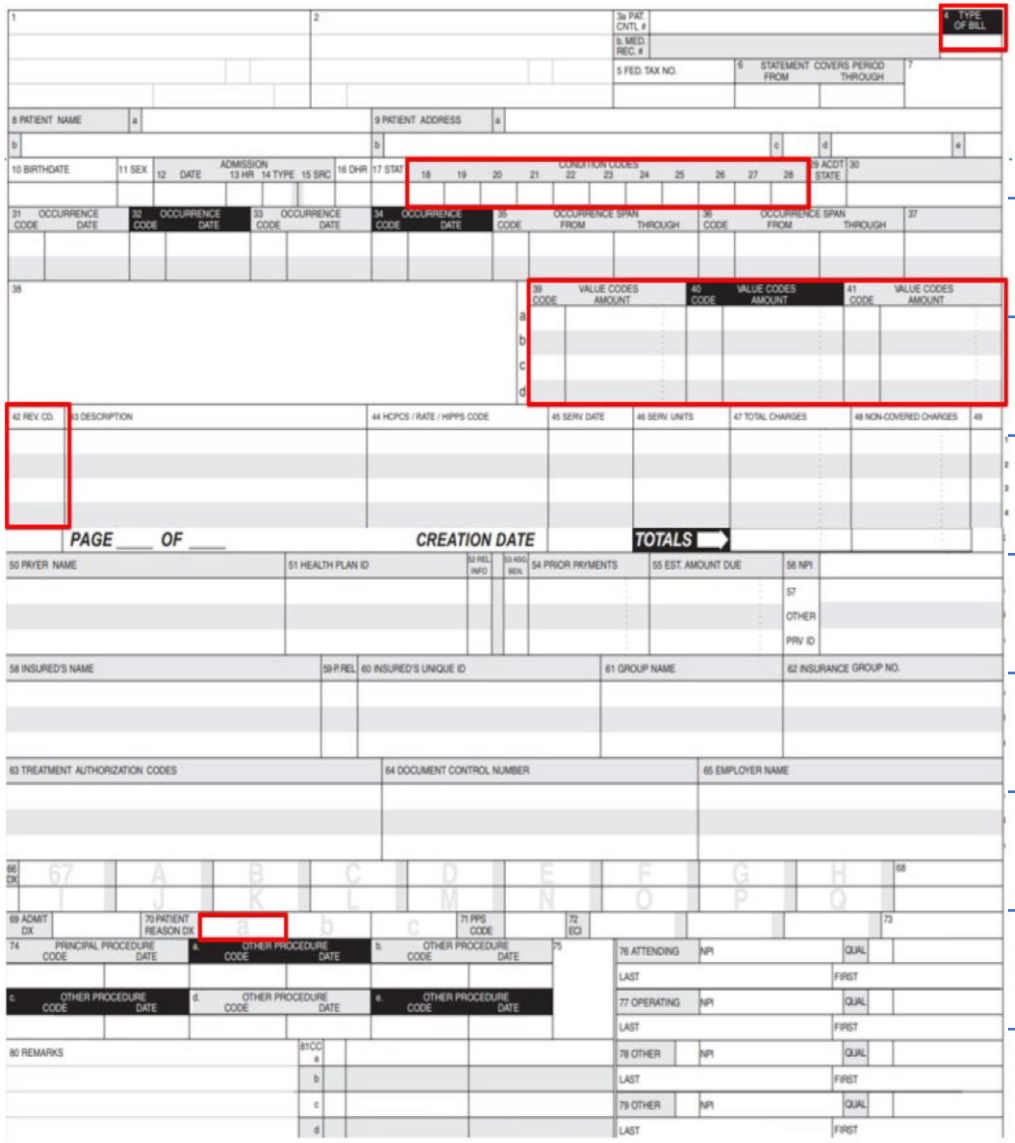
Other Diagnosis Codes, FL 67A-Q
The RHC/FQHC enters diagnosis coding as required by ICD-9-CM or ICD-10-CM Coding Guidelines.

Attending Provider Name and Identifiers, FL 76
The RHC/FQHC enters the NPI and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care.

Other Provider Name and Identifiers, FL78-79
The RHC/FQHC enters the NPI and name
NOTE: For electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

60 - Billing Requirements for RHCs and FQHCs
(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

UB-04 Field Locators



04 – Type of Bill

18-28 – Condition Codes – Why

31-38 – Occurrence Codes – When

39-41 – Value Codes – How much

42- Where (Revenue Code)

56 – RHC Group NPI Number

70 – Patient reason for visit

76 – Attending Provider NPI #

Medicare Benefit Policy Manual, Chapter 13 outlines covered services, visits, payment policies, etc.

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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Transmittals for Chapter 13

Index of Acronyms
10 - RHC and FQHC General Information
- 10.1 - RHC General Information
- 10.2 - FQHC General Information

20 - RHC and FQHC Location Requirements
- 20.1 - Non-Urbanized Area Requirement for RHCs
- 20.2 - Designated Shortage Area Requirement for RHCs

30 - RHC and FQHC Staffing Requirements
- 30.1 - RHC Staffing Requirements
- 30.2 - RHC Temporary Staffing Waivers
- 30.3 - FQHC Staffing Requirements

40 - RHC and FQHC Visits
- 40.1 - Location
- 40.2 - Hours of Operation
- 40.3 - Multiple Visits on Same Day
- 40.4 - Global Billing
- 40.5 - 3 Day Payment Window

50 - RHC and FQHC Services
- 50.1 - RHC Services
- 50.2 - FQHC Services
- 50.3 - Emergency Services

60 - [illegible]
- 60.1 - Description of Non-RHC/FQHC Services

70 - RHC and FQHC Payment Rate
- 70.1 - RHCs Billing Under [illegible]

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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Transmittals for Chapter 13

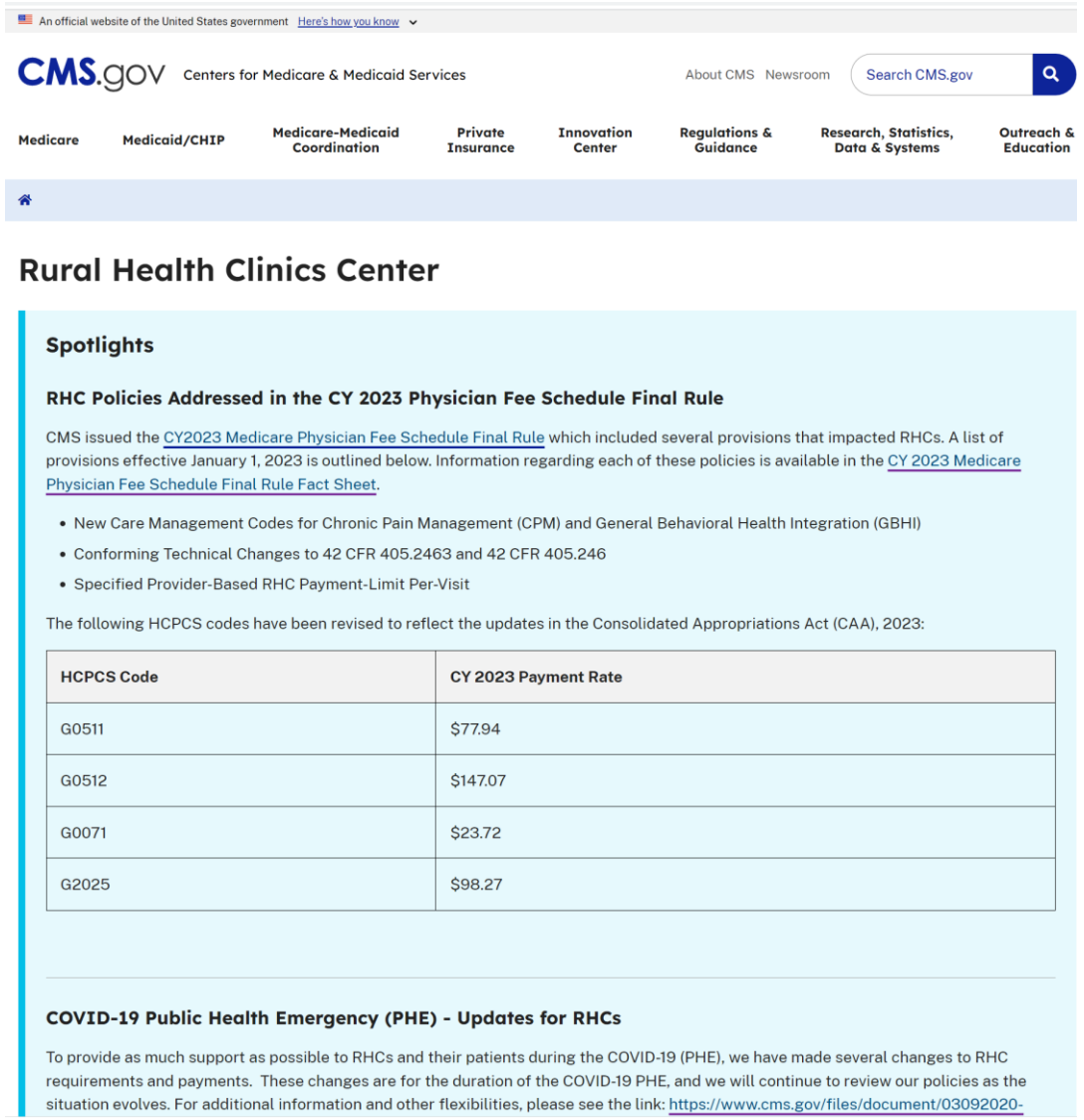
70.1 - RHC Payment Limit
- *70.2.1 - Payment Limits Applicable to Independent RHCs, and Provider-Based RHCs in a Hospital with 50 or More Beds, and New RHCs*
- *70.2.2 – Payment Limits Applicable to Provider-Based RHCs in a Hospital with Less than 50 Beds*
  - *70.2.2.1 - Determining Payment Limits for Specified (that is, Grandfathered) Provider-Based RHCs with an AIR Established for RHC Services Furnished in 2020*
  - *70.2.2.2 - Determining Payment Limits for Specified (that is, Grandfathered) Provider-Based RHCs that did not have an AIR Established for RHC Services Furnished in 2020*

210.1 - Hospice Attending *Physician Services Payment*
230 – Care Management Services
- 230.2- General Care Management Services
  - *230.2.1 – Chronic Care Management (CCM) Services*
  - *230.2.2 – Principal Care Management (PCM) Services*
  - *230.2.3 – Chronic Pain Management (CPM) Services*
  - *230.2.4 – General Behavioral Health Integration (BHI) Services*
  - *230.2.5 – Payment for General Care Management Services*

https://www.cms.gov/files/document/r11803BP.pdf#page=6

CMS Rural Health Clinics Center

Spotlights has updated billing information for RHCs



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Rural Health Clinics Center

Spotlights

RHC Policies Addressed in the CY 2023 Physician Fee Schedule Final Rule

CMS issued the CY2023 Medicare Physician Fee Schedule Final Rule which included several provisions that impacted RHCs. A list of provisions effective January 1, 2023 is outlined below. Information regarding each of these policies is available in the CY 2023 Medicare Physician Fee Schedule Final Rule Fact Sheet.

- New Care Management Codes for Chronic Pain Management (CPM) and General Behavioral Health Integration (GBHI)
- Conforming Technical Changes to 42 CFR 405.2463 and 42 CFR 405.246
- Specified Provider-Based RHC Payment-Limit Per-Visit

The following HCPCS codes have been revised to reflect the updates in the Consolidated Appropriations Act (CAA), 2023:

HCPCS Code	CY 2023 Payment Rate
G0511	$77.94
G0512	$147.07
G0071	$23.72
G2025	$98.27

COVID-19 Public Health Emergency (PHE) - Updates for RHCs

To provide as much support as possible to RHCs and their patients during the COVID-19 (PHE), we have made several changes to RHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will continue to review our policies as the situation evolves. For additional information and other flexibilities, please see the link: https://www.cms.gov/files/document/03092020-

http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Important Links

Billing / Payment

- CY 2022 Payment Rate Increases for RHCs
- CY 2021 Payment Rate Increases for RHCs
- CY 2020 Payment Rate Increase for RHCs
- Communication Technology Based Services and Payment for Rural Health Clinic (RHCs) and Federally Qualified Health Centers (FQHCs) [January 2019]: MM10843 (PDF)
- CY 2019 Payment Rate Increase for RHCs. See MM10989 (PDF) .
- Medicare Claims Processing Manual: Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers (PDF)
- Medicare Benefit Policy Internet Only Manual: Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services - See MM11019 (PDF)
- RHC Preventive Services Chart (PDF) – Information on preventive services in RHCs including HCPCS coding, same day billing, and waivers of co-insurance and deductibles (Updated on 08/10/2016).
- SE1606 (PDF) - Guidance on the Physician Quality Reporting System (PQRS) 2014 Reporting Year and 2016 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)
- Chapter 29-(T14) -- Independent Rural Health Clinic and Freestanding Federally Qualified Health Center cost Report Form CMS 222-92 (Instructions) (ZIP)

Conditions for Coverage/Participation

- Conditions for Coverage (CfCs) & Conditions of Participations (CoPs)
- CfC and CoP: Rural Health Clinic/Federally Qualified Health Center

Enrollment/Certification

- Quality, Safety & Oversight - General Information
- Policy & Memos to States and Regions
- Form CMS-1561A : Health Insurance Benefit Agreement - Rural Health Clinic
- Form CMS 29 : Request to Establish Eligibility to Participate in HI for Aged/Disabled to Provide Rural Health Clinic Services

CMS Manuals & Transmittals

- Manuals
- Transmittals
- State Medicaid Manual Paper-Based Manual

Frequently Asked Questions

- CY 2022 Physicians Fee Schedule Final Rule Frequently Asked Questions (FAQs) (PDF)
- COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (PDF)
- Virtual Communication Services in RHCs and FQHCs Frequently Asked Questions (PDF)

Contacts

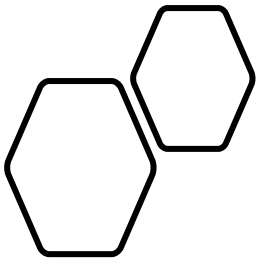
- CMS Regional Office Rural Health Coordinators (PDF) - Updated July 2021
- Medicare Certified Rural Health Clinics
- CMS Regional Survey and Certification Contacts (PDF)
- CMS Regional Offices and HHS Regions - Map (PDF)
- Coordination of Benefits Information

Coverage

- Medicare Coverage - General Information
- Medicare Coverage Database
- Medicare NCD Manual

Educational Resources

- RHC Fact Sheet
- Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611 (PDF) . For additional information, see RHC Reporting Requirements FAQs (PDF).
- MM10175 (PDF) - Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)



CMS Guidance on Rural Billing (43 pages)

mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Rural Providers & Suppliers Billing

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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

RHC Information Pages 24 to 28

Rural Health Clinic (RHC)

Medically Necessary Services

Service	Billing Information	Patient Cost Sharing	Manual
Advance Care Planning Physician, Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse-Midwife (CNM), Clinical Psychologist (CP), and Clinical Social Worker (CSW) Provided Office Visits Services and Supplies (including Part B-Covered Drugs) Provided Incident to Physician, PA, NP, CNM, or CP Services Transitional Care Management Visiting Nurse Services Provided to Homebound Patients in Home Health Shortage Areas	Bill medically necessary, face-to-face (1-on-1) medical, mental, and qualified preventive health visits to your A/B MAC (A) when services take place at: • RHC. • Patient's residence (including an assisted living facility). • Medicare-covered Part A skilled nursing facility. • Scene of an accident. Only bill your MAC for professional services. Your MAC pays you through the RHC All-Inclusive Rate (AIR). Encounters with more than 1 RHC practitioner on the same day, regardless of the length or complexity of the visit or multiple encounters with the same RHC practitioner, count as a single visit, **except** when the patient has: • Illness or injury requiring additional diagnosis or treatment after first encounter. • Qualified medical and mental health visit on the same day. • An Initial Preventive Physical Examination (IPPE) and a separate medical or mental health visit on the same day.	Deductible, copayment, and coinsurance applies.	Medicare Benefit Policy Manual Chapter 13 Medicare Claims Processing Manual Chapter 9
Chronic Care Management (CCM), General Behavioral Health Integration (BHI) Services, and Psychiatric Collaborative Care Model (CoCM) Services	Bill your RHC claim using HCPCS code G0511 for CCM or general BHI services or G0512 for psychiatric CoCM services, alone or with other payable A/B MAC (A) services.	Copayment and coinsurance applies.	Medicare Benefit Policy Manual Chapter 13 Medicare Claims Processing Manual Chapter 9

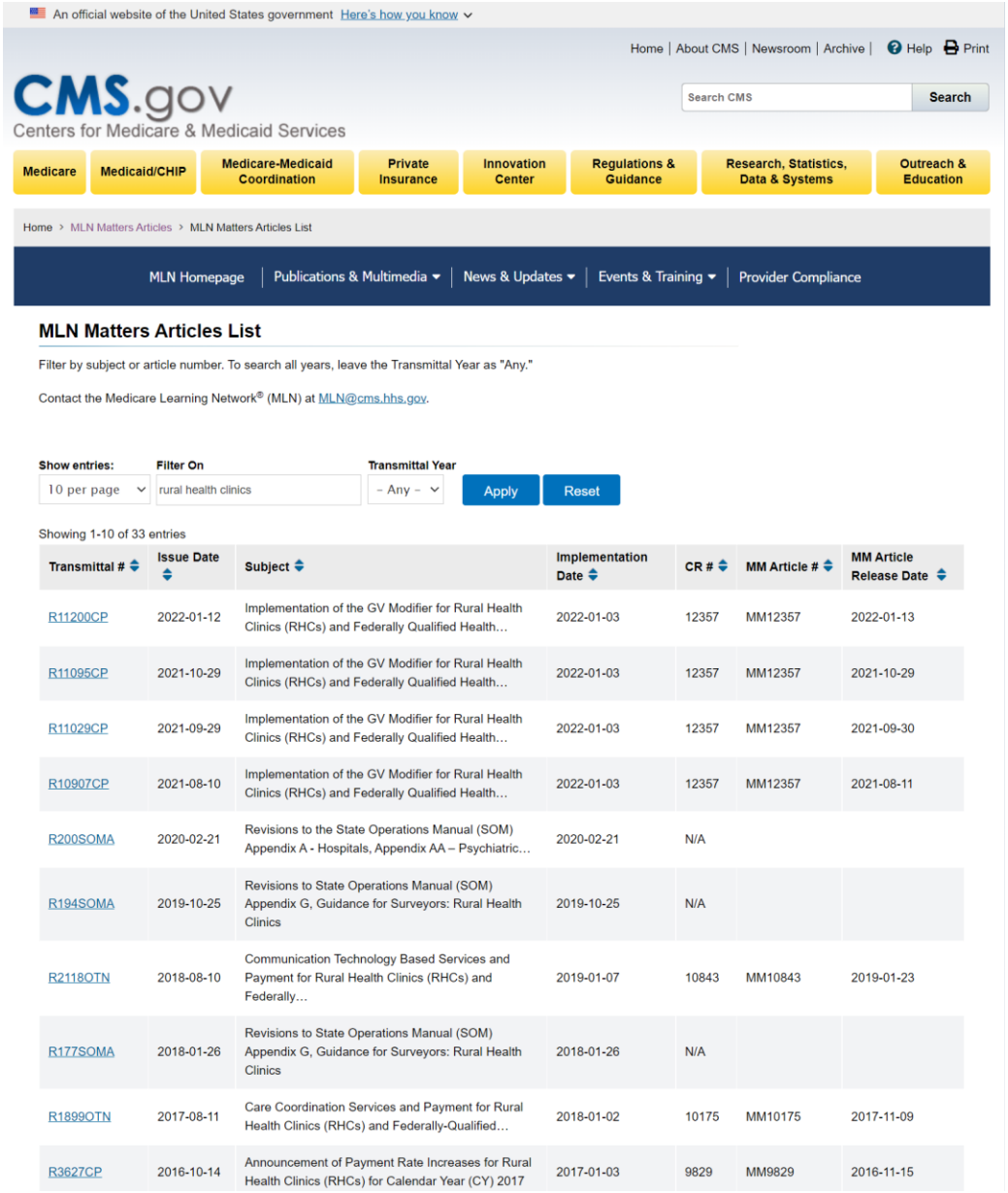
Rural Health Clinic (RHC)

Preventive Services (cont.)

Service	Billing Information	Patient Cost Sharing	Manual
Flu and Pneumococcal Shots	Your cost reports include the shot costs and their administration; your MAC bases the payment on cost.	Deductible, copayment, and coinsurance waived.	Medicare Benefit Policy Manual Chapter 13 Medicare Claims Processing Manual Chapter 9 Medicare Claims Processing Manual Chapter 18
Hepatitis B Shots	You get no additional MAC payment for these shots; the AIR payment includes the costs. Bill your MAC for shots and their administration as separate line items if the visit is a qualifying visit.	Deductible, copayment, and coinsurance applies.	Medicare Benefit Policy Manual Chapter 13 Medicare Claims Processing Manual Chapter 9 Medicare Claims Processing Manual Chapter 18
Initial Preventive Physical Examination (IPPE) Ultrasound Abdominal Aortic Aneurysm (AAA) Screening	You may bill an IPPE provided service visit. If you provide an IPPE on the same day as another billable medical visit, you can file 2 visits. Practitioners and facilities providing the technical component service separately bill A/B MAC (A) (provider-based RHCs) or A/B MAC (B) (independent RHCs) using practitioners' or facilities' ID number and non-RHC POS codes.	IPPEs and AAA screenings deductibles, copayments, and coinsurance waived. Electrocardiogram (ECG) Part B deductible, copayment, and coinsurance applies.	Medicare Benefit Policy Manual Chapter 13 Medicare Claims Processing Manual Chapter 9 Medicare Claims Processing Manual Chapter 18
Medical Nutrition Therapy (MNT)	The AIR payment covers these stand-alone billable visits. Don't separately bill them.	Deductible, copayment, and coinsurance waived.	Medicare Benefit Policy Manual Chapter 13 Medicare Claims Processing Manual Chapter 18

MLN Matters Transmittals

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles



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Contact the Medicare Learning Network® (MLN) at MLN@cms.hhs.gov.

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Showing 1-10 of 33 entries

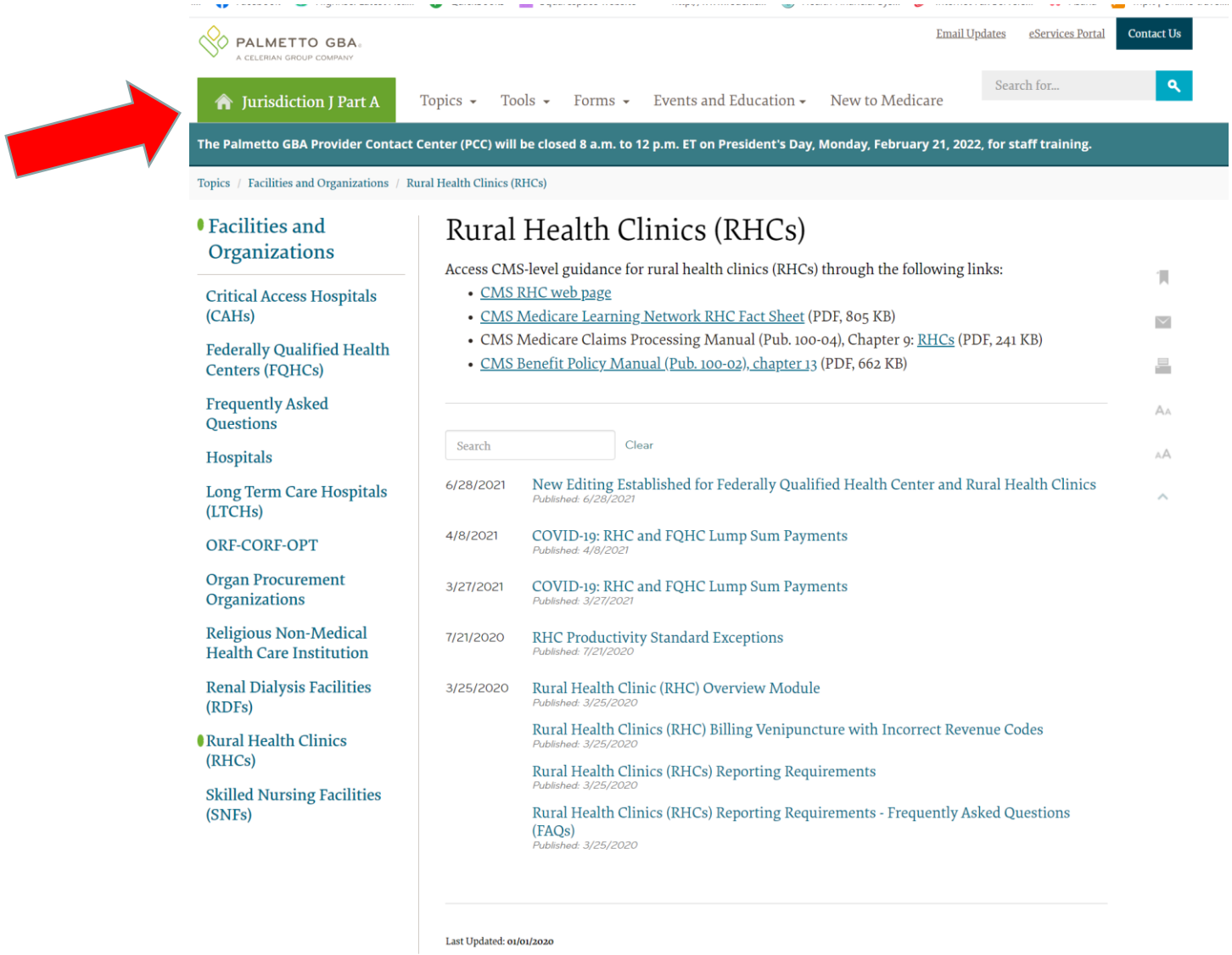
Transmittal #	Issue Date	Subject	Implementation Date	CR #	MM Article #	MM Article Release Date
R11200CP	2022-01-12	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health…	2022-01-03	12357	MM12357	2022-01-13
R11095CP	2021-10-29	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health…	2022-01-03	12357	MM12357	2021-10-29
R11029CP	2021-09-29	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health…	2022-01-03	12357	MM12357	2021-09-30
R10907CP	2021-08-10	Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health…	2022-01-03	12357	MM12357	2021-08-11
R200SOMA	2020-02-21	Revisions to the State Operations Manual (SOM) Appendix A - Hospitals, Appendix AA – Psychiatric…	2020-02-21	N/A		
R194SOMA	2019-10-25	Revisions to State Operations Manual (SOM) Appendix G, Guidance for Surveyors: Rural Health Clinics	2019-10-25	N/A		
R2118OTN	2018-08-10	Communication Technology Based Services and Payment for Rural Health Clinics (RHCs) and Federally…	2019-01-07	10843	MM10843	2019-01-23
R177SOMA	2018-01-26	Revisions to State Operations Manual (SOM) Appendix G, Guidance for Surveyors: Rural Health Clinics	2018-01-26	N/A		
R1899OTN	2017-08-11	Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified…	2018-01-02	10175	MM10175	2017-11-09
R3627CP	2016-10-14	Announcement of Payment Rate Increases for Rural Health Clinics (RHCs) for Calendar Year (CY) 2017	2017-01-03	9829	MM9829	2016-11-15

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

RHC Billing Guide

Requirement	Description
RHC Provider Number Ranges CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 10.1	Third - Sixth digits: • 3400-3499 • 3800-3974 • 3975-3999 • 8500-8999 A provider-based CMS Certification Number (CCN) is not an indication that the RHC has a provider-based determination for purposes of an exception to the payment limit
RHC Bill Type CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 50	• 0711 - Admit to discharge • 0717 - Adjustment • 0718 - Cancel • 0710 - No payment
Billable Visit CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100 CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 110.1	Face-to-face encounter between the patient and a physician, physician assistance (PA), nurse practitioner (NP), certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW) or in limited situation a visiting nurse (VN) during which a RHC service is rendered. RHCs can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is on the list of qualifying visits for the RHC and all other staffing requirements are met. All services furnished must be within the state scope of practice for the practitioner and all HCPCS codes must reflect the actual services that were furnished.
RHC Practitioners and Staffing CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 10.1 and 30.1	• Physicians • NP • PA • CNM • CP • CSW • Register professional nurse (RN) - homebound services • Licensed professional nurse (LPN) - homebound services NP, PA or CNM must work in the clinic at least 50 percent of the time the RHC is open. One practitioner must be present in the RHC and available at all times to furnish patient care.

Medicare Administrative Contractor



https://palmettogba.com/palmetto/jja.nsf/DID/BDZP763383

https://www.palmettogba.com/internet/eLearn2.nsf/RHC_Overview/story_html5.html

Using Artificial Intelligence to answer questions

MA How to bill telehealth in a rural health clinic with links and reference provided?

Billing for telehealth services in a rural health clinic typically follows the same rules as for traditional in-person visits, with some exceptions and special considerations. Here are some general guidelines:

1. Use appropriate billing codes: Telehealth services are billed using specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. The codes used for telehealth are generally the same as those used for in-person visits, but with a modifier code (GT, GQ, 95, or asynchronous) to indicate that the service was provided via telehealth.
2. Follow Medicare guidelines: Rural health clinics that bill Medicare for telehealth services must follow specific guidelines, including the requirement that the patient be located in a rural area and that the telehealth service be provided from an approved originating site.
3. Check with your state Medicaid program: Medicaid policies for telehealth billing vary by state, so it's important to check with your state's Medicaid program for guidance.
4. Understand payment rates: Payment rates for telehealth services may vary depending on the payer and the type of service provided. Medicare typically pays the same rate for telehealth services as it does for in-person visits, but other payers may have different payment policies.

For more detailed guidance on billing for telehealth in a rural health clinic, the following resources may be helpful:

- Centers for Medicare & Medicaid Services (CMS) Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Telehealth Services: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/RHC-and-FQHC-Telehealth-Services
- National Rural Health Association Telehealth Billing Toolkit: https://www.ruralhealthweb.org/getattachment/Resources/telehealth/Telehealth-Billing-Toolkit.pdf.aspx
- American Telemedicine Association State Telehealth Laws and Reimbursement Policies: https://www.americantelemed.org/policy/state-policy-resource-center/#telehealth-policies-by-state

https://chat.openai.com/chat

Pre-Test

Check your progress!

1. Billing and Coding are the same thing.

a.True

b.False

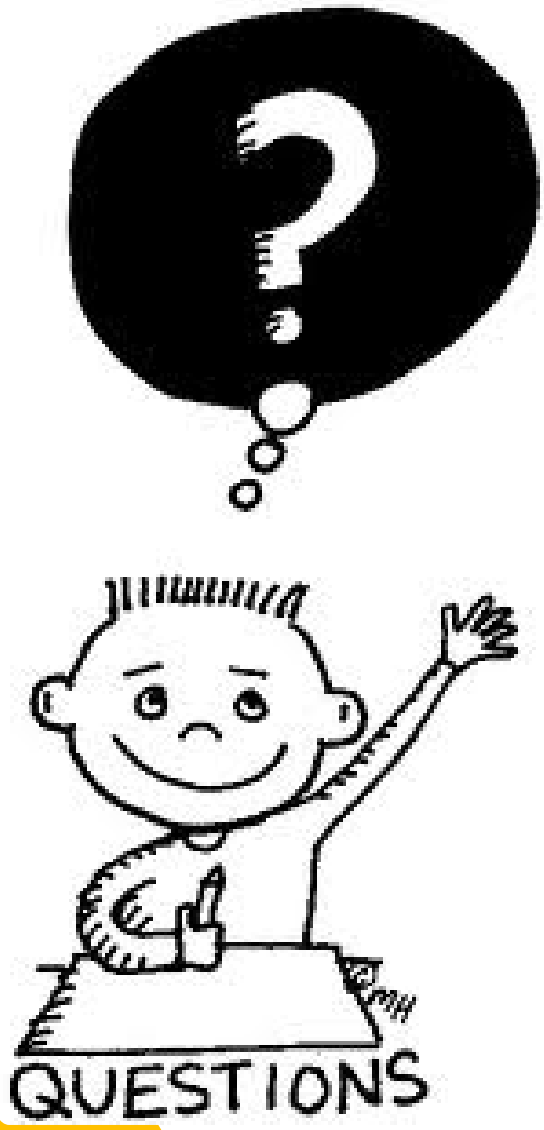
Billing and Coding are not the same thing

Description	Coding	Billing
Creator	AMA	CMS
Types of Codes *ICD-10-CM (AMA/AHA/CMS/ NCHS) Why did you perform the service? Do you have current coding guidelines?*	CPT Codes – Current Procedural Terminology (What did you do)	HCPCS II Codes Healthcare Common Procedure Coding System (What you did and what supplies were used)
Definition	It was designed to describe medical, surgical, and diagnostic services accurately. It is also used as a form of uniform communication among physicians, coders, patients, accreditation organizations, and those who pay for administrative, financial, and analytical purposes about certain medical procedures and services.	is a set of health care procedure codes based on CPT. It was designed to provide a standardized coding system in order to describe specific items and services that are provided when health care is delivered. It is a necessary form of coding for anyone who carries Medicare, Medicaid, and other health insurance programs in order to ensure that insurance claims are processed efficiently.
Example:	An RHC provides a 99213 via telehealth. The CPT Code is 99213.	The 99213 converts to a G2025 when billed to Medicare plus any required modifiers (CG/95/FQ)
Responsibility	Physicians, NPs, PAs, providers, Coders	Billers, Office Manager, CFO, Administrator

Billing and Coding Crosswalk Cheat Sheet

Service	Example Coding CPT	Example Billing HCPCS	Payment	Cost Report Visit?	Allowable Medicare Cost?	Notes
Medicaid Visit (in some states)	99213 (QVL)	T1015	AIR	Yes	Yes	Only count 1 visit on your RHC Cost Report
Telehealth Visit	99213	G2025	$98.27	No	No	Medicaid may pay AIR
Mental Telehealth Visit (starting in 2022)	90834	90834 CG 95	AIR	Yes	Yes	Keep records on the costs of two different types of telehealth visits
Virtual Communication Services (G0071)	99421	G0071	$23.72	No	No	Exclude cost on cost report.
Chronic Care Management	99484	G0511	77.94	No	No	Exclude cost on cost report.

Note: The CPT Code column is not an all-inclusive list of CPT codes.



2. Rural Health Clinic Status directly impacts payments from the following:

A. Medicare

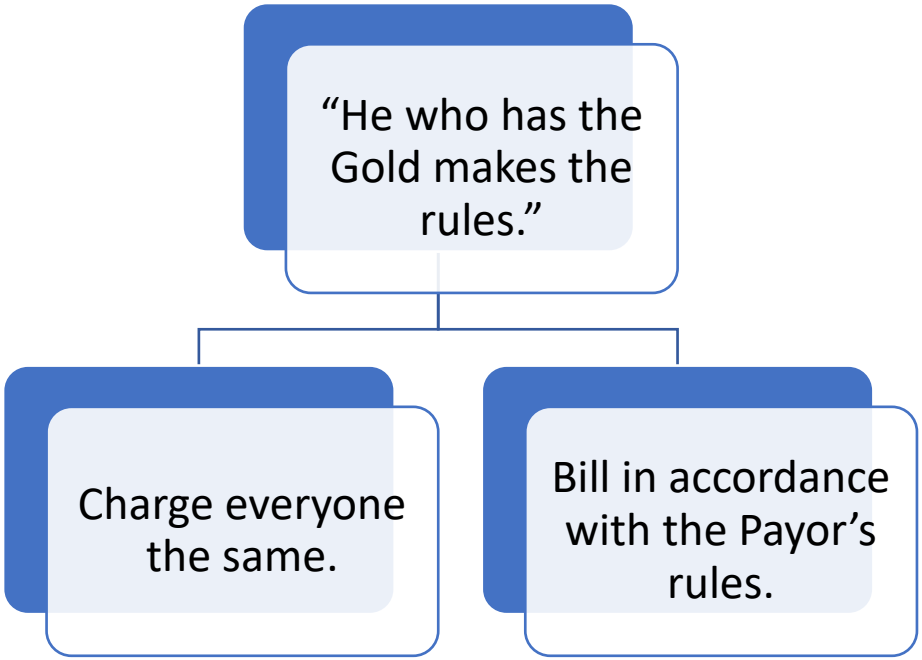
B. Medicaid

C. All Payers

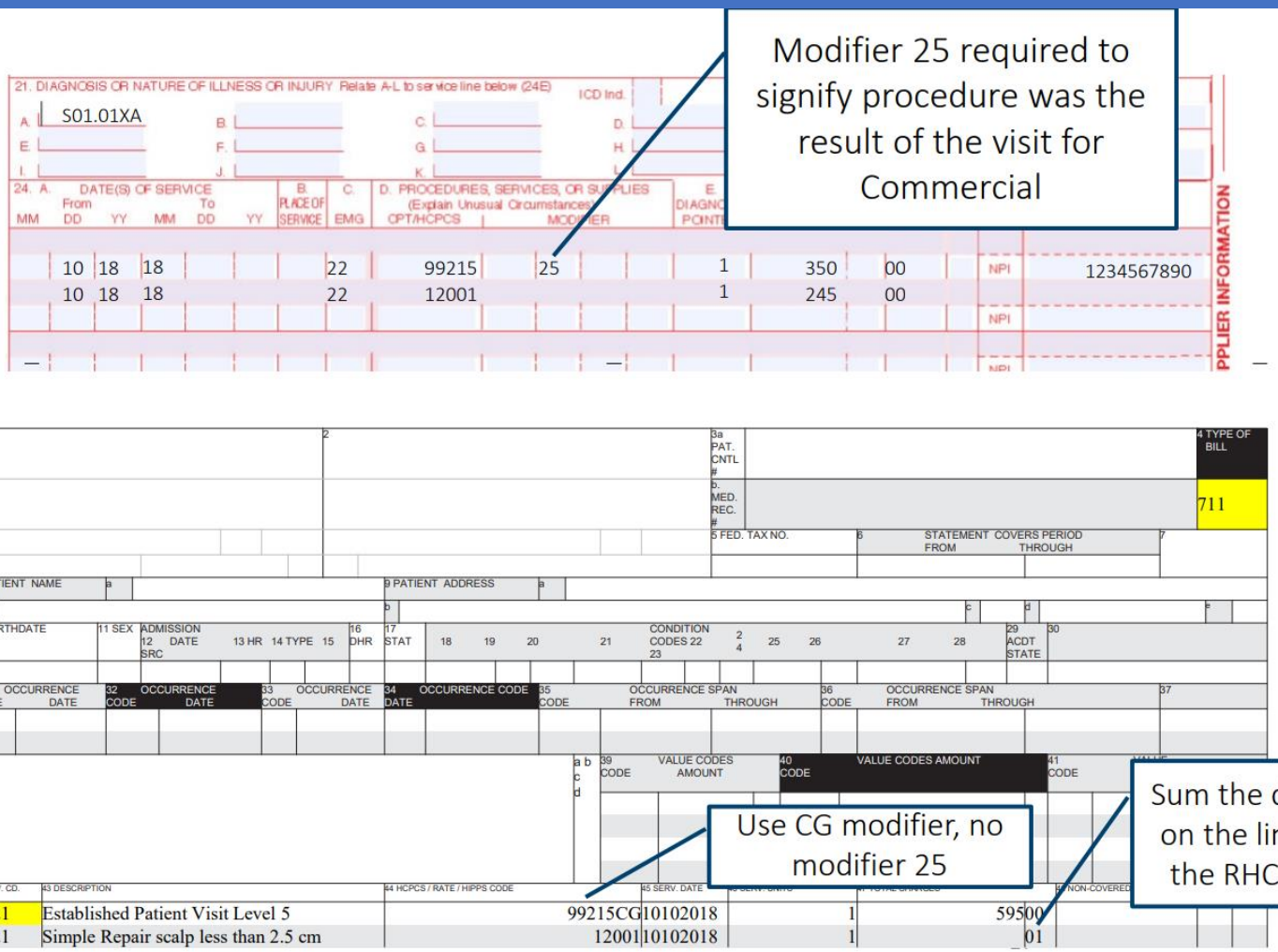
D. Medicare and Medicaid

RHC Status only affects reimbursement from:

The Golden Rule



The Difference between Commercial and RHC Billing



3. RHCs bill Medicare RHC claims for RHC covered services using the following Claim Form?

A. 1500

B. UB-04

RHCs use the Form CMS-1450 (UB-04) or 837 Institutional to bill Medicare for RHC Services

- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/837i-formcms-1450-icn006926.pdf

Independent RHCs use the Form CMS-1500 (837P) to bill Medicare for Labs, technical components, and hospital services.

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/837p-cms-1500.pdf

mln FACT SHEET

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Medicare Billing: 837P & Form CMS-1500

CPT codes, descriptions and other data only are copyright 2020 American Medical Association. All rights reserved. Applicable FARS/HHSAR apply. CPT is a registered trademark of the American Medical Association. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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4. RHCs should charge:

A. Only the RHC reimbursement rate to Medicare and Medicaid

B. All payors using the same chargemaster

C. All payors the same chargemaster except indigent patients

D. As much as possible

Charge Example

I recommend 150 to 200 percent of the Medicare Fee Schedule.

For example, 150% = $130 (85.59 *1.5) and 200% = $170 (85.59*2). I would split the difference and charge $150.

https://www.palmettogba.com/palmetto/fees_front.nsf/fee_main?OpenForm

Effective Date:	01/01/2022	**Locality:**	35
State:	Tennessee	**Modifier:**	
Procedure Code	99213		

Fees	Non-Facility	Facility	OPPS Cap Non-Facility	OPPS Cap Facility	Reduced Therapy
Participating Amount:	$85.59	$63.67	$0.00	$0.00	$37.96
Non-Participating Amount:	$81.31	$60.49	$0.00	$0.00	$0.00
Limiting Charge Amount:	$93.51	$69.56	$0.00	$0.00	$0.00

RHCs can have a sliding fee schedule

5. RHCs are paid an All-Inclusive Rate which pays for all Medicare services provided to the patient while at the RHC?

a. True

b. False

The All-Inclusive Rate does not cover the following:

- Lab services (services except Venipuncture – CPT 36415)
- Technical components
- Hospital services
- Telehealth (except Mental Health Services starting in 2022)
- Chronic Care Management
- Principal Care Management

Note: The six required lab services are not covered under the RHC benefit.

Types of Services Provided in an RHC

Part of the All-Inclusive Rate (AIR) Calculation	Not Part of the All-Inclusive Rate Calculation	Pass-though Costs paid above the AIR
Office Visits	Laboratory Services (except 36415)	Influenza Vaccinations
Incident-to Services	Hospital Services & Chronic Care Management	Pneumococcal Vaccinations
Mental Health Telehealth Visits	Telehealth Visits (medical, not mental health)	Covid-19 Vaccinations & MABS
Lab Draws (36415)	Private Practice Time (Non-RHC hours)	Bad Debts
Radiology Services (Professional Portion)	Radiology Services (Technical Portion)	Graduate Medical Education

6. To Bill Medicare RHCs must always have a Face-to-Face encounter.

A. True

B. False

What is a Face-to-Face Encounter

40 - RHC and FQHC Visits
(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

Source: Chapter 13 Medicare Benefits Manual

Examples of Medicare Services that do not require a Face-to-Face Encounter:

Telehealth Service

Chronic Care Management

Principal Care Management

7. For an RHC to bill an encounter to Medicare and receive the All-Inclusive Rate the encounter must be located on the Qualifying Visit List (QVL) ?

a. True

b. False

The published Qualifying Visit List is no longer updated!!!

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

Rural Health Clinic Qualifying Visit List (RHC QVL)

(8-01-16)

The RHC QVL is intended as guidance for RHCs beginning to report HCPCS codes. It consists of frequently reported Healthcare Common Procedure Coding System (HCPCS) codes that qualify as a face-to-face visit between the patient and an RHC practitioner and it is not an all-inclusive list of stand-alone billable visits for RHCs. More information on what is considered a RHC visit is included in the "RHC Visits" section of this guidance.

In this update to the QVL, *HCPCS code G0490 has been added as a stand-alone billable visit effective October 1, 2016 and HCPCS codes G0436 and G0437 have been replaced with CPT codes 99406 and 99407 effective October 1, 2016.* See the table below and accompanying footnotes for more information. The billable visits shown in black below are both effective and payable as stand-alone services beginning with dates of service on or after April 1, 2016. The billable visits shown in red below are effective for dates of service on or after April 1, 2016, for claims and adjustments received on or after October 1, 2016. RHCs should hold claims solely for these billable visits (shown in red) until October 1, when RHCs can bill these claims for payment *with the CG modifier (explained below)*. For dates of service on or after October 1, 2016, a medically-necessary service not on the current QVL can be billed as a stand-alone billable visit if the service meets Medicare coverage requirements, is within the scope of the RHC benefit, and is not furnished incident to a physician's service.

NOTE: The use of a HCPCS code from the below QVL does not guarantee payment of the claim. All of the conditions for coverage and payment must be met for payment to be made. RHCs must retain adequate documentation of a patient's condition and the services furnished as part of the patient's medical record, which, along with the claim, may be subject to review by CMS, its contractors, or other oversight authorities.

HCPCS Reporting Requirements

For dates of service on or after April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with revenue code on their Medicare claims. Services furnished through March 31, 2016, are not required to be reported with HCPCS code and should be billed under the previous guidelines.

From April 1, 2016 through September 30, 2016, all charges for a visit must be reported on the service line with the qualifying visit HCPCS code, minus any charges for preventive services using revenue code 052x for medical services and/or revenue code 0900 for mental health services. RHCs are allowed to report additional 052x or 0900 revenue code lines. Beginning on October 1, 2016, the Medicare administrative contractors (MACs) will accept modifier CG (policy criteria applied) on RHC claims and adjustments. RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line, which includes all charges subject to coinsurance and deductible for the visit. Modifier CG should only be used to indicate which revenue code 052x and/or 0900 service line should receive the all-inclusive rate (AIR) and be subject to coinsurance and deductible. Each additional service furnished during the visit should be reported with charges greater to or equal to $0.01. The additional service lines are for informational purposes only. MACs will package/bundle the additional service lines, which do not receive the

8. An RHC must include a CG modifier on all claims for RHC covered services.

A. True

B. False

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

(Revised 10-14-16)

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

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

- https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/rhc-reporting-faqs.pdf

9. The MSP payer questionnaire questions must be asked

A. Every visit

B. Annually

C. Every 90 days

Medicare Secondary Payor Rules

Medicare Secondary Payer MLN Booklet

Gathering Accurate Data

You must determine if Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter before submitting a Medicare claim. Ask patients about other coverage. Questions you ask help update patient insurance information and verify the patient's CWF record is correct and current.

CMS developed tools, including an MSP model questionnaire, Admissions Questions to Ask Medicare Beneficiaries, to help providers identify the correct primary claims payers for all patient hospital services provided. CMS electronic tools help identify and verify MSP situations. Get more information in Medicare Secondary Payer Manual, Chapter 3, Section 20 or contact your MAC.

Providers must keep completed MSP questionnaire copies and other MSP information for 10 years after the service date. You may keep hard copy files, optical images, microfilms, or microfiches. When storing these files online, keep negative and positive question responses.

- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf

Medicare Secondary Payer Questionnaire

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

https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/providerservices/downloads/pro_othertool.pdf

20.2.1 - Admission Questions to Ask Medicare Beneficiaries

(Rev.)

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 ONLY FOR CLAIMS RELATED TO BL.

___ No.

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

___ Yes; Government Program will pay primary benefits for these services

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for 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 WC plan:

_____

Policy or identification number: _____

Name and address of your employer:

_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

___ No. **GO TO PART II.**

10. CPT Category II Codes can not be included on the UB-04.

A. True

B. False

Answer from the NARHC Forum on Category II CPT Codes

- Contributor: Patty Harper, InQuiseek Consulting

- Cat II codes cannot be reported on institutional UB claims. The codes must be reported through a registry-either through CMS or a 3rd party. The codes can be reported on the 1500 format for states which use the 837P for RHC Medicaid claims.

Patty Harper, RHIA, CHTS-IM, CHTS-PW, CHCR
Healthcare Consultant/Principal
318-243-2687 (Cell)
866-855-0683 (Fax)

940 Ratcliff Street
Shreveport, LA 71104

11. What Place of Service Code should an RHC use when billing Medicare?

A. 72

B. 11

C. The Revenue Code serves as the Place of Service Code on the UB-04

Revenue Codes can be found in Chapter 9 Medicare Claims Processing Manual

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf

Revenue Codes, FL42
The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge.

For FQHC claims with dates of service on or after January 1, 2010, FQHCs may report additional revenue codes when describing services rendered during an encounter. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in the following table:

Code	Description
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)
0519	Clinic, Other Clinic (only for the FQHC supplemental payment)
0900	Mental Health Treatment/Services

12. An RHC treats a patient on January 1, 2022 and charges $233. The RHCs AIR is $113. When the bill is submitted to Medicare how much does Medicare pay?

A. 0

B. $120

C ($120)

D. $46.60

Negative Reimbursement

Rural Health Clinics (RHC)

For Rural Health Clinics (RHCs), negative reimbursement is encountered when the cost of the visit is greater than the provider encounter rate and the billed amount is applied to the patient's Medicare deductible.

Example	2022	
Total billed amount	$233	$115.00
Provider all-inclusive reimbursement rate	$113	$75.00
Amount applied to deductible	$233	$115.00
Beneficiary's responsibility	$233	$115.00
Medicare reimbursement	-$120	-$40.00

When posting it is important to balance to the patient responsibility per the EOB.
The variance is Medicare contractual and is an adjustment (not collectable from the patient).

13. When posting a negative reimbursement claim an RHC should always:

A. Ensure that the Patient Balance remains correct after posting.

B. Post the withhold to the patient balance.

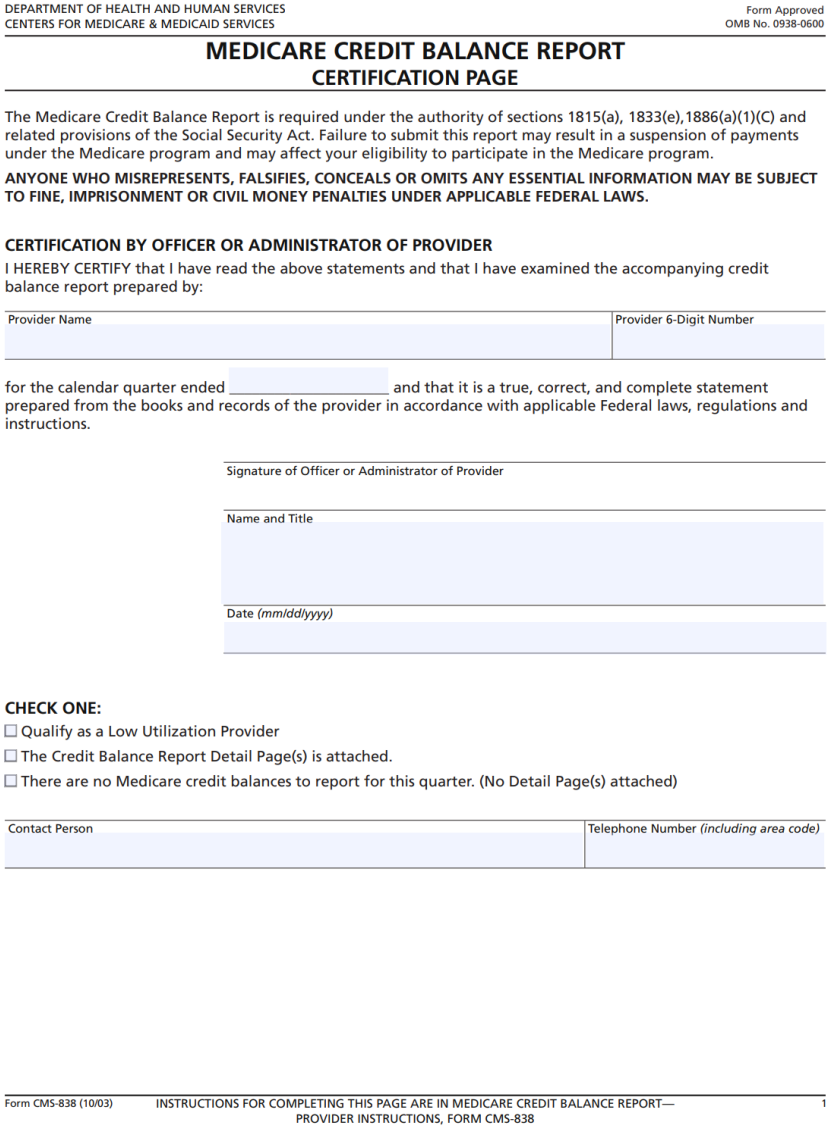
C. Include the negative reimbursement on the Credit Balance Report.

14. How often does an RHC have to complete a Form 838 Credit Balance Report?

- A. Weekly
- B. Monthly
- C. Quarterly
- D. Annually

The Medicare Credit Balance Report must be completed Quarterly or your payments will be cut off.

https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms838.pdf



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0600

MEDICARE CREDIT BALANCE REPORT
CERTIFICATION PAGE

The Medicare Credit Balance Report is required under the authority of sections 1815(a), 1833(e),1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by:

Provider Name	Provider 6-Digit Number

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

Signature of Officer or Administrator of Provider

Name and Title

Date *(mm/dd/yyyy)*

CHECK ONE:

- ☐ Qualify as a Low Utilization Provider
- ☐ The Credit Balance Report Detail Page(s) is attached.
- ☐ There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached)

Contact Person	Telephone Number *(including area code)*

Form CMS-838 (10/03) INSTRUCTIONS FOR COMPLETING THIS PAGE ARE IN MEDICARE CREDIT BALANCE REPORT—PROVIDER INSTRUCTIONS, FORM CMS-838 1

15. Influenza and Pneumococcal shots as well as Covid Vaccines and MABs in a Rural Health Clinic are:

A. Paid using a log on the RHC Cost Report

B. Billing on the 1500 Form

C. Billed on the UB-04 incident to an encounter

D. Billed to Medicare Part D

16. To Bill for RHC services a new RHC needs the following:

A. Type 2 Institutional NPI number

B. CCN/PTAN number from CMS (See the Tie-In Letter)

C. An All-Inclusive Rate set by the MAC

D. A Submitter ID for Electronic filing

E. All of the Above

Tie-In Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

SENT VIA INTERNET EMAIL TO dani.gilbert@outlook.com
(Receipt of this notice presumed to be January 21, 2022– date notice e-mailed)

January 21, 2022

[redacted]

Re: Rural Health Clinic (RHC) CMS Certification Number (CCN): **88-3857**

Dear Administrator:

The Centers for Medicare and Medicaid Services approves your participation as a Rural Health Clinic (RHC) in the Medicare program effective **December 21, 2021**. The identification number shown above should be referenced on all forms and correspondence relating to the Medicare Program. **Palmetto GBA** serves as your Medicare Administrative Contractor (MAC) and the fiscal year end (FYE) date is **December 31**. You should report any changes in staffing, services, ownership, or other significant information to Palmetto GBA.

If you believe that this determination is incorrect, you may request that it be reconsidered. Your request must be submitted in writing, to this office, within sixty (60) days of receipt of this letter. If you have any questions, please contact Jackie Whitlock at (404) 562-7437 or jacqueline.whitlock@cms.hhs.gov.

Sincerely,

Jacqueline J. Whitlock -S

Digitally signed by Jacqueline J. Whitlock -S
Date: 2022.01.21 12:01:50 -05'00'

Linda D. Smith
Director
Division of Survey and Enforcement

cc: Palmetto GBA (10311)
Tennessee State Survey Agency

Submitter ID

Medicare Claims Processing Manual

Chapter 24 - EDI Support Requirements

Draft June 3002

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24_edi_support_jun2003.pdf

17. We are an Independent RHC and have non-rhc hours. Can we bill the non-rhc services with the same NPI number?

A. Yes

B. No

New Edits are affecting RHC payments

New Editing Established for Federally Qualified Health Center and Rural Health Clinics

For claims processed on and after July 1, 2021, editing is being established for claims submitted by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) for Medicare Part B Jurisdiction J.

If you are designated by Medicare as a FQHC or a RHC and perform services that are outside the scope of the FQHC or RHC, it is the responsibility of the clinic to ensure that the service is submitted to the correct Medicare Administrative Contractor, for either Part A or Part B.

Only Independent FQHCs or RHCs should be submitting services to Medicare Part B for non-clinic services. Please follow CMS Internet Only Manual instructions found in the Benefit Policy Manual, 100-2, Chapter 13 (PDF, 470 KB) and the Claims Processing Manual, 100-4, Chapter 9 (PDF, 312 KB) to ensure proper billing.

Monitoring will continue to ensure that services are not paid by both A and B. Clinic services submitted to Part B that should be included in the All Inclusive Rate (AIR) or those that are considered a FQHC or RHC benefit will be denied as they should be submitted to Part A. Claims will be denied with the following CARC and RARC messages below:

CARC 109 – Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.

RARC N418 – Misrouted claim. See the payer's claim submission instructions.

Last Updated: **06/28/2021**

https://palmettogba.com/palmetto/jja.nsf/DIDC/AD6P2U7755~Facilities%20and%20Organizations~Rural%20Health%20Clinics%20(RHCs)

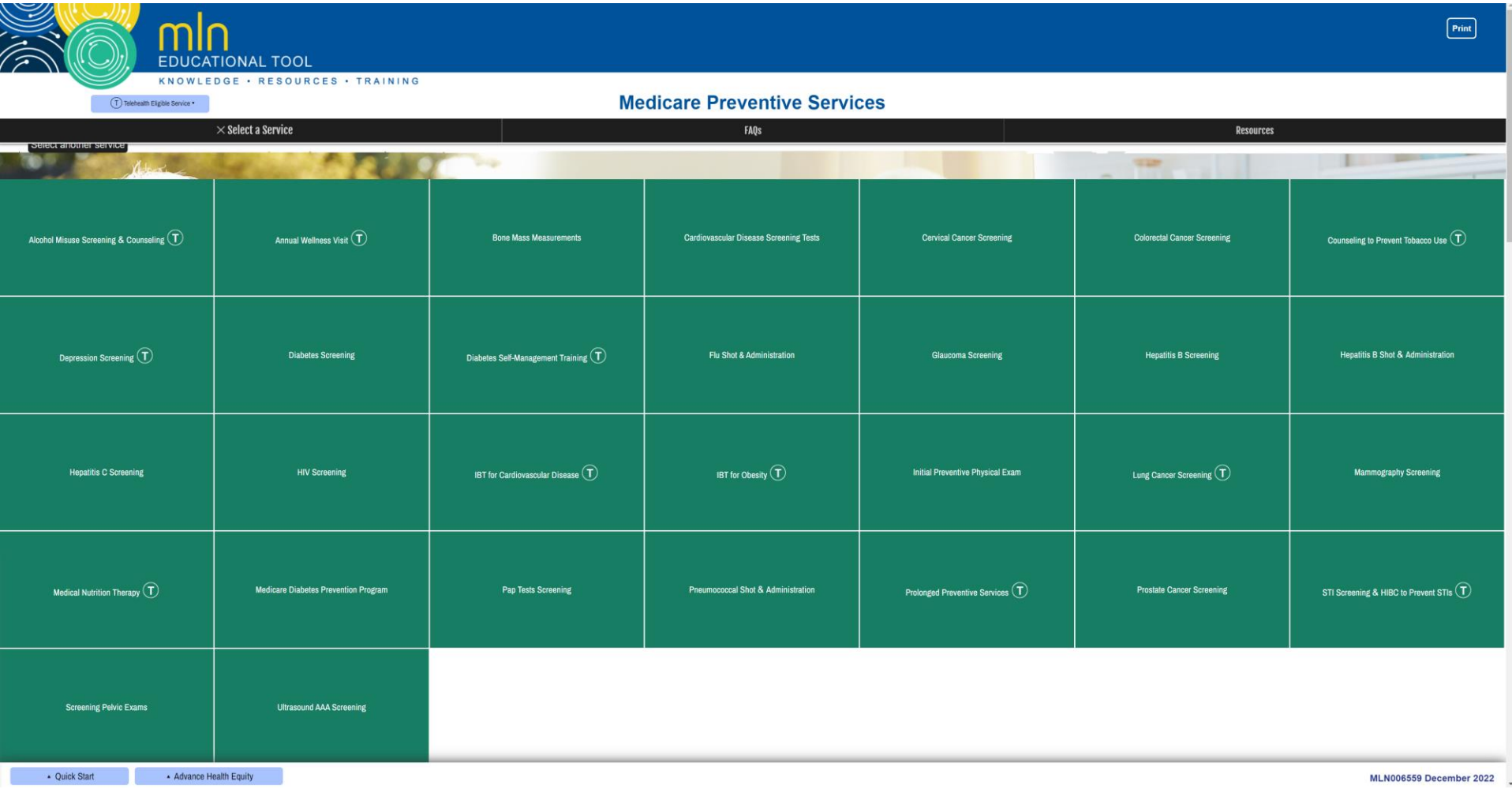
Summary Table for Counting Visits

Description	UB-04	1500*	Incident to	CR Visit	CR Allowable Cost	AIR
Office Visits – See QVL for CPT Codes	X			X	X	X
Lab Services		X				
Technical Components		X				
Hospital Services		X				
Telehealth (Not Mental Health)	X					
Telehealth – Mental Health	X			X	X	X
Chronic Care Management (G0511)	X					
Lab Draw (36415)	X		X		X	
Allergy Shots, Injections, Home Care Plan oversight, Diabetic & Nutritional counseling	X		X		X	
Medicare Preventive Services # (See Table)	X			X	X	X

* Provider-based RHCs will bill using the UB-04 and the hospital's outpatient NPI.

Preventive Services that qualify for the AIR are listed here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

Finding the Hidden Gold in your RHC



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

Up to 22 visits per year for Weight Loss paid at the AIR

Telehealth Eligible

Print

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

Select another 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 changes from the last quarter

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, Z68.45

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 webpage. Find your MAC's website for more information.

Medicare Covers

Patients with Medicare Part B and obesity when:

- Obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared)
- Competent and alert when counseling is delivered
- Qualified primary care physician or other primary care practitioner conducts counseling in a primary care setting

Frequency

We pay up to 22 visits billed with codes G0447 and G0473, combined, in a 12-month period:

- **First month:** 1 face-to-face visit every week
- **Months 2–6:** 1 face-to-face visit every other week
- **Months 7–12:** 1 face-to-face visit every month if patient meets certain requirements

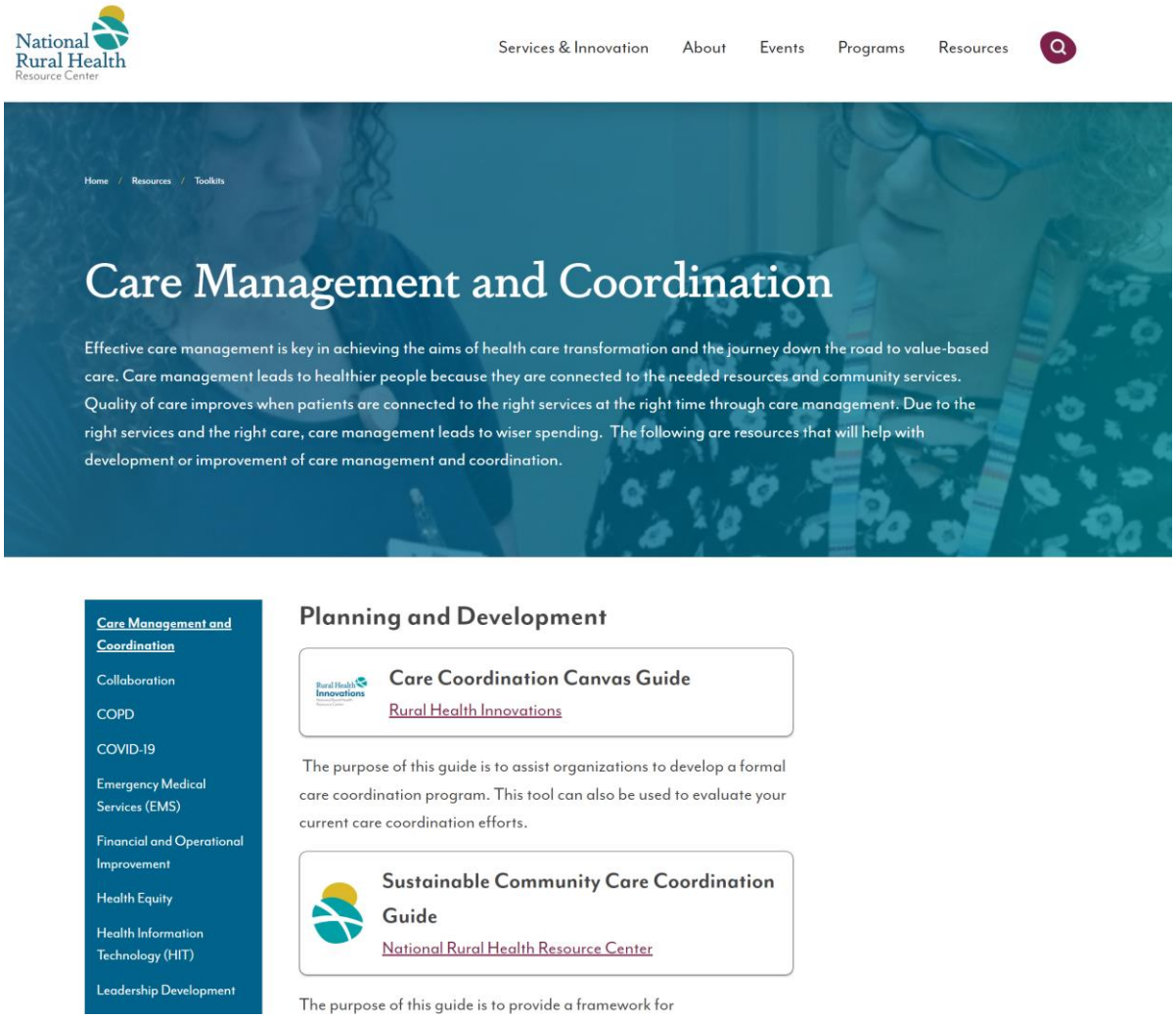
Note: See FAQ on how to check eligibility.

Patient Pays

- No copayment, coinsurance, or deductible

Other Notes

- Obesity reassessment and weight loss determination required at 6-month visit
- If the patient loses at least 3 kg during the first 6 months, they're eligible for additional face-to-face visits occurring once a month for months 7–12
- Patients who don't achieve a weight loss of at least 3 kg during the first 6 months, reassess their readiness to change and BMI after an additional 6-month period



https://www.ruralcenter.org/resources/toolkits/care-management-and-coordination

Thank You!

Mark Lynn, Healthcare Business Specialists

marklynnrhc@gmail.com