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Blue & Co. at a Glance

FOUNDED IN 1970

450+ EMPLOYEES

10 OFFICES

3 STATES

70+ DIRECTORS

200+ CPAS

$110M+ IN REVENUE

TOP 50 ACCOUNTING FIRM

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OUR SERVICES

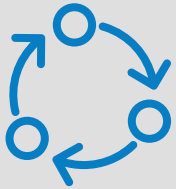
TAX & BUSINESS SERVICES

AUDIT & ASSURANCE

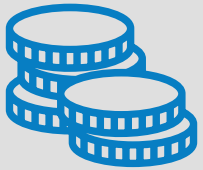
DATA ANALYTIC SERVICES

BUSINESS VALUATIONS

REIMBURSEMENT OPPORTUNITIES



MARGIN IMPROVEMENT PLANS



REVENUE CYCLE MANAGEMENT

FEASIBILITY STUDIES

… and more!

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RHC Billing 101:
The Basics of Medicare Billing for RHCs

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Manager, Blue & Co., LLC

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Disclaimers

- The information in this webinar is current as of today. As with any healthcare regulation, you should always verify that any references or resources are current and have not been replaced with more current guidance.
- The billing rules we are going to discuss during today's session are for **regular MEDICARE only.**
  - We will briefly discuss Medicare Advantage billing.
- If you want to know about how to bill your State Medicaid as a RHC, reach out to your State Medicaid agency – every state is similar, but still slightly different in their requirements.

What we will cover today:

- RHC Encounters
- Eligible Providers
- Claim Form
- Bill Types
- Revenue Codes
- RHC Claim Details
- Multiple Services on the Same Day
- Medicare Payment
- Incident to Services
- Non-RHC Services

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RHC Visit Definition

"A RHC 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 services are rendered. However..."

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Resource: Medicare Benefit Policy Manual, 100-02, Chapter 13, Section 40

RHC Visit Definition, Expanded

"However, effective January 1, 2022, a mental health visit is a face-to-face encounter, or an encounter furnished using interactive real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation of treatment of a mental health disorder."

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Resource: Medicare Benefit Policy Manual, 100-02, Chapter 13, Section 40

What is *NOT* a RHC Encounter?

Visits only for medication refills

Visits only for lab results

Visits only for injections (i.e. allergy)

Suture removal or dressing change without an additional face-to-face visit

Visits billed using CPT code 99211 (nursing visit)

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RHC Eligible Provider Types

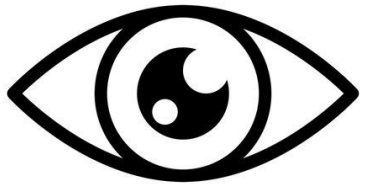
- The following are considered "billable RHC providers":
  - Physician (MD or DO)
  - Nurse Practitioner (NP)
  - Physician Assistant (PA)
  - Certified Nurse Midwife (CNM)
  - Certified Psychologist (CP)
  - Licensed clinical Social Worker (LCSW)
  - *Licensed Marriage & Family Therapist (LMFT)**
  - *Licensed Mental Health Counselor (driven by State definition)**
- Note that most State Medicaid agencies consider additional provider types to be billable in the RHC space.

*Eligible effective January 1, 2024

Dentists, Podiatrists, Optometrists and Chiropractors

- Medicare Benefit Policy Manual, Chapter 13, Section 110.1:
  - "Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare statute, and qualified services furnished by physicians are billable visits in an RHC."
  - ***"An RHC can bill for face-to-face, medically necessary services furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is a qualifying visit…"***
    - Must be within the scope of their practice and not excluded from coverage.



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Dentists, Podiatrists, Optometrists and Chiropractors

- **Caution:**

  RHCs are required to primarily provide primary health care.

- These types of providers are **not considered primary care**, and therefore do not meet the requirement to be either:
  - A physician medical director, or
  - The physician or non-physician practitioner the must be available all times the clinic is open.

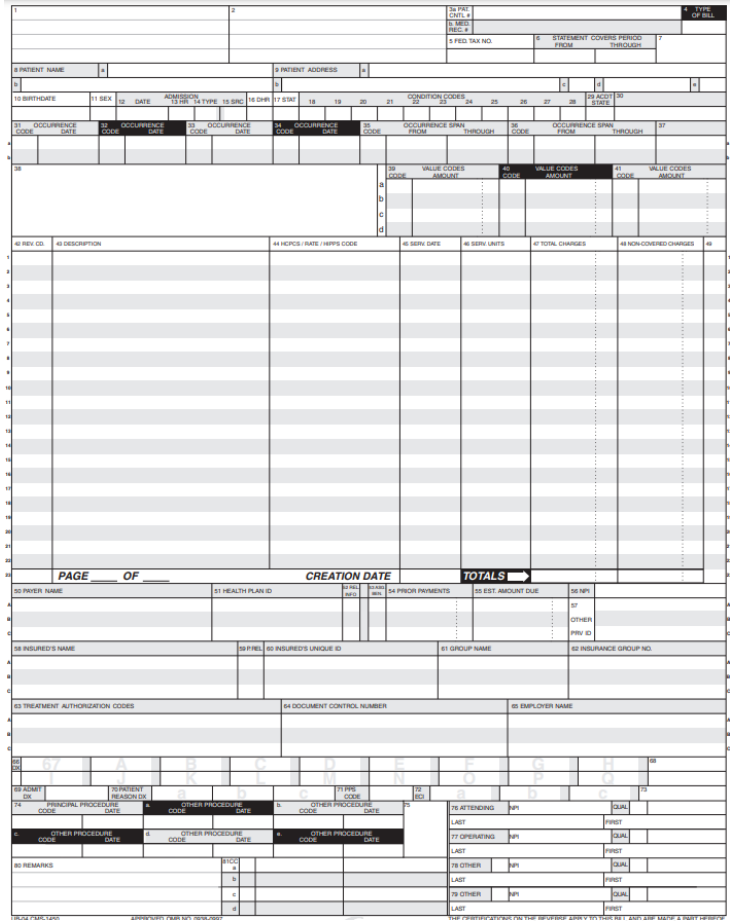
What about other specialist providers?

- Specialists can provide billable services in a RHC
  - Think all of the "–ologists"…cardiologist, neurologist, endocrinologist, etc.
  - Specialists may be employed by the RHC, or parent hospital.
  - You may also have visiting specialists from an outside organization who are contracted providers of the RHC and are billed as RHC providers.
- A few things to remember:
  - RHCs must primarily provide primary care services (a little bit of a gray area in terms of definition).
  - If a patient sees their primary care provider, and another non-mental health provider specialist, on the same day, **only 1 AIR will be paid**.

Medicare Claim Form for RHC Services

- RHC services are billed on a UB-04 (paper format). The electronic format is the 837**i**.
  - Medicare Claims Processing Manual, Chapter 9, Section 60: **"RHCs are institutional claims…All professional services in the RHC benefit are paid through the AIR system for each patient encounter or visit."**
- Yes, RHC services are professional services. But RHCs are considered to be an institutional provider, similar to how a hospital is an institutional providers.
  - As such, RHCs bill claims to Medicare Part A, but are paid by the Medicare Part B benefit.

Confused yet?



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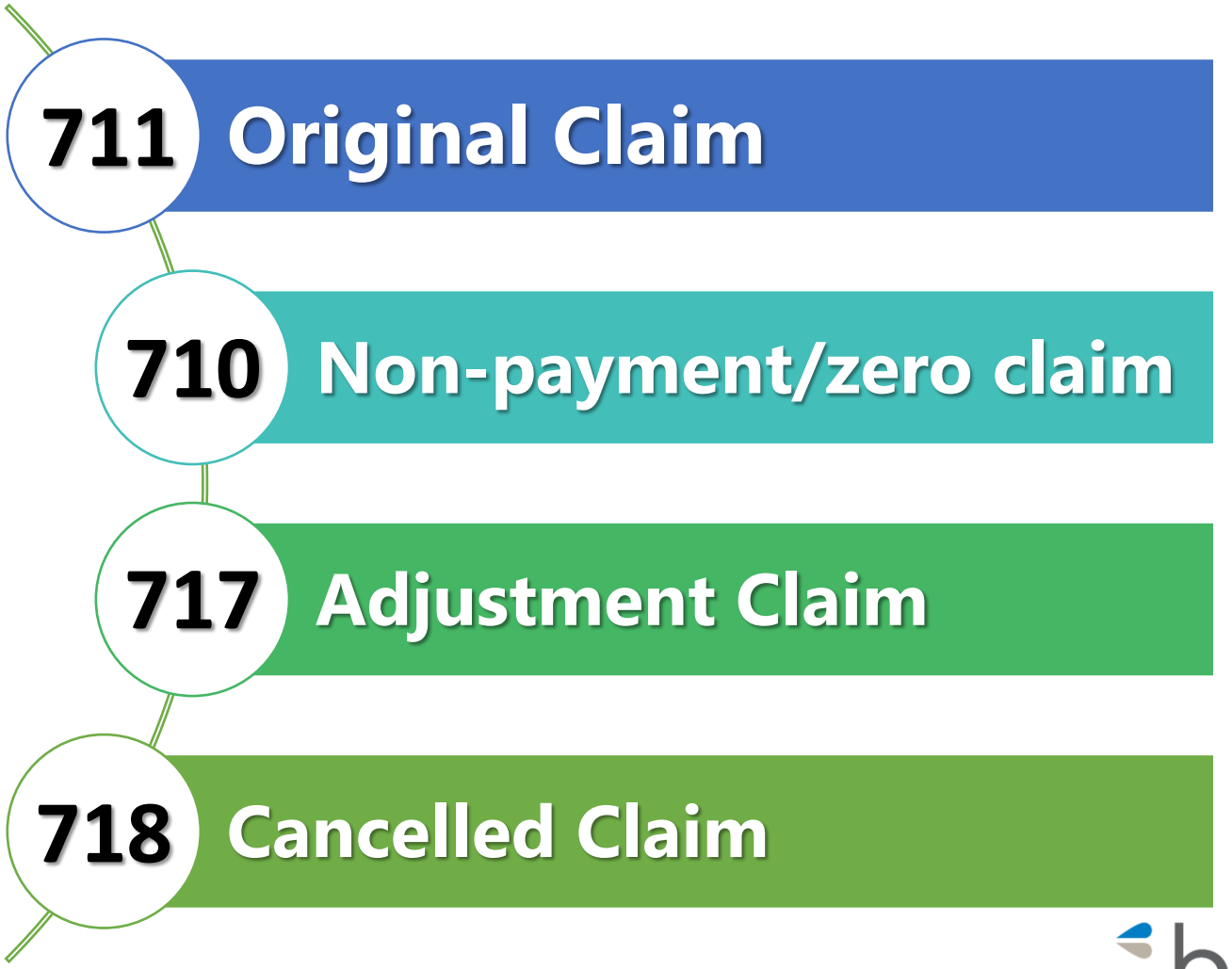
RHC Type of Bills (TOB)

- RHC bill types fall under **71X**.
- These are the common bill types used on RHC claims:

Guidance: CMS Claims Processing Manual, Chapter, 9, Section 50, Type of Bill, FL 4



RHC Revenue Codes

0521	Clinic visit by a member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to member in a covered Part A stay at a SNF
0525	Visit by RHC practitioner to member in a non-Part A SNF, NF, ICF, or other residential facility
0527	RHC visiting nursing services to a member's home in a Home Health Shortage Area
0528	Visit by RHC practitioner to another non-RHC site (i.e. scene of an accident)
0900	Mental health visit (both in person and via telehealth)

Other Common Revenue Codes in RHCs

0250	Pharmacy – drug with no J-code
0300	Venipuncture
0636	Drugs with detailed HCPCS J-code
0780	Telemedicine originating site

RHC Claim Details

- RHCs are required to line-item, detail code for all services provided during the RHC visit
  - Include HCPCS codes for all RHC services, incident to services, and applicable professional components performed during that visit on the UB-04
- All services should be reported with either:
  - Actual charges; or
  - A penny ($0.01) (except for the qualifying visit line).
- Charges for all services provided during the visit should be "rolled up" to the qualifying visit line/CG modifier line
  - The exception to this rule is charges for qualifying preventive health services
    - Coinsurance and deductible are waived for certain preventive health services
- Total Charges for the entire claim are reported on line 0001
  - However, not used to adjudicate for payment

Qualifying Visit Line

- Every RHC claim must have a Qualifying Visit Line
  - Identifies the primary reason for the patient encounter on a given date of service.
  - Can be E/M code, procedure code, preventive service code…
- The qualifying visit is *likely* listed on the Qualifying Visit List:
  - The Qualifying Visit List was developed by CMS and "**it consists of frequently reported HCPCS codes that qualify as a face-to-face visit between the patient and an RHC practitioner**…"
  - … "it is **not** an all-inclusive list of stand-alone billable visits for RHCs."
    - **Last updated August 1st, 2016**
    - Does not account for changes to the CPT code book.
    - RHC Qualifying Visit List

CG Modifier

- CG modifier identifies the qualifying visit for a given date of service.
- CG modifier tells Medicare what claim line to use to calculate applicable coinsurance and deductible
- Generally, there will only be **1 CG modifier** per RHC claim, but…there are a few exceptions to this rule.

Multiple Providers – CMS Guidance

- "Except as noted below, encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit."
- "This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit."
- "This would include situations here an RHC patient has a medically-necessary face-to-face visit with an RHC practitioner, and is then seen by another RHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or for evaluation of a different condition on that same day."

Reference: CMS Claims Processing Manual, Chapter 9, Section 20.1; CMS Benefit Policy Manual, Chapter 13, Section 40.3

Multiple Visits on the Same Day – Exceptions

- **Subsequent illness or injury:**

  The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day.

- The subsequent visit may be an E/M visit, it may be a procedure. Either way, it requires a separate diagnosis and treatment from what the patient was initially seen for.
- ***"In this situation only, the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits."***
  - These modifiers do NOT mean the same thing in a RHC as they do in the physician office world. They should be used rarely.

Reference: CMS Claims Processing Manual, Chapter 9, Section 20.1; CMS Benefit Policy Manual, Chapter 13, Section 40.3

Multiple Visits on the Same Day – Exceptions

- **Medical + Mental Health, Same Day:**

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

- **Medical + Mental Health + IPPE, Same Day:**

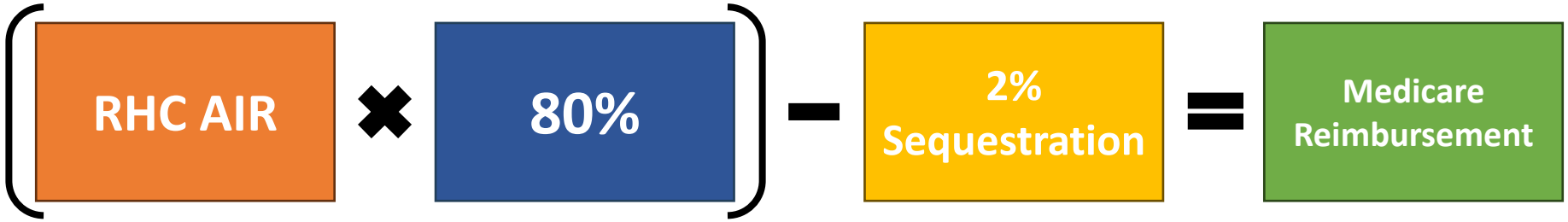
  The patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits).

- CMS RHC Reporting Requirements FAQ

Reference: CMS Claims Processing Manual, Chapter 9, Section 20.1; CMS Benefit Policy Manual, Chapter 13, Section 40.3

RHC Medicare Payment

- Actual payment from Medicare is **80%** of your **AIR**, less **2%** sequestration.
- Exception for qualifying preventive services
  - Paid at 100% of AIR when the only service provided on that day
- Remember, Medicare will not start paying on your RHC claims until the patient has met their Medicare Part B deductible each year.



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Non-RHC Services

- RHCs may *"furnish certain services that are beyond the scope of the RHC benefit or are not a Medicare benefit"*. These are considered Non-RHC Services
- **"Non-RHC" does not mean "Non-Payable"**
  - It means payment is not based on the same payment structure as RHC services (aka – paid outside of the AIR).
- All costs associated with non-RHC services (i.e. space, equipment, supplies, facility, overhead, personnel) should be removed from the RHC cost report.

Non-RHC Services, CMS Examples

- Medicare excluded services
- Technical component of RHC service (i.e., x-rays, EKGs)
- Laboratory services ***(yes, even the 6 required ones)***
- Durable medical equipment (DME)
- Ambulance services
- Prosthetic devices
- Body braces
- Practitioner services at certain other Medicare facilities
- Group services

Resource: CMS Benefit Policy Manual (100-02), Chapter 13, Section 60.1

Payment of Non-RHC Services

- Non-RHC services are billed separately to the appropriate MAC under the payment rules specific to that service.
  - Independent RHCs bill Part B using RHC CCN
  - Provider-Based RHCs bill Part B under the parent hospital CCN
- Payment for Non-RHC Services:
  - CAHs receive cost-based reimbursement
  - PPS hospitals and IRHCs reimbursed based on a fee schedule

Independent vs. Provider Based RHC Billing

	Encounter for RHC Service(s)	CLIA Labs in RHC	Technical Component	Professional Services - Hospital
Independent RHC	Bill to Part A on UB-04; RHC CCN	Bill to Part B on CMS-1500; Use RHC CCN	Bill to Part B on CMS-1500; Use RHC CCN	Part B on CMS-1500 Medicare Group
Provider-Based RHC	Bill to Part A on UB-04; RHC CCN	Billed by Parent Hospital on UB04; PPS Hospital: TOB 141/ 131 CAH: TOB 851	Billed by Parent Hospital on UB04; PPS Hospital: TOB 131 CAH: TOB 851	Part B on CMS-1500 Medicare Group

Incident-to Services

- "Incident to" – services and supplies that are an integral, though incidental, part of the physician's professional service and are:
  - Commonly rendered without charge and included in the RHC payment;
  - Commonly furnished in an outpatient clinic setting
  - Furnished under the physician's direct supervision; except for authorized care management services which may be furnished under general supervision; and
  - Furnished by RHC auxiliary personnel
- All services and supplies incident to a physician's visit must result from the patient's encounter with the physician and furnished within a medically appropriate time frame

Payment for Incident to Services

- When services and supplies are furnished incident-to an RHC, ***payment for the services are included in the RHC AIR***
- An encounter that includes only incident to services is not a stand-alone billable visit.
  - The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit.
- Incident to services still generate coinsurance for the patient, even though payment for the service is included in the RHC's AIR.

Options for Addressing Incident-to Services

1. **Add the incident-to services to a qualifying claim within a medically-appropriate time frame (usually 30 days before or after)**
   - Requires RHC to hold claims until the end of each month and add on any incident-to services; or
   - RHC can submit an adjusted claim each time an incident-to service is rendered (TOB 717)
   - DOS for the qualifying visit should be used for the incident-to services; do not use span dates
2. **Depending on the volume of incident-to services, adjust them off; all associated cost is reported on the cost-report**
   - Requires appropriate tracking of expense related to incident-to services

Either way, incident-to services do not generate separate payment from Medicare – they **DO** increase the patient's coinsurance.

RHC Medicare Claim Examples

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Claim Example #1

RHC Encounter – E/M Office Visit Only

- Scenario: RHC Provider completed a level 3 E/M office visit. Charge for the visit is $100.00. No additional work (incident-to or non-RHC services) were required.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	RURAL HEALTH CLINIC, OFFICE VISIT	99213 CG	12/05/2023	1	100.00	00.00		1
2									2
3									3
4									4
5									5
6									6
23	0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	100.00			23

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Claim Example #2

RHC Encounter – Procedure Only

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	RURAL HEALTH CLINIC, PROCEDURE	10160 CG	12/05/2023	1	150.00	00.00		1
2									2
3									3
4									4
5									5
6									6
23	0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	150.00			23

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Claim Example #3

RHC Encounter – E/M Office Visit and Procedure

- Scenario: RHC Provider completed a level 3 E/M office visit. While in the office, the patient also asked the provider to take a look at an abscess on their arm. The provider completed a simple I&D. Charge for the visit is $100.00 and for the procedure is $150.00.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	RURAL HEALTH CLINIC, OFFICE VISIT	99213 CG	12/05/2023	1	250.00	00.00	
0521	RURAL HEALTH CLINIC, PROCEDURE	10160	12/05/2023	1	150.00	00.00	
0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	400.00		

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Claim Example #4a

RHC Encounter – E/M Office Visit and Injection

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	RURAL HEALTH CLINIC, OFFICE VISIT	99214 CG	12/05/2023	1	207.00	00.00		1
2	0521	INJ ADMIN	96372	12/05/2023	1	12.00	00.00		2
3	0636	ROCEPHIN	J0696	12/05/2023	1	45.00	00.00		3
4									4
5									5
6									6
23	0001	PAGE 1 OF 1	CREATION DATE	07/01/2023	TOTALS	264.00			23

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Claim Example #4b

RHC Encounter – E/M Office Visit and Injection

- Scenario: RHC Provider completed a level 4 E/M office visit and a gave the patient a Rocephin injection. Charge for the E/M visit is $150.00, but the administration and drug are reported as $0.01 (“Penny Method”)

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	RURAL HEALTH CLINIC, OFFICE VISIT	99214 CG	12/05/2023	1	207.02	00.00		1
2	0521	INJ ADMIN	96372	12/05/2023	1	0.01	00.00		2
3	0636	ROCEPHIN	J0696	12/05/2023	1	0.01	00.00		3
4									4
5									5
6									6
23	0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	207.04			23

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Claim Example #5

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 AWV. Charge for the E/M visit is $150.00, and for the AWV is $195.00.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	RURAL HEALTH CLINIC, OFFICE VISIT	99213 CG	12/05/2023	1	150.00	00.00	
0521	PREVENTIVE SERVICE	G0439	12/05/2023	1	195.00	00.00	
0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	345.00		

Note: RHC will receive only receive 1 AIR payment. Coinsurance and deductible are only applicable to the E/M service.

Claim Example #6

RHC Encounter – Medical Visit & Subsequent Visit, Same Day

- Scenario: RHC Provider completed a level 4 office visit with a patient who has diabetes. Later in the day the patient fell, cut their leg and came back to the RHC. Charge for the first medical visit is $150.00 and for the subsequent visit is $100.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	RURAL HEALTH CLINIC, OFFICE VISIT	99214 CG	12/05/2023	1	150.00	00.00	
0521	RURAL HEALTH CLINIC, PROCEDURE	12002 CG, 59	12/05/2023	1	100.00	00.00	
0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	250.00		

Note: RHC will receive only receive 2 AIR payments. Remember, this is one of the only situations when modifier 59 or 25 would be used in the RHC.

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Claim Example #7

RHC Encounter – Medical Visit & Mental Health Visit (In-Person), 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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	RURAL HEALTH CLINIC, OFFICE VISIT	99213 CG	12/05/2023	1	100.00	00.00	
0900	RURAL HEALTH CLINIC, MENTAL HEALTH	90791 CG	12/05/2023	1	200.00	00.00	
0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	300.00		

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Claim Example #8

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

- Scenario: RHC Provider completed a patient's IPPE. While they were in the office, they were seen for their hypertension. The patient also saw a mental health provider who had a 30-minute psychotherapy session. Charge for IPPE is $195.00, for the medical visit is $150.00, and for the mental health visit is $220.00.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	RURAL HEALTH CLINIC, OFFICE VISIT	99214 CG	12/05/2023	1	150.00	00.00	
0521	PREVENTIVE VISIT	G0402	12/05/2023	1	195.00	00.00	
0900	RURAL HEALTH CLINIC, MENTAL HEALTH	90832 CG	12/05/2023	1	220.00	00.00	
0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	565.00		

Note: RHC will receive 2 AIRs at 80% for medical visit + mental health visit, and 1 AIR at 100% for the IPPE

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Claim Example #9

RHC Encounter – E/M Office Visit and EKG (professional component)

- Scenario: RHC Provider completed a level-3 E/M office visit. While in the office, the provider also did an EKG. Charge for the E/M visit is $100.00, and for the professional fee for the EKG is $50.00.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	RURAL HEALTH CLINIC, OFFICE VISIT	99213 CG	12/05/2023	1	150.00	00.00	
0521	EKG, INTERPRETATION & REPORT	93010	12/05/2023	1	50.00	00.00	
0001	PAGE 1 OF 1	CREATION DATE	12/05/2023	TOTALS	200.00		

Note: EKG interpretation and report only included when completed by RHC provider.

Claim Example #9

RHC Encounter – E/M Office Visit and EKG (technical component)

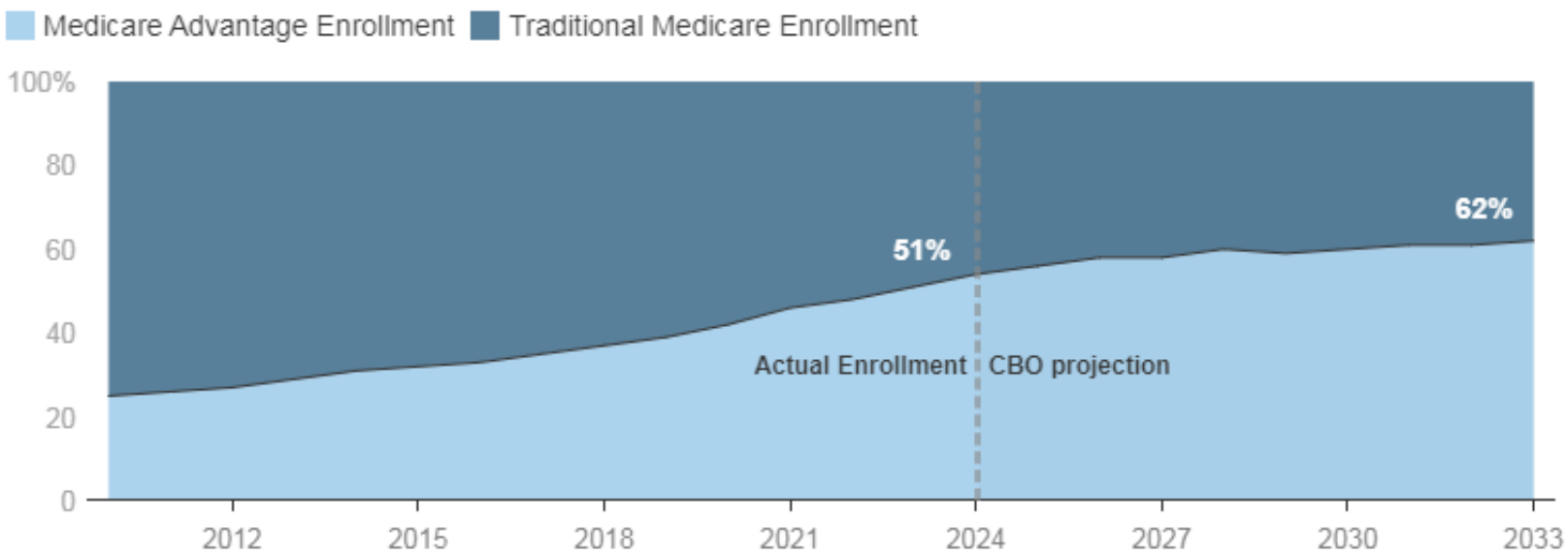
- In this scenario, the technical component of the EKG (a non-RHC service) is billed differently depending on whether the RHC is independent or provider-based:

Independent RHC	RHC will bill HCPCS code 93005 (EKG, tracing only) to Part B on CMS-1500. Fee schedule payment.
Provider-Based RHC	Parent entity will bill HCPCS code 93005 (EKG, tracing only) to MAC. Fee schedule payment (unless CAH – then payment at cost).

Medicare Advantage

Figure 2

Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



SOURCE: KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023. Enrollment numbers from March of the respective year. Projections for 2023 to 2033 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2023. • PNG

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Medicare Advantage

- There are now more **3,998** MA plans nationwide…up 6% from 2022.
  - Which means there are 3,998 different sets of rules!
  - ***There is no "one size fits all"***
- Medicare Advantage plans will pay you according to how you are contracted with that individual plan.
  - They will *not* automatically pay you as RHC.
  - Reach out to them EARLY to make sure you know what billing requirements they have or what paperwork they will need to make sure you are billing appropriately, and that you are paid appropriately.
  - A lot follow same billing "rules" as Medicare, with some exceptions

Helpful Resources

- CMS Benefit Policy Manual, Chapter 13: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- CMS Claims Processing Manual, Chapter 9: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
- CMS Rural Health Clinic Center: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center
- CMS Claims Processing Manual, Chapter 25 (Completing the UB04): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf

Questions?

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