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RHC Billing - Introduction

www.ruralhealthclinic.com

Fall, 2017

HBS

Healthcare Business Specialists

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Like Healthcare Business Specialists on Facebook for more RHC information

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RHC Information Exchange Group on Facebook

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

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Rural Information Exchange Group on Facebook

Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs

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

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

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What does Healthcare Business Specialists do?

1. We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics. In 2016, we will prepare 140 cost reports.
2. We prepare annual evaluations of RHCs. We conduct 50 of these on an annual basis.
3. We help clinics startup as RHCs. (about 10 per year)
4. Billing and Cost Report Seminars

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Presentation Materials

Presentations were emailed previously to you to print. The USB drives provided have all the presentations and much more including Policies and Procedures, Annual Evaluation Templates, Cost Report Workpapers, Billing Cheatsheets, Compliance Forms, and Presentations.

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Questions or Comments?

Raise your hand button and I will call on you to ask your question or comment.

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Disclaimer

1. Information is current as of 10/25/2017.
2. Medicaid is different in each state. We will not be able to answer state specific questions in many states.
3. I am not young enough to know everything, nor am I an expert in all areas of RHCs.

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Goals of this Session

1. What is a RHC.
2. When does and RHC increase reimbursement.
3. The two types of RHCs.
4. RHC Resources

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What is a rural health clinic?

Is a certification from CMS that allows physician practices to qualify for cost-based reimbursement from Medicare and Medicaid. (P.1, 1.)

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RHC Status only affects reimbursement from:

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There are 4,200 RHCs in the USA out of 230,187 physician practices (1.7%)

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Who are the RHCs in your State CMS listing updated 10/16/2016

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Name and Address Listing For Rural Health Clinic Based on Current Survey Maine

Run Date: 09/08/2016
Job # 50077740
Last Update: 09/07/2016
Page 1 of 2

CCN	Key	Provider Name	Address	City, State and ZIP	Telephone #	County Name
203825	*	ISLESBORO HEALTH CENTER	150 MAIN ROAD	ISLESBORO, ME 04848	(207)734-2213	Waldo
203835	*	DEXTER FAMILY HEALTH	51 HIGH STREET SUITE A	DEXTER, ME 04930	(207)924-7349	Penobscot
203839	*	SEAPORT FAMILY PRACTICE, P A	41 WIGHT ST	BELFAST, ME 04915	(207)338-6900	Waldo
203849	*	ARNOLD MEMORIAL MEDICAL CENTER	70 SNARE CREEK LANE	JONESPORT, ME 04649	(207)497-5614	Washington

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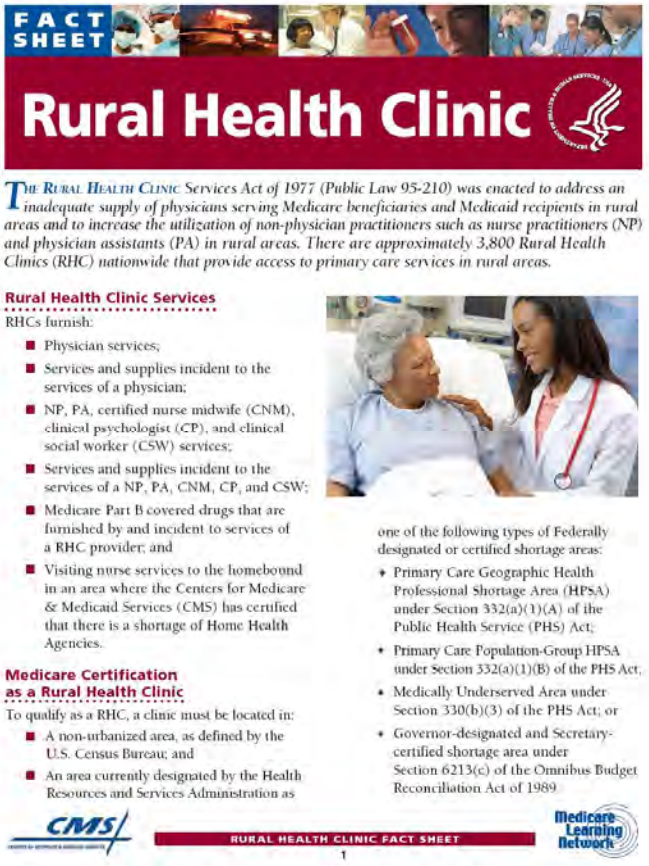
What is a rural health clinic?

RHC Fact Sheet

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



FACT SHEET

Rural Health Clinic

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas. There are approximately 3,800 Rural Health Clinics (RHC) nationwide that provide access to primary care services in rural areas.

Rural Health Clinic Services

RHCs furnish:

- Physician services;
- Services and supplies incident to the services of a physician;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies incident to the services of a NP, PA, CNM, CP, and CSW;
- Medicare Part B covered drugs that are furnished by and incident to services of a RHC provider; and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there is a shortage of Home Health Agencies.

Medicare Certification as a Rural Health Clinic

To qualify as a RHC, a clinic must be located in:

- A non-urbanized area, as defined by the U.S. Census Bureau; and
- An area currently designated by the Health Resources and Services Administration as one of the following types of Federally designated or certified shortage areas:
  - Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act;
  - Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act;
  - Medically Underserved Area under Section 330(b)(3) of the PHS Act; or
  - Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act of 1989

CMS

RURAL HEALTH CLINIC FACT SHEET

Medicare Learning Network

1

Last Update: January, 2017

Print this and place in the P & P manual for the inspectors. Some don't know the rules.

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Advantages of RHCs

Enhanced Medicaid Reimbursement

No payment reductions for NPs, Pas, CNMs. No MACRA reductions.

Provider-based RHC > 50 beds are paid at cost.

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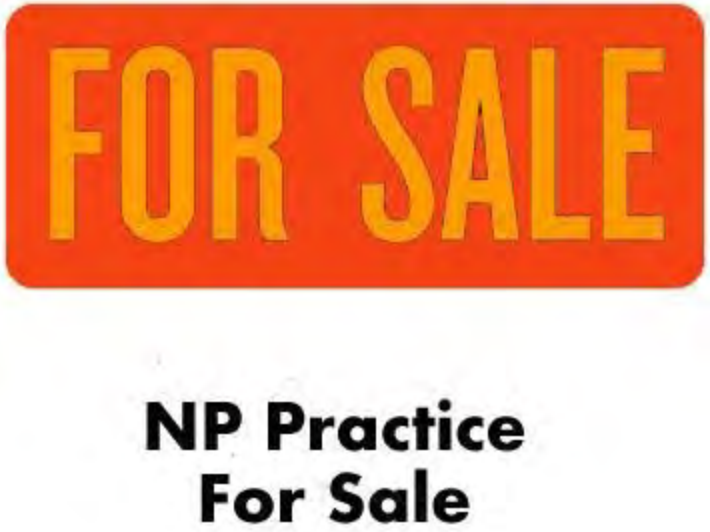
RHCs may be either

Independent



Provider-based

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Reimbursement Differences between

Independent

Payment capped at $82.30
Use Form 222
Owned by physicians, NPs, PAs, or even hospitals.

Provider-based

Payment capped at $82.30 except for less than 50 beds
Use Form 2552, M-Series of the cost report
Owned by the hospital

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Provider-Based Clinics Attestation

MACs may make you Attest to receive provider-based reimbursement if you are off campus. Each MAC has their own attestation form. Here is Cahaba's:

http://www.cahabagba.com/documents/2012/02/part-a-enroll_attest.pdf

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Provider-Based RHCs

PBC may be on the hospital's main campus or within 35 miles of the main campus *(no mileage limit hospitals less than 50 beds)*

•On Campus is defined as within 250 yards of the main provider building. Attestation is voluntary for On Campus. Must Attest for off campus Provider-based RHCs. Attest after receiving the Tie-In Notice.

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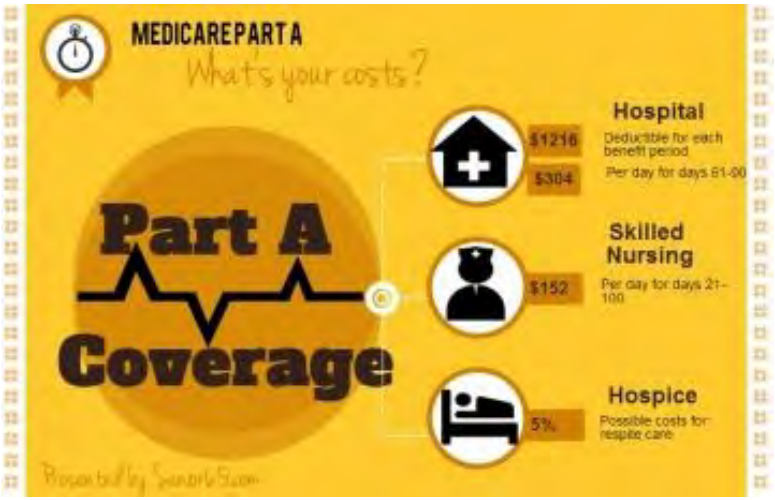
Are RHC Services Part A or B



Claims are paid through Part A

The money comes from the Part B Trust Fund. Patients receive all Part B benefits.

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RHCs – The Original Bundled Payment

RHCs are paid a bundled payment. Independent RHCs are paid a maximum of $64.52 per visit (AIR). Provider-based RHCs will get more.

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Payment Differences for RHCs

1. They are paid on a cost per visit basis.
2. They file Medicare Cost Reports
3. Medicaid Rates are based upon cost.
4. The cost per visit is not all-inclusive.
5. Some services are still paid fee for service
    A. Lab (minus CPT 36415)
    B. Radiology
    C. Hospital

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What are the Medicare RHC Payment Rates?

Type	Cap	Payment
Independent RHC	82.30	$64.52
Provider-based < 50 beds (2012)	None Mean Cost=$178.95	Mean Payment = $140.30 *if meeting productivity standards

Medicare pays 80% minus 2% sequestration

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Comparison of Total Medicare Payments

Type	Charge 99213	Copayment	Medicare	Total Payment
Independent	$125	$25* *No Par limits	$64.52	$89.52
Provider-based (less than 50 beds)	$125	$25* *No Par limits	$140.30	$165.30 NO LCC

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Rural Health Clinic Payment Review					
CPT Code	Service	Charge RHC	Charge Traditional	Payment RHC	Payment Traditional
CPT 99213	Established Visit	100	100	84.52	69.08
CPT 96372	Injection Code	40	40	8.0	23.73
CPT 36415	Venipucture	10	10	2.0	3.00
CPT J3301	Triaminolone acetonide	10	10	2.0	1.34
Total Payments				96.52	97.15
Medicare Payment				64.52	83.31
Patient Payment				32.00	13.84
Patient Payment Percentage				33%	14%

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CPT Code	Service	Charge RHC	Charge Traditional	Payment RHC	Payment Traditional
CPT 99214	Established Visit	150	150	94.52	101.94
CPT 96372	Injection Code	40	40	8.0	23.73
CPT 36415	Venipucture	10	10	2.0	3.00
CPT J3301	Triaminolone acetonid	10	10	2.0	1.34
Total Payments				106.52	130.01
Medicare Payment				64.52	109.62
Patient Payment				42.00	20.39
Patient Payment Percentage				39%	16%

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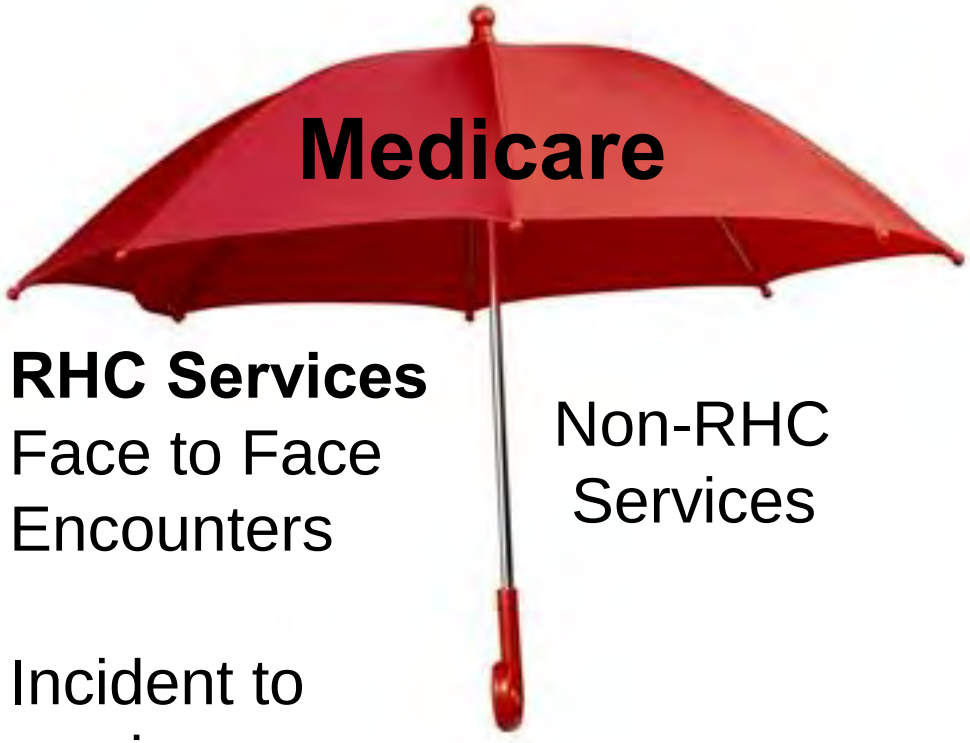
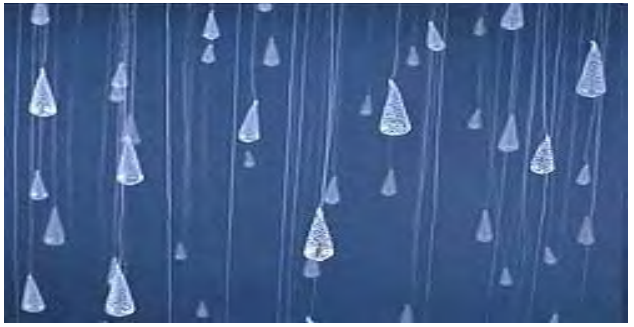
Four Categories of Services



RHC Services
Face to Face Encounters

Incident to services

Non-RHC Services



Medicare Non-covered services

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Medicare

Part A

Part B

Professional Services

Technical Components

Lab Diagnostic

Hospital

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Face to Face Encounters - Visits

RHC Services - Face to Face -Encounters- Visits

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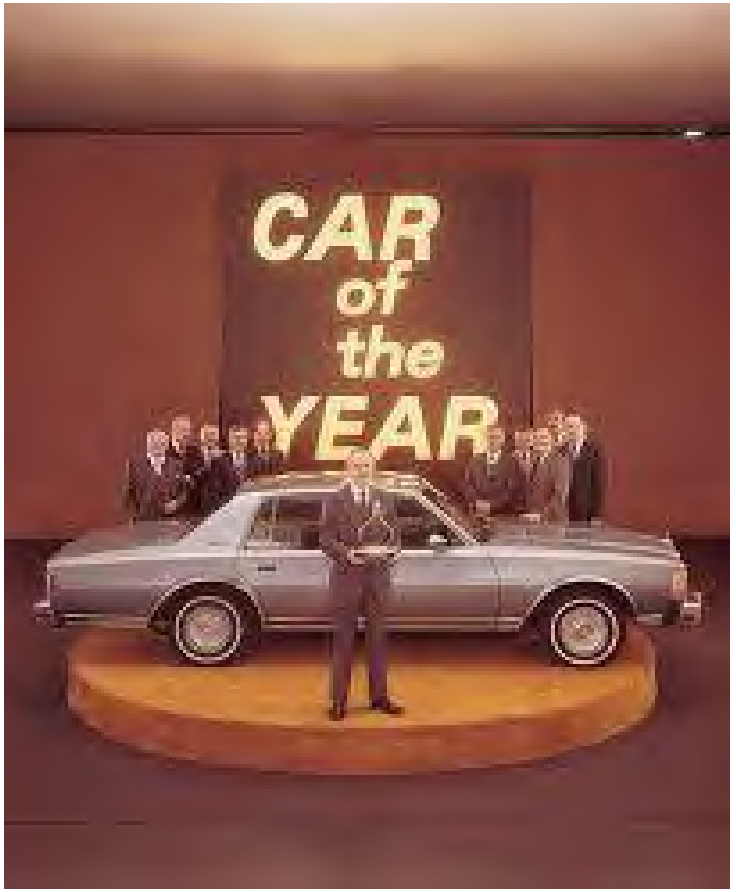
The RHC Program has been around since 1977. the visit definition has not changed (much) since then. Also, most of the incentives do not apply. Its like we are driving around in the 1977 Car of Year, a Chevy Caprice.



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The History of the RHC Visit

Date Began	Definition	Date Changed
3/1/1978	Face to Face, Med necessary, Physician, NP, PA	12/31/2015
1/1/2016	Added Chronic Care Management - No face to Face	3/31/2016
4/1/2016	Must Be on QVL to Bill. Procedures held until 10/1/2016	9/30/2016
10/1/2016	No more QVL. Now add CG modifier	Present

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What is a Rural Health Clinic Visit?

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Definition of a Visit per Chapter 13 of the RHC Manual

40 - RHC and FQHC Visits (Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17) A RHC visit is defined as 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. A Transitional Care Management (TCM) service can also be a RHC visit. Services furnished must be within the practitioner's state scope of practice.

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What is a visit in a rural health clinic?

Has Three Components	1. Is a face to face encounter with a physician, nurse practitioner, PA, NP, or CNM, CP, or CSW. 2. There is a medically necessary service provided (should reach the level of a 99212) 3. Is provided by the appropriately trained provider within their scope of practice.

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Where can you have an RHC Visit?

40.1 - Location (Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16) A RHC visit may take place:

1. **in the RHC,**
2. **the patient's residence,**
3. **an assisted living facility,**
4. **a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1) or the scene of an accident.**

RHC visits may not take place in either of the following:

- **an inpatient or outpatient department of a hospital, including a CAH, or**
- **a facility which has specific requirements that preclude RHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).**

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Where can a RHC visit occur?

In Three Locations	1. In the certified rural health clinic (0521) 2. In the patientôs home A. home (0522) B. SNF (Part A) (0524) C. ICF/NF (Not Part A) (0525) D. Assisted Living Facility (0522) 3. Scene of an accident (0528) 4. Telehealth (0780) Originating site only 5. Behavioral Health (0900) Note: Do not use POS 72 on any Medicare Claim

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RHC Revenue Codes

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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17 Preventive Visits are included in the RHC Benefit

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

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Preventive Services – Key Points

1. If a sick visit and a preventive visit are provided on the same day, only the sick visit will be paid at the AIR. (Exception IPPE)
2. Most Preventive services do not have a co-pay or deductible due from the patient.
3. If a preventive service is provided as a standalone visit, the RHC will receive the full AIR. (No reduction for co-pay)
4. If the preventive service is provided with a sick visit, Medicare will reimburse the clinic for the lost co-pays on the cost report.
5. Validate that the patient has not exceeded the frequency limitations before providing the service. (ABN?)

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Preventive Health Services on the QVL

Approved Preventive Health Services

HCPCS Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0102*	Prostate ca screening; dre
G0117*	Glaucoma scrn hgh risk direc
G0118*	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

**Coinsurance and deductible are not waived*

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IPPE – Only Preventive Service eligible for both the preventive and sick visit paid on the same day

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

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Medicare Stand Alone Encounters

Medicare Preventive Service	HCPCS Code/ Short Description	AIR?	Same Day?	Coins/Ded
Annual Wellness Visit – Initial	G0438/ AWV - I	Yes	No	Waived
Annual Wellness Visit – Subsq	G0439/ AWV-S	Yes	No	Waived
Screening Pelvic Exam	G0101/ Pelvic-breast Exam	Yes	No	Waived
Prostate Cancer Screening	G0102/ Prostate Screening	Yes	No	Not Waived
Glaucoma Screening	G0117 Glaucoma	Yes	No	Not Waived
Glaucoma Screening	G0118 Glaucoma	Yes	No	Not Waived
Screening Pap Test	Q0091 Obtaining Pap Smear	Yes	No	Waived
Alcohol Screening /Behavioral Counseling	G0442 Alcohol Screen 15 min	Yes	No	Waived
Alcohol Screening /Behavioral Counseling	G0443 Brief alcohol misuse counseling	Yes	No	Waived
Screening for Depression	G0444 Depression screen annual	Yes	No	Waived

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Medicare Stand Alone Encounters

Medicare Preventive Service	HCPCS Code/ Short Description	AIR?	Same Day?	Coins/Ded
Screening for Sexually Transmitted Infections	G0445/ STD 30 Minutes	Yes	No	Waived
Intensive Behavioral Therapy for Cardiovascular Disease	G0446/ Cardio-disease	Yes	No	Waived
Intensive Behavioral Therapy for Obesity	G0447/ Obesity 15 minutes	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99406[1]/Smoking 3-10 minutes	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99407[1]/Smoking > 10 Minutes	Yes	No	Waived
Lung Cancer Screening With Low Dose Computed Tomography	G0296/ Lung Cancer LDCT	Yes	No	Waived

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

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Its All about that Visit (QVL)

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

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Visits - The RHC Qualifying Visit List (QVL)

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

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MLN 9269 – What You Need to Know

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

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

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RHCs Must Report a Qualifying Visit on the first line of the UB-04 effective April 1, 2016

RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis.

The charges for all services that create a deductible or co-payment are bundled into the charge for this Qualifying visit. (exclude the charges for the majority of the preventive services)

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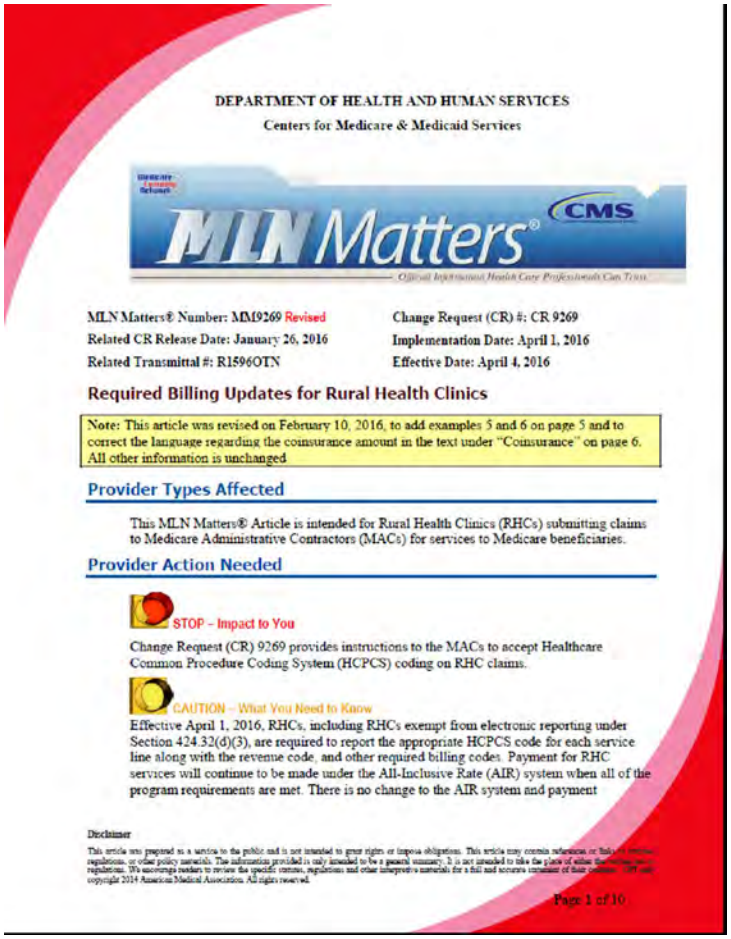
Medlearn Matters – MM9269 Released and Revised

What the Memorandum covers

1. HCPCS Coding
2. Procedures
3. Modifier 59
4. Qualified Visit Listing



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® CMS

MLN Matters® Number: MM9269 Revised | Change Request (CR) #: CR 9269

Related CR Release Date: January 26, 2016 | Implementation Date: April 1, 2016

Related Transmittal #: R1596OTN | Effective Date: April 4, 2016

Required Billing Updates for Rural Health Clinics

Note: This article was revised on February 10, 2016, to add examples 5 and 6 on page 5 and to correct the language regarding the coinsurance amount in the text under "Coinsurance" on page 6. All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Change Request (CR) 9269 provides instructions to the MACs to accept Healthcare Common Procedure Coding System (HCPCS) coding on RHC claims.

CAUTION – What You Need to Know

Effective April 1, 2016, RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes. Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met. There is no change to the AIR system and payment

Disclaimer

Page 1 of 10

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Home visits, Transition Care, and Advanced Care Planning are included on the QVL

HCPCS Code	Short Descriptor
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min

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99211 Visits (Nurse Only) are not Medicare RHC Visits

- Brief Established visits (99211ôs) do not meet the RHC guidelines. No history or judgment involved with this level of service. Do not bill Medicare a visit for these services.

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Paid RHC Encounters are very limited

The definition of a rural health clinic encounter does not include:

1. **Nurses**
2. **Physical Therapists**
3. **Dietitians**
4. **Nutritionists**

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

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Procedures – Chapter 13 Updates

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

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Procedures - Continued

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

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Hospital Services are not covered under the RHC Benefit

Hospital services for independent and provider-based RHCs are billed on the 1500 form and paid fee for service.

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Three Day Payment Window

40.5 - 3-Day Payment Window 3-Day Payment Window (Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)
Medicare's 3-day payment window applies to outpatient services furnished by hospitals and hospitals' wholly owned or wholly operated Part B entities.
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.
Note: If the admitting hospital is a CAH, the payment window policy does not apply.

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Can we bill a Hospital Admission and an Office Visit on the same day?

We asked CMS this question and their response was to bill it to the MAC and let them decide if it is payable or not. Most are paid; however, some do get rejected if the patient becomes observation instead of a hospital admission.

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Place of Service (POS)

The UB-04 does not have Place of service (POS) codes, but when billing Medicare on the 1500 use Place of service 72.

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Medicare Advantage Plans

When a beneficiary enrolls in a Medicare Advantage (MA) plan, they are no longer classified as a Medicare patient for cost reporting purposes. These individuals are effectively treated as privately insured individuals.

MA plans must show that they have an "adequate" provider network in each market they serve. In an underserved area, it may be difficult for the MA plan to meet the market adequacy requirement if an existing RHC is not part of the network.

If an RHC is a contracted provider within a MA network, the RHC is obligated to follow whatever is established in the contract. Payment could be cost-based, fee-for-service, or even capitation.

plan.

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf (see page 25)

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Medicare Advantage Plans

Non-network providers are able to see patients enrolled in MA plans, but the terms and conditions for payment vary by type of plan (fee schedule, capitation, enhanced fee-for-service, etc.). The most common MA plan in rural communities is private fee-for-service (PFFS). Under this type of arrangement, the MA plan is required to pay the RHC its all-inclusive rate. However, the billing format is up to the plan.

Flu and pneumonia vaccines administered to MA patients are <u>not</u> captured on the RHC cost report. Reimbursement should come through the MA

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Incident to

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Define Incident to Services

Chapter 13 - 110 - Services and Supplies Furnished "Incident to" Physicianôs Services (Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)"Incident to" refers to services and supplies that are an integral, though incidental, part of the physicianôs professional service and are:

- Commonly rendered without charge or included in the RHC bill;
- Commonly furnished in an outpatient clinic setting;
- Furnished under the physicianôs direct supervision; and
- Furnished by a member of the RHC staff.

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Incident to Services and supplies include:

Å **Drugs and biologicals that are not usually self-administered**, and Medicare covered preventive injectable drugs

Å**Venipuncture;**

ÅBandages, gauze, oxygen, and other supplies; or

Å Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician.

Markôs Note: Funny thing ï the example CMS gives of this are not really incident to ï (Influenza and Pnu)

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110.1 - Provision of Incident to Services and Supplies

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15) Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physicianôs visit must result from the patientôs encounter with the physician and be furnished in a medically appropriate timeframe.

More than one incident to service or supply can be provided as a result of a single physician visit.

Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC to provide services.

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Chapter 13 - 110.3 Payment for Incident to Services and Supplies in a Rural Health Clinic

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with a RHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. 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 provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.

Incidental services or supplies must represent an expense incurred by the RHC.

For example, if a patient purchases a drug and the physician administers it, the cost of the drug is not covered and cannot be included on the cost report.

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Many services do not qualify as a visit under RHC

- Dressing changes
- Allergy shots/inject.
- Nutritional counseling
- Diabetic counseling
- Paperwork

Family Consultation
Telephone Services
Prescription Changes
Therapy Services

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The 30 Day Rule – Incident to

- **Incident to services can be combined with claims with visits within 30 days. List only the date of the visit and bundle all charges into Revenue Code 0521.**
- May use a Bill Type in 717 for an adjustment. Condition Code = D1, In the Remarks Form Locator indicate "change in charges"

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RHC Bill Types

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

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Non-RHC Services

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Laboratory services are not covered under the RHC benefit

All Laboratory services are not included under the RHC benefit including the six required laboratory tests.

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF ACCREDITATION

LABORATORY NAME AND ADDRESS
MEDICAL LABORATORY SERVICES MEDICAL GROUP INC
25470 MEDICAL CENTER DR, SUITE 105
MURRIETA, CA 92562

CLIA ID NUMBER
05D0716342

EFFECTIVE DATE
06/24/2008

LABORATORY DIRECTOR
ERNEST N HOLBURT MD

EXPIRATION DATE
06/23/2010

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

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What are the six laboratory tests required for Rural Health Clinic certification?

1. Chemical examinations of urine by stick or tablet method or both
2. Hemoglobin or hematocrit
3. Blood sugar
4. Examination of stool specimens for occult blood
5. Pregnancy tests
6. Primary culturing for transmittal to a certified laboratory (No CPT code available)

Reference: CMS Publication 100-04, Chapter 9, Section 130

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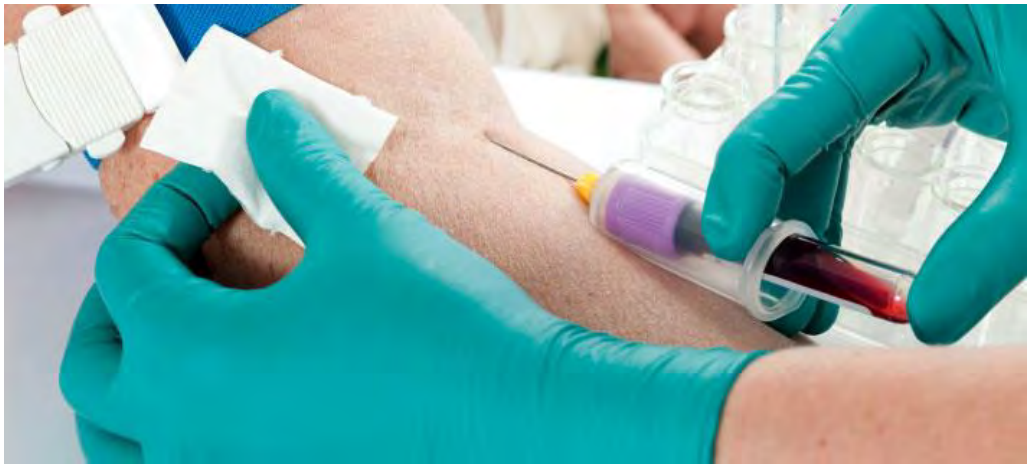
Venipuncture – Lab Draw (36415)

Effective 1/1/2014, Venipuncture is covered by Part A and is included in the billing to Part A on the UB-04 Form. You can continue to charge for the service. It will increase the co-pay from the patient. MLM 8504.



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Laboratory Services

CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 60.1

- Venipuncture is included in AIR and is not separately billable
- Laboratory services are not an RHC benefit and not included in AIR
  - Provider-based RHCs bill under parent provider to on UB-04 or 837I equivalent
  - Independent RHCs submit claim on CMS-1500 Claim Form or 837P equivalent

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RHC Laboratory services are paid as follows in a CAH

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Laboratory Use the Hospital Outpatient Provider Number	851	UB-04	Cost

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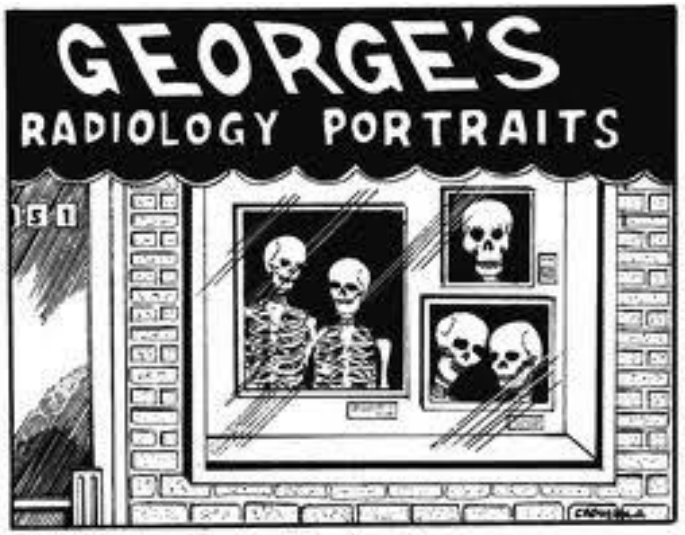
Diagnostic Tests are not covered under the RHC Benefit

Technical components were excluded under Public Law 95-10 establishing RHCs.



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RHC Provider-based - Diagnostic Tests - Technical Component Only – CAH

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Radiology, EKG	851	UB-04	Fee for service

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Diagnostic Tests – Professional Components

Professional components are covered under the RHC benefit and are included on the UB-04 and billed to the RHC MAC. (they must be billed with a face to face encounter)

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RHC -What happens to the professional component of Radiology?

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Radiology, EKG	711	UB-04	Cost

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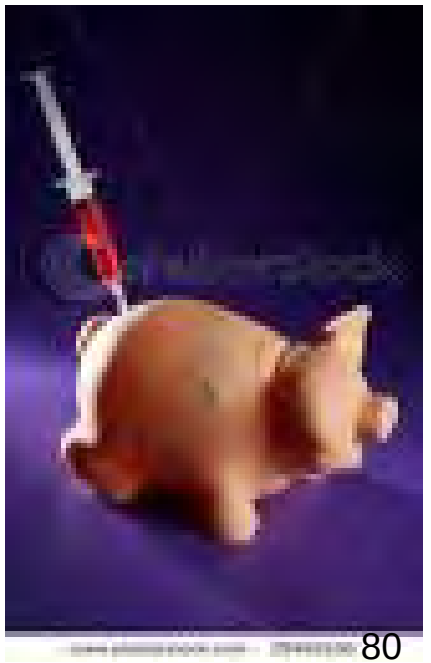
Flu and Pnu shots are paid very well in the RHC setting . Use a log on the cost report. Do NOT Bill!!!!

Average payment was $135 for pnuemococal. (Cost is $63)

Average payment was $35 for influenza in 2013. (Cost is 11)

Place Patient Name, HIC Number, and Date of Injection on a Log.



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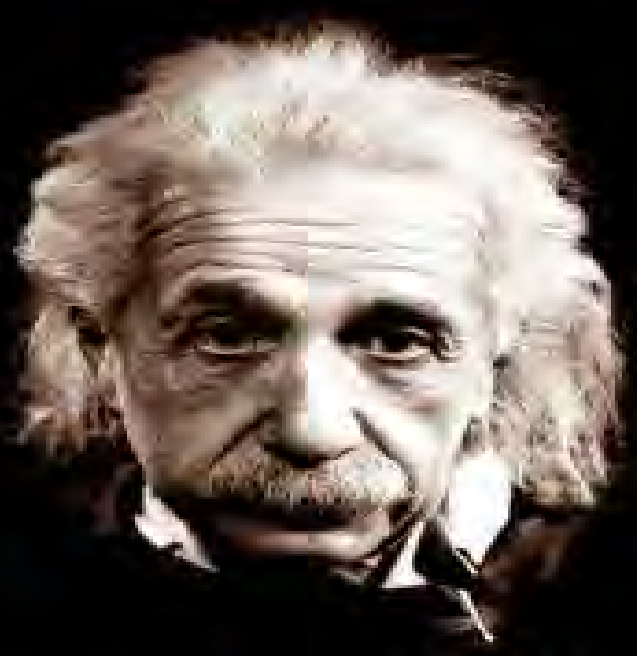

"The secret to creativity is knowing how to hide your sources."

Albert Einstein
smarty-pants physicist

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HRSA/NARHC Technical Assistance Webinar on March 29, 2016

Healthcare Common Procedure Coding System (HCPCS) Requirements for RHCs - March 29, 2016

Slides - CMS Presentation (PDF - 379 KB)
Slides - BKD Presentation (PDF - 749 KB)
Slides - FORHP Overview (PDF - 966 KB)
Webinar Recording
Audio (PDF - 19 MB)
Transcript (PDF - 199 KB)

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HRSA/NARHC Technical Assistance Webinar on December 22, 2016

https://www.hrsa.gov/ruralhealth/resources/conferencecall/

RHC HCPCS Reporting

December 22, 2016

Slides (PPT - 240KB)

Webinar Recording

Audio (MP3 - 15MB)

Transcript (PDF - 475 KB)

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HRSA/NARHC Technical Assistance Webinar on June 29, 2017

RHC Common Claim Errors

June 29, 2017

Slides (PDF - 808 KB)

Webinar Recording

Audio (MP3 - 12.5 MB)

Transcript (PDF - 280 KB)

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RHC CG Modifier – 10/1/2016

HBS

Healthcare Business Specialists

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

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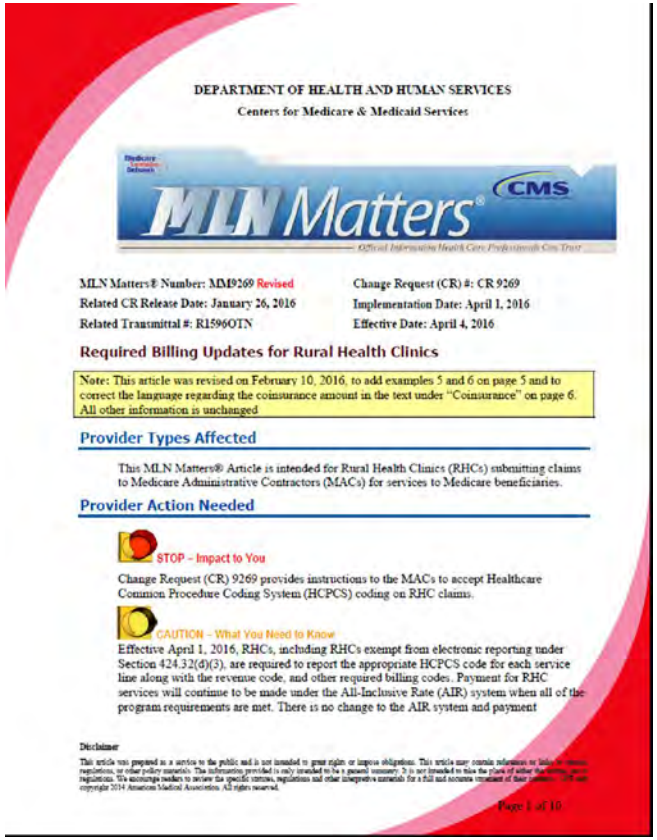
Medlearn Matters – MM9269 Released and Revised and Revised Again

What the Memorandum covers

1. HCPCS Coding
2. Procedures
3. Modifier 59
4. Qualified Visit Listing



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® CMS

MLN Matters® Number: MM9269 Revised | Change Request (CR) #: CR 9269

Related CR Release Date: January 26, 2016 | Implementation Date: April 1, 2016

Related Transmittal #: R1596OTN | Effective Date: April 4, 2016

Required Billing Updates for Rural Health Clinics

Note: This article was revised on February 10, 2016, to add examples 5 and 6 on page 5 and to correct the language regarding the coinsurance amount in the text under "Coinsurance" on page 6. All other information is unchanged

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Change Request (CR) 9269 provides instructions to the MACs to accept Healthcare Common Procedure Coding System (HCPCS) coding on RHC claims.

CAUTION – What You Need to Know

Effective April 1, 2016, RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes. Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met. There is no change to the AIR system and payment

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either statutes, regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved.

Page 1 of 10

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The History of the RHC Visit

Date Began	Definition	Date Changed
3/1/1978	Face to Face, Med necessary, Physician, NP, PA	12/31/2015
1/1/2016	Added Chronic Care Management - No face to Face	3/31/2016
4/1/2016	Must Be on QVL to Bill. Procedures held until 10/1/2016	9/30/2016
10/1/2016	**Now add CG modifier (QVL is a guide)**	**Present**

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

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

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Bundling Under April 1, 2016 HCPCS Coding Guidelines

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

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

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Bundling using .01 for the Ancillary Services

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

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

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Change of Charges

For Incident to billing

1. Use Bill Type 0717
2. Use Condition Code D1 in FL 18-28
3. Place DCN in FL64 (Document Control Number)
4. In Remarks indicate “Change of Charges”

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Example 1a – Patient's Account

Patient has a medical visit on *April 1, 2016.*

CHARGES TO THE PATIENT'S ACCOUNT			
DATE OF SERVICE	**REV. CODE**	**HCPCS**	**CHARGE**
04/01/2016	0521	99213	$8.00
04/01/2016	0300	36415	$5.00
	CHARGE TOTAL		***$13.00***

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Example 1a – UB-04 Claim

Patient has a medical visit on *April 1, 2016.*

UB-04 CLAIM EXAMPLE

http://www.x12.org/codes/claim-adjustment-reason-codes/

EXAMPLE RESULTS	
CLAIM COINS	$2.60

	42 Rev. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGE	48 NON-COVERED CHARGES	49
1	0521	*	99213 CG	*04/01/2016*	1	*$13.00*	*	*
2	0300	*	36415	*04/01/2016*	1	$5.00	*	*
3	0001	*	*	*	*	$18.00	*	*
	*	*	*	*	*	*	*	*

COMMENTS	
1	Paid at the AIR
2	Medicare assigns CARC 97
3	

* Field intentionally left blank

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Example 4a – UB-04 Claim

Ex 4a: Patient has two medical visits from the RHC qualifying visit list *(additional lines reported with charges ≥$0.01).*

UB-04 CLAIM EXAMPLE

	42 Rev. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGE	48 NON-COVERED CHARGES	49
1	0521	*	99213 CG	04/01/2016	1	$20.00	*	*
2	0521	*	12002	04/01/2016	1	*$0.01*	*	*
3	0300	*	36415	04/01/2016	1	*$0.01*	*	*
4	0001	*	*	*	*	*$20.02*	*	*
	*	*	*	*	*	*	*	*

EXAMPLE RESULTS

CLAIM COINS	$4.00

COMMENTS

1 Paid at the AIR
2 Medicare assigns CARC 97
3 Medicare assigns CARC 97
4

* Field intentionally left blank

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Billing Example #8
Procedure only (Red QVL) – October 1, 2016

A minor surgical procedure which is on the Qualifying Visit List can be billed alone as an encounter. The appropriate HCPCS code for the procedure should be amended with the CG modifier.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Procedure	11100 CG	10/2/2016	1	$ 250.00
0001	Total Charge				$ 250.00

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Claim Example #6:
Medical and Behavioral Health Services

Modifier CG should be reported once per day for a qualified medical visit (revenue code 052x) and/or once per day for a qualified mental health visit (revenue code 0900).

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Level 3	99213 CG	4/2/2016	1	$ 100.00
0900	BH Session	90834 CG	4/2/2016	1	$ 120.00
0001	Total Charge				$ 220.00

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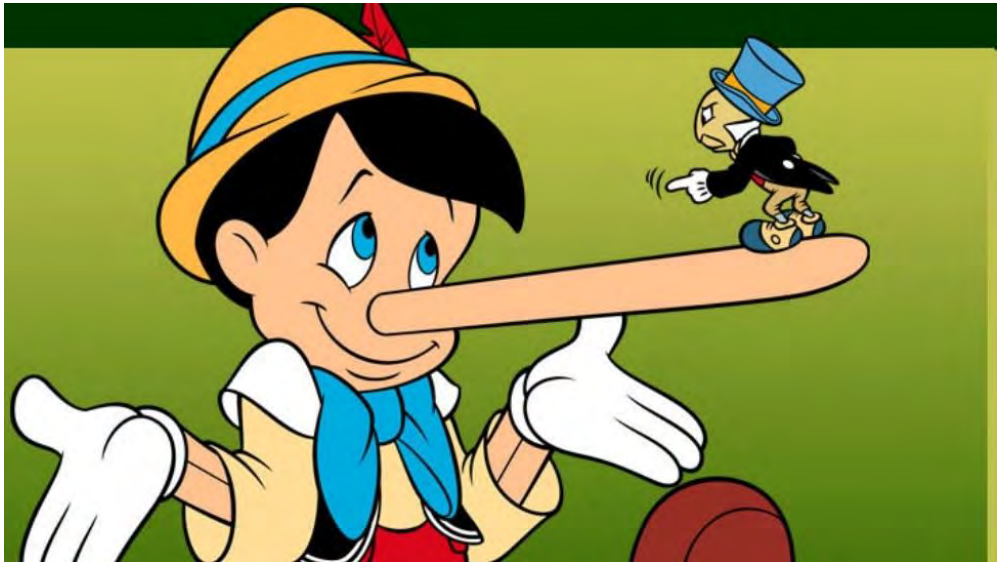
The CG Modifier – Effective October 1, 2016

Most of the Medicare Contractors handled this transition relatively smoothly with a notable exception.



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CG Modifier FAQ Summary

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

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CG Modifier FAQ Summary (2)

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

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

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

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

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

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Billing Example #7 – Multiple Preventive Stand Alone Encounters

A breast and pelvic exam (G0101) and a pap collection (Q0091) were performed on the same day. Both services are "stand-alone" preventive services. Report one of these with the CG modifier. No co-insurance or deductible amount should be applied.

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Breast/Pelvic	G0101 CG	4/2/2016	1	$ 75.00
0521	Pap Collection	Q0091	4/2/2016	1	$ 40.00
0001	Total Charge				$ 115.00

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Billing Example #9
IPPE Only

"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." RHC FAQ

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	IPPE	G0402	4/2/2016	1	$ 200.00
0001	Total Charge				$ 200.00

The IPPE was the only service performed. The G0402 does NOT need a CG modifier when billed. **Make sure and report preventive charges on your Cost Report!!

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Billing Example #10
IPPE and a Medical Visit

"RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the [certain preventive services] when they are performed on the same day." RHC Reporting FAQ

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Est Pt Level 3	99213CG	4/2/2016	1	$ 100.00
0521	IPPE	G0402	4/2/2016	1	$ 200.00
0001	Total Charge				$ 300.00

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Billing Example #11:
Well Woman Exam

Medicare does not pay a well-woman exams (99381-99387). Each component will be billed instead. An annual or subsequent wellness visit (G0438/G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091).

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Subsq AWV	G0439 CG	4/2/2016	1	$ 175.00
0521	Breast/Pelvic	G0101	4/2/2016	1	$ 75.00
0521	Pap Smear	Q0091	4/2/2016	1	$ 50.00
0001	Total Charge				$ 300.00

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Modifier 59 – Modifier 25

"...the RHC should report modifier 25 or modifier 59 on the line with the medical service that represents the primary reason ***for the subsequent visit*** and has the bundled charges for all services for the subsequent visit. Modifier 59 or modifier 25 should be reported with a medical service using revenue code 052x."

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Modifier-59 Example

The CG Modifier will amend the initial visit. The 59 modifier will amend the subsequent visit laceration repair. The CG modifier should NOT accompany the subsequent visit code.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 4	99214 CG	4/2/2016	1	$ 340.00
0521	Laceration	12002 59	4/2/2016	1	$ 200.00
0001	Total Charge				$ 540.00

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Modifier 59 – MLN - 9269

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

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

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

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

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We need to Talk
Communicating with the MAC

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Who is your MAC?

State	MAC	Website
Indiana	WPS J8 Part A	https://www.wpsgha.com

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WPS Claims Resources - DDE

Access & Reference Material

Did you know you can access FISS directly through DDE? Learn more about obtaining access, as well as the UB-04 claim form, and Remittance Advices:

§DDE Access
§FISS Manual
§Claim & Remittance materials
§Overpayments

https://www.wpsgha.com/wps/portal/mac/site/forms/dde-electronic-access-request-form/

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

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

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

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Filing a Claim – Completing the UB-O4

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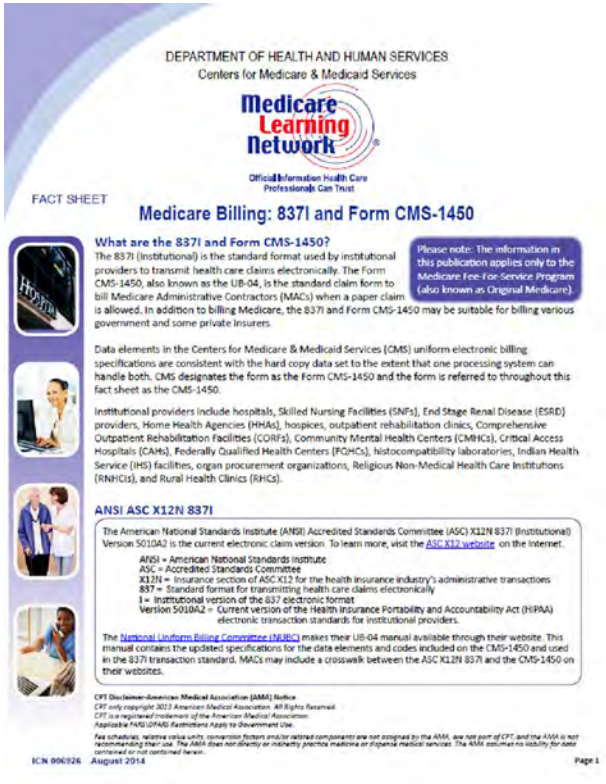
UB-04 Fact Sheet

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

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



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official Information Health Care Professionals Can Trust

FACT SHEET

Medicare Billing: 837I and Form CMS-1450

What are the 837I and 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.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

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 fact sheet as the CMS-1450.

Institutional providers include hospitals, Skilled Nursing Facilities (SNFs), End Stage Renal Disease (ESRD) providers, Home Health Agencies (HHAs), hospices, outpatient rehabilitation clinics, 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 on the Internet.

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.

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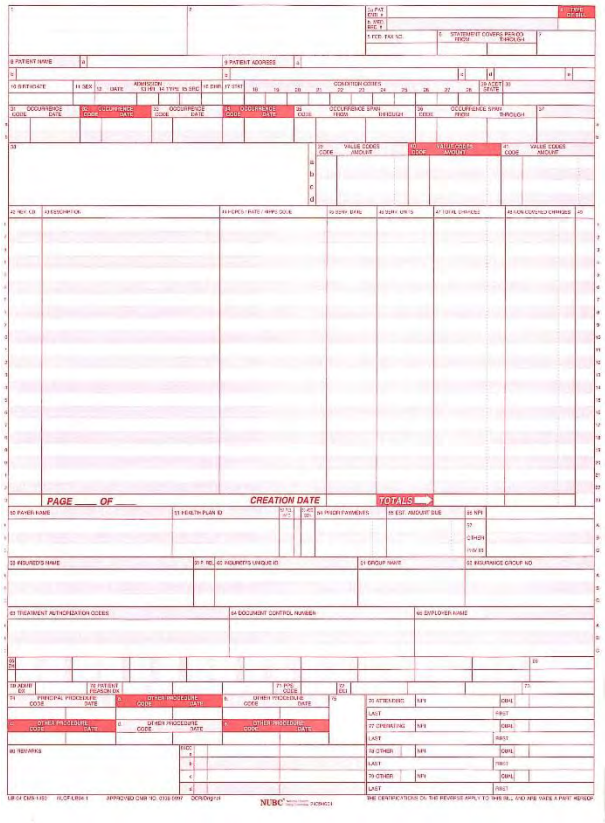
Completing the UB-04

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

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



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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 *.

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5010 Requirements for RHC Billing
General Guidelines

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

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

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

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

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

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

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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
18-28	N	Condition Codes (rarely used with RHCs except for secondary payer, denials, and Hospice.	Typical Responses for RHCs 07=hospice patient for nonhospice DX 21=claim sent for denial purposes. See Cahaba reference guide for secondary billing codes at the end of this document

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Condition Codes UB-04 FL 16-28

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

Modifier	Description	How to bill
93000	Global interpretation and technical component	Do not bill this way in a RHC.
93005	Technical Component	Bill to Part B ï Paid on 1500 for Independent and use UB-04 and hospital outpatient provider number
93010	Interpretation	Bill on UB-04 (incident to ï No visit)

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Questions, Thank You

H B S

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