Introduction to RHC Billing

2:00 to 3:00 PM

Fall, 2019

RHC Billing

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

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

RHC MEDICARE BILLING RESOURCES

Healthcare Business Specialists, LLC is pleased to provide you with these billing resources to help your rural health clinic bill Medicare for your services. Billing RHC services requires the ability to create a UB-04 in an electronic format (837I). Many clinics that are new to RHC billing rely on outside help to bill for services. We have worked with AMS Software out of Raleigh, North Carolina who has been working with RHCs on billing since 1989. Many RHCs need access to Direct Data Entry (DDE) to verify coverage or adjust claims. Many of our clients use Ability to connect to Direct Data Entry.

Healthcare Business Specialists Beginning Billing for Independent Rural Health Clinics Webinar Series in February, 2018

In February, 2018, Healthcare Business Specialists, LLC conducted a series of webinars on RHC billing for Independent RHCs. We have provided the information from the webinars including PDFs of the slides and links to the recording of the presentations on Youtube:

- RHC Billing Webinar Session 1 Presentation (PDF)
- RHC Billing Webinar Session 2 Presentation (PDF)
- RHC Billing Webinar Session 3 Presentation (PDF)
- RHC Billing Webinar Session 4 Presentation (PDF)

The Youtube Recording of the sessions are below:

- RHC Billing Recording of Webinar Session 1
- RHC Billing Recording of Webinar Session 2
- RHC Billing Recording of Webinar Session 3
- RHC Billing Recording of Webinar Session 4

Medicare Online Manuals with RHC Billing Guidance:

- Preventive Services Table from CMS for RHCs (3-Page PDF, August, 2016)
- FAQs from CMS regarding the CG Modifier (6-page PDF, October, 2016)
- RHC Fact Sheet from CMS issued January, 2018 (8-page PDF)
- Rural Health Clinics Center - CMS Information Portal for RHCs
- Chapter 9 - Medicare Claims Processing Manual
- Chapter 13 - Medicare Benefit Manual
- FAQs from CMS regarding Care Management Services in Rural Health Clinics (17-Page PDF, February 2018)

Healthcare Business Specialists RHC Billing Policies

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

RHC Billing Guides and Tables from Medicare Administrative Contractors:

- RHC Billing Guide from Noridian
- RHC Condition Codes from Noridian
- Medicare Part A Billing Guide from Noridian

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

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

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

Subscribe to our RHC email newsletter here.

RuralHealthClinic.com

Experienced Knowledge

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

noridian Healthcare Solutions

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

Contact Us | Help | Noridian Medicare Portal (NMP) Login

Search

Browse by Topic | Browse by Provider Type | Fees & News | Policies | Audit & Reimbursement | Medical Review | Education & Outreach | Enrollment | Forms

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

Share

Vulnerability

BROWSE BY PROVIDER TYPE

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

Educational Resources

Rural Health Clinic (RHC)

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

Access the below RHC related information from this page.

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

Resources

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

Last Updated May 21, 2018

Related Articles

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

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

RHC Status only affects reimbursement from:

The Golden Rule

"He who has the Gold makes the rules."

1. **Charge everyone the same.**
2. **Bill in accordance with the Payor's rules.**

Reference Materials

RuralHealthClinic.com
Experienced Knowledge

Other Useful Links

Description	Link
Revised Chapter 13 Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf
CMS Rural Health Clinics Center (Google rural health clinic.asp)	http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html
Qualified Visit List from the Rural Health Clinic Center website. (4 pages in your handouts – Updated Quarterly)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

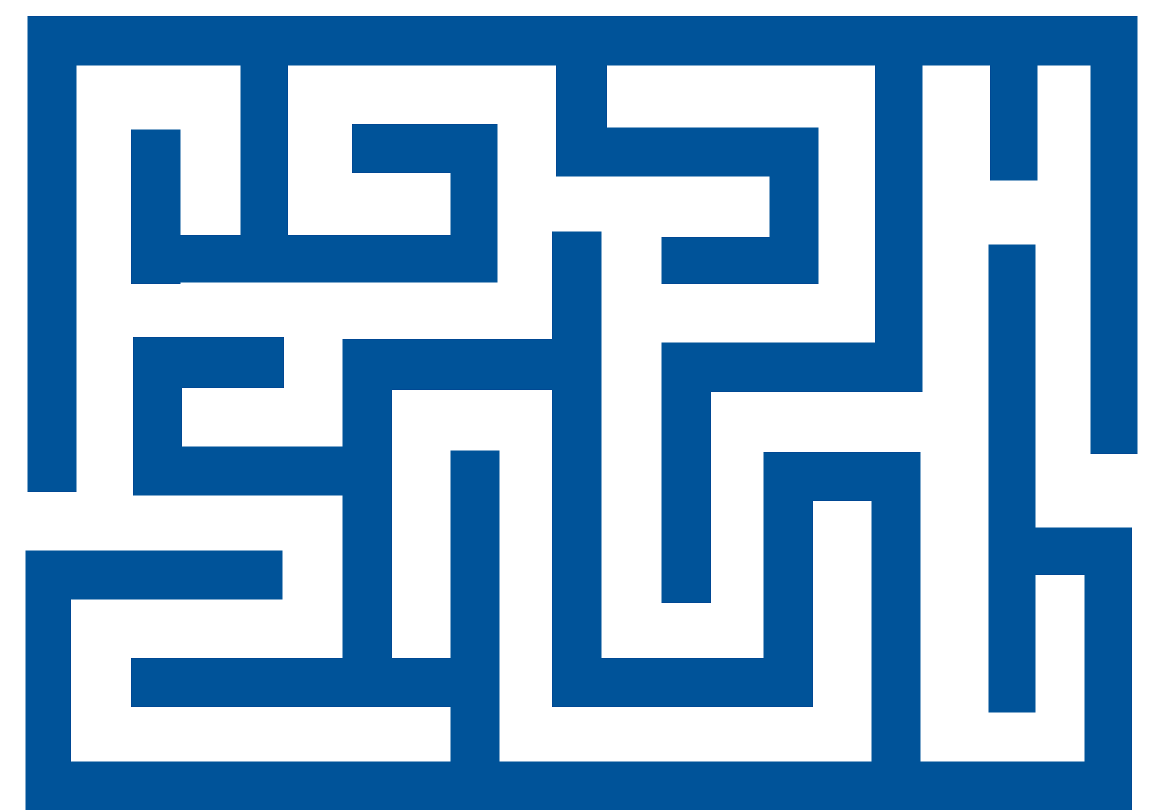
Other Useful Links (2)

Description	Link
RHC Benefits Manual Chapter 9	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

RuralHealthClinic.com
Experienced Knowledge

Links to the Transmittals

Description	Links
Medlearn Matters Revised Transmittal on HCPCs Billing with changes on February 29, 2016. MM9269.	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf
MedLearn Matters Revised Transmittal on Chapter 13 changes on January 16, 2016 MM9442	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9442.pdf



Resources for RHCs

Resources for RHCs

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

Healthcare Business Specialists RHC Billing Policies

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

Definitions of Common Acronyms

Term	Definition
AIR	All Inclusive Rate (the amount the RHC is paid on an interim basis capped at $83.45 for Independent RHC)
CMS	Centers for Medicare and Medicaid Services
RHC	Rural Health Clinic (PL-95210)
MAC	Medicare Administrative Contractor
MLN	Medlearn Matters

Definitions of Common Acronyms (2)

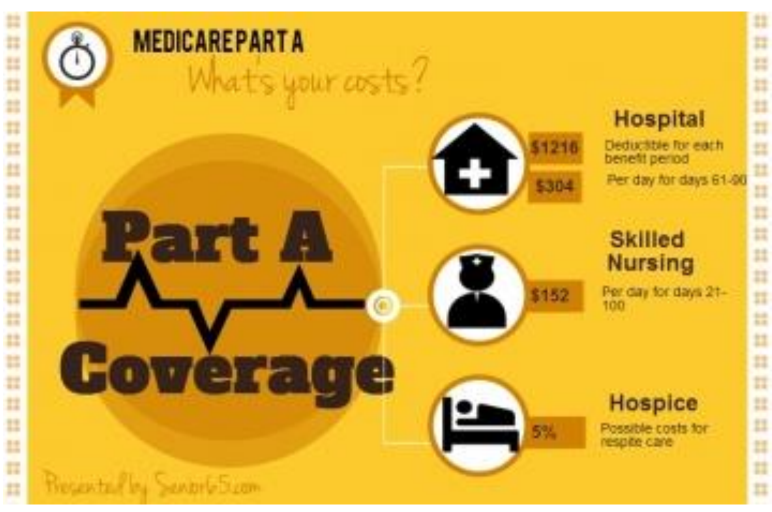
Term	Definition
QVL	Qualified Visit List
DDE	Direct Data Entry
CWF	Common Working File
FISS	Fiscal Intermediary Standard System
MSP	Medicare Secondary Payor

RuralHealthClinic.com
Experienced Knowledge

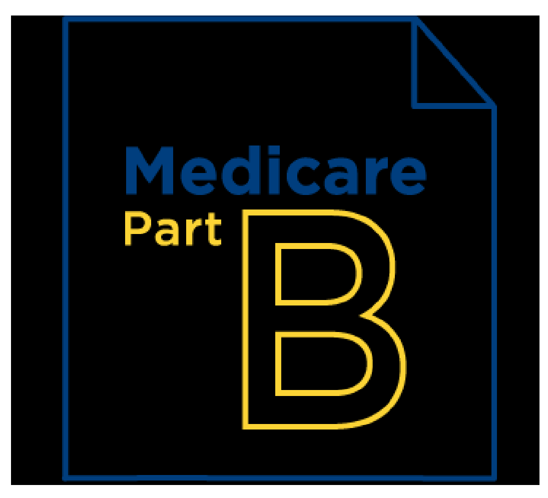
Definitions of common Acronyms (3)

CMS	Centers for Medicare and Medicaid Services
PTAN	A six Digit Number that is assigned to the RHC by Medicare. It is not used on the UB-04.
NPI	The Nine Digit Number assigned in PECOS and it is used on the UB-04
UB-04	The Electronic Claim formatting used to bill Medicare RHC Claims
1500	The Electronic Claim formatting used to bill hospital claims in a provider-based clinic.

Are RHC Services Part A or B



Claims are paid through Part A UB-04



The money comes from the Part B Trust Fund. Patients receive all Part B benefits. Typically HCFA-1500

Part A versus Part B

RHCs submit claims to a Part A MAC, so they are often referred to as Part A providers; however, they are paid from the Part B trust fund. Beneficiaries must have Part B coverage at the time of service in order to be reimbursed.

It is confusing because sometimes the Part A rules apply and sometimes the Medicare Part B rules apply. For example, to be paid for an AWV, a rural health clinic must have physician, PA, or NP have a face to face visit, while for Part B a nurse is only required to bill this service.

How to bill Begin Billing Medicare

In order to bill Medicare for services provided to a beneficiary, a facility or clinician must:

1) **obtain a National Provider Identifier (NPI) via the National Plan & Provider Enumeration System (NPPES), then**
2) **enroll using the appropriate CMS-855 form via the Provider, Enrollment, Chain and Ownership System (PECOS).**

NPIs and 855As

There are two types of NPI: Type 1 (individual) and Type 2 (organization). RHCs bill Medicare under a clinic Type 2 NPI. Clinicians and facilities submit CMS-855 enrollment forms through PECOS according to their situation:

1) 855A is for facilities such as RHCs
2) 855I is for individual clinicians for Part B services
3) 855B is a group practice form
4) 855R is used to reassign billing privileges
5) 855O is an individual form for clinicians who do not bill Medicare Part B, but need to order and refer.

855A/CCN or 855B/PTAN

An RHC typically enrolls twice:

1) **an 855A to receive a CMS Certification Number (CCN; formerly the Medicare/Medicaid Provider Number or OSCAR Provider Number), which facilitates RHC claims; and**
2) **an 855B to receive a Provider Transaction Access Number (PTAN; frequently called the "legacy provider ID number" or "Medicare PIN"), which facilitates claims for non-RHC services (e.g., labs and diagnostic tests).**

855I/855R Reassignment

An RHC clinician also typically completes two forms for Part B billing:

1) **an 855I to receive a PTAN; and**
2) **an 855R to reassign billing privileges established via the 855I enrollment to the RHC 855B group entity to facilitate non-RHC claims.**
3) **RHC clinicians do not need reassign benefits to the RHC**

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. Technical Components
   - C. Hospital

Independent vs. Provider Based RHC Billing

	Encounter for RHC Service(s)	CLIA Lab in RHC	Technical Component (Non-RHC Service)
Independent RHC	Bill to Part A on UB-04	Bill to Part B on CMS-1500	Bill to Part B on CMS-1500
Provider-Based RHC	Bill to Part A on UB-04	Billed to MAC by Parent Entity PPS Hospital: TOB 141/ 131 CAH: TOB 851	Billed to MAC by Parent Entity PPS Hospital: TOB 131 CAH: TOB 851

Charges

All patients must be charged the same amount for services, though what the RHC collects can vary based on policies such as cash and same day payment discounts, sliding fee schedule, etc. Do not charge your Medicare rate to Medicare patients. Note: Some states use a T1015 code for Medicaid services and an RHC may be required to include the Medicaid rate as the charge to Medicaid.

RuralHealthClinic.com

Experienced Knowledge

RHCs – The Original Bundled Payment

RHCs are paid a bundled payment. Independent RHCs are paid a maximum of $67.75 per visit (AIR). Provider-based RHCs will get more.

What are the Medicare RHC Payment Rates?

Type	Cap	Payment
Independent RHC	84.75	$67.75
Provider-based < 50 beds (2018)	None Mean Cost=$207	Mean Payment = $166 *if meeting productivity standards

Medicare pays 80% minus 2% sequestration

Comparison of Total Medicare Payments

Type	Charge 99213	Copayment	Medicare	Total Payment
Independent	$125	$25* *No Par limits	$67.75	$92.75
Provider-based (less than 50 beds)	$125	$25* *No Par limits	$166	$191 NO LCC

Strange new rules

1. Must bill Medicare on a UB-04
2. No limiting charges - collect 20% of charges
2. Collecting more than you charge.
3. Remittance Advices are strange. How to record contractual adjustments correctly.
4. What services to bill Part A? Part B???
5. How is Medicaid affected by this?
6. We get Negative Reimbursement?????
7. HCPCS Billing changed on April 1, 2016.
8. CG Modifier Added October 1, 2016

Some things remain the Same

1. The $186 Deductible is the same.
2. Continue Coding and charging the appropriate level of service.
3. Charges must be consistent across the board.
4. Continue using either the 95 or 97 CPT Documentation guidelines.
5. Preventive Services are the same.

Four Categories of Services

RHC Services
Face to Face Encounters

Incident to services

Non-RHC Services

Medicare Non-covered services

Medicare

Part A

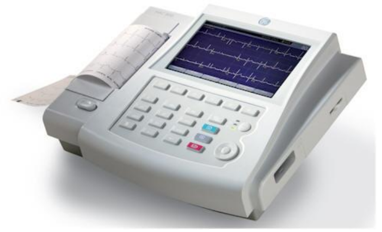
Part B

Professional Services

Technical Components

Lab Diagnostic

Hospital



What is a Rural Health Clinic Visit?

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

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.

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.

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

99211 Visits (Nurse Only) are not Medicare RHC Visits

- Brief Established visits (99211's) 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.

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.).**

RuralHealthClinic.com

Experienced Knowledge

Where can a RHC visit occur?

In Three Locations	1. In the certified rural health clinic (0521) 2. In the patient's 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

Revenue Codes

Code	Description
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

RuralHealthClinic.com

Experienced Knowledge

Other Common Revenue Codes in RHCs

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

Claim Form, Bill Types & Place of Service

- RHC services are billed on a CMS-1450 (also known as a UB-04 form)
- RHCs should use Place of Service (POS) code **72**
- These are the common bill types (TOBs) used on RHC claims:

711	Original Claim
710	Non payment/zero claim
717	Adjustment Claim
718	Cancelled Claim

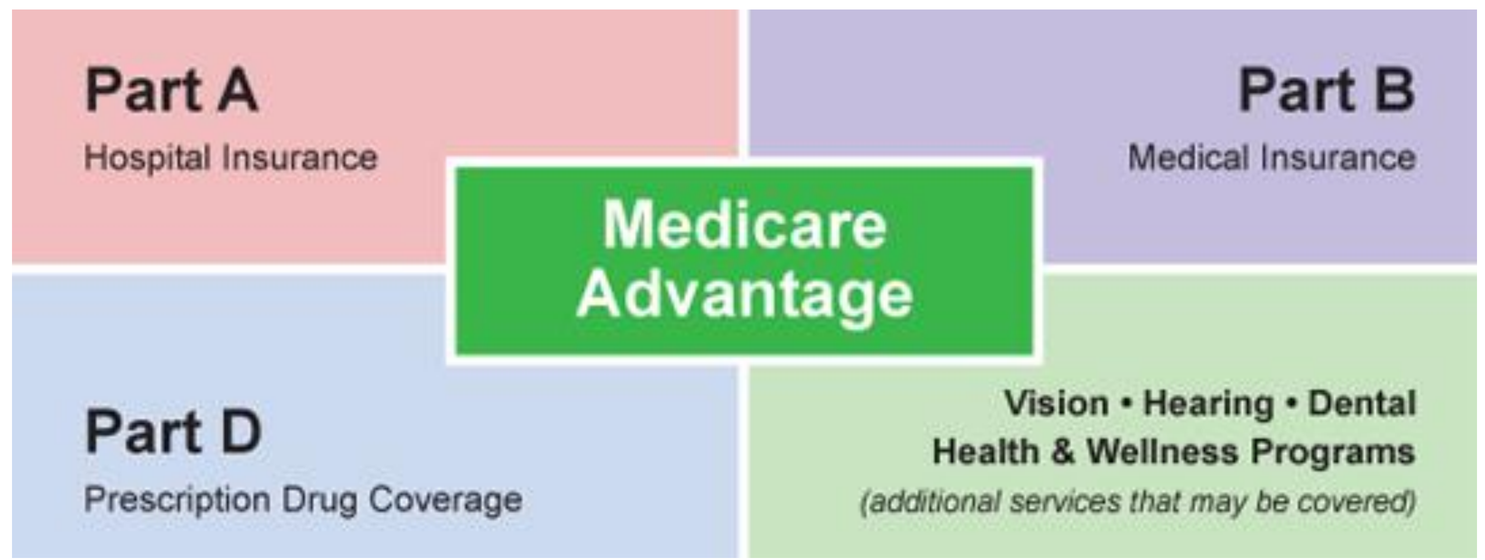
Why is Medicare not paying you in January, 2019?

- Medicare is in the Deductible season and in RHCs there is something called **Negative reimbursement** which means RHCs not only are not paid from Medicare, but Medicare takes money away from them. For example.

Charge to Medicare patient on January 1, 2019	$186
Medicare Deductible for 2019	$186
RHC Interim reimbursement rate	$85
Amount withheld from Medicare Check by MAC	($101)

- Medicare's logic (seems a little flawed to me) is that the RHC collected $186 from the patient and the RHCs cost per visit cap (about $30 less than the RHCs actual cost per visit on average) so in order not to over pay the RHC, the MAC will take money away from the RHC that they should have paid. The claims are not denied, they are paid correctly (in Medicare's eyes), so this may be your issue of not getting paid by Medicare.

Medicare Advantage Plans



https://www.modernhealthcare.com/article/20180210/NEWS/180219989?fbclid=IwAR0MkzSTIwRI_rNk-irYTA94T33XeQf5GzWAsrnpBifhITwL_4Q7ZXtqvcg

RuralHealthClinic.com

Experienced Knowledge

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)

Its All about that Visit (QVL)

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

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.

Goodbye QVL – We hardly knew you.

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

Multiple Visits on One Day

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

Multiple Visits on the Same Day – Exceptions

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

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

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

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

- RHC CG Modifier – 10/1/2016

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.

RuralHealthClinic.com

Experienced Knowledge

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

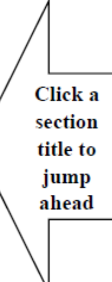
Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

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

Sections

- Reporting Modifier CG
  - Reporting Modifier CG with Preventive Services
  - Reporting Modifier CG with Medical and/or Mental Health Services
  - Other Modifier CG Questions
- Reporting Modifier 25 or Modifier 59
- Other Questions



Reporting Modifier CG

Q1. When should modifier CG be reported?

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

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

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

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

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

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

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

Reporting Modifier CG with Preventive Services

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

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

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

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

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

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

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

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

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

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

RuralHealthClinic.com
Experienced Knowledge

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

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

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

RuralHealthClinic.com

Experienced Knowledge

Simple example of a patient with a only a 99213

1	2	3a PAT. CNTL #	4 TYPE OF BILL
RURAL HEALTH CLINIC		3333	
123 ANY STREET		b. MED. REC. # 3333	0711
ANYWHERE NE 666661234		5 FED. TAX NO. / 6 STATEMENT COVERS PERIOD FROM / THROUGH / 7	
3333333333 3333333334		47-0607118 / 011012 / 011012	

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
08101940	F			3	1		01			

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

38

PATIENT, IMA
123 AVENUE
SMALLTOWN, NE 66666

39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a		
b		
c		
d		

	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	CLINIC VISIT BY MEMBER T	99213CG	011012	1	132.50		
2								
3								
4								
5								

Insert HCPCS Here

See Note 1

Note 1: Total charges for all services provided during the encounter, minus any charges for the approved preventive service"

RHC Encounter – E/M Office Visit Only

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

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

RHC Encounter – E/M Office Visit Only

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

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

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

Medical Services and Incident to Services

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

Example 6:

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

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

RuralHealthClinic.com
Experienced Knowledge

Incident To Services Example (99213 charge is $100)

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

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

RuralHealthClinic.com

Experienced Knowledge

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

RuralHealthClinic.com

Experienced Knowledge

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

RHC Encounter – E/M Office Visit and Injection

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

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

RHC Encounter – E/M Office Visit and EKG

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

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

Why is this so hard

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

CMS Programming the changes

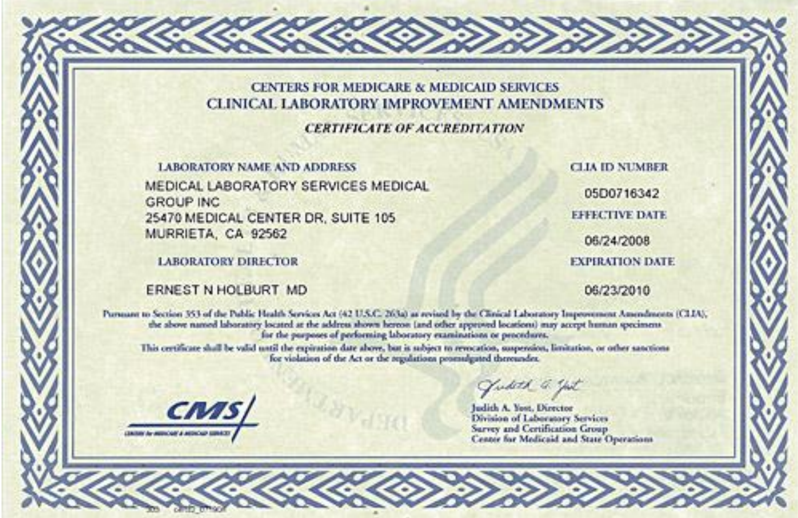
Non-RHC Services

Non-RHC Services

- MCR excluded services, i.e. dental, hearing & eye tests = Patient responsibility
- DME - Must have DME provider number to bill items
- Emergency Room, Hospital Rounds, Admits- Part B Services
- Labs- Part B Services
- Noncovered services do not require an Advanced Beneficiary Notice, however one is encouraged.
- If all charges are noncovered, send 710 TOB with all charges as noncovered and condition code 21.
- Part D Drugs- www.mytransactrx.com

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

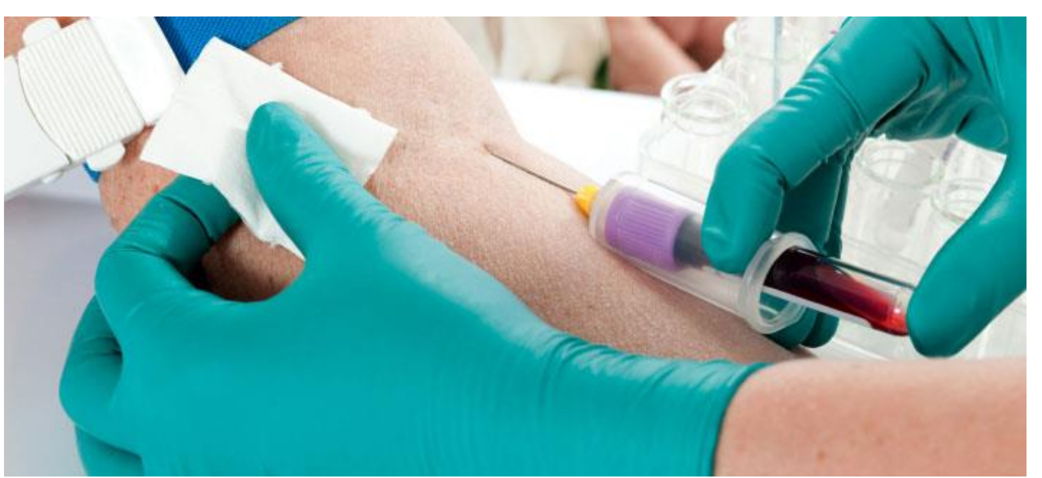
What are the six laboratory tests required for Rural Health Clinic certification?

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

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.



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

RuralHealthClinic.com

Experienced Knowledge

Independent RHC – Laboratory services

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Laboratory Except 36415	NA	1500	Fee for Service

RuralHealthClinic.com
Experienced Knowledge

Provider-based RHC Laboratory services are paid as follows in a PPS Hospital

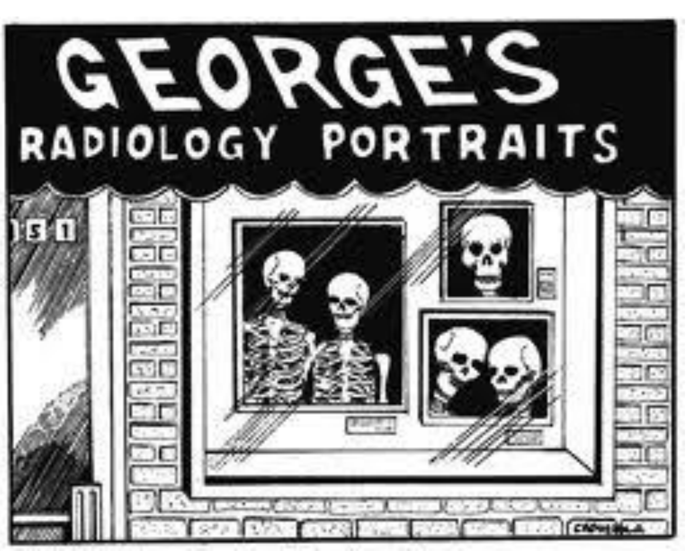
SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Laboratory Use the Hospital Outpatient Provider Number	131/141	UB-04	Fee-for-Service

Provider-based 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

Diagnostic Tests are not covered under the RHC Benefit

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



RHC Independent - Diagnostic Tests - Technical Component Only

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Radiology, EKG	NA	1500	Fee for service

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

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Radiology, EKG	131	UB-04	Fee for service

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

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Radiology, EKG	851	UB-04	Cost

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)

RHCs (Ind/Prov) -What happens to the professional component of Radiology?

SERVICES	BILL TYPE	CLAIM FORM	PAYMENT
Radiology, EKG	711	UB-04	Incident to. No visit

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 – Paid on 1500 for Independent and use UB-04 and hospital outpatient provider number
93010	Interpretation	Bill on UB-04 (incident to – No visit)

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.

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.

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 $250 for pnuemococal. (Cost is $125)

Average payment was $40 for influenza in 2017. (Cost is 11)

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

Ancillary Services and Incident to Billing

The Basics

Description	Type	Payment
E and M – Face to Face	RHC – Face to Face	AIR
Shots, Allergy shots, 99211s	RHC – Incident to or Ancillary services	Part of AIR. No extra payment from Medicare
Flu and Pnu	RHC – Do not bill	Paid extra money on cost report
Lab	Non-RHC	FFS
Diagnostic Tests	Non-RHC	FFS
Hospital Services	Non-RHC	FFS

Incident to

RuralHealthClinic.com
Experienced Knowledge

Incident to Per TA Session

- Direct supervision by provider required
  - Must be in clinic, not in same room
  - being in the hosp when attached to clinic is NOT “incident to”
  - Exception is the Chronic Care Management services
- Part of provider’s services previously ordered
  - integral, though incidental
  - covered as part of an otherwise billable encounter
  - I.e. dressing change, injection, suture removal, blood pressure monitoring

Medicare (Medicaid if State requires) services should be billed under the provider that performed the service unless it is an “incident to” service

Sometimes the words don't really mean what they say

YOU KEEP USING THAT WORD

I DO NOT THINK IT MEANS
WHAT YOU THINK IT MEANS

120 - Services and Supplies Furnished "Incident to" Physician's Services

"Incident to" refers 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.

120.3 - Payment for Incident to Services

Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with an 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.

140 - Services and Supplies Furnished Incident to NP, PA, and CNM Services

NOTE: The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service **only if such a person is permitted to exercise such supervision under the written policies governing the RHC**. Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.

Incident to Billing in RHCs
The Options

#	Description
1	Include the charges with a face to face visit within 30 days by: A. Holding claims B. Adjusting claims
2.	Writing the service off and not bill.
3.	Set up non-rhc hours and perform during that time. A. Must treat everyone the same (Non-Medicare) B. Must exclude cost and visits from cost report. C. Avoid commingling issues

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.**

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”

Non-RHC Hours – What you have heard?

1. Your going to jail.
2. Its complicated
3. Cost Report Nightmare
4. AIR will go down.

Non-RHC Hours - Reality

1. No one is going to jail
2. Not that hard
3. Cost Report is designed for it.
4. AIR will not go down if done correctly

Keys to making it work

1. Treat everyone the same
2. Keep up with Non-RHC visits
3. Place a sign on the door indicating times
4. Notify your Cost Report Person.

Keys to making it work

1. Treat everyone the same
2. Keep up with Non-RHC visits
3. Place a sign on the door indicating times
4. Notify your Cost Report Person.

What services can be done during Non-RHC Hours

99214	Trigger Point Injections
99215	Procedures
36415	Allergy Shots
AWE	Nurse Only Visits
IPPE	TCM

What services can be done during Non-RHC Hours

99214	Trigger Point Injections
99215	Procedures
36415	Allergy Shots
AWE	Nurse Only Visits
IPPE	TCM

108

RuralHealthClinic.com
Experienced Knowledge

100 – Commingling

Commingling refers to the sharing of RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- **Selectively choosing a higher or lower reimbursement rate for the services.**

109

No Magic Part B Room – Treatment Room

RHC practitioners may not furnish or separately bill for RHC covered professional services as a Part B provider in the RHC, or in an area outside of the certified RHC space such as a treatment room adjacent to the RHC, during RHC hours of operation. If an RHC practitioner furnishes an RHC service at the RHC during RHC hours, the service must be billed as an RHC service. **The service cannot be carved out of the cost report and billed to Part B.**

Costs must be properly allocated

If an RHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC space must be clearly defined. If the RHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

111

Sharing Services - Commingling

RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC and non-RHC usage to avoid duplicate reimbursement.

112

Preventive Services

The Most Profitable Patient in the World?

MEDICARE PREVENTIVE SERVICES

SELECT A SERVICE	FREQUENTLY ASKED QUESTIONS	RESOURCES

Target Audience: Medicare Fee-For-Service Providers
Watch the CMS Provider Minute: Preventive Services video for pointers to help you submit sufficient documentation when billing for certain preventive services.
You may provide some preventive services via telehealth where you see the following symbol:

Alcohol Misuse Screening and Counseling	Annual Wellness Visit (AWV)	Bone Mass Measurements	Cardiovascular Disease Screening Tests	Colorectal Cancer Screening	Counseling to Prevent Tobacco Use	Depression Screening
Diabetes Screening	Diabetes Self-Management Training (DSMT)	Glaucoma Screening	Hepatitis B Virus (HBV) Screening	Hepatitis B Virus (HBV) Vaccine and Administration	Hepatitis C Virus (HCV) Screening	Human Immunodeficiency Virus (HIV) Screening
Influenza Virus Vaccine and Administration	Initial Preventive Physical Examination (IPPE)	Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)	Intensive Behavioral Therapy (IBT) for Obesity	Lung Cancer Screening Counseling and Annual Screening for Lung Cancer With Low Dose Computed Tomography (LDCT)	Medical Nutrition Therapy (MNT)	Pneumococcal Vaccine and Administration
Prostate Cancer Screening	Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests	Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs	Screening Mammography	Screening Pap Tests	Screening Pelvic Examinations (includes a clinical breast examination)	Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

• CLOSE

This educational tool will help you properly furnish and bill Medicare preventive services with information by service that includes:

- A link to the National Coverage Determination (NCD) webpage for the service, if it applies
- HCPCS/Current Procedural Terminology (CPT) codes
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes
- Coverage requirements
- Frequency requirements
- Medicare beneficiary liability

NOTE: When you request the Medicare eligibility status of a beneficiary, the Centers for Medicare & Medicaid Services (CMS) provides the dates a beneficiary may receive many of these preventive services. If you are not able to get this data, contact your eligibility service provider. Refer to the Frequently Asked Questions section of this document for information on how to request the next eligible date.

ICN 006559 September 2018

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

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

PRINT THIS SERVICE

HCPCS/CPT Codes

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

What's Changed?

- No 2018 fourth quarter changes

ICD-10 Codes

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

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

Who Is Covered

Medicare beneficiaries when all of the following are true:

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

Frequency

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

- First month: one face-to-face visit every week
- Months 2–6: one face-to-face visit every other week
- Months 7–12: one face-to-face visit every month if certain requirements are met

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Other Notes

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

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

PRINT THIS SERVICE

HCPCS/CPT Codes

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

What's Changed?

- No 2018 fourth quarter changes

ICD-10 Codes

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

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

Who Is Covered

Medicare beneficiaries when all of the following are true:

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

Frequency

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

- First month: one face-to-face visit every week
- Months 2–6: one face-to-face visit every other week
- Months 7–12: one face-to-face visit every month if certain requirements are met

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Other Notes

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

Preventive Health Services

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

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

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

Rural Health Clinic (RHC) Preventive Services Chart

(Rev. 08-10-16)

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

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

Table 1: RHC Preventive Services

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

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

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

RuralHealthClinic.com
Experienced Knowledge

Hepatitis B Vaccine

Hepatitis B Vaccine (G0010)

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

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

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

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

RuralHealthClinic.com
Experienced Knowledge

Payment Comparison of Typical CCM Services

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

*** Plus 20% of charges**

Preventive Visit Only

Preventive Services

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

Example 3:

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

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

The RHC will receive the full AIR minus sequestration.

Preventive Visit Only

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

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

Example of an E & M and a Preventive Visit

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

Example 2:

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

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

An E & M Code & a Preventive Visit

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

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

Two AIRs would be paid in this example

RHC Encounter – E/M Office Visit and Preventive

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

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

RHC Encounter – Mental Health Visit Only

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

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

RuralHealthClinic.com
Experienced Knowledge

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

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

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

Modifier 59 is Defined

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

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

Modifier 59 – MLN - 9269

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

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

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

Definition of Modifier 25

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

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

Why is Modifier 25 important

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

Why is Modifier 25 important

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

Modifier 25 – Use it - Don't Abuse it

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

RHC Billing – No Globals – No Groups

RuralHealthClinic.com
Experienced Knowledge

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.

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.

RHC Encounter – Procedure Only

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

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

RHC Encounter – E/M Office Visit and Procedure

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

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

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

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

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

Hospice

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

Common Billing Errors

Why We Need to Review RHC Billing

CERT Jurisdiction J November 2017 Report

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

Alabama has a 16.1% Projected Error Rate

To Avoid Errors Document Timely

Timely

- Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- The CMS IOM does not provide any specific period to reflect "as soon as practicable," however, WPS GHA medical directors would offer a reasonable time frame of 24-48 hrs.

Provider Signature on Medical Record

Physician Authentication

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

MSP Form Completed each visit

Lack of MSP Form

- Medicare Secondary Payer (MSP) is the term used when another payer is responsible for paying a beneficiary's claims before Medicare pays.
- This form protects and preserves the Medicare Trust Fund by ensuring that Medicare benefits are coordinated with all other appropriate payers and Medicare pays only when and what it should pay.

Consent to Treat

Signature

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

Use an ABN for Non-covered Services

Lack of Advanced Beneficiary Notice (ABN)

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

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

  for full payment if Medicare denies

  payment.

Modifier 59

- Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.
- This is an unconventional use of -59 and is only used in this way, unique to RHC billing of multiple visits on the same date of service.

- Use of modifiers (-59, -25) other than the -CG modifier on Medicare claims with multiple services may trigger an incorrect overpayment.

Questions, Comments, Thank You

www.ruralhealthclinic.com