RHC Billing 201:

The Basics of Medicare Billing for RHCs

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Disclaimer

- The billing rules we are going to discuss during today's session are for **regular MEDICARE only.**
- We will briefly discuss Medicare Advantage billing.
- If you want to know about how to bill your State Medicaid as a RHC, reach out to your State Medicaid agency – every state is similar, but still slightly different in their requirements.

RHC Visit = RHC Encounter

"A RHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered."

Medicare Benefit Policy Manual, 100-02, Chapter 13

Mental Health Telehealth = RHC Encounter

MLN006398

Mental Health Visits Furnished Using Telehealth

Beginning January 1, 2022, RHCs can report and get payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the patient isn't capable of, or doesn't consent to, using video technology.

An in-person, non-telehealth visit must be furnished at least every 12 months for these services; however, we may make exceptions to the in-person visit requirement based on patient circumstances (with the reason documented in the patient's medical record) and also allow more frequent visits as driven by clinical needs on a case-by-case basis.

What is *NOT* a RHC Encounter?

Visits only for medication refills

Visits only for lab results

Visits only for injections (i.e. allergy)

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

Visits billed using CPT code 99211 (nursing visit)

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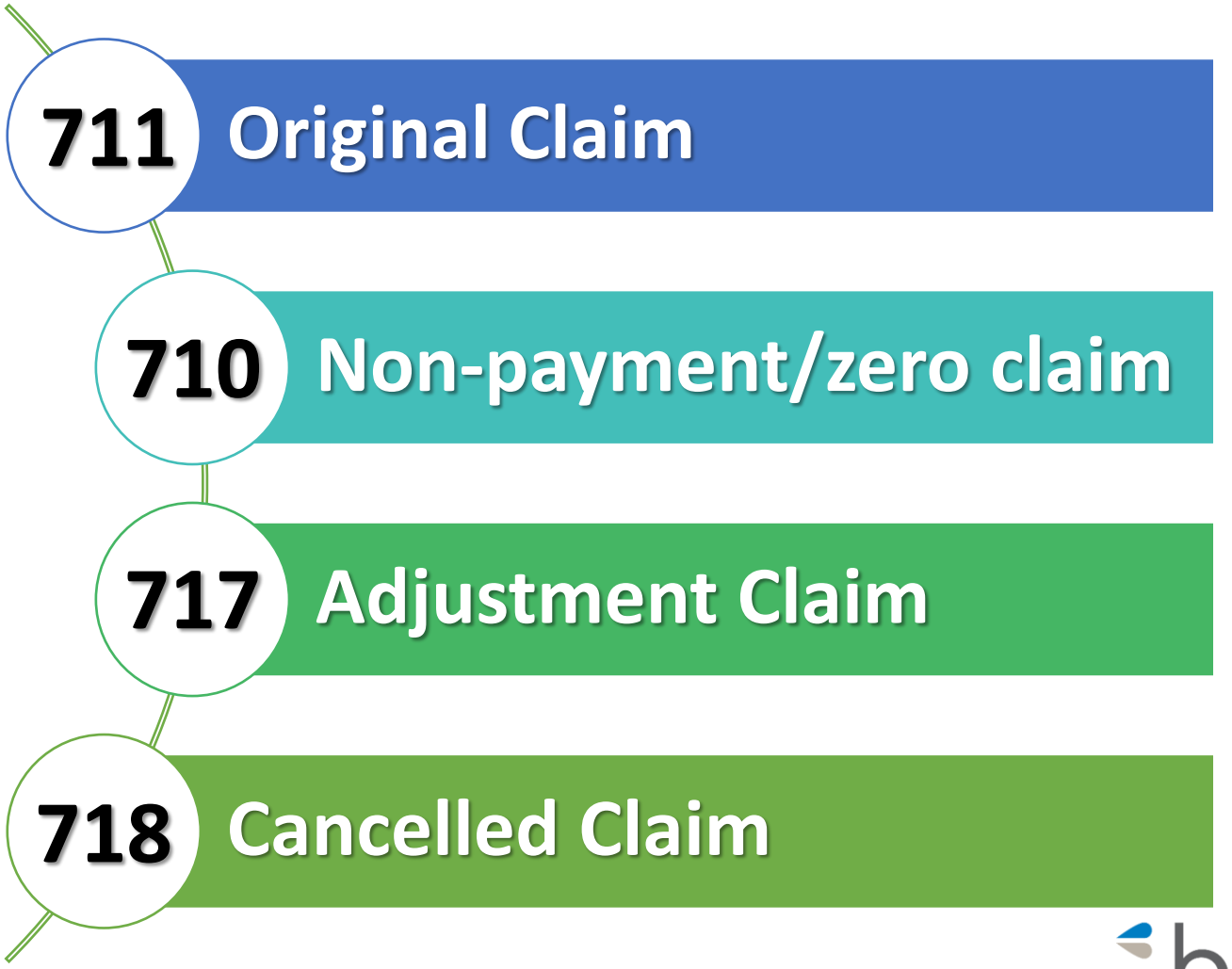
Medicare Claim Form & Type of Bill

- RHC services are billed on a UB-04
- The electronic form is the 837i
- These are the common bill types (TOBs) used on RHC claims:



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Revenue Codes

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

Other Common Revenue Codes in RHCs

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

RHC Claim Details

- RHCs are required to line-item, detail code for all services provided during the RHC visit
  - Include HCPCS codes for all RHC services, incident to services, and applicable professional components performed during that visit on the UB-04
- Charges for all services provided during the visit should be “rolled up” to the qualifying visit line/CG modifier line
  - The exception to this rule is for charges for qualifying preventive health services
    - Coinsurance and deductible are waived for certain preventive health services
- Total Charges for the entire claim are reported on line 0001
  - However, not used to adjudicate for payment

QVL and CG Modifier

- Every RHC claim must have a Qualifying Visit Line identifying the primary reason for the patient encounter
- Modifier CG should be attached to identify the qualifying visit
  - Modifier CG signals to Medicare which line to use when calculating applicable coinsurance and deductible

Qualifying Visit List (QVL)

- Last updated **August 1st, 2016**

QVL consists of "frequently reported HCPCS codes that qualify as a face-to-face visit between the patient and an RHC practitioner…"

"…NOT an all-inclusive list of stand-alone billable visits for RHCs."

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

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RHC Medicare Payment

- Actual payment from Medicare is 80% of your AIR, less 2% sequestration (when in effect)
  - Exception for qualifying preventive services – paid at 100% of AIR when the only service provided on that day
- The amount you are paid by Medicare, has nothing to do with what you charge.
  - What IS impacted by your charge amounts, is the patient's coinsurance.

Coinsurance & Deductible

- Coinsurance is equal to 20% of the ***total charges*** submitted on the RHC claim.
  - It is ***not*** the Medicare allowable amount
  - Calculated from the qualifying visit line, as identified by the CG modifier
- Coinsurance and deductible are waived for qualified preventive health services
- The Part B deductible is applied to RHC services.
  - Medicare will kick in and start paying your AIR once the patient's deductible has been satisfied.

Math is Hard...So are EOBs

Scenario: Deductible owed, amount exceeds RHC's AIR (Negative Reimbursement)

Date	HCPCS	Unit	Billed	Paid	Allowed	Copay	Coins	Reduct	Deduct	Other	Adj Codes	
2020/08/20	99214	1	175.00	-40.90	175.00	0.00	0.00	0.00	175.00	40.90	CO:45	40.90
	CG										PR:1	175.00
			175.00	-40.90	175.00	0.00	0.00	0.00	175.00	40.90		

Adjustments

NL	-40.90	Negative Ledger Balance
AU	175.00	Coverage Amount
DY	134.10	Per Day Limit

Adj Code	Text
1	deductible amount
45	charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

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Math is Hard...So are EOBs

Scenario: Deductible met, portion of AIR still owed by Medicare

Date	HCPCS	Unit	Billed	Paid	Allowed	Copay	Coins	Reduct	Deduct	Other	Adj Codes	
2020/02/18	99213	1	120.00	37.84	120.00	0.00	0.00	0.00	120.00	-37.84	CO:45	-38.61
	CG										CO:253	0.77
											PR:1	120.00
			120.00	37.84	120.00	0.00	0.00	0.00	120.00	-37.84		

Adjustments

AU	120.00 Coverage Amount
DY	168.26 Per Day Limit

Adj Code	Text
1	deductible amount
253	sequestration - reduction in federal payment
45	charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

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Non-RHC Services

- RHCs may ***"furnish certain services that are beyond the scope of the RHC benefit".*** These are considered "Non-RHC Services"
- Non-RHC services are billed separately to the appropriate MAC under the payment rules specific to that service.
  - Independent RHCs bill Part B using RHC CCN
  - Provider-Based RHCs bill Part B under the parent hospital CCN
- All costs associated with non-RHC services (i.e. space, equipment, supplies, facility, overhead, personnel) should be removed from the cost report.

Non-RHC Services Examples

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

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

Non-RHC Payment: Technical Components or Lab Services

- "Non-RHC" does not mean "Non-Payable"
  - It means payment is not based on the same payment structure as RHC services
  - CAHs receive cost-based reimbursement
  - PPS hospitals and IRHCs reimbursed based on a fee schedule

Independent vs. Provider Based RHC Billing

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

Incident-to Services

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

Incident-to Services

- Examples of “incident to” services:
  - Drugs and biologicals not usually self-administered, and Medicare covered preventive injectable drugs (i.e., influenza, pneumococcal)
  - Venipuncture
  - Bandages, gauze, oxygen, and other supplies; or
  - Services furnished by auxiliary staff acting under the supervision of a physician

Payment for Incident to Services

- When services and supplies are furnished incident-to an RHC, payment for the services are included in the RHC AIR
- An encounter that includes only incident to services is not a stand-alone billable visit
- The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit
- Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate time frame

Claim Examples

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Claim Example

RHC Encounter – E/M Office Visit Only

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

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	02/22/2022	1	$100.00
0001	Total Charge				$100.00

Claim Example

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	02/22/2022	1	$150.00
0001	Total Charge				$150.00

Claim Example

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 $50.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	02/22/2022	1	$150.00
0521	EKG, interpretation and report	93010	02/22/2022	1	$50.00
0001	Total Charge				$200.00

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

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Claim Example

RHC Encounter – E/M Office Visit and EKG

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

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

Claim Example

RHC Encounter with Incident to Services: Option 1

- 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 $20.00 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	02/22/2022	1	$215.00
0636	Inj Admin	96372	02/22/2022	1	$20.00
0636	Rocephin, 250 mg	J0696	02/22/2022	1	$45.00
0001	Total Charge				$280.00

Claim Example

RHC Encounter with Incident to Services: Option 2

- 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 $20.00 and for the drug is $45.00, ***but additional items are reported with a penny ($00.01) charge.***

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	02/22/2022	1	$215.02
0636	Inj Admin	96372	02/22/2022	1	$00.01
0636	Rocephin, 250 mg	J0696	02/22/2022	1	$00.01
0001	Total Charge				$215.04

Claim Example

RHC Encounter with Incident to on Different Date

- Scenario: RHC Provider completed a level-3 E/M office visit and instructed the patient to come back weekly for allergy injections for the next four weeks. Charge for the E/M visit is $100.00, and for each allergy shot is $10.00. Date of service on claim is date of office visit.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	02/22/2022	1	$140.00
0636	Allergy Injection	95115	02/22/2022	4	$40.00
0001	Total Charge				$180.00

Medicare Advantage

- There are **3,834** MA plans nationwide…
  - Which means there are 3,834 different sets of rules!
  - ***There is no "one size fits all"***
- Medicare Advantage plans will pay you according to how you are contracted with that individual plan.
  - They will not automatically pay you as RHC.
  - Reach out to them EARLY to make sure you know what billing requirements they have or what paperwork they will need to make sure you are billing appropriately, and that you are paid appropriately.
  - A lot follow same billing "rules" as Medicare, with some exceptions
    - Contract must state that they will accept, and process claims like regular Medicare

Helpful Resources

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

Questions?

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Contact me!

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