

PROVIDER-BASED RHCS
Cost Reimbursement,
Encounters, Billing Guidelines

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Objectives

- Participants will understand the following:
 - RHC's and cost based reimbursement
 - Providers who may render services
 - Services that are cost based services versus those that are fee-for-service
 - Directives for submitting claims to receive reimbursement
 - New directives billing for wellness benefits Medicare patients
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Sources of Information -
Medicare

- <http://www.wpsmedicare.com/>
 - WPS Medicare
 - <http://www.wpsmedicare.com/j5macpartb/policy/active/local/>
 - Coverage policies from WPS
 - https://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
 - Preventive Medicine Coverage Medicare
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Medicare Information (cont.)

- <https://www.cms.gov/transmittals/downloads/R1104CP.pdf>
 - Medicare instructions for filing a UB-04 claim form
- <http://www.cms.gov/Manuals/IOM/list.asp>
 - Policy manuals from CMS – specific attention to 100-4, Chpt. 9 & 12
- http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
 - Guide to Preventive Services from Medicare

Medicaid Information

- <http://manuals.momed.com/manuals/>
 - Mo HealthNet Manuals
- <http://manuals.momed.com/manuals/hyperlinkPage.render?idLinkParmName=rhp>
 - Provider-based RHC Manual
- <http://www.dss.mo.gov/mhd/providers/education/pro/promanual.pdf>
 - Professional Billing Handbook
- http://manuals.momed.com/collections/collection_rhp/Rural_Health_Clinic_Provider_Based_Section15.pdf
 - Claim filing instructions provider-based RHC

Rural Health Clinics (RHC)

- RHC–Rural Health Clinics
 - Criteria pertaining to RHC
 - Federal regulations CMS Publication 27 October, 1997 (New Publication 100-4 Chpt. 9) or Medicare Benefit Policy Manual, Chpt. 13 - Rural Health Clinic (RHC)
 - Federal Register beginning with Part 491
 - Rendering primary care services
 - Cost-based reimbursement from Medicare and Medicaid

Intro to RHCs

- Must be in a designated rural area according to the Census Bureau (approximately 3800 nationwide-approximately 340 in MO)
- Must be in a designated shortage area
 - Ratio of primary care physicians to residents (1 per 3,500)
 - Number of residents 65 and older
 - Number of residents in which family income is below the poverty level (20%)
 - Infant mortality rate

RHC –the Concept

- Rural Health Clinic
- APPLICABLE TO MEDICARE & MEDICAID ONLY
 - Commercial payers do not see the RHC any differently than any other clinic – bill locator code “11” on the claim

Types of RHCs

- Free-standing-certified as an independent entity
 - Owned by group of physicians, nurse-practitioners, etc.
- Subject to regulations listed in certification requirements

Provider-Based

- Provider based-certified as part of a provider, e.g., a hospital
 - Physically located in close proximity of the provider where it is based, and both facilities serve the same patient population
 - Entity functions as a department of the provider
 - Operates under the same administrative personnel

Provider Based (cont.)

- Entity is held out to the public as part of the provider
- Entity and provider are financially integrated
- Entity reports its cost in the cost report of the provider where it is based

Key Certification Requirements for RHCs

- Clinic must be under the medical direction of a physician
- Must have a physician on staff who provides medical supervision at the clinic at least every two weeks
- Physician must be available by phone at all times
- Must employ a non-physician practitioner who is on duty 50% of the time the clinic is open
- Must adhere to scope of licensure for State (Missouri requires physician to be within 50 miles)
- PA supervision requirement 66% unless waiver obtained from the state

Key Certification Requirements (cont.)

- RHC must have written policies and procedures with physician involvement and be reviewed annually
- RHC must provide first response emergency care
- RHC must assure security of patient records (6 yrs by Federal Gov regs) BUT, state of MO more stringent with 7 years
- RHC must have mechanism for an annual evaluation of the clinic's program

Key Certification Requirements (cont.)

- RHC must have arrangements to care for patients outside the clinic, e.g. hospital
- Must be able to provide routine diagnostic tests:
 - Dipstick UA-81002
 - Occult Blood-82270 (requires 3 specimens)
 - Hematocrit/Hemoglobin-85014/85018
 - Fasting Blood Sugar-82962
 - Urine Pregnancy Test-81025
 - Obtain Cultures (no code)

Key Certification Requirements (cont.)

- A physician, nurse practitioner, or physician's assistant must be available to furnish patient care services at all times during the clinic's regular hours of operation
 - 42 CFR Part 491.8

Reimbursement RHC Services

- Payment based on actual cost to perform services
 - Cost divided by number of encounters to determine cost per encounter
 - Cost report is filed
 - Actual cost is compared to interim payment & adjustments are made
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Encounter Definition

- Encounter
 - A face-to-face encounter ("visit") between a physician or a mid-level during which a RHC/FQHC service is performed
 - Only one encounter allowed per day UNLESS subsequent to the first encounter the patient either suffers illness or injury requiring additional diagnosis or treatment
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Reimbursement RHC Services

- RHC services paid on the basis of the encounter
 - 2011 upper limit rate is \$78.07, 2010 - \$77.76, \$76.84 in 2009, \$75.63 2008, \$74.29 in 2007)
<http://www.cms.gov/Transmittals/downloads/R2123CP.pdf>
 - NO cap if provider has less than 50 beds
-

Services Subject to Co-Insurance and Deductible

- ❑ All services subject to the Medicare coinsurance and deductible rules
 - EXCEPTION: 2011 Preventive medicine services (most of them) waive co-insurance and deductibles
- ❑ <http://www.trailblazerhealth.com/Publications/Job%20Aid/WaiverofDedandCoinsforPrevSvcs.pdf>
- ❑ Change Request (CR) 7012, Transmittal 739, dated July 30, 2010.

Productivity Expectations

- ❑ Physicians
 - Government expectation- 4,200 encounters per year
- ❑ Mid-levels
 - Government expectation 2,100 encounters per year
 - NOTE: This is collectively determined, e.g. 1 FTE physician and 1 FTE NP together need 6,300 visits

RHC Reimbursement

Based on Encounters/Costs

Reimbursement (cont.)

- Payment is 80% of the established encounter rate
- Co-insurance=20% of billed RHC charges
 - Co-insurance not applicable to lab (2001)
- NOTE: A lab or TC of an x-ray or EKG are NOT part of the 20% co-insurance
 - Lab has NO co-insurance
 - Part B Medicare co-insurance rules apply for the TC

Encounter Example RHC

- Total costs are \$275,000
- If physician saw 4,200 pt cost would be $\$275,000 / 4,200 = \65.47 per patient
- If physician saw 3,000 pts cost would be $\$275,000 / 3,000 = \91.67 (cap \$78.07)
- Payment would be limited to the cost if the provider had seen 4,200

Encounters with Auxillary Staff

- May attach services for up to 30 days
 - Bill with the date of the actual face-to-face encounter ("from" and "to" date may reflect total time period)
- On line equal with revenue, use the date of the actual encounter
- NOTE: Medicaid does not allow ancillary services to be attached to other encounters (generally bill service as it occurs with appropriate hospital revenue code on the RHC claim)

Encounters-No Face-to-Face

- Interpretation of results of tests or procedures which do **NOT** require a face-to-face contact between a physician/provider & the patient are **NOT** considered a reimbursable encounter
 - Reading an EKG or x-ray is **NOT** an encounter
 - Drawing blood is **NOT** an encounter

Encounters Face-to-Face But Not Medically Necessary

- Even if have face-to-face with a provider to
 - Draw blood
 - Render injection
 - Change a dressing
- AND it is not medically necessary for the NP, PA, or physician to see patient again for the condition, it may **NOT** be counted as encounter-MUST be **INCIDENT TO** service

Billing Two Encounters On Same Day of Service

- Only when patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment
 - Bill each service on the same UB-04 form Medicare. Skip one line before listing 2nd visit. Add modifier 59 (new 2011)
 - Medicaid – File on 1 claim with certificate of medical necessity
http://manuals.momed.com/collections/collection_rh/p/Rural_Health_Clinic_Provider_Based_Section15.pdf

New Billing Rules 2011

- When reporting multiple services on the same day that are unrelated, modifier 59 must be used to report these services, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.

□ Example B: Line

□	Rev Code	Modifier	DOS	Charges
□ 1	0521	Office Visit	01/01	150.00
□ 2	0521	Office Visit 59	01/01	450.00

- <https://www.cms.gov/MLNMattersArticles/downloads/SE1039.pdf>

Providers Who May Render Care for Reimbursement

Physicians, either M.D. or D.O.

- Non-physician practitioners included are:

- Nurse practitioner
- Physician's assistant
- Certified midwife
- Clinical social worker
- Clinical nurse specialist
- Clinical psychologist

- Visiting nurse (ONLY if so designated by CMS due to shortage)

Place Of Service Covered

- Services **IN** the RHC
- Services performed away from the clinic such as nursing home rounds, home visits **IF**
 - Physician is an employee of the clinic/center
 - Compensation for physician includes agreement to render these services

Place Of Service Covered

- Covered services
 - Those rendered to the homeless
 - Those rendered to people in a shelter
 - May count these as encounters
 - May bill Medicare **IF** patient has coverage
- NON**-covered services
 - Services rendered to those who are incarcerated

RHC Services (Reimbursed based on cost)

- Medically necessary **professional** services rendered by a provider
 - Surgical care
 - Interpreting x-rays or EKGs
 - Treatment of illness or injury including injections
- Services provided "incident to" if the service would be covered when rendered by a physician

"Incident to" Services & Supplies

- Covered if the service is:
 - An integral, although incidental, part of the physician's plan of treatment
 - Of a type commonly furnished in a physician's office
 - The ancillary personnel are employees of the physician (or both employees of the provider)
 - Furnished under **DIRECT** supervision of the ordering physician or mid-level

Incident to (cont.)

- NOT APPLICABLE TO NON-PHYSICIAN PRACTITIONERS IN A RHC
 - Claims are submitted under the RHC provider number
 - Non-physician practitioners in a RHC do not require direct supervision in order to see new patients and new conditions
 - Must be able to prove collaboration with a physician (document presence of physician at least once every two weeks)
 - Must adhere to scope of licensure e.g. PA 66% supervision unless obtain a waiver
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RHC Preventive Services

Billing Guidelines for Preventive Care

Preventive Medicine Coverage Medicare

- Entire list – see**
 - http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf (screening services)
 - http://www.cms.hhs.gov/mlnproducts/downloads/qr_immun_bill.pdf
http://www.cms.hhs.gov/mlnproducts/downloads/qr_immun_bill.pdf (immunizations)
 - http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf (IPPE)
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Covered Services Preventive Primary Care

- G0402 Initial Preventive Physical Examination (IPPE)
 - G0403 EKG for IPPE (note-no longer mandated)
 - G0404 EKG tracing for IPPE (bill to carrier)
 - G0405 EKG Interpret & report (bill on UB RHC claim)
 - G0101 & Q0091 Well-woman exam with pap smear every 2 years
 - (as of July 1, 2001-every 2 yrs.-CMS Transmittal 1823)
 - G0102 Prostate screening rectal exam yearly
 - (not separately reportable with an E/M)
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Covered Services Preventive Primary Care (cont.)

- G0103 PSA blood test yearly
 - 82270 Occult blood testing
 - 77057, 77052, G0202 Mammogram yearly
 - Bill to Medicare Part B if performed in the RHC
 - 80061, 82465, 83718, 84478 Cardiovascular disease screening (note: an LDL is NOT included)
 - 82047, 82950, 82951 DM screening (pts. at risk)
 - 99406 & 99407 Smoking and tobacco-use cessation counseling
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IPPE Visit Reminder of Criteria

- G0402 – Initial Preventive Physical Exam
 - https://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf
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Initial Preventive Physical Exam

- ❑ Medicare pays one initial physical performed within the first year of Medicare eligibility
- ❑ EKG no longer required as of 1/1/2009
- ❑ Very strict concerning the documentation
- ❑ <http://www.laoncologysociety.org/documents/clm104c12.pdf>
- ❑ Medicare Claims Processing Manual Chapter 12, Section 30.6.1.1 page 36
- ❑ <http://www.aafp.org/fpm/2009/0100/fpm20090100p19-rt1.pdf> Encounter form developed for documentation of IPPE

Components to IPPE

- ❑ Initial Preventive Physical Examination components: (G0402) (Must be on the UB FL 44)
 - Review of medical, family, and social hx including illnesses, hospital stays, operations, allergies, injuries, treatment, meds, fm hx
 - A list of providers and suppliers involved with caring for the patient
 - Review of individual's risk factors for depression. Must use an approved screening instrument
 - Examination, ht, wt, BP, visual acuity, hearing impairment, screen and other systems as appropriate
 - Activities of daily living, fall risks, home safety
 - Plan for preventive work up
 - Personalized health advice as applicable such as smoking cessation, physical activity, wt loss, nutrition
 - Voluntary advance care planning

Billing the IPPE

- ❑ G0402 for complete physical with all components (no co-ins or ded.)
- ❑ G0404 – EKG tracing only (bill under the hospital provider number)
- ❑ G0405 – EKG interpretation and report
 - If RHC physician performs, add the dollar value to the 521 encounter code – co-ins & deductible apply (NOT waived)

New Medicare Preventive Services for 2011

- Annual Wellness Visit (AWV) – G0438
 - Cannot be billed during first 12 months of Medicare eligibility- bill IPPE
 - Must be at least 11 months after IPPE
 - Subsequent AWV – G0439
 - Co-insurance and deductibles do NOT apply
 - Codes must go in FL 44 of the UB claim
 - http://sitemaker.umich.edu/coding101/files/awn_and_ppps_cms_bulletin2010.12.pdf
-

Annual Wellness Visit

- G0438** - Annual wellness visit, includes a personalized prevention plan of service, first visit- fee schedule \$154.59
 - G0439** - Annual wellness visit, includes a personalized prevention plan of service, subsequent visit – fee schedule \$102.55
 - Annual wellness visit, includes a personalized prevention plan of service (PPPS)
MLN Matters® Number: MM7079
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Annual Wellness Visit 1st Visit- G0438

- G0438- The initial AWV providing PPPS provides for the following services to an eligible beneficiary by a health professional:
 - Establishment of an individual's **medical/family history**.
 - Establishment of a list of **current providers** and suppliers that are regularly involved in providing medical care to the individual.
 - Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP,** and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.
-

Annual Wellness Visit (cont)

- Detection of any **cognitive impairment** that the individual may have as defined in this section.
 - Review of the individual's potential (risk factors) for **depression**, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.
 - Review of the individual's **functional ability** and level of **safety** based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
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Annual Wellness Visit (cont.)

- Establishment of a **written screening schedule** for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.
 - Establishment of a **list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual**, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.
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Annual Wellness Visit (cont.)

- Furnishing of personalized **health advice** to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
 - Any other element(s) determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination (NCD) process.
 - <http://www.idmed.org/d/sites/default/files/wfm/public/reimbursement/Medicare/07.%20Annual%20WellnessTemplate%202011.xls>
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Subsequent AWW – G0439

- In subsequent AWWs, the following services would be provided to an eligible beneficiary by a health professional:
- An update of the individual's medical/family history.
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWW providing PPS.
- Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined

AWV Subsequent Visit (cont.)

- An update to the written screening schedule for the individual as that schedule is defined in this section, that was developed at the first AWW providing PPS.
- An update to the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWW providing PPS.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.

Frequency Limitations

- IPPE – performed within the first 12 months of Medicare eligibility
- AWW – performed at least one year after the IPPE
- AWW subsequent visit – performed one year after initial AWW
- If patient had an IPPE, still bill the AWW initial visit
- No payment for AWW in first 12 months of Medicare eligibility – need IPPE

Medicare's Other Preventive Physical – Well Woman Exam

G0101-Allowed once every 2 years July 1,

2001, allowed once every 2 years, HCFA Transmittal 1823

Must have 7 of these 11 components:

- Inspection & palpation of breasts
- Digital rectal exam including sphincter tone, presence of hemorrhoids, and rectal masses
- Pelvic exam with or without collection of smears and cultures
- External genitalia-general appearance, hair distribution, or lesions

G0101 (cont.)

- Urethral-masses, tenderness, scaring
- Bladder-fullness, masses, or tenderness
- Vagina-general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele
- Cervix-appearance, lesions or discharge
- Uterus-size, contour, position, mobility, tenderness, consistency, descent, or support
- Adnexa-masses, tenderness, organomegaly
- Anus and perineum

■ Note: Breast exam now 1 of 11 components

G0101 (cont.)

- V76.2-for screening for malignant neoplasm, cervix
- V76.49-screening for malignant for patients who do not have a uterus or a cervix
- <http://www.cms.hhs.gov/Transmittals/downloads/R1541CP.pdf>

G0101 for High Risk

- May perform more than every 23 mo. IF
 - Early onset of sexual activity (under 16 yrs)
 - Multiple sex partners (five or more)
 - Hx of sexually transmitted disease
 - Fewer than 3 negative pap smears within the previous 7 years
 - DES-exposed daughters of women who took diethylstilbestrol (DES)
- Dx code-V15.89-personal Hx presenting hazards to health

Billing G0101& Q0091

- Q0091 – Obtaining and preparing a pap specimen for submitting to a laboratory for SCREENING pap only – paid every other year (Part of RHC claim)
- Must track internally frequency of tests
 - Sign ABN if more frequent than guidelines
 - Do not need to send claim to Medicare
- 2011 co-insurance and deductible is waived – submit separate line items on the UB claim

Preventive Medicine Coverage-Medicaid-Adults

- SECTION 13 - BENEFITS AND LIMITATIONS
- 13.31 ADULT PHYSICALS
- One adult "preventive" examination/physical, including a well woman exam (ages 21 and older) per 12 months is covered by MO HealthNet. Physicals are also covered when required as a condition of employment. Diagnosis code V70.0, "routine general medical examination at a health care facility", or diagnosis code V72.3, "gynecological examination", should be used and billed under the appropriate preventative medicine procedure code (99385-99387 or 99395-99397).
- 13.47. I (5) Noncovered Services (lab section)
- Services performed for screening purposes, in the absence of known disease, injury or malformed body part, are non-covered. (Exception: Lead and pap screens)

http://207.15.48.5/collections/collection_phy/Physician_Section13.pdf for all benefits

Preventive Medicine Medicaid Children (EPSDT)

- **9.4 DIAGNOSIS CODE**
- The Early Periodic Screening (V20.2) diagnosis code *must* appear as the primary diagnosis on a claim form submitted for HCY screening services. (Exception: V20.31 less than 8 days & V20.32 8-28 days old)
 - A full HCY/EPST screen includes the following:
 - A comprehensive **unclothed** physical examination;
 - A comprehensive health and developmental history including assessment of both physical and mental health developments;
 - Health education (including anticipatory guidance);
 - Appropriate immunizations according to age; *
 - Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated); *
 - Lead screening according to established guidelines;
 - Hearing screening;
 - Vision screening; and
 - Dental screening.
 - http://www.mnhealth.com/collections/collection_gen/General_Section09.pdf see for all instructions relating to the EPSDT screening

Other Covered Services

- **Immunizations**
 - **Flu**
 - **Pneumonia**
- **Pays 100% for the serum & administration of the above**
 - **Neither co-insurance nor deductible apply**
- **NEVER put on claim-considered on cost report only (Medicare)**
 - **Note: Provider-based RHC may file immunizations as they are rendered for MEDICAID patients**
- **Medicare Quick Reference Guide for immunizations**
- http://www.cms.hhs.gov/mlnproducts/downloads/qr_immun_bill.pdf

Immunizations (cont.)

- Hepatitis B-Patient must be at risk.
- Separate line item on the UB as co-insurance and deductible **WAIVED** for 2011.
- Bill G0010 for the administration of the Hep B on a separate line item – coins/ded waived
- Tetanus-Covered only with an injury and billed as a part of the RHC claim-co-ins/ded **apply**
- Immunoglobulin, rabies, etc., covered under the all inclusive rate when injury or direct exposure has occurred-bill as part of the RHC claim
 - **NOTE:** When you bill something as part of the RHC claim it all rolls into 0521

Non-RHC Services (Still Covered by Medicare)

- TC of diagnostic tests such as x-rays/EKGs
 - Bill under hospital's provider number (Medicare)
 - Bill on RHC claim under correct hospital revenue center for Medicaid)
- All laboratory tests (including the required RHC labs) performed on-site (bill as above)
- Screening mammography (bill to Part B)
- DME (bill to regional DME carrier)
- Ambulance services
- Services provided in a hospital setting (bill under physician's own provider # on a 1500 form)

Non-RHC Services Example for MoHealthNet (Medicaid)

521 OV 99212 4/11/11 \$60.00
 300 Dip UA 81002 4/11/11 12.00
 320 x-ray 71020 4/11/11 60.00

Total \$132.00

NOTE: If your RHC physician does not read the x-ray then modifier TC is applicable

**Non-RHC Services
 Non-Covered Medicare Services**

- Services not necessary or reasonable
- Routine foot care
- Hearing aids or eyeglasses
- Personal comfort items
- Cosmetic surgery
- Custodial care
- Preventive dental care including filling, removal or replacement of teeth
- Routine TB tests, hepatitis, tetanus

Filing a RHC Claim

UB-04 for Medicare & Medicaid

RHC Claims Submission

- Remember-the RHC is only an RHC in the eyes of Medicare and Medicaid
- Bill Medicare and Medicaid RHC services on a **UB-04** claim form
- Bill type 711
 - 7 means clinic
 - 1 means rural health
 - 1 means admit through discharge date

Additional Bill Types (Medicare)

- 710 = non-payment/zero claim (a claim with only noncovered charges)
- 711 = Admit through discharge (original claim)
- 717 = Replacement of prior claim (adjustment)(requires a condition code to explain the reason – Dx)
- 718 = Void/cancel prior claim (cancellation)

NEW Revenue Codes as of July 1, 2006

- 0521 Clinic visit by beneficiary to the RHC
 - 0522 Home visit by RHC practitioner
 - 0524 Visit by RHC practitioner to a member in a covered Part A stay at a SNF
 - 0525 Visit by RHC practitioner to a member in a SNF (not part A stay), NF, ICF, or other residential facility
 - 0527 RHC visiting nurse service to a beneficiary when in a home health shortage area
 - 0528 Visit by RHC practitioner to other non RHC site (e.g. scene of accident)
 - 0900 psychiatric visits
 - If visit is to diagnosis or to treat medically should use 521
- Per Publication 100, Rev. 820, Issued:02-01-06, Effective: 07-01-06, Implementation: 07-03-06

Only One Other Revenue Code

- 0780 – Telehealth originating site facility fee is billed IN ADDITION to the 052X revenue code
- Must add Q3014 in FL 44 on the claim to indicate facility fee
- *Note-telehealth is NOT an RHC service. Use the Q3014 to report originating site facility fee

UB 04 Claim Form

UB -04 Claims

- <http://manuals.momed.com/manuals/hyperlinkPage.render?idLinkParmName=rhp> PROVIDER-BASED RHC INSTRUCTIONS MOHEALTHNET
 - <http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf> MEDICARE
 - <https://www.cms.gov/transmittals/downloads/R1104CP.pdf> Explains all the condition, value, occurrence, status codes needed on the claims
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FL1-FL2-FL3 Provider & Patient Information

- FL1 Provider Name, city, state, and zip code, phone number (where service actually rendered)
 - FL2 Where payments to be sent
 - FL3a Pt Control Number (Account Number)
 - FL3b Medical record number patient
-

FL4, FL5

- FL 4 - TOB
 - First digit = 7 Clinic (type of facility)
 - Second digit = 1 Rural Health (bill classification)
 - Third digit = 1 admit thru discharge on same date (frequency of bill)
 - FL 5 – Federal Tax ID#
-

FL6-Statement Covers Period

- To report the beginning and ending dates of service for the entire period reflected on the bill.
 - For services rendered on a single day, both the "from" and "through" dates must be the same.
 - For RHC generally the same date except for "incident to" services.

FL 08-11 Patient Information

- FL 8 Patient name
- FL 9 Patient address
- FL 10 Patient birth date
- FL 11 Sex

FL 12-17

- FL 12 – Admission date
- FL 14- Type of admission/visit
 - 1 Emergency
 - 2 Urgent – patient seen first available time
 - 3 Elective – patient's condition allowed adequate time to schedule visit
- FL 15 –point of origin for admission
 - 1(generally) patient self-referred
- FL 17 – Status of patient at discharge
 - 1 (generally) discharged to home or self-care

FL18-28 Condition Codes

- These codes are used to help determine patient eligibility and benefits and are used to administer primary or secondary insurance coverage. The most common are the following:
 - 02 Patient alleges work related
 - 07 Hospice pt being treated for non-hospice condition
 - 20 Patient request bill for non covered services
 - 21 Billing for Denial Notice (ABN issued)
 - 28 Pt and/or Spouse's EGHP is secondary
 - 29 Disabled Pt LGHP is secondary

FL31-34 Occurrence Codes

- These codes are used to define a specific event relating to the bill that may affect payer processing. (e.g. liability & COB)
 - 05 Related to accident and there is no third party liability
 - 24 Date Insurance Denied (Use when filing Medicare secondary with date of primary EOB for deductible or denials)
 - 32 Used when ABN was issued

FL38-41

- FL 38 Address of where claim is being sent
- FL 39-41 Value Codes
 - 12 LGHP denied coverage – applying for conditional payment
 - 14 & 47 No fault or other liability insurance – applying to Medicare for conditional payment

FL42 & 43 Revenue Codes and Descriptions

- Revenue Code (RC) that represents a specific service.
- 0521 Clinic visit by beneficiary to the RHC
- 0522 Home visit by RHC practitioner
- 0524 Visit by RHC practitioner to a member in a covered Part A stay at a SNF
- 0525 Visit by RHC practitioner to a member in a SNF (not part A stay) , NF, ICF, or other residential facility
- 0527 RHC visiting nurse service to a beneficiary when in a home health shortage area
- 0528 Visit by RHC practitioner to other non RHC site (e.g. scene of accident)
- 0900 psychiatric visits

FL 44 – HCPCS Codes

- FL 44 – HCPCS code of the service/procedure provided.
 - (Not required for Medicare claims)
 - Exception: Preventive Medicine Services whose co-pay and deductible is waived
 - "Bundled" services for RHC claims on line item with Rev 521 (Medicare) (except preventive services)
 - Applicable rev codes individually reported on UB to Medicaid- provider-based

FL 44 Medicaid Claim

- Enter the CPT or HCPCS procedure code(s) and any applicable modifier.
 - If the service is a full or partial EPSDT/HCY screening, diagnosis code V20.2 must be shown as the primary dx in FL 67
- NOTE: Surgical procedures performed in the rural health clinic must be entered in Field #74.
 - Explanation: A surgical procedure code may not be reported in FL 44. A "dummy" visit code must be entered to correlate with the 0521 rev code; however, the dollar value is that of the surgical procedure.

**FLs 45-47 Revenue Dates,
Units & Charges**

- FL 45 Service Date
 - FL 46 Service Units
 - FL 47 Total Charges
-

FLs 50-66

- FL50 Payer Identification
 - Field A Primary Payer
 - Field B Secondary Payer
 - FL 52 Release of Information Certification Indicator
 - FL53 Assignment of Benefits Certification Indicator
 - Y Yes-Benefits Assigned
 - N No-Benefits Not Assigned
-

FLs 58-60

- FL 58 Insured's Name – Required
 - FL 59 Patient's Relationship to Insured
 - Use 18 self
 - FL60 Health Insurance Claim (HIC)- Identification Number
 - FL 60 Diagnosis codes for the visit
-

FLs 74-79

- FL 74 Principal Procedure Code & Date (only required by Medicaid – list surgical procedure performed –FL 76 Attending Physician ID
 - Enter NPI and name of provider that rendered services
- FL 80 Remarks – additional information to communicate to payer
- FL 81 – Taxonomy code of provider who rendered the service

Instructions from Medicare

- Basic RHC Billing for Preventive Services:**
When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance and deductible. For example, if the total charge for the visit is \$150, and \$50 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on \$100 of the total charge.
- Line RevCode HCPCS code DOS Charges**
- 1 052X 01/01/2011 100.00
- 2 052X Prev Service Code 01/01/2011 50.00

MLN Matters Number: SE1039

- The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate, coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable to the service line with the preventive service.*

Example Medicare Claim as 2011

FL 42	FL 43	FL 44	FL 45	FL 46	FL 47
0521	Limited OV		1/5/2011	\$ 70.00	\$ 70.00
	Well woman exam	G0101	1/5/2011	\$ 70.00	\$ 70.00
0521	Prep of specimen	Q0091	1/5/2011	\$ 40.00	\$ 40.00

Payment Exception-Additional Payment

- When an **IPPE** is performed in conjunction with an E/M, each will be billed on a separate line item. The G0402 will be needed in FL 44 for the IPPE....
- Separate payment for an encounter, in addition to the payment for IPPE will be made when they are performed on the same day.
- ONLY applicable to the IPPE for additional reimbursement
- <http://www.cms.gov/MLN MattersArticles/downloads/MM6445.pdf>

Claim Submission Wellness Exam Medicaid

- Medicaid wellness exam-Adult physical paid once a year for 21 and older
 - Provider-based bill 521 revenue code with preventive medicine code FL 44, Dx V70.0
- Medicaid wellness exam - Children
 - Provider based – preventive code with EP, Dx V20.2 (Exception: V20.31 newborn-8 days & V20.32 8-28 days old)

Preventive Service & Treatment of Problem

- ❑ IF a problem encountered during a wellness visit is significant and is treated, bill both preventive medicine code and E/M code on separate line items (as discussed in previous slides)
- ❑ (Medicaid does allow for preventive and sick visit on same day generally-must file CERTIFICATE OF MEDICAL NECESSITY if truly merit a separate claim)

Billing "Global" Services

- ❑ RHC Medicare
 - No global services exist
 - Bill each service for each day patient is seen
- ❑ RHC Medicaid MO – 30 day global if pd \$75+ for the procedure
- ❑ Commercial insurance-global services must be tracked as **encounters**
 - Suggest 99024 (services rendered during a global period)
- ❑ If surgery performed in **HOSPITAL** by RHC physician
 - Add modifier -54 on CMS-1500 claim for the surgery (not applicable to surgeries when the code reads for surgery service only)

Billing OB Services

- ❑ Medicare & Medicaid patients - bill E/M that represents the service at time of each encounter plus any additional lab/service
- ❑ Bill the **delivery only code** (59409 or 59514 generally) for the delivery performed in the hospital to Medicare Part B & Medicaid under the physician's own provider number

Billing Encounter + Lab

- Make the same entry for tracking charges for all payers
- For RHC
 - Medicare – provider based – bill under the hospital's provider number
 - Medicaid – Provider-based – bill all services on the RHC claim under the appropriate revenue center, e.g. lab under rev code 300
 - Must carve out associated costs for labs on the cost report

Flu & Pneumonia Shots

- Do not send a claim for influenza or pneumonia (track on a log) considered on cost report (Medicare only)
- Log should include:
 - Beneficiary name
 - Beneficiary HIC#
 - Date of service
 - Type of injection received, e.g. influenza or pneumococcal
 - May not count as visit if encounter for shot only
 - May not include \$ value of shots in visit
 - Medicaid - Provider-based RHCS bill serum on pharmacy form at time of service

Billing Injections

- Must be attached to a face-to-face encounter (Medicare)
- \$ value of injection "collapses" into E/M code (Internally the actual HCPCS code should indicate the type of injection and \$ value)
- Medicaid - Provider-based bill on a pharmacy claim form for the date injection was rendered
- NOTE: Medicaid never allows the administration of any injection including allergy injections

Billing Injections Example

- May attach services for 30 days to the face-to-face encounter (Medicare)
 - Example
 - OV is on Wednesday (\$50)
 - Patient receives a Rocephin inj. (\$50) \$10 adm fee (as of 2005)
 - Patient gets another Rocephin injection on Thursday & Friday (\$100) + \$10 administration fee each day
 - Claim is filed for \$230 with "from & to" dates on claim to represent the time span
 - One unit because only one time face-to-face with provider (use date actually saw patient) (incident to rules apply)
 - NOTE: Medicaid does not allow this**

Billing E/M & Procedure

- Document each service separately
- Report one line entry on claim with revenue code 521 and the dollar value of the E/M and procedure OR procedure only (billing guidelines for Medicare applicable in RHCs)
- Include the CPT code of the procedure in FL 74 (Medicaid)
- May charge E/M for same diagnosis as the procedure if significant service above and beyond what is always performed for the procedure
- NOTE: MEDICAID requires a visit CPT code, e.g. 99213 in FL 44 and the actual procedure code in FL 74

Billing for X-rays and EKGs

- Medicare – the professional interpretation and report is rolled into the E/M service and billed on one line item under 0521
- The TC of the x-ray, e.g. 71020 TC is filed to Medicare under the hospital's provider number
- The 93005 for the technical component of the EKG is filed under the hospital's provider number

Treatment of Hospice Patients in the RHC

- A beneficiary who elects to enroll in the hospice program waives all rights to Medicare payments for all services related to the terminal illness. The only exceptions are for those services furnished by his or her non-hospice employed attending physician. A physician working for a RHC has the option of continuing to follow his or her patient as an attending physician. In this case, the attending physician's services is provided and billed to the carrier under his or her provider number.

Hospice (cont)

- Non-physician for hospice care and condition is non-hospice condition, physician is not "attending physician"
 - Condition code 07 is required
 - May bill as RHC claim
- IF non-hospice physician and condition IS related to hospice condition, BILL hospice
- IF non-hospice physician but designated as "attending physician" bill the carrier
Publication 100-04, chapter 11, section 50

Billing Non-Covered Services Patient Request

- Patient asks that a non-covered service be submitted to Medicare
 - RHC – Bill type 710
 - Fill in FL 48 with total non-covered charges
 - Condition code 20 or 21
 - 20 patient requests to get a Medicare determination
 - 21 patient wants denial to submit to other insurance
 - Occurrence code 32

Posting RHC Payments

RHC Charge	Charge of total service submitted	\$110
Payment from patient	Deductible	\$0
Medicare pay rate	Determined from previous cost report	\$75
Medicare's net payment	\$75 less 20% co-insurance	\$60
Co-payment from pt/2nd ins	20% X total chg \$110	\$22
Total to be received all payers	\$60 + \$22	\$82
Medicare Adjustment	Diff of \$110 - \$82 is contractual adj	\$28

Posting Payment Greater Than Charge

RHC Charge	Charge of total service submitted	\$60
Payment from patient	Deductible	\$0
Medicare pay rate	Determined from previous cost report	\$75
Medicare's net payment	\$75 less 20% co-insurance	\$60
Co-payment from pt/2nd ins	20% X total chg \$60	\$12
Total to be received all payers	\$60 + \$12	\$72
Medicare Adjustment	Diff of \$60 - (\$72) is contractual adj	(\$12)

Remember

- The patient's healthcare is priority
- The documentation to support everything that was billed is priority
- The success of the clinic depends on you!

References

- Medicare RHC Manual
 - CMS Internet Only Manual (IOM), Pub 100-04 Medicare Claims Processing, Chpt 9
 - CMS (IOM) 100-2 Benefit Policy Manual Chpt. 13
 - MoHealthNet Provider Manual
 - Websites as indicated in presentation
 - Medicare MedLearn Matters
 - Medicare Transmittals (referenced in presentation)
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Thank You!

Questions or Comments?
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