



Rural Health Clinic Billing 2011

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Overview

- This presentation will discuss the basic elements of RHC billing.
- The following areas will be discussed:
 - The RHC Encounter and Medical Necessity
 - Rural Health Services
 - Non-RHC Services
 - Preventive Services
 - Basic claim submission requirements
 - Online RHC Resources

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Medicare Administrative Contractor

- RHCs no longer have specialized FIs;
- All claims usually* go to the regional MAC:
 - administers new, existing, and terminating RHCs;
 - processes and settles the cost report;
 - sets the RHC encounter rate;
 - adjudicates RHC claims;
 - determines RHC billing and coverage issues;
 - Should be the same as MAC for FFS (1500) claims.

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RHC Assignment to MAC

- New RHCs will be assigned to their regional MACs.
- 'Legacy RHCs' (those formerly with Riverbend) will remain with Cahaba.
- Ultimately, these independent RHCs will be transitioned to their regional MAC.
- We just don't know when.

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Medicare Part B (FFS)

- Medicare fee-for-service carrier
- Processes fee-for-service claims
- Regional Medicare Administrative Contractors (MAC)

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Never assume...

In general, RHC billing rules are very similar from payer to payer, but...

Always check with your own FI or Medicare Part B payer for their individual payment policies.

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State Law and Medicaid

- State medical practice laws, collaborative requirements, and Medicaid programs vary widely.
- Always check with state agencies and Medicaid offices before making any assumptions.

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Independent RHCs

- Independent RHCs are generally private physician offices or hospital clinics whose parent is > 50 beds.
- RHC encounters are paid using the current RHC cap.
- Independent RHCs must file an annual cost report, which is due 5 months after the end of each fiscal year.
- Failure to file timely cost reports can result in full refunds of RHC payments.

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Provider-Based RHCs

- Provider-based RHCs (PBRHC) are those owned by a parent entity such as a hospital, nursing facility, or home health agency.
- Claims are billed to the MAC which services the parent entity.
- PBRHCs owned by a hospital with 50 beds or less qualify for an un-capped RHC rate.
- PBRHCs whose parent entity is greater than 50 beds have the same cap as independents.
- PBRHCs rate is set under the parent entity's cost report.

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RHC Encounter Rate 2011

The Current RHC maximum encounter rate is \$78.07. This represents a .4% increase over 2010.

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Rural Health Clinic Billing 101*

It's all about the encounter!

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The RHC Encounter is:

"...the professional services performed by a physician for a patient including diagnosis, therapy, surgery and consultation. A service may be considered to be a physician service if the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization is possible by means of X-rays, electrocardiogram (EKG) and electroencephalogram tapes, tissue samples, etc."

(Trailblazer's RHC Manual Page 11)

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RHC Service Locations

- Rural Health Clinic services can be provided at:
 - the clinic (or center)
 - a nursing home (SNF beds included)
 - the patient's place of residence
 - elsewhere (i.e. the scene of an accident)

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Rural Health Services

- Physicians' services
- Services and supplies incident to a physician's service
- Services of nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM)
- Services and supplies incident to the services of nurse practitioners and physician assistants (including services furnished by nurse midwives)

(Medicare Benefit Policy Manual Chapter 13)

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Rural Health Services (Continued)

- Visiting nurse (VN) services to the homebound
- Clinical psychologist (CP) and clinical social worker services (CSW)
- Services of registered dietitians or nutritional professionals for diabetes training services and medical nutrition therapy
- Otherwise covered drugs that are furnished by, and incident to, services of physicians and non-physician practitioners of the RHC/FQHC

(Medicare Benefit Policy Manual Chapter 13)

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Determining Professional Services

- The services of a physician performed at the clinic are RHC services and are payable only to the clinic.
- Services by means of a telephone call between a physician and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are not separately billable but can be included as part of another billable visit by the RHC practitioner (e.g., revenue code 0521).

(Trailblazer's RHC Manual)

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RHC Encounters are not:

- Visits for the sole purpose of obtaining or renewing a prescription, in which the need was previously determined (so that no examination of the patient is performed), are not covered services.
- Time used in completion of claim forms.
- Care plan oversight is not allowed by either Part A or Part B for RHC providers.

(Trailblazer's RHC Manual Page 11)

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Medical Necessity is not:

- A visit solely for administration of an injection (e.g. B-12, allergy);
- Dressing changes;
- Lab results or tests;
- Writing or re-filling prescriptions.

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Qualified RHC Providers

An RHC encounter can be billed for the following providers:

- Physicians
- Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives
- Clinical Psychologists (PhD)
- Clinical Social Workers (CSW or LCSW)

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Incident-to Services Defined

- Furnished as an incidental, although integral, part of an RHC practitioner's services.
- A type commonly furnished either without charge or included in the RHC's bill.
- A type commonly furnished in a physician's office.
- Services provided by **clinic employees that are furnished under the direct and personal supervision of an RHC practitioner.** ☐
- Furnished by a member of the clinic or staff who is an **employee of the clinic.** (Trailblazers RHC Manual Page 12)

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Incident-to Services Defined

- Incident-to services are considered covered **and paid** under the RHC get bundled with the RHC encounter. They are not separately billable or payable.
- Services that do not occur on the same date as the encounter can be bundled if they occur 30 days before or after.
- The effect on payment is an increase in the charge, and therefore in the co-insurance.
- The cost for these services are included in the cost report, but are not separately payable on claims.

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Examples of incident-to services

- Injections
- Suture Removal
- Dressing Changes
- Prescription Services
- Blood Pressure Monitoring

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How to Bundle Services

Example: An office visit for \$65.00 and an injection for \$40.00 is provided by the physician, NP, PA, or CNM.

One line item for \$105.00 will be submitted to Medicare. The patient (or secondary) will be responsible for \$21.00 (20% co-insurance).

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Bundled Injection

	Amount	Description
Office Visit - 99212	\$65.00	Clinic's Customary Fee
Rocephin Injection	\$40.00	Injection Fee
\$21 Rev Code Line Item	\$105.00	Office Visit and Injection Bundled
Patient Co-insurance	\$21.00	Billed to Patient or Secondary

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Commingling

- For RHCs commingling is fraud. Commingling is getting paid twice from Medicare.
- Submitting incident-to services to Medicare Part B, since they are covered under the RHC benefit, is fraudulent billing.

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Billing NP/PAs

- It has been common practice to bill NP/PA claims under the supervising physician.
- This practice should only continue if the physician is on-site.
- NP/PA providers should be enrolled with plans under their own name.

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99211 Office Visits

- E/M code 99211 is commonly used for nursing visits, (injection administration, etc.), even though physicians sometimes bill them.
- For RHC purposes, these are NOT considered encounters.

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More on 99211

- If a service is a 99211 and performed by a nurse, it does not qualify as an encounter.
- If it was performed by a physician (or NP):
 - A: it is probably under-coded;
 - B: the service does not require the expertise of a physician.

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Influenza, Pneumococcal Injections

- Flu and pneumonia shots are covered under the RHC program. These are the only injections that are separately payable.
- These are not billed on a claim, but are submitted on the cost report.
- They are paid with the clinic's annual cost report reconciliation.

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Non-Rural Health Services

Non-Rural Health Services can be billed to the fee-for-service carrier (or hospital FI). These services include:

- Diagnostic testing - X-Ray, EKG, etc.
- Laboratory services
- Professional services rendered in the hospital

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Diagnostic Testing and Lab: Independent

- ➔ The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.
- ➔ The technical component of these tests are billed to the Medicare Part B carrier using the fee-for-service provider number.
- ➔ All lab services are also billed to the Part B carrier.

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Diagnostic Testing and Lab: Provider-Based

- ➔ The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.
- ➔ The technical components for X-Ray, EKG, ultrasounds, etc. are billed to the FI using the parent entity's provider number.
- ➔ Lab services are also billed to the FI using the parent entity's provider number.

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Bundling and EKGs

	Amount	Description
Office Visit - 99213	\$120.00	Clinic's Customary Fee
EKG (Interpretation and Report) - 93010	\$50.00	EKG Professional Component
521 Rev Code Line Item	\$170.00	Bundled RHC Encounter
93005 - EKG Tracing Only	\$75.00	Billed Fee-For-Service
Patient RHC Co-Insurance	\$34.00	Co-Insurance From RHC Portion

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CMS Quick Reference Guide

- See the following chart for a quick reference on RHC billing.
- This is also posted on www.northamericanhms.com.

www.cms.gov/MLNProducts/downloads/RuralChart.pdf

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Hospital Services

- Physician services at the hospital are billed to the Medicare Carrier for fee-for-service reimbursement.
- If the parent-entity is a Critical Access Hospital (CAH) using option II billing – out-patient hospital services are billed to the parent's FI.

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Hospital Admit and RHC Encounter

- Some MACs will NOT pay the Hospital admit and an RHC encounter on the same day. (Trailblazers, WPS)
- Others will (Cahaba).
- Check with yours to confirm.

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Preventive Services

- Initial Preventive Physician Examination
- Annual Wellness Visit (AWV) and Personalized Prevention Plan Services (PPPS)
- Subsequent Annual Wellness Visit
- Medicare Preventive Screenings

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IPPE – Initial Preventive Physician Exam

- Otherwise known as the 'Welcome to Medicare Visit'.
- Payable once per lifetime.
- Must be rendered within 12 months of the beneficiaries' Medicare coverage date.
- Co-Insurance and deductible do not apply.
- When rendered during an RHC encounter, only one payment is made.
- Any preventive diagnostic screenings are billed to Medicare Part B.

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IPPE Billing

The total charge is \$150 and the preventive service charge is \$100, the line items would be reported as follows:

Rev Code	HCPCS	DOS	Charges
052X		3.22.2011	\$150.00
052X	G0402	3.22.2011	\$100.00

One encounter rate will be paid. Patient co-ins and deductible are based on \$150.00.

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Two Payments or One?

Payment for professional services that meet all of the program requirements is made under the all-inclusive rate.

"...in rare circumstances, depending on the clinical appropriateness of a separate visit, to allow RHCs and FQHCs to receive separate payment for an encounter, in addition to the payment for IPPE or AAA encounter, when they are performed on the same day."

(CMS MM6445 pg. 2)

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Trailblazers – One Payment

"The preventive service reported on the second line item will not receive reimbursement, as it is part of the all-inclusive rate. Deductible and coinsurance will not apply."

(Trailblazers RHC Manual pg 25)

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Annual Wellness Visit and PPS

- Effective January 1, 2011.
- The Annual Wellness Visit and Personalized Prevention Plan Service are new benefits under the Affordable Care Act.
- The patient is eligible if they are no longer in the first 12 months of Medicare coverage and have NOT had the IPPE in the last twelve months.
- Co-Insurance and deductible do not apply.
- When rendered during an RHC encounter, only one payment is made.

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Annual Wellness Visit Billing

The total charge is \$150 and the preventive service charge is \$100, the line items would be reported as follows:

Rev Code	HCPCS	DOS	Charges
052X		3.22.2011	\$150.00
052X	G0438	3.22.2011	\$100.00

One encounter rate will be paid. Patient co-ins and deductible are based on \$150.00.

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AWV and PPPS – Subsequent Billing

The total charge is \$150 and the preventive service charge is \$100, the line items would be reported as follows:

Rev Code	HCPCS	DOS	Charges
052X		3.22.2011	\$150.00
052X	G0439	3.22.2011	\$100.00

One encounter rate will be paid. Patient co-ins and deductible are based on \$150.00.

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Other Preventive Services

- The professional component for the biennial screening pap/pelvic exam can be billed as an encounter. The labs will be billed to the carrier or hospital FI.
- All diagnostic tests for the cardiovascular screening are billed to the Part B carrier or Hospital FI.
- Encounters with **routine diagnoses** are not payable.

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Diabetic and Nutrition Counseling

- These are incident-to the physician or mid-level services.
- These CANNOT be billed to the Medicare Part B carrier and are not an encounter.
- The costs for these services are included in the cost report.

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Zostavax and Hepatitis

These are considered covered, but not separately payable. These will be bundled with an RHC encounter.

The patient cannot be charged, nor can these be submitted with Flu/Pneumo logs.

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Claim Submission

- All claims are billed on a UB-04.
- Type of Bill 711 for initial claims.
- Actual charges should be submitted, **not** the RHC encounter rate.
- Co-insurance and deductible amounts are applied based on the **charge**.
- A medically-necessary diagnosis is required.
- Only one encounter per day is billable.

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Claim Submission (Continued)

- Visits with more than one RHC professional on the same day are one encounter.
- Some payors allow an RHC encounter and a hospital admission on the same day. Others don't.
- Theoretically, two encounters on the same day but for different diagnoses are payable.
- An RHC encounter and a mental health visit on the same day are payable.

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Revenue Codes

The following revenue codes are used on UB04 claims:

- 0521 - Clinic Visit at RHC by qualified provider;
- 0522 - Home visit by RHC provider;
- 0524 - Visit by RHC provider to a Part A SNF bed;
- 0525 - Visit by RHC provider to a SNF, NF or other residential facility (non-Part A);
- 0527 - Visiting Nurse service in home health shortage area
- 0528 - Visit by RHC provider to other non-RHC site (scene of an accident)

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Medicare RHC Payments

- Medicare will pay 80% of the RHC encounter rate.
- The patient will be responsible for 20% co-insurance and deductible amounts, which are based on the charge.
- Medicare Deductibles are now \$162.

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Medicare Claim Issues

- ➔ Medicare timely filing limits have changed to one year from the date of service.

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Payment Example – Independent RHC

- ➔ The clinic office charge for 99213 is \$85.00.
- ➔ The clinic's RHC encounter rate is \$76.34.
- ➔ The full patient deductible has already been met.

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Payment Example - Independent

	Amount	Description
Office Visit – 99213	\$85.00	Clinic's Customary Fee
Patient Co-Insurance	\$17.00	Co-Ins. Is 20% of the Charge Amt
Medicare Payment	\$ 61.07	80% of the RHC Rate
Total Payment	\$78.07	Clinic receives more than rate
Contractual Adjustment	\$ 6.33	Will be written off as charge is more than the RHC rate.

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Payment Example – Independent RHC

- ➔ The clinic office charge for 99203 is \$120.00.
- ➔ The clinic’s RHC encounter rate is \$76.34.
- ➔ The full \$120 charge is applied to deductible.

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Payment Example - Independent

	Amount	Description
Office Visit – 99203	\$120.00	Clinic’s Customary Fee
Patient Co-Insurance	\$ 0.00	Full charge amount applied to ded.
Medicare Payment	(\$ 42.24)	Payment ‘taken back’ so patient payment does not exceed rate.
Total Payment	(\$ 42.24)	\$120.00 minus \$76.34
Contractual Adjustment	(\$ 42.24)	Will be written off as charge is more than the RHC rate.

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Medicare Advantage

There are two types of Medicare Advantage Plans:

1. Private Fee For Service – no contract necessary. Send RHC rate letter. Submit claims on UB04. **Should** pay the RHC encounter rate.
2. Regional PPO – must negotiate RHC payment in contract. Not required to pay rate.

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Credit Balance Reports

- Due 30 days after the end of each fiscal quarter.
- Used to report over-payments from Medicare. Does not include patient credits.
- Failure to submit a report will result in no payments.

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Medicaid HMO Plans

- All claims are typically submitted to Medicaid HMO plans as a regular commercial, carrier on a 1500.
- A wrap-around report is usually submitted to the State Medicaid Agency Audit and Reimbursement department to receive a reconciliation to the RHC rate.

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MoHealthnet: Independent RHC

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Mo Health Net: Core Providers

Face-to-face encounters between Rural Health Clinic (RHC) patients and RHC core practitioners (physician, nurse practitioner, nurse midwife, physician assistant, licensed clinical social worker, or clinical psychologist) *must include a medically necessary evaluation and management service in order to be reimbursed at the RHC visit (encounter) rate.*

Mo Health net. Rural Health Clinic Independent Manual.
Section 13, Page 2.

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MoHealthNet: Covered Services

An independent RHCs encounter rate (procedure code T1015) covers the patient's visit to the clinic, including all services and supplies incidental to such visit.

Mo Health net. Rural Health Clinic Independent Manual.
Section 13, Page 2.

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MoHealthNet: Non-Covered Services

When a face-to-face encounter with a core service practitioner does not occur or when a patient presents to the clinic for a routine non-covered service, such as a blood pressure check, follow-up reading of a TB skin test, venipuncture, etc., an RHC encounter may not be billed.

Mo Health net. Rural Health Clinic Independent Manual.
Section 13, Page 2.

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MoHealthNet Place of Service

An encounter is billable only for services provided in the clinic, in the patient's home or in a nursing home.

Mo Health net. Rural Health Clinic Independent Manual.
Section 13, Page 2.

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Mo Health net – Multiple Visits

- Multiple Visits are payable on the same day only when a Certificate of Medical Necessity has been obtained.
- Encounters with multiple providers on the same day are one encounter, except when:
 - Patient suffers additional injury/illness
 - Patient has a medical and mental visit.

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MoHealthNet: Lab Services

- RHCs are required to provide the following lab tests on-site:
 - Urinalysis by stick or tablet;
 - Hemoglobin or Hematocrit;
 - Blood Glucose;
 - Occult Blood in Stool;
 - Pregnancy.

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MoHealthNet: Primary Culturing

Primary culturing for transmittal to a certified laboratory. (This service is required for RHC certification but is not separately billable through any MO Health Net program; reimbursement is included in the fee for the visit.)

Mo Health net. Rural Health Clinic Independent Manual.
Section 13, Page 4.

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MoHealthNet: Technical Components

Independent Rural Health Clinics (RHCs) may bill MO Health Net using their active 50 provider number (Clinic/Group) for technical components of laboratory, radiology and electrocardiogram (EKG) services. Independent RHCs may bill using the MO Health Net fee schedule. Reimbursement is according to the fee schedule.

Mo Health net. Rural Health Clinic Independent Manual.
Section 13, Page 4.

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MoHealthNet: VNC

Independent Rural Health Clinics (RHCs) may not bill an administration fee for Vaccines for Children (VNC) immunizations. The administration fee is included in the all-inclusive encounter rate for the visit.

Mo Health net. Rural Health Clinic Independent Manual.
Section 13, Page 5.

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MoHealthNet: EKG and Radiology

Current provider type 50 (Clinic/Group) provider numbers may be used to bill technical components for laboratory, radiology and EKG services performed at the RHC for dates of service on or after July 1, 2006.

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MoHealthNet: Hospital

- All hospital services are non-RHC and payable under the private practice MoHealthNet provider number.
- OB/Gyn services: Prenatal visits = RHC encounters; Delivery is billed non-RHC.
- Post-op period of 30 days for follow-up visits still enforced under RHC.

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MoHealthNet: UB04 Codes

- Type of Bill: 715
- Enter HCPCS procedure code T1015.
- The T1015 is submitted with the clinics approved RHC encounter rate.

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MoHealthNet: CPT detail

If the service is a full or partial EPSDT/HCY screening, enter encounter code T1015EP. The 5-digit EPSDT/HCY screening code must be shown in Field #74. V20.2 must be shown as the primary diagnosis in Field #67.

NOTE: Surgical procedures performed in the rural health clinic must be entered in Field #74.

See Section 15 for detailed UB04 form completion.

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MC Plus Plans

- All claims are submitted to McPlus plans as a regular commercial, carrier on a 1500.
- A wrap-around report must be submitted to Mo HealthNet audit and reimbursement to receive a reconciliation to the RHC rate.

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Mo Health net Resources

Independent RHC Mo Medicaid Manual

http://manuals.momed.com/collections/collection_rhi/Rural_Health_Clinic_Independent_Section13.pdf

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CMS and Medicare Resources

CMS Rural Health Center – www.cms.gov/center/rural.asp

Online Manuals -
www.cms.gov/Manuals/IOM/list.asp?listpage=1

Cahaba – www.cahabaqba.com

Mo Medicaid Manuals -
<http://manuals.momed.com/manuals/>

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Preventive Service Links

- IPPE (MM6445)
<http://www.cms.gov/MLN MattersArticles/downloads/MM6445.pdf>
- Annual Wellness Exam (MM7079)
<https://www4.cms.gov/MLN MattersArticles/downloads/MM7079.pdf>
- Medicare Preventive Services Quick Reference Chart
https://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

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More CMS Resources

Medicare Claims Processing Manual _ UB04 Completion
www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC
Coverage Issues
www.cms.gov/manuals/downloads/clm104c09.pdf

MedLearn Catalog
www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf

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