Basic RHC Billing v.2020

Oregon Office of Rural Health | OHSU

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RHC Billing v.2020: Presentation Objectives

Part I – RHC Services

- ✓ RHC Services
- ✓ Definitions/Basics
- ✓ Incident to Services
- ✓ Claim Form, Charges, Revenue Codes, Types of Bill
- ✓ RHC Locations and Providers
- ✓ RHC Services
- ✓ Incident-to Services
- ✓ Surgeries, Injections, Specialists, Global Billing
- ✓ Non-RHC Services

What is an RHC?

Rural Health Clinics were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas. RHCs have been eligible to participate in the Medicare program since March 1, 1978, and are paid an all-inclusive rate per visit for qualified primary and preventive health services.

(Medicare Benefit Policy Manual. Chapter 13. Section 10.1.)

What is an RHC?

- ✓ A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.
- ✓ 51% of Clinic Services must be Primary Care (FP,IM,OB,Ped)
- ✓ The purpose of the RHC program is improving access to primary care in underserved rural areas.
- ✓ The clinic must be staffed at least 50% of the time with a midlevel practitioner.

(Rural Assistance Center FAQ)

The Rules - 42 CFR 491

This is the Code of Federal Regulations (CFR) which stipulates Rural Health Clinics' Conditions for Certification.

http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/RHC_FQHC.html

Rural Health Clinic Requirements

- ✓ Compliance with Federal, State, and Local laws
- ✓ Location of Clinic
- ✓ Physical Plant and Environment
- ✓ Organizational Structure
- ✓ Staffing and Staff Responsibilities
- ✓ Provision of Services
- ✓ Policy and Procedure Manual
- ✓ Medical Records
- ✓ Emergency Preparation
- ✓ Annual Evaluation (vs. Quality Assurance)

RHC Regulations and Interpretive Guidelines

Social Security Act Section 1861(aa)(2)(K)

42 CFR §405.2402 (Basic Requirements)

42 CFR Part 491, Subpart A (Conditions for Participation!)

State Operations Manual – Appendix G (Surveyor Guidance)

Accreditation Organization Standards:

- ✓AAAASF
- ✓The Compliance Team

The RHC Encounter Rate

The Current RHC maximum encounter rate CY 2020 is $86.31. (for independent/freestanding RHCs or PBRHCs ineligible for an uncapped rate).

“In general, the all-inclusive rate (AIR) for an RHC or FQHC is calculated by the MAC/FI by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation.”

(Medicare Benefit Policy Manual. Chapter 13. Section 70.)

RHC Productivity Standard

1 FTE Physician – 4,200 Visits

1 FTE NP or PA – 2,100 Visits

If the RHC or FQHC has furnished fewer than expected visits based on the productivity standards, the MAC/FI substitutes the expected number of visits for the denominator and use that instead of the actual number of visits.

(Medicare Benefit Policy Manual. Chapter 13. Section 70.4.)

RHC Rate and Cost Reporting

- ✓ The RHC Encounter Rate is set via the RHC Cost Report.
- ✓ Provider-based Clinics are part of the hospital cost report.
- ✓ Costs must be appropriately allocated for RHC space and personnel.
- ✓ Provider FTEs should be measured via formal time study (one week per month).
- ✓ Only time spent in the RHC counts.
- ✓ Medical Director, Physician, PA, NP, Nursing FTEs have a major impact on cost reporting.
- ✓ Laboratory Expenses must be allocated and reclassified appropriately. (RHC vs. Non-RHC)

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.

Provider-Based RHCs

Provider-based RHCs (PBRHC) are those owned by a parent entity such as a hospital, nursing facility, or home health agency.

- ✓ 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.
- ✓ Claims are billed to the MAC which services the parent entity.

RHC Claims - Medicare Part A

The Centers for Medicare and Medicaid Services administers Rural Health Clinics payments under Medicare Part A. RHC services are a Part B (Physician Service) benefit, but our reimbursement structure is Medicare Part A.

Medicare Part B (FFS)

In the RHC world, the term ‘Medicare Part B’ typically indicates those claims which will continue to be paid ‘fee-for-service’ and billed on a CMS-1500 under the Medicare Physician Fee Schedule (MPFS) payment structure.

RHC claims are NOT paid based on the Medicare Fee Schedule. Non-RHC services are those that may be paid outside of the RHC Benefit.

Outpatient PPS 2017

"A key proposal in this year's rule is to implement Section 603 of the Bipartisan Budget Act of 2015, which will affect how Medicare pays for certain items and services furnished by certain ***off-campus outpatient departments of a provider*** (hereinafter referenced as off-campus "provider-based departments" (PBDs)."

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-06.html

Provider-Based RHCs: *Not Outpatient Departments*

42 eCFR 413.65 (a)(2):

For purposes of this part, the term “department of a provider” does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC.

Rural Health Clinics and MIPS

Medicare Part A reimbursement for claims submitted on a CMS-UB04 is NOT subject to MIPS negative/positive payment adjustments at present.

Any non-RHC/non-FQHC billing which is submitted on a CMS-1500 WILL be subject to MIPS adjustments.

Where do we send Medicare RHC claims?

Type of RHC	Encounter	CLIA Lab	Other Lab/Ancillary	Outside RHC Hours
Independent or Freestanding	Part A UB-04	Part B* Form 1500	Part B* Form 1500	Part B* Form 1500
Provider Based	Part A UB-04	Billed by Parent hospital	Billed by Parent hospital/entity	Billed either Part B to MAC or as hospital charge if appropriate.

*** Costs related to services reimbursed under Part B are carved out on the RHC cost report so that the encounter rate is not overstated (commingling).**

Qualified RHC Providers

An RHC encounter can be billed for the following providers:

- ✓ Physicians (MD, or DO)
- ✓ Nurse Practitioners
- ✓ Physician Assistants
- ✓ Certified Nurse Midwives
- ✓ Chiropractor, Dentist, Optometrist, Podiatrist

Behavioral Health Providers

Medicare RHC providers are:

- ✓ Clinical Psychologist (PhD)
- ✓ LCSW
- ✓ LCPC or CPC is not payable by Medicare

  (Check with your own state to see if LCPC or CPC are eligible – in most states they are not)

RHC Locations

RHC visits may take place in:

- ✓ the RHC or FQHC,
- ✓ the patient's residence (including an assisted living facility),
- ✓ 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.

(Medicare Benefit Policy Manual. Chapter 13. Section 40.1)

Never an RHC Location

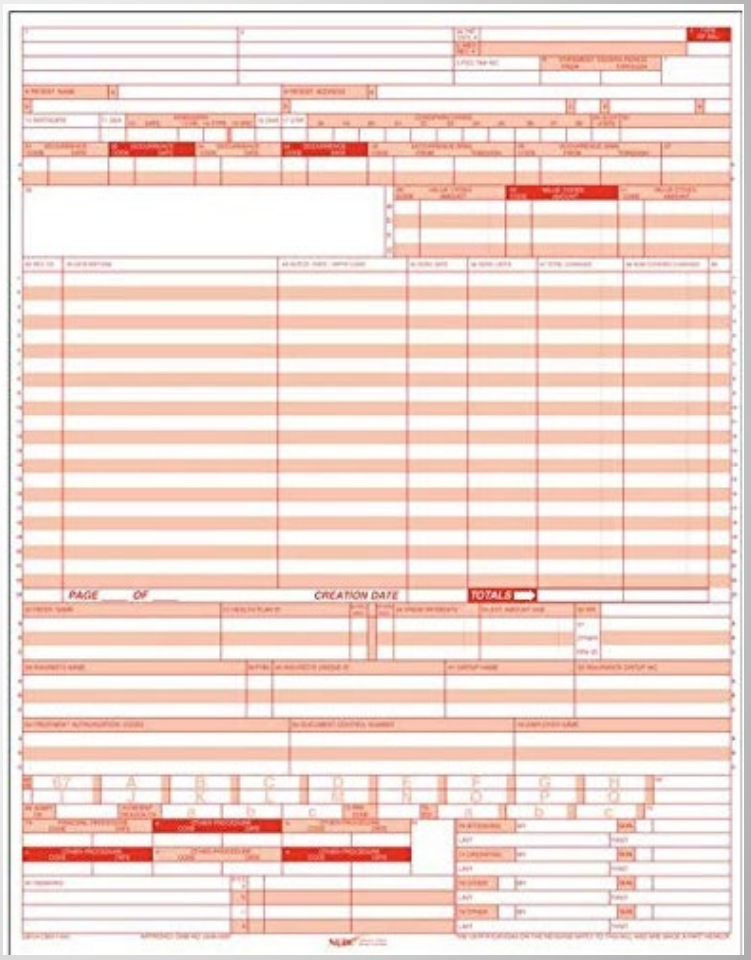
RHC Visits may never take place in:

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

(Medicare Benefit Policy Manual. Chapter 13. Section 40.1)

$64,000 Question:

What goes on the RHC claim?!?



Rural Health Services

- ✓ Physicians' services, as described in section 100;
- ✓ Services and supplies incident to a physician’s services, as described in section 110;
- ✓ Services of NPs, PAs, and CNMs, as described in section 120;
- ✓ Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 130;
- ✓ Clinical Psychologist and Clinical Social Worker services, as described in Section 140;
- ✓ Services and supplies incident to the services of CPs and CSWs, as described in Section 150; and
- ✓ Visiting nurse services to the homebound as described in Section 180.

(Medicare Benefit Policy Manual Chapter 13)

Incident-to Services Defined

- ✓ Commonly rendered without charge or included in the RHC or FQHC bill;
- ✓ Commonly furnished in a physician office or clinic;
- ✓ Furnished under the physician's direct supervision; and
- ✓ Furnished by a member of the RHC or FQHC staff.
- ✓ Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal);
- ✓ Bandages, gauze, oxygen, and other supplies; or
- ✓ Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician.

Incident-to Services Defined

- ✓ Incident-to services are considered covered ***and paid*** under the RHC.
- ✓ They must be 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.

Provision of Incident-to Services

- ✓ Incident to services and supplies can be furnished by auxiliary personnel.
- ✓ More than one incident to service or supply can be provided as a result of a single physician visit.
- ✓ Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC or FQHC to provide services

Provision of Incident-to Services

Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service.

Direct supervision does not mean that the physician must be present in the same room…the physician must be in the RHC or FQHC and immediately available.

(Medicare Benefit Policy Manual. Chapter 13. Section 110.1)

Examples of Non-Encounter – No Medical Necessity

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

Venipuncture

"Although RHCs and FQHCs are required to furnish certain laboratory services…laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit." (MLN Matters® MM8504)

The RHC Encounter is:

"An RHC or FQHC 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 or FQHC services are rendered."

(Medicare Benefit Policy Manual. Chapter 13. Section 40.)

Qualifying Visits

Medical Services RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

RHC Qualifying Visit List

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

RHC Services – Claim Form

- ✓ RHC Services are submitted on a CMS-UB04 claim form.
- ✓ The electronic format is ANSI837-Institutional.
- ✓ Type of Bill is “711” for an original claim.
- ✓ All services must be reported using the appropriate revenue code.
- ✓ All claims must have a qualifying visit denoted with a “CG” Modifier.
- ✓ Incident-to services must be reported on the claim, but bundled with the qualifying visit.

Revenue Codes

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. RHCs should report the most appropriate revenue code for the services being performed. (MLN 9269)

Revenue Codes

0521	All Clinic Visits and Professional Services by qualified RHC 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 non-SNF bed, 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)
0250	Pharmacy (Does not need the HCPCS)
0300	Venipuncture
0636	Injection/Immunization
0780	Telehealth
0900	Behavioral Health

Medicare Fees (Patient Charges)

"RHCs and FQHCs must charge Medicare beneficiaries the same rate that non-Medicare beneficiaries are charged."

(Medicare Benefit Policy Manual. Chapter 13. Section 80.)

Medicare Payments

"In general, Medicare pays 80 percent of the RHC or FQHC's all-inclusive rate, subject to a per-visit payment limit. The beneficiary in an RHC must pay the deductible and coinsurance amount."

(Medicare Benefit Policy Manual. Chapter 13. Section 80.)

CG Modifier

"…beginning on October 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible." (Med Learn Matters SE1611)

"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."

Billing Example: CG Modifier

An established patient is seen and a qualifying visit of 99213 for $100 is generated. The applicable coinsurance and/or deductible is calculated using $100.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	04/02/2020	1	$ 100.00
0001	Total Charge				$ 100.00

Billing Example: Incident-To Services

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	6/10/2020	1	$ 150.00
0636	Injection Admin	96372	6/10/2020	1	$ 20.00
0636	Toradol	J1885	6/10/2020	1	$ 30.00
0001	Total Charge				$ 200.00

- ✓ J1885 ($30.00) and 96372 ($20.00) are bundled with 99213 ($100) on the qualifying visit line.
- ✓ The total QVL Charge is $150.00; the sum of all services reported on the claim.
- ✓ The total charge line (0001) is inflated due to duplicating the injection/admin charges from the detail lines.

“Alternate Method” for Reporting Service Detail

- ✓ The additional services lines CAN be reported as $.01.
- ✓ This eliminates artificial inflation of revenue, adjustments, and AR.
- ✓ Patient Co-Insurance and Deductible are based on the CG Modifier-QVL line.

“Alternate Method” Service Detail Reporting

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2019	1	$ 200.02
0636	Injection Admin	96372	4/2/2019	1	$ 0.01
0636	Toradol	J1885	4/2/2019	1	$ 0.01
0001	Total Charge				$ 200.04

- ✓ The Injection and Medication Charges ($20.00/$30.00) are added to the 99213 qualifying visit line.
- ✓ The detail lines are reported as $.01.
- ✓ The total charges are no longer falsely inflated.

Bundled Services – Different Dates

"...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." (MBPM 13; Section 120.3)

Do NOT span dates on the "Admit From" and "Admit Through" dates. This will cause other claims submitted within those dates to reject.

Billing Example: Bundled Injection/Different Dates

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	04/02/2020	1	$ 120.01
0636	Allergy Injection	95115	04/02/2020	1	$ 0.01
0001	Total Charge				$ 120.02

The Allergy injection charge amount ($20.00) for the line item is bundled with the $100 charge on the 99213 qualifying visit line. Medicare will use the line with the qualifying visit code (99213) to determine the total charge and calculate co-insurance.

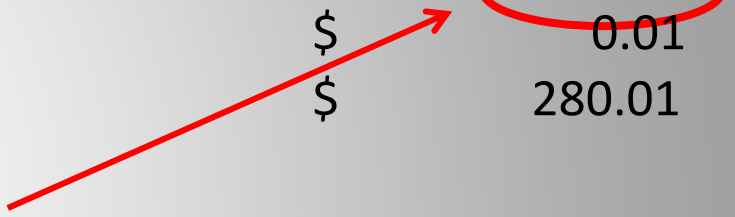
Office Visit and Surgical Procedure

If an office visit is performed during the same visit as a minor surgical procedure, the clinic will only have one encounter to bill.

These should be bundled and submitted as one line item.

Billing Example: Medical Visit plus Procedure

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 4	99213 CG	04/02/2020	1	$ 280.00
0521	Joint Injection	20610	04/02/2020		$ 0.01
0001	Total Charge				$ 280.01



- ✓ An office visit is performed in addition to a joint-injection at the same visit.
- ✓ The joint injection ($180.00) is bundled with the ($100.00) office visit charge.
- ✓ These should be bundled and submitted on the same encounter.
- ✓ The joint injection is on the QVL; if performed independently it is paid at the AIR.

Global Billing

Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services.

The RHC is paid based on its all-inclusive rate and is not subject to the Medicare global billing requirements.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements.

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

Minor Surgical Procedures

Minor surgical procedures performed in the RHC, during RHC hours, must be billed as encounters.

Follow-up visits for dressing changes, or suture removal can only be billed as encounters if there is a medically-necessary, documented reason and it is performed by an RHC provider.

Billing Example: Procedures only

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Procedure	11100 CG	04/02/2020	1	$ 150.00
0001	Total Charge				$ 150.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Offfice Procedure	11402 CG	04/02/2020	1	$ 650.01
0521	Wound Rpr < 2.5 cm	12031	04/02/2020	1	$ 0.01
0001	Total Charge				$ 650.02

Medicare Preventive Services (MPS)

"RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits (where applicable) have not been exceeded.

The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade or A or B."

Preventive RHC Services

RHC services also include certain preventive services. These include:

- ✓ Welcome To Medicare Visit (G0402)
- ✓ Annual Wellness Visit/Subsequent Annual Wellness (G0438/G0439)
- ✓ Medicare-covered Preventive Services (DSMT/MNT is NOT eligible as an RHC Visit!)
- ✓ Influenza, Pneumococcal (Medicare Cost Report – Medicare Flu/Pneumo Only)
- ✓ Chronic Care Management (G0511/G0512)
- ✓ Virtual Communication Services (G0071)

(Medicare Benefit Policy Manual Chapter 13)

Preventive Services and Same Day Billing

"RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the [Certain Preventive Services] when they are performed on the same day." MLN SE1039

The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.

Billing Example: IPPE Only

The IPPE was the only service performed. The CG modifier is optional when G0402 is reported.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	6/10/2020	1	$ 200.00
0001	Total Charge				$ 200.00

Billing Example: IPPE plus Office Visit

"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."

(RHC Reporting FAQ)

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient III	99213CG	6/10/2020	1	$ 100.00
0521	IPPE	G0402	6/10/2020	1	$ 200.00
0001	Total Charge				$ 300.00

Preventive Services and Stand-Alone Encounters

All other preventive services are ‘stand-alone’ encounters. If a “stand-alone” encounter is the only service rendered on a particular date of service, then it will be paid at the AIR. If it is furnished on the same day as another medical visit, it is not a separately billable visit.

The beneficiary coinsurance and deductible may be waived, depending on the service rendered.

Non-RHC Services

Non-Rural Health Services

- ✓ “RHCs and FQHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit.
- ✓ If these services are authorized…the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service.
- ✓ RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.”

(Medicare Benefit Policy Manual Chapter 13; Section 60)

Technical Components and Lab: Non-RHC Services

“These services may be billed separately to the A/B MAC by the facility). (The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner or furnished incident to an RHC or FQHC visit).”

“… laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report.”

Non-Rural Health Services

Non-RHC/FQHC services include, but are not limited to:

List of Non-RHC Services	
Medicare Excluded Services	Ambulance Services
Technical Components	Prosthetic Devices
Laboratory Services	Body Braces
Durable Medical Equipment	Practitioner Services At Certain Other Medicare Facility
Telehealth Distant-site Services	Hospice Services
Group Services	

Non-Rural Health Services

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

- ✓ Diagnostic testing - X-Ray, EKG, etc.
- ✓ Laboratory services – except Venipuncture!
- ✓ Professional services rendered in the hospital

Technical Components and Lab: Non-RHC Services

All lab and technical components are billed to the Medicare Part B MAC – NOT Part A.

- ✓ The *technical* component of these tests are ***Non-RHC services, billed fee-for-service***.
- ✓ CAHs receive cost-based reimbursement.
- ✓ Independents and PPS hospitals are paid on a fee schedule.

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.

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 hospital CCN number.
- ✓ Lab services are also billed to the FI using the hospital CCN number.

Provider-based Diagnostic Claims - CAH

PBRHC owned by **CAH**: Billed using ***parent's CCN***, payment is cost-based.

LAB: TOB 851/Rev Code 300/UB04

RAD-TC: TOB 851/Rev Code 320/UB04

EKG-TC: TOB 851/Rev Code 730/UB04

Provider-based Diagnostic Claims - PPS

PBRHC owned by **PPS**: Billed using ***parent's CCN***, payment is based on the Medicare Fee Schedule.

Lab:	TOB 141/Rev Code 300/UB04
Rad-TC :	TOB 131/Rev Code 320/UB04
EKG-TC:	TOB 131/Rev Code 730/UB04

Professional Components: Diagnostic Testing

The *professional* component for X-Ray, EKG, and diagnostic testing is bundled with the RHC encounter.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
521	OV Est 3	99213 CG	04/02/2020	1	$ 130.00
521	EKG-PC	93010	04/02/2020	1	$ 30.00
001	Total Charge				$ 160.00

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 MAC.

Visiting Specialists in an RHC

- ✓ Any qualified provider (MD, DO, NP, PA) can see patients in an RHC.
- ✓ RHC must provide primary care services fifty-one percent of operating hours. (FP, IM, Peds, OB)
- ✓ Specialists can be integrated into the RHC.
- ✓ Commercial and Medicaid enrollment should be assessed.

Behavioral Health Services

Behavioral Health Services performed by a qualified provider are billed using revenue code 900.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Rx Management	90832CG	04/02/2020	1	$ 120.00
0001	Total Charge				$ 120.00

Behavioral Health Qualified Visits

HCPCS	Short Description
90791	Psych Diagnostic Evaluation
90792	Psych Diag Eval w/Med Srvcs
90832	Psytx Pt/Family 30 minutes
90834	Psytx Pt/Family 45 minutes
90837	Psytx Pt/Family 60 minutes
90839	Psytx Crisis Initial 60 min
90845	Psychoanalysis

Claim Example: Sick Visit and Behavioral Health

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	04/02/2020	1	$ 220.00
0900	Rx Management	90832CG	04/02/2020	1	$ 120.00
0001	Total Charge				$ 340.00

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

NOTE: Limited number of scenarios that require TWO CG Modifiers!

RHC Telehealth Distant Site Services: furnished between January 27, 2020, and June 30, 2020

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020:

- ✓ RHCs must report HCPCS code G2025 on their claims with the CG modifier.
- ✓ Modifier “95” (Rendered via Real-Time Interactive Audio and Video) may also be appended but is not required.
- ✓ These claims will be paid at the RHC’s all-inclusive rate (AIR), and automatically reprocessed beginning on July 1, 2020, at the $92.03 rate.
- ✓ RHCs do not need to resubmit these claims for the payment adjustment.

Medicare Telephone Only Visits = G2025

During the COVID-19 PHE, RHCs and FQHCs can furnish any telehealth service that is approved as a Medicare Telehealth Service under the PFS. (See Medicare Approved Telehealth Services)

Effective March 1, 2020, these services include CPT codes 99441, 99442, and 99443, which are audio-only telephone evaluation and management (E/M) services. RHCs and FQHCs can furnish and bill for these services using HCPCS code G2025.

We can adjust telephone only claims that were billed G0071 to G2025 to be paid the higher rate – back to March 1, 2020.

RHC Telehealth Distant Site Services: furnished between January 27, 2020, and June 30, 2020

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025CG95	01/27/2020	1	$ 94.00
0001	Total Charge				$ 94.00

- ✓ RHCs must report HCPCS code G2025 on their claims with the CG modifier.
- ✓ Modifier “95” (Real-Time Interactive Audio and Video) may also be appended but is not required.

CS Modifier for COVID-Related Services: Co-Insurance MUST be Waived

- ✓ For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries.
- ✓ For COVID-related services in which the coinsurance is waived, RHCs and FQHCs must report the “CS” modifier on the service line.

CS Modifier – Claims with Co-Insurance Applied

COVIDRHC and FQHC claims with the “CS” modifier will be paid with the coinsurance applied.

- ✓ *Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1.*
- ✓ Coinsurance should not be collected for COVID-related services.

Virtual Communication – NOT an Encounter!

RHCs can receive payment for Virtual Communication Services when *at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner* to a patient who has had an RHC billable visit within the previous year.

- ✓ The medical discussion or remote evaluation is for a condition *not related to an RHC service* provided within the previous 7 days, and -

- ✓ The medical discussion or remote evaluation ***does not lead*** *to an RHC visit* within the next 24 hours or at the soonest available appointment.

G0071: Virtual Check-In

Virtual Check-In (Brief Communication Technology-based Service):

- ✓ Performed by a physician or other qualified health care professional;
- ✓ Revenue Code: 0521
- ✓ COVID-19: Available to ALL patients, including new patients, effective 3.17.2020.
- ✓ not originating from a related E/M service provided within the previous 7 days;
- ✓ nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment;
- ✓ 5-10 minutes of medical discussion.
- ✓ Text and email count.

Virtual Check-In RHC Claim Example

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Virtual Check-In	G0071	4/2/2020	1	$ 13.69
0001	Total Charge				$ 13.69

- ✓ G0071 is for RHCs only.
- ✓ We do not bill G2010 OR G201.
- ✓ Virtual Check-In G0071 encompasses Remote Check-In AND Remote Evaluation.
- ✓ It does NOT include remote monitoring.

Medicare Advantage Plans

Medicare Advantage plans are considered commercial payers for RHC purposes and cost reporting purposes.

- ✓ Most of these will pay your RHC encounter rate and follow Medicare RHC reimbursement.
- ✓ RHC services should be submitted on a CMS-UB04;
- ✓ Non-RHC services ***may*** be submitted on a CMS-1500.
- ✓ Pneumoccal and Influenza injections should not be reported on the RHC Cost Report.

RHC - CMS Resources

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Benefit Policy Manual- Chapter 15 Other Services

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

RHC - CMS Resources

Virtual Communication FAQ

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

State Operations Manual Appendix G (Updated 1.2.18)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

Provider-Based Rules (42 CFR 413.65)

https://www.law.cornell.edu/cfr/text/42/413.65

RHC - CMS Resources

Virtual Communication FAQ

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

Provider-Based Rules (42 CFR 413.65)

https://www.law.cornell.edu/cfr/text/42/413.65

MSP Information Resources (CGS)

MSP Reference Chart!! Medicare Secondary Payer (MSP) Billing & Adjustments quick resource tool

Medicare Secondary Payer (MSP) Billing & Adjustments Online Tool

MSP FAQ

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