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Rural Health Clinic Regulatory & Billing Updates

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Overview

- Overview of RHC Regulations
- RHC Billing Requirements
- RHC Billing "How To's"
- RHC Key Internet sites

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TYPES OF RHCs

- **Independent Rural Health Clinic**
  - Owned by any person that State allows
    - I.e. Physicians, NPs, PAs, Hospitals, or anyone allowed
  - Individual practitioner(s)
  - Can be sole proprietor, partnership, corp. or LLC
  - Completes the IRHC cost report each year
- **Provider Based Rural Health Clinic**
  - Owned by a Hospital, Skilled Nursing Facility or a HHA
  - Treated as a department of the parent facility
  - Generally within a 35 mile radius of the parent facility
  - Integrated financials
  - Access to medical records between departments
  - Cost report completed as part of the "parent" cost report

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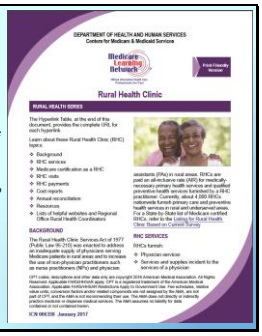
What

- CMS has an "RHC Fact Sheet"

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf

7 pages of information


DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network

Print Friendly Version

Rural Health Clinic

RURAL HEALTH SERIES

The Hyperlink Table, at the end of the document, provides the complete URL for each hyperlink.

Learn about these Rural Health Clinic (RHC) topics:

- Background
- RHC services
- Medicare certification as a RHC
- RHC visits
- RHC payments
- Cost reports
- Annual reconciliation
- Resources
- Lists of helpful websites and Regional Office Rural Health Coordinators

BACKGROUND

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address the shortage of health care providers for Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners (NPs) and physician assistants (PAs) in rural areas. RHCs are paid an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by a RHC practitioner. Medicare pays the AIR to nationwide furnish primary care and preventive health services in rural and underserved areas. For a State-by-State list of Medicare certified RHCs, refer to the Listing for Rural Health Clinic (Based on Current Survey

RHC SERVICES

RHCs furnish:

- Physician services
- Services and supplies incident to the services of a physician

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ONSITE SURVEY PROCESS

- Survey for Certification as an RHC
  - NE Clinics must contract with a Credentialing Firm
  - Initial Survey
  - Periodic Self-Surveys
  - Complaint Surveys—States required to do complaint surveys
  - State Survey Team may come in at any time also
- Surveys after Initial
  - Credentialing Firm—every 3 years w/self survey annual
  - Not necessarily after a Change of Ownership but maybe
  - Deficiency Statement
  - Plan of Correction

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RHC Regulatory Compliance

- State Operations Manual—Conditions for Certification
  - Compliance with Federal, State, and Local Laws
  - Location of Clinic
  - Physical Plant and Environment
  - Organizational Structure
  - Staffing and Staff Responsibilities
    - This section was updated with more specifics
  - Provision of Services
  - Patient Health Records
  - Program Evaluation

Appendix G – Guidance to Surveyors: Rural Health Clinics (RHCs) – (Rev. 137, 04-01-15)

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ASSURE SHORTAGE AREA DESIGNATION

- RHC must be located in a healthcare shortage area
  - Health Professional Shortage Area (HPSA)
  - Medically Underserved Area (MUA)
    - Medically Underserved Population does not meet the shortage area designations (MUP)
  - Governor's list of Healthcare Shortage Areas
- Check website:
  - http://www.hrsa.gov/shortage/find.html
  - Search to find your area as either a HPSA or MUA
- Check the State website for governor's list of shortage areas

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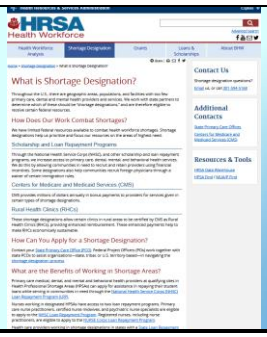

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PHYSICAL PLANT & ENVIRONMENT

- Safe Environment (inside and out)
  - Inspection of Local Fire Marshall
- Preventive Maintenance
  - Equipment checked <u>annually</u> by bioengineer
  - Routine Maintenance on building
- Non-Medical Emergencies
  - New Emergency Preparedness effective 11/2017
  - Tornado preparedness and drills
  - Fire policies and drills
  - Flood, Bomb & workplace violence policies

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STAFFING & STAFF RESPONSIBILITIES

- Sufficient Staffing
  - Clinic directed by a Physician
- Staffing Availability
  - Physician, PA, NP or CNM must be available to furnish patient care services at all times the clinic operates
  - PA, NP or CNM available at least 50% of scheduled operating hours
  - No medical services provided w/o provider onsite in RHC
- Staff responsibilities
  - Physician, PA, NP, CNM jointly develop and review policies
  - Medical Director must review sample patient records, medical orders, and provide medical care services
  - Physician Supervision is per State Guidelines for PA & NP

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PROVISION OF SERVICES

- Scope of Practice
  - Follows State's Medical Practice Act
  - Have written delineation of duties for PAs and NPs
- Providing RHC Services
  - Medical Services that are normally performed in a physician clinic
  - RHC must be "primarily engaged" in RHC services at least 51% of the total operating schedule
- Patient Care Policies
  - All policies signed off by providers and Governing body
  - Description of services—direct and indirect services

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PROVISION OF SERVICES (con't)

- Patient Care Policies (continued)
  - Guidelines for medical management of patients
    - Regimens to follow and conditions that are treated
  - Describe medical procedures allowed by NP, PA or CNM
  - Describe medical conditions that require consultation/referral
- Drugs and Biologicals
  - Policies on storage of drugs—humidity, temp, light, etc.
  - No multi-dose vials used in patient care areas
  - Policies on outdated, deteriorated or adulterated drugs
  - All drugs locked; all narcotics double locked & counted
  - Have current drug references and antidote information
  - Prescribe and dispense in compliance with State law

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PROVISION OF SERVICES (con't)

- Review of Policies
  - Patient Care Policies reviewed by professional personnel at least annually and documented
  - Keep all prior outdated policies on file
- Direct Services
  - Required Services
    - Diagnostic Examination
    - 6 Basic Laboratory Services (CLIA Waived Certificate)
    - Emergency treatments

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PROGRAM EVALUATION

- Evaluation of Clinic's Total Operation
  - Must be Completed Annually by the "Advisory Council"
    - Must include one "third party person" on Council
  - Not All Has to be Completed at the Same Time by the Same Staff
  - Written Report of Annual Evaluation Required
- Annual Review Must Include
  - Review of Services Provided to Include Numbers of Patient Services and What Services Provided
  - Review of Records to include Active and Closed Charts
  - Review of All Policies and Procedures and changes made

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RHC CHART REVIEW

- ✓ Documentation !!!
  - ✓ Must use either 1995 or 1997 documentation guidelines
  - ✓ Provider MUST document all parts of the visit or state they have reviewed each area, i.e. CC, ROS (CMS rule)
- ✓ Develop policies as to which guidelines used
- ✓ Develop billing policies and assure claims are sent correctly
- ✓ Develop Collection policies and assure RHC is following policy when determine RHC bad debt
- ✓ Support Billing?
- ✓ Are lab tests warranted by diagnoses?
- ✓ If not, do we have an ABN signed?
- ✓ Does the Chart, Claim and Encounter form match for services and level of care?
- ✓ Have we asked the MSP questions?
  - ✓ Required at time of each visit

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KNOW THE RHC REGULATIONS

- Medicare Benefit Policy Manual Ch 13 – RHC and FQHC Services Rev 230 issued 12/09/16 **http://www.cms.gov/Regulations-and-Guidance /Guidance/Manuals/Downloads/bp102c13.pdf**
- CMS clarification of stand-alone preventive services **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf**
- Codes list of CPT codes that have the CG modifier

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

  - Updates not continued as RHC knows when it was a provider visit
- CMS Rural Health Clinics Center **https://www.cms.gov/center/provider-type/rural-health-clinics-center.html**

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RHC UPDATED REGULATIONS

- 40.3 – Multiple Visits Same Day, Payable if
  - Patient has second visit for additional DX
  - A **medical visit** and a **mental health visit** same day (2 visits)
  - **IPPE** and **Medical Visit** and **Mental Health Visit** (3 visits)
  - **AWV** and a **Mental Health Visit** (2 visits)
  - Clinic visit and Hospital admit is per your MAC
    - Generally allows based on medically necessary
    - Patient must have face-to-face contact in hospital

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RHC UPDATED REGULATIONS

- 40.4 – Global Billing
  - All procedures in the RHC are not subject to Globals
  - If RHC sees PT for the surgical DX of another provider, must assure the proc was billed w/54 mod
  - If RHC prov performs hosp proc, bill w/54 mod, and then bill each visit at clinic level as not in global
  - Services never included in global surgical package
    - Initial visit to determine surgery required
    - Visits unrelated to DX for surgical procedure
    - Treatment for underlying condition or an added course of treatment which is not part of normal recovery
- 40.5 – 3-Day Payment Window
  - RHC services are not subject

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RHC UPDATED REGULATIONS

- 50.1 – RHC Services
  - Physician Services & services & supplies incident to
  - NP, PA, CNM Services & services & supplies incident to
  - CP and CSW Services & services & supplies incident to
  - Visiting Nurse services in HHA shortage area
    - Must verify with the State to determine shortage area
  - Medicare allowed Preventive Services
    - Influenza, Pneumococcal & Hepatitis B Vaccinations
    - IPPE
    - AWV
    - All Medicare-covered preventive services

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RHC ELIGIBLE PROVIDERS

- Physician – MD or DO
- Physician Assistant
- Nurse Practitioner
- Certified Nurse Midwife
- Clinical Psychologist
  - Must have PHD
  - Licensed in the State providing services
- Clinical Social Worker
  - Minimum of Masters Degree
  - Worked minimum of 2 years of supervised clinical social work
  - Licensed in the State providing services

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RHC UPDATED REGULATIONS

- 50.3 – Emergency Services
  - Neither IRHCs or PBRHCs are subject to EMTALA
  - Must have drugs & biologicals commonly used in life-saving procedures
    - Antibiotics i.e. Rocephin
    - Analgesics i.e. Tylenol, Ibuprophen
    - Anesthetics i.e. Xylocaine, Lidocaine
    - Serums, Toxoids i.e. Vaccines, Tetanus
    - Antidotes i.e. EpiPenR, EpiPen R Jr, Epinephrine
    - Anti-convulsant i.e. Valium (contrd), Cerebyx (noncntrd)
    - Emetics i.e. activated charcoal
  - Must have Emergency Procedures in writing for most common emergencies using meds in clinic

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RHC UPDATED REGULATIONS

- 60.1 - Non RHC Services
  - MCR excluded services, i.e. dental, hearing & eye tests, **physicals**
  - Technical component of an RHC service
  - Laboratory Services (does not include venipuncture)
  - DME, Prosthetic devices, Braces
  - Ambulance Services
  - Hospital Services, ASC, MCORF
  - Telehealth distant-site services
  - Hospice Services (if for DX of hospice)
  - Auxiliary Services, i.e. language interp, transp, security

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RHC UPDATED REGULATIONS

- 90.1 – Charges & Waivers
  - Must charge all patients the same rates
  - Copays and Deductibles apply within the RHC
  - May waive copays and deductibles only after good faith determination made that patient is in financial need but cannot be on a routine basis (42 U.S.C. 1320a7a(6)(A))
- 90.2 – Sliding Fee Scale
  - Not required, but may have
  - Must be applied to all patients
  - Policy must be posted
  - If based on income, must document that info from patient
  - Copies of wage statements or income tax return not required
  - Self-attestations are acceptable
  - Is required if using National Health Service Corp provider

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RHC UPDATED REGULATIONS

- 100 – Commingling
  - Sharing space, staff, supplies, equipment and/or other resources with an onsite Medicare PT B or Medicaid FFS practice operated by the same RHC providers. Commingling is prohibited to prevent:
    - Duplicate reimbursement or selectively choosing a higher or lower reimbursement rate for services
    - May NOT furnish RHC services as a PT B provider in the RHC or in an area outside the RHC such as a treatment room adjacent to the RHC during RHC hours of operation
    - If RHC is in the building with another entity the RHC space MUST be clearly defined.

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RHC UPDATED REGULATIONS

- 100 – Commingling (con't)
  - If RHC leases/rents space, all costs must be offset by the fees paid or costs must be deducted from C.R.
  - Does not prohibit provider going to hosp for emergencies
  - Must follow schedules for hospital and RHC time
  - Hours of operation must be clearly stated on signage visible from outside of RHC. Show RHC and nonRHC hours
- ***If a RHC practitioner furnishes a RHC service at the RHC during RHC hours, the service must be billed as a RHC service. The service cannot be carved out of the cost report and billed to Part B.***

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RHC UPDATED REGULATIONS

- 110 – Physician Services
  - Physician services furnished include diagnosis, therapy, surgery and consultation
  - Must directly examine the patient
  - If patient not directly seen, services must be included in an otherwise billable visit
  - TCM allows for indirect services to be a part of the TCM and billable as the TCM service
  - CCM allows for indirect services be provided and billed once monthly under the provider without a face-to-face visit and is paid under the National Medicare Physician Fee Schedule
  - Services are payable only to the RHC

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RHC UPDATED REGULATIONS

- 110.1 – Dental, Podiatry, Optometry, & Chiropractic Services
  - Effective 3/9/17
  - Services must meet Medicare qualification for coverage
  - Services are not considered "primary care"
  - Provider cannot be Medical Director nor are they considered NPP
- 110.2 – Treatment Plans or Home Care Plans
  - Effective 2/1/16
  - Services are considered part of an otherwise billable visit and are **not to be billed separately**
    - Notice to NOT bill G0179 (& G0372) with visit until after 4/1/18
  - Exception for the comprehensive care plan that is a component of the CCM

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RHC UPDATED REGULATIONS

- 130 – NP, PA & CNM Services
  - Professional services furnished by PA, NP or CNM are services that would be considered covered physician services under Medicare and which are permitted by State laws and RHC policies
  - Must directly examine the patient
  - If patient not directly seen, services must be included in an otherwise billable visit
  - General medical supervision of physician required
  - Type of service PA, NP or CNM allowed to furnish per State and per policies of the RHC
  - Service which would be covered if furnished by a physician

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PHYSICIAN SUPERVISION

- 130.2 – Physician Supervision
  - Effective 7/11/14, supervision of NP, PA, and CNM is per your State Regulations
  - Chart reviews must still be done but don't have to be done on site.
  - Physician must be available for NP or PA at any time needed
  - NE allows for PA and NP supervision to be general supervision and not direct; must be available by phone or other communication

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RHC UPDATED REGULATIONS

- 120 & 140 – Services and Supplies "incident to" providers
  - Direct supervision by provider required; Must be in clinic, not in same room; if in patient home, provider must be there
  - In the hosp when attached to clinic is NOT "incident to"
  - Part of provider's services **previously ordered**
  - Integral, though incidental
  - Performed by auxiliary personnel, i.e. nurse or MA
  - Covered as part of an otherwise billable encounter
    - I.e. dressing change, injection, suture removal, blood pressure monitoring, venipuncture, oxygen
    - DMEPOS supplies or PT D drugs are NOT included

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RHC UPDATED REGULATIONS

- 200 – Telehealth Services
  - RHCs may only serve as the originating site for telehealth
  - Billable as only service or in addition to the visit
  - CANNOT serve as the distant site of the provider service
- 210 – Hospice Services
  - Can treat Patient for condition not related to hospice DX, must use a condition code of 07 on claim to be paid
  - If treat hospice ailment, cannot bill for visit, even if medically necessary and must look to the hospice company for payment or write off. **Cannot** send to Pt B.
  - Providers should coordinate care with the Hospice Co.
  - Hospice service would be billable by provider if provider provides service during nonRHC hours. (not likely in a clinic that is 100% RHC hours)

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HOSPICE SERVICES EXPLANATION

- Medicare beneficiaries who elect the Medicare hospice benefit may choose either an individual physician or NP to serve as their attending practitioner *(Section 1861(dd) of the Act). RHCs are not authorized under the statute to be hospice attending practitioners. However, a* physician or NP who works for a RHC may provide hospice attending services during a time when he/she is not working for the RHC (unless prohibited by their RHC contract or employment agreement). These services would not be considered RHC services*, since they are not being provided by a RHC practitioner during RHC hours.*

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RHC UPDATED REGULATIONS

- 220 – Preventive Services
  - Medicare allowed preventive services are billed either as the only service provided or with other office services
  - A list of preventive services that can be performed as the only service and is considered "stand alone" service
  - Periodically check the Medicare list of allowed preventive services on the CMS.gov website
  - Remember, Medicare does not pay for preventive annual physicals – they only pay for what is on their list with specific information to be documented

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

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RHC UPDATED REGULATIONS

- 220 – Preventive Health Services
  - Only the professional services are billed as RHC
  - TCs are billed as nonRHC
  - Must use the appropriate G-codes or Q code
  - Flu and Pneumo Vaccines (paid through cost report)
  - Hepatitis Vaccines (a part of a billable service)
    - Cannot be for i.e. work requirement
  - Most preventive services have no copay or deductible
  - Diabetes Counseling and Medical Nutrition Services
    - Not separately billable but "incident to" service
    - Costs allowed on the cost report
    - Dieticians not viewed as a "provider" in the RHC
    - Deductibles and coinsurance does apply

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2017 Medicare

- Patient Deductible = $183 per year
- IRHC Rate = $82.30/visit
- PBRHC PPS Hospital Rate = $82.30/visit
- PBRHC <50 bed hospitals = No limit

** *New Medicare cards to be issued in 2018 with numbers not associated with beneficiary social security numbers.*

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Billing Overview

- RHC Billing Regulations
  - CMS RHC Internet Only Claims Manual

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

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What is a Visit?

- Face-to-Face with the Provider
  - Physician, PA, NP, CNM
  - Clinical Social Worker or Clinical Psychologist
- Medically necessary
  - Does it require the skills of a Provider?
- Payer Class
  - All payer classes are counted in the total visit count
- Place of Service
  - Clinic, Home, NH, SNF/SW B, Scene of Accident
- Level of Service
  - All levels apply, to include procedures
  - To include all services "incident to"

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CPT PROCEDURE CODES

- All Procedure Codes that are normally performed in a physician's clinic are applicable in the RHC
- If your coder is also your biller, the knowledge of what service to bill to which payer is imperative
- Some CPT codes will have to be "split" billed, i.e. EKG tracing and interp, xray prof & tech comp

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Medicare Covered But Nonbillable Services

- Nurse service w/o face-to-face visit or "incident to" visit
  - I.e. allergy injection, hormone injection, dressing change, venipuncture
  - Provider MUST be in clinic to have "incident to"
  - Service MUST be "previously" ordered
  - CMS Manual 100-02 Chapter 13 Section 110.2
- Telephone services
  - CMS Manual 100-02 Chapter 13 Section 100 & 120
- Prescription services
  - CMS Manual 100-02 Chapter 13 Section 100 & 120

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EXAMPLES OF NO MEDICAL NECESSITY

- Routine INR visit for lab
- Simple suture removal
- Dressing change
- Results of normal tests
- Blood pressure monitoring
- B12 injection
- Allergy Injection
- Lab tests for screening w/o med necessity
- Prescription service only
  - Chief Complaint: "here for refills"

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PREVENTIVE SERVICE CODING

Definitions:

- Preventive CPT codes
  - CPT codes for physical exams based on age
  - Use when patient has no significant complaints or follow up of ailments
  - **Medicare does not pay for Preventive physical CPT codes** and only pays the allowable G or Q-codes to include: IPPE, paps, breast & pelvic exam, annual wellness visit, PSA, etc. (those listed in the Medicare beneficiary booklet)

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MODIFIER -25

- Significant, separately identifiable E/M service by same provider on the same day of a procedure or other service.
  - Append to E/M code , I.e. 99214-25 (***in system only***)
- Use Modifier 25 when:
  - Visit for a problem **unrelated** to the procedure
  - Visit for a new problem or a problem that has changed significantly and requires re-evaluation before performing the procedure.
  - Visit for the same problem in different sites; one treated surgically and one treated medically.

(DO NOT use -25 on claim as it means there was a separate visit on the same day for unrelated diagnosis, effective 10/1/16)

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EXAMPLES OF MODIFIER -25

- Visit for a problem unrelated to the procedure or service
  - Preventive AWV = patient seen for annual wellness visit
  - E/M service = Patient also c/o leg pain, swelling and hot spot. Evaluated for phlebitis
- Supporting Documentation
  - E/M documentation identifiably distinct from procedure documentation
  - Must meet ALL requirements for E/M visit along with documentation of procedure. Can only count "bullets" of documentation once in setting the level.

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Medicare Part A Billing RHC Services

- UB 04 form or 837i electronic format
- Bill Type 711
- 52X and/or 900 Revenue Code(s) with CPT code of face-to-face visit with CG modifier and the bundled charges minus any preventive service charges
- All other revenue codes listed on separate lines with CPTs of the "bundled" charge line items
- Charges on subsequent lines must be $.01 or >
- Sent to MAC
- Claims for all RHC visits
  - Office, Skilled Nursing Home, Swing Bed, Nursing Home, Home, Scene of an accident

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Medicare Part A "QVC" Revenue Codes

- 521 Office visit in clinic
- 522 Home visit
- 524 Visit to a Part A SNF or SW patient
  Only prof service as labs, drugs, x-ray TC, EKG tracing gets billed to the SNF.
- 525 Visit to a Pt in a SNF, NF, ICF/IID, AL
  Patient not on a Part A SNF Stay
- 527 Visiting Nurse Service in a HHA shortage
- 528 Visit at other site, I.e. scene of accident
- 900 Mental Health Services

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Rev Codes, HCPCS Codes, & CG modifier

- 052X and/or 0900 Rev Code w/Qualifying Visit code and the CG mod, HCPCS of QVC, total bundled charges of all service lines except preventive codes; separate line for each bundled service with charge > $.01, list each preventive service w/code and charge.
  - Any stand alone preventive code or primary code of several preventive codes requires CG modifier.
  - ALL RHC claims MUST have a CG modifier to receive payment
- Detail of Revenue codes **except** the following are allowed:
  - 002X-024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X-072X, 080X-088X, 093X, 096X-310X

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Rev Codes, HCPCS Codes, & CG modifier

- Some common allowed Revenue codes may be:
  - 052X, 0250, 0300, 0636, 0780, 0900 (this is not an all inclusive list)
- All HCPCS codes must match Rev code used; 0250 does not require a CPT code
- **Currently, QVC list is not updated and RHCs are allowed to bill for a service that is deemed as a provider service**
- If providing a service on the QVC list, assure that code is the one that has the CG modifier

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

* References are CMS CR9269 and SE1611

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Timely Filing

MEDICARE:
Must file claims within one year from date-of-services—effective 3/23/10.
I.e. January 1, 2017 must be filed by Dec 31, 2017

NE MEDICAID: Must file claims within 6 months from date-of-service
I.e. January 1, 2016 must be filed by Jul 31, 2016
Any adjustment must be completed w/I 90 days
MCD MCOs may have longer timely filing; Heritage Health began 1/1/17
*If any Xover payments are not received, these can be put on your Medicare Bad Debt log for your cost report

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Medicare RHC Provider Number

- RHC office visit services
  - **Excludes** all labs, x-ray TC & EKG Tracing, any TC
  - **Includes** venipuncture effective 1/1/14
- Billed to the MAC, UB04 Form or electronic
- Paid on the clinic's "all inclusive rate"
- All Medicare coverage rules apply
  - Reasonable & necessary
  - Allowed preventive is covered, I.e. pap, PSA, AWV

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Medicare Part B Provider Number (IRHC)

- All labs, x-ray TC, EKG tracing, any technical components (venipuncture is part of the office visit bundled service)
- All hospital services (IP, OP, ER, OBS)
- Billed to MAC, HCFA 1500 Form
- Paid on the Medicare Pt B fee schedule

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Medicare Part B Provider Number (PBRHC)

- All hospital services (IP, OP, ER, OBS)*
- Billed to WPS MAC, HCFA 1500 Format
- Paid on the Medicare existing fee schedule

* The only exception is if the CAH is Method II reimbursement; then the OP, ER & OBS professional component is part of the hospital's claim.

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PBRHC - Hospital OP Provider Number

- ALL Laboratory performed in the RHC, including 6 basic tests (venipuncture is part of the office visit bundled service)
  - Billed as would have been if provided at the hospital
- Technical Component
  - X-ray
  - EKG
  - Holter Monitor
  - All TC's Billed as would have been if provided at the hospital
  - Paid on the Medicare Pt B Fee Schedule

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PBRHC - Hospital OP Provider Number

CAH Method II

- Hospital bills for both the professional and technical component when performed in the hospital setting:
  - X-ray
  - EKG
  - Holter Monitor
  - ER
  - OP/OBS/ASC
  - Must have separate line item for the prof service
- Paid on the Medicare Pt B Fee Schedule + 15%

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State Medicaid RHC/nonRHC Billing

- Each State Medicaid is specific as to their State requirements—50 states, 50 plans
- May use either the 1500 or UB04
  - Managed Care Plans have choice as well
- Coverage is specific to each state
- Most States require both RHC and nonRHC Medicaid provider numbers
- Paid on the RHC rate or a PPS rate
- NE has transitioned to Managed Care Payers
  - Heritage Health began 1/1/17

http://dhhs.ne.gov/medicaid/Pages/med_medcontracts.aspx

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NE Medicaid

- Each Managed Care Payer (MCP) can require either/both—UB04 or 1500
- All Services for the Managed Care patients are sent to the MCP—nothing sent to DHHS
  - Nebraska Total Care (Centene)
  - UnitedHealthcare Community Plan of Nebraska
  - WellCare of Nebraska
- MCP can determine how to bill and how to pay claims
- MCPs are given RHCs facility specific payment rates to assure MCP is paying the most current rate—RHC Medicaid year is 7/1 through 6/30 each year

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NE Medicaid

- Must have RHC and nonRHC number
- Form for each is per the Managed Care Payer
  - NE Plans use the UB04 for RHC services
  - Use the 1500 for the nonRHC services
- Ailments are RHC services
- Preventive services are nonRHC services
- IRHCs receive 100% of their Medicaid PPS rate
- PB of <50 bed hosp receive 100% of their actual charges
- PB of >50 bed hosp receive 100% of MCD PPS rate
- Must send in a copy of your Medicare CR annually as is a Federal Requirement
- With PPS payments there are no cost report settlements

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NE Medicaid IRHC

- RHC services = bundled services—UB04
- Lab, X-ray TC and EKG tracings (nonRHC) are billed on the nonRHC provider # on the 1500
- X-ray PC and EKG interp is part of visit and bundled on the RHC Provider #
- All preventive, IP, OP, ER, OBS are nonRHC services, billed with nonRHC Provider # (1500)
- OB is global with exception of first visit (1500)
- If only visits, then nonRHC# and list visit dates
- All surgeries at the hospital have 2 wk global

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NE Medicaid PBRHC

- RHC services —UB04
- Detailed line items
- Lab, X-ray TC, EKG tracing billed with Hosp OP #
- Professional components are part of the visit
- All preventive, IP, OP, ER, OBS are nonRHC services, billed with the nonRHC # (1500)
- OB is global with exception of first visit (1500)
- If only OB visits, bill nonRHC# and list visit dates
- All surgeries at the hospital have 2 wk global

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NE Medicaid

- "Incident to" services without a face-to-face visit are billed on the nonRHC # i.e. injection only
- Must have both the administration CPT code and the NDC of the drug administered
- If VFC is used, administration CPT is billed on the nonRHC # with charge; CPT of vaccine given with 0 charge and SL modifier on claim (DHHS PB 1549)
- nonRHC services paid using the fee schedule and not your RHC rates

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Private Pay or Private Insurance

- Billed as in fee-for-service clinic
- No changes in reimbursement
- Must not discount charges at time of service
  - RHC rule that all patients be charged the same fees
  - no cash discounts
  - no professional discounts given
- All discounts given should be based on finances of patients
  - i.e. sliding fee scales can be developed to as high as 400% of poverty guidelines per Federal Regulations

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Medicare Advantage (MA)

Two types of plans

PFFS – Private Fee for Service

Send Claims on UB04 with Medicare Rate letter

Regional/PPO Plans

Must provide service to the entire region per CMS

Send Claims on UB04; you negotiate payment

When patients switch to MA, they are on your "Private" section of your visit counts

You may want to keep them separate as they will count as Medicare patients if you need to figure the % of Medicare utilization.

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RHC "How To's" & Examples

- The RHC Encounters and Medical Necessity
- Rural Health Services
- Non-RHC Services
- Preventive Services
- "Incident to" Services
- Transitional Care Management
- Chronic Care Management
- Advance Care Planning
- Basic claim submission requirements
- Cost Reporting Basics and why we need the info

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MEDICARE INJECTIONS

- Injections with an Office Visit
  - Charge All CPT codes in system
  - Bundle all charges with the QVC; list the 0250 w/no CPT code listed, or 0636 Rev Code with the J-code & submit claim to RHC MCR
  - If it is a Pt D drug, it must be sent to Pt D plan or Patient
- Injections only—nurse service (Incident to service)
  - Charge in system
  - Either DO NOT bill (write off) as there is no f-t-f visit
  - OR can be bundled with a visit within 30 days pre or post nursing service and submitted with that f-t-f visit
  - If injectable is a Part D drug it MUST not be a part of an RHC claim as it is only billable to the patient or to Part D

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