Nebraska Rural Health Association
RHC Conference
09/02/2020

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Today's Discussion:

- ❑ What is an RHC?
- ❑ Compliance Basics
- ❑ Reimbursement Methodology
- ❑ Medicare Billing
  - ❑ Basic Bill Set-up
  - ❑ Billing Examples
  - ❑ COVID Coding and Billing
- ❑ Medicaid Billing Basics

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RHC Basics

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What is an RHC?

A rural health clinic is a **CMS-certified type of healthcare facility**. There are unique qualifications for the location of a rural health clinic.

There are also specific requirements for the location of the facility, the staffing of the facility, and the provision of services which differ greatly from the way that a traditional medical practice is operated.

RHCs are reimbursed differently than other medical clinics.

The conditions of certification are found in 42 CFR §491

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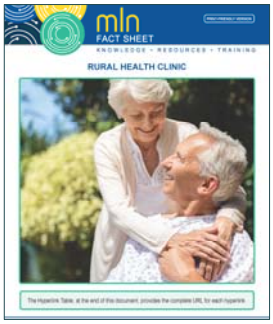

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf

What is a Rural Health Clinic?

This CMS publication is an excellent resource as an overview of the RHC Program.

- Program Basics
- Certification Process
- Qualified Providers
- RHC Services
- Non-RHC Services
- Required Labs
- Places of Service
- Cost-Based Reimbursement
- MORE

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RHC Federal Regulations

42 CFR § 491
https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part491.pdf

CMS Policy Benefit Manual, Chapter 13
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

CMS Claims Processing Manual, Chapter 9
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

State Operations Manual, Appendix G
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

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Basic Requirements and Qualifications of RHC

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Types of RHCs

- RHCs may be independent; or
- RHCs may be provider-based to a hospital, nursing home or home health agency
- Provider-based RHCs are subject to additional guidelines found in 42 CFR §413.65

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Ownership of the RHC

An RHC can have many different types of ownership structures.

- For Profit
- Non-Profit
- Governmental
- Any type entity that can legally provide medical services in your state

Ownership must be fully disclosed to CMS and to the public.

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Location Requirements

- Must be in a non-urban area and classified as rural by the US Census Bureau.
- Must be in a Shortage Area: Primary Care HPSA or Medically Underserved Area
- HPSA = Healthcare Professional Shortage Area
- The HPSA designation must be current. Good for 3 years to the end of the calendar year.
- The RHC can be either a mobile unit or a permanent structure.

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RHIhub and HRSA data

There are several places to find out if a location qualifies for the RHC program.

RHIhub "Am I Rural"
https://www.ruralhealthinfo.org/am-i-rural

HRSA Data Warehouse
https://data.hrsa.gov/

US Census Bureau
https://www.census.gov/data/software.html

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Hours of Operation

RHCs must post their hours of operation.

Patient care hours must be posted for times when a provider is always available to see patients.

If the RHC is closed during lunch or a provider is not there during lunch, then lunch hours must be posted separately.

Administrative hours may be posted when the office staff is on-site for non-patient care activities.

No patient care services can be performed when a provider is not in the four walls of the clinic.

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Signage, Advertising and Changes in Leadership

- Signage must reflect legal and dba names as reported on the 855A enrollment.
- Phone answered using the correct name.
- The RHC must hold itself out to the public as it has been certified and enrolled by CMS.
- Changes in legal or dba names are reported as a change of information using PECOS or 855A.
- Changes in key personnel as found on sections 5 and 6 of the 855A must also be reported.
- Changes in medical director are reported on CMS-29.

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Staffing Requirements for RHCs

- NP or PA or CNM staffed 50% of patient care hours
- MD or DO is required for medical directorship.
- State scope of practice prevails.
- A provider on site all the posted patient care hours.
- Specialist can be RHC providers. They should be bill as RHC providers.

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- Primary care services must be 51% of services by visits.
- Chiropractors, podiatrists, optometrists and dentists are counted as physician but not for medical directorship or as primary care or as only on-site provider. Dental services are not a Medicare benefit.
- No patient services without a provider present.
- No patients in treatment areas prior to a provider being on-site.

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RHC Core Services

- RHC services are professional services including evaluation & management services, procedures typically performed in a medical office, and RHC encounters taking place in other qualified settings.
- Technical components of diagnostic services, including lab are not RHC core services and are not reimbursed by the all-inclusive rate (AIR).
- Venipuncture is included in the AIR.
- 51% Primary Care; See 42 CFR 491.9 and SOM, Appendix G.

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Provision of RHC Services

In addition to primary care and treatment of acute and chronic conditions, these are RHC services:

Qualified Preventive Services
- IPPE
- AWV
- Breast/Pelvic Screening
- Tobacco Cessation
- Prostate Screening
- Depression Screening

Transitional Care Management

Advanced Care Management

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Laboratory Services

Laboratory Services are not core RHC services because they have a technical component.

However, RHCs are required to be able to perform six point of care lab services:
- Urinalysis
- Urine Pregnancy
- Hemoglobin or Hematocrit
- Blood Glucose
- Fecal Occult Blood
- Collection of Specimens

Provider-based and independent RHCs are both required to perform these tests in the clinic. RHCs can perform more tests if desired and covered by the CLIA certificate.

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Emergency Care & Treatment

- Be able to be a first responder as a medical office. Location may require more capability than others.
- Maintain emergency drugs and supplies, i.e., emergency kit. Inventory contents and check expiration dates. New Guidance says that providers must document the decisions for what is stocked and why.
- 42 CFR §491.9
- BLS and ACLS as appropriate for staff/clinicians.
- Transfer agreements
- Admitting arrangements

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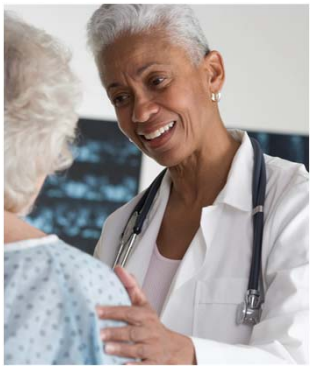

What is an encounter ?

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It's All About the Encounter

- RHC visits (encounters) are medically necessary face-to-face medical or mental health visits or qualified preventive visits between the patient and a physician, NP, PA, CNM, CP, or CSW during which a qualified RHC service is furnished.
- Qualified preventive and screening services may also be standalone RHC visits.
- Transitional Care Management
- Professional Services of a physician, NP, PA or other qualified RHC provider.

Citations:

IOM, Medicare Policy Benefit Manual, Chapter 13, Section 40

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

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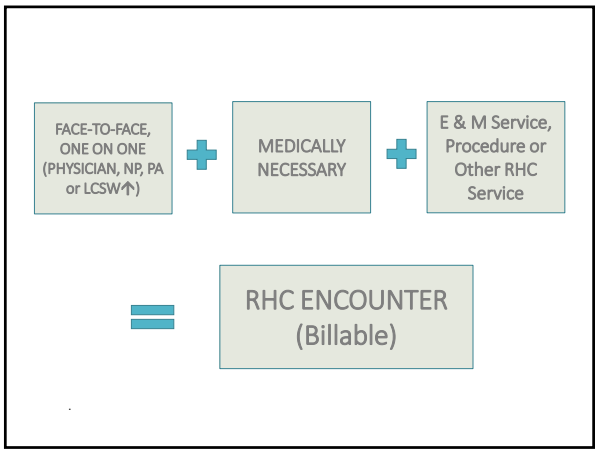

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Qualifying Visit List

- All codes in either red or black ink on the list can be used for services after 10/01/2016.
- At least one code from the QVL should appear on a claim and be appended by –CG.
- QVL is not an exclusive list. However, most MACs have written their claims processing rules based on the QVL.
- CMS was supposed to update this list quarterly, but it has not been updated since 2016.

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

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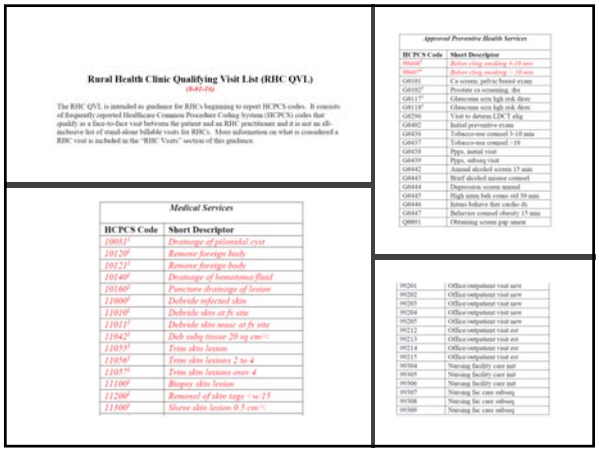

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CPT® 99211 visits are not billable Medicare RHC encounters.

- An incident-to service which occurs subsequent to an RHC encounter may be bundled with an otherwise billable visit within 30 days provided there is appropriate clinical documentation of the service. Or adjusted off.
- An injection only visit does not meet the definition of a RHC encounter and cannot be billed as a standalone visit.
- **These are covered benefits for the Medicare patient but are not billable as an encounter. Do not bill as non-covered or self-pay.**
- Excluded from the # of visits reported on the cost report.

Citation:
https://med.noridianmedicare.com/web/jfa/education/event-materials/rhc-qa

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Exceptions to Face-to-Face Encounter

- Care Management and Care Coordination Services
  - CCM
  - BHI
  - Psychiatric CoCM
- Virtual Communication Services
- Distant Site Telemedicine during COVID-19
- These services are not reimbursed at the AIR.

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RHC Reimbursement Methodology, Productivity and Basic Billing Set Up

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Reimbursement

- RHCs can be Independent or Provider-Based.
- RHCs are paid an all-inclusive rate by Medicare (CMS) through claims filed with the MAC.
- Independent RHCs are capped for 2020 at $86.31
- Provider-based RHCs with parent entity < 50 beds are not capped. Bed count is not licensed beds, but is determined by available beds as defined by CMS.
- The AIR is adjusted annually based on the cost report data calculation.
- **Not all cost report preparation is equal**.

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RHC AIR Calculation

$$\frac{\text{Total Allowable RHC Costs}}{\text{\# of RHC Encounters (all payer types using definition)}} = \text{RHC All-Inclusive Rate for Medicare Encounters}$$

Independent RHCs are subject to a capped rate (ceiling) each year.
Provider-based RHC are not capped and receive the actual cost per encounter based on the cost report data.

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Questions So Far?

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PROVIDER PRODUCTIVITY

- CMS defines productivity standards to be applied to the cost report calculation to prevent abuse of the cost-based reimbursement methodology.
- Physician productivity standard is 4,200 encounters per FTE
- NP or PA productivity standard is 2,100 encounters per FTE
- When the productivity standard is not met, the number of visits the RHC should have had is used as the denominator in the rate calculation which reduces the resulting rate.

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What is a Provider FTE?

The FTE calculation is based on time the provider is available to see patients. PTO comes out. Education time comes out. Administrative time comes out.

FTE =2080 Hours

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Comparison of Staffing and Productivity Requirements

Provider Type	Qty	Required Visits	Productivity Standard
Physician	3.00	4,200.00	12,600.00
NP/PA	1.00	2,100.00	2,100.00
	4.00		14,700.00

Provider Type	Qty	Required Visits	Productivity Standard
Physician	0.50	4,200.00	2,100.00
NP/PA	3.50	2,100.00	7,350.00
	4.00		9,450.00

Staffing with a physician heavy model will increase the productivity standard requirement increases the required number of visit by > 5,000. For a new RHC or one that has not yet built a stable panel, the difference in staffing models could result in a higher AIR.

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PROVIDER TIME ALLOCATION SHEET								Provider Name:	
For the Two Weeks Ending:								Facility/Clinic:	
Week/Week day	Total Hours	Clinic Patient Care Hrs	Clinic Admn Hours	Hospital Inpatient	ER/ED Hours	Other Hospital Dept Hrs	Hospital Admn Hrs	Comments	
Week 1									
Monday	8	6.5		1.5					
Tuesday	6	3	2	1				Work on Annual Eval	
Wednesday	8	5	1	1	0.5		0.5	Trauma in ER; Chart Catch up	
Thursday	9	7		1			1		
Friday	4	4							
Saturday	0								
Sunday	0								
Total Hours	35	25.5	3	4.5	0.5	0	1.5		

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What else is reported on the cost report?

- Flu and Pneumococcal Immunizations
  - Cost of Private Stock Vaccines
  - Nursing Time per Immunization
  - Total number of Immunizations
  - Total number of Medicare shots
- The cost of services which do not qualify as encounters are used in the next year's rate calculation.
- Medicare Bad Debt

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Patient Deductible and Coinsurance

- The Part B Deductible amount for the current calendar year is applied to RHC Visits. Pts with Part A only not covered.
- $198.00 for 2020
- Co-insurance = 20% of total visit charges – not the Medicare Fee-for-service Allowable.
- Medicare remit will be 80% of the RHC AIR. The cost share will be 20% of charges.
- At the first of each calendar year, the first RHC claim for the patient may reflect a negative payment if the encounter rate is less than the deductible, because Medicare expects the RHC to collect the Part B deductible amount.

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Credit Balance Reporting

- Due Quarterly to the MAC
- Reports Amounts Overpaid by Medicare
- Does not necessarily include all patient credit balances
- Reimbursement held if credit balance report is late

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How are we doing so far?

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15 Minute Break

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General RHC Billing

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Common UB-04 RHC Bill Types

Bill Type	Type of Service	Comment
711	RHC Covered Services; or mixed covered/non-covered	For example: covered services with a B-12 injection
710	All charges are non-covered; claim is sent to trigger denial	Condition Code 21
717	Adjusted Claims	Replacement of Prior Claim; Comment on reason
718	Cancelled Claims	Void already processed claim.

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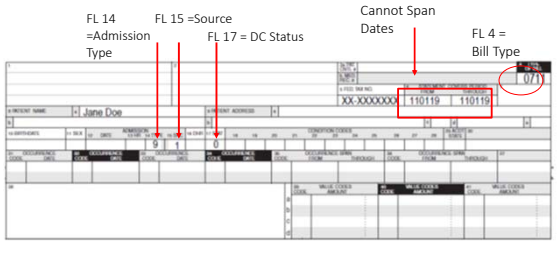

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RHC Billing By Type Matrix

Type of RHC	Encounter Professional Services RHC Service	CLIA Lab Performed in RHC	Other Technical Components (non-RHC)	Professional Services 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 to MAC by Parent hospital TOB 141/131 for PPS hospital; CAH: 851.	Billed to MAC by Parent hospital TOB 131 for PPS hospital; CAH:851	Billed to MAC as a professional service or CAH Method II Billing.

* Don't double-dip; don't bill Part B for RHC services; don't pick & choose.

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Revenue, CPT® & HCPCS® Codes

Revenue Codes are 4-digit number (the leading zero is sometimes omitted) that indicates the place or type of service the patient received. When the revenue code is correlated to a CPT®/HCPCS®, the payer can determine the appropriateness of the service based on where it was provided.

CPT ®/HCPCS ® Codes are five characters in length and can be numeric or alphanumeric. Level I HCPCS codes are identical to the AMA CPT codes and are used to report professional and technical services. Level II HCPCS codes begin with a letter and are used to report supplies and other services. For example J codes for drugs or G codes for Medicare services. Category II CPT codes are used to report outcomes and data measure.

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Revenue Codes: Place of Service

Revenue Code	Description
0521	Clinic Visit by a member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at SNF
0525	Visit by a RHC practitioner to a member in a Part B SNF or Nursing Facility or other residential facility
0528	Visit by a RHC practitioner to other non RHC site (e.g., scene of accident)

For Medicare claims only.

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Revenue Codes for CPT/HCPCS® Billing

Revenue codes are used in institutional billing to reflect the place of service and to validate the service performed in that place of service.

All Revenue codes EXCEPT the following are allowed for RHC billing:

002X-024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X-072X, 080X-088X, 093X, 096X-310X

Some common allowed Revenue codes might include:

- 0250: Pharmacy (no J code)
- 0636: Drugs with J code
- 0300: Venipuncture
- 0420, 0430, 0440: PT/OT/ST
- 0780: Telemedicine originating site
- 0900: Behavioral Health

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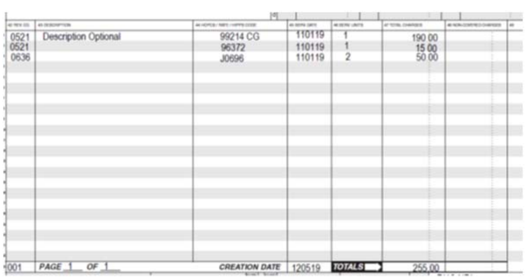
Revenue Codes are listed for each line item



0521	Description Optional	99214 CG	110119	1	190 00	
0521		96372	110119	1	15 00	
0636		J0696	110119	2	50 00	
001	PAGE 1 OF 1	CREATION DATE	120519	TOTALS	255.00	

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Medicare RHC Billing for Dates after April, 1, 2016

Beginning on April 1, 2016, RHCs were required to report the appropriate HCPCS code for each service line along with a revenue code on their Medicare claims. Prior to this, all services and charges were rolled up/bundled to one revenue code line.

Initially, the codes which could be reported had been underestimated by CMS. Consequently, CMS went back to the drawing board and identified a more complete Qualifying Visit List for RHC services.

Beginning October 1, 2016, RHCs were instructed to append the –CG modifier to the line which reported the CPT/HCPCS Code from the Qualifying Visit List.

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RHC Medicare Billing

- CPT/HCPCS® Level Codes are reported for ALL services that are provided.
- Revenue Codes are reported for each CPT/HCPCS® Code.
- ALL Charges are totaled and reported on the line with the ***qualifying visit code*** for that encounter. This is the "pay" line.
- The qualifying visit code/pay line is designated by the **CG modifier**. All charges are rolled up to this line item. This line is either the E & M code or the code which is most closely related to the chief complaint.
- All other line items must include a charge amount of ≥ $.0.01. The amount may be your actual charge or the penny amount.
- The total line (0001) will NOT equal the total for all charges. It will appear overstated. Coinsurance is calculated from the -CG line and not the total line.

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The –CG "Pay" Line

A RHC visit must include one of the services listed on the RHC Qualifying Visit List. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services.

RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the CMS RHC center webpage. The code appended with –CG should be the service most related to the reason for the visit.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf

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15 Minute Break

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RHC Claim Examples

Codes and Prices in Examples for demonstration purposes only and are not intended to suggest specific methodologies or clinical scenarios.

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RHC Encounter with E & M Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est Pt III	99213 CG	11/01/2017	1	100.00
0001	Total Charge				100.00

Provider performed an E & M service ($100.00) for a problem which required no lab, no ancillary or incidental services or other non-RHC services. The patient responsibility is $20 and the MAC will reimburse 80% of rate if the deductible has been met.

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RHC Encounter with In-Office Procedure Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	I & D Abscess	10160 CG	11/01/2017	1	150.00
0001	Total Charge				150.00

Provider performed a simple I & D ($150.00) during this encounter. No other services were provided. The supplies and local anesthesia would be integral to the procedure. The patient would be responsible for a $30 co-insurance payment.

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RHC Encounter with Multiple Services # 1

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/1/2017	1	250.00
0521	I & D Abscess	10160	11/1/2017	1	150.00
0001	Total Charge				400.00

Provider performed an E & M service ($100) and an in-office procedure ($150.00) during the same visit. The supplies and local anesthesia would be integral to the procedure. The patient would be responsible for a $50.00 co-insurance payment. The total 001 line appears overstated.

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RHC Encounter with Multiple Services # 1-Alternative Method

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2017	1	250.00
0521	I & D Abscess	10160	11/01/2017	1	.01
0001	Total Charge				250.01

Provider performed an E & M service ($100) and an in-office procedure ($150.00) during the same visit. The supplies and local anesthesia would be integral to the procedure. Additional service items are reported ≥ .01. The patient would be responsible for a $50.00 co-insurance payment. The total 001 line appears overstated. Using this method depends on your PM/EHR and your facility's method for tracking charges.

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RHC Billing Type Example

Mary presents to ABC Rural Health Clinic, with symptoms of a lower respiratory infection. The provider orders an in-house chest x-ray to confirm the diagnosis. During the ROS and exam, the provider also suspects that Mary may have a UTI. An in-house UA (one of the required RHC tests) is also performed. Mary also receives one unit of Rocephin IM.

*Red is provider-based RHC.

Service	Billed On	Provider #	Reimbursed
E & M Service for office visit (99214)	UB-04	RHC Number	Encounter Rate AIR
Rocephin (J0696)	UB-04	RHC Number	Encounter Rate AIR
Urinalysis	1500/ UB-04	Part B Group # if independent; Hospital # if provider-based	PFS, Lab Fee Schedule
X-ray (Technical Component Only)	1500/UB-04	Part B Group #; Hospital # if provider-based	PFS, OPPS or % of charges.

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RHC Encounter with Multiple Services #2

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2017	1	190.00
0521	Inj Admin	96372	11/01/2017	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2017	2	50.00
0001	Total Charge				255.00

Provider performed an E & M service ($125) and an abx injection ($15 + $50) during the same visit. Also, a UA and an x-ray were performed in the RHC. Total RHC services would be $190.00. The patient would be responsible for a $38.00 co-insurance payment. The total 001 line appears overstated. ***Lab and x-ray services would be billed separately under the appropriate method for the type of RHC.***

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RHC Encounter: Office Visit & EKG

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2017	1	145.00
0521	EKG- Prof	93010	11/01/2017	1	20.00
0001	Total Charge				165.00

Provider performed an E & M service ($125) and an EKG tracing/TC ($40) and interpretation/PC ($20) during the same visit. The RHC provider read the EKG. Total RHC services would be $145. The patient would be responsible for a $29.00 co-insurance payment. The total 001 line appears overstated. Additional service lines could be reported ≥ 0.01. ***The technical component of the EKG ($40) would be billed separately under the appropriate method for the type of RHC.***

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RHC Encounter: Mental Health Visit Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Psych Eval	90791 CG	11/01/2017	1	200.00
0001	Total Charge				200.00

Provider performed a Psychiatric Diagnostic Evaluation ($200) on the date of service. Total RHC services would be $200. The patient would be responsible for a $40.00 co-insurance payment.

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RHC Encounter: Medical Visit and Mental Health Visit on Same Date of Service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV New	99204 CG	11/01/2017	1	175.00
0900	Psych Eval	90791 CG	11/01/2017	1	200.00
0001	Total Charge				375.00

The physician performed an sick visit ($175) and the behavioral health provider performed a psych eval ($200) on the same date of service. Both services would be reported separately with the –CG modifier. Total RHC services would be $375.00. The patient would be responsible for a $40.00 co-insurance payment. Medication management for behavioral health if it were incidental-to the medical visit would not be a separately billable mental health visit.

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Modifier -59

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has an injury and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit code, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

This is an unconventional use of -59 and is only used in this way, unique to RHC billing of multiple visits on the same date of service.

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Multiple Encounters on Same Date of Service Different Problems

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est	99213 CG	11/01/2017	1	175.00
0521	Laceration	12001 59	11/01/2017	1	150.00
0001	Total Charge				325.00

The physician performed an E & M service in the morning to manage the patient's chronic conditions. Later in the afternoon, the patient cuts his hand while working in his garden. On the second visit of the day, the provider repairs the 2 cm laceration. The first service is appended with –CG. The second service is appended with -59. Total RHC services would be $325.00 The patient would be responsible for a $65 co-insurance payment. The RHC should receive two AIR payments.

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Wellness Visits

Medicare wellness visits and screening visits and Commercial wellness visits are not typically the same services. Make sure that providers understand the requirements for each service as defined by the payer. For example, the Medicare AWV is not a physical exam at all although it does require that the provider perform the service in the RHC. Medicare does not reimburse for routine services (i.e., annual physical or yearly check-up). However, most Medicare patients have chronic comorbidities which require ongoing, periodic management.

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Preventative Services Guide

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

This CMS reference give examples of preventative services and indicates when the AIR is received and how the deductible and coinsurance amounts are applied.

The –CG modifier is appended if the only service provided is the preventative service. The –CG modifier if not needed for the IPPE but may be added. Preventative services provided on the same day as a qualifying medical visit are reported but are not bundled into the –CG line.

IPPE is the ONLY preventive service which will qualify for an additional AIR on the same DOS as a sick visit.

Preventive services should be tracked for cost-reporting.

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RHC Encounter: IPPE Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2017	1	200.00
0001	Total Charge				200.00

The physician performed IPPE (Welcome to Medicare) service on this date of service. No –CG modifier is required. The patient has no cost share for this visit because the deductible and co-insurance is waived.

Is the IPPE the same as a beneficiary's yearly physical?
No. The IPPE is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

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RHC Encounter: IPPE and Sick Visit on same date of service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2017	1	150.00
0521	IPPE	G0402	11/01/2017	1	200.00
0001	Total Charge				350.00

The physician performed IPPE ($200) and an E & M ($150) for a problem visit on the same date of service. The office visit is listed first with the -CG modifier. The patient has no cost share for the IPPE service because the deductible and co-insurance is waived. The co-insurance amount due for the sick visit is $30.00. The RHC will receive two AIR payments for this visit.

You should track all preventive services for cost-reporting purposes.

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RHC Encounter: IPPE with EKG Interpretation/Report as Part of IPPE

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2017	1	200.00
0521	EKG IPPE Interpret/Report	G0405	11/01/2017	1	100.00
0001	Total Charge				300.00

The RHC physician performed IPPE ($200) and also interpreted the EKG ($100) performed as part of the IPPE. Only the HCPCS codes for the two services are reported on each respective line. The clinic will receive one AIR rate but the coinsurance and deductible will be waived per HCPCS code.

You should track all preventive services for cost-reporting purposes.

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EKG Billing in Rural Health Clinics

Code	Description	RHC UB-04	Independent RHC Part B	PBRHC Hospital side
93000	EKG, 12 Lead with interpretation/report	NO	NO	NO
93005	EKG, 12 lead, tracing only	NO	YES	YES
93010	EKG, 12 lead, interpretation and report only.	Maybe*	NO	Maybe*

* Depends on the provider who does the interpretation and the report.

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Medicare Annual Wellness Visit

- Is NOT a routine physical exam.
- Must include certain components
- Is payable as a stand-alone RHC visit when it is the only service performed; Must include face to face with provider.
- Is not payable as a separate service when performed on the same day of service as other medical or screening services.

Is the AWV the same as a beneficiary's yearly physical?
No. The AWV is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

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RHC Encounter: "Woman Well Visit" AWV and Other Screenings

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	AWV-Subsequent	G0439 CG	11/01/2017	1	150.00
0521	Breast/Pelvic	G0101	11/01/2017	1	100.00
0521	Pap Smear	Q0091	11/01/2017	1	50.00
0001	Total Charge				300.00

The patient received a subsequent AWV along with other preventive services on the same date of service. The –CG is appended to the AWV. There is no cost share for this visit.

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Care Management

RHC Care Management FAQ

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

RHC Care Management MLN
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf

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Example of CCM Billing

CCM Reported Alone

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	CCM	G0511	02/01/2018	1	75.00
0001	Total Charge				75.00

The –CG Modifier is NOT appended to G0511 because the service is paid under fee-for-service reimbursement. Deductibles and co-insurance apply. **The 2020 rate for G0511 is $66.77 The patient's coinsurance will be 20% of the allowable.**

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Example of CCM Billed with an Encounter

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213-CG	02/28/2018	1	100.00
0521	CCM	G0511	02/28/2018	1	75.00
0001	Total Charge				175.00

If CCM is billed with another RHC service, the charge for CCM is NOT added to the first line. The –CG modifier is only added on the first line. The clinic will receive the RHC all-inclusive rate for the office visit/encounter and the $66.77 for the CCM. The coinsurance will be $20.00 for the office visit and another $13.35 for the CCM (Total $33.35). It is important to explain to the patient the value of the CCM when enrolling them.

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Home Health Certifications and Care Plan Oversight

110.2 - Treatment Plans or Home Care Plans (Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Except for comprehensive care plans that are a component of authorized care management services (see section 230), treatment plans and home care oversight provided by RHC or FQHC physicians to RHC or FQHC patients are considered part of the RHC or FQHC visit and are not a separately billable service.

These services ***cannot*** be billed as Part B services as G0179, G0180, G0181 for example.

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Advanced Care Planning

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Sample-Billing.pdf

- As a standalone service, the AIR is paid.
- When provided on same date of service as AWV, the service is included in the one AIR payment.

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Advance Care Planning	99497 CG	11/01/2018	1	150.00
0001	Total Charge				150.00

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Hospice Patients

When providing RHC services to a Hospice Patient for an acute condition or injury not related to the hospice admitting diagnosis:

Use Condition Code 07

Use the diagnosis code which relates to the visit. Do not use the terminal illness as the diagnosis.

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Medicare Flu and Pneumococcal Shots

- RHCs do **NOT** bill Medicare for Flu or Pneumococcal Immunizations on claims.
- CPT codes for administration and for the vaccine are never included in the claim detail. Can be set up as zero charge/no bill for tracking.
- Charges for Flu and Pneumococcal Injections are not included in the total encounter charge.
- RHCs must keep a log with Patient's name, HIC, date of immunization, etc. Some EMR and PM systems will generate log; if not, must be manual.
- Medicare Advantage Plans/Medicare HMOs **are** billed for these immunizations. However, make sure your contracts have provisions for additional reimbursement. These immunizations are not included on the regular Medicare cost report.

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MEDICARE SECONDARY PAYER

- Rural Health Clinics must use the MSP Questionnaire just as any other Medicare provider to make sure that the encounter is not related to services for which another payer/third-party is responsible.
- Short forms, alternative forms, or electronic forms may be used to satisfy the requirement. **Some MACs are requiring the long questionnaire be completed every visit. MSP Questionnaires must be retained and are subject to audit.
- Report the appropriate condition code and occurrence code.
- To file MSP, must drop primary payer claim and wait 120 days before filing a conditional payment claim as MSP.

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WHEW! That was a lot of information…

Make sense or clear as mud?

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10 Minute Break

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COVID-19 Coding and Billing

- Distance Site Telehealth
- Diagnosis Coding
- Waivers
- -CS Modifier
- LAB
- COVID Counseling

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PHE Waiver Overview

- Staffing waivers for RHCs if NP or PA cannot be staffed 50% of time.
- Expansion Site Waivers: Allow alternate sites to be used for testing or to separate well/sick patients without additional certification.
- Temporary Closure of RHCs due to low volumes. Must reopen within 60 days of end of PHE.
- Distant Site Telehealth Services in RHC.
- Document and Notify State Agency or Accrediting Organization of major operational changes.

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Distance Site Telemedicine in RHC

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Telemedicine in RHCs

Prior to COVID, RHCs could only be the originating site for telehealth (hosting the patient in the clinic for another telehealth provider).

RHCs were statutorily prohibited from being distance site providers until Congress authorized HHS to allow RHCs to be distance site providers.

There are no restrictions on where the patient or the provider are located for telehealth during COVID.

Permanent changes will be required to authorize RHC distance site telehealth after the PHE is resolved.

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What services can be performed as Telehealth Services?

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

The list is quite extensive and can be downloaded as a zip file.

It includes Evaluation and Management services, other evaluation and therapeutic services, preventive services and other medical services.

All services are reported using G2025 and will reimburse a net amount of $92.03

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RHC Distant Site Telehealth Example Before July 1, 2020

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 CG 95	06/30/2020	1	100.00
0001	Total Charge				100.00

The RHC will temporarily receive the AIR and then the claim will be adjusted to pay $92.03. Coinsurance and deductible apply.

The claims are not adjusting as had been expected and this is being investigated.

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RHC Distant Site Telehealth Example After 7/1

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	08/15/2020	1	100.00
0001	Total Charge				100.00

The RHC will be reimbursed $92.03 for claims submitted after 7/1/2020. Coinsurance and deductible apply.

Coinsurance is being calculated at 20% of the charge which we think is an error.

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Challenges with Telehealth Billing

- Clinical Documentation
- All services are reported using G2025
- No way to report preventive services
- Services not posted to the patient's common working file
- How to track internally?
  - -95 Modifier
  - Report "real" CPT code and suppress on claim.

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What about billing COVID-19 Lab Testing?

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Does there need to be an order for COVID Testing?

The Interim Final Rule can be found here.

https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-09608.pdf

In part, it states this:

Given the critical importance of expanding COVID-19 testing to combat the pandemic and the heightened risk that the disease presents to Medicare beneficiaries, we are amending our regulation at § 410.32(a) to remove the requirement that certain diagnostic tests are covered only based on the order of a treating physician or NPP. Under this interim policy, during the COVID19 PHE, COVID-19 tests may be covered when ordered by any healthcare professional authorized to do so under state law. Additionally, because the symptoms for influenza and COVID-19 might present in the same way, during the COVID-19 PHE, we are also removing the same ordering requirements for a diagnostic laboratory test for influenza virus and respiratory syncytial virus, a type of common respiratory virus. CMS will make a list of diagnostic laboratory tests for which we are removing the ordering requirements publicly available.

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What about lab testing in the parking lot or other locations?

9. Can my facility perform COVID-19 testing in their parking lots or other areas outside of the laboratory?

A. As long as the facility has the appropriate CLIA certificates and follows applicable CLIA regulations, state regulations and guidelines, the laboratory may perform testing in the parking lot or any other designated overflow location in its facility.

https://www.cms.gov/files/document/clia-laboratory-covid-19-emergency-frequently-asked-questions.pdf

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Collection of the COVID Swab

HCPCS codes G2023 and G2024 are for specimen collection by an independent lab.

In the April rule, CMS notes that in the March rule they changed Medicare payment policies to allow for independent labs to be paid for specimen collection under certain circumstances. They were allowed a small payment for specimen collection during the public health emergency for collection and for associated travel. **These are not for use by medical practices.**

Collection of the swab is incident-to (not separately billable) the evaluation and management service which resulted in the order/collection. FFS can bill a 99211 but not RHCs.

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COVID Counseling

- You can report COVID Counseling at the time that lab is performed.
- The appropriate E & M Code is reported based on the time spent counseling the patient.
- CMS requires specific counseling components to be documented.
- "More than 50% of the time was spent on counseling"
- Most appropriate for use of counseling is when the patient presents only for COVID testing.
- If the testing results from a telehealth visit or a previous face-to-face, the swap collection is incident to the RHC encounter.

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CLIA WAIVED Point of Care Testing for COVID and QW Modifier

MLN 11765 : https://www.cms.gov/files/document/mm11765.pdf

This article informs you about the addition of the QW modifier to HCPCS code U0002 (2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC) and 87635 [Infectious agent detection by nucleic acid DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique]. Medicare will permit the use of codes
U0002QW and 87635QW for claims submitted by facilities with a valid, current CLIA certificate of waiver with dates of service on or after March 20, 2020. Make sure your billing staffs are aware of these changes.

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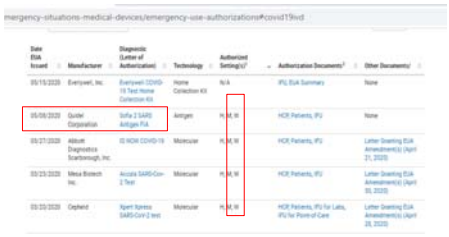

CLIA WAIVED COVID TESTS

"W" denotes that the kit is approved for clinics with Waived Certificates. All approved kits and equipment including those only approved for H-complex labs and M-moderately complex labs can be found at:

https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#covid19ivd

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ICD-10 Coding for COVID-19

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Positive COVID-19 Diagnosis

ICD-CM Code	Code Description	Assign when	Sequencing
U07.1	COVID-19	When there is a confirmed positive diagnosis documented by the provider. The patient may be symptomatic or asymptomatic. The provider must document that the patient has COVID-19. Do not use as a rule-out or suspected diagnosis.	First-listed Do not use a Z code above if the positive is confirmed; List any manifestations (respiratory infection, pneumonia or bronchitis for example) as secondary diagnoses.

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ICD-CM Code	Code Description	Assign when	Sequencing
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out	There is a concern about a possible exposure to COVID-19.	First-listed
Z20.828	Contact with and suspected exposure to other viral communicable diseases.	The person with an exposure or suspected exposure either tests negative or the test results are unknown.	First-listed
Z11.59	Encounter for screening for other viral diseases	When an asymptomatic patient is screened and either tests negative or the test results are unknown.	First-listed

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ICD-CM Code	Code Description	Assign when	Sequencing
O98.5x	Other viral diseases complicating pregnancy, childbirth, and the puerperium.	When a patient during pregnancy, childbirth or the puerperium presents with positive confirmation of COVID-19.	The O98.5 code is first listed followed by U07.1 for COVID-19 and then by any manifestation codes.
Other signs and symptoms: R05 Cough R06.02 Shortness of Breath R50.9 Fever	When a patient presents with respiratory symptoms but there is no definitive diagnosis (COVID or non-COVID).	First-listed when no screening or testing is performed; may be secondary to the testing Z codes for known or suspected exposure.	

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Optional Cost Share Waiving for Telehealth

Optional Waiving of Telehealth Co-Insurance

Under normal circumstances, providers cannot waive a Medicare patient's co-insurance amount for a service billed to the Medicare program. Discounts to Medicare patients are considered to be kickbacks because they offer Medicare services below the standard cost. However, during the Public Health Emergency, CMS is giving providers the flexibility to waive coinsurance for telehealth services. Providers are not required to waive the patient's cost share of coinsurance but can do so during COVID-19. If a provider chooses to waive the coinsurance, the provider does NOT receive the full allowable amount of reimbursement. The coinsurance amount is written off and the provider agrees to provide the service for a reduced 80% of the allowable reimbursement. Providers may want to create a new adjustment code for COVID write-offs of co-insurance.

The Office of the Inspector General has issued the following opinion concerning Telehealth and the Waiving of Co-insurance. Please read this document for more details on how to implement this option compliantly.

https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

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-CS Modifier

- Appended to the E & M code of a COVID-related services
- Not appended to technical components or lab
- To waive co-insurance when the patient seeks care out of a feared complaint about COVID or COVID signs and symptoms
- Clinical Documentation should support that the visit was related to COVID-19

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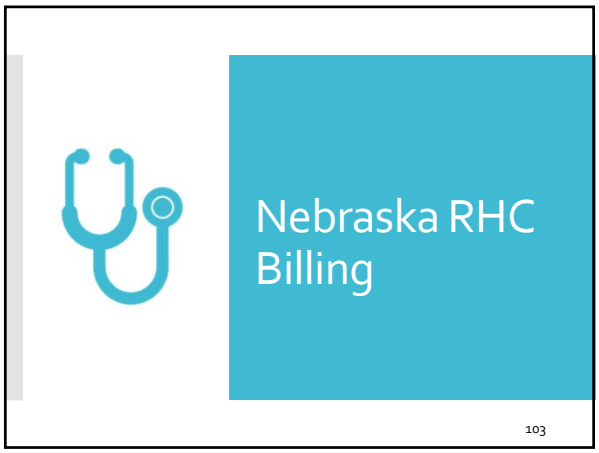

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Reimbursement Methodology

- RHC Rates adjusted annually.
- Cost report required but no settlement
- PBRHC < 50 beds receive 100% of charges
- PBRHC > 50 beds receive a PPS rate
- PBRHC claims split like Medicare claims with technical components billed as hospital OP services and with the exception that preventive services are non-RHC and are billed on 1500.
- Independent RHCs receive PPS for RHC services and split bill other services as Non-RHC.

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RHC Provider Number (UB-04)	Non-RHC Provider Number (1500)
Problem/Complaint/Ailment Visits	Preventive Services on 1500
1st OB Visit (Pregnancy Confirmed)	Non-RHC Professional Services: IP, OP, ED or OBS on 1500
	Non-Face to Face Visit with Injection; Requires administration code; J code and NDC
	VFC Injection Only; Billed with allowable charge and –SL modifier
	Global OB (except 1st visit); visits and delivery
	OB visits only w/o delivery
	Kindergarten and Jr. High physicals are covered as non-RHC; other sports physicals are not covered separately.

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Closing Remarks and Questions

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