A Crash Course in RHC Billing

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Agenda

Foundations of RHC Billing

- What is a RHC encounter?
- Bill Types, Revenue Codes, QVLs…oh my!
- Independent vs. Provider-Based RHC Billing

RHC Billing Examples

- How do I bill for RHC services?
- What if I have preventive services to bill?
- What about non-RHC services?

The More You Know…

- Multiple Services
- Coinsurance & Deductible
- Non-Covered Services

RHC Visit = RHC Encounter

"A RHC 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 services are rendered."

CMS Internet Only Manual 100-02, Chapter 13

What is *NOT* a RHC Encounter?

Visits only for medication refills

Visits only for lab results

Visits only for injections (i.e. allergy)

Suture removal or dressing change without an additional face-to-face visit

Visits billed using CPT code 99211 (nursing visit)

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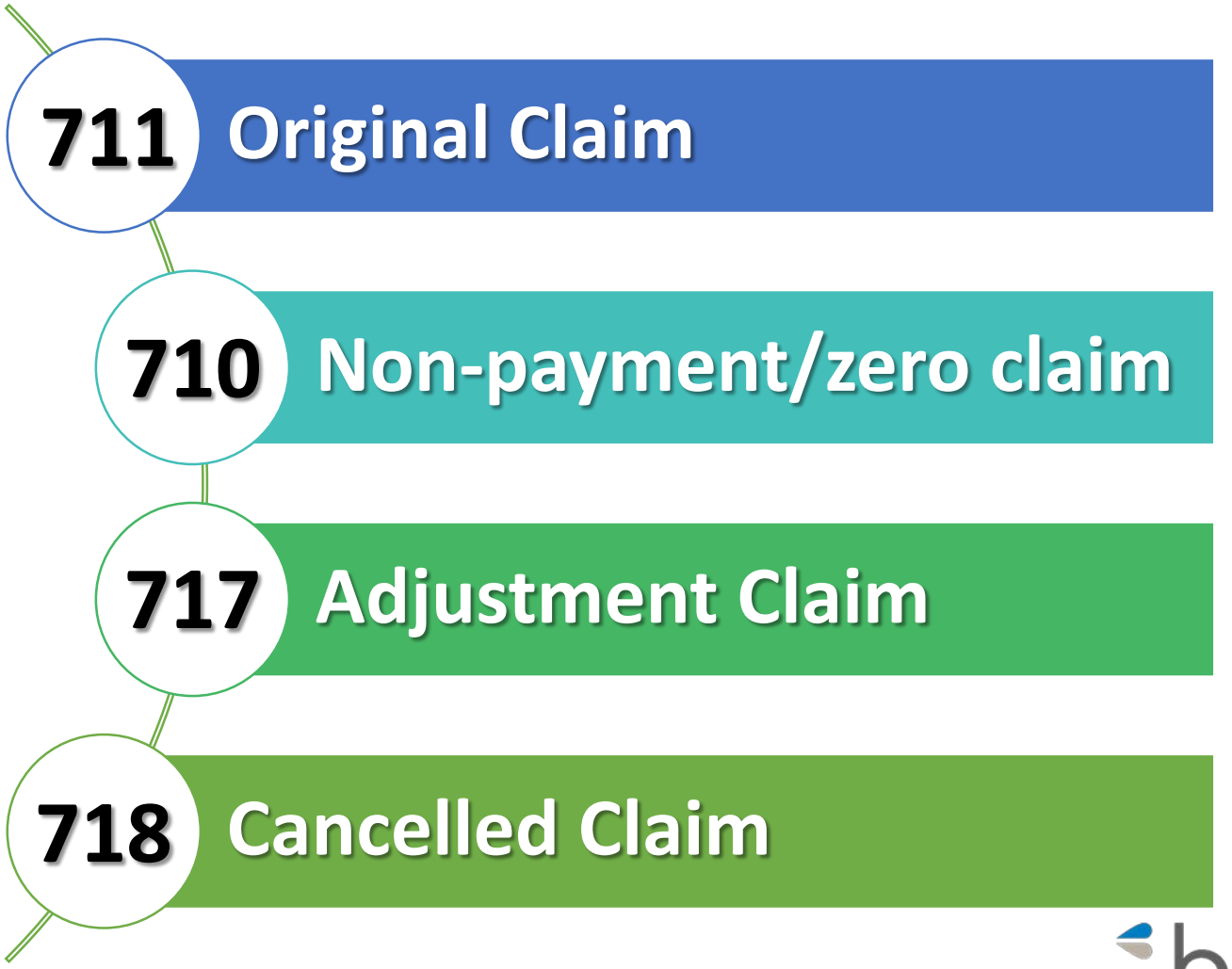
Claim Form & Bill Types

- RHC services are billed on a CMS-1450 (also known as a UB-04 form)
- The electronic form is the 837i
- These are the common bill types (TOBs) used on RHC claims:



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Revenue Codes

0521	Clinic visit by a member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to member in a covered Part A stay at a SNF
0525	Visit by RHC practitioner to member in a non-Part A SNF, NF, ICF, or other residential facility
0527	RHC visiting nursing services to a member's home in a Home Health Shortage Area
0528	Visit by RHC practitioner to another non-RHC site (i.e. scene of an accident)
0900	Mental health visit

Other Common Revenue Codes in RHCs

0250	Pharmacy – drug with no J-code
0300	Venipuncture
0636	Drugs with detailed HCPCS J-code
0780	Telemedicine originating site

RHC Claim Details

- RHCs are required to line-item, detail code for all services provided during the RHC visit
  - Include HCPCS codes for all services performed during that visit
- Every RHC claim must have a Qualifying Visit Line identifying the primary reason for the patient encounter
  - Modifier CG should be attached to identify the qualifying visit
  - Modifier CG signals to Medicare which line to use when calculating applicable coinsurance and deductible

RHC Claim Details

- Charges for all services provided during the visit should be “rolled up” to the qualifying visit line/CG modifier line
  - The exception to this rule is for charges for qualifying preventive health services
    - These are paid at 100% of the AIR by Medicare
    - Coinsurance and deductible are waived
- Total Charges for the entire claim are reported on line 0001
- Actual payment from Medicare is 80% of your AIR, less 2% sequestration (when in effect, currently suspended during the PHE)
  - Exception for qualifying preventive services – paid at 100% of AIR

Qualifying Visit List (QVL)

- Last updated **August 1st, 2016**

QVL consists of "frequently reported HCPCS codes that qualify as a face-to-face visit between the patient and an RHC practitioner…"

"…NOT an all-inclusive list of stand-alone billable visits for RHCs."

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

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Independent vs. Provider Based RHC Billing

	Encounter for RHC Service(s)	CLIA Lab in RHC	Technical Component (Non-RHC Service)
Independent RHC	Bill to Part A on UB-04	Bill to Part B on CMS-1500; Use RHCs ID numbers for billing	Bill to Part B on CMS-1500; Use RHCs ID numbers for billing
Provider-Based RHC	Bill to Part A on UB-04	Billed to MAC by Parent Entity PPS Hospital: TOB 141/ 131 CAH: TOB 851	Billed to MAC by Parent Entity PPS Hospital: TOB 131 CAH: TOB 851

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Claim Example #1

RHC Encounter – E/M Office Visit Only

- Scenario: RHC Provider completed a level-3 E/M office visit. Charge for the visit is $100.00. No additional work (incident-to or non-RHC services) were required.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	05/25/2021	1	$100.00
0001	Total Charge				$100.00

Claim Example #2

RHC Encounter – Procedure Only

- Scenario: RHC Provider completed a simple I&D in the office. Charge for the visit is $150.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	I&D Abscess	10160 CG	5/25/2021	1	$150.00
0001	Total Charge				$150.00

Claim Example #3a

RHC Encounter – E/M Office Visit and Procedure

- Scenario: RHC Provider completed a level-3 E/M office visit and a simple I&D in the office. Charge for the E/M visit is $100.00 and for the procedure is $150.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	5/25/2021	1	$250.00
0521	I&D Abscess	10160	5/25/2021	1	$150.00
0001	Total Charge				$400.00

Claim Example #3b

RHC Encounter – E/M Office Visit and Procedure

- Scenario: RHC Provider completed a level-3 E/M office visit and a simple I&D in the office. Charge for the E/M visit is $100.00 and for the procedure is $150.00. Additional charges are reported with $0.01

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	5/25/2021	1	$250.01
0521	I&D Abscess	10160	5/25/2021	1	$0.01
0001	Total Charge				$250.02

Claim Example #4

RHC Encounter – E/M Office Visit and Injection

- Scenario: RHC Provider completed a level-4 E/M office visit and a gave the patient a Rocephin injection. Charge for the E/M visit is $150.00, for the administration is $12.00 and for the drug is $45.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	5/25/2021	1	$207.00
0521	Inj Admin	96372	5/25/2021	1	$12.00
0636	Rocephin, 250 mg	J0696	5/25/2021	1	$45.00
0001	Total Charge				$264.00

Preventive Health Services

- When billing for preventive health services, DO NOT include charges for those services in the “roll up” to the qualifying visit line
- Medicare pays for qualifying preventive health services at 100%
- Coinsurance and deductible do not apply for qualifying preventive health services.
- **Resource:** United States Preventive Services Task Force (Grade A or B)
- **Resource:** Rural Health Clinic Preventive Services Chart https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

Claim Example #5

RHC Encounter – E/M Office Visit and Preventive

- Scenario: RHC Provider completed a level-4 E/M office visit. While in the office, the provider completed the patient's IPPE. Charge for the E/M visit is $150.00, and for the IPPE is $195.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	5/25/2021	1	$150.00
0521	IPPE	G0402	5/25/2021	1	$195.00
0001	Total Charge				$345.00

Note: Will receive 2 AIR payments for medical + IPPE on the same day.

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Non-RHC Services

- RHCs may ***"furnish certain services that are beyond the scope of the RHC benefit".*** These are considered "Non-RHC Services"
- Non-RHC services are billed separately to the appropriate MAC under the payment rules specific to that service.
  - Independent RHCs bill Part B using RHC ID numbers
  - Provider-Based RHCs bill Part B under the parent hospital ID numbers
- All costs associated with non-RHC services (i.e. space, equipment, supplies, facility, overhead, personnel) should be removed from the cost report.

Claim Example #6

RHC Encounter – E/M Office Visit and EKG

- Scenario: RHC Provider completed a level-3 E/M office visit. While in the office, the provider also did an EKG. Charge for the E/M visit is $100.00, and for the professional fee for the EKG is $25.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	5/25/2021	1	$125.00
0521	EKG, interpretation and report	93010	5/25/2021	1	$25.00
0001	Total Charge				$150.00

Note: EKG interpretation and report only included when completed by RHC provider.

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Claim Example #6

RHC Encounter – E/M Office Visit and EKG

- In this scenario, the technical component of the EKG (a non-RHC service) is billed differently depending on whether the RHC is independent or provider-based:

Independent RHC	RHC will bill HCPCS code 93005 (EKG, tracing only) to Part B on CMS-1500. Fee schedule payment.
Provider-Based RHC	Parent entity will bill HCPCS code 93005 (EKG, tracing only) to MAC. Fee schedule payment (unless CAH – then payment at cost).

Claim Example #7

RHC Encounter – Mental Health Visit Only

- Scenario: RHC Provider completed psychiatric diagnostic evaluation with a patient. Charge for the visit is $200.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psychiatric diagnostic evaluation	90791 CG	5/25/2021	1	$200.00
0001	Total Charge				$200.00

Multiple Visits on the Same Day

- In general, encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day count as a single RHC visit and will only receive one AIR payment.
- "This applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit."
  - **Resource:** CMS IOM 100-02, Chapter 13, Section 40.3
- However, there are a few ***specific*** exceptions…

Multiple Visits on the Same Day – Exceptions

- Exceptions are for the following circumstances ***only***:

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. In this situation only, the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits.

The patient has a qualified medical visit and a qualified mental health visit on the same day (2 billable visits).

The patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits).

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Claim Example #8

RHC Encounter – Medical Visit & Subsequent Visit, Same Day

- Scenario: RHC Provider completed a level-4 office visit with a patient who has diabetes. Later in the day the patient fell and came back to the RHC to be seen. Charge for the first medical visit is $150.00 and for the subsequent visit is $100.00

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	5/25/2021	1	$150.00
0521	Office Visit – Established Pt III	99213 CG 25	5/25/2021	1	100.00
0001	Total Charge				$250.00

Claim Example #9

RHC Encounter – Medical Visit & Mental Health Visit, Same Day

- Scenario: RHC Provider completed a level-3 office visit with a patient and a mental health provider in the same office completed a psychiatric diagnostic evaluation on the same day. Charge for the medical visit is $100.00 and for the mental health visit is $200.00

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	5/25/2021	1	$100.00
0900	Psych eval	90791 CG	5/25/2021	1	$200.00
0001	Total Charge				$300.00

Claim Example #10

RHC Encounter – IPPE, Medical Visit, & Mental Health Visit, Same Day

- Scenario: RHC Provider completed a patient's IPPE. While they were in the office, they were seen for their hypertension. The patient also saw a mental health provider who had a 30 minute psychotherapy session. Charge for IPPE is $195.00, for the medical visit is $150.00, and for the mental health visit is $220.00.

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	5/25/2021	1	$150.00
0521	IPPE	G0402	5/25/2021	1	$195.00
0900	Psychotherapy, 30 m	90832 CG	5/25/2021	1	$220.00
0001	Total Charge				$565.00

Coinsurance & Deductible

- Coinsurance is equal to 20% of the ***total charges*** submitted on the RHC claim.
  - It is ***not*** the Medicare allowable amount
  - Calculated from the qualifying visit line, as identified by the CG modifier
- Coinsurance and deductible are waived for qualified preventive health services
- The Part B deductible is applied to RHC services. Patients who only have Medicare Part A coverage are not covered.

Coinsurance Calculation – Example #1

RHC Encounter – E/M Office Visit Only

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	5/25/2021	1	$100.00
0001	Total Charge				$100.00

- **Coinsurance = 20% of $100.00**
- **Coinsurance is $20.00**

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Coinsurance Calculation – Example #2

RHC Encounter – E/M Office Visit and Procedure

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt III	99213 CG	5/25/2021	1	$250.00
0521	I&D Abscess	10160	5/25/2021	1	$150.00
0001	Total Charge				$400.00

- **Coinsurance = 20% of $250.00**
- **Coinsurance is $50.00**

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Coinsurance Calculation – Example #3

RHC Encounter – E/M Office Visit and Preventive

FL42 Rev Code	FL43 Description	FL44 HCPCS Code	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit – Established Pt IV	99214 CG	5/25/2021	1	$150.00
0521	IPPE	G0402	5/25/2021	1	$195.00
0001	Total Charge				$345.00

- **Coinsurance = 20% of $150.00**
- **Coinsurance is $30.00**
- Coinsurance is *waived* for the IPPE.

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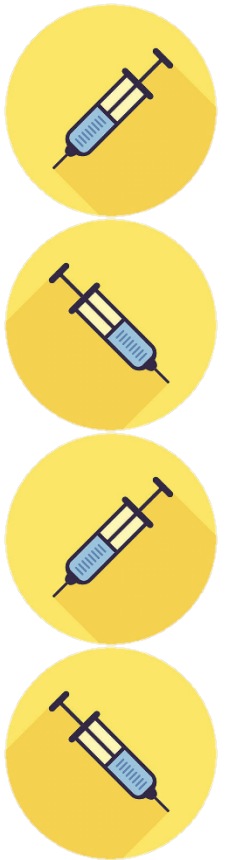
Influenza & Pneumococcal Vaccines

- RHCs are reimbursed for flu and pneumococcal vaccines, and their administration, through the cost report.
- DO NOT report flu and pneumococcal vaccines, nor their administration on the RHC claim.
- You should have a mechanism in place for tracking vaccines (all payers) and their administration in order to accurately reconcile these on your cost report.
  - Keep a log with patient's name, DOB, insurance information, date of immunization, at a minimum.



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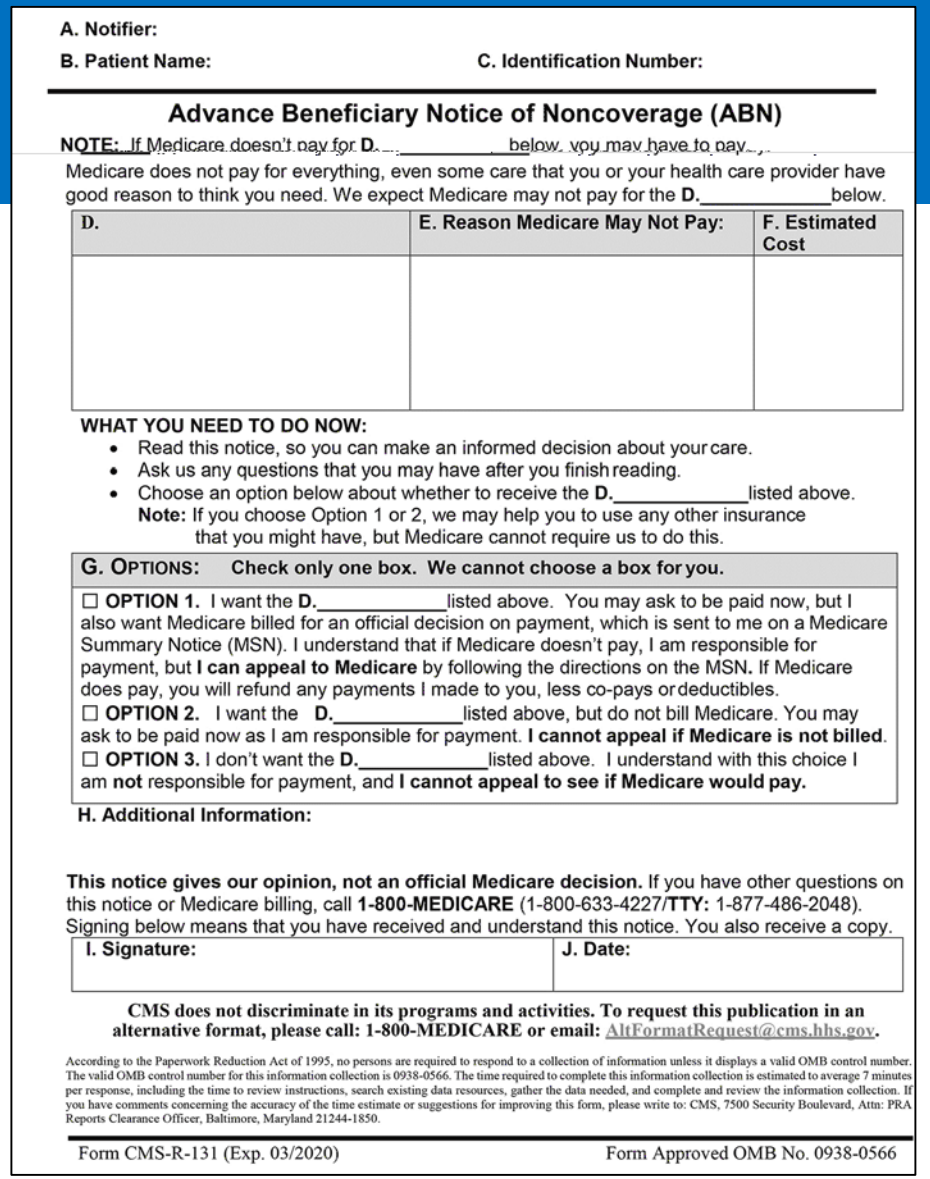
Non-Covered Services

- Non covered services are not considered medically-necessary, therefore not covered by the RHC benefit, nor any Medicare benefit
- The RHC should complete an Advance Beneficiary Notice of Non-Coverage (ABN) for all non covered services.
- Submit these charges using TOB 710
- Payment for charges associated with non covered services is the responsibility of the patient.



A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay ...

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

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Care Management Services: G0511

- RHC/FQHC-specific G-codes:
  - G0511 – Chronic Care Management (CCM) or General Behavioral Health Integration (General BHI)
    - Requires 20+ minutes of time per month
    - Can bill for the initiating visit separately as E/M, AWV, IPPE
    - Payment is based on the national PFS payment for applicable codes ($65.25 in 2021)
    - Payment is per member, per month
    - Can be included on the claim with other RHC services, or separately
    - Only one provider may bill these services
    - Patient must consent to these services
    - Other requirements: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Care Management Services: G0512

- RHC/FQHC-specific G-codes:
  - G0512 – Psychiatric Collaborative Care Model (CoCM)
    - Requires 70+ minutes the first month, and 60+ minutes in any subsequent month
    - Can bill for the initiating visit separately as E/M, AWV, IPPE
    - Payment is based on the national PFS payment for applicable codes ($154.23 in 2021)
    - Payment is per member, per month
    - Can be included on the claim with other RHC services, or separately
    - Only one provider may bill these services
    - Patient must consent to these services
    - Other requirements: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Principal Care Management Services

- Effective January 1, 2021 – RHCs may bill for Principal Care Management (PCM) services using G0511
- Principal Care Management is for those patients with only **1** chronic condition being managed by the RHC provider
- All requirements for G0511 still apply
- Payment is based on the payment rules for G0511 ($65.25 for 2021)

RHC as Distant Site for Telehealth

- **During the COVID public health emergency** CMS has allowed for several telehealth flexibilities for RHCs
- During the PHE, RHCs are authorized to serve as the distant site
  - Distant site = location of the provider during the encounter
  - Both patient and provider can be in any location (including their home) during the encounter
    - Must be during RHC hours
- The distant site service only qualifies for reimbursement if it is on the CMS list of approved telehealth services: https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip

RHC as Distant Site for Telehealth

- Qualifying RHC distant site services should be billed using the RHC-specific G-code G2025
  - For dates of service from 1/27/2020 – 6/30/2020:
    - Bill using G2025 with modifier CG and optional modifier 95
  - For dates of service on or after 7/1/2020:
    - Bill using G2025 and optional modifier 95 (CG modifier no longer required)
- Payment rates for G2025 are as follows:
  - DOS 2020: $92.03
  - DOS 2021: $99.45
- Keep up to date on RHC telehealth flexibilities here: https://www.cms.gov/files/document/se20016.pdf

Helpful Resources

- CMS Benefit Policy 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
- CMS Rural Health Clinic Center: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center

Questions?

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