SESSION 1: 2022 RHC CODING AND BILLING UPDATE

Nebraska Rural Health Clinic Workshop

May 25, 2022

inQuiseek Consulting

LEARNING OBJECTIVES FOR THIS SESSION

The following topics will be discussed:

- Review of RHC Medicare Basic Billing Concepts
- Medicare Billing Update from the MPFS 2022 Final Rule
- Nebraska Medicaid Highlights

UNDERSTANDING RHC REIMBURSEMENT

- Rural Health Clinics follow a cost-based reimbursement under Medicare and Medicaid.
- RHCs are reimbursed an all-inclusive rate (AIR) for encounters between a qualified provider and a patient.
- An encounter has a specific definition.
- The AIR reimburses for professional services and incident-to services of a qualified provider. All RHC core services reimburse the AIR regardless of the provider credential.
- Under Medicare, lab services and other technical services are reimbursed separately since they are not RHC core services.
- Straight commercial payers do not recognize RHC status concerning reimbursement. These plans will contract with the RHC as a fee for service group.

MEDICARE ALL-INCLUSIVE RATE

- The all-inclusive rate is calculated each year on the RHC cost report.
- The total allowable cost of providing care is divided by the number of qualifying RHC encounters to determine the AIR.
- Provider-based RHC are grandfathered in at an upper payment limit based on their 2020 cost report. The rates going forward are the lesser of the actual cost per visit or the grandfathered rate.

AIR calculation

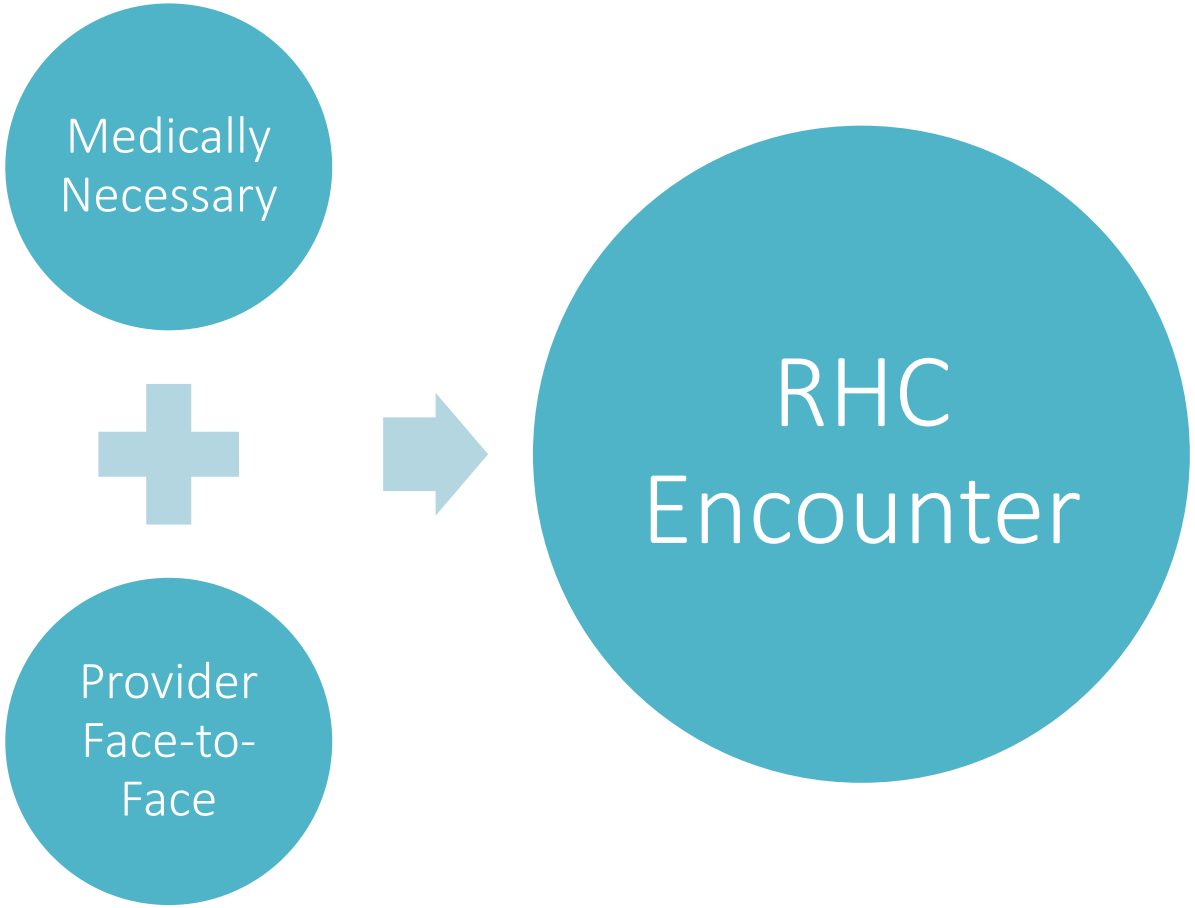
$$\frac{\text{Total Allowable RHC expenses}}{\text{Total Visits Meeting the RHC encounter definition}} = \text{AIR (RHC Encounter Rate) Subject to Upper Payment Limits}$$

What is an Encounter?

40 - RHC and FQHC Visits

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits.


Medically Necessary
Provider Face-to-Face
RHC Encounter

Qualifying Visit List

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

- 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 exclusive list. However, most MACs have written their claims processing rules based on the QVL.
- CMS can update this list quarterly through OCE edits, but the document itself has not been updated since October 2016.

Rural Health Clinic Qualifying Visit List (RHC QVL)

(8-01-16)

The RHC QVL is intended as guidance for RHCs beginning to report HCPCS codes. It consists of frequently reported Healthcare Common Procedure Coding System (HCPCS) codes that qualify as a face-to-face visit between the patient and an RHC practitioner and it is not an all-inclusive list of stand-alone billable visits for RHCs. More information on what is considered a RHC visit is included in the "RHC Visits" section of this guidance.

Medical Services	
HCPCS Code	**Short Descriptor**
10081[1]	*Drainage of pilonidal cyst*
10120[1]	*Remove foreign body*
10121[1]	*Remove foreign body*
10140[1]	*Drainage of hematoma/fluid*
10160[1]	*Puncture drainage of lesion*
11000[1]	*Debride infected skin*
11010[1]	*Debride skin at fx site*
11011[1]	*Debride skin musc at fx site*
11042[1]	*Deb subq tissue 20 sq cm/<*
11055[1]	*Trim skin lesion*
11056[1]	*Trim skin lesions 2 to 4*
11057[1]	*Trim skin lesions over 4*
11100[1]	*Biopsy skin lesion*
11200[1]	*Removal of skin tags <w/15*
11300[1]	*Shave skin lesion 0.5 cm/<*

Evaluation & Management Services

99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq

Approved Preventive Health Services	
HCPCS Code	**Short Descriptor**
99406[4]	*Behav chng smoking 3-10 min*
99407[4]	*Behav chng smoking > 10 min*
G0101	Ca screen; pelvic/breast exam
G0102[5]	Prostate ca screening; dre
G0117[5]	Glaucoma scrn hgh risk direc
G0118[5]	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

Incident-to Services

Incident-to services are defined as services which are performed but to not meet the RHC Encounter definition. “Incident-to” in this example is not used to describe NP or PA services which are billed incident to a physician service. These examples are subsequent services which occur outside of an encounter Examples of Incident-to services include:

- Injection Only Visits
- Bandage Changes
- Blood pressure checks
- Suture removal
- Any “Nurse” visit that doesn’t require the skill of a provider. No 99211s billable to Medicare/Medicaid. However, these are covered services.

These services are either held and reported on the next encounter claim within 30 days or may be adjusted off. There is no separate reimbursement for the services as far as filing a claim. The costs of providing the services are included in total costs for the cost reporting calculations.

WHERE CAN A MEDICARE RHC ENCOUNTER TAKE PLACE?

Location	Revenue Code	Comments
Within the RHC Certified Space	521	Most common type of encounter
In the patient's home	522	Must be a qualified RHC provider unless in a designated home health shortage area.
In a Part A skilled nursing facility or swingbed	524	Documentation must also be in RHC medical record
In a Part B nursing facility, assisted living or other residential setting	525	Documentation must be in the RHC medical record and must include a treatment consent.
Other location (scene of an accident)	528	Qualified RHC provider provides a face-to-face encounter when responding to an accident.

Exceptions to Face-to-Face Encounter

- Care Management and Care Coordination Services (G0511)
  - CCM or PCM
  - BHI
  - Psychiatric CoCM
- Virtual Communication Services (G0071)
- Distant Site Medical Telemedicine during the COVID-19 Public Health Emergency (G2025)
- These services are not reimbursed at the AIR. They are reimbursed at a composite FFS amount with RHC specific HCPCS Codes.

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.
- $233.00 for 2022
- 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.

§405.2410 Application of Part B deductible and coinsurance.

(a) Application of deductible. (1) Medicare payment for RHC services begins only after the beneficiary has incurred the deductible. (Note: Negative Remit Issue)

(b) Application of coinsurance. Except for preventive services for which Medicare pays 100 percent under §410.152(l) of this chapter, a beneficiary's responsibility is either of the following:

(1) For RHCs that are authorized to bill on the basis of the reasonable cost system—

(I) A coinsurance amount that does not exceed **20 percent** of the RHC's reasonable customary charge for the covered service; and

(ii)(A) The beneficiary's deductible and coinsurance amount for any one item or service furnished by the RHC may not exceed a reasonable amount customarily charged by the RHC for that particular item or service;

https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=00be946f47b166173d900f43acd59949&h=L&n=sp42.2.405.x&r=SUBPART&ty=HTML#se42.2.405_12401

These Immunizations are reported on the Cost Report and are not billed on a MEDICARE claim

- Flu Immunizations
- Pneumococcal Immunizations

- COVID-19 Immunizations and Monoclonal Antibody Infusions for traditional Medicare. Medicare Advantage billed directly.

Cost of Private Stock Vaccines
Nursing Time per Immunization
Total number of Immunizations
Total number of Medicare shots
Logs of Vaccines Given

- Not dropped on claim at all.
- Not billed to patient
- Not billed to secondary

Credit Balance Reporting

CMS Form 838 is Due Quarterly to the MAC

Reports Amounts Overpaid by Medicare

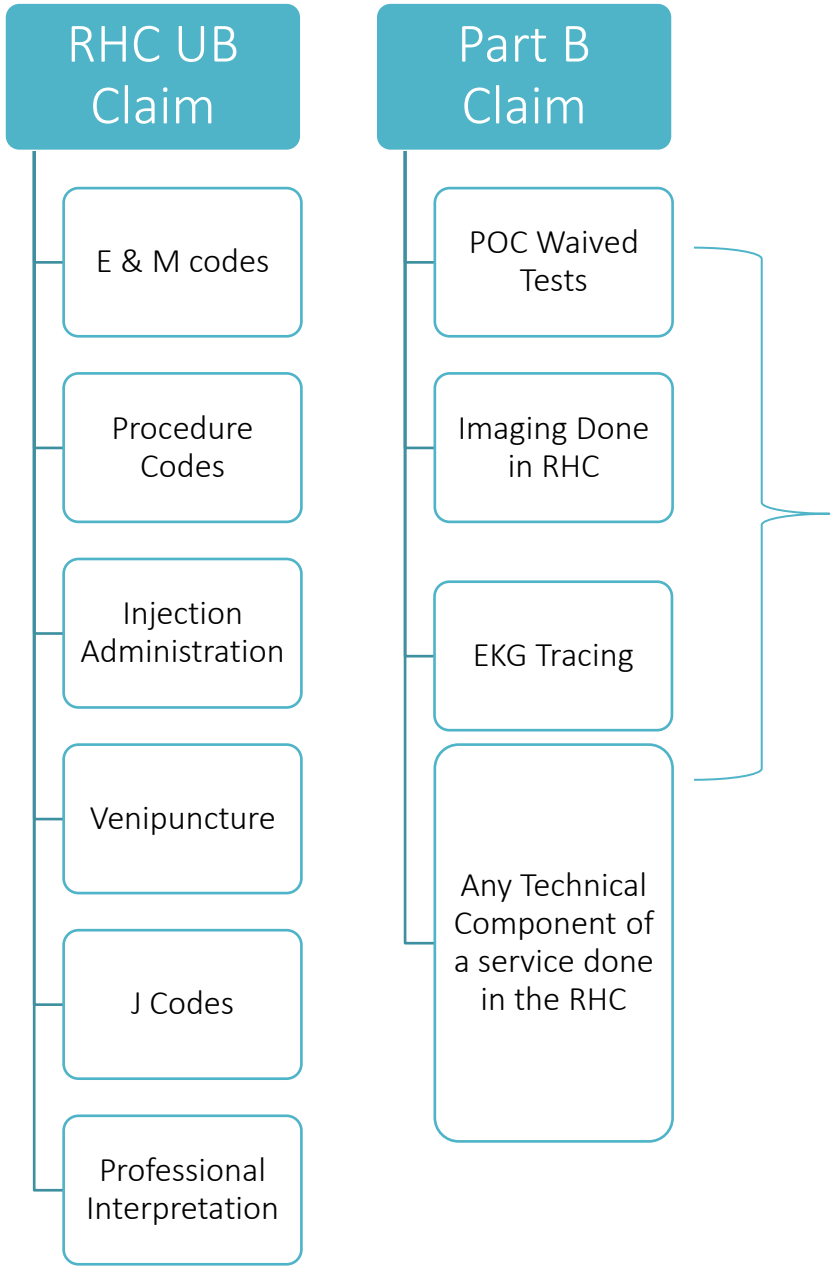
Does not necessarily include all patient credit balances

Reimbursement held if credit balance report is late

https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms838.pdf

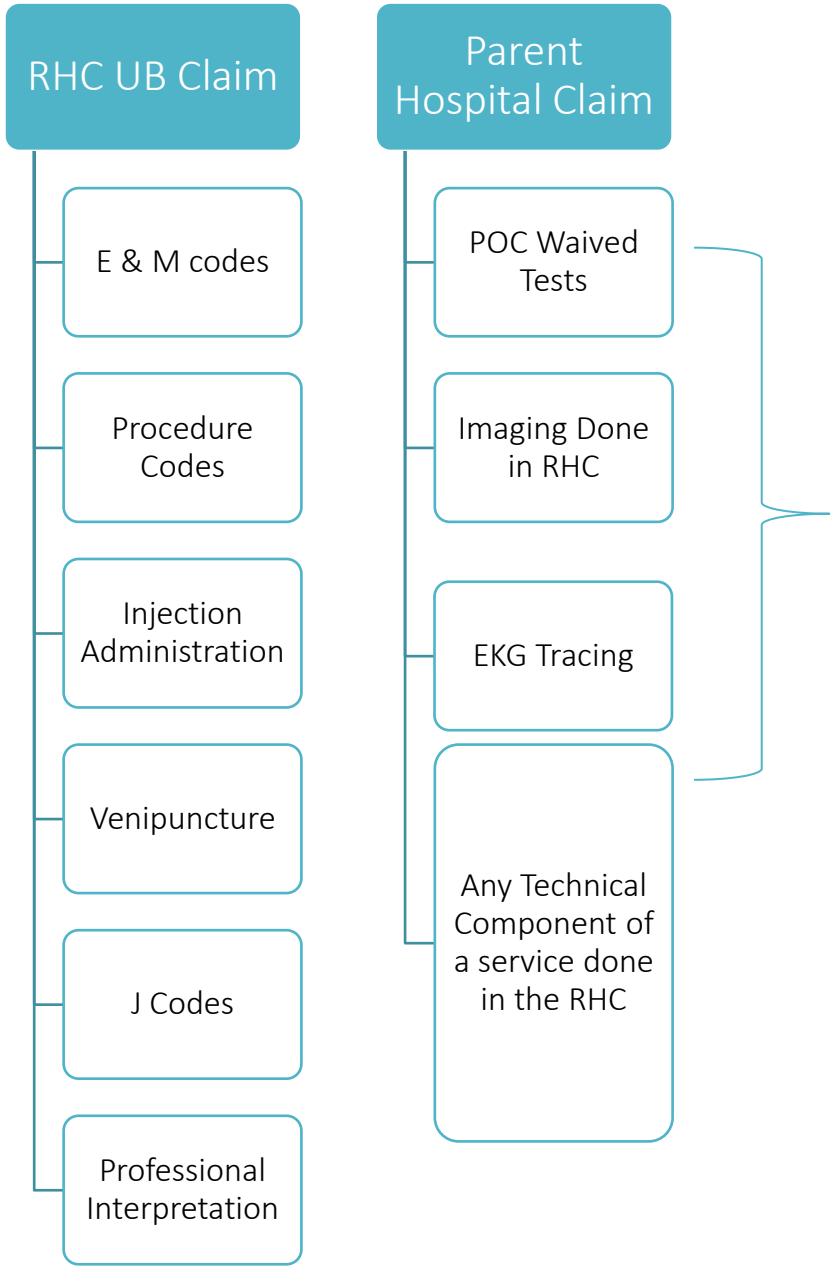
Medicare Split Billing

Medicare Split Billing Independent RHC



- You should not bill professional procedures to Part B for increased reimbursement.
- You should NOT have a separate “treatment” room in your RHC.
- Do not include the six required tests on the RHC UB Medicare Claim.

Medicare Split Billing PBRHC



Caution: Only One Hospital OP Claim per date of Service per patient.

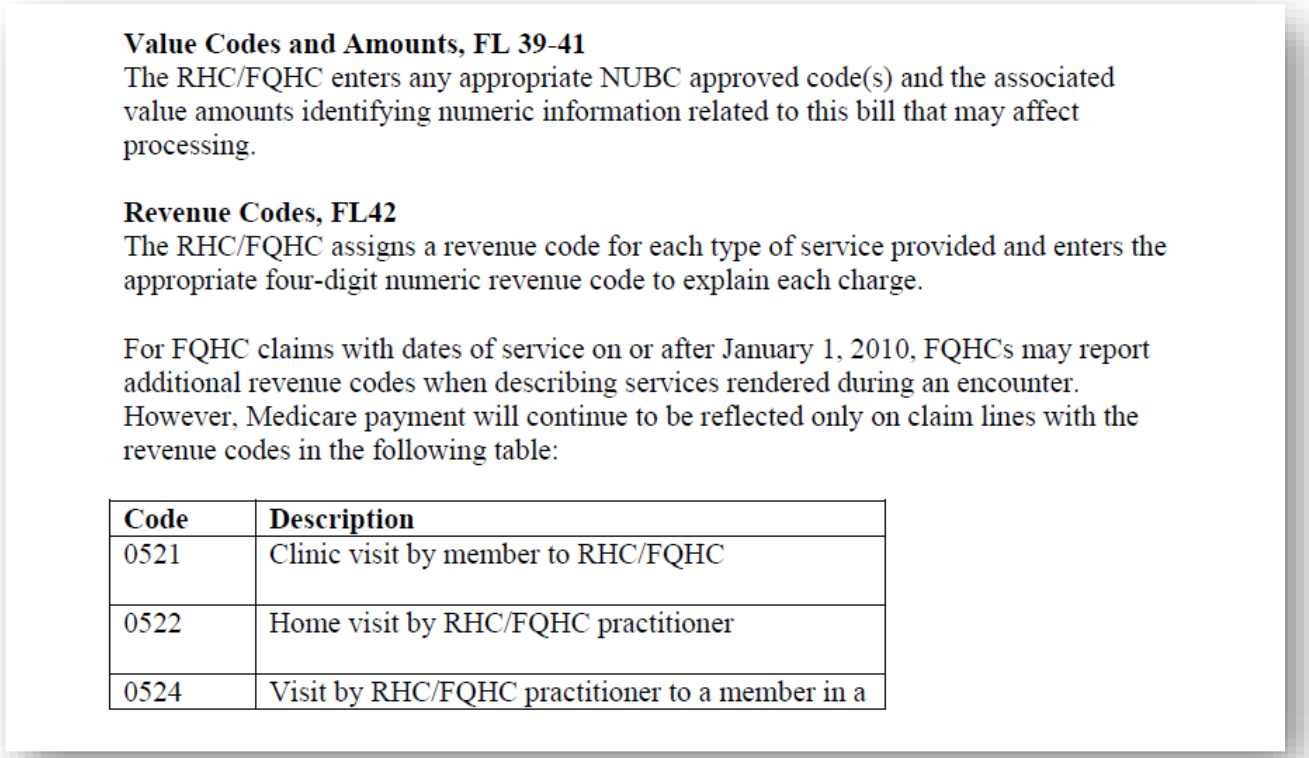
Type of RHC	Encounter Professional Services RHC Service	CLIA Lab Performed in RHC	Other Technical Components Performed in RHC- EKG, X-ray, Imaging	Professional Services Outside RHC Hours- Hospital Services
Provider-Based	Part A UB-04 Using the RHC NPI And Parent Entity EIN	Billed to MAC by Parent hospital 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.
Independent	Part A UB-04 Using RHC NPI and RHC EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B Professional Group PTAN to which the provider is linked.

RHC UB-04 CLAIMS

RHC UB-04 By FL

CMS Claims Processing Manual, Chapter 9
50 - General Requirements for RHC and FQHC Claims

https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/clm104c09.pdf



Value Codes and Amounts, FL 39-41
The RHC/FQHC enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing.

Revenue Codes, FL42
The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge.

For FQHC claims with dates of service on or after January 1, 2010, FQHCs may report additional revenue codes when describing services rendered during an encounter. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in the following table:

Code	Description
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a

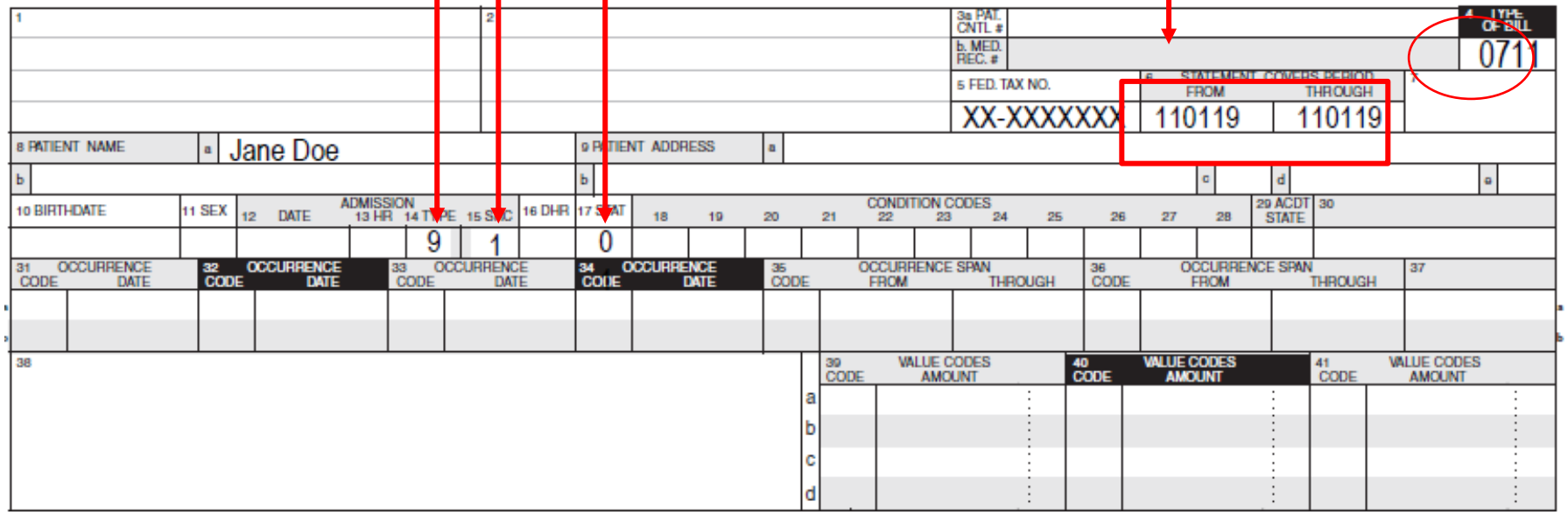
FL 14 =Admission Type

FL 15 =Source

FL 17 = DC Status

Cannot Span Dates

FL 4 = Bill Type



Revenue Codes by Encounter Location or Type of Service:

Use one of these rev code with the CPT code from the QVL list.

This will be the line with the –CG modifier.

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.

Revenue Codes for CPT/HCPCS ® Billing for subsequent line items

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 (not an encounter, no separate reimbursement.)
- 0780: Telemedicine originating site
- 0900: Behavioral Health

Revenue Codes and CPT/HCPCS codes are listed for each line item.
The –CG Modifier is appended to the QVL code.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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		

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.

The –CG Modifier

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

RHC Claim Examples

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

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	11/01/2021	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.

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	11/01/2021	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.

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	11/1/2021	1	250.00
0521	I & D Abscess	10160	11/1/2021	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.

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	11/01/2021	1	250.00
0521	I & D Abscess	10160	11/01/2021	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.

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.

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	11/01/2021	1	190.00
0521	Inj Admin	96372	11/01/2021	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2021	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.***

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	11/01/2021	1	145.00
0521	EKG- Prof	93010	11/01/2021	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.***

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	11/01/2021	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.

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	11/01/2021	1	175.00
0900	Psych Eval	90791 CG	11/01/2021	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 $75.00 coinsurance.

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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.

A -25 appended to the E & M code can also result in an overpayment.

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	11/01/2021	1	175.00
0521	Laceration	12001 59	11/01/2021	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.

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.

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	11/01/2021	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

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	11/01/2021	1	150.00
0521	IPPE	G0402	11/01/2021	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.

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	11/01/2021	1	200.00
0521	EKG IPPE Interpret/Report	G0405	11/01/2021	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.

EKGs 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.

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	11/01/2021	1	150.00
0521	Breast/Pelvic	G0101	11/01/2021	1	100.00
0521	Pap Smear	Q0091	11/01/2021	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. When performed alone, the AWV and the Breast/Pelvic Screening both reimburse at the AIR.

Care Management

Beginning in 2021, RHC can now perform Principal Care Management which means the patient has only 1 condition which is managed. G0511 is used for both reporting CCM and PCM. RPM is NOT separately billable by RHCs and is considered incident-to care management. Reimbursement for G0511 in 2022 is $79.25 There is a 20% coinsurance amount or roughly $16.00.

Change in 2022:
TCM and CCM can be performed within the same 30-day period. Documentation should support both services.

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

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	02/01/2021	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 2022 rate for G0511 is $79.25 The patient's coinsurance will be 20% of the allowable.**

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	02/28/2021	1	100.00
0521	CCM	G0511	02/28/2021	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.

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.

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	11/01/2021	1	150.00
0001	Total Charge				150.00

Medicare Flu and Pneumococcal Shots

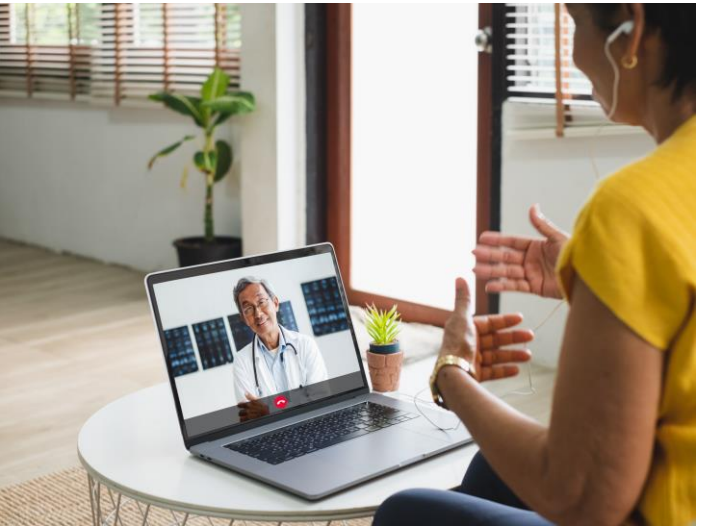
- RHCs do **NOT** bill Medicare for Flu or Pneumococcal Immunizations on claims.
- CPT codes for administration and for the vaccine are never included in the claim detail. Can be set up as zero charge/no bill for tracking.
- Charges for Flu and Pneumococcal Injections are not included in the total encounter 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.
- See additional slides on COVID-19 vaccine administration

Medicare RHC Distant Site Telehealth

MEDICAL AND MENTAL HEALTH

Telehealth Site Definitions

Originating Site versus Distant Site



Originating Site: This is the location of the patient who is receiving the telehealth service.

Distant Site: This is the location of the healthcare provider who is rendering the telehealth service.

Be very careful when entering into agreements for contracted telehealth. Make sure contract terms align with RHC reimbursement methodology.

RHC Distant Site Medical Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	05/15/2022	1	100.00
0001	Total Charge				100.00

Optional

Effective January 1, 2022, the payment rate for distant site medical telehealth services is $97.24. This is a composite fee schedule amount.

Add the -CS Modifier if G2025 is reporting a preventive service that would not be subject to deductible and coinsurance.

No –CG Modifier since this does not reimburse at the AIR. Not an encounter.

New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MLN Matters Number: SE20016 Revised

Related Change Request (CR) Number: N/A

Article Release Date: January 13, 2022

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

Beginning July 1, 2020, you should no longer put the CG modifier on claims with HCPCS code G2025.

Table 1. RHC Claims for Telehealth Services from January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95 (optional)

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Change to definition of mental health visit to allow telehealth

New for 2022

§ 405.2463 What constitutes a visit

Current

(3) Visit - Mental health. A mental health visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:

(i) Clinical psychologist.
(ii) Clinical social worker.
(iii) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

Proposed

(3) Visit - Mental health. A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder between an RHC or FQHC patient and one of the following:

(i) Clinical psychologist.
(ii) Clinical social worker.
(iii) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

2022 Mental Health Telehealth Example

These visits are different from telehealth services provided during the Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See MLN Matters Article SE20016 for information on billing G2025 for professional telehealth distant site services other than mental health visits during the PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 Revised on 05/05/2022 : -CG now required
- Is an encounter; pays at the AIR.

2022 Mental Health Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Telehealth	90791 CG and either FQ or 95	05/05.2022	1	100.00
0001	Total Charge				100.00

Mental Health Services

HCPCS Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

- Mental Health Codes on the QVL
- Do NOT use –CG on medical telehealth visits
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001

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Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE22001 Revised

Related Change Request (CR) Number: N/A

Article Release Date: May 5, 2022

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this Article to show that RHCs must include modifier CG on claims for mental health visits via telecommunications. This change is in dark red font on page 2. All other information is the same.

Services to Hospice Patients by RHC Providers

New in 2022!

- The final rule now allows RHC providers who are also the attending hospice physician to bill hospice care as RHC encounters.
- RHC claims will be appended with both the –CG modifier and the new –GV modifier. Appropriate revenue codes are used.
- Non-hospice related services provided by regular RHC practitioners would be billed as they currently are with the 07 condition code and –GW modifier **with a non-hospice diagnosis.**
- Coinsurance and deductible amounts apply.

Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services

MLN Matters Number: MM12357 Revised
Related Change Request (CR) Number: 12357
Related CR Release Date: January 12, 2021
Effective Date: January 1, 2022
Related CR Transmittal Number: R11200CP
Implementation Date: January 3, 2022

Note: We revised this Article to reflect a revised CR 12357. The CR revision didn't impact the substance of the Article. We did change the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected

This MLN Matters Article is for RHCs and FQHCs billing hospice attending physician services to Medicare Administrative Contractors (MACs) on behalf of Medicare patients.

Provider Action Needed

In this Article, you'll learn about:

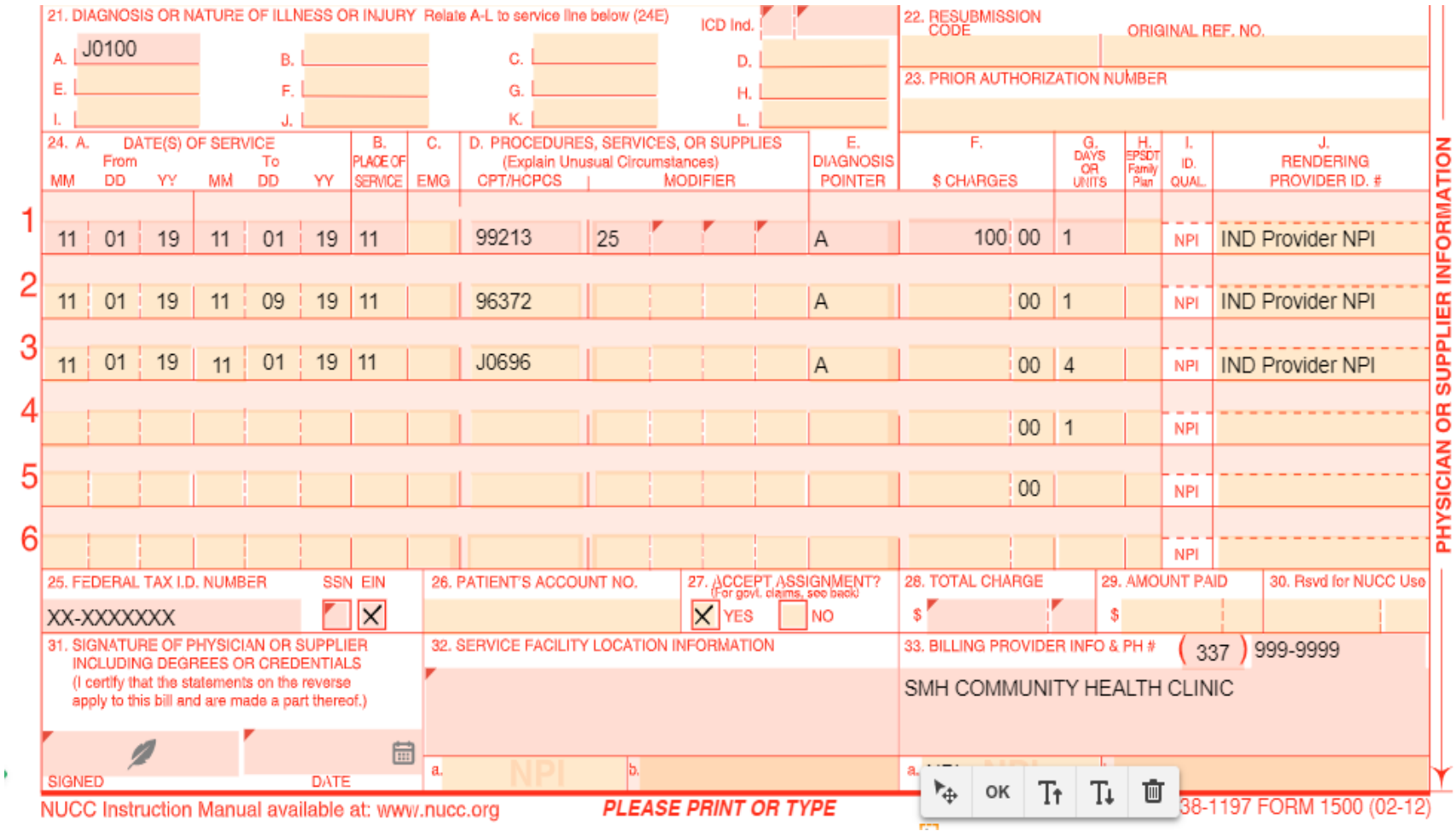
- When RHCs report the GV modifier
- When FQHCs report the GV modifier

Commercial Claims

Commercial RHC Claims

- ❑Normal coding guidelines apply except where individual payers may have a deviation from the guidelines.
- ❑Normal use of modifiers
- ❑Reimburse as fee-for-service
- ❑-SA modifier may be needed for nurse practitioners resulting in a reduction of reimbursement.

Commercial Claim
POS 11 (or 72)
Same TIN/NPI used for contracting
Conventional Modifier Use
Established Office Visit with Antibiotic Injection



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. J0100 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	01	19	11	01	19	11		99213	25	A	100 00	1		NPI	IND Provider NPI
2	11	01	19	11	09	19	11		96372		A	00	1		NPI	IND Provider NPI
3	11	01	19	11	01	19	11		J0696		A	00	4		NPI	IND Provider NPI
4												00	1		NPI	
5												00			NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
XX-XXXXXXX ☐ ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
☒ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # (337) 999-9999
SMH COMMUNITY HEALTH CLINIC
a. b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE 38-1197 FORM 1500 (02-12)

OK

Nebraska Medicaid

KMAP Definition of an Encounter

A covered RHC or FQHC “visit” means a face-to-face encounter between a clinic/center patient and a clinic/center health care professional or practitioner (listed below) during which a covered RHC/FQHC service or dental service is rendered:

- Physician
- Physician assistant (PA)
- Advanced registered nurse practitioner (ARNP)
- Nurse midwife
- Dentist (for FQHCs only)
- Clinical psychologist
- Clinical social worker
- Registered nurse (RN), for KBH nursing screen only, bill with modifier TD
- Visiting nurse (if the conditions listed under “visiting nurse services” are fulfilled)
- Registered dental hygienist, extended care permit (RDH ECP)

Note: The RDH ECP applies to FQHCs only, not RHCs. Encounters with more than one health professional, or multiple encounters with the same professional, on the same day constitute a single visit.

Reimbursement Methodology

- RHC Rates adjusted annually.
- Cost report required but no settlement
- Reimbursement methodology is different for provider-based RHCs based on the bed size of the parent hospital.
- 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.

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.

KMAP RHC Rate Setting

Reimbursement

KMAP has established the Prospective Payment System (PPS) for RHCs and FQHCs mandated by the Benefits Improvement and Protection Act (BIPA) of 2000.

• Prospective Payment System (PPS)

Under this methodology, clinics/centers are paid prospective rates based on an average of the reasonable costs for the two base years with no retroactive cost settlements.

• Change in scope of services

If an RHC or FQHC expects a change in the scope of covered services, a written description of the proposed change with budgeted increase or decrease in cost and total number of visits should be submitted to the State. An adjustment to the rate may be made based on a review of the submitted information.

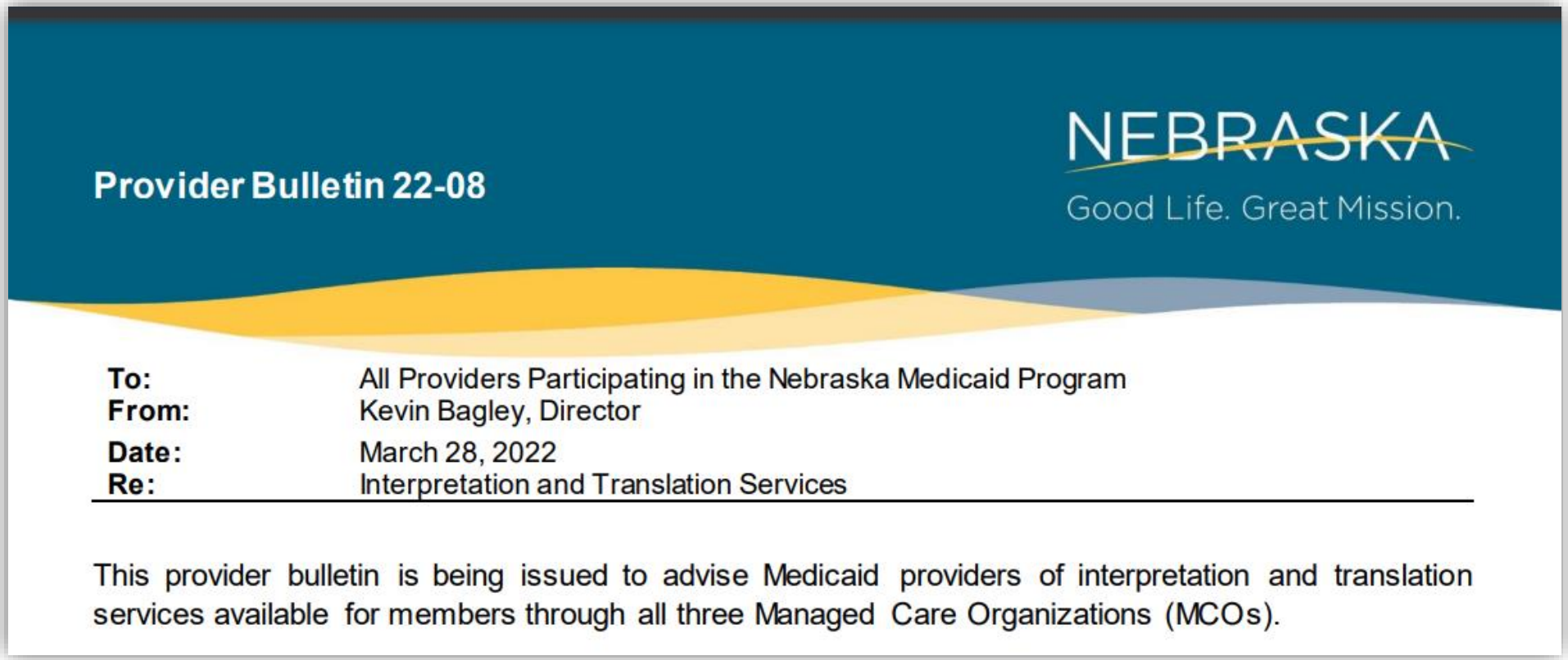
Services Performed in the Hospital Setting

Services in a Hospital Services provided by a clinic/center practitioner in an outpatient, inpatient, or emergency room of a hospital or in a swing-bed do not constitute covered RHC or FQHC services under KMAP.

These services may be billed under the performing provider's individual Medicaid provider number.

Note: If these services are rendered during a timeframe for which the practitioner is compensated by the RHC/FQHC for providing services at the clinic/center, all expenditures associated with these services must be carved out on the RHC/FQHC cost report.

Recent Provider Bulletins



Provider Bulletin 22-08

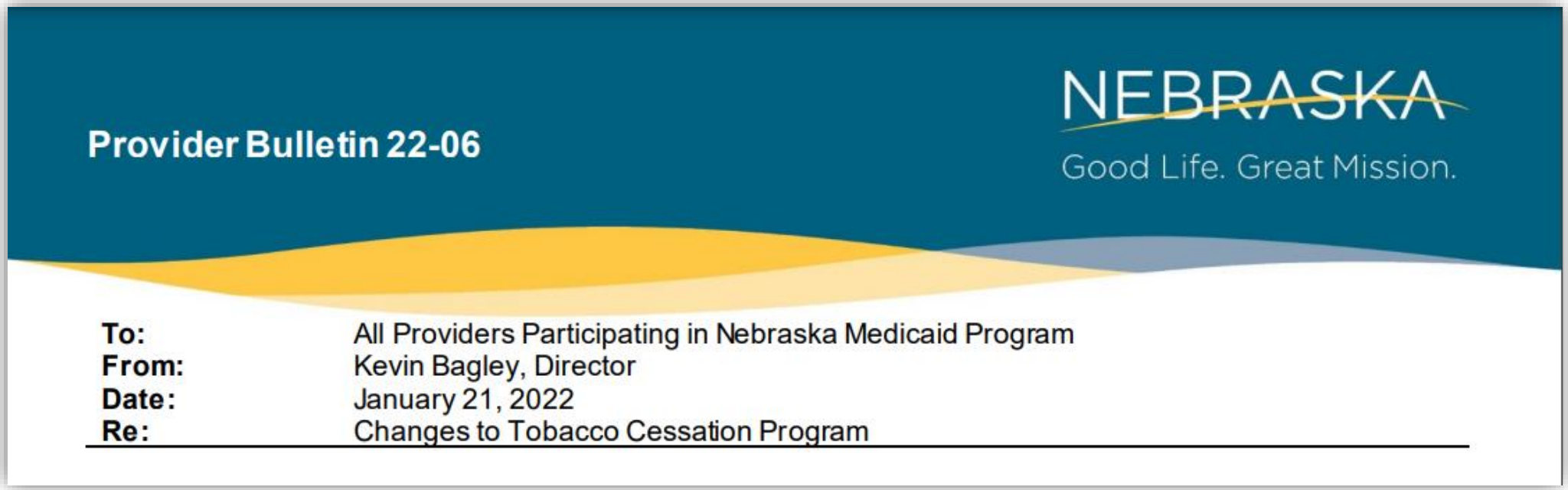
NEBRASKA
Good Life. Great Mission.

To: All Providers Participating in the Nebraska Medicaid Program
From: Kevin Bagley, Director
Date: March 28, 2022
Re: Interpretation and Translation Services

This provider bulletin is being issued to advise Medicaid providers of interpretation and translation services available for members through all three Managed Care Organizations (MCOs).

https://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2022-08.pdf

This bulletin give guidance on how providers can obtain free language interpretation services from Healthy Blue Nebraska, Nebraska Total Care and UnitedHealthcare Community Plan of Nebraska. Providing language services is required by all Medicare and Medicaid providers under the Office of Civil Rights.



Provider Bulletin 22-06

NEBRASKA
Good Life. Great Mission.

To: All Providers Participating in Nebraska Medicaid Program
From: Kevin Bagley, Director
Date: January 21, 2022
Re: Changes to Tobacco Cessation Program

https://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2022-06.pdf

This bulletin discusses changes to tobacco cessation services and products. Effective December 26, 2021, beneficiaries are no longer required to enroll in the Nebraska Tobacco Free Quitline to be able to receive tobacco cessation products; enrollment is still encouraged, but it is no longer required.

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 24 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. She has held memberships regional, state and national organizations throughout her healthcare career including NARHC, NRHA, AHIMA, MGMA, and HFMA. Patty currently serves on the Board of NARHC.