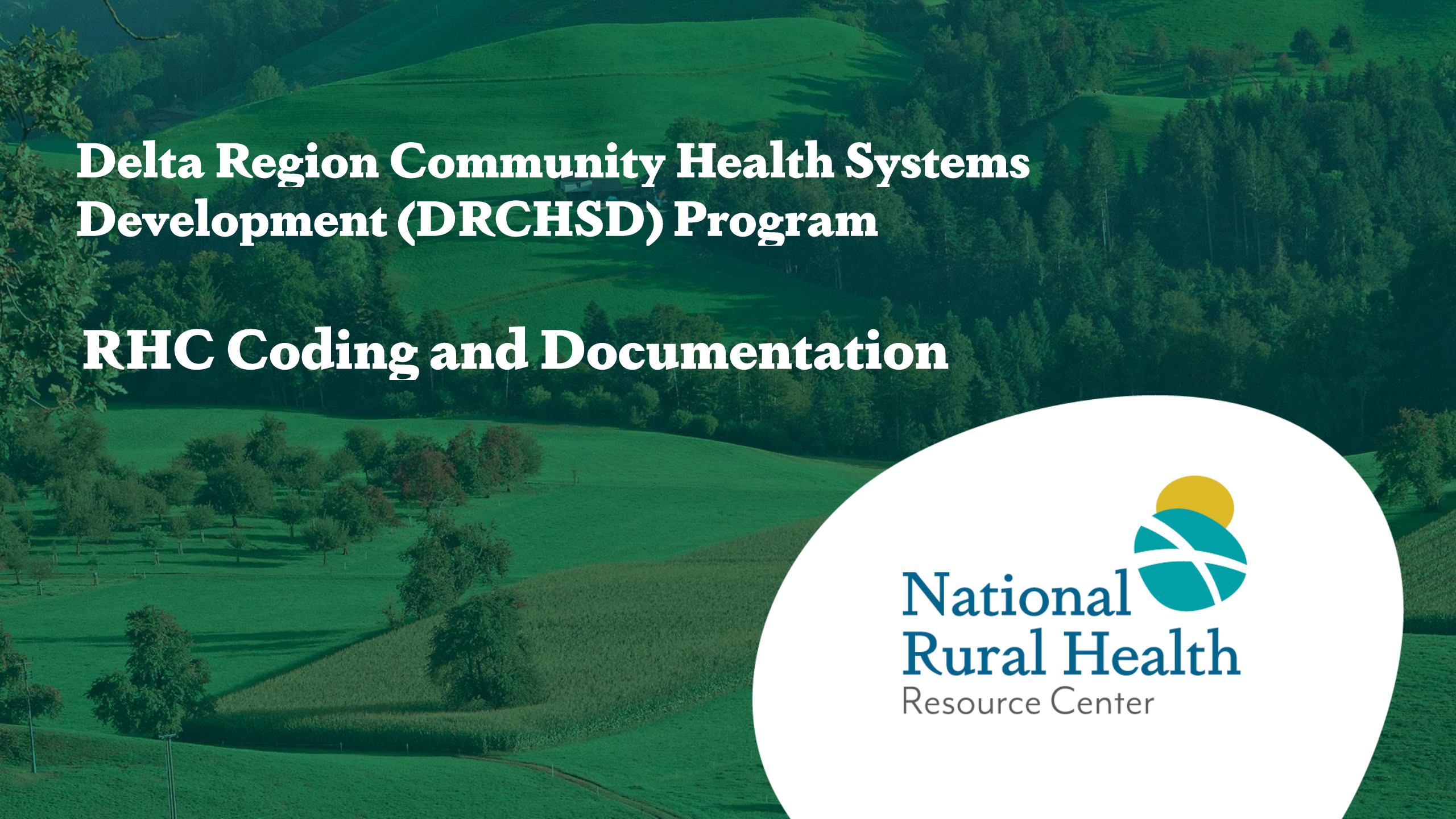
Delta Region Community Health Systems Development (DRCHSD) Program

RHC Coding and Documentation



National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

DRCHSD Program Supported by FORHP and DRA

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Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

https://www.ruralcenter.org/about/dei

DRCHSD Upcoming Webinars

- DRCHSD Clinic Webinar Series: FQHC Coding and Documentation
  - August 17 from 11:00am- 12:00 pm CT
- DRCHSD Webinar: HCC Risk Adjustment Update
  - August 24 from 11:00am- 12:00 pm CT
- DRCHSD Webinar: Telehealth Insights Post PHE
  - August 31 from 11:00am- 12:00 pm CT

Pre-Polling Questions

1. I am ___ in my understanding of billing processes specific to rural health clinics, including Medicare and Medicaid reimbursement guidelines, accurate documentation, and coding.

2. I am ___ in my understanding of the importance of streamlined billing for my organization's financial sustainability.

Todays Speakers

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Stacey Gee, COC, CRCR, CPHT

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RHC Coding and Documentation

August 10, 2023

Agenda

- Introductions
- What is RHC
- Claim Billing Differences
- Services Provided
- Reimbursement
- Questions

Meet the Presenters

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Stacey Gee, COC, CRCR, CPHT

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What is an RHC?

- Rural Health Clinic (RHC) is certified to receive special reimbursement from the Medicare and Medicaid programs
- The purpose of an RHC is to improve patient access to primary care in underserved rural areas
- Clinics that are designated as an RHC are reimbursed based on a:
  - AIR (All Inclusive Rate) for **Medicare** visits
  - PPS (Prospective Payment System) for **Medicaid** visits
  - Other plans will vary
- This program significantly enhances reimbursement
- There are specific location and condition eligibility requirements that must be met to be certified as an RHC

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Different RHC Types

- Provider Based (PB)
  - Refers to an RHC that is owned by a hospital – these are **NOT** hospital outpatient departments
  - Billing is based on the hospital's EIN

- Independent
  - Refers to an RHC that is free standing
  - Billing is based on the RHC's EIN

- *EIN (Employer Identification Number)

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Qualified RHC Providers

- Physicians (MD or DO)
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Chiropractor, Dentist, Optometrist, Podiatrist
- Clinical Psychologist (PhD)
- Licensed Clinical Social Worker (LCSW)

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Behavioral Health Providers

- Medicare RHC providers:
  - Clinical Psychologist (PhD)
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Clinical Professional Counselor (LCPC) or Clinical Professional Counselor (CPC) is not payable by Medicare

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

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Medicare RHC Locations

- The RHC or FQHC
- The patient's residence (including assisted living facility)
- A Medicare-covered Part A SNF (see Pub 110-04, Medicare Claims Processing Manual, Chapter 6, Section 20.1.1)
- The scene of an accident

Medicare Benefit Policy Manual, Chapter 13, Section 40.1

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RHC Locations - NEVER

- RHC visits may never take place in:
- An inpatient or outpatient department or a hospital, including a CAH
- A facility which has specific requirements that preclude RHC or FQHC visits (i.e., Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.)

- Medicare Benefit Policy Manual, Chapter 13, Section 401

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RHC Bill Types

- TOB = 071X
- 0710 = nonpayment/zero claim (all charges are noncovered)
- 0711 = admit through discharge – used for an original claim
- 0717 = claim adjustment
- 0718 = claim cancel
- DOS cannot overlap calendar years
- Split billing periods that overlap calendar year

Reference: CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 9, Section 100A

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Applicable Revenue Codes

- 0521 All Clinic Visits and Professional Services by qualified RHC provider
- 0522 Home visit by RHC provider
- 0524 Visit by RHC provider to a Part A SNF bed
- 0525 Visit by RHC provider to a non-SNF bed, NF or other residential facility (non-Part A)
- 0527 Visiting Nurse service in home health shortage area
- 0528 Visit by RHC provider to other non-RHC site (scene of an accident)
- 0250 Pharmacy (does not need the HCPCS)
- 0300 Venipuncture
- 0636 Injection/Immunization
- 0780 Telehealth
- 0900 Behavioral Health

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RHC Medicare Claims Go To:

Type of RHC	Encounter Visit Incident-To/PC	CLIA LAB	Diagnostic	Hospital Professional Services
Independent	Part A / UB04 RHC CCN RHC NPI RNC EIN	Part B / 1500	Technical Components Part B / 1500	Part B / 1500 Medicare Group
Provider Based	Part A / UB04 RHC CCN RHC NIP Hospital EIN	Parent Hospital UB 04 RHC NPI Hospital CCN Hospital EIN	Parent Hospital UB 04 RHC NPI Hospital CCN Hospital EIN	Part B / 1500 Medicare Group

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RHC Claims by Payer Type

Type of RHC	Medicare	Medicaid/Medicaid MCO	M/Care Advantage	Commercial
Independent	Part A / UB04 RHC NPI RHC CCN Hospital EIN	MCO => POS 72 RHC NPI RHC EIN	Some Pay AIR => UB04 Others = > 1500 RHC EIN	Part B / 1500 POS = > 11 Non-RHC NPI RHC EIN
Provider Based	Part A / UB04 RHC NPI RHC CCN Hospital EIN	MCO = > POS 72 RHC NPI Hospital EIN	Same as above Hospital EIN	Part B / 1500 POS = > 11 Non RHC NPI Hospital EIN

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Services Provided

- RHCs are reimbursed based on the encounter. This would be a medically necessary medical or mental health visit or qualified preventive health visit face-to-face visit with a: physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist or clinical social worker
  - Primary Care and Preventative Services
  - Services and supplies furnished incident to RHC services (ex. Venipuncture)
  - Homebound visiting nurse services in CMS-certified HHA shortages
  - Some care management (new in 2022 – Transitional Care Management)
  - Flu, pneumococcal, COVID-19 are 100% covered by Medicare on the cost report
  - RHC tele-health visits (restrictions apply) – Originating Site vs. Distant Site
  - Mental Health tele-health visits (new in 2022)

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Noncovered RHC Services

- Medicare exclusions (routine physicals, dental care, routine eye exams, hearing tests)
- Technical component of RHC services
- Laboratory services
- Note - venipuncture included in AIR when furnished in RHC or incident to RHC service
- DME (crutches, hospital beds, wheelchairs)
- Ambulance services
- Prosthetic devices which replace all or part of an internal body organ
- Body braces

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Importance of Correct Coding

- Integrity behind coding
  - Diagnosis coding needs to correlate to CPT/ HCPCS coding
- Coding needs to reflect the true health of the patient
- Payers reimburse differently, it is important to accurately code/report services to the most accurate and specific levels
- Your claim tells the story of the patient:
  - CPT/HCPCS codes tell what happened
  - Diagnosis codes tell why it happened

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Reimbursement

- AIR (All-Inclusive Rate) is a bundled payment per visit for primary care and preventive health services
  - Preventive services (Annual Wellness Visit (AWV) & Initial Preventive Physical Exam (IPPE) receive full AIR and patient will pay nothing
  - Other services, Medicare pays 80% of AIR and the patient pays the remaining 20%
- RHCs must report modifier CG on one revenue code 052x and/or 0900 service line per day, for the bundled service. This indicates the service line is subject to coinsurance and deductibles

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RHC Medicare Payment Limit Per Visit

Year	Payment Rate
2021	$100
2022	$113
2023	**$126**
2024	$139
2025	$152
2026	$165
2027	$178
2028	$190

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Incident-To Services

- Commonly rendered without charge or included in the RHC bill;
  - Commonly furnished in a physician office or clinic
  - Furnished under the physician's direct supervision; and
  - Furnished by a member of the RHC staff
  - Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal)
  - Bandages, gauze, oxygen, and other supplies; or
  - Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician
- Incident-to services are considered covered *and paid* under the RHC
  - They must be bundled with the RHC encounter. They are not separately billable or payable
  - Services that do not occur on the same date as the encounter can be bundled if they occur 30 days before or after
  - The effect on payment is an increase in the charge, and therefore in the co-insurance
  - The cost for these services are included in the cost report, but are not separately payable on claims

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Examples of Non-Encounter – Does not warrant Medical Necessity

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

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Qualifying Visits

- RHCs report one service line per encounter/visit with revenue code 052X and a qualifying medical visit or revenue code 0900 and a qualifying behavioral health visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line

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

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QVL Charge (052X) VS Total Charge (001)

- Medicare does not adjudicate RHC claims based on the 0001 Total Charge amount
- Medicare adjudicates RHC claims using the Qualifying Visit Line
- The qualifying visit line should be the sum of all RHC charges minus any preventive services
- Total Charges WILL be reported as allowed charges on remits, BUT:
- Patient Co-Insurance/Deductible amounts are based on the Qualifying Visit Line

RHC Services are submitted on a CMS-UB04 claim form.

- The electronic format is ANSI837-Institutional
- Type of Bill is “0711” for an original claim
- All services must be reported using the appropriate revenue code
- All claims must have a qualifying visit denoted with a “CG” Modifier
- Incident-to services must be reported on the claim, but bundled with the qualifying visit

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CG Modifier

- Beginning October 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible (MedLearn Matters SE1611)

- If only preventive services are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the medically necessary face-to-face visits and the bundled charges

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CG Modifier - Example

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charges
0521	Office Visit Est III	99123 CG	08/12/2021	1	$ 100.00
0001	Total Charge				$ 100.00

An established patient is seen and a qualifying visit of 99213 for $100 is generated. The applicable coinsurance and/or deductible is calculated using $100.00

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Incident-To Services: Billing - Incorrect

FL42 Revenue Code	FL43 Description	FL44 HCPCS/CPT	FL45 Date of Service	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213 CG	08/12/2021	1	$150.00
0636	Injection Admin	96372	08/12/2021	1	$ 20.00
0636	Rocephin	J0696	08/12/2021	1	$ 30.00
0001	Total Charge				$200.00

- J0696 ($30) and 96372 ($20) are bundled with 99213 ($100) on the qualifying visit line
- The total QVL charges is $150; the sum of all services reported on the claim
- The total charge line (001) is inflated due to duplicating the injection and admin charges from the detail lines

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Incident-To Services: Alternative Billing - Correct

FL42 Revenue Code	FL43 Description	FL44 HCPCS/CPT	FL45 Date of Service	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213 CG	08/12/2021	1	$150.02
0636	Injection Admin	96372	08/12/2021	1	$. 01
0636	Rocephin	J0696	08/12/2021	1	$ .01
0001	Total Charge				$150.04

- J0696 ($30) and 96372 ($20) are added to the 99213 QVL line
- The detail lines are reported as $0.01
- The total charge line (001) are no longer falsely inflated

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Bundled Services – Different Dates of Service

- Services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe. (MBPM 13: Section 120.3)
- Do NOT span dates on the ‘admit from’ and admit through’ dates. This will cause other claims submitted within those dates to reject

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Bundled Injection/Different Dates

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213 CG	08/12/2021	1	$180.04
0636	Allergy injection	95115	08/12/2021	4	$ 0.04
0001	Total Charge				$180.08

- Four weekly allergy injections at $20 each were provided with no corresponding E/M in July 2021. An office visit occurred 8/12/2021
- Four allergy injections are bundled with the $100 charge on the 99213 QVL line
- Medicare will use the line with the QVL code (99213) to determine the total charge and calculate coinsurance

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Behavioral Health Qualified Visits

HCPCS/CPT	Short Description
90791	Psych Diagnostic Evaluation
90792	Psych Diagnostic Evaluation w/Medical Services
90832	Psytx PT/Family 30 minutes
90834	Psytx PT/Family 45 minutes
90837	Psytx PT/Family 60 minutes
90839	Psytx Crisis Initial 60 minutes
90845	Psychoanalysis

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Behavioral Health Services

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charge
0900	Psytx PT/Family 30 minutes	90832 CG	08/12/2021	1	$120.00
0001	Total Charge				$120.00

- Behavioral Health Services performed by a qualified provider are billed using revenue code 0900

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Minor Surgical Procedures

- Minor surgical procedures performed in the RHC, during RHC hours, must be billed as encounters
- Follow-up visits for dressing changes, or suture removal can only be billed as encounters if there is a medically-necessary, documented reason and it is performed by an RHC provider
- If an office visit is performed during the same visit as a minor surgical procedure, the clinic will only have one encounter to bill
- These should be bundled and submitted as one line item
- Surgical procedures furnished in an RHC by an RHC practitioner are considered RHC services

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Procedures – Billing Example

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charge
0521	Wound Repair	11102 CG	08/12/2021	1	$150.00
0001	Total Charge				$150.00

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213 CG	08/12/2021	1	$650.01
0521	Wound Repair	12031	08/12/2021	1	$ 0.01
0001	Total Charge				$650.02

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Influenza (G0008) and Pneumococcal and Vaccines (G009)

- Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report
- No line items should be billed
- These costs should not be included on a claim
- These are the only injections that are payable outside of RHC claim
- The beneficiary coinsurance and deductible are waived

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Multiple Encounters – Same Day, Modifiers 25, 59

- Modifier-59 indicates that separate conditions on the same treatment day are unrelated. This is used only if a subsequent illness or injury on the same day as another visit.
  - Modifier-25 in an RHC in interchangeable with -59
- Modifier-59 and -25 indicate two encounters
  - -25 is different in an RHC
  - Modifier 25 or 59 is only on the subsequent service line item UB-04 on a claim form

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Modifier Example – Subsequent Visit

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45Offic Date of Service	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213 CG	08/12/2021	1	$350.00
0521	Laceration Repair	12002 59	08/12/2012	1	$ .01
0001	Total Charge				$350.01

- ❑ Modifier CG and modifiers 25/59 are NOT reported on the same service line together
- ❑ Assign modifier 25 or 59 to the subsequent service line to indicate the subsequent medically necessary visit

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Well Woman Exams

- Medicare does not pay well-woman exams (99381-99387). An annual or subsequent wellness visit (G0438, G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091)

FL42 Revenue Code	FL43 Description	FL44 CPT/HCPCS	FL45 Date of Service	FL46 Units	FL47 Total Charge
0521	Subsq AWV	G0439 CG	08/12/2021	1	$175.00
0521	Breast/pelvic	G0101	08/12/2021	1	$ 75.00
0521	Pap Smear	Q0091	08/12/2021	1	$ 50.00
0001	Total Charge				$300.00

All Preventive Services are listed to capture quality measure and to report utilization to Medicare for COB. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

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Other Resources Available

- CMS RHC Qualifying Visit List Link https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf
- CMS Medicare Benefit Policy Manual
- CMS Medicare Claims Processing Manual
- CMS RHC Reporting Requirements FAQs
- Medlearn MLN006762 Publication

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Questions?

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Thank you!

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Post-Polling Questions

1. I am ___ in my understanding of billing processes specific to rural health clinics, including Medicare and Medicaid reimbursement guidelines, accurate documentation, and coding.

2. I am ___ in my understanding of the importance of streamlined billing for my organization's financial sustainability.

3. I am ___ that I will apply the knowledge gained from this educational training to identify leading practices to mitigate risks and improve processes that enhance my organization's financial position.