BILLING AND CODING BOOT CAMP - RURAL HEALTH CLINIC (SESSION 2)

National Rural Health Resource Center
Delta Region Community Health Systems Development Program
Friday, March 22, 2019 – 9:00 to 11:00 CT
ROUTINE ANNUAL PHYSICALS VS. MEDICARE WELLNESS/PREVENTIVE SERVICES

Time For Your Annual Physical?
INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)
INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE), DETAILED

• The goal of the IPPE, which includes an optional electrocardiogram (EKG), is health promotion & disease detection & includes education, counseling & referral to screening & preventive services also covered under Medicare Part B
IPPE - HCPCS CODES

- **G0402** = physical examination performed face-to-face with the patient
  - Patient in the first year of Medicare eligibility
  - Is **NOT** a routine annual physical (i.e., 99397, 99387)
- **G0404** = screening *EKG tracing only* (without interpretation and report)
- **G0405** = screening *EKG interpretation and report only*, (without the EKG tracing)
- RHCs should follow normal billing procedures and list codes on the UB-04 under RC 0521
IPPE – REIMBURSEMENT

• Deductible & copay are not applied to the IPPE
• Payment is made at the all inclusive rate
• Assign revenue code 052X
• Meets one of the exceptions, & would result in a separate encounter rate payment IF performed on the same day as a medical or behavioral health service
ADVANCED CARE PLANNING
ADVANCED CARE PLANNING – COVERAGE AND BILLING

• Effective January 1, 2016, ACP is a stand-alone billable visit in RHC setting
  ▪ CPT code 99497

• Performed by a RHC physician or qualified health professional
  ▪ Physician
  ▪ Nurse Practitioner
  ▪ Physician Assistant
ADVANCED CARE PLANNING – COVERAGE AND BILLING, CONTINUED

• ACP services may be furnished on same day as another billable medical visit
  - Only one encounter will be paid
  - Coinsurance and deductible will apply

• ACP services may be furnished on the same day as an Annual Wellness Visit (AWV)
  - Only one encounter rate will be paid
  - Coinsurance and deductible will not apply
ANNUAL WELLNESS VISITS (AWV)
ANNUAL WELLNESS VISITS

• G0438 Annual Wellness Visit (AWV), Initial
  ▪ First visit AFTER the IPPE has been performed in the first year of Medicare eligibility, or
  ▪ When the patient has passed the year of Medicare eligibility but needs to start wellness visits

• G0439 AWV, Subsequent
  ▪ Picks up the next year after the initial AWV occurs & then every 12 months on an ongoing basis

• Also NOT a routine annual physical
AWV – REIMBURSEMENT & BILLING

• Benefit allows for an initial AWV & subsequent wellness visits annually
• Coinsurance & deductible are not applicable
• RHCs will report according to detailed billing guidelines
• May be performed in addition to a medical E/M encounter on the same date of service
  ▪ Only one AIR payment made

Source: CMS MLN Matters, MM7079
AWV ELIGIBLE PROVIDERS

• Physicians
• Non-physician practitioner
• Medical professional or a team of such medical professionals, working under DIRECT supervision of an eligible physician

• NOTE: An RN may record data under direct supervision but may not perform the entire service and/or report a billable encounter if performed without physician participation
AN INITIAL AWV MUST INCLUDE:

• Medical/family history
• Working list of current providers & suppliers that are regularly involved in the patient’s care
• Measurement of height, weight, BMI (or waist circumference), BP & other routine measurements as appropriate
• Detection of cognitive impairment
• Review of potential risk factors for depression
• Review of functional ability & level of safety based on direct observation
• Written screening schedule & list of risk factors & conditions for which interventions are recommended or are underway
• Provision of referrals to health education or preventive counseling
AWV - SUBSEQUENT

• Must include all of the initial required elements
• The provider must update the written screening schedule
• The provider must update the list of risk factors & conditions & recommended interventions
AWV HEALTH RISK ASSESSMENT

- Initial & subsequent visits will need to include completion of a Health Risk Assessment (HRA)
- Must be completed prior to the visit (by the patient) or during the encounter (with the RN or provider)
- Will be updated at each subsequent visit
- Will include list of all prescription & OTC medications
- Form is not currently developed by Medicare. Providers should develop a form that is user friendly, can be completed on paper or electronically
HRA COMPLETION

• Collection of self-reported information
• Can be administered independently by the patient or with the assistance of a nurse or provider during the encounter
• Is tailored to communicate the needs of any underserved populations, persons with limited English proficiency and/or persons with health literacy needs

Source: CM-1524-FC, pages 281-282
HRA COMPLETION, CONTINUED

• Takes no more than 20 minutes to complete
• Addresses at a minimum:
  ▪ Demographic data (i.e., age, gender, race, ethnicity)
  ▪ Self assessment of health status, frailty & physical functioning
  ▪ Psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain or fatigue
  ▪ Behavioral risks (i.e., tobacco use, physical activity, nutrition, oral health, alcohol consumption, etc.)
HRA COMPLETION, AGAIN

• Activities of daily living
  ▪ Dressing, feeding, toileting, grooming, ambulation, balance/risk of falls & bathing

• Instrumental activities of daily living (ADLs)
  ▪ Shopping, food preparation, using the telephone, housekeeping, laundry, taking medications, handling finances, etc.

Source: Centers for Disease Control and Prevention (CDC), Interim Guidance for Health Risk Assessment and their Modes of Provision for Medicare Beneficiaries
MEDICARE PREVENTIVE RESOURCES

• Interactive Preventive Services Tool
  ▪ [https://www.cms.gov/Medicare/Prevention/PreventionGenInfomedicare-preventive-services/MPS-QuickReferenceChart-1.html](https://www.cms.gov/Medicare/Prevention/PreventionGenInfomedicare-preventive-services/MPS-QuickReferenceChart-1.html)

• IPPE

• AWV
MEDICARE PREVENTIVE SERVICES

Target Audience: Medicare Fee-For-Service Providers

Watch the CMS Provider Minut: Preventive Services video for pointers to help you submit sufficient documentation when billing for certain preventive services. You may provide some preventive services via telehealth where you see the following symbol:

This educational tool will help you properly furnish and bill Medicare preventive services with information by service that includes:

- A link to the National Coverage Determination (NCD) webpage for the service, if it applies
- Information on Prolonged Preventive Services
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes
- Coverage requirements
- Frequency requirements
- Medicare beneficiary liability

NOTE: When you request the Medicare eligibility status of a beneficiary, the Centers for Medicare & Medicaid Services (CMS) provides the dates a beneficiary may receive many of these preventive services. If you are not able to get this data, contact your eligibility service provider. Refer to the Frequently Asked Questions section of this document for information on how to request the next eligible date.

ICN 006559 December 2018
PREVENTIVE SERVICES

• Frequency limits exist

• If service is not in compliance (e.g., when service is provided more often than frequency limit states), beneficiary may be held liable for payment, unless it becomes a diagnostic situation
  ▪ An Advanced Beneficiary Notice (ABN) may be required
ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

• Only services that may exceed “frequency” limitations or that do not meet coverage guidelines
• Medicare does not require an ABN for services that are never paid by Medicare
Routine Annual Physicals
Routine Annual Physicals, continued

• *Don’t confuse...*
  – Routine annual physicals (CPT 99387, 99397)
  – Covered Medicare preventive/wellness visits (*i.e.*, IPPE, AWV)

• Base coding on documented work performed, not what may have been on schedule (if different)
  – Example: Patient scheduled for annual physical but came in with COPD exacerbation & respiratory distress
Routine Annual Physicals, again

• Annual physicals are covered annually by most commercial payers & state Medicaid
  – Medicare does not cover an annual physical other than a breast/pelvic examination. Charge must be carved out of total charges & assigned to patient responsibility

• Work is based on comprehensive history & examination that is based on the patients age, gender & risk factors
  – Extent of history & examination are not defined except to say “age appropriate”

• CPT code selection is based on age & status of patient
Medicare Breast/Pelvic Exam (G0101)

- **G0101** – Covered preventive service for breast and pelvic examination
  - Is an eligible qualified RHC stand-alone visit
  - Paid under encounter rate
  - Coinsurance and deductible are waived
  - Eligible for coverage every 2 years unless patient is high risk, then covered annually
  - NOT a head-to-toe annual physical
  - If head-to-toe annual physical is performed in addition to the breast/pelvic examination, the appropriate CPT preventive code (i.e., 99387, 99397) is reported
    - Patient is responsible for the difference (i.e., noncovered amount)

- **Q0091** – professional service to obtain pap smear
Medicare Breast/Pelvic Exam (G0101), continued

- A screening pelvic examination should include at least 7 of the following elements:
  - Breast exam
  - Digital rectal exam
  - Pelvic exam:
    - External genitalia, Urethral meatus, Urethra, Bladder, Vagina, Cervix, Uterus, Adnexa/parametria and Anus and perineum


Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 210.2
Preventive Medicine...

• Not problem focused!!

• Includes –
  – Discussion of issues common to age group/gender
  – Contraception with women of child bearing age
  – Anticipatory guidance for parents of pediatric patients
  – Diet, smoking cessation, etc.
  – Review of safety issues
  – Need for screening tests
  – Status of previously diagnosed, stable conditions
  – Ordering immunizations or lab/diagnostic procedures
    • Billed separately
Example A: Routine Physical, Not Medical...

• CPT preventive medicine guidelines state:
  – “An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.”
  – This applies to stable, chronic conditions that do not require further evaluation or to minor problems that do not require a full work-up

• Report only the preventive CPT code
Example B: Medical + Routine Physical

• “If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, **and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem oriented E/M service**, then the appropriate office/outpatient code 99201-99215 should also be reported.”

• Report both preventive & medical E/M CPT codes with modifier -25
Example C: Medical, Not Routine Physical

• If the patient presents for a scheduled “well visit”, but has signs, symptoms and/or conditions that are new, exacerbated or worsening

• The focus of the encounter is now fully on the medical problems

• Tests are ordered

• Treatment plans are developed

• Report only the medical E/M CPT code
POLLING QUESTION

• A patient presents for a nurse visit to receive an administration of steroids for upper respiratory infection, or a vaccine in follow-up to an annual physical, is this a billable RHC encounter?

  a. No
  b. Yes
  c. Not sure
Transitional Care Management Services (TCM)

- Partial Hospitalization at a Community Mental Health Center
- Hospital Outpatient Observation Status
- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Inpatient Rehabilitation Facility
- Skilled or Non-skilled Nursing Facility

Home
Domiciliary Care
Rest Home
Assisted Living
TCM Service Criteria

• Required “contact” must occur within 2 days of discharge
  – By ancillary staff or core provider
  – May be with the patient or caregiver
  – Direct contact, telephone or other electronic means
  – Addressing patient status and needs post discharge

• On Business Days = Monday through Friday except holidays

• If 2 or more separate attempts are made but are unsuccessful, then the criteria for contact are met
TCM Service Criteria, Once More

• The 7 or 14 day FTF visit with a core provider qualifies for a RHC stand alone encounter paid under the AIR
  – If performed on the same day as another service, only one AIR is paid

• TCM services must be furnished within the 30 days post discharge

• Ancillary staff work may be performed under general supervision (effective January 1, 2017)

• Patient coinsurance & deductible applies
Transitional Care Management Services (TCM), again

- 99495 – TCM services with these required elements
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver **within 2 business days** of discharge
  - Medical decision making/ moderate
  - Face-to-face visit, **within 14 calendar days** of discharge
    - Must occur with a RHC core provider to meet criteria for billable encounter
  - Medication reconciliation/management no later than the date of the FTF visit
Transitional Care Management Services

• 99496 – TCM services with these required elements
  – **Communication** (direct contact, telephone, electronic) with the patient and/or caregiver *within 2 business days of discharge*
  – Medical decision making/*high*
  – **Face-to-face visit within 7 calendar days** of discharge
    • Must occur with a core provider to meet criteria for a billable encounter
  – Medication reconciliation/management no later than the date of the FTF visit
CARE COORDINATION SERVICES (CCS)
PATIENT ELIGIBILITY – TWO OPTIONS

• Option A – **General Medical CCM**
  • Patient has 2+ chronic medical conditions
  • Conditions expected to last at least 12 months or until the death of the patient or place the patient at significant risk of death, acute exacerbation/decompensation or functional decline

• Option B – **BHI**
  • Patient with any behavioral health or psychiatric condition being treated by a RHC provider that is determined to warrant BHI services
  • Includes substance use disorders
  • Is a team-based collaborative approach that focuses on integrative treatment
BHI SERVICE CRITERIA

• For those patients who warrant general behavioral health integration services, the following criteria are required
  ▪ Initial assessment
  ▪ Follow-up monitoring
  ▪ Behavioral health care planning, including revisions for patients who may not be progressing or whose status changes
  ▪ Facilitating & coordinating additional treatment (separately billable)
    • Psychotherapy
    • Pharmacotherapy
    • Psychiatric counseling or consultation
  ▪ Continuity of care by the designated care team member
• Similar to BHI, with the additional criteria of:
  ▪ Attending medical provider will work with a collaborative care team to include non-physician practitioners
  ▪ Attending medical provider directs the behavioral health care manager and/or clinical staff and provides medication management services, treatment of related medical conditions, and providing oversight
  ▪ Requires a behavioral health care manager who provides assessment and care management, maintains the relationship with the patient, and facilitates behavioral health care plan and services (i.e., therapy)

Source: CMS, MLN Matters MM10175
PSYCHIATRIC COLLABORATIVE CARE MODEL, CONTINUED

• This care model also requires a Psychiatric consultant
• Outside of the practice
• Participates in regular review of the clinical status of the patient and advises the medical care provider
• Adjusts the care plan when needed
• Manages negative interactions between the behavioral health and medical care teams
• Facilitates referrals
# Care Coordination Services

<table>
<thead>
<tr>
<th>Billing Code – <strong>Primary Medicare</strong> (RHC/FQHC Only)</th>
<th>Scope</th>
<th>Clinical Staff Time</th>
<th>Billing Codes – <strong>Non-Medicare</strong></th>
<th>Clinical Staff Time</th>
<th>Example: Medicare Payment (Nonfacility Rate)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Care Management</strong> (HCPCS Code G0511 – Revenue code 521)</td>
<td>General chronic care management services for medical</td>
<td>Minimum of 20 minutes per calendar month</td>
<td>99490 99487 99489</td>
<td>20 minutes 60 minutes Each additional 30 minutes</td>
<td>2018 estimated rate – $62.28</td>
</tr>
<tr>
<td><strong>BHI (HCPCS Code G0511 – Revenue code 521)</strong></td>
<td>General chronic care management for behavioral/mental health conditions</td>
<td>Minimum of 20 minutes per calendar month</td>
<td>99484</td>
<td>20 minutes</td>
<td>2018 estimated rate – $62.28</td>
</tr>
<tr>
<td><strong>Psychiatric CoCM (HCPCS Code G5012 – Revenue code 521)</strong></td>
<td>Complex chronic care management: behavioral health, mental health, psychiatric or substance abuse conditions</td>
<td>Minimum of 70 minutes in the first month, 60 minutes for any subsequent calendar months</td>
<td>99492 99493 99494</td>
<td>70 minutes 60 minutes Each additional 30 minutes</td>
<td>2018 estimated rate – $145.08</td>
</tr>
</tbody>
</table>
GLOBAL BILLING

Source: CMS, Medicare Benefit Policy Manual, Chapter 13, Section 40.4
BEHAVIORAL HEALTH
BILLING COVERED BEHAVIORAL HEALTH SERVICES TO *MEDICARE*

• Eligible providers:
  - Licensed Clinical Psychologists
  - Licensed Clinical Social Workers
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
CLINICAL PSYCHOLOGIST

• Must have:
  ▪ Doctoral degree in psychology
  ▪ Meet licensing or certification standards
  ▪ Possess 2 years of supervised clinical experience, with one done post degree

• Can perform:
  ▪ Diagnostic & therapeutic services under scope of practice
  ▪ Mental health services commonly performed
  ▪ Can have services billed incident to the psychologist if applicable (by ancillary staff)
**CLINICAL SOCIAL WORKER**

• Must:
  ▪ Have a masters or doctoral degree in social work
  ▪ Perform at least two years of supervised clinical social work
  ▪ Licensed or certified in the state where services are performed
  ▪ If state does not provide licensure or certification, social worker must have completed 2 years or 3,000 hours of post-master degree supervised social work under supervision of master’s level social worker in hospital, SNF or clinic
ELIGIBLE PROVIDERS - ARKANSAS MEDICAID

- Licensed Clinical Psychologists (PsyD)
- Licensed Clinical Social Workers (LCSW)
  - Must have a master’s degree in social work
- Licensed Marriage and Family Therapist (LMFT)
  - Must have a master’s degree in mental health counseling
- Licensed Professional Counselor (LPC)
  - Must have a master’s degree in mental health counseling
- Physicians
- Physician Assistants
- Nurse Practitioners
BILLING COVERED BEHAVIORAL HEALTH SERVICES

• Service categories:
  ▪ Psychiatric diagnostic interview
  ▪ Medication management (billed with E/M codes)
    • Report under revenue code 521
  ▪ Therapy
    • Report under revenue code 900

• *AR Medicaid* has required modifiers for behavioral health providers. Verify billing with the State.
EXCEPTIONS TO THE RULE FOR MULTIPLE PAID VISITS IN ONE DAY

• Behavioral Health visits are considered one of the exceptions to the rule of one encounter payment rate per day

• If a patient has a medical visit and a mental health visit, both are paid

• If a psychiatrist renders a medication management E/M service, that is considered “medical”, not “behavioral health”
  ▪ Only one encounter rate would be paid if medication management was performed on the same day as another medical visit with a different specialty.
MEDICARE BILLING FOR RHC SERVICES

• Use UB-04 form or electronic equivalent
• HIPAA compliant
• Bill to Medicare Administrative Contractor (MAC)
• Claims cannot overlap calendar years
RHC DETAILED BILLING – QUALIFYING VISIT

• A RHC “qualifying visit” is defined by CMS as:
  ▪ A medically necessary medical visit (E/M or “procedure only”)
  ▪ A medically necessary mental health visit
  ▪ A qualified face-to-face preventive health visit
    ▪ Examples: IPPE, AWV, or G0101 (well woman breast/pelvic exam)
  ▪ Transitional care management (TCM) & Advanced Care Planning (ACP) now allowed as stand-alone visits
  ▪ Still a face-to-face visit, with a core provider, during which RHC services are furnished
    ▪ Includes services furnished “incident to” core provider during visit
## DETAILED BILLING – COMMON REVENUE CODES

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Center visit by member to RHC</td>
</tr>
<tr>
<td>0522</td>
<td>Home visit by RHC provider</td>
</tr>
<tr>
<td>0524</td>
<td>Visit by RHC provider to member in covered Part A stay at the SNF</td>
</tr>
<tr>
<td>0525</td>
<td>Visit by RHC provider to a member in a SNF not in a covered Part A stay/assisted living/domiciliary care</td>
</tr>
<tr>
<td>0527</td>
<td>RHC visiting nurse service to a member’s home when in a home health shortage area</td>
</tr>
<tr>
<td>0900</td>
<td>Mental Health therapeutic visits</td>
</tr>
<tr>
<td>0780</td>
<td>Telehealth originating site facility fee</td>
</tr>
<tr>
<td>771</td>
<td>Vaccine administration</td>
</tr>
<tr>
<td>636</td>
<td>Administered drugs (J codes)</td>
</tr>
<tr>
<td>300</td>
<td>Blood draw (if performed during encounter)</td>
</tr>
</tbody>
</table>
DETAILED BILLING – “ROLLING” CHARGES

• EXCEPTION

  ▪ A covered preventive service (i.e., IPPE, AWV, well woman exam) is listed separately with CPT/HCPCS code & 052x revenue code.

  ▪ The charge is not rolled into total, but is deducted from total charge for purposes of calculating beneficiary coinsurance accurately

  ▪ Report modifier CG on the preventive service line item, so that appropriate payment can be made
MODIFIER CG

• Effective October 1, 2016, RHCs are required to append modifier CG on one line (medical and/or mental health) representing the primary reason for the qualifying visit (i.e., 99213, 90843)

• If the only service provided is a covered preventive service (i.e., G0101), the RHC appends modifier CG
  ▪ If a covered preventive service is performed on the same day as a medical/behavioral health service, the CG is appended to only the medical/behavioral line item
  ▪ **Exception** – CG is not appended to the IPPE service
MODIFIER CG – COINSURANCE/DEDUCTIBLE

• CMS flags the line item with modifier CG to prompt the AIR payment
  ▪ On the line with the “rolled” total charges

• For medical & mental health services, the coinsurance & applicable deductible is calculated

• For a covered preventive service, the coinsurance & applicable deductible are NOT calculated
DETAILED BILLING EXAMPLE – MEDICAL + PREVENTIVE

• Preventive annual well woman exam (*i.e.*, G0101) furnished with a medical visit (*i.e.*, 99213 established visit) will not prompt an additional AIR payment, except for IPPE

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied</th>
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</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213-CG</td>
<td>10/6/16</td>
<td>1</td>
<td>$76.00</td>
<td>AIR</td>
<td>Yes</td>
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<td>052X</td>
<td>G0101</td>
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<td>$38.00</td>
<td>Included in AIR</td>
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<td>0300</td>
<td>36415</td>
<td>10/6/16</td>
<td>1</td>
<td>$3.00</td>
<td>Included in AIR</td>
<td>No</td>
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DETAILED BILLING EXAMPLE – PREVENTIVE SERVICE

- Furnishing a covered preventive service (i.e., annual well women/breast & pelvic examination G0101) as only “qualifying visit” will prompt appropriate AIR payment. Calculation of coinsurance/deductible is waived if applicable

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance /Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G0101-CG</td>
<td>10/6/16</td>
<td>1</td>
<td>$38.00</td>
<td>AIR</td>
<td>No</td>
</tr>
</tbody>
</table>
DETAILED BILLING EXAMPLE – MENTAL HEALTH SERVICE

- Furnishing psychotherapy with patient & family (90834) will prompt an AIR payment. The charge from the additional medication management service (90863) will be listed separately & the charge “rolled” to the “qualifying service” line.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
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<tbody>
<tr>
<td>0900</td>
<td>90834-CG</td>
<td>10/8/16</td>
<td>1</td>
<td>$100.00</td>
<td>AIR</td>
<td>Yes</td>
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<tr>
<td>0900</td>
<td>90863</td>
<td>10/8/16</td>
<td>1</td>
<td>$25.00</td>
<td>Included in the AIR</td>
<td>No</td>
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</tbody>
</table>
DETAILED BILLING EXAMPLE – MULTIPLE VISITS/SAME DAY

• Multiple visits by same patient with more than one RHC core provider, or with same core provider, result in a single AIR payment

• EXCEPTIONS
  ▪ If patient is seen for qualifying medical & qualifying mental health visit on same date
  ▪ If patient suffers an illness or injury subsequent to their initial visit & requires additional diagnosis or treatment on same day
  ▪ If patient has a medical or mental health visit & an IPPE on same date of service. Coinsurance/deductible are waived for IPPE service
**DETAILED BILLING EXAMPLE – MULTIPLE VISITS/SAME DAY (2)**

- **Modifier CG** is appended to the initial qualifying service line.
- **Modifier -59 or -25** should be appended to service line CPT/HCPCS code(s) to identify *additional qualifying visit(s)* if a patient, subsequent to the first visit, has a distinctly separate illness or injury.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied</th>
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<td>$XX.XX</td>
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<td>1</td>
<td>$XX.XX</td>
<td>AIR</td>
<td>NO</td>
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</tbody>
</table>
QUESTIONS?
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CONTACT INFORMATION

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