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CPAs & Advisors



BILLING AND CODING BOOT CAMP - RURAL HEALTH CLINIC (SESSION 1)

National Rural Health Resource Center

**Delta Region Community Health Systems Development
Program**

Thursday, March 21, 2019 – 9:00 to 11:00 CT

IMPORTANT RESOURCES



- **CMS**

- <https://www.cms.gov/center/provider-type/rural-health-clinics-center.html>
- Medicare Claims Processing Manual, Chapter 9 – RHC & FQHC Services
- Medicare Benefit Policy Manual, Chapter 13 – RHC & FQHC Services

- **Medicare Administrative Contractor (MAC)**

- <https://www.novitas-solutions.com> (Jurisdiction JH – Arizona, Arkansas, Louisiana & Mississippi)
- <https://www.palmettogba.com/palmetto/providers.nsf/DocsCatH/JJ%20Part%20A> (Alabama & Tennessee)

- **Bureau of Primary Health Care ~ HRSA**

- <http://www.hrsa.gov/ruralhealth/>
- Technical Assistance Calls

<http://www.hrsa.gov/ruralhealth/resources/conferencecall/>



IMPORTANT RESOURCES CONTINUED

- National Association of Rural Health Clinics
 - <http://narhc.org/>
- Arizona Rural Health Association
 - <https://www.azrhassociation.org/>
- Alabama Rural Health Association
 - <https://arhaonline.org/>
- Louisiana Rural Health Association
 - <https://lrha27.wildapricot.org/>
- Mississippi Rural Health Association
 - <https://msrha.org/>
- Missouri Association of Rural Health Clinics
 - <https://www.marhc.org/>
- Missouri Rural Health Association
 - <https://www.morha.org/>



Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and
Federally Qualified Health Center (FQHC) Services

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(Rev. 252, 12-07-18)

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Rural Health Clinic Survey Protocol

Introduction

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- Task 3 - Information Gathering/Investigation*
- Task 4 - Preliminary Decision Making and Analysis of Findings*
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- §491.5 Condition for Certification: Location of clinic*
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 - §491.5(c) Standard: Criteria for designation of rural areas*
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THE MEDICARE PROGRAM

- In general, Medicare covered services are considered medically reasonable & necessary to the overall diagnosis & treatment of the beneficiary's condition. Services or supplies are considered medically necessary if they are:
 - Needed for the diagnosis or treatment of the beneficiary's medical condition
 - For the diagnosis, direct care & treatment of the beneficiary's medical condition
 - Meeting the standards of good medical practice
 - Not mainly for the convenience of the beneficiary, provider or supplier

THE MEDICARE PROGRAM CONTINUED

- For every service billed, the provider or supplier must indicate the specific sign, symptom or beneficiary complaint necessitating the service
- Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without beneficiary symptoms or complaints (with a few defined exceptions)
 - Example Non-covered - Annual physicals (*i.e.*, 99397, 99387)
 - Example Covered – Annual Wellness Exam (AWV)



WHAT IS COVERED IN THE RHC?



MEDICARE BENEFIT ENTITLEMENT

- A beneficiary is eligible to receive RHC services under Part B
- Medicare reimbursed under an All-Inclusive Rate (AIR)
 - Services are billed on a UB-04
 - Medicare pays 80% of the RHC AIR
 - Patient is responsible for payment of *20% of clinic's reasonable & customary charge(s) for covered services, plus an annual deductible each calendar year*
- No coinsurance or deductible is applied to the following services:
 - Initial Physical Preventive Examination (IPPE)
 - Annual Wellness Visits (AWV)
 - Other covered preventive services that have a Grade A or B & identified by CMS

MEDICARE REIMBURSEMENT - RHC

- Paid an all-inclusive rate, which is established annually
 - CY2019 payment limit per visit = \$84.70
 - For a **hospital provider based RHC**, 50 beds or under, the cap is adjusted based on cost.

RHC CORE SERVICES

- **Physician Services:** professional services performed by a physician for a patient, including diagnosis, therapy, surgery & consultation
- **Nurse Practitioner, Physician Assistant & Midwife Services:** services are of a type that practitioners can legally perform in their state & would be covered if furnished by a physician
- **Clinical Psychologist & Clinical Social Worker Services:** professional services may include diagnosis, treatment & consultation, those that are otherwise covered if furnished by a physician, & are of the type which can be performed if legally permitted to furnish in the state where furnished

RHC CORE SERVICES CONTINUED

- The core services of the RHC benefit are professional, meaning the hands-on delivery of care by medical professionals
- Some preventive services are also encompassed in primary care under the benefit



FOUR CATEGORIES OF SERVICES PROVIDED IN THE RHC

SERVICE CATEGORY	MEDICARE REIMBURSEMENT METHODOLOGY
RHC Encounters (Face to Face Visits) <ul style="list-style-type: none">• With a Core Provider	<ul style="list-style-type: none">• Paid under the All Inclusive Rate (AIR)
RHC Services Provided “Incident To” <ul style="list-style-type: none">• Performed by ancillary staff	<ul style="list-style-type: none">• Paid under the AIR if part of a FTF encounter• NOT paid under the AIR if outside a FTF encounter (<i>i.e.</i>, nurse only)
“Non-RHC” Services	<ul style="list-style-type: none">• NOT covered under the AIR• Paid under Medicare Physician Fee Schedule or applicable payment methodology (<i>i.e.</i>, cost, APC)
Non-Covered Services	<ul style="list-style-type: none">• NOT paid under the AIR• Not covered by the Medicare program• Patient responsibility or covered under secondary insurance post denial

RHC ENCOUNTERS



ALL INCLUSIVE RATE OR ENCOUNTER RATE

- Encounter rate includes:
 - Services provided by the core provider(s)
 - Related services & supplies (“incident-to services”)
- Rate does **not** include services not defined as RHC services
 - Lab, radiology films, EKG tracing, etc.
 - Hospital professional services

ENCOUNTER DEFINITION

- Face-to-face (one-on-one) encounter between a patient & a RHC physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered.
- A medically necessary medical or mental health visit, or covered preventive health visit
- Can also be a Transitional Care Management (TCM) or Advanced Care Planning (ACP) visit

RHC ENCOUNTERS OCCUR WHERE?

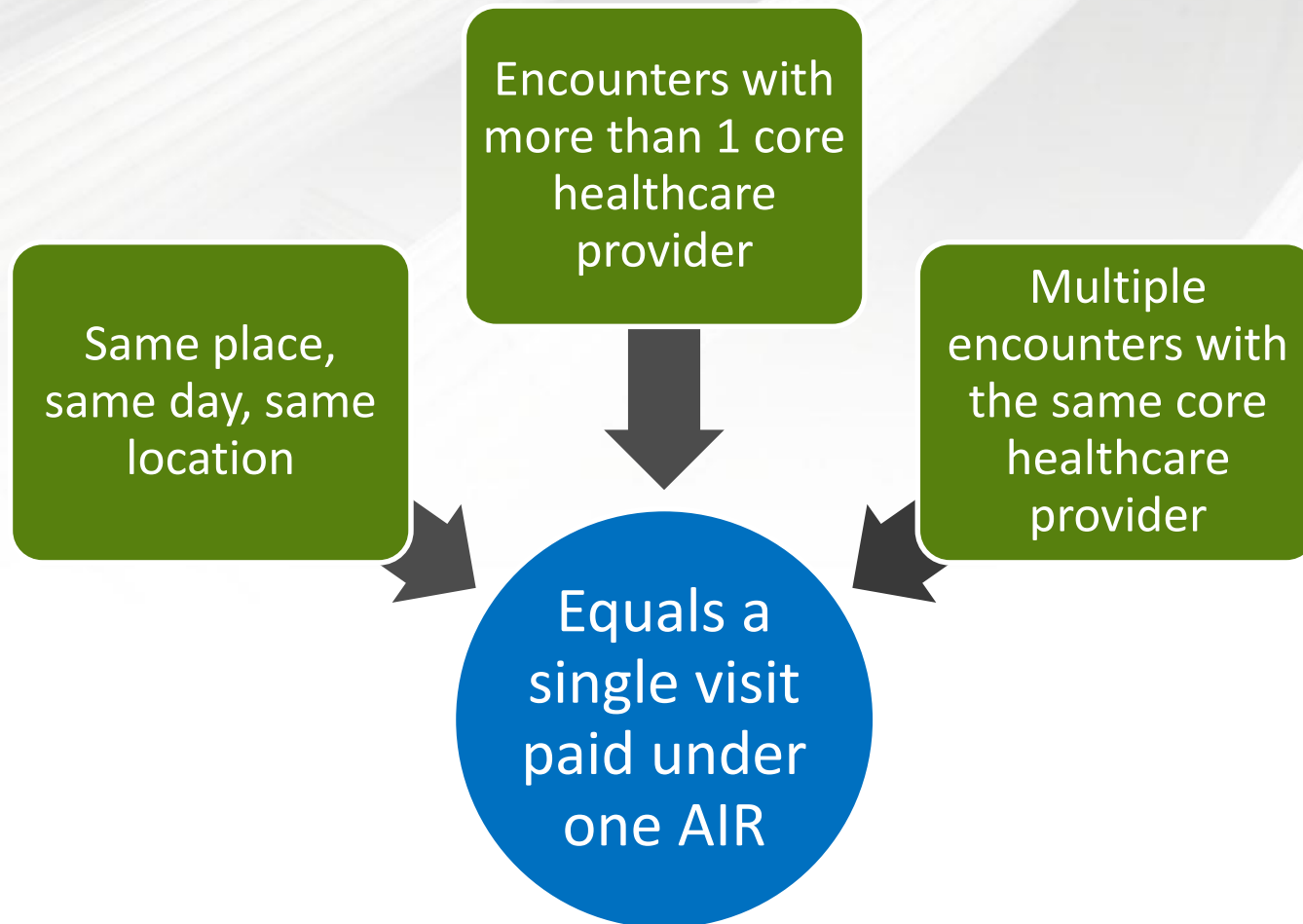
- In the RHC
- Patient's place of residence (*i.e.*, home)
- Nursing facility (*i.e.*, SNF, NF, swing bed)
- Assisted living facility or domiciliary care facility
- At the scene of an accident, school clinics, etc.

POLLING QUESTION 1

- A RHC is required to submit a UB-04 to primary Medicare for RHC professional services. What site of service is excluded from this billing guidance?
 - a. RHC
 - b. Hospital
 - c. Nursing facility
 - d. School clinic



DEFINING THE “SINGLE VISIT” OR ENCOUNTER



EXCEPTIONS TO THE “SINGLE VISIT” RULE

- If one of the following exceptions exists, then Medicare or State Medicaid would reimburse more than one AIR on a date of service
 - Subsequent to first encounter, patient suffers an illness or injury requiring additional diagnosis or treatment
 - Patient has a medical visit & a mental health visit
 - Patient has an Initial Preventive Physical Exam (IPPE) & a medical and/or mental health visit on the same day

NOT EVERY SCHEDULED PATIENT VISIT IS A REIMBURSABLE ENCOUNTER

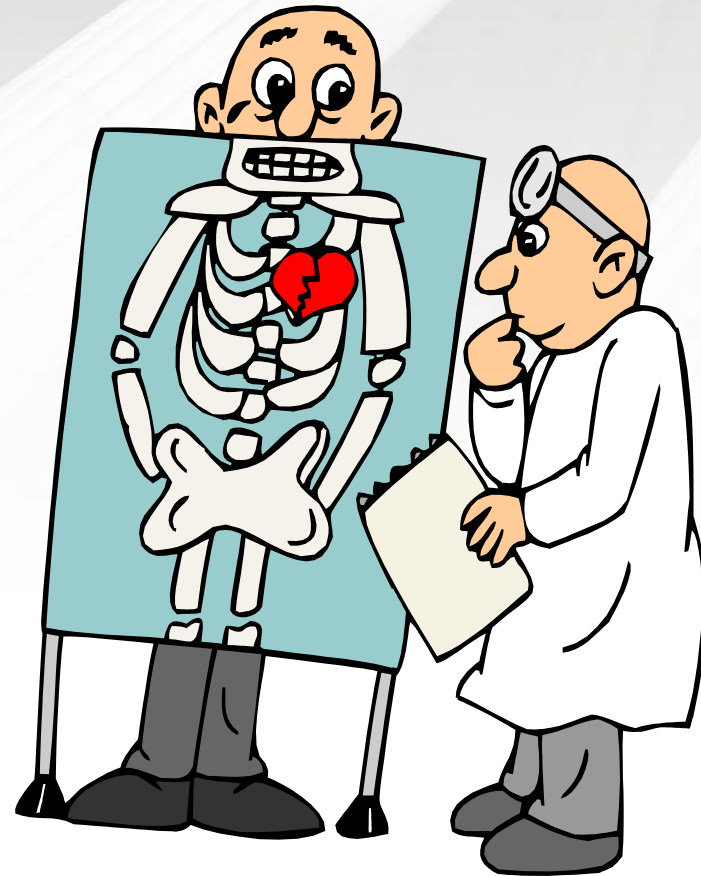
- The provider called the patient to let them know due to the laboratory test results, new medications would be called in to the pharmacy
- Interpretation of results of tests or procedures which *do not require face-to-face* contact between a *core provider* & the patient
- The patient is following up with the registered nurse per the provider's order – “incident to”
- Medication refills

MEDICATION REFILLS – ENCOUNTER NOT SUPPORTED

- When documentation states reason for patient visit is to refill meds
- Medicare does not consider “med refills” as medically necessary
- IF medically necessary for the core provider to evaluate the patient before updating the care plan (*i.e.*, remove meds, change meds, add meds), the conditions should be the reason for encounter

REMINDER: DIAGNOSTIC INTERPRETATION

- Performing the professional interpretation (reading) of an EKG or X-ray on a different date of service than the date when the diagnostic test is performed is *not an encounter*



INCIDENT-TO SERVICES



INCIDENT TO SERVICES

- Medicare Benefit Policy Manual, Chapter 13, Section 120.3:
“Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with a RHC...practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to 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.”

“INCIDENT TO” RHC SERVICES

- Services & supplies commonly rendered by clinic employees under *direct supervision* (i.e., ancillary staff)
 - *Direct supervision* is defined by CMS as within the office or suite & immediately available at the time of service
- Incidental part of professional service (e.g., injections, BP check, prescription renewals, dressing changes by nursing staff, blood draws, etc.)
- Tied to a visit (i.e., ordered as part of an established treatment plan) but not a separately billable visit

30-DAY RULE FOR INCIDENT-TO SERVICES

- Services such as B-12 injections or blood draws, when ordered by the provider & performed subsequent to the encounter, can be billed with the date of service of the original encounter *or* an encounter following the service *if within 30 days*
- “Incident to 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”

Source: Medicare Benefit Policy Manual, Chapter 13, §120.3

BLOOD DRAWS (INCIDENT-TO SERVICE)

- Venipuncture, arterial sticks, finger sticks, etc.
 - If performed as part of an encounter, list the CPT or HCPCS code on the RHC UB-04 & roll the charge into the total charges
 - If performed outside an encounter, the service is not billed on claim
 - Cost is captured on the annual cost report
 - In the **provider based RHC**, the parent hospital does not bill the blood draw to Part A. In the **independent RHC**, the blood draw is not billed to Part B



DIABETES EDUCATION

- DSMT & MNT *do not meet criteria* for a billable encounter in the RHC setting
 - Program (i.e., billing entity) must be accredited
 - Services may be furnished by a registered dietician or nutritional professional
- May be considered an “incident to” service
 - Must be a medically necessary part of an encounter with a core provider
 - Would not be common to be performed “incident to” on a frequent basis

NON-RHC SERVICES



NON-RHC SERVICES - MEDICARE

Paid under Part B for independent RHC, or the applicable reimbursement methodology in a provider based RHC

- X-rays & EKGs
 - Technical component
- Hospital services
 - If appropriate compensation agreement exists between RHC & core provider
- Lab services
 - CMS Clinical Diagnostic Laboratory Fee Schedule
- Ambulance services
- Leg, arm, back & neck braces
- Prosthetic devices
- Hospice patient
 - Conditions related to the reason for hospice care
- Durable medical equipment (DME)

LABORATORY TESTS (NON-RHC SERVICE)

- All labs, *including the six required onsite lab tests*, are billed separately from the RHC encounter
 - Dipstick UA
 - Hemoglobin (or hematocrit)
 - Glucose test (for home monitoring use)
 - Occult blood (diagnostic)
 - Urine pregnancy test
 - Primary culturing to submit to a lab

LABORATORY TESTS (NON-RHC SERVICE) CONTINUED

- *Independent RHC* - The RHC bills all lab services performed within the RHC on a CMS-1500 under the RHC group number. Testing is paid under fee schedule.
- *Provider based RHC* – The parent hospital bills all lab services performed within the RHC on a hospital outpatient UB-04, under the hospital group number, to Part A
 - RHC services are excluded from the 3-day window for PPS facilities
 - *Medicare Benefit Policy Manual, Chapter 13, Section 40.5*

NON-COVERED OR EXCLUDED SERVICES



EXCLUSIONS FROM MEDICARE COVERAGE

- RHC covered services *do not include* items & services that are not reasonable & necessary for the diagnosis, or treatment of illness or injury, or to improve the function & are statutorily excluded from payment



EXCLUDED SERVICES

- Never paid by Medicare (Examples)
 - Routine annual physicals (*i.e.*, CPT code 99397, 99387)
 - Dental care, hearing tests, routine eye exams
 - Routine nail trimming (without chronic illness)
 - B-12 Injections (without documented deficiency or anemia supported by diagnostic testing)
- Experimental procedures or services
- NOTE: Prescription drugs, oral medications, Shingles vaccines, etc., would be covered under Part D

ROUTINE VS NON-ROUTINE IMMUNIZATIONS

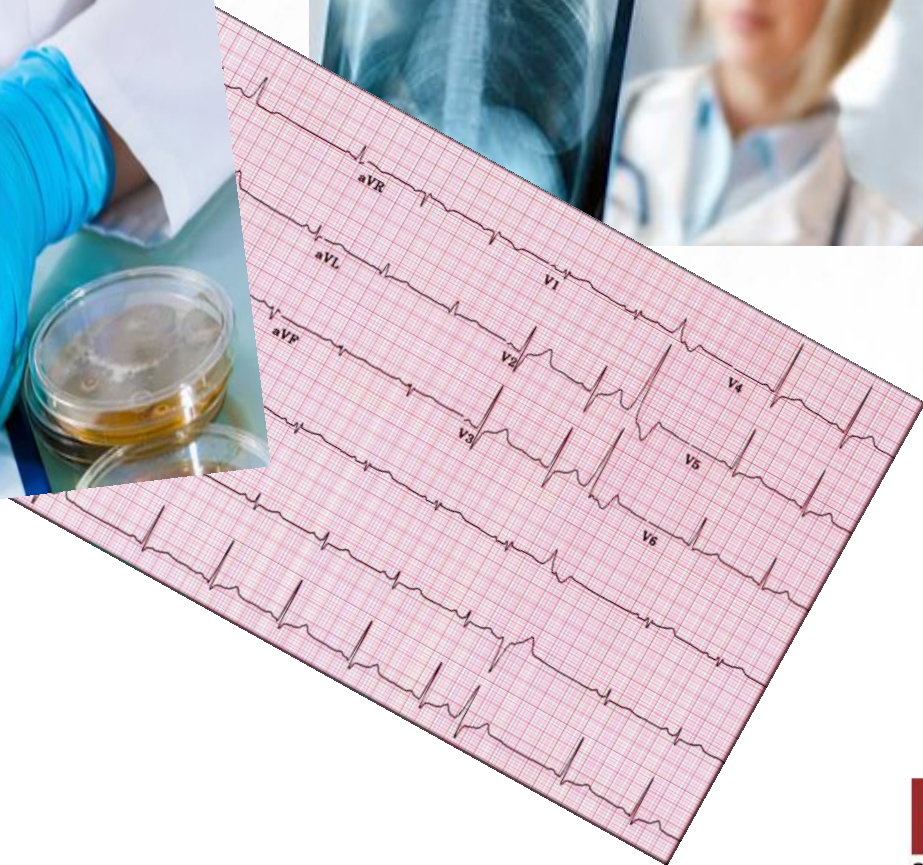
- Hepatitis A Tetanus injections & Tuberculosis (TB) tests are not “routinely” covered by Medicare
- If a patient has been exposed or injured requiring a TB test, Tetanus or Hepatitis injection, this is not considered “routine” & should be billed with appropriate diagnosis with an encounter

POLLING QUESTION 2

- Is a provider based or freestanding rural health clinic required to perform laboratory or imaging services during business hours?
 - a. A RHC may outsource all of their diagnostic services
 - b. A RHC must provide both laboratory and imaging services
 - c. A RHC must be able to perform six waived laboratory test, and may choose to offer imaging services



SPLIT BILLING – PROFESSIONAL & TECHNICAL SERVICES



DIAGNOSTIC TESTS – BILLING FOR INDEPENDENT RHC

- The ***technical component*** of all radiology & other diagnostic tests, including EKGs, are billed separately from the RHC encounter
 - RHC bills TC to Part B on a clinic CMS-1500 under the RHC group NPI
- ***Professional component*** is billed with encounter, unless a non-RHC physician interprets
 - A radiology service would require the CPT code with modifier -26 on the UB-04
 - An EKG professional interpretation would be billed with CPT 93010 without the modifier
 - *NOTE: Laboratory will not have a professional component*

DIAGNOSTIC TESTS – BILLING FOR PROVIDER BASED RHC

- The **technical component** of all radiology & other diagnostic tests, including EKGs, are billed separately from the RHC encounter
 - Parent hospital bills TC to Part A on a hospital UB-04 under the hospital group number
- **Professional component** is billed with encounter, unless a non-RHC physician interprets
 - A radiology service would require the CPT code with modifier -26 on the UB-04
 - An EKG professional interpretation would be billed with CPT 93010 without the modifier
 - *NOTE: Laboratory will not have a professional component*

STATE MEDICAID BILLING FOR RHC SERVICES

- RHC encounter services are submitted on a *UB-04* or a *CMS-1500* depending on the State
- Claim is billed under the RHC group/clinic provider number
- List all services (i.e., codes) provided during the encounter
- Revenue codes:

Revenue Code	Revenue Code Description
520	Encounter—Independent Rural Health Clinic
521	Encounter—Provider-based Rural Health Clinic
524	Basic or Periodic Family Planning Visit—Independent Rural Health Clinic
525	Basic or Periodic Family Planning Visit—Provider-based Rural Health Clinic

- RHCs are paid under an cost based encounter rate or PPS visit rate methodology
- Services paid under the visit rate –
 - Professional core services (in the clinic, nursing facility, home and hospital inpatient and outpatient setting if part of the providers' contract)
 - Incident-to services such as injections administered during the encounter
 - EPSDT
 - Family planning
 - Prenatal Services
- “Nurse Only” services are not billed to Medicaid, rather included on the annual cost report

STATE MEDICAID – NON-RHC SERVICES

- Services paid outside the encounter rate or PPS rate (i.e., fee schedule)
 - Hospital services
 - Physical, occupational, audiology or speech-language therapy
 - Medication dispensed by a pharmacy (that is part of the RHC)
 - Laboratory/radiology/EKG technical components
- Billed on a CMS-1500
- Billed under the individual provider's NPI number or a "non-RHC" group provider number
- ***Verify with your State Medicaid Program***

RHC MEDICARE BILLING GUIDELINES



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

A red UB-04 Medicare claim form, tilted at an angle, showing various fields for patient information, provider details, and billing data. The form is a standard industry form used for submitting claims to Medicare Administrative Contractors (MACs).

TYPE OF BILL (TOB)

- Third digit provides additional information on individual claims:
 - 710 = non-payment/zero claim (non-covered charges)
 - *711 = Admit through discharge (original claim)*
 - 717 = Replacement of prior claim (adjustment)
 - 718 = Void/cancel prior claim (cancellation)

MEDICARE SECONDARY PAYER

- Medicare requires that potential MSP issues be reviewed at the time of each visit
 - It does not have to be signed by the patient
 - It must be updated for each visit
 - MSP investigation must be documented
- References:
 - *Medicare Secondary Payer Manual, Chapter 3, §20.2.1*
 - *CMS, MSP Fact Sheet - [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP Fact Sheet.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP_Fact_Sheet.pdf)*

RHC UB-04 DETAILED BILLING



RHC DETAILED BILLING REQUIREMENTS – PROFESSIONAL SERVICES

- **Effective April 1, 2016**, all RHCs, to include those exempt from electronic reporting, are required to report CPT/HCPCS codes on the UB-04 claim for each service furnished during an encounter
- Appropriate revenue code(s) are reported for each line item
- Payment will continue to be made under all-inclusive rate (AIR)

RHC DETAILED BILLING REQUIREMENT – FLU & PNEUMONIA

- The current reporting requirements for flu & pneumonia vaccinations are unchanged
 - Tracking is for Medicare flu & pneumonia vaccinations
 - *Information (i.e., log sheet) is included in the annual cost report*
 - Medicare reimburses 100% of allowed amount
 - Coinsurance & deductible do not apply



HOSPITAL PROFESSIONAL SERVICES

- Current reporting requirements for non-RHC hospital professional services are unchanged
 - CMS-1500 claim form is submitted regardless of payer
 - Inpatient, Outpatient (ER, observation, other outpatient clinic)
 - *If* RHC is provider based to a critical access hospital (CAH), Method II election *may* be applicable to outpatient hospital services



TELEHEALTH

- Telehealth originating site facility fee
 - Revenue code 0780
- Service is not paid under AIR, although listed on the UB-04
- Paid under fee schedule



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, AWW, 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 – ADDITIONAL SERVICES & REVENUE CODES

- Every RHC service furnished during a billable encounter will be listed on a separate line item on UB-04 with CPT/HCPCS code
- “Qualifying visit service lines” will be tied to the 052x & 0900 revenue codes. Modifier CG is appended.
- Additional medical services or incident to services will be reported on separate lines with revenue codes & CPT/HCPCS codes
 - All valid UB-04 revenue codes may be reported EXCEPT FOR 002x-024x, 029x, 045x, 054x, 060x, 067x-072x, 080x-088x, 093x or 096x-310x
 - REMINDER: Sole performance of “incident to” services does not meet criteria for a billable encounter

DETAILED BILLING – COMMON REVENUE CODES

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

DETAILED BILLING – “ROLLING” CHARGES

- The RHC charge (*i.e.*, greater than or equal to \$0.01) should be listed for each additional line item
- When multiple services are furnished during an encounter, the 052x or 0900 revenue code line (*i.e.*, qualifying service line) will include the total charges for all services on claim to exclude any preventive services
 - The qualifying service line will prompt the AIR payment & be subject to coinsurance & deductible
- Additional line items will be processed by the MAC as “informational only” & considered bundled or packaged to the AIR payment

DETAILED BILLING – “ROLLING” CHARGES CONTINUED

- EXCEPTION

- A covered preventive service (*i.e.*, IPPE, AWW, 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

DETAILED BILLING – CLAIM ORDER

- The claim lines will be sorted in numerical order by revenue code
- It will not matter if the qualifying visit line does not appear on the first line of the claim
- AIR payment will be prompted by the qualifying visit line CPT/HCPCS code, revenue code & modifier CG
- The total line (0001 revenue code) will reflect the *sum* of all line item charges on the claim, to include the qualifying visit line
 - Appears as an “inflated” charge

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

```

MAP1033  PG 03  NATIONAL GOVERNMENT SERVICES,#13001 UAT  ACMFA561 04/02/14
RXR9220  SC      UB04 CLAIM  INQUIRY    REV CD PAGE 01  C201423F 06:47:58
DCN 11111111111111111111MEA      HIC 9990000000A  RECEIPT DATE 111613  TOB 771
STATUS P  LOCATION B9997      TRAN DT 121813  STMT COV DT 121413  TO 121413
    ESRD HRS:      PAT TERM ILL:      MULTI-LAB:      BENEFIT SAVINGS: N
                SERV                TOT  COV
CL  REV  HCPC MODS DATE      RATE  UNIT  UNIT  TOT CHRG  COV CHRG  NCOV CHRG
1  0521  99212 -CG 1214 (E&M=150.00)  1  1  350.00  350.00
2  0320  71022      1214      125.00  125.00
3  0636  J0690      1214      75.00   75.00
4  0001
    
```

DETAILED BILLING EXAMPLE – MEDICAL

- Single medical service
 - A single line item will be listed on UB-04, with appropriate 052x revenue code & charge. Payment is made under AIR

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance /Deductible Applied
052X	99213-CG	10/6/16	1	\$73.00	AIR	Yes

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

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/Deductible Applied
052X	99213-CG	10/6/16	1	\$76.00	AIR	Yes
052X	G0101	10/6/16	1	\$38.00	Included in AIR	No
0300	36415	10/6/16	1	\$3.00	Included in AIR	No

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

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance /Deductible Applied
052X	G0101-CG	10/6/16	1	\$38.00	AIR	No

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.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance /Deductible Applied
0900	90834-CG	10/8/16	1	\$100.00	AIR	Yes
0900	90863	10/8/16	1	\$25.00	Included in the AIR	No

DETAILED BILLING EXAMPLE – MULTIPLE MEDICAL SERVICES

- RHCs will report a separate line item for each service performed during medical encounter. Example: an established patient visit (*i.e.*, 99213) with performance of a simple laceration repair (*i.e.*, 12002). 99213 service line (revenue code 521) will prompt AIR payment

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance /Deductible Applied
052X	99213-CG	10/8/16	1	\$176.00	AIR	Yes
052X	12002	10/8/16	1	\$100.00	Included in the AIR	No

DETAILED BILLING EXAMPLE – MEDICAL + INCIDENT TO

- Services & supplies furnished “incident to” core provider’s encounter are included in AIR & not separately paid. “Service line” will include total charges for encounter. An example is an established visit with ordered lab draw & Hep B vaccination.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance /Deductible Applied
052X	99213-CG	10/13/16	1	\$127.00	AIR	Yes
0300	36415	10/13/16	1	\$ 3.00	Included in the AIR	No
0636	90746	10/13/16	1	\$ 35.00	Included in the AIR	No
0771	G0010	10/13/16	1	\$ 13.00	Included in the AIR	No

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 CONTINUED

- **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

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213 -CG	4/3/16	1	\$XX.XX	AIR	YES
0900	90834 -59	4/3/16	1	\$XX.XX	AIR	YES
052X	G0402-59	4/3/16	1	\$XX.XX	AIR	NO

POLLING QUESTION 3

- Modifier -25, CG and 59 are eligible for reporting in the RHC setting. What modifier(s) is appended to a qualifying visit code to prompt appropriate AIR payment from primary Medicare?
 - a. 25
 - b. CG
 - c. 59
 - d. All of the above



QUESTIONS?





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