CMS drastically overhauled rural health clinic (RHC) billing in 2016. RHCs now must report revenue codes, HCPCS codes, and charges for all services on separate lines outside of the qualifying visit line—a significant change. Proper reporting of revenue codes, HCPCS codes, modifiers, and charges for qualifying visits, items, and services is now more important than ever. RHCs have struggled to adapt to CMS' extensive billing changes, causing revenue flow problems. Combined with the unique staffing requirements and qualifications RHCs must meet, the challenges these vital providers face can seem overwhelming—but they don't have to.

The Essential Rural Health Clinic Billing and Management Guide breaks down RHC rules and regulations in an easy-to-understand format. This resource outlines how to meet the RHC designation, addresses the challenges of practice management at an RHC, and explains the latest RHC billing regulations and their impact.
The Essential Rural Health Clinic Billing and Management Guide

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Introduction

The Essential Rural Health Clinic Billing and Management Guide is a comprehensive go-to resource for training on critical billing, reimbursement, compliance, and business management issues for rural health clinics (RHC). RHCs, both independent and provider-based, are unique organizations. The Centers for Medicare & Medicaid Services (CMS) recognizes the vital role RHCs play in their communities and creates unique reimbursement models to meet their needs. However, RHC billing and reimbursement has become increasingly complicated. Staff must keep up with a growing number of revenue codes, Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT)® codes, and the use of appropriate modifiers. These changes mean revenue cycle management at RHCs is critical.

The information in this book can be useful as a training tool for on-boarding new staff as well as providing a refresher for seasoned RHC staff. This book comes with additional downloadable resources, including:

- An RHC billing and reimbursement training webinar. Both the MP4 and PDF files for this presentation are included for your use. Print out the PDF and tune into the webinar on your own time, or use this resource to train staff by scheduling a time to view the presentation together and distributing the PDF to the team before the training session.

- Billing case studies with UB-04 forms. Case studies describe how to bill for certain services and items. Each case study walks through choosing the correct codes and applicable modifiers, calculating reimbursement, and determining the patient’s financial responsibility. Completed sample UB-04 forms for each case study show how
the encounter would be billed to receive the correct reimbursement. Use this resource as a training tool by presenting the case study encounters as questions then working through the explanation. The corresponding UB-04 forms can be printed and used as answer keys.

- **A revenue cycle management flowchart.** This flowchart illustrates an efficient revenue cycle process with steps for each responsibility that will facilitate reimbursement and help staff understand what they need to do at each point. Save a copy to a central location or print copies for each member of the revenue cycle team.

- **A modifier selection flowchart.** This flowchart guides staff through the complexities of modifier selection step-by-step. It also illustrates expected reimbursement based on correct assignment of modifiers. Share a copy with team members so they can use it as a reference tool.

These materials are available for download at www.hcpro.com/downloads/12602. This will enable you to provide staff with a takeaway following any training you may develop around the information included in this book.
Chapter 1

Overview of the Medicare Program and Designation as a Rural Health Clinic

Debbie Mackaman, RHIA, CPCO, CCDS

Rural health clinics (RHC) provide vital outpatient services in their communities. They provide primary care and certain preventive health services in areas of the country that are federally designated as rural and medically underserved. RHCs must meet specific staffing requirements, which include mandatory utilization of nonphysician practitioners, and also must be able to provide certain laboratory services.

An RHC may be classified as an independent RHC or a provider-based RHC. This classification has certain ramifications on an RHC’s operations and reimbursement. RHCs must also be aware of restrictions and prohibitions that apply to staff, services provided, and sharing resources with another onsite Medicare Part B or fee-for-service practice.

There are more than 4,000 RHCs in the country. The Centers for Medicare & Medicaid Services (CMS) maintains a list of all current RHCs by region and state. This list is a useful reference to see how many RHCs are in a given area and may be interested in sharing information and networking.

Overview of the Medicare Program and Medicare Part B

Medicare is administered by CMS and is the largest payer for healthcare in the United States. Generally, Medicare provides coverage for individuals who are:

- 65 or older
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- Any age with end-stage renal disease (ESRD), permanent kidney failure requiring dialysis, or a kidney transplant
- Under 65 with certain disabilities

There are four parts to Medicare:

- Part A (hospital insurance)
- Part B (medical insurance)
- Part C (Medicare Advantage)
- Part D (prescription drug coverage)

Medicare Parts C and D are operated by Medicare-approved private insurance companies.

RHC services are covered under Medicare Part B, which also covers other services and supplies including the following (CMS, "What Part B Covers", 2017):

- Clinical diagnostic laboratory services
- Durable medical equipment (DME)
- Outpatient hospital diagnostic and nondiagnostic (therapeutic) services
- Physician and other professional services, including outpatient therapy
- Preventive services provided to outpatients and inpatients
- RHC and federally qualified health centers (FQHC)

Beneficiaries generally pay a premium for Part B and may purchase Part B even if they are not eligible for or do not purchase Part A (CMS, "What Part B Covers", 2017).

Although RHC services are covered under Part B, most services are billed to the Part A Medicare Administrative Contractor (MAC) on the UB-04/837I claim format using the appropriate bill type (MLN, "Medicare Billing", 2016). The technical portion of certain diagnostic services, including laboratory services performed by a provider-based RHC, are billed by the main provider to the Part A MAC on the UB-04/837I claim format. The technical portion of certain diagnostic services, including laboratory services performed by an independent RHC, are billed by the RHC to the Part B MAC on the CMS 1500/837P claim format.

RHCs may also see patients covered by Medicare Part C, which is an alternative to traditional fee-for-service Parts A and B. Private insurance companies offer Part C in the form of Medicare
Advantage (MA) plans (CMS, *Your Medicare Coverage Choices*, 2017). MA plans must cover all services traditional Medicare covers except hospice care (CMS, *What Medicare Covers*, 2017). MA plans may cover additional services, including vision, hearing, dental, or preventive services not covered by traditional fee-for-service Medicare. MA plans pay according to their contract with the provider, and if they are not contracted, they must generally pay the provider at least the traditional Medicare payment rate. Medicare publishes a guide for payments by MA plans to out-of-network providers (CMS, *MA Payment Guide*, 2015).

**Medicare contractors**

CMS uses multiple contractors to perform the functions necessary to administer the Medicare program (CMS, *Functional Contractors Overview*, 2016). RHCs will work with Part A/B MACs. MACs are Medicare contractors who perform all core claims processing functions and act as the primary point of contact for providers and suppliers for functions such as enrollment, coverage, billing, processing, payment, and auditing (CMS, *What Is a MAC*, 2016). MACs publish substantial claims processing, billing, and coding guidance on their websites, including medical review and documentation guidelines, coverage policies, and appeals and audit information.

There are 12 Part A/B MACs, designated by either a letter or number (CMS, *Who Are the MACs*, 2016). In 2010, CMS began consolidating the original 15 MACs (designated by numbers) into 10 consolidated MACs (designated by letters). In 2014, after consolidating to 12 jurisdictions, CMS discontinued the consolidation, leaving four numbered jurisdictions unconsolidated (J5, J6, J8, and J15) (CMS, *What’s New*, 2016).

**Other CMS contractors**

CMS works with contractors to perform several different auditing programs in both the inpatient and outpatient settings.

Recovery Auditors (RA) are paid a contingency fee based on identified overpayments and underpayments. CMS identified four Part A/B Recovery Audit jurisdictions and contracts with one RA for each jurisdiction (CMS, *Medicare Fee-for-Service Recovery Audit Program*, 2017). The current RAs and their recovery percentages are:

- Region 1 – Northeast/Great Lakes: Performant Recovery, Inc., 8.38%
- Region 2 – Midwest/Southwest: Cotiviti, LLC, 6.74%
RAs can make a limited number of additional documentation requests (ADR) from providers, physicians, nonphysician practitioners, and suppliers (CMS, *Physician/Nonphysician Practitioner Additional Documentation Limits*, 2011).

Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIO) manage beneficiary complaints and quality-of-care reviews, including beneficiary discharge appeals and short-stay hospital reviews (CMS, *Quality Improvement Organizations*, 2016). CMS contracts with two BFCC-QIOs, KEPRO and LiV ANTA, to provide services in five distinct areas designated by CMS.

CMS contracts with Comprehensive Error Rate Testing (CERT) contractors to perform audits to measure the error rate of Medicare-paid claims (CMS, *Comprehensive Error Rate Testing*, 2016). The CERT contractor uses a statistically random sample of approximately 50,000 claims to determine a national improper payment rate for the Medicare program.

Zone Program Integrity Contractors (ZPIC) identify cases of suspected fraud, investigate them, and take corrective action to protect the Medicare Trust Fund. There are seven geographical zones covered by the ZPICs (CMS, *MLN Matters*, 2012).

Supplemental Medical Review Contractors (SMRC) perform and provide support for a variety of tasks, including nationwide medical review audits aimed at lowering improper payment rates by conducting reviews focused on vulnerabilities identified by CMS (CMS, *Supplemental Medical Review Contractor*, 2013).

Qualified Independent Contractors (QIC) conduct the second level of appeal if the MAC denies the provider's first level of appeal (CMS, *Second Level of Appeal*, 2016). Administrative law judges (of the Office of Medicare Hearings and Appeals), who conduct third-level appeals, and the Medicare Appeals Council (of the Department Appeals Board), who conduct fourth-level appeals, are not Medicare contractors but rather employees of the Department of Health and Human Services.

**Purpose of an RHC**

The Rural Health Care Services Act of 1977 established RHCs to assist rural communities to meet the healthcare needs of Medicare beneficiaries where inadequate supplies of physicians
Overview of the Medicare Program and Designation as a Rural Health Clinic

existed (GPO, 1977). The act also provided a way to utilize nonphysician practitioners (i.e., physician assistants or nurse practitioners) to provide care in an alternative setting (Medicare Benefit Policy Manual, Chapter 13, §10.1, 2016; CMS, Rural health clinic fact sheet, 2016).

Although the benefits are similar, a facility approved as an RHC cannot be simultaneously approved as an FQHC (CMS, State Operations Manual, 2015). An RHC must provide primary medical services typically provided in an outpatient clinic and can choose whether to provide certain preventive services that are covered under its Medicare certification (Medicare Benefit Policy Manual, Chapter 13, §10.1, 2016). An FQHC must provide certain preventive services under its enrollment agreement with Medicare, as well as meet other criteria for payment (Medicare Benefit Policy Manual, Chapter 13, §10.2, 2016).

In general, approximately 51% of services provided in an RHC must be primary care services rather than specialty services. Advanced practice providers (APP), such as nurse practitioners (NP), physician assistants (PA), clinical nurse specialists (CNS), and certified nurse-midwives (CNM), are essential to provide care at an RHC. An RHC is required to have an NP or a PA to meet staffing requirements.

Certification Criteria

A clinic must meet certain criteria to be certified as an RHC by CMS. The certification criteria include geographic location and provider-to-resident population, services provided, and staffing requirements. A clinic must meet all requirements of each specific criterion to be certified.

Location requirements

A clinic must meet two location requirements (GPO, 2010; Medicare Benefit Policy Manual, Chapter 13, §§20, 20.1, 20.2, 2015; CMS, Rural Health Clinic, 2016). It must be located in a nonurbanized area and in a shortage area.

Nonurbanized areas are determined based on data from the U.S. Census Bureau. You can obtain information on whether a location is in an urbanized area from the appropriate CMS Regional Office or the U.S. Census Bureau.
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A shortage area is a federally designated area where a shortage of personal health services exists and the designation occurred within the previous four years. Determination that a shortage of personal health services exists is based on many factors; however, only three shortage area designations are considered by CMS for RHC certification:

1. Primary care health professional shortage area (HPSA), either geographic or population group
2. Medically underserved area (MUA)
3. Governor-designated and secretary-certified shortage area (this classification does not include a governor's medically underserved population designation)

An HPSA is identified by the ratio of primary care physicians practicing in the area to the population, and the ratio indicates the physicians are overutilized, excessively distant, or inaccessible to the population in the area. The MUA designation is based on the ratio of primary care physicians practicing in the area to the resident population.

A clinic applying to become a Medicare-certified RHC must meet both the nonurbanized and underserved location requirements (Medicare Benefit Policy Manual, Chapter 13, §20, 2016). Once certified, an existing RHC whose location no longer meets the rural, nonurbanized location requirement is not automatically decertified and may continue to operate as an RHC. However, if an existing RHC wants to relocate, the new location must meet both the rural location and the shortage area or underserved designation requirements. An RHC that plans to relocate or expand should contact their regional office to determine if the location requirements will continue to be met.

An RHC may be physically located in a permanent structure or in a mobile unit, as long as the location requirements are met (Medicare Benefit Policy Manual, Chapter 13, §20, 2016). If an RHC is located in several permanent locations, each location is independently certified by CMS. If an RHC is located in a mobile unit, it must have a fixed schedule that specifies the date(s) and location(s) for providing services. Each site where the services are provided must meet the location requirement.
Staffing requirements

An RHC can be certified by CMS only if the state does not explicitly prohibit the delivery of primary healthcare by a PA, NP, or CNM (CMS, State Operations Manual, Appendix G, §491.4 B, 2015). A surveyor may consider this condition met if state law is silent or doesn’t specifically prohibit a PA, NP, or CNM from providing services under limited physician supervision. A physician, NP, PA, CNM, clinical psychologist (CP), or clinical social worker (CSW) must be available to furnish patient care services within the scope of practice at all times the RHC is open to provide patient care according to its posted schedule (Medicare Benefit Policy Manual, Chapter 13, §§30.1, 40.2, 2016).

Physician staffing and services

An RHC must be under the medical direction of at least one physician who oversees the operations of the clinic and provides medical supervision of the healthcare staff (GPO, 42 CFR 491.8, 2017). The physician may own the clinic, be employed by the clinic, or provide services “under arrangement” to the clinic. Where state law allows, the RHC physician is no longer required to provide a supervisory visit for nonphysician practitioners at least once every two weeks, since many of the physician’s required functions may be performed remotely via electronic means (GPO, Federal Register, 2014). The physician, in collaboration with the NP and/or PA, develops and periodically reviews the clinic’s policies and procedures. The physician also conducts reviews of the patients’ records and provides medical orders and care to the RHC’s patients.

If the loss of a physician reduces the RHC’s staff below the required minimum, the clinic will be given a reasonable amount of time to comply with the staffing requirement, as long as the clinic can demonstrate a good faith effort was made to obtain the services of a physician on a permanent basis (CMS, State Operations Manual, Appendix G, 2015). The clinic must also make arrangements for a temporary physician(s) to perform the required physician responsibilities. The clinic should inform the state of all actions taken to recruit a replacement.

The term physician includes doctors of medicine (MD), osteopathy (DO), dental surgery/medicine, podiatry, optometry, or chiropractic who are licensed and practicing within their scope (Medicare Benefit Policy Manual, Chapter 13, §110.1, 2016). However, a physician other than an MD or DO is not considered to be a primary care physician for the purposes of meeting the statutory physician staffing requirement. A qualifying visit by a dentist, podiatrist, optometrist,
or chiropractor can only be performed when a physician (MD or DO) or other qualified nonphysician practitioner (PA, NP, or CNM) is also available in the clinic and the RHC practitioner is allowed to provide supervision under the written policies of the clinic, their scope of practice, and as allowed under state law. The Healthcare Common Procedure Coding System (HCPCS) codes must be reported to reflect the actual service(s) that were furnished, and the service(s) furnished cannot generally be services excluded from coverage.

Services furnished by a physician include those that would normally be provided in a physician’s office, such as the examination and diagnosis of the patient, preventive services, therapy services, consultations, and minor surgical procedures (Medicare Benefit Policy Manual, Chapter 13, §§10.1, 110, 2016). Prior to January 1, 2017, CMS provided a qualifying visit list that included frequently reported HCPCS codes that qualified as a face-to-face visit between the patient and an RHC practitioner. The list was not intended to be an all-inclusive list of stand-alone billable visits. CMS has since removed the list from its Rural Health Center website.

**Nonphysician practitioner staffing and services**

The RHC must employ at least one NP or PA on a part-time or full-time basis (GPO, Federal Register, 2014; Medicare Benefit Policy Manual, Chapter 13, §30.1, 2016). An NP or PA who is providing services similar to a locum tenens physician does not meet the statutory requirement that one of these practitioners must be employed by the clinic. An advance practice registered nurse (APRN) who is not an NP or PA does not meet the statutory requirement.

An NP, PA, or CNM must be available to provide services in the RHC at least 50% of the time that it is open (according to its posted schedule). This requirement is fulfilled through any combination of NPs, PAs, or CNMs as long as the total time equals 50% of the time the RHC is open to provide patient care (Medicare Benefit Policy Manual, Chapter 13, §30.1, 2016). Time spent furnishing patient care in the RHC or time spent directly furnishing patient care in another location (e.g., the patient's home, skilled nursing facility [SNF]) as an RHC practitioner is counted toward the requirement. Travel time to another location or time spent not furnishing patient care when in another location outside the RHC will not count toward the requirement.

In addition to providing patient care, an NP or PA must also review patients’ records and assist the clinic physician in the development and periodic review of the RHC’s policies (GPO, 42 CFR 491.8, 2017).
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The clinic may enter into staffing contracts with other NPs, PAs, CNMs, CPs, or CSWs as long as there is at least one NP or PA employed by the RHC at all times (GPO, 42 CFR 491.8, 2017; Medicare Benefit Policy Manual, Chapter 13, §30.1, 2016).

Services furnished by an NP, PA, or CNM to an RHC patient are those that would also be considered covered physician services under Medicare, such as the examination and diagnosis of the patient, preventive services, therapy services, consultations, and minor surgical procedures (Medicare Benefit Policy Manual, Chapter 13, §130, 2016). Services provided by an NP, PA, or CNM must meet additional requirements. These services must be:

- Provided under the general medical supervision of a physician (or direct supervision, if required by state law)
- Furnished according to the RHC’s internal policies that specify what services nonphysician practitioners may order and furnish to its patients
- Within the practitioner's scope of practice and permitted under state law

An RHC that is not physician-directed must have an arrangement with a physician that provides supervision for NPs, PAs, and CNMs. The arrangement must be consistent with state law (Medicare Benefit Policy Manual, Chapter 13, §130.2, 2016).

Employment exception and temporary staffing waiver

A clinic located on an island (i.e., completely surrounded by water, regardless of size and accessibility to the mainland) is not required to employ an NP or PA (Medicare Benefit Policy Manual, Chapter 13, §30.1, 2016).

If an existing RHC loses its nonphysician practitioner(s) and is unable to meet the requirement for the minimum 50% availability during the RHC’s operating hours, it may request a temporary staffing waiver (Medicare Benefit Policy Manual, Chapter 13, §30.2, 2016). The RHC must demonstrate in the 90-day period prior to the request that it made a good faith effort to recruit and retain the required NP or PA. A waiver cannot be extended beyond one year, and another waiver cannot be granted until a minimum of six months has passed since the prior waiver has expired. The RHC should inform the state of any changes in staffing that would affect its certification status, and it should continue to recruit the required provider to avoid termination of such.
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Services provided by other professionals

A CP must hold a doctoral degree in psychology and be licensed or certified to practice independently in the state in which he or she practices (Medicare Benefit Policy Manual, Chapter 13, §150, 2016). A CSW must hold a master’s or doctoral degree in social work, have performed two years of supervised clinical social work, and be licensed or certified as a CSW by the state in which he or she practices (Medicare Benefit Policy Manual, Chapter 13, §150, 2016). Where a state does not provide licensure, a CSW must have completed at least two years or 3,000 hours of post-master’s degree clinical social work practice, supervised by a master’s level social worker in an appropriate setting, such as a hospital, SNF, or clinic (GPO, 1998).

Services furnished by a CP or CSW to an RHC patient are those that would also be covered physician services under Medicare, including the examination and diagnosis of the patient and consultations, when performed by direct examination or by personally reviewing the patient’s medical information (Medicare Benefit Policy Manual, Chapter 13, §150, 2016). Telephone or electronic communication between the CP and CSW and the patient or someone acting on behalf of the patient are covered services that are included in a qualifying visit and may not be billed separately. A CP or CSW providing services to RHC patients must also be:

- Acting under the general supervision of a physician (or direct supervision, if required by state law)
- Furnished according to the RHC’s policies that specify what services a CP or CSW may order and furnish to patients
- Within the practitioner’s scope of practice and permitted under state law

Hours of Operation and Services Provided After Hours

The days of the week and the hours of operation must be posted at or near the clinic’s entrance. The notice must be easily readable and accessible for all patients (e.g., patients with vision problems, patients in wheelchairs). A clinic that is open solely to address administrative matters or to provide shelter from inclement weather is not considered to be in operation during this period and is not subject to the staffing requirements.
Services that are provided before or after the posted hours of operation can be billed by the clinic only when provided by a practitioner that is compensated by the RHC and those services are reported on the cost report (Medicare Benefit Policy Manual, Chapter 13, §40.2, 2016). If the services are provided before or after the posted hours of operation in accordance with the RHC’s policies, procedures, and employment contracts, and are not reported on the cost report, the practitioner may separately bill those services to Part B. The appropriate Medicare coverage policies and payment methodology will apply. All costs associated with non-RHC services billed separately to Part B must be removed from the cost report, including costs associated with space, equipment, supplies, facility overhead, and personnel (Medicare Benefit Policy Manual, Chapter 13, §60, 2016).

“Incident to” Services and Items

In general, “incident to” refers to those covered services and supplies that are integral, though incidental, to an RHC practitioner’s services and are the following (Medicare Benefit Policy Manual, Chapter 13, §§120, 140, 160, 2016):

- Usually provided in an outpatient clinic setting
- Usually included in the RHC all-inclusive rate (AIR) payment
- Performed by a staff member of the RHC in a medically appropriate time frame
- Generally furnished under the appropriate RHC practitioner’s direct supervision

“Incident to” includes a service or supply that is either provided without charge (e.g., routine supplies) or is included in the clinic’s total charge for the visit (e.g., venipuncture performed by a nurse or medical assistant) (Medicare Benefit Policy Manual, Chapter 13, §§120, 140, 160, 2016). More than one “incident to” service or supply can be provided as a result of a single visit with an RHC practitioner. Supplies that must be billed to the DME MAC are not included as part of the billable visit.

Most drugs and biologicals are covered when they are provided as part of a qualifying visit and are not considered to be “usually self-administered.” Payment for Medicare-covered Part B drugs is included in the AIR (Medicare Benefit Policy Manual, Chapter 13, §120, 2016). Drugs that are considered to be usually self-administered (e.g., oral pain medication or oral antihypertensive medication) are not included as part of the billable visit and are not paid as part of the qualifying
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visit (Medicare Benefit Policy Manual, Chapter 13, §120, 2016). Drugs that are billed to Medicare Part D are not included as part of the billable visit. Drugs that are specifically covered by a Medicare statute (e.g., influenza or pneumococcal vaccine) are not reported on the RHC claim nor paid as part of the qualifying visit. These vaccines are only reimbursed under the cost reporting process (Medicare Benefit Policy Manual, Chapter 13, §220.1, 2016).

Services provided by RHC staff

Services and supplies provided by auxiliary staff, either employed by or under an employment contract with the RHC, are covered as “incident to” when provided as a result of a qualifying visit and performed under the practitioner’s direct supervision, excluding certain services (discussed later in this chapter). Direct supervision does not require that the practitioner be present in the same room; however, the supervising practitioner must be in the RHC and immediately available to provide assistance and direction during the time when the services are being provided. Direct supervision is met for an NP, PA, CNM, or CP who supervises the performance of services by RHC staff only if the nonphysician practitioner is allowed to provide supervision under the written policies of the clinic, under their scope of practice, and as allowed under state law (Medicare Benefit Policy Manual, Chapter 13, 2016).

Services furnished by an RHC employee “incident to” a physician’s visit in a patient’s home or location other than the RHC must be provided under the direct supervision of the physician (Medicare Benefit Policy Manual, Chapter 13, §120.2, 2016). The availability of the physician by telephone or in a different location in the same building does not meet the definition of direct supervision.

The direct supervision requirement does not apply to visiting nurse services appropriately provided in the home.

Exceptions to “incident to”

Effective January 1, 2017, transitional care management (TCM) and chronic care management (CCM) may be furnished under general supervision rather than direct supervision (CMS, Transmittal R230BP, 2016). These services will be discussed in more detail in Chapter 2.

The Part B benefit for a CSW does not authorize a CSW to have services furnished “incident to” their own professional services (CMS, Transmittal R230BP, 2016).
Overview of the Medicare Program and Designation as a Rural Health Clinic

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Services Not Included in the RHC Benefit

An RHC may provide other services beyond the scope of its certification and the RHC benefit (Medicare Benefit Policy Manual, Chapter 13, §60, 2016). If the service is covered under another Medicare benefit category, the RHC must separately bill Part B under the payment rules that apply to that service (e.g., Medicare Physician Fee Schedule [MPFS] or other methodology). All costs associated with non-RHC services (e.g., overhead, staff, supplies, etc.) are not considered to be allowable costs and may not be reported on the RHC’s cost report.

See Chapter 2 for more information on non-RHC, or excluded, services.

Independent and Provider-Based RHCs

An RHC is classified as independent or provider-based for payment purposes. The classification is based on ownership and affects payment limits that may apply to the clinic.

Independent RHCs

An independent RHC is a freestanding clinic that is not owned or controlled by another healthcare entity (Medicare Benefit Policy Manual, Chapter 13, §10.1, 2016). An independent RHC is assigned a provider number (CMS Certification Number [CCN]) in the range of 3800–3974 or 8900–8999. The national upper payment limit will apply in an independent RHC (see Chapter 3 for more information about the national upper payment limit).

Provider-based RHCs

A provider-based RHC is owned, operated, or otherwise controlled by a hospital or other healthcare facility (GPO, 42 CFR 413.65, 2011). It is an integral and subordinate part of a hospital, CAH, SNF, or home health agency (Medicare Benefit Policy Manual, Chapter 13, §10.1, 2016) and is assigned a provider number in the range of 3400–3499, 3975–3999, or 8500–8899. However, a provider-based provider number is not an indication that the RHC has a provider-based determination for the purposes of an exception to the national upper payment limit (see Chapter 3 for more information).
CHAPTER 1  Overview of the Medicare Program and Designation as a Rural Health Clinic

In general, a provider-based clinic must meet all Medicare requirements that require that the clinic is integrated into the operations of the hospital or other healthcare facility (GPO, 42 CFR 413.65, 2011). Although a provider-based RHC is considered to be fully integrated with its parent provider, an RHC is not considered to be a department of the provider for the purposes of application of the entire regulation (GPO, 42 CFR 413.65(a)(2), 2011).

REFERENCES


Overview of the Medicare Program and Designation as a Rural Health Clinic

CHAPTER 1


Rural health clinics (RHC) must follow specific Medicare requirements for coverage and billing. Certain types of services must be available in an RHC, but only certain types of visits and services are billable under the RHC benefit. Medicare's limitation on liability (LOL) explains financial liability in situations in which a service does not qualify for Medicare reimbursement. In some situations, the RHC may be expected to absorb the cost and will not be reimbursed. In other situations, the patient may be expected to pay for the noncovered service. Ideally, before a potentially noncovered service or item is provided, the patient should be informed that the item or service may not be covered by Medicare and he or she may be financially liable. A thorough understanding of the coverage and billing requirements will reduce denials and write-offs for noncovered services and ensure that the RHC meets compliance requirements.

**Medicare Research**

The Centers for Medicare & Medicaid Services (CMS) publishes a large amount of coverage information on its website, and additional statutory information can be found in the *Federal Register* and the U. S. Government Publishing Office (GPO) website. However, staying up to date with the latest changes can be challenging. CMS and other government agencies publish a large volume of information, and finding the lists and sources that will be specifically beneficial may take some digging.

There are two main websites with Medicare source authority (i.e., Medicare “rules”). The GPO Federal Digital System (FDsys) website hosts statutes and regulations. The FDsys generally
has prior versions of statutes and regulations going back several years. The CMS website hosts CMS subregulatory guidance, including manuals, transmittals, and other guidance on the Medicare program.

**Tip**

The CMS website does not maintain an archive of prior versions of manuals and often removes transmittals or other guidance without notice. If you rely on guidance from the CMS website, you should retain a printed or electronic copy to ensure you have it for future reference.

**Key sources of authority**

Research should begin by consulting the source. In the case of Medicare and Medicaid, that means CMS, the Federal Register, and other official sources. Figure 2.1 contains a table with key sources of authority, or Medicare “rules,” as well as where they are published, where to find them on the Internet, and example citations. These sources include statues, regulations, subregulatory guidance, and CMS publications.
### Figure 2.1  
**Key Sources of Medicare Authority**

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CHAPTER 2 General Coverage Requirements for Rural Health Clinic Services

Statutes

Congress adopts new statutes as public laws. Public laws are found on Congress.gov, maintained by the Library of Congress. Each public law has a home page that provides information on the adoption of the bill and the final text.

The United States Code (USC) is a compilation of the U.S. statutes and contains the Medicare laws. Frequently, Medicare laws are cited by their Social Security Act section number rather than by their USC section number. The Social Security Administration maintains an updated version of the Social Security Act.

Regulations

CMS adopts new regulations in the Federal Register. Typically, regulations are first published as proposed rules, with a request for public comment. After gathering the comments, the agency publishes a final rule responding to the comments in the preamble of the rule and adopting the final regulations.

CMS also makes display copies of important proposed and final rules, along with accompanying data files and tables, available on its website. Proposed and final rules can be large and difficult to navigate. Use the table of contents to find sections of interest and the find feature to navigate to pertinent sections. The “Summary of the Major Provisions” section in the “Executive Summary” at the beginning of the rule can be a good place to start. Follow-up questions can be directed to the individuals in the “For Further Information Contact” section.

An RHC should monitor rule changes that affect Medicare’s Conditions of Participation and the Medicare Physician Fee Schedule (MPFS).

The Code of Federal Regulations (CFR) is a compilation of the regulations of the United States. Title 42 contains the Medicare regulations. To find important preamble discussion related to the regulation, use the notations at the end of each regulation containing the Federal Register citation and the date the regulation and each amendment were adopted. The CFR is published in an official annual edition and as a regularly updated electronic version referred to as the e-CFR, an unofficial compilation of the CFR and recent Federal Register amendments.

Subregulatory guidance

Subregulatory guidance, such as manuals (paper-based and Internet-only) and transmittals, is not binding on Medicare contractors or administrative law judges (ALJ). Regulations require
Medicare contractors and ALJs give “substantial deference” to the guidance applicable to a case and, if they do not follow it, explain why in their decision letter (42 CFR 405.1062).

The Provider Reimbursement Manual contains charging and cost reporting guidelines and is available in a paper-based version that can be downloaded from the CMS website. The Provider Reimbursement Manual has two parts. Part I provides cost report information such as Medicare’s policies on “Bad Debts, Charity, and Courtesy Allowances” or the “Determination of Costs of Services,” which provides information on the structure of charges. Part II primarily provides cost report formats and completion instructions.

CMS provides significant subregulatory guidance in Internet-only manuals published directly on its website. However, CMS often removes or revises manual sections without providing an archive of prior versions. You should retain a printed or electronic copy of manual sections you rely on to ensure you have them for future reference. The following Internet-only manuals may be particularly helpful:

- Pub. 100-02 – Medicare Benefit Policy Manual provides basic coverage rules.
- Pub. 100-04 – Medicare Claims Processing Manual provides coding, billing, and claims guidance.
- Pub. 100-08 – Medicare Program Integrity Manual provides guidance to Medicare auditors, including Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractors (SMRC), Comprehensive Error Rate Testing (CERT), Recovery Auditors (RA), and Zone Program Integrity Contractors (ZPIC), and may also be helpful to providers preparing for and responding to audits.

**Tip**

To access detailed information in the State Operations Manual, such as tag numbers, interpretive guidelines, and survey procedures, open the “Appendices Table of Contents” and click on the “Appendix Letter” for the provider or survey type (e.g., “G” for RHCs).
**Transmittals and program memoranda**

Transmittals communicate new or revised policies or procedures, as well as new, deleted, or revised manual language. Program memoranda were used prior to October 1, 2013, to communicate information similar to transmittals.

Transmittals are numbered with an “R,” followed by a sequential number distinct to the transmittal and two or more letters representing the manual the transmittal is associated with (e.g., CP for claims processing). Transmittals with the One Time Notification (OTN) designation are global in nature and not tied to a particular substantive manual.

Transmittals are linked to a change request (CR) number, CMS’ internal tracking number, tying together documents associated with a particular policy change. CMS representatives often use the CR number rather than transmittal number when referring to policy changes. A single CR may be associated with multiple transmittals if the policy represented by the CR affects multiple manuals; for example, one change request may have an associated Medicare Claims Processing Manual Transmittal and a Medicare Benefit Policy Manual Transmittal. The CR number is also used in the numbering of associated MLN Matters articles, discussed later in this chapter.

**Transmittal dates**

Pay close attention to the dates listed on a transmittal. There will typically be three dates. “Date” in the header represents the actual date CMS published the transmittal. The “effective date” gives the date of service the policy in the transmittal will begin to apply, unless noted otherwise.

The effective date of a transmittal may be prior to the date CMS published the transmittal, which may affect coverage, coding, billing, or payment of services already rendered. The “implementation date” shows the date processing systems will be able to process claims correctly according to the policies in the transmittal, unless noted otherwise.

The implementation date is generally the first business day of the quarter or year after the transmittal is effective, but may be substantially after the effective date. A provider may need to hold claims affected by the transmittal until system changes are implemented.
**MLN Matters articles**

MLN Matters articles explain Medicare policy in easy-to-understand format, often written for specific provider types as noted at the top of the article. There are two types of MLN Matters articles. MLN Matters articles linked to a particular transmittal are intended to provide practical and operational information about the transmittal. MLN Matters articles linked to transmittals are numbered “MM” followed by the CR number for the transmittal.

**Tip**

In addition to being published on the Medicare Learning Network (MLN) website, a link for MLN Matters articles associated with a transmittal appears below the link for the transmittal on the transmittal’s home page.

Special edition MLN Matters articles are not linked to a transmittal, but rather provide information on topics CMS believes require additional clarification. These articles frequently provide information not found in transmittals or manuals. Special edition MLN Matters articles are numbered “SE,” followed by two digits representing the year it was published and a sequential number distinct to the article. For example, SE1418 would be the 18th special edition MLN Matters article published in 2014.

**Tip**

In addition to appearing on the MLN website, special edition MLN Matters articles are listed on the transmittals website for the year they were published.
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Other guidance

CMS maintains an FAQ website with questions and answers indexed by an FAQ number.

The agency also often posts other guidance on its website in the form of documents, FAQs, algorithms, or other information. CMS’ Rural Health Clinics Center, Care Management Physicians Center, and Telehealth web pages may be particularly helpful.

Ways to stay current

You can subscribe to CMS updates via the “receive email updates” feature located on the bottom right corner of most pages on the CMS website. Suggested CMS mailing lists include:

- CMS Coverage Email Updates
- CMS News Releases (including proposed and final rule fact sheets
- Open Door Forums
- MLN Connects™ Provider eNews

CMS conducts periodic Open Door Forum conference calls that provide valuable information to providers. You can receive dial-in information by signing up to this list or checking the Open Door Forum page. The Rural Health Open Door Forum will include topics that mainly affect rural providers. The Physicians, Nurses, and Allied Health Professionals Open Door Forum will include topics that mainly affect physician and nonphysician practitioner coding and billing.

You can also subscribe to your MAC’s email list. Contact your MAC for more information on how to receive email updates.

General Coverage Rules in an RHC

The RHC benefit is based on a face-to-face visit between the patient and a qualified practitioner, such as a physician, nurse practitioner (NP), physician assistant (PA), clinical nurse midwife (CNM), clinical psychologist (CP), or clinical social worker (CSW) (Medicare Benefit Policy Manual, Chapter 13, §§10.1, 40; Medicare Claims Processing Manual, Chapter 9, §§10.1, 20.1). Other “incident to” services may be provided that don’t require a face-to-face visit with a practitioner. “Incident to” services will be discussed in more detail in Chapter 3.
General Coverage Requirements for Rural Health Clinic Services

CHAPTER 2

In some circumstances, items or services may be billed separately. Each of these circumstances create unique reporting requirements, such as billing for multiple medical visits on the same day or billing for the technical component of diagnostic services on a separate claim. Both of these scenarios, as well as other circumstances, will be discussed in more detail in Chapter 3.

RHC services are those that are typically provided in a physician’s office. In general, the following services must be provided under the RHC certification (42 CFR 405.2446, 405.2450, 405.2452; Medicare Benefit Policy Manual, Chapter 13, §§10.1, 50.1, 110, 120, 130, 140):

- Physician services and supplies “incident to” a physician’s service.
- NP and/or PA services and supplies “incident to” their services.
- Although laboratory services are not considered to be part of the RHC benefit, the clinic must be able to provide certain laboratory services onsite. Laboratory services will be discussed in greater detail later in this chapter.

In general, an RHC may provide the additional services included under its certification, such as:

- Covered drugs and other services when provided “incident to” a qualifying visit with a clinic practitioner
- Routine diagnostic services (professional component only)
- Services of a CNM or CP and supplies “incident to” their services
- Services of a CSW
- Services of a registered dietitian or nutrition professional for diabetes self-management training services and medical nutrition therapy when “incident to” a qualifying visit with a clinic practitioner
- Visiting nurse services for patients confined to home, in certain circumstances

An RHC may provide certain preventive services when specified by statute or national coverage determination (NCD) policy, which may include:

- Influenza, pneumonia, and hepatitis B vaccines
- Hepatitis C screening
- Initial preventive physical examination (IPPE)
- Annual wellness visit (AWV)
Other covered preventive services as recommended by the United States Preventive Services Task Force with a grade of A or B may also be provided. When appropriate, an RHC practitioner can refer patients to other facilities for preventive services that are not usually provided in a physician’s office.

**Excluded services**

Certain services are excluded from the RHC benefit and must be separately billed on the appropriate claim (Medicare Benefit Policy Manual, Chapter 13, §60). If the service is covered under another Medicare benefit category, the RHC bills Part B under the payment rules that apply to that service (e.g., MPFS or other methodology). All costs associated with non-RHC services (e.g., overhead, staff, supplies) are not considered to be allowable costs and cannot be reported on the RHC’s cost report. See Chapter 4 for more information on cost reports.

Some excluded services are as follows (Medicare Benefit Policy Manual, Chapter 13, §60.1):

- Practitioner services furnished to inpatients or outpatients in a hospital or critical access hospital, ambulatory surgery center, or comprehensive outpatient rehabilitation facility
- Services excluded from coverage under the Medicare program (e.g., routine physical exams, hearing tests, eye exams, self-administered drugs)
- Telehealth distant-site services
- The technical component of a diagnostic service performed in an RHC (e.g., x-ray, EKG)
- Laboratory services, excluding the venipuncture
- Hospice services
- Medically necessary ambulance transport services to the nearest appropriate facility
- Group services including education activities or classes
- Durable medical equipment
General Coverage Requirements for Rural Health Clinic Services

CHAPTER 2

National and Local Coverage Policies

All healthcare providers, including RHCs, and MACs must comply with NCDs. Local coverage determinations (LCD) are issued by a region’s MAC and apply to Part A and Part B providers within a MAC’s specific regional jurisdiction.

CMS publishes NCDs, LCDs, and related documents on its Medicare Coverage Database website. Check CMS and MAC publications regularly for coverage updates.

National coverage determinations

NCDs describe national Medicare coverage policy and generally provide the conditions under which an item or service is considered to be covered. NCDs are binding on all Medicare contractors and in most cases on administrative law judges (ALJ) in the appeals process (42 CFR 405.1060; Medicare Program Integrity Manual, Chapter 13, §13.1.1).

National coverage analyses and decision memoranda

CMS also publishes national coverage analyses (NCA) and decision memoranda describing CMS coverage decisions and providing the clinical basis and the rationale of the decisions, including clinical evidence and studies. NCAs and coverage decision memoranda are not binding on Medicare contractors or ALJs, but CMS directs contractors to consider them in their medical review activities (Medicare Program Integrity Manual, Chapter 12, §13.1.1).

Coding analyses for labs, Medicare Evidence Development & Coverage Advisory Committee meeting minutes, technology assessments (TA), and Medicare coverage documents (MCD) provide additional guidance on national Medicare coverage policies and decisions.

Local coverage determinations

MACs publish LCDs to describe local coverage policy and as an educational tool to assist and furnish guidance to providers within their jurisdiction. LCDs were formerly called local medical review policies (LMRP) and were converted to LCDs between 2003 and 2005 (Medicare Program Integrity Manual, Chapter 13, §13.1.3).
MACs also publish coverage articles addressing local coverage, coding, billing, medical review, and claims considerations. The articles may include newly developed educational materials, coding instructions, or clarification of existing billing or claims policy.

**Coverage With Evidence Development (CED)**

CED policies cover items or services on the condition they are furnished in the context of approved clinical studies or with the collection of additional clinical data (Guidance for the Public, Industry, and CMS Staff; Coverage with Evidence Development Document, issued on November 20, 2014).

The routine costs of items and services associated with services covered under CED are also covered as long as the items or services are generally covered for Medicare beneficiaries (Guidance for the Public, Industry, and CMS Staff; Coverage with Evidence Development Document, issued on November 20, 2014).

Billing information for reporting services under CED can be found in MLN Matters Article MM840 and the Medicare Claims Processing Manual, Chapter 32, §§68.2, 69.5, 69.6.

**Laboratory NCD Manual**

CMS publishes laboratory NCDs, along with additional coding and coverage information related to laboratory services, in a “lab NCD manual” entitled Medicare National Coverage Determination (NCD) Coding Policy Manual and Change Report, Clinical Diagnostic Laboratory Services.

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**Tip**

The lab NCD manual includes additional coding and coverage guidelines not included in the Medicare Coverage Database or Medicare NCD manual.

The lab NCD manual contains national policy decisions “granting, limiting, or excluding Medicare coverage” for clinical diagnostic lab tests (Program Memorandum AB-02-110). Although the lab NCD manual is available on CMS’s website, it is not part of CMS’s “Internet
only” manual system. However, portions of the lab NCD manual are incorporated into the National Coverage Determinations Manual (Pub. 100-03) that is included in CMS’ “Internet only” manual system.

The lab NCD manual contains national policies, and MACs may not issue or maintain local policies (e.g., LCDs) that are inconsistent with the lab NCD manual (Program Memorandum AB-02-110).

There are three “lists” of diagnosis codes applicable to each NCD: noncovered ICD-10-CM codes for all NCD edits, ICD-10-CM codes covered by Medicare, and ICD-10-CM codes that do not support medical necessity.

**Noncovered ICD-10-CM codes for all NCD edits**

This section lists codes that are never covered by Medicare for a diagnostic lab testing service. If a code from this section is given as the reason for the test, the test may be billed to the Medicare beneficiary without billing Medicare first because the service is not covered by statute, in most instances because it is performed for screening purposes and is not within an exception. The beneficiary, however, does have a right to have the claim submitted to Medicare upon request (Medicare National Coverage Determinations Coding Policy Manual and Change Report, 2017).

**ICD-10-CM codes covered by Medicare**

This section includes “covered” codes: codes for those lab test services that Medicare presumes are medically necessary. However, Medicare may review a claim for such services to determine whether the service was reasonable and necessary (Medicare National Coverage Determinations Coding Policy Manual and Change Report, 2017).

**ICD-10-CM codes that do not support medical necessity**

This section lists/describes noncovered codes for which there are only limited exceptions. However, additional documentation could support a determination of medical necessity in certain circumstances. Subject to section 1879 of the Social Security Act, 42 CFR 411, subpart K, section 7330 of the Medicare Carriers Manual, section 3440–3446.9 of the Medicare Fiscal Intermediary Manual, and any applicable rulings, it would be appropriate for the ordering physician or the laboratory to obtain an Advance Beneficiary Notice (ABN) from the beneficiary (Medicare National Coverage Determinations Coding Policy Manual and Change Report, 2017).
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Limitation on Liability

The general coverage rules for an RHC and Medicare’s limitation on liability (LOL) outline what services and items are covered and who is financially responsible if a service or item is not covered. In general, staff should be aware of these rules and be able to explain them to patients. If a patient is made aware that a service will not be covered by Medicare and wishes to receive the service anyway, a thorough explanation should be provided to the patient. In certain circumstances, issuance of the ABN is mandatory, as well an explanation that the patient may be expected to pay the full bill. Under the LOL, an RHC may not send an unexpected bill to a patient. Even in circumstances when the RHC is not required to inform the patient in advance of the service, a best practice would be to inform the patient, which prevents misunderstandings and customer dissatisfaction.

Beneficiaries and providers may be protected from unexpected liability for charges associated with denied claims under certain circumstances. These financial liability protections include the LOL, which applies very specifically to coverage policies and is dependent upon statutory provisions and the statutory basis of the denial (Medicare Claims Processing Manual, Chapter 30).

The protections afforded under the LOL are provided for all Part A and Part B services. As discussed in Chapter 1, RHC services are covered under Part B and are, therefore, subject to the statute.

Medicare contractors must follow accepted standards of medical practice and Medicare statutes, regulations, and national coverage instructions when they make a coverage determination (Medicare Claims Processing Manual, Chapter 30).

Determining liability

If a claim is denied and not covered by the LOL financial protections, the Medicare contractor will determine whether the provider or the beneficiary is responsible for payment. The provider will be responsible if it (Medicare Claims Processing Manual, Chapter 30):

- Had actual knowledge that services were not covered in the specific case
- Could reasonably be expected to know that services wouldn’t be covered
General Coverage Requirements for Rural Health Clinic Services

Medicare will not pay the claim and the beneficiary will not be responsible for paying the bill including deductible and coinsurance.

If a beneficiary was given written notice with an ABN that an item or service is not covered the contractor may determine that the beneficiary is liable. In this circumstance, the beneficiary is responsible for payment, and no Medicare payment will be made to the provider (Medicare Claims Processing Manual, Chapter 30).

The beneficiary has the right to appeal. Chapter 29 of the Medicare Claims Processing Manual discusses appeals, including time limits for filing, guidelines for writing appeal letters, and steps in the appeal process.

Occasionally, the Medicare contractor may determine that neither the provider nor the beneficiary knew or could reasonably have known that the services or items were not covered. In this case, Medicare will accept liability and make payment.

**Advance Beneficiary Notice**

The ABN falls under Medicare’s LOL provisions, which require that beneficiaries receive prior notice when providers and/or suppliers do not expect Medicare to cover certain services based on the condition for which they were ordered. The purpose of the ABN is to notify the beneficiary the RHC does not expect certain outpatient services to be covered. If Medicare does not pay for the services, the beneficiary will be financially responsible. The notice is designed to give the beneficiary sufficient information to decide whether to have the services performed, in light of his or her financial liability if Medicare does not pay.

In general, an ABN is mandatory when:

- An item or service is not reasonable and necessary (Medicare Claims Processing Manual, Chapter 30, §20.1.1, 50.3.1)
- The item or service is not considered by Medicare to be medically necessary under the circumstances
- The service is a preventive service that is usually covered but will not be covered in this instance because frequency limitations have been exceeded
- The service is custodial care (Medicare Claims Processing Manual, Chapter 30, §20.1.1, 50.3.1)
CHAPTER 2  General Coverage Requirements for Rural Health Clinic Services

- The item or service is experimental (e.g., research use–only or experimental use–only laboratory tests) (Medicare Claims Processing Manual, Chapter 30, §50.3.1)

An ABN is voluntary in certain circumstances. In the case of services that are statutorily excluded or fail to meet a technical benefit requirement, advance notice of noncoverage is voluntary, and the beneficiary can be held financially liable even if they are not provided notice that Medicare will not pay (Medicare Claims Processing Manual, Chapter 30, §§20.2.1, 50.3.2).

An ABN is voluntary for “categorical denials.” These are items or services that are statutorily excluded from coverage or are not a Medicare benefit, such as the following (Medicare Claims Processing Manual, Chapter 30, §§20.2.1, 50.3.2):

- Routine physicals (except the IPPE and AWV) and most tests for screening
- Most vaccinations (except pneumonia and influenza vaccines and hepatitis B in certain circumstances)
- Routine eye examinations, eye care, and most eyeglasses
- Hearing examinations and hearing aids
- Cosmetic procedures
- Routine foot care, flat foot care, orthopedic shoes, and orthotic foot supports
- Most dental care

Technical denials, a denial due to the item or service not being furnished in a manner that satisfied the conditions of coverage, also do not require an ABN. For example, noncoverage of most self-administered drugs is considered a technical denial (Medicare Claims Processing Manual, Chapter 30, §20.2.2).

The ABN, only available in English and Spanish, is the required form for providing notice of noncoverage for outpatient services. The ABN may not be modified except as specifically allowed in the completion instructions (Medicare Claims Processing Manual, Chapter 30, §50.6.2). See Chapter 5 for a copy of the ABN. Check the CMS website for updates on the ABN and copies of the form in English and Spanish.
Tip
The ABN form may not be used for services provided under Medicare Advantage plans (Medicare Claims Processing Manual, Chapter 30, §§10, 50.3).

Delivery of the ABN

The ABN should be delivered by hand to the beneficiary or their representative, and the provider must answer all inquiries of the beneficiary, including the basis for the determination that the service is not covered. If in-person delivery is not possible, delivery may be made by telephone, mail, secure fax, or email. If notice is by telephone, a copy should be mailed, faxed, or emailed to the beneficiary, who should sign it and return it to the provider. If the beneficiary does not return the signed copy of the notice, document on the notice that attempts were made to obtain the signature (Medicare Claims Processing Manual, Chapter 30, §50.7.2).

An ABN will not be considered to be effective unless the beneficiary or his or her authorized representative was able to comprehend the notice (Medicare Claims Processing Manual, Chapter 30, §40.3.4.3). Oral assistance should be provided for languages other than English and Spanish and documented in the “Additional Information” section (Medicare Claims Processing Manual, Chapter 30, §50.6.1.A). Other types of assistance may include accommodations to meet the needs of hearing- or vision-impaired individuals; they should also be documented on the ABN.

CMS defines an authorized representative as “a person who is acting on the beneficiary’s behalf and in the beneficiary’s best interests, and who does not have a conflict of interest with the beneficiary.” For example, a person (such as a family member) who the beneficiary has indicated may act for him or her may serve as an authorized representative even if the person has not been formally designated as an authorized representative in any “legally binding document” (Medicare Claims Processing Manual, Chapter 30, §40.3.5).

The beneficiary must be notified far enough in advance of receiving the item or service to permit the beneficiary to “make a rational, informed consumer decision without undue pressure” (Medicare Claims Processing Manual, Chapter 30, §40.3.3).
Completion of the ABN

Instructions on completing the ABN can be downloaded from CMS’ website under the fee-for-service (FFS) ABN tab of the beneficiary notices initiative page. The following will discuss the sections of the ABN form and valid information that may be included.

“Notifier(s)”

The header should identify the name, address, and phone number of the entity providing the notice. An otherwise valid ABN is not invalidated simply because the header contains the identifying information for the person or entity that “obtained the ABN” (e.g., a physician office), rather than the “billing entity” (Medicare Claims Processing Manual, Chapter 30, §40.3.4.5).

“Patient name” and “identification number”

Enter the patient’s name as it appears on their Medicare HICN card. An optional identification number may be entered and should be an internal RHC number, such as the medical record or account number. The beneficiary’s Medicare number (HICN) or Social Security number may not appear on the form.

Tip

The HICN will become the Medicare Beneficiary Identifier (MBI) beginning in 2018.

“Blank D”

Enter a general category on “Blank D” throughout the form to describe the type of services on the ABN (e.g., item, service, care, test, laboratory test, equipment). In the first column, under the general category descriptor (“Blank D”), enter the items or services expected to be denied by Medicare. For groups of items, a general description is sufficient; an itemized list is not necessary. For repetitive or continuous noncovered services, the frequency and/or duration of the item or service must be specified, and the ABN will be effective for one year (Medicare Claims Processing Manual, Chapter 30, §50.7.1.B).
“Reason Medicare may not pay”

Explain the reason the item may not be covered by Medicare, which may include:

- “Medicare does not pay for this test for your condition”
- “Medicare does not pay for this test as often as this (denied as too frequent)”
- “Medicare does not pay for experimental or research use tests”

Simply stating “medically unnecessary” or the equivalent is not acceptable (Medicare Claims Processing Manual, Chapter 30, §40.3.8).

“Estimated cost”

Provide a good faith estimate of the cost of the noncovered services to the patient. The cost to the patient is the provider’s usual and customary charge and is not limited by the Medicare allowable or payment amount (Medicare Claims Processing Manual, Chapter 30, §50.13).

**Tip**

The final amount billed to the patient may be affected by state laws requiring providers to give uninsured patients a discount, including discounts based on financial need or equal to the discount given to their largest payer.

Multiple services may be grouped together into a single cost estimate. An average daily cost estimate may be provided for complex projections, such as a series of injections over the course of several days.

In some cases, the cost may be unknown. The RHC should not have a policy of routinely or frequently failing to provide a cost estimate; however, the patient may sign an ABN without a cost estimate in limited circumstances. If additional services may be required, the cost of the initial services should be given, along with a notation that additional services may be provided. If the costs cannot be determined, make a notation in the cost estimate area that no cost estimate is available.

An estimate will be considered to be made in “good faith” if the estimate is within the greater of $100 or 25% of the cost of the service to the patient (i.e., amount billed to the patient). The
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estimate may be given as a range, and an estimate in excess of the actual cost is acceptable. Examples of good-faith cost estimates for a service that the RHC charges $100 for would be:

- Any estimate greater than $75
- “Between $75–110”
- “No more than $120”

“Options”

The beneficiary, or his or her representative, must select and check one of the options or have the provider check the option if they are unable to do so. If the provider checked the option at the request of the beneficiary, he or she should make a note of that on the ABN. If the beneficiary refuses to choose an option, make a note on the ABN (i.e., “beneficiary refused to choose an option”). If there are multiple items on the ABN and the beneficiary wants to select different options for each of the items, more than one ABN should be used to accommodate the beneficiary’s choices.

“Additional information”

This field may be used to make annotations or for witness signatures. If items are added after the date of the ABN, they must be dated.

“Signature”

The beneficiary or his or her representative should sign and date the notice. If the representative signs the notice, he or she should annotate his or her signature with “(representative).” A beneficiary’s refusal to sign an ABN does not invalidate the ABN. If the beneficiary refuses to sign but still desires to receive the item or service, CMS recommends that two witnesses sign the ABN form attesting to the provision of the ABN to the beneficiary and the beneficiary’s refusal to sign (Medicare Claims Processing Manual, Chapter 30, §40.3.4.6(A)).

Copy of the ABN

The RHC should retain the original ABN and give a copy to the beneficiary. The ABN should be retained for five years or longer, as required by state law. The ABN should be retained even if the beneficiary refuses service or refuses to sign or choose an option. Carbon copies, fax copies, electronically scanned copies, and photocopies are all acceptable (Medicare Claims Processing Manual, Chapter 30, §§40.3.4.1, 50.6.4).
Prohibition on routine, blanket, and generic ABNs

In general, “generic” ABNs (i.e., merely stating denial is possible), “routine” ABNs (i.e., no specific reason Medicare will not pay), and “blanket” ABNs (i.e., given for all claims) will not be considered to be effective. However, this general rule does not apply to items or services furnished for which coverage is limited based on frequency (e.g., AWV). In this circumstance, a routine ABN is acceptable if the notice states the frequency limitation (e.g., “Medicare does not pay for this more often than ______.”) (Medicare Claims Processing Manual, Chapter 30).

REFERENCES


Chapter 3

Billing and Claims Processing for Rural Health Clinics

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Rural health clinic (RHC) billing was relatively straightforward until recently. Prior to April 1, 2016, RHCs used a limited set of revenue codes. Healthcare Common Procedure Coding System (HCPCS) codes and modifiers were not required for medical and/or mental health visits, although they were required to report preventive services and telehealth. On April 1, 2016, the Centers for Medicare & Medicaid Services (CMS) began to require reporting of all valid revenue codes and HCPCS codes for qualifying visits and introduced expanded use of modifiers. This interim system was used until October 1, 2016, when CMS rolled out additional modifiers and billing requirements.

RHCs must pay close attention to CMS transmittals, regulations, and other communications to stay on top of any future changes.

Claims Processing Requirements for RHC Billing

An RHC submits a claim for its services on the UB-04 Form/837 I Electronic Format (Medicare Claims Processing Manual, Chapter 9, §50; Medicare Billing: 837I and Form CMS-1450 Fact Sheet).

Instructions and code descriptions for the fields on the UB-04 are no longer contained in Chapter 25 of the Medicare Claims Processing Manual. Providers can obtain the field code descriptions from the National Uniform Billing Committee (NUBC) by subscribing to the current version of the Official UB-04 Data Specification Manual on the NUBC website. Medicare
Administrative Contractors (MAC) also provide substantial claims processing, billing, and coding guidance on their websites that may assist RHCs with billing questions (Medicare Claims Processing Manual, Transmittal 1973).

CMS will continue to communicate specific code implementation directions via change requests (Medicare Claims Processing Manual, Transmittal 1973). General billing and claims processing information can be found in Chapter 1 of the Medicare Claims Processing Manual. General admission and registration requirements for all claims can be found in Chapter 2 of the Medicare Claims Processing Manual.

In certain circumstances, non-RHC services provided by a practitioner furnishing services in an independent RHC are submitted to the Part B MAC on Form CMS-1500/837P. General billing and claims processing information for professional services can be found in the Medicare Claims Processing Manual, Chapter 12.

Key fields on the UB-04 claim form

The following information addresses only the key fields that are required on the RHC claim. See the Medicare Claims Processing Manual, Chapter 9, §50, for details about other fields.

Type of bill

An RHC reports its services on type of bill (TOB) 071X (Medicare Claims Processing Manual, Chapter 25, §75.1 (FL 4)). The TOB is a four-digit alphanumeric code that gives four specific pieces of information. The first digit is always a leading zero and is ignored by CMS for claims processing. The second digit identifies the type of facility (7 – Special facility [clinic]). The third digit identifies the type of care (1 – Rural health clinic). The fourth digit identifies the bill sequence or frequency.

The most commonly used TOBs for an RHC are:

- 0710 = nonpayment/zero claim that contains only noncovered charges (when no payment from Medicare is anticipated)
- 0711 = admit through discharge (original claim)
- 0717 = replacement of a prior claim (used to correct a previously submitted claim)
- 0718 = void prior claim (used to cancel a previously processed claim)
From/through dates

RHC claims cannot overlap calendar years, and services must be billed in the same calendar year for the appropriate application of the annual Part B deductible and coinsurance (Medicare Claims Processing Manual, Chapter 9, §100). Although it would be rare, an RHC may submit a claim that spans multiple days of service, as long as the date range is within the same calendar year.

Reporting Revenue Codes and HCPCS Codes

For many years, RHCs reported revenue codes only within three specific groups for medical and preventive visits (052X), mental health visits (0900), and telehealth (0780). HCPCS codes and modifiers were not required for medical and/or mental health visits, which simplified the reporting process. However, HCPCS codes were always required for preventive services to verify coverage and frequency limitations, as well as to prevent the application of the patient's deductible and coinsurance. Beginning with dates of service on or after April 1, 2016, RHC billing changed considerably. Now, an RHC must report all valid revenue codes for each line and use HCPCS codes with specific modifiers where appropriate.

Revenue codes

Revenue codes are four-digit numbers used on claim forms to reflect the categories of items, accommodations, or services provided to patients and billable by providers. A revenue code indicates either where a patient was while receiving treatment or what type of item he or she might have received as a patient.

Revenue codes play a key role in determining the final reimbursement amount of the claim. A claim form sent to Medicare without a revenue code will be rejected, and only revenue codes that are recognized by Medicare will be considered for payment.

Revenue codes indicate the appropriate revenue center for each charge included on the bill to capture charges by location and type of item or service provided. This information is used for cost report reconciliation, data collection for rate setting, and cost/charge-based payment purposes. In an RHC, the qualifying visit line should be reported with revenue code 052X or 0900. Beginning with dates of service on or after April 1, 2016, an RHC must report the most appropriate revenue code for any additional services performed with the qualifying visit (Medicare One-Time Notification, Transmittal 1637).
The additional revenue lines should be reported with detailed HCPCS code(s) and charges that are informational only and are not processed for payment purposes (Medicare Claims Processing Manual, Chapter 9, §60.1).

The following revenue codes are excluded from reporting on TOB 071X (Medicare One Time Notification, Transmittal 1637):

- 002X–024X
- 029X
- 045X
- 054X
- 056X
- 060X
- 065X
- 067X–072X
- 080X–088X
- 093X
- 096X–310X

In most circumstances, all charges for the services that are eligible for payment under the all-inclusive rate (AIR) are bundled into one line and reported with a revenue code from the 052X series or 0900 (Medicare Claims Processing Manual, Chapter 9, §50):

- 0521
- 0522
- 0524
- 0525
- 0527
- 0528
- 0900
HCPCS codes

RHCs are required to report the appropriate HCPCS code for a qualifying visit and any items or services that are provided “incident to” the qualifying visit (Medicare One-Time Notification, Transmittal 1637).

Although an appropriate revenue code and HCPCS code, if applicable, are required for each item or service provided during a visit, only the line reported with a qualifying visit HCPCS code will be eligible for payment under the AIR. Calculation of the deductible and/or coinsurance will be applied to the qualifying visit line only.

Tip

Generally, an RHC can receive only one AIR payment per patient per day; however, there are some exceptions to this rule. For example, if an IPPE visit is furnished on the same day as another medical visit and/or mental health visit, the IPPE is billed on a separate line in addition to the other qualifying visit(s) and will also receive a separate AIR, while the patient’s deductible and coinsurance are waived (Medicare Benefit Policy Manual, Chapter 13, §220.1; Medicare Claims Processing Manual, Chapter 9, §70.6).

Modifiers

There are only a handful of valid modifiers that may be reported with HCPCS codes on an RHC claim. These include modifiers -25 and -59 to indicate a multiple medical visit exception has been met. Modifier -CG is used to identify the qualifying visit that may be entitled to reimbursement under the RHC’s AIR.

Usually, multiple visits with more than one RHC practitioner on the same day, or multiple encounters with the same practitioner on the same day, constitute a single visit and are only payable as one qualifying visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related to the subsequent visit. CMS has built in several exceptions to this policy.
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If a patient returns to the RHC on the same day for treatment of an illness or injury that is unrelated to the first visit, a separate qualifying visit may be reported with revenue code 052X, and the second visit is reported with modifier -25 or modifier -59 (RHC reporting requirements frequently asked questions [FAQ]; MLN Matters article SE1611). In this case, modifier -CG (discussed later in this chapter) would not be reported on the second visit with either modifier -25 or modifier -59.

From a coding and billing perspective, modifier -25 is usually associated with an evaluation and management (E/M) service that is “significant” and “separately identifiable” from other services reported on the same date and on the same claim (CMS, Program Memoranda A-00-40 page 1; CPT Professional Edition). On the other hand, modifier -59 is usually reported to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances (MLN Matters article SE1418). According to CMS, this is the only circumstance in which either modifier -25 or -59 should be used, and both visits would be paid a separate AIR.

Effective October 1, 2016, for dates of service on or after April 1, 2016, modifier -CG is required to identify the qualifying visit reported with revenue code 052X and/or 0900 that may be entitled to receive an AIR payment. The line reported with modifier -CG is also subject to application of the deductible and coinsurance, except for certain preventive services (MLN Matters article SE1611). An RHC must report modifier -CG with the qualifying visit HCPCS code on one revenue code 052X or 0900 line, which includes the total charge for the qualifying visit, as well as the related items or services. Modifier -CG is reported only once per date of service for a medical visit reported with revenue code 052X and/or once per date of service for a mental health visit reported with revenue code 0900 (RHC reporting requirements FAQ). For example, if the patient came to the RHC and received both medical services and mental health services on the same date, both visits would be reported with their associated revenue code and HCPCS code, and both lines would be reported with modifier -CG. In this case, modifier -25 or modifier -59 are not reported in addition to modifier -CG.

Each additional medically necessary item or service furnished “incident to” the qualifying visit should be reported on a separate line with the appropriate revenue code, HCPCS code without modifier -CG, and charges equal to or greater than $0.01. The additional lines of
medically necessary items or services are for informational purposes only and will not receive a separate AIR.

If a preventive service is reported with revenue code 052X, excluding an initial preventive physical examination (IPPE), and is the only qualifying visit on that date of service, an RHC should report modifier -CG. Modifier -CG does not need to be reported with the IPPE HCPCS code, whether it is billed alone or with other payable services on the same claim (RHC reporting requirements FAQ). Each additional medically necessary item or service furnished “incident to” the preventive service visit should be reported on a separate line with the appropriate revenue code, HCPCS code without modifier -CG, and charges equal to or greater than $0.01 (MLN Matters article SE1611). The additional lines of medically necessary items or services are for informational purposes only and will not receive a separate AIR.

If the deductible and coinsurance are waived, Medicare will pay 100% of the AIR for the preventive service rather than the usual 80% (MLN Matters article SE1611). When charges for separately billable “incident to” services and supplies are included in the preventive service qualifying visit line, the deductible and/or coinsurance will also be waived, where applicable. For example, if a preventive service and a venipuncture for labs are furnished during the same visit, the venipuncture charge is rolled into the preventive service line, and the patient pays nothing out of pocket.

See the modifier selection flowchart in Chapter 5 for additional guidance on choosing the correct modifier.

### Qualifying Visit: Billing and Application of Modifier -CG

A qualifying visit is defined as a medically necessary medical visit or mental health visit or a visit for certain preventive services. The visit must be a face-to-face encounter between the patient and an RHC practitioner (Medicare Benefit Policy Manual, Chapter 13, §40; Medicare Benefit Policy Manual, Transmittal 230). A qualifying medical visit is typically an evaluation an E/M type of service or a screening for certain preventive services, and it is reported with revenue code 052X. A qualifying mental health visit is typically a psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis and is reported with revenue code 0900.
Prior to January 1, 2017, CMS provided a qualifying visit list that included frequently reported HCPCS codes that qualified as a face-to-face visit between the patient and an RHC practitioner. The list was not intended to be an all-inclusive list of stand-alone billable visits. It was last updated on August 1, 2016. CMS has since removed the list from its Rural Health Clinics Center website. An RHC should monitor the CMS website for any updated posting to the qualifying visit list. For dates of service on or after October 1, 2016, a medically necessary service that was not on the qualifying visit list could be billed as a stand-alone billable visit if the service met Medicare coverage requirements, is within the scope of the RHC benefit, is usually performed in a physician’s office, and is not being furnished solely as “incident to” a physician’s service.

To qualify for Medicare payment, all of the coverage requirements for an RHC visit must be met and the visit must be furnished in accordance with the applicable RHC regulations (42 CFR 405.2463). The reporting of a HCPCS code as a qualifying visit does not guarantee payment of the service.

**Coverage and Billing for Preventive Services**

The professional component of a preventive service is considered to be an RHC benefit when all of the conditions of coverage are met and frequency limits have not been exceeded (Medicare Benefit Policy Manual, Chapter 13, §220.1). Preventive services include the IPPE and the annual wellness visit (AWV). These services will be discussed in more detail later in this chapter. The deductible, copayment, and coinsurance are waived for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B (Medicare Claims Processing Manual, Chapter 18).

A complete list of covered preventive services, including coding and billing requirements and statutorily waived deductible and coinsurance amounts, can be found in Chapter 18 of the Medicare Claims Processing Manual.

When certain preventive services are the only medical service provided during the visit, the service can be billed as a stand-alone visit (Medicare Benefit Policy Manual, Chapter 13, §220.1). These preventive services include but are not limited to:

- IPPE (G0402)
- AWV (G0438 and G0439)
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- Screening pelvic and clinical breast examination (G01001)
- Screening Pap smear (Q0091)
- Prostate cancer screening (G0102)
- Glaucoma screening (G0117 and G0118)
- Alcohol screening and behavioral counseling (G0442 and G0443)
- Smoking and tobacco cessation counseling (99406 and 99407)

If the preventive service, excluding the IPPE, is the only qualifying service furnished during the visit, the RHC should report modifier -CG with the preventive HCPCS code that represents the primary reason for the visit and the bundled charges (RHC reporting requirements FAQ).

**Initial preventive physical exam**

Medicare will only cover one IPPE for a new beneficiary within the first 12 months of eligibility (Medicare Claims Processing Manual, Chapter 18, §80). The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day. If an IPPE visit is furnished on the same day as another medical visit and/or mental health visit, the IPPE is billed on a separate line in addition to the other qualifying visits (Medicare Benefit Policy Manual, Chapter 13, §220.1; Medicare Claims Processing Manual, Chapter 9, §70.6). The IPPE must be billed on a separate line from the qualifying visit using a revenue code in the 052X series with HCPCS code G0402 and the appropriate charge. The patient’s deductible and coinsurance will be waived for the IPPE, whether it is performed as the only service that day or performed in conjunction with another medical visit and/or mental health visit. Remember, modifier -CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other separately payable services on the claim (RHC reporting requirements FAQ).

When an EKG (G0405) is performed in conjunction with the IPPE, the professional component of the diagnostic test is considered to be part of the RHC visit (Medicare Claims Processing Manual, Chapter 9, §70.6; Medicare Claims Processing Manual, Chapter 18, §80). However, the technical component of the EKG (G0404) cannot be billed on TOB 071X. If an EKG is performed in conjunction with the IPPE at an independent RHC, the practitioner who performs the service may bill for the technical component on the CMS-1500 claim form to the Part B MAC. If an EKG is performed in conjunction with the IPPE at a provider-based RHC, the technical component can be billed by the main provider on their usual outpatient type of bill.
(e.g., TOB 0851 CAH or TOB 0131 OPPS). For both the professional and technical components of the EKG, neither the deductible nor coinsurance is waived.

**Annual wellness visit**

The AWV is a personalized prevention plan for beneficiaries who are not within the first 12 months of Medicare eligibility and have not received an IPPE or AWV within the past 12 months (*Medicare Claims Processing Manual*, Chapter 18, §140.4).

The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day. Unlike the IPPE, the AWV will not receive an additional AIR payment if it is performed on the same day as another qualifying medical visit. The AWV must be billed on a separate line from a qualifying visit using a revenue code in the 052X series with HCPCS code G0438 (initial) or G0439 (subsequent) and the appropriate charge. The patient’s deductible and coinsurance will be waived for the AWV, whether it is performed as the only service that day or performed in conjunction with another qualifying medical visit (*Medicare Benefit Policy Manual*, Chapter 13, §220.1).

**Billing a Qualifying Visit and Preventive Service During the Same Encounter**

In certain circumstances, when a Medicare preventive service is provided as part of a qualifying visit, the charge for the preventive service must be deducted from the total charge for the visit. This allows for calculating the correct deductible and coinsurance amounts for the qualifying visit when these amounts are waived for the preventive service (*Medicare Benefit Policy Manual*, Chapter 13, §§220, 220.2; *Medicare Claims Processing Manual*, Chapter 9, §70.1; *Medicare One-Time Notification*, Transmittal 1434). The total charge for the qualifying visit and related medically necessary items and services are billed on one line and will receive an AIR payment, and the patient’s coinsurance will be 20% of the total billed charges.

The preventive service is billed on a separate line with the appropriate revenue code, HCPCS code, and charge. The preventive service will not receive a separate AIR payment, excluding the IPPE. For certain preventive services, the patient’s deductible and/or coinsurance will be waived.
Preventive vaccinations

There are various vaccinations that are provided in an RHC, both in conjunction with other medical services and the sole purpose for the visit. If the only reason for the visit was the administration of an influenza or pneumococcal vaccine, a qualifying visit cannot be billed separately. However, if there was another reason for the visit, the RHC should not add the cost of these vaccines to the claim (Medicare Benefit Policy Manual, Chapter 13, §220.1; Medicare Claims Processing Manual, Chapter 9, §70.4; Medicare Claims Processing Manual, Chapter 18, §10.2.2.2).

The costs associated with the administration of the influenza and pneumococcal vaccines are excluded from reporting on an RHC claim in any circumstance. The vaccines and their administration are reimbursed at 100% of reasonable cost through the cost report settlement process. Coinsurance and deductible do not apply to these vaccines (Medicare Claims Processing Manual, Chapter 18, §10.2.2.2).

Unlike influenza and pneumococcal vaccinations, charges for hepatitis B vaccine and administration are included in the line with the qualifying visit charge, and payment will be made under the AIR for the qualifying visit only (Medicare Benefit Policy Manual, Chapter 13, §220.1; Medicare Claims Processing Manual, Chapter 9, §70.4; Medicare Claims Processing Manual, Chapter 18, §10.2.2.2). The deductible and coinsurance are applied to the total visit charge, which includes the charges for the vaccine and the administration. As with influenza and pneumococcal vaccines, an RHC cannot bill separately for a qualifying visit if it is the only service (Medicare Claims Processing Manual, Chapter 18, §10.2.2.2).

“Incident to” Services

“Incident to” services (e.g., injections that are provided on a different day than a qualifying visit) may be included in the charge for the visit if the service is furnished in a “medically appropriate” time frame and the conditions of coverage are met for all services provided (Medicare Benefit Policy Manual, Chapter 13, §120.3). CMS does not define what it considers to be a medically appropriate time frame. An RHC should develop a policy for consistent billing practices, including a medically appropriate time frame, for all patients who present to the clinic. If a qualifying visit was previously billed and the injection occurred within the RHC’s medically appropriate time frame policy, the RHC may adjust the original claim using TOB 0717.
(replacement claim). The charges for the injection can be added to a qualifying visit charge and the claim rebilled using the qualifying visit as the date of service for payment under the AIR. If an injection is the only “incident to” service that was provided on a specific date of service, it is not eligible to be separately billed as a qualifying visit. The service does not generate a separately billable qualifying visit alone; however, the costs can be reported on the cost report.

Other services that are covered by Medicare but do not meet the requirements for a face-to-face visit with an RHC practitioner are considered to be “incident to.” All services and supplies provided “incident to” an RHC practitioner’s visit must result from the patient’s encounter with an RHC practitioner, be performed under the appropriate level of supervision, and be provided in a medically appropriate time frame. Examples of typical “incident to” services furnished by RHC staff include serial blood pressure checks, obtaining new or refilling prescriptions, wound care, and other routine nursing services. These types of services do not generate a separately billable qualifying visit alone; however, the costs can be reported on the cost report (Medicare Benefit Policy Manual, Chapter 13).

**Coverage and Billing for Laboratory and Special Services**

An RHC is required to furnish certain laboratory services onsite, although only certain components of these services are covered under the RHC benefit. An RHC may also offer other special services, such as chronic care management (CCM), telehealth, and home health services. Coverage and billing restrictions may apply to these services.

**Laboratory and diagnostic services**

An RHC must be able to furnish the following laboratory services onsite for the immediate diagnosis and treatment of its patients (42 CFR 491.9; Medicare Claims Processing Manual, Chapter 9, §90):

- Blood glucose
- Hemoglobin or hematocrit
- Occult blood stool examination
- Pregnancy tests
- Primary culturing for transmittal to a certified laboratory
- Urinalysis by dipstick or tablet method
Laboratory services are not considered to be an RHC benefit and, therefore, are not included in the AIR payment. These services must be billed separately on the appropriate claim form (Medicare Claims Processing Manual, Chapter 9, §90). Application of the deductible and/or coinsurance will not apply to laboratory services that are listed in the clinical laboratory fee schedule (CLFS). In most cases, when services are provided in an RHC, the coinsurance is calculated to be 20% of the billed amount. The costs of the space, equipment, supplies, facility overhead, and staff associated with the laboratory services may not be reported on the cost report (Medicare Benefit Policy Manual, Chapter 13, §60.1).

Laboratory services performed by an independent RHC will be billed to the Part B MAC on the CMS 1500 claim form. Payment will be made under the CLFS amount.

Laboratory services performed by a provider-based RHC will be billed to the Part A MAC on the UB-04 claim form using the main provider’s TOB. Payment will be made under the appropriate payment methodology to the main provider.

The cost associated with the venipuncture is included in the AIR payment when performed by the physician, nonphysician practitioner, or other qualified staff “incident to” a qualifying visit (Medicare Benefit Policy Manual, Chapter 13, §60.1; Medicare Claims Processing Manual, Chapter 9, §90). The venipuncture charge is included with the charge for the qualifying visit, and it must also be reported on a separate line with the appropriate revenue code, HCPCS code, and charge. If the venipuncture is the only service provided without a qualifying visit, the service cannot be billed separately; however, the cost is reported on the cost report.

The technical component of a diagnostic test is not a benefit of an RHC and cannot be billed on a TOB 071X. Generally, only the professional component of a diagnostic test is included in the RHC benefit (Medicare Claims Processing Manual, Chapter 9, §§60, 90). Technical services/components performed by an independent RHC that are not part of the RHC benefit are billed to the Part B MAC on a CMS-1500 claim form (Medicare Claims Processing Manual, Chapter 12, §80.2). Technical services/components performed by a provider-based RHC that are not part of the RHC benefit are billed to the Part A MAC on the UB-04 claim form with an appropriate base-provider bill type (e.g., TOB 085X CAH or TOB 0131 OPPS) (Medicare Claims Processing Manual, Chapter 4, §280).
Visiting nurse services

A visiting nurse may provide skilled nursing services in a patient’s home as determined by an RHC practitioner to be medically necessary for the diagnosis and treatment of an illness or injury based on the patient’s unique medical condition (Medicare Benefit Policy Manual, Chapter 13, §190.1). The determination of whether visiting nurse services are reasonable and necessary is made by the practitioner based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

All of the following requirements must be met for a visiting nurse service to be considered a covered RHC visit (Medicare Benefit Policy Manual, Chapter 13):

- There is a shortage of home health agencies in the area where the RHC is located as determined by CMS
  - An RHC that is located in an area that does not have a current home health shortage may make a written request to the CMS Regional Office for authorization to provide visiting nurse services
- The patient is considered to be confined to the home (SSA § 1835(a); Medicare Benefit Policy Manual, Transmittal 230)
- The services are furnished under a written plan of treatment and under the supervision of a physician, nurse practitioner (NP), physician assistant (PA), clinical nurse midwife (CNM), clinical psychologist (CP), or clinical social worker (CSW)
  - The plan of treatment must be reviewed by the supervising practitioner at least once every 60 days
  - If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated unless:
    - The supervising practitioner has made a recertification within the 60-day period and the lapse of visits is part of the treatment plan
    - The documentation supports that visiting nurse services are required at predictable intervals less than once every 60 days (e.g., once every 90 days)
- The nursing services are furnished on a part-time or intermittent basis only
- Drugs are not provided during the visit
**Chronic care management**

Effective January 1, 2016, an RHC may provide and bill for chronic care management (CCM) services for non-face-to-face care coordination if a minimum of 20 minutes of qualifying CCM services are provided during a calendar month and all CCM coverage requirements are met (Medicare Benefit Policy Manual, Chapter 13, §§40, 110.5; Medicare One-Time Notification, Transmittal 1576). The patient must have multiple chronic conditions that are expected to last at least 12 months or until the death of the patient and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. The patient must agree to receive CCM from the RHC. The CCM services must include development of a comprehensive care plan, management of care transitions and coordination of care with other providers, and use of secure messaging capabilities and meet other health IT requirements. Services furnished by RHC staff “incident to” a CCM visit may be furnished under general supervision (Medicare Benefit Policy Manual, Transmittal 230). A separate CCM initiating visit (e.g., E/M, IPPE, AWV) is required only for new patients or patients who have not been seen within one year prior to the start of CCM (81 Fed. Reg. 80245).

An RHC may not bill for CCM for a patient if another practitioner or facility has already billed for the services for the same beneficiary during the same calendar month. An RHC also may not bill for CCM and transitional care management (TCM) services for the same beneficiary during the same time period.

Although CCM is an RHC benefit, it is paid based on the Medicare Physician Fee Schedule (MPFS) national average nonfacility payment rate when CPT code 99490 is billed alone or with other payable services on an RHC claim. Modifier -CG is not reported with the CCM HCPCS code. When CCM is furnished with another separately billable service, modifier -CG is reported only with the qualifying visit (RHC reporting requirements FAQ). Deductible and coinsurance will apply to CCM.

An RHC is not eligible to bill for complex CCM (HCPCS 99487), each additional 30 minutes of complex CCM (HCPCS 99489), or separately billable face-to-face assessment and care planning (HCPCS G0506) (81 Fed. Reg. 80244-80247).

CCM requirements and annual changes are contained in the MPFS Final Rule.
Transitional care management services

Transitional care management services (TCM) may be provided in an RHC when all of the following coverage requirements are met (Medicare Benefit Policy Manual, Chapter 13, §§40, 110.4; CMS Transitional Care Management Fact Sheet, March 2016). TCM must be furnished within 30 days of the date of the patient’s discharge from:

- A hospital or critical access hospital, including outpatient observation or partial hospitalization
- A SNF
- A community mental health center

Discharge from the appropriate setting must be to the patient’s home (i.e., actual residence, assisted living facility, rest home, or domiciliary care).

Communication with the patient or caregiver by direct contact, telephone, or electronic media must start within two business days of discharge. If a practitioner or other qualified staff member makes two or more separate attempts to contact the patient in a timely manner but is unsuccessful, TCM can still be reported if the attempts are documented in the medical record, all other TCM coverage criteria are met, and attempts are made until successful (CMS Transitional Care Management Fact Sheet, March 2016). To report TCM code 99495, a face-to-face visit of moderate-complexity decision-making must occur within 14 days of discharge. To report TCM code 99496, a face-to-face visit of high-complexity decision-making must occur within seven days of discharge. Medication reconciliation and management must be completed no later than the date of the face-to-face visit. Only one TCM visit may be paid per beneficiary for services furnished during the 30-day postdischarge period regardless of which practitioner provides the service (e.g., RHC or non-RHC provider). The period begins on the day of discharge from a qualifying setting.

When all TCM coverage requirements are met, the service may be provided by an RHC practitioner (Medicare Benefit Policy Manual, Chapter 13, §§40, 110.4). Elements related to TCM may be furnished by qualified RHC staff under general supervision (Medicare Benefit Policy Manual, Transmittal 230). If the service is the only medical service provided on that day, the RHC can bill the service as a qualifying visit using revenue code 052X, the appropriate HCPCS code with modifier -CG, and the actual date that the face-to-face visit was provided. TCM will
be paid under the AIR, and the deductible and coinsurance will apply. If the TCM visit occurs on the same day as another qualifying medical visit, mental health visit, or preventive visit, TCM cannot be billed in addition to the qualifying visit. For more information on CCM, TCM, and advance care planning (ACP), visit the CMS care management physician center webpage.

**Telehealth services**

Although telehealth is not an RHC benefit, the clinic may serve as an originating site for telehealth services, which refers to the location of the patient in the RHC at the time the service is being furnished via telecommunications systems (*Medicare Benefit Policy Manual*, Chapter 13, §200). The originating site facility fee is reported with revenue code 0780 and HCPCS code Q3014 without modifier -CG. Telehealth services may be billed as the only billable service provided or in addition to a qualifying visit billed with revenue code 052X or 0900 (*Medicare One-Time Notification*, Transmittal 1540). The charge for the telehealth service is reported on the claim; however, the cost is not reported on the cost report (CMS, Rural Health Clinic Fact Sheet). The payment for the telehealth service is made under the MPFS, and the deductible and coinsurance will apply.

The distant site fee for telehealth services, which refers to the location of the practitioner in the RHC while the patient is elsewhere at the time of the service, may not be billed by the RHC or reported on the cost report (*Medicare Benefit Policy Manual*, Chapter 13, §200). This includes telehealth services that are furnished by an RHC practitioner who is employed by or under contract with the RHC or a non-RHC practitioner furnishing services through a direct or indirect contract.

For more information on telehealth services, visit the CMS telehealth website.

**Physical therapy, occupational therapy, and speech therapy services**

Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services may be performed by a physician, NP, or PA when the services provided are within their scope of practice and state law (*Medicare Benefit Policy Manual*, Chapter 13, §180; *Medicare Benefit Policy Manual*, Transmittal 230). A physician, NP, or PA may also supervise a physical therapist, occupational therapist, or speech therapist who provides services “incident to” a qualifying visit in the RHC. The physical therapist, occupational therapist, or speech therapist may be employed
by or contracted by the RHC. However, “incident to” therapy services are not separately billable visits. The charges are included in the qualifying visit if:

- The therapy services are furnished by a qualified therapist as part of an otherwise billable visit
- The service is within the scope of practice of the therapist

If the services are provided by a therapist on a day when a qualifying visit was not provided, the therapy service would be reported only on the cost report.

If a therapist in private practice furnishes services in the RHC, the charges may not be reported on the RHC claim. All associated costs must also be carved out of the RHC’s cost report.

**Diabetes self-management training and medical nutrition therapy**

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services that are provided by a registered dietitian or nutrition professional may be considered “incident to” a visit with a clinic practitioner when all conditions of coverage are met (42 CFR 405.2463; Medicare Benefit Policy Manual, Chapter 13, §220.1; Medicare Claims Processing Manual, Chapter 9, §70.5). DSMT and MNT services alone are not eligible for payment under the AIR. The deductible and coinsurance will apply to DSMT and MNT services billed as “incident to” a qualifying visit. An RHC can become a certified provider of DSMT services and report the costs of the services on the cost report, which are used to compute the AIR.

**Hospice services**

Hospice services are not included in the RHC benefit. However, an RHC may provide care to hospice patients for any medical condition that is not related to their terminal illness (Medicare Benefit Policy Manual, Chapter 13, §210). In most cases, if the patient receives care from an RHC practitioner during clinic hours for a condition that is related to the terminal illness, the RHC cannot separately bill for or be reimbursed for the face-to-face visit even if it is medically necessary.

There are two exceptions to this rule (42 CFR 418.64; Medicare Benefit Policy Manual, Chapter 13, §210.2):
• The RHC has a contract with the hospice provider to furnish core hospice services when extraordinary circumstances exist within the hospice, such as temporary staffing shortages, unanticipated high census, or temporary travel by the patient outside of their hospice’s service area.

• The RHC has a contract with the hospice provider to furnish highly specialized nursing services that are not usually provided by the hospice and for the hospice to employ a nurse with that skill would be considered to be impractical and prohibitively expensive.

Costs associated with these hospice exceptions should not be reported on the clinic’s cost report since the RHC is reimbursed by the hospice under its contract.

Unless prohibited by their employment contract or scope of practice, practitioner who are employed by the RHC can provide hospice services when they are not working at the RHC (Medicare Benefit Policy Manual, Chapter 13, §210.1). Practitioners would bill the hospice service to Part B under their own provider number. Any service provided to a hospice patient by an RHC practitioner must comply with the prohibition on commingling.

**Surgical procedures and application of global surgery billing**

Surgical procedures furnished in the RHC during a qualifying visit are included in the payment for the visit (Medicare Benefit Policy Manual, Chapter 13, §40.4). If a procedure is associated with an RHC visit, the charge for the procedure is reported on the qualifying visit line and also reported on a separate line with the applicable revenue code, HCPCS code, and charge. Medicare global billing requirements do not apply to surgical procedures performed in an RHC.

If an RHC provides services to a patient who had a surgical procedure elsewhere and is still in the global billing period, the RHC must determine whether the services provided are already included in another facility’s or clinic’s surgical global billing period and payment (Medicare Benefit Policy Manual, Chapter 13, §40.4). The RHC may bill for a qualifying visit during the global surgical period if the visit is for a service that is not part of the usual surgical service, including the following (Medicare Claims Processing Manual, Chapter 12, §40.1):

• An initial consultation by the surgeon to determine the need for major surgery

• A medical visit unrelated to the diagnosis for which the surgical procedure was performed
• A medical visit due to complications from the surgery, treatment for the underlying condition, or an added course of treatment that is not part of the normal recovery period

Billing Noncovered Items or Services

An RHC will occasionally need to bill for noncovered items or services. How the bill is generated and submitted, and whether it can be paid, depends on if an Advance Beneficiary Notice (ABN) was required, whether it was issued, and whether it is valid. See Chapter 2 for more information on when an ABN is required and how to complete an ABN.

If an effective ABN was issued, the RHC has several choices. The RHC can submit the bill to its MAC, using occurrence code 32 on the claim. The occurrence date should be the date that the ABN was given to the beneficiary. Alternatively, the items or services for which an ABN was given should be billed as “covered charges” (Medicare Claims Processing Manual, Chapter 1, §60.4.1).

If other covered or noncovered items or services are billed on the same claim, modifier -GA should be used to identify those items or services for which an ABN was given (Medicare Claims Processing Manual, Chapter 1, §60.4.1).

If the MAC denies payment for services, even though an effective ABN was provided, payment for the services is collected from the Medicare beneficiary. Medicare charge limits do not apply to services for which an effective ABN was given (Medicare Claims Processing Manual, Chapter 30, §50.12).

In circumstances in which an ABN was required but was not issued, the RHC should bill the items or services as noncovered charges. If other covered or noncovered services are billed on the same claim, modifier -GZ should be used to indicate a line item expected to be denied as not reasonable and necessary, but for which no ABN was given. The -GZ triggers automatic denial and RHC liability (Medicare Claims Processing Manual, Chapter 1, §§60.1.3.1 and 60.4.2, Table 8; Medicare Program Integrity Manual, Chapter 3, §3.3.1.1 [G]).
Demand bill

When the RHC expects a service to be noncovered due to a categorical or technical denial, but the beneficiary requests that the claim be submitted to Medicare for a determination anyway, the claim should be submitted with condition code 20. This has traditionally been referred to as a “demand bill.” The beneficiary has the right to have any service provided to them billed to Medicare for an official payment decision that they may appeal if they choose. Covered services may, but are not required to, appear on the same claim as noncovered services billed with condition code 20 (Medicare Claims Processing Manual, Chapter 1).

The charges for which coverage is “in dispute” must be submitted as noncovered charges (Medicare Claims Processing Manual, Chapter 1, §60.3.1).

Other noncovered services (e.g., billed with occurrence code 32 or condition code 21) must be submitted on a separate claim from demand bill services. Claims with condition code 20 are exempt from same-day billing rules (Medicare Claims Processing Manual, Chapter 1, §60.3.2).

If a voluntary ABN was issued, the LOL does not apply. Modifier -GX may be used to identify items subject to categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). Modifier -GX may be reported with other liability modifiers, including modifier -GY (Medicare Claims Processing Manual, Transmittal 1921).

Billing for denial notices for secondary payers (no-pay bill)

Where services are clearly noncovered (i.e., categorical or technical denials) but a claim is being submitted to Medicare for purposes of obtaining a denial notice that can be forwarded to secondary payers, the claim should be submitted with condition code 21. These types of claims are sometimes referred to as “no-pay bills.” All charges on no-pay bills must be submitted as noncovered charges (Medicare Claims Processing Manual, Chapter 1, §60.1.3).

Noncovered services being billed for a denial must be submitted with modifier -GY, rather than condition code 21, when they appear on the same claim as covered and other noncovered services. Modifier -GY indicates a line item that is statutorily excluded or does not meet the definition of any Medicare benefit (i.e., categorical and technical denial). Modifier -GY triggers beneficiary liability (Medicare Claims Processing Manual, Chapter 1).
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Modifier -GY may be reported with other liability modifiers, including modifier -GX (Medicare Claims Processing Manual, Transmittal 1921).

REFERENCES


Billing and Claims Processing for Rural Health Clinics

CHAPTER 3


Chapter 4

Basic Reimbursement Principles for Rural Health Clinic Services

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A rural health clinic (RHC) receives payment under an all-inclusive rate (AIR) for a qualifying visit and covered items and services provided incident to a visit with a qualified practitioner. In general, the AIR is an interim payment rate based on the prior year’s cost report, which includes services and supplies that are related to a qualifying visit (Medicare Benefit Policy Manual, Chapter 13 § 70.1; Medicare Claims Processing Manual, Chapter 9 § 20.1). The AIR payment methodology is applied to either an independent or provider-based RHC.

A qualifying visit is defined as a medically necessary face-to-face medical visit, mental health visit, or preventive visit between the patient and a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse midwife (CNM), clinical psychologist (CP), or clinical social worker (CSW) (Medicare Benefit Policy Manual, Chapter 13 § 40). When certain conditions are met, transitional care management (TCM) or a visit between a patient confined to the home and a registered nurse or licensed practical nurse may also be considered an RHC visit.

Calculating the All-Inclusive Rate and Reporting Allowable Costs

The AIR is calculated by the Medicare Administrative Contractor (MAC) based on the RHC’s allowable costs and the total number of visits for all patients during the cost reporting period. Productivity, payment limits, and other factors are also considered in the calculation (Medicare Benefit Policy Manual, Chapter 13 § 70.1).
An RHC must submit an annual Medicare cost report to its MAC to determine its actual payment rate and also to reconcile interim payments (Medicare Benefit Policy Manual, Chapter 13, §§ 70.1, 80.1). The cost report must include statistical visit data and all allowable costs for providing the clinic services, including direct and shared costs, for the specific reporting period. Allowable costs are those that are “incurred by the RHC that are reasonable in amount and necessary for the delivery of the services” provided in the clinic, which includes practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of clinic services (Medicare Benefit Policy Manual, Chapter 13, § 70.1). The Medicare principles of reimbursement for allowable costs are stated in 42 CFR 413 and in the Medicare Provider Reimbursement Manual, 15-1. Information on cost report forms and the reporting process can be found in the Medicare Provider Reimbursement Manual, 15-2. Items or services that are not usually covered under the Medicare program (e.g., self-administered drugs, routine physical exam) or those that are covered under another Medicare Part B benefit (e.g., laboratory services, technical components of diagnostic tests) are not considered to be allowable costs and are not reported on the cost report (Medicare Benefit Policy Manual, Chapter 13 § 60.1).

An RHC is allowed to claim bad debt and unpaid deductible and coinsurance (42 CFR 413.80; Medicare Benefit Policy Manual, Chapter 13 § 80.1). If an RHC claims bad debt, it must be able to show that reasonable efforts were made to collect the amounts. Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed as allowable costs. Although reported as allowable costs, certain vaccines and their administration costs are excluded from the calculation of the RHC-specific AIR (Medicare Benefit Policy Manual, Chapter 13 § 80.1).

If an RHC is newly certified and in its initial reporting period, the clinic submits a budget that estimates the allowable costs and number of visits expected during the first reporting period (Medicare Benefit Policy Manual, Chapter 13 § 80.1; Medicare Claims Processing Manual, Chapter 9 § 20.2). The MAC calculates an interim payment rate based on the expected expenses and volume. At the end of the cost reporting period, the MAC determines the total payment due and reconciles with the total payments made during the period based on the actual costs and visits. The interim rate is adjusted when the actual cost report is filed, which will reflect any changes in expenses and utilization.
An RHC with more than one site may file consolidated cost reports if approved by the MAC in advance of the reporting period for which the consolidated cost report is to be used (Medicare Benefit Policy Manual, Chapter 13 § 80.2). Once an RHC elects to use a consolidated cost report, it cannot revert back to individual reporting without the prior approval of the MAC.

**Productivity standards**

CMS has established productivity standards to help determine the average cost per patient. All visits, regardless of payer, are included in determining the productivity standards for the cost report. The current productivity standards require 4,200 visits per full-time equivalent (FTE) physician and 2,100 visits per FTE non-physician practitioner (NP, PA, or CNM). The FTE productivity guidelines are applied to physicians and non-physician practitioners that furnish services at the clinic and in other qualifying locations (e.g., SNF, home, or scene of accident). The guidelines are applied to the time spent seeing patients or scheduled to see patients and does not include administrative time. When making the productivity determination, the MAC can use a combination of time for the physicians and non-physician practitioners. When an RHC has demonstrated reasonable justification for not meeting the productivity standards, the MAC may waive the productivity standards based on individual circumstances.

**Physician productivity and payment exceptions**

Physician services that are provided under a short term or irregular basis under contractual agreements are not subject to the productivity standards. Instead of the productivity standards, purchased physician services are subject to a limitation on what Medicare would otherwise pay for the services under the Medicare Physician Fee Schedule (MPFS) amount. However, if a physician works on a regular ongoing basis, regardless if he or she is paid as an employee or independent contractor, the productivity standards will be applied.

**Annual reconciliation**

At the end of the annual cost reporting year, the MAC re-calculates the AIR by dividing the total allowable costs across all patients (the numerator) by the number of actual visits for all patients (the denominator) to determine a final rate for the period (Medicare Benefit Policy Manual, Chapter 13 § 80.4; CMS, Rural Health Clinic Fact Sheet). The MAC determines the total payment due based on the re-calculated AIR. Both the interim and final payment rates are
reviewed for productivity, reasonableness, and payment limitations. If the RHC provides fewer than the expected visits based on the productivity standards, the MAC substitutes the expected number of visits for the denominator instead of using the actual number of visits in the above formula. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator) which would actually lower the AIR.

**Application of Part B Deductible and Coinsurance**

Each calendar year (CY), a single deductible is established for most Medicare Part B services, including RHC services (Medicare Claims Processing Manual, Chapter 9 § 40.1; CMS, Rural Health Clinic Fact Sheet). For example, the CY 2017 Part B deductible was $183 (81 Fed. Reg. 80063). In general, the beneficiary must pay the annual Part B deductible before Medicare begins to pay for the services. The beneficiary’s responsibility for the unmet deductible is capped at 20% of the RHC's total billed charge for each qualifying visit, except for certain preventive services. Non-RHC services (e.g., laboratory) and non-covered services (e.g., self-administered drugs) do not count towards meeting the deductible in the RHC.

After the deductible is met, Medicare pays the clinic 80% of its specific AIR or per visit payment limitation amount, where applicable (Medicare Benefit Policy Manual, Chapter 13; Medicare Claims Processing Manual, Chapter 9; CMS, Rural Health Clinic Fact Sheet).

The total covered charge for the qualifying visit is reduced by the applicable unmet deductible amount. The patient is then responsible for a coinsurance amount of 20% of the remaining charge (Medicare Benefit Policy Manual, Chapter 13; Medicare Claims Processing Manual, Chapter 9; CMS, Rural Health Clinic Fact Sheet). Certain preventive services are statutorily waived and are not included in the calculation of the deductible or coinsurance. An RHC may waive the deductible and coinsurance after good faith determination that the patient is in financial need, as long as the waivers are not routinely offered and are not advertised.

When an independent RHC bills the Part B MAC on a 1500 claim form for non-RHC services, the coinsurance amount is usually based on 20% of the MPFS allowed amount. For more information, see Medicare Claims Processing Manual, Chapter 12. When a provider-based RHC bills the Part A MAC on the UB-04 claim form for non-RHC services, the coinsurance amount is based on the rules applicable to the main provider and type of bill (e.g., type of bill (TOB).
0851 critical access hospital or TOB 0131 outpatient prospective payment system). For more information, see the Medicare Claims Processing Manual, Chapter 4.

**Sliding fee scale**

An RHC may establish a sliding fee scale as long as it is applied equally to all patients (Medicare Benefit Policy Manual, Chapter 13 § 90.2). The charges for services furnished to Medicare beneficiaries must be the same as the charges for non-Medicare beneficiaries. The payment policy must be posted so that all patients are aware of the policy. Income information must be obtained and documentation retained to determine that a patient qualified for the reduced charge. Unlike other healthcare settings, copies of wage statements or income tax returns are not required in an RHC. Self attestations are an acceptable means for making the determination. The attestation must be kept on file in the RHC.

**National Upper Payment Limitation**

Each CY, CMS establishes a national payment limit per visit for RHC services (Medicare Benefit Policy Manual, Chapter 13; CMS, Rural Health Clinic Fact Sheet). In general, the payment limit serves as a cap on the amount an RHC can be paid per visit.

On January 1, the RHC payment limit is increased by the percentage increase in the Medicare Economic Index applicable to primary care physician services. CMS announces the annual increase and the payment limit through transmittals. For CY 2017, the upper payment limit per visit for RHC services is $82.30 (Medicare Claims Processing Manual, Transmittal 3627). This is a 1.2% increase over the limit for CY 2016 ($81.32). The payment limit applies to services provided during the entire calendar year. It is possible for different payment limits to apply during an RHC’s reporting period based on its fiscal year.

**Application of the national upper payment limit for independent RHCs**

An independent RHC is reimbursed its specific AIR that is established by the MAC based on its allowable costs and the total number of visits for all patients during the cost reporting period up to the national upper payment limit.
After a patient meets his or her deductible, Medicare will pay a qualifying visit at 80% of the RHC’s AIR, unless the amount exceeds the national payment limit. If it does, Medicare will apply the national payment limit instead.

**Exception to the payment limit for provider-based RHCs**

A provider-based RHC may be eligible to receive an exception to the per visit payment limit when either of the following exceptions are met (42 CFR 413.65; Medicare Benefit Policy Manual, Chapter 13; Medicare Claims Processing Manual, Chapter 9; CMS Rural Health Clinic Fact Sheet):

- The hospital has fewer than 50 beds as determined under the definition at 42 CFR 412.105(b)

- The hospital’s average daily patient census bed count as described in 42 CFR 412.105(b) does not exceed 40 and the hospital meets both of the following conditions:
  - The hospital has been designated as a sole community hospital or an essential access community hospital
  - The hospital is located in a level 9 or level 10 rural-urban commuting area

The exception to the payment limit per visit only applies during the time in which the RHC meets the applicable requirements for the exception (Medicare Benefit Policy Manual, Transmittal 230).

This exception does not apply to independent RHCs.

**The Medicare Cost Report**

Providers participating in the Medicare program are required to submit information to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries. The Medicare cost report is a year-end report of statistical and financial data used to determine such costs throughout the year. Various types of healthcare providers must submit an annual cost report to Medicare, including hospitals, skilled nursing facilities, home health agencies, and RHCs. Most state Medicaid programs also require that cost reports be filed using the Medicare annual cost report as the basis of the Medicaid cost report.
The Medicare cost report is used to determine the program’s financial liability to an RHC by computing the difference between the RHC’s estimated costs and the actual Medicare payments the RHC received during the year. The cost report covers a 12-month fiscal year (FY) period and reports information on an RHC’s costs and provider utilization during its FY. Medicare uses the cost report to calculate the RHC’s AIR and to determine whether the RHC must pay any money back to it.

The cost report is comprised of a series of worksheets and schedules which makes its completion a complicated process. The preparation of the cost report is more than just accurate data collection and entry. Preparation must encompass the principles of Medicare reimbursement and a clear understanding of Medicare regulations and financial accounting for the RHC to ensure it receives the correct AIR in its current FY. Throughout the RHC’s FY, an interim cost report may be used to verify if its AIR payments are accurately reflecting its costs of care.

In general, cost reports contain data on costs and charges by cost center, utilization data, Medicare settlement data, financial statement data, and facility characteristics (CMS, Cost Reports). In an RHC, productivity standards are also applied to both physician and non-physician practitioners. A MAC has the authority to waive productivity guidelines where an RHC has demonstrated a reasonable justification for not meeting either standard. Some examples include an overall decline in population or a change in the economy of the rural community. In such cases, the MAC may set its own standard rather than using the 4,200 visits for each physician and 2,100 visits for each non-physician practitioner. Either way, the productivity standard is used as a mechanism to calculate the cost per visit. The greater of the actual visits or the productivity standard is used in the denominator of the calculation which may impact the AIR, as previously discussed.

**Function of a cost center**

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Providers link codes for items or services to department cost centers to allow charges to be applied by department or service line, or to track revenue and usage by department. Under certain conditions, a provider may elect to use different cost centers for allocation purposes. Form CMS-222-92 provides preprinted cost center descriptions that may apply to RHC services on Worksheet A (Provider Reimbursement Manual).
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The cost report is due to the MAC on the last day of the fifth month following the end of the RHC’s cost reporting period. When a provider fails to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments. All filed cost reports are subject to review by the MAC. The review can be conducted as a desk review or a field audit and it is critical that all documentation used to prepare the cost report is readily available for either situation. Once the audit is completed, the MAC prepares an audit adjustment report and a notice of program reimbursement is issued to settle up with the RHC or the Medicare program.

The following information applies primarily to independent RHCs. Provider-based RHCs file cost reports on Schedule M of the parent organization's cost report.

Forms and worksheets

The cost report consists of Form CMS-222-92 and a series of worksheets. Worksheets included in the cost report are:

- Worksheet A
- Worksheet A-1
- Worksheet A-2
- Worksheet A-2-1
- Worksheet B
- Worksheet B-1
- Worksheet C
- Worksheet S

Chapter 29 (T14) of the Provider Reimbursement Manual, Part 2 contains line by line instructions for completing the worksheets. CMS recommends RHCs complete the worksheets in the following order:

- Worksheet S, Part I
- Worksheet A, columns 1–3, lines 1–62
- Worksheet A-1, entire worksheet (if applicable)
- Worksheet A, columns 4 and 5, lines 1–62
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- Supplement A-2-1, Parts I–III (if applicable)
- Worksheet A-2, entire worksheet
- Worksheet A, columns 6 and 7, lines 1–62
- Supplement B-1 (if applicable)
- Worksheet B, Parts I–II, entire worksheet
- Worksheet C, Parts I–III, entire worksheet
- Worksheet A, Part II, certification statement

Worksheets may be updated annually to add, remove, or edit lines. Always use the most recent version available, and refer to Chapter 29 of the Provider Reimbursement Manual, Part 2 for instructions. Changes from the previous version are noted in red text in the Provider Reimbursement Manual, Part 2.

RHCs must assemble the worksheets in a specific order for submission to the MAC. CMS requests RHCs use the following order:

- Worksheet S
- Worksheet A
- Worksheet A-1
- Worksheet A-2
- Supplement A-2-1
- Worksheet B
- Worksheet B-1
- Worksheet C

REFERENCES


CHAPTER 4  Basic Reimbursement Principles for Rural Health Clinic Services


This chapter will describe some key business areas with recommendations to help develop a revenue cycle integrity program that promotes best practices and secures proper reimbursement for a rural health clinic (RHC). Although there are many areas of focus to employ for a successful revenue cycle program, the most effective revenue cycle operations begin with ensuring staffing, processes, and systems are appropriately set up in key areas to promote optimization.

**Key Points for Business Management**

Sound business management practices will help an RHC meet financial and compliance goals. Consider implementing best practice strategies in the various areas of the revenue cycle process, including scheduling, registration, charge capture, billing, and collections.

**Scheduling and pre-registration processes**

The optimal revenue cycle begins with pre-registration and scheduling. It is vital to have accurate demographic and insurance information for each patient in the system prior to their arrival. Various tools can help accomplish these tasks. Establish basic processes that ensure timely capture of the correct information. Consider the following processes and policies:

- Pre-registration staff should be working the schedule one to two weeks out, contacting patients to create the registration, and verifying insurance benefits in the system.
- Pre-registration staff shifts should be staggered to accommodate evening phone calls until 7:30 pm or 8:00 pm to catch individuals who are at work during the day. In
addition, schedules should be reviewed two days out to ensure any add-on patients are also captured.

- On the first day of the month, patients should be re-verified as coverage can lapse from month to month. This is particularly important for Medicare and Medicaid HMO plans where patients can change plans monthly.

An integrated electronic verification tool will help in obtaining and documenting accurate benefit information. Many verification programs also allow for “batch verifications submission,” whereby a certain population is sent in a group to verify the payer for eligibility. This is especially useful for Medicaid beneficiaries, as they can become retroactively eligible during a month and can also switch Medicaid HMO plans from month to month. Including self-pay patients in these batch submissions may help identify additional sources of reimbursement, as some self-pay patients may become eligible for Medicaid or other insurance for the month of service.

For walk-in patients, the registrar should attend the schedule and ensure that the patient is added as a walk-in. It is important to attend the schedule (i.e., record daily visits, walk-ins, cancellations, no shows, and rescheduled patients) to accurately capture visits. The information should be gathered along with a copy of the insurance card or verification of a previous card on file. Insurance should be verified either by the electronic tool or the payer website. Once the information has been verified, the patient can be checked in at the front desk.

Registration and check-out

If, per the insurance plan verification, the patient is responsible for a copayment, the copayment should be collected when the patient checks in prior to the visit. If the patient is responsible for a coinsurance, the coinsurance should be calculated based upon the charge entered after the visit and collected when the patient is escorted back to the front desk for check-out. For example, with Medicare patients, some services are subject to the annual Part B deductible and 20% of certain charges. Some preventive charges are not subject to coinsurance and these should not be included in the coinsurance calculation. See Chapter 13 of the Medicare Benefit Policy Manual for a list of preventive services for which the coinsurance and deductible are waived. Be aware of charges, patient payer mix, and timing when determining deductibles.

Keep the following tips in mind when developing processes for calculating and collecting deductibles:
January tends to be a high volume month for application of deductibles. It is beneficial to have a summary of deductible amounts that need to be collected based upon payer.

The outstanding specific beneficiary deductible information is also reported in the electronic verification process. If the charge is collected during the visit electronically, the patient account representative at discharge/checkout should be able provide the amount due (deductible and/or coinsurance amount) from the patient for that visit.

Best practice is to have the rates, calculation tables and information built into the system. If an RHC does not have these capabilities built in, electronic spreadsheets and/or paper grids can be set up based upon the most common scenarios and per visit rates.

Coverage of services and items vary from payer to payer. It is critical to understand benefits and coverage. Depending upon the area, charges for non-covered, self-pay services and items should be collected at the time of service. For example, state Medicaid programs pay for certain dental services. However, Medicare does not cover dental work or hearing aids. Medicare patients presenting at the clinic for these services should be informed, preferably in advance, at pre-registration, that the items or services are not covered. See Chapter 2 for a discussion of scenarios that require delivery of an Advance Beneficiary Notice. Amounts due for non-covered items or services should be collected when the patient presents at the clinic. Patients without coverage should be screened during the pre-registration process for charity care eligibility according to the RHC policy and amounts due should be collected at the time of service.

**Billing and charge capture**

The patient accounting system and/or EHR system should be set up to appropriately capture charges and generate clean claims. Charges should be entered into the system at the time of service. Relying on paper super bills, physician notepads, charge slips, and other manual forms of charge entry lead to potential revenue leakage for charges not captured.

A daily charge reconciliation process should be drafted and implemented to ensure that all services are charged in a timely manner. Charges should be captured for all patients seen in the clinic. For RHCs, it is particularly important to ensure that billing edits in the system or bill scrubber are set up and customized to accommodate all-inclusive rate (AIR) billing. One way to catch these claims is to trigger edits if a particular charge is missing that is required for a visit and/or associated with a particular revenue code. In addition, routines may be set up
in the background to assist in processing clean claims to the payer. For Medicare patients, it is recommended to obtain a Medicare Direct product. These products send Medicare claims directly to the Medicare Administrative Contractor (MAC) for processing rather than to a clearinghouse. The benefits of this direct submission are numerous, but include:

- One to two days less processing time
- Faster remittance and cash in the bank
- The ability to identify edits that will send the claim back

**Credentialing**

RHCs have special circumstances around credentialing. It is important to check the locum tenens rule and bill accordingly for physicians who will be filling in for a staff physician.

For new physicians joining the clinic, the Centers for Medicare & Medicaid Services (CMS) enrollment forms (CMS 855) should be updated prior to the new physician coming aboard. In addition, all contracted payers and health plans (especially Medicaid plans) also need to be notified in a timely fashion as some plans deny coverage for non-contracted providers.

To assist onboarding physicians, consider creating a grid with various payers and their requirements for credentialing. Some plans credential back to the date of the application, and others allow for retroactive credentialing for one calendar year. Accounts that may have already been billed and denied but qualify for retroactive credentialing should be segregated in the accounts receivable (AR) and resubmitted promptly upon credentialing approval.

**Follow-up and denials management**

Collection follow-up is an important part of the revenue cycle process. It is considered best practice to set up system parameters that will electronically drive workflow into queues at given times for patient account representatives to work in. Various routines and system logic can be implemented to ensure timely follow-up. For example, Medicare pays clean claims within 14 days of submission. The Medicare work queue(s) could be set up to route any account to a work queue that is 21 days from billing without a payment or denial. This alerts teams to check the status on the claim. If a denial is received, the claim should route to a denial work queue to be addressed within timely filing guidelines. Set up a “catch-all” work queue for accounts that do not qualify for other work queues. Periodically checking the catch-all queues helps ensure accounts do not
remain untouched and do not exceed timely filing or appeal limits. Work queues should be managed daily to ensure prompt follow-up.

Contracts also play a big role in reimbursement. It is critical to negotiate good reimbursement rates, ensure some items are carved out for additional reimbursement, and also spell out services that may require authorization or certification if the patient has a primary care physician in the community who is not part of the RHC medical team. At the time of contract negotiation, special circumstances regarding credentialing should be discussed with plan representatives. Some plans will waive the regular waiting period, accelerate the credentialing process and/or provide retroactive credentialing when the nature of the RHC is explained as distinct from clinics in urban areas.

Another overlooked source of reimbursement is claiming of Medicare bad debts. The process should be set up with collections agencies to ensure tracking and return of uncollectable deductibles and coinsurance to be claimed on the annual CMS cost report. Rules for processing and claiming Medicare bad debt can be found at the CMS website.

Building a Successful Revenue Cycle Department

The key to building a successful revenue cycle department is staffing appropriately with well-trained personnel. Consider the unique culture, payer mix, and visit volumes when staffing. Detailed job descriptions, policies, procedures, and process flows are essential tools for educating staff and ensuring all bases are covered. Recruitment can be tricky in rural areas. Investment in training and/or outside education may be necessary to bring individuals up to speed in their respective roles.

Below are some important considerations by position/area:

- Scheduling and pre-registration—Staff should be flexible and able to work extended hours (e.g., 7 pm). They should be familiar with insurance verification, HIPAA and privacy laws, medical benefits, and knowledgeable about payer programs including government programs such as Medicare and state Medicaid. These individuals will also need to be able to calculate self-pay patient responsibility and communicate this information to self-pay patients prior to their arrival.
CHAPTER 5  Rural Health Clinic Business Management Concepts

- Front desk/registration staff—Staff should be flexible with strong interpersonal skills. It is preferred that individuals will possess an in-depth knowledge of insurance benefits, various payer programs, and patient financial responsibility.

- Billers—Staff should be familiar with billing regulations, forms, and information needed to generate clean claims. Knowledge of third-party payer regulations, government billing regulations, and bill processing using electronic bill scrubbers is preferred.
  - For Medicare and Medicaid billers, knowledge of Medicare billing regulations is essential. It is recommended that government billers are also assigned follow-up duties for those claims due to the nature of the online claims follow-up processes and the intricacies of government program regulations.

- Follow-up representatives—Staff should be knowledgeable in third-party payer regulations, contract language, interpretation for contracted plans and insurance reimbursement methodology. Excellent communication and analytical skills are required. Experience with denial codes, management of claims, and appeals processes is preferred.

Training

Staff training and regular education is required and an important element in maintaining a strong revenue cycle team and program; therefore, developing a custom-tailored training program for revenue cycle operations is recommended. Staff training tools should include technical system guides from each product’s vendor. Ideally, these guides will include screenshots to illustrate instructions, but content will vary based on the vendor and the product. An operational training guide or tool specific to the RHC should be developed to address specifics within the revenue cycle operation. For example, the user training guide may show how to generate and transmit a claim. Supplemental training information would detail types of claims, responsibility for transmission of claims, what happens when a claim is rejected, etc. These operational trainings are essential in utilizing the technology and staff most effectively and efficiently.

In addition to training, developing productivity standards and a quality assurance program for each area should be a priority. Staff productivity usually can be gleaned from system reports. Below are standard volumes and guidelines from Healthcare Financial Management Association (HFMA). These metrics are not created specifically for RHCs, but are approximately the same for hospitals, physician practices, RHCs, and other clinics.
• Pre-registration—40 pre-registrations/registrations per day
• Billers—100-145 claims per day
• Follow-up representatives—45-55 accounts worked per day

A quality assurance (QA) program is essential not only for maintaining quality of work, but for being a valuable ongoing training tool to support performance for an individual’s annual evaluation. Often when performing annual evaluation reviews, management becomes aware of a new issue and must work to resolve the problem. In each area, a template should be developed to check certain key attributes that ensure optimal receivables outcomes.

Some examples may include:

• Pre-registration/registration—Select 10 accounts per representative per month and develop a template to check on key data fields for accuracy and correct information. Validate that the insurance identification name and number from the card copy is accurately reflected in the system. Review insurance verification to ensure benefits are correct in the system.
• Billing—Select 10 accounts per biller per month and develop a template to check on accuracy of key data, measure rejection rates, and gauge quality based on performance goals as set forth in process workflows.
• Follow-up/denials management—Select 10 accounts per follow-up representative and develop a template to ensure accurate and timely follow-up. Clear and concise documentation is of importance in account follow-up and denials management.

Employees new to the job should receive additional QA monitoring to allow for timely corrections and continued training. Management should review new employees starting at 100% of workload. When accuracy on the accounts reviewed is at 95% or higher overall, the number of accounts reviewed can be reduced to 50%. Once the accuracy reaches the appropriate level on these accounts, the quantity can be reduced to the regular 10 accounts per month. Ten accounts serves as an example, but it may make sense to sample 20 or 30. Each organization should develop and establish its own QA program.
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Volumes

Nonclinical staffing should be based on visit volumes as well as on unique electronic health record (EHR)/billing system functionality and capabilities. Below are some rules of thumb for staffing based on HMFA and Medical Group Management Association (MGMA) guidelines:

- Billers – 1 full-time employee per 2,500-3,500 bills per month
- Follow-up – 1 full-time employee per 1,500-3,000 accounts per month

Systems

EHR/billing system functionality and capabilities are essential to support an optimal revenue cycle operation. Furthermore, staffing can be updated and aligned based upon automated processes performed by the system. Economies in costs and manpower can be realized when charges are captured, when missing charges are identified prior to claims submission, when clean claims are submitted electronically, and when payment is electronically posted to accounts.

Ideally, system reports should be set up accurately and run automatically based upon a scheduler in the system. Your organization’s IT department, IT system vendor, and revenue cycle key stakeholders need to collaborate and communicate to ensure an optimal build for system features, functions, and reporting of analytics. Proper setup of dictionaries, tables, edits, and work queues will drive workflow to streamline revenue cycle processes. Once the system workflows are functioning properly and reports are set up appropriately, the revenue cycle team will have the tools to monitor and improve operations.

Monitoring for Success: Revenue Cycle Management Key Performance Indicators

Organizations strive toward best practice standards to ensure optimal revenue cycle operations and cash flow. To achieve these goals, it is imperative to benchmark your organization’s key performance indicators. Even if your organization is not at best practice yet, determining your metrics can help guide action plans and increase progress toward your goal. Some common key performance indicators and best practice standards per HFMA guidelines are shown in Figure 5.1.
Rural Health Clinic Business Management Concepts

CHAPTER 5

FIGURE 5.1 Revenue Cycle Key Performance Indicators

<table>
<thead>
<tr>
<th>Metric</th>
<th>Recommended Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts receivable (AR) days</td>
<td>&lt;50 days</td>
</tr>
<tr>
<td>AR over 90 days</td>
<td>&lt;15%</td>
</tr>
<tr>
<td>AR over 365 days</td>
<td>&lt;2%</td>
</tr>
<tr>
<td>Collections percent of net revenue</td>
<td>100%</td>
</tr>
<tr>
<td>Denial as percent of net revenue</td>
<td>&lt;2%</td>
</tr>
</tbody>
</table>

Revenue cycle flow chart

The revenue cycle begins with scheduling and ends with resolution of payment. Along the way, a myriad of staff are responsible for moving the account through the cycle. Creating an efficient process with steps for each responsibility will facilitate reimbursement and help staff understand what they need to do. Figure 5.2 illustrates the revenue cycle process flow.

FIGURE 5.2 Revenue Cycle Flow Chart

Source: Sheri Hughes, CMPA, FHFMA, and Denise Stark, MPA/Moss Adams.
Key takeaways

The revenue cycle is a critical process that must be managed properly and tracked carefully to be successful, regardless of whether your organization is a stand-alone rural health clinic, hospital-affiliated health clinic, or part of a healthcare system with more than 100 facilities. Revenue cycle includes “all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue,” according to the HFMA. The revenue cycle requires a careful assessment of all relevant touch points and an understanding of how they impact the bottom line and ultimately the RHC’s performance. Employing best practices, key performance indicators and benchmarks, and ensuring that your staff is well trained are fundamental pillars of a properly-performing revenue cycle program.
Resources and Tools

Debbie Mackaman, RHIA, CPCO, CCDS

Billing and reimbursement for rural health clinics (RHC) can be complex. Even with a thorough knowledge of the Centers for Medicare & Medicaid Services (CMS) regulations, an RHC may sometimes run into problems understanding how to put them into practice. The resources and tools in this chapter will help provide context for the billing and reimbursement information contained in Chapters 2, 3, and 4. An FAQ addresses some additional common questions.

Rural Health Clinic FAQ

Q: Because a rural health clinic (RHC) bills its professional charges on the UB-04 claim form but they are really Medicare Part B services, don’t we have to complete the Physician Quality Reporting System (PQRS) or Merit-based Incentive Payment System (MIPS) quality reporting for those services?

A: That’s a common question for RHCs because you change your perspective and bill professional services on a UB-04 claim form. Generally, RHCs are exempt from PQRS reporting. However, if an RHC practitioner provides outpatient services at a hospital and you have to bill his or her services on the 1500, then PQRS or MIPS/advanced payment models (APM) will apply.

Q: Is the EKG professional fee included in the RHC visit if the EKG is read by a cardiologist who is not an RHC provider rather than the RHC provider?

A: The EKG interpretation will be billed by the cardiologist on his or her 1500 claim form using their own provider number. It’s the cardiologist’s professional service; don’t include that interpretation as part of the RHC visit because it wasn’t performed by an RHC practitioner.
Q: Should RHC chargemasters include two lines for each incidental or ancillary service, one with price and one with one cent?

A: You could set it up that way. It depends on how “smart” your billing system is. Sometimes, you’re able to set it up with one line and then it will do a charge explosion (e.g., drop two lines on the claim). For example, if you bill for procedure 12001 that’s going to get rolled up into an E/M level for a separate medical service, you will have one line in the chargemaster that actually drops the one cent on the claim form and then the other line gets rolled up. It comes down to how those charges are going from your chargemaster onto your claim. Setting up a chargemaster to be efficient is one thing, but consider what it looks like when it drops on the claim form. That may require some testing.

Q: If you can be reimbursed for more than one line item, why not bill for each line and not bill the one cent?

A: RHC billing is unique because the all-inclusive rate (AIR) payment is for all services provided during the visit. Essentially, you are getting paid for every line on your claim that’s separately reportable as an allowed cost on the cost report; however, each line is packaged into the qualifying visit line, which drives the AIR reimbursement. For example, the RHC provides an E/M service and an EKG, as well as a venipuncture and a minor procedure. The RHC will bill all four of those lines on the claim. It could put the actual charge for every single one of those lines, but if it’s done that way you would need to add all of those charges and push the total into the qualifying visit line. The qualifying visit line drives all reimbursement: AIR and the Medicare patient’s coinsurance and deductible. Regardless of whether you list the actual charge or one cent, it will roll up into that one line. Using one cent for all other lines can help with small balance write-off issues and keeps you from giving patients the impression that you’re double billing.

Q: We are able to obtain an AIR payment, effective October 1, 2016, for both an evaluation and management (E/M) and initial preventive physical exam (IPPE) visit on the same dates of service. Does this also apply to an E/M and an annual wellness visit?

A: RHCs have always been paid for both of those services. Whether you do a mental health visit under a 900 revenue code with an IPPE same day or an E/M under 52X revenue code and the IPPE exam the same day, you have always been able to get two AIRs. If the annual wellness visit
is the only qualifying visit on the claim, it will trigger the AIR payment. However, if the annual wellness visit is also done with an E/M, you have to bill them on two separate lines, because deductible and coinsurance do not apply to the annual wellness visit. However, the annual wellness visit will not trigger a separate AIR like the IPPE. The IPPE is a unique preventive service for which Medicare will always pay its own AIR.

Q: Are the productivity standards for the physicians of 4,200 visits per full-time employee (FTE) and for nurse practitioners (NP), physician assistants (PA), and clinical nurses (CN) of 2,100 visits per FTE hard standards?

A: They are hard standards; Medicare uses that as a starting point. A Medicare Administrative Contractor (MAC) can waive those productivity fees based on your circumstances, or they can use a combination of both of them. Physicians may not always have to do 4,200 visits, and an NP or PA may not always have to do 2,100 visits. Talk to your MAC about productivity standards before making any changes.

Q: What is the best way to set up the charge structure in our chargemaster for Healthcare Common Procedure Coding System (HCPCS) code reporting?

A: If you’re a provider-based RHC, you may have a few more options because the hospital’s chargemaster and billing process might be more robust than an independent RHC. The structure you choose depends on what your billing system can do and how much confidence you have in its ability to adapt to an RHC’s special billing issues. Can it explode charges? Can it bundle certain charges? Is it accurate? Is it efficient in how you’re going to use those functions? An EKG interpretation may have a line for bundling the actual charge into the qualifying visit line and then a line for informational only. It’s not always a one-size-fits-all answer. Simply because a charge structure is set up in a certain way doesn’t always mean it looks exactly like that when it gets to the UB-04 claim form, by the time it gets to the clearinghouse, or by the time your MAC gets it.

Always do test claims any time you set these charge structures up to bundle or explode. Often, some manual intervention by your billing staff or your clearinghouse will be required. CMS has not made this an easy process.

Q: After October 1, 2016, should modifier -CG be submitted on all claims that the AIR is to be paid on?
A: Yes. The -CG modifier is an RHC’s way of indicating which line the AIR is paid on and which line the patient’s coinsurance and deductible will apply to, if any. Modifier -CG won’t always trigger patient responsibility, but it does tell Medicare that an AIR applies. Modifier -CG is required on claims with a filing date of October 1, 2016 or later. for dates of service beginning on April 1, 2016.

Q: Will Medicare require national drug codes (NDC) for drugs for RHCs?

A: RHCs are not reimbursed based on the HCPCS code itself; therefore, Medicare may not require NDCs for drugs. RHC reimbursement is a cost-based reimbursement, the AIR, created by cost reporting. However, that may change in the future. Ask your MAC and/or CMS rural health coordinator for more information.

Q: On the AIR, how do you determine what the patient would owe for the visit?

A: The patient’s financial responsibility is not based on the AIR. The AIR is the cost-based reimbursement that the RHC receives for its services. The patient’s financial responsibility, such as deductible and coinsurance, is calculated in a different manner for the qualifying visit line.

Q: We are updating our charges in our RHC and we want to make sure we are capturing all of the preventive services that we can perform in our clinic. Along with that, we want to audit the documentation. Where can we find a list of RHC preventive services?

A: Start by going to the list of preventive services on CMS’ RHC website. This list may not be complete and may not be updated in the future; therefore, it should be considered only a partial list. You can also use MLN publications. MLN publishes an interactive document that lists preventive services. The document displays the HCPCS code, coinsurance and deductible amounts, frequencies, and other information.

Chapter 18 of the Medicare Claims Processing Manual lists the HCPCS codes of preventive services. It also lists the specific frequency and diagnosis code information.

Q: Should we monitor local coverage determinations (LCD)?

A: An RHC has always been required to follow the applicable national coverage determinations (NCD) and LCDs for any services provided. Prior to April 1, 2016, it was difficult for Medicare to know whether RHCs were meeting those requirements because they did not report HCPCS codes.
Any time you bill Medicare, you must consider whether the service provided is a benefit under the RHC designation and NCD and LCD coverage rules, and, lastly, how you were reimbursed for the service.

Q: We've always done Department of Transportation (DOT) physicals in our RHC, and we bill those to Medicare. When you look at the qualifying visit list, the CPT® code is not listed. How should our clinic bill for DOTs?

A: DOT physicals are not listed in the qualifying visit list because they’ve never been a covered service by Medicare; however, now that you are reporting CPT codes, you may receive an edit saying it’s a noncovered service. Medicare doesn’t cover screening type services such as regular physical exams and employment-type services. It does cover certain preventive services.

If a patient has traditional Medicare and wants a DOT physical, you could issue a voluntary Advance Beneficiary Notice (ABN). That tells the patient that Medicare doesn’t cover that service and the patient is responsible for the full payment.

Q: How does our RHC sign up to participate in CPC Plus?

A: CPC Plus is one of Medicare’s new payment models for traditional fee-for-service providers. Services eligible for CPC Plus are those paid on the Medicare Physician Fee Schedule and billed on the 1500 claim. Therefore, in general, an RHC is not able to participate in CPC Plus until it drops the RHC designation and is certified as a freestanding physician clinic. If you are considering this, research whether your facility would be better off as a freestanding physician clinic.

Q: If there is a global code for the service, like for an EKG 93000, should we report the global service on the RHC claim since it is performed in our clinic and our practitioner also interprets them and documents a chart note?

A: This is one of the unique problems that RHCs run into. It’s very confusing because you are billing professional services on a UB-04 claim form. If there is a CPT code series that breaks the global service into both a professional and technical component code, you will want to report only the professional service CPT code on the RHC claim. In this example, that’s going to be the 93010 code. That’s strictly the interpretation and the report, and that has to be documented in the chart note as well.
Then, if you’re a provider-based RHC, the hospital or the main provider will bill the tracing piece, which will be the 93005 code. You would never see a global-type service on an RHC claim for CPT procedure codes.

**Billing Case Studies**

The following case studies illustrate how to bill for certain services and items. The completed UB-04 claim forms for each case study can be found on the downloads page for this book.

**Case study 1: Multiple medical visits on the same date of service**

A new patient presented to an independent RHC April 3 for shortness of breath and saw a physician. A comprehensive examination was completed and the physician documented E/M services for a level 4 visit (99204). During the visit, lab was drawn, and the specimen was sent to the hospital for processing. The patient was discharged home with a follow-up appointment in 30 days. Later the same day, the patient stepped off of a curb and twisted his ankle. He returned to the RHC and was seen by the NP. Upon further examination, the patient was diagnosed and treated for a minor ankle sprain. The NP documented E/M services for an established level 2 visit (99212), and the patient was sent home with care instructions and told to follow-up in the clinic in 10 days.

The following services will be billed:

- E/M (99204) = $225.00
- E/M (99212) = $150.00
- Venipuncture (36415) = $35.00

Appendix A on the downloads page for this book demonstrates key fields on the UB-04 claim form that are required when billing for the services.

- All services are reported on separate lines with the appropriate revenue code, HCPCS code, and modifier.
- All lines will be reordered by revenue code and then HCPCS code in the Medicare claims processing system listing the lowest revenue code (i.e., 0300) to the highest (i.e., 0521).
• Modifier -CG is reported on one qualifying visit to request an AIR payment.
• Modifier -25 (or -59) is reported on the subsequent visit line to request an additional AIR.
• Reporting modifier -25 or -59 is allowed only when the patient returns to the clinic the same day for treatment of an illness or injury after the first visit.
• All charges are reported on one qualifying visit line reported with modifier -CG, and the patient’s deductible and coinsurance will be applied.
• All subsequent lines can be billed with a charge equal to or greater than $0.01, up to the actual charge.

The hospital will bill for the laboratory service on its usual type of bill.

**Case study 2: Preventive service and medical visit the same date of service**

On May 1, an established patient presented to a provider-based RHC for his IPPE under the Medicare benefit. In conjunction with the IPPE, the physician performed an EKG and the nurse drew blood for a cardiovascular blood screening test that will be performed by the hospital. During the visit, the patient also asked the physician to evaluate his chronic back pain. The physician documented E/M services for a level 2 visit.

The following services will be billed:

• IPPE (G0402) = $175.00
• Venipuncture (36415) = $35.00
• EKG interpretation/report with IPPE (G0405) = $50.00
• E/M (99212) = $120.00

Appendix B, which can be found on the downloads page for this book, demonstrates key fields on the UB-04 claim form that are required when billing for the services.

• All services are reported on separate lines with the appropriate revenue code, HCPCS code, and modifier.
• The IPPE qualifies for an AIR payment as a stand-alone visit or when billed with another qualifying visit the same day.
• Modifier -CG is reported only on the qualifying visit to request an additional AIR payment.

• The IPPE HCPCS should not be reported with modifier -CG.

• The charge for the IPPE cannot be rolled into the qualifying visit line, which prevents the patient from paying the deductible and coinsurance on a preventive service that is statutorily waived.

• The charge on the qualifying visit line includes the E/M service, venipuncture, and EKG interpretation, and the patient's deductible and coinsurance will be applied.

• Deductible and coinsurance are applied to the EKG when performed in conjunction with an IPPE.

The hospital will bill for the laboratory service and the EKG technical component on its usual type of bill.

**Case study 3: Preventive service, telehealth, and mental health visit on the same date of service**

On May 14, an established patient presented to an independent RHC for her initial annual wellness visit (AWV) under the Medicare benefit. During the visit, a consultation with a cardiologist was conducted via the RHC’s interactive telecommunication system. Later that day, the patient also saw her clinical psychologist for evaluation and medication management.

The following services will be billed:

- AWV (G0438) = $175.00
- Originating site telehealth with a cardiologist (Q3014) = $75.00 Mental health visit (90792) = $235.00

Appendix C, which can be found on the downloads page for this book, demonstrates key fields on the UB-04 claim form that are required when billing for the services.

- All services are reported on separate lines with the appropriate revenue code, HCPCS code, modifier, and actual charges for each service.
- Modifier -CG is reported on the AWV visit to request an AIR payment for the medical service.
• Modifier -CG is also reported on the mental health visit to request an additional AIR payment.

• The patient’s deductible and coinsurance will be waived for the AWV.

• The patient will be responsible for her usual deductible and coinsurance amounts for the mental health visit based on the charge for the visit.

• The telehealth service is paid based on the Medicare Physician Fee Schedule (MPFS), and the patient is responsible for her usual deductible and coinsurance based on the MPFS allowed amount. Modifier -CG is not reported with services paid under the MPFS.

Case study 4: Medical visit and procedure during same visit

On June 1, an established patient presented to an independent RHC after tripping and falling in his home. The NP repaired a 2.8-cm laceration to the patient’s forehead. During the visit, the NP evaluated the patient for other minor injuries related to the fall. The staff nurse dressed the wound and instructed the patient to return in 10 days for suture removal. No other services were provided.

The following services will be billed:

• E/M (99212) = $105.00

• Simple laceration repair of face, 2.6–5.0 cm (12013) = $160.00

Appendix D, which can be found on the downloads page for this book, demonstrates key fields on the UB-04 claim form that are required when billing for the services.

• All services are reported on separate lines with the appropriate revenue code, HCPCS code, and modifier.

• Modifier -CG is reported only on the qualifying visit to request an AIR payment. The laceration repair should not be reported with modifiers -CG, -25, or -59 in this scenario.

• All charges are reported on one qualifying visit line reported with modifier -CG, and the patient’s deductible and coinsurance will be applied.

• The patient will be responsible for his usual deductible and coinsurance amounts for the qualifying visit line reported with modifier -CG based on the total charge for the visit.
Case study 5: Preventive service as qualifying visit

On June 6, an established patient presented to a provider-based RHC for her subsequent AWV under the Medicare benefit. During the visit, the physician has the nurse draw blood for the cardiovascular disease blood screening test that will be performed by the hospital.

The following services will be billed:

- AWV (G0439) = $175.00
- Venipuncture (36415) = $35.00

Appendix E, which can be found on the downloads page for this book, demonstrates key fields on the UB-04 claim form that are required when billing for the services.

- All services are reported on separate lines with the appropriate revenue code, HCPCS code, and modifier.
- Modifier -CG is reported on the AWV as the qualifying visit to request an AIR payment.
- The charge for the venipuncture is rolled into the qualifying visit line, which prevents the patient from paying the deductible and coinsurance on both the preventive service that is statutorily waived and the venipuncture.
- When the deductible and coinsurance are waived for certain preventive services, Medicare will pay 100% of the AIR payment rather than the usual 80%. The patient will not be responsible for any portion of the venipuncture charge.

The hospital will bill for the laboratory service on its usual type of bill.

Case study 6: Medical visit and subsequent “incident to” services

On July 10, an established patient presented to an independent RHC for continuing care of a wound infection treated at another facility. The patient saw their usual NP for assessment of the wound and evaluation of her diabetes complications. During the initial visit, the dressing was changed and an injection of Rocephin was given. The NP ordered an additional three-day course of Rocephin injections (750 mg each) and dressing changes to be performed by the nurse. The NP plans to reevaluate the patient in the RHC after completion of the antibiotic injections and dressing changes.
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CHAPTER 6

The following services will be billed for July 10:

- E/M (99214; NP) = $185.00
- Injection, intramuscular (96372) = $60.00
- Injection, ceftriaxone sodium (Rocephin), per 250 mg (J0696) = $54.00 ($18.00 each)

The following services will be billed each subsequent day for July 11, 12, 13:

- E/M (99211; “incident to” nursing service; dressing change) = $45.00
- Injection, intramuscular (96372) = $60.00
- Injection, ceftriaxone sodium (Rocephin), per 250 mg (J0696) = $54.00 ($18.00 each)

Appendix F, which can be found on the downloads page for this book, demonstrates key fields on the UB-04 claim form that are required when billing for the services.

- All services are reported on separate lines with the appropriate revenue code, HCPCS code, and modifier.
- Report modifier -CG on the qualifying visit line to indicate which qualifying visit line will be paid an AIR and also will be subject to deductible and coinsurance.
- Report revenue code 0636 for the Rocephin.
- When billing “incident to” services related to the qualifying visit, report the actual visit date for all subsequent lines.
- Usually, all services provided in an RHC are listed as a unit of 1, regardless of the number of units/services actually provided. For example, rather than bill for 12 units of J0696 for all four days, a unit of 1 is reported instead.
- The qualifying visit line includes the charge for all services: the E/M visit, drugs, injections, dressing changes performed by the nurse.
- The patient will pay the deductible and coinsurance on the total charge for the visit.

Case study 7: Preventive service and advance care planning

On July 12, a new patient presented to the RHC for his initial AWV under the Medicare benefit. In addition, the PA asked the staff nurse to discuss with the patient and his daughter any wishes pertaining to his medical treatment in the future if he lacked the ability to make his own healthcare decisions. The discussion was conducted over 60 minutes, and the nurse provided an advance directive form at the end of the visit.
The following services will be billed:

- Initial AWV (G0438) = $200.00
- Advance care planning (ACP), first 30 minutes (99497) = $50.00
- ACP, each additional 30 minutes (99498) = $40.00

Appendix G, which can be found on the downloads page for this book, demonstrates key fields on the UB-04 claim form that are required when billing for the services.

- All services are reported on separate lines with the appropriate revenue code, HCPCS code, and modifier.
- Modifier -CG is reported on the AWV as the qualifying visit to request an AIR payment.
- The charges for the ACP services are rolled into the qualifying visit line.
- The deductible and coinsurance are statutorily waived for the AWV.
- ACP services must be reported with modifier -33 when they are performed with the AWV to waive any deductible and coinsurance.
- When the deductible and coinsurance are waived for certain preventive services, Medicare will pay 100% of the AIR payment rather than the usual 80%. The patient will not be responsible for any portion of the ACP charge.

**Case study 8: Medical visit with chronic care management and diagnostic services**

A hospital discharged a patient July 30 with end-stage COPD complicated by diabetic nephropathy and valvular insufficiency. The patient required development of a comprehensive care plan and consented to coordination of care with multiple providers via secure messaging and other electronic communications. The patient’s physician, a practitioner at an independent RHC, will be following the patient for chronic care management (CCM). On August 1, the physician’s nurse contacted the patient via phone to establish baseline services for CCM and informed the patient she would be following up on a weekly basis for approximately 15 minutes. The initial call to establish the CCM process was 30 minutes in length. On August 30, the patient returned to the RHC for a follow-up visit for his COPD, diabetes, and heart valve disease. The physician completed a comprehensive exam and also performed an EKG. During the visit, the patient complained of burning urination, and a urine dip was also performed in the RHC.
The following services will be billed:

- E/M (99214) = $275.00
- CCM (99490) = $75.00
- EKG (93010) = $45.00

Appendix H, which can be found on the downloads page for this book, demonstrates key fields on the UB-04 claim form that are required when billing for the services.

- All services are reported on separate lines with the appropriate revenue code, HCPCS code, and modifier.
- Modifier -CG is reported on the E/M as the qualifying visit to request an AIR payment.
- The qualifying visit line includes the charges for the E/M and the EKG interpretation.
  - The patient will pay the deductible and coinsurance on the total charge for the visit.
- The charges for the CCM services are not rolled into the qualifying visit line.
  - Although CCM is an RHC benefit, it is paid based on the MPFS national average nonfacility payment rate, whether it is billed alone or with other separately payable services. Modifier -CG is not reported with CCM.
  - The patient’s deductible and coinsurance will apply based on the MPFS amount rather than the charge.

The urinalysis (81002) and EKG tracing (93005) will be billed by the independent RHC on the 1500 claim form and will be paid under the usual fee schedule amounts, as well as the applicable deductible and coinsurance.
Advance Beneficiary Notice

In some circumstances, RHC staff are required to deliver an Advance Beneficiary Notice (ABN). See Chapter 2 for a detailed discussion of when an ABN is required and how to complete one. A sample blank English-language ABN is shown in Figure 6.1. The ABN is also available on the downloads page for this book.
FIGURE 6.1  Advance Beneficiary Notice of Noncoverage

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

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

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

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHAT YOU NEED TO DO NOW:

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

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

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

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

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

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

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
CHAPTER 6

Resources and Tools

Modifier Selection Flow Chart

Selecting the correct modifier can be challenging. Use the modifier selection flow chart in Figure 6.2 to help you choose the right modifier.
CHAPTER 6

FIGURE 6.2  Modifier Selection Flow Chart

Patient presents to RHC for treatment of an injury or illness and is released.

Later the same day, the patient returns to the RHC for treatment of a separate injury or illness.

Was the subsequent visit related to the initial visit on the same day?

YES

Review all documentation and appropriately assign an E/M and/or procedure code. Roll all charges to one line reported with revenue code 0521. Report modifier -CG on total charge line. Report a charge of $0.01 on any subsequent lines with applicable HCPCS codes and without modifier -CG.
Payment = 1 AIR

NO

Was a procedure performed?

YES

Review all documentation and appropriately assign the subsequent procedure code. Roll all charges to the initial qualifying visit line reported with revenue code 0521. Report modifier -CG on the total charge line. Report modifier -59 on the subsequent procedure line with a charge of $0.01.
Payment = 2 AIRs

NO

Was an E/M service provided?

YES

Review all documentation and appropriately assign a separate E/M code for the subsequent visit. Roll all charges to the initial qualifying visit line reported with revenue code 0521. Report modifier -CG on the total charge line. Report modifier -25 on the subsequent E/M visit with a charge of $0.01.
Payment = 2 AIRs

NO

Later the same day, the patient returns to the RHC for treatment of a separate injury or illness.

Was the subsequent visit related to the initial visit on the same day?

YES

Review all documentation and appropriately assign an E/M and/or procedure code. Roll all charges to one line reported with revenue code 0521. Report modifier -CG on total charge line. Report a charge of $0.01 on any subsequent lines with applicable HCPCS codes and without modifier -CG.
Payment = 1 AIR

NO

Was a procedure performed?

YES

Review all documentation and appropriately assign the subsequent procedure code. Roll all charges to the initial qualifying visit line reported with revenue code 0521. Report modifier -CG on the total charge line. Report modifier -59 on the subsequent procedure line with a charge of $0.01.
Payment = 2 AIRs

NO

Was an E/M service provided?

YES

Review all documentation and appropriately assign a separate E/M code for the subsequent visit. Roll all charges to the initial qualifying visit line reported with revenue code 0521. Report modifier -CG on the total charge line. Report modifier -25 on the subsequent E/M visit with a charge of $0.01.
Payment = 2 AIRs
CMS drastically overhauled rural health clinic (RHC) billing in 2016. RHCs now must report revenue codes, HCPCS codes, and charges for all services on separate lines outside of the qualifying visit line—a significant change. Proper reporting of revenue codes, HCPCS codes, modifiers, and charges for qualifying visits, items, and services is now more important than ever. RHCs have struggled to adapt to CMS’ extensive billing changes, causing revenue flow problems. Combined with the unique staffing requirements and qualifications RHCs must meet, the challenges these vital providers face can seem overwhelming—but they don’t have to be.

The Essential Rural Health Clinic Billing and Management Guide breaks down RHC rules and regulations in an easy-to-understand format. This resource outlines how to meet the RHC designation, addresses the challenges of practice management at an RHC, and explains the latest RHC billing regulations and their impact.