

The cover features a background of wavy, layered shapes in shades of blue and yellow. The top half is dominated by various shades of blue, while the bottom half transitions into shades of yellow and gold. The text is centered and uses a clean, sans-serif font.

THE ESSENTIAL RURAL HEALTH CLINIC BILLING AND MANAGEMENT GUIDE

DEBBIE MACKAMAN, RHIA, CPCO, CCDS

with SHERI HUGHES, CMPA, FHFMA, and DENISE STARK, MPA

The Essential Rural Health Clinic Billing and Management Guide

DEBBIE MACKAMAN, RHIA, CPCO, CCDS, AUTHOR
SHERI HUGHES, CMPA, FHFMA, CO-AUTHOR
DENISE STARK, MPA, CO-AUTHOR

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ISBN: 978-1-68308-205-7

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Debbie Mackaman, RHIA, CPCO, CCDS, Author

Sheri Hughes, CMPA, FHFMA, Co-Author

Denise Stark, MPA, Co-Author

Nicole Votta, Editor

Andrea Kraynak, CPC, Product Manager

Erin Callahan, Vice President, Product Development & Content Strategy

Elizabeth Petersen, President, H3.Group

Matt Sharpe, Production Supervisor

Vincent Skyers, Design Services Director

Vicki McMahan, Sr. Graphic Designer

Melody Chew and Sheryl Boutin, Layout/Graphic Design

Zak Whittington, Cover Designer

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Arrangements can be made for quantity discounts. For more information, contact:

HCPro

100 Winners Circle, Suite 300

Brentwood, TN 37027

Telephone: 800-650-6787 or 781-639-1872

Fax: 800-785-9212

Email: customerservice@hcpro.com

Visit HCPro online at www.hcpro.com and www.hcmarketplace.com.

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About the Authors

Debbie Mackaman, RHIA, CPCO, CCDS

Debbie Mackaman, RHIA, CPCO, CCDS, is the lead instructor for HCPro's Medicare Boot Camp®—Critical Access Hospital Version and Rural Health Clinic Version and an instructor for the Hospital Version and Utilization Review Version. Mackaman serves as a regulatory specialist for HCPro's Medicare Membership and Watchdog services, specializing in regulatory guidance on coverage, billing and reimbursement. She has more than 25 years of experience in the healthcare industry, including inpatient and outpatient prospective payment systems (IPPS, OPSS), critical access hospital, and rural health clinic documentation, coding, billing, and reimbursement issues. She has held the position of the compliance officer and director of health information services for healthcare systems.

Mackaman consults with hospitals, physicians, and other healthcare providers on a wide range of revenue cycle issues, including high-risk areas identified by government program auditors. She has expertise in conducting coding and billing compliance audits; charge description master reviews and maintenance; and providing oversight of documentation improvement programs.

Mackaman holds a bachelor's degree in health information administration and is certified in healthcare compliance. She is accredited as a registered health information administrator and a certified professional compliance officer. She is a nationally recognized speaker on a variety of compliance topics for various organization and revenue cycle events. Mackaman is an active member of the American Health Information Management Association and the Montana Health Information Management Association.

ABOUT THE AUTHORS

Sheri Hughes, CMPA, FHFMA

Sheri Hughes, CMPA, FHFMA, brings more than 40 years of experience in revenue cycle management to the healthcare consulting practice at Moss Adams. Prior to joining Moss Adams in 2008, she led revenue cycle operations at hospitals, health systems, medical groups, skilled nursing facilities, and ancillary providers. Hughes spent 22 years at Hoag Hospital in Newport Beach, California, a hospital that is continuously ranked among the nation's top 100. Her experience includes reviewing operational and financial systems, as well as processes, including charge capture, billing, and payment reconciliation functions. Most recently, she worked with organizations on operational improvements and new system implementation and optimization.

Hughes is well-versed in industry best practices for these functions and helps clients capture accurate coding and data to enhance and improve operational efficiencies. Hughes reviews processes and risk areas in systems to improve overall revenue function. She frequently integrates training and support for charging, coding, and billing departments.

Hughes is a certified manager of patient accounts, a fellow of the Healthcare Financial Management Association, and earned her bachelor of science in healthcare administration from the University of La Verne in California. She has served on numerous statewide and national healthcare committees throughout her career, including FI/MAC advisory boards, and is an active member of the Healthcare Financial Management Association. She has spoken on revenue cycle improvement performance and compliance topics at national industry events.

ABOUT THE AUTHORS

Denise Stark, MPA

Denise Stark, MPA, has helped hospitals, healthcare systems, multispecialty physician groups, clinics, home health agencies, and skilled nursing facilities to improve cash flow and boost productivity for more than 20 years. In her role at Moss Adams, Stark brings experience in a wide range of healthcare revenue cycle operations to clients including patient access, revenue cycle management, patient accounting, denial management, consulting, CDM, process improvement, and financial operational protocols. She is able to conduct operational assessments for various healthcare entities to include measurement and analysis of key performance indicators, benchmarking, and performance in accordance with industry best practices. Stark has implemented revenue cycle redesign initiatives as well as process improvements and restructuring to achieve improved cash flow. She has prepared education and training related to patient access, billing, and follow-up to optimize revenue cycle operations.

Stark has experience evaluating, developing, and implementing new or existing computer system applications to improve accounts receivable. Previously, Stark held various key revenue cycle management positions within health system corporate offices, hospitals, and medical groups. She is experienced with systems including SMS Invision, Relay Assurance, EPIC, Meditech, and Paragon. Stark has a master's degree in public administration from the University of Arizona and a BS in pre-medicine from Loyola-Marymount University.

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%

- Region 3 – Southeast: Cotiviti, LLC, 7.61%
- Region 4 – West/Mid-Atlantic: HMS Federal Solutions, 17.46%

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 LiVANTA, 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

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).

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.

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

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).

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).

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).

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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 AWW.
- 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.

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.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

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:
----------------------	-----------------

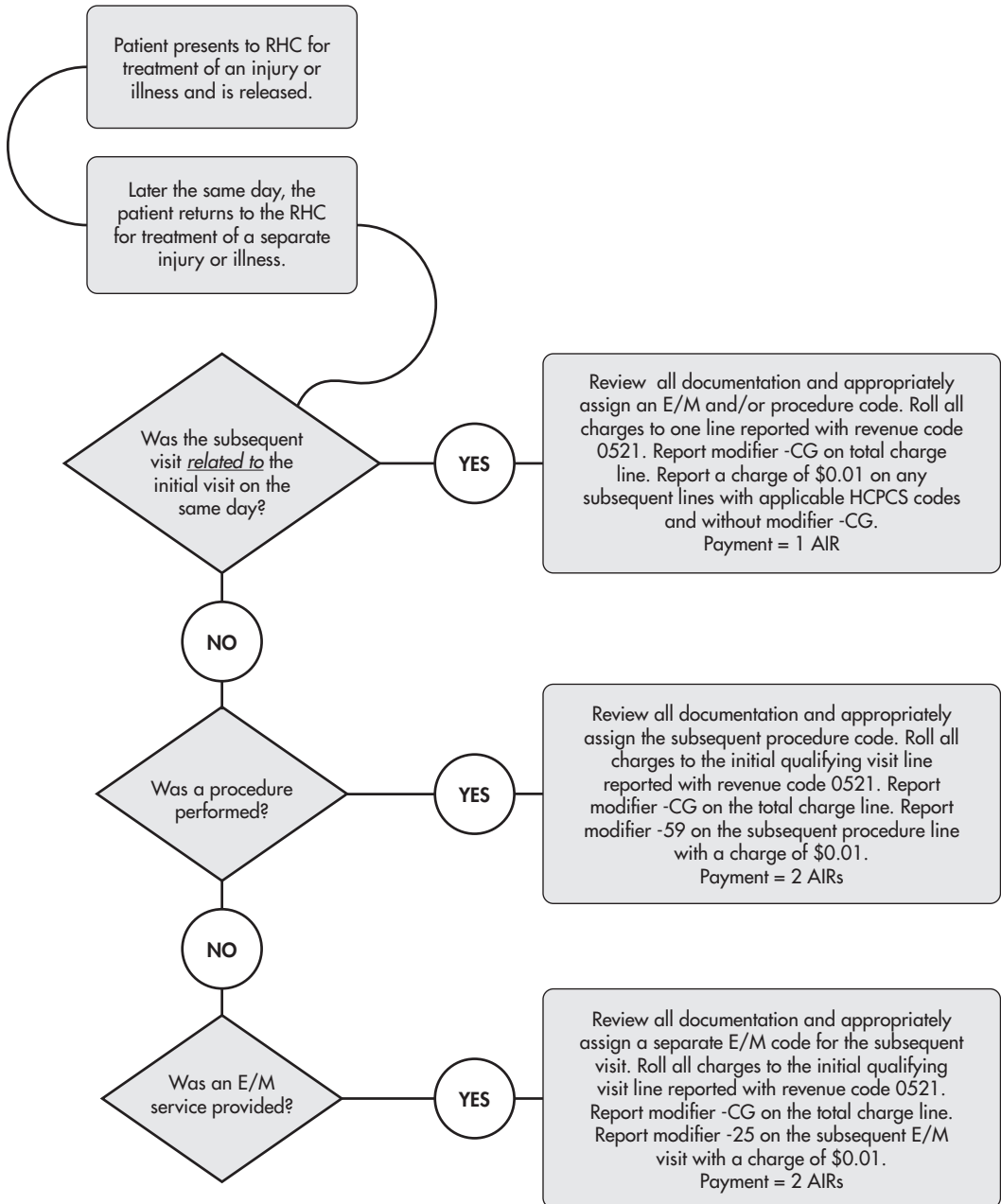
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Modifier Selection Flow Chart

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

FIGURE 6.2 Modifier Selection Flow Chart



THE ESSENTIAL RURAL HEALTH CLINIC BILLING AND MANAGEMENT GUIDE

DEBBIE MACKAMAN, RHIA, CPCO, CCDS

with SHERI HUGHES, CMPA, FHFMA, and DENISE STARK, MPA

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.

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