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NEBRASKA RHC WORKSHOP
MAY 24, 2023

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TODAY'S AGENDA

- RHC Introduction to Compliance and Medicare Billing
- The Status of Nebraska RHCs in 2023/Common Deficiencies
- 2023 RHC Billing and Compliance Update
- Program Evaluation
- Open Discussion/ Q & A

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Understanding What An RHC is

The Medical Practice becomes a healthcare facility
Institutional Provider for Medicare
Regulatory Compliance
Remains a Commercial Payer for non-government payers
Has a "split personality"

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What is an RHC?

A rural health clinic is a **CMS-certified type of healthcare facility**. There are unique qualifications for the location of a rural health clinic. There are also specific requirements for the location of the facility, the staffing of the facility, and the provision of services which differ greatly from the way that a traditional medical practice is operated. RHCs are reimbursed differently than other medical clinics.

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History of the RHC Program

- Rural Health Clinic Services Act of 1977 (Public Law 95-210)
- Enacted to address an inadequate supply of physicians serving Medicare beneficiaries in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas
- 45 years ago-- it was a progressive and forward-thinking program
- Provided opportunities for non-physician providers to practice in underserved, rural shortage areas.
- Cost-based Reimbursement Methodology

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RHC Federal Regs & Guidance

42 CFR § 491
https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part491.pdf

CMS Policy Benefit Manual, Chapter 13
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

CMS Claims Processing Manual, Chapter 9
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

State Operations Manual, Appendix G
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

Everything RHC Manual, page 4

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Understanding RHC Reimbursement

Cost-based Reimbursement
Institutional Provider
Annual Cost Report
Paid per Encounter by Medicare
All-inclusive rate (AIR changes annually)

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Medicare ALL-INCLUSIVE RATE

- The all-inclusive rate is calculated each year on the RHC cost report.
- The total allowable cost of providing care is divided by the number of qualifying RHC encounters to determine the AIR.
- Provider-based RHC are grandfathered in at an upper payment limit based on their 2020 cost report. The rates going forward are the lesser of the actual cost per visit or the grandfathered rate.

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AIR calculation

Total Allowable RHC expenses

Total Visits Meeting the RHC encounter definition

= **AIR (RHC Encounter Rate) Subject to Upper Payment Limits**

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Independent RHC Upper Payment Limits

The RHC payment limit per visit over an 8-year period is as follows:

- In 2021, after March 31, at $100 per visit
- In 2022, at $113 per visit
- In 2023, at $126 per visit
- In 2024, at $139 per visit
- In 2025, at $152 per visit
- In 2026, at $165 per visit
- In 2027, at $178 per visit
- In 2028, at $190 per visit

https://www.cms.gov/files/document/mm12185.pdf

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Understanding Basic RHC Medicare Billing

What is an Encounter
The UB-04/837I Format
Split Billing
The –CG Modifier
The Roll-up
Modifer Use

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What is an Encounter? What is a Billable Service?

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What is an Encounter?

40 - RHC and FQHC Visits

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

An RHC or FQHC visit is a **medically-necessary medical or mental health visit, or a qualified preventive health visit.** The visit must be a **face-to-face (one-on-one) encounter** between the patient and **a physician, NP, PA, CNM, CP, or a CSW** during which time one or more RHC or FQHC services are rendered. A **Transitional Care Management (TCM) service can also be an RHC or FQHC visit**. Services furnished must be **within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits.**

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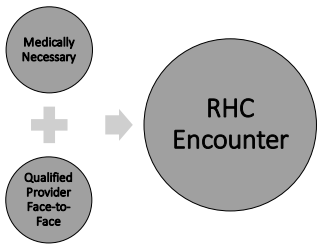

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CMS Qualified RHC Providers

- Physician
  - MD or DO must be the Medical Director
  - Chiropractor or Podiatrist are considered "physicans"; however, these providers are not primary care and cannot be the only provider on duty. Their services are not primary care.
  - Other specialist other than primary care providers, as defined: Internal Medicine, Family Medicine, Pediatrics, Women's Health and Gerontology) can perform RHC services but their services must be less than 49% of all services.
- Primary Care Nurse Practitioner (no other advanced RN credential such as CRNAs or CNS)
- Physician Assistant
- Clinical Psychologist
- Clinical Social Worker

- State Medicaid Programs may recognize other provider types within an RHC. These visits will not be counted by CMS on the cost report.

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What is a Qualified RHC Service?

Standalone & Billable

- **Medically Necessary**
  - Acute/problem visits
  - Chronic conditions (periodic visits for ongoing treatment)
  - Preventive Services
- **Requires the Level of Skill of the Rendering/Billing Provider**
  - No lab only visits
  - No injection only visits
  - No services normally performed by ancillary staff
  - No **normal** lab results only return visits
- **Examples (See QVL)**
  - Preventive Services and Screenings
  - Evaluation and Management Services
  - In-office procedures
  - Transitional Care Management

Note: Services may be covered Medicare or Medicaid benefit and not be a standalone, billable encounter.

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Staffing Requirements for RHCs

- NP or PA or CNM staffed 50% of patient care hours
- MD or DO is required for medical directorship
- State scope of practice prevails
- A provider on site all of the posted patient care hours
- Specialist can be RHC providers. Some rules apply.

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Qualifying Visit List

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

- All codes in either red or black ink on the list can be used for services after 10/01/2016.
- At least one code from the QVL should appear on a claim and be appended by modifier –CG.
- QVL is not exclusive list. However, most MACs have written their claims processing rules based on the QVL.
- CMS can update this list quarterly through OCE edits, but the document itself has not been updated since October 2016.

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Rural Health Clinic Qualifying Visit List (RHC QVL)
(8-01-16)

The RHC QVL is intended as guidance for RHCs beginning to report HCPCS codes. It consists of frequently reported Healthcare Common Procedure Coding System (HCPCS) codes that qualify as a face-to-face visit between the patient and an RHC practitioner and it is not an all-inclusive list of stand-alone billable visits for RHCs. More information on what is considered a RHC visit is included in the "RHC Visits" section of this guidance.

Medical Services

HCPCS Code	Short Descriptor
10061	Drainage of pilonidal cyst
10120	Remove foreign body
10121	Remove foreign body
10140	Drainage of hematoma/fluid
10160	Puncture drainage of lesion
11000	Debride infected skin
11010	Debride skin at fx site
11011	Debride skin muscle at fx site
11042	Deb subq tissue 20 sq cm/<
11055	Trim skin lesion
11056	Trim skin lesions 2 to 4
11057	Trim skin lesions over 4
11100	Biopsy skin lesion
11200	Removal of skin tags /<or 15
11300	Shave skin lesion 0.5 cm/<

Evaluation & Management Services

99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq

Approved Preventive Health Services

HCPCS Code	Short Descriptor
99406[M]	*Behav chng smoking 3-10 min*
99407[M]	*Behav chng smoking > 10 min*
G0101	Ca screen; pelvic/breast exam
G0102[F]	Prostate ca screening; dre
G0117[F]	Glaucoma scrn hgh risk direc
G0118[F]	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annul alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High intns beh couns std 30 min
G0446	Intens behavr ther cardio dz
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

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Incident-to Services

Not Incident-to physician billing

Incident-to services are defined as services which are performed but to not meet the RHC Encounter definition. "Incident-to" in this example is not used to describe NP or PA services which are billed incident to a physician service. These examples are subsequent services which occur outside of an encounter Examples of Incident-to services include:

- Injection Only Visits
- Bandage Changes
- Blood pressure checks
- Suture removal

These are COVERED services. The patient is not billed; There is no ABN. The costs go on the cost report with no corresponding visits.

- Any "Nurse" visit that doesn't require the skill of a provider. No 9921 are billable to Medicare/Medicaid. However, these are covered services.

These services are either held and reported on the next encounter claim within 30 days or may be adjusted off. There is no separate reimbursement for the services as far as filing a claim. The costs of providing the services are included in total costs for the cost reporting calculations.

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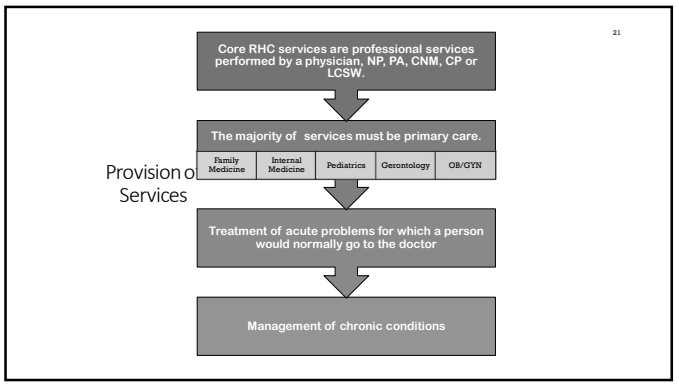

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Where can an RHC encounter take place?

Location	Revenue Code	Comments
Within the RHC Certified Space	521	Most common type of encounter
In the patient's home	522	Must be a qualified RHC provider unless in a designated home health shortage area.
In a Part A skilled nursing facility or swingbed	524	Documentation must also be in RHC medical record
In a Part B nursing facility, assisted living or other residential setting	525	Documentation must be in the RHC medical record and must include a treatment consent.
Other location (scene of an accident)	528	Qualified RHC provider provides a face-to-face encounter when responding to an accident.

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What is Billed on the UB-04 But Doesn't Pay the RHC All-Inclusive Rate?

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Exceptions to Face-to-Face Encounter

- Care Management and Care Coordination Services (G0511)
  - CCM or PCM
  - BHI
  - Psychiatric CoCM
- Virtual Communication Services (G0071)
- Distant Site Medical Telemedicine during the COVID-19 Public Health Emergency (G2025)
- These services are not reimbursed at the AIR. They are reimbursed at a composite FFS amount with RHC specific HCPCS Codes. These allowable amount are updated annually.

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Deductibles & Coinsurance

For RHC Services

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Patient Deductible and Coinsurance

- The Part B Deductible amount for the current calendar year is applied to RHC Visits. Pts with Part A only not covered. Although RHC claims go out as Part A claims, the Part B deductible applies.
- $233.00 for 2022; $226.00 for 2023
- Co-insurance = 20% of total visit charges –not the Medicare Fee-for-service Allowable. The allowable is paid for services that are exceptions to the encounter rule.
- Medicare remit will be 80% of the RHC AIR. The cost share will be 20% of charges.
- At the first of each calendar year, the first RHC claim for the patient may reflect a negative payment if the encounter rate is less than the deductible, because Medicare expects the RHC to collect the Part B deductible amount. However, the RHC can only keep its AIR.

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Example of RHC Coinsurance Calculation

RHC Encounter Example of CoInsurance								
CPT Code	Charge Amount		The coinsurance is 20% of the total charges.					
99213	120.00		The PMFS allowable only applies to non-face to face exceptions.					
96372	25.00							
J0696	50.00							
Total Charges	195.00		$195 x .20 =	=	$ 39.00			

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§405.2410 Application of Part B deductible and coinsurance.

(a) Application of deductible. (1) Medicare payment for RHC services begins only after the beneficiary has incurred the deductible. (Note: Negative Remit Issue)

(b) Application of coinsurance. Except for preventive services for which Medicare pays 100 percent under §410.152(l) of this chapter, a beneficiary's responsibility is either of the following:

(1) For RHCs that are authorized to bill on the basis of the reasonable cost system—

(l) A coinsurance amount that does not exceed **20 percent** of the RHC's reasonable customary charge for the covered service; and

(ii)(A) The beneficiary's deductible and coinsurance amount for any one item or service furnished by the RHC may not exceed a reasonable amount customarily charged by the RHC for that particular item or service;

https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=00be946f47b166173d900f438cd599493&h=L&n=sp42.2.405.x&r=SUBPART&ty=HTML#se42.2.405_12401

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Credit Balance Reporting

- RHCs are required to file Quarterly Credit Balance Reports since they are an institutional provider.
- Form 838
- Can be filed on the MAC portal or faxed to the MAC
- Due not later than 30 days after the calendar quarter
- Report only true overpayments from Medicare that created a credit balance. Do not report credit balances created by patient overpayments or posting errors.
- If the report is late, payments will be held until the report is filed.

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Medicare Split Billing

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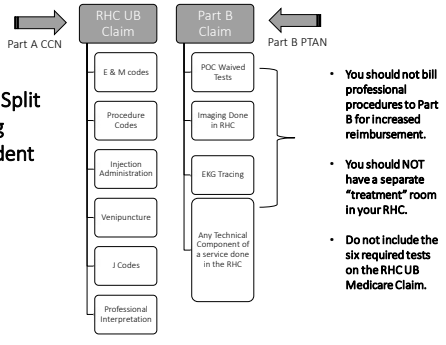
Medicare Split Billing Independent RHC



- **You should not bill professional procedures to Part B for increased reimbursement.**
- **You should NOT have a separate "treatment" room in your RHC.**
- **Do not include the six required tests on the RHC UB Medicare Claim.**

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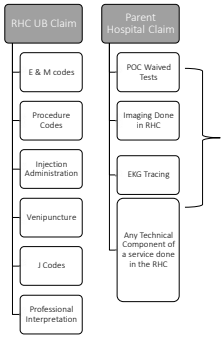
Medicare Split Billing PBRHC



<u>Caution</u>: Only One Hospital OP Claim per date of Service per patient.

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These Immunizations are reported on the Cost Report and are NOT billed on a MEDICARE claim

- Flu Immunizations
- Pneumococcal Immunizations
- COVID-19 Immunizations and Monoclonal Antibody Infusions for traditional Medicare. Medicare Advantage billed directly.

  Cost of Private Stock Vaccines
  Nursing Time per Immunization
  Total number of Immunizations
  Total number of Medicare shots
  Logs of Vaccines Given

- Not dropped on claim at all.
- Not billed to patient
- Not billed to secondary

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Type of RHC	Encounter Professional Services RHC Service	CLIA Lab Performed in RHC	Other Technical Components Performed in RHC- EKG, X-ray, Imaging	Professional Services Outside RHC Hours- Hospital Services
Provider-Based	Part A UB-04 Using the RHC NPI And Parent Entity EIN	Billed to MAC by Parent hospital TOB 141/131 for PPS hospital; CAH: 851.	Billed to MAC by Parent hospital TOB 131 for PPS hospital; CAH:851	Billed to MAC as a professional service or CAH Method II Billing.
Independent	Part A UB-04 Using RHC NPI and RHC EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B Professional Group PTAN to which the provider is linked.

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EKGs in Rural Health Clinics

Code	Description	RHC UB-04	Independent RHC Part B	PBRHC Hospital side
93000	EKG, 12 Lead with interpretation/report	NO	NO	NO
93005	EKG, 12 lead, tracing only	NO	YES	YES
93010	EKG, 12 lead, interpretation and report only.	Maybe*	NO	Maybe*

* Depends on the provider who does the interpretation and the report.

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Medicare Flu, Pneumococcal and COVID Immunizations

- RHCs do **NOT** bill Medicare for Flu,Pneumococcal or COVID Immunizations on traditional Medicare (RW & B) claims.
- CPT codes for administration and for the vaccine are never included in the claim detail. Can be set up as zero charge/no bill for tracking.
- Charges for Flu, Pneumococcal and COVID Injections are not included in the total encounter charge for Medicare.
- RHCs must keep a log with Patient's name, HIC, date of immunization, etc. Some EMR and PM systems will generate log; if not, must be manual.
- Medicare Advantage Plans/Medicare HMOs **are** billed for these immunizations. However, make sure your contracts have provisions for additional reimbursement. These immunizations are not included on the regular Medicare cost report.
- See additional slides on COVID-19 vaccine administration

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RHC UB-04 CLAIMS

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RHC UB-04 By FL

CMS Claims Processing Manual, Chapter 9
50 - General Requirements for RHC and FQHC Claims

https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/clm104c09.pdf

Value Codes and Amounts, FL 39-41
The RHC/FQHC enters any appropriate NUBC approved code(s) and the associated value amounts identifying numeric information related to this bill that may affect processing.

Revenue Codes, FL42
The RHC/FQHC assigns a revenue code for each type of service provided and enters the appropriate four-digit numeric revenue code to explain each charge.

For FQHC claims with dates of service on or after January 1, 2010, FQHCs may report additional revenue codes when describing services rendered during an encounter. However, Medicare payment will continue to be reflected only on claim lines with the revenue codes in the following table:

Code	Description
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a

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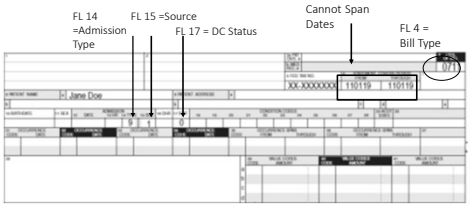

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Revenue Codes by Encounter Location or Type of Service:

Use one of these rev code with the CPT code from the QVL list.

This will be the line with the –CG modifier.

Revenue Code	Description
0521	Clinic Visit by a member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at SNF
0525	Visit by a RHC practitioner to a member in a Part B SNF or Nursing Facility or other residential facility
0528	Visit by a RHC practitioner to other non RHC site (e.g., scene of accident)

For Medicare claims only.

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Revenue Codes for CPT/HCPCS ® Billing for subsequent line items

Revenue codes are used in institutional billing to reflect the place of service and to validate the service performed in that place of service.

All Revenue codes **EXCEPT** the following are allowed for RHC billing:

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

Some common allowed Revenue codes might include:

- 0250: Pharmacy (no J code)
- 0636: Drugs with J code
- 0300: Venipuncture
- 0420, 0430, 0440: PT/OT/ST (not an encounter, no separate reimbursement.)
- 0780: Telemedicine originating site
- 0900: Behavioral Health

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Revenue Codes and CPT/HCPCS codes are listed for each line item. The –CG Modifier is appended to the QVL code.

0521	Description Optional	99214 CG	110119	1	190.00
0521		96372	110119	1	15.00
0636		J0696	110119	2	50.00
0001	PAGE 1 OF 1		CREATION DATE 120519	TOTALS	255.00

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RHC Medicare Billing

- CPT/HCPCS® Level Codes are reported for ALL services that are provided.
- Revenue Codes are reported for each CPT/HCPCS® Code.
- ALL Charges are totaled and reported on the line with the ***qualifying visit code*** for that encounter. This is the "pay" line.
- The qualifying visit code/pay line is designated by the **CG modifier**. All charges are rolled up to this line item. This line is either the E & M code or the code which is most closely related to the chief complaint.
- All other line items must include a charge amount of ≥ $.0.01. The amount may be your actual charge or the penny amount.
- The total line (0001) will NOT equal the total for all charges. It will appear overstated. Coinsurance is calculated from the -CG line and not the total line.

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The –CG Modifier

A RHC visit must include one of the services listed on the RHC Qualifying Visit List. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services.

RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the CMS RHC center webpage. **The code appended with –CG should be the service most related to the reason for the visit.**

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf

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One UB-04 Claim per patient per DOS
One AIR per DOS

There can only be one UB-04 Claim per patient per date of service **with these exceptions** and only one AIR paid per visit with these exceptions:

- A medical visit and a mental health visit on the same day with different providers. One claim, different revenue code.
- Two unrelated medical visits in one day in which one is a scheduled visit and the second is an unscheduled, unexpected visit such as a subsequent injury or illness. (No staging of appointments- one claim with special modifier use)
- A medical visit and the IPPE preventive visit (Two payments, one claim)

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RHC Claim Examples

Codes and Prices in Examples for demonstration purposes only and are not intended to suggest specific methodologies or clinical scenarios.

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RHC Encounter with E & M Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est Pt III	99213 CG	11/01/2021	1	100.00
0001	Total Charge				100.00

Provider performed an E & M service ($100.00) for a problem which required no lab, no ancillary or incidental services or other non-RHC services. The patient responsibility is $20 and the MAC will reimburse 80% of rate if the deductible has been met.

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RHC Encounter with In-Office Procedure Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	I & D Abscess	10160 CG	11/01/2021	1	150.00
0001	Total Charge				150.00

Provider performed a simple I & D ($150.00) during this encounter. No other services were provided. The supplies and local anesthesia would be integral to the procedure. The patient would be responsible for a $30 co-insurance payment.

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RHC Encounter with Multiple Services # 1

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/1/2021	1	250.00
0521	I & D Abscess	10160	11/1/2021	1	150.00
0001	Total Charge				400.00

Provider performed an E & M service ($100) and an in-office procedure ($150.00) during the same visit. The supplies and local anesthesia would be integral to the procedure. The patient would be responsible for a $50.00 co-insurance payment. The total 001 line appears overstated.

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RHC Encounter with Multiple Services # 1-Alternative Method

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2021	1	250.00
0521	I & D Abscess	10160	11/01/2021	1	.01
0001	Total Charge				250.01

Provider performed an E & M service ($100) and an in-office procedure ($150.00) during the same visit. The supplies and local anesthesia would be integral to the procedure. Additional service items are reported ≥ .01. The patient would be responsible for a $50.00 co-insurance payment. The total 001 line appears overstated. Using this method depends on your PM/EHR and your facility's method for tracking charges.

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RHC Billing Type Example

Mary presents to ABC Rural Health Clinic, with symptoms of a lower respiratory infection. The provider orders an in-house chest x-ray to confirm the diagnosis. During the ROS and exam, the provider also suspects that Mary may have a UTI. An in-house UA (one of the required RHC tests) is also performed. Mary also receives one unit of Rocephin IM.

*Red is provider-based RHC.

Service	Billed On	Provider #	Reimbursed
E & M Service for office visit (99214)	UB-04	RHC Number	Encounter Rate AIR
Rocephin (J0696)	UB-04	RHC Number	Encounter Rate AIR
Urinalysis	1500/ UB-04	Part B Group # if independent; Hospital # if provider-based	PFS, Lab Fee Schedule
X-ray (Technical Component Only)	1500/UB-04	Part B Group #; Hospital # if provider-based	PFS, OPPS or % of charges.

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RHC Encounter with Multiple Services #2

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2021	1	190.00
0521	Inj Admin	96372	11/01/2021	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2021	2	50.00
0001	Total Charge				255.00

Provider performed an E & M service ($125) and an abx injection ($15 + $50) during the same visit. Also, a UA and an x-ray were performed in the RHC. Total RHC services would be $190.00. The patient would be responsible for a $38.00 co-insurance payment. The total 001 line appears overstated. ***Lab and x-ray services would be billed separately under the appropriate method for the type of RHC.***

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RHC Encounter: Office Visit & EKG

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2021	1	145.00
0521	EKG- Prof	93010	11/01/2021	1	20.00
0001	Total Charge				165.00

Provider performed an E & M service ($125) and an EKG tracing/TC ($40) and interpretation/PC ($20) during the same visit. The RHC provider read the EKG. Total RHC services would be $145. The patient would be responsible for a $29.00 co-insurance payment. The total 001 line appears overstated. Additional service lines could be reported ≥ 0.01. ***The technical component of the EKG ($40) would be billed separately under the appropriate method for the type of RHC.***

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RHC Encounter: Mental Health Visit Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Psych Eval	90791 CG	11/01/2021	1	200.00
0001	Total Charge				200.00

Provider performed a Psychiatric Diagnostic Evaluation ($200) on the date of service. Total RHC services would be $200. The patient would be responsible for a $40.00 co-insurance payment.

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RHC Encounter: Medical Visit and Mental Health Visit on Same Date of Service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV New	99204 CG	11/01/2021	1	175.00
0900	Psych Eval	90791 CG	11/01/2021	1	200.00
0001	Total Charge				375.00

The physician performed an sick visit ($175) and the behavioral health provider performed a psych eval ($200) on the same date of service. Both services would be reported separately with the –CG modifier. Total RHC services would be $375.00. The patient would be responsible for a $75.00 coinsurance.

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Modifier -59

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has an injury and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit code, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

This is an unconventional use of -59 and is only used in this way, unique to RHC billing of multiple visits on the same date of service.

A -25 appended to the E & M code can also result in an overpayment.

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Multiple Encounters on Same Date of Service Different Problems

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est	99213 CG	11/01/2021	1	175.00
0521	Laceration	12001 59	11/01/2021	1	150.00
0001	Total Charge				325.00

The physician performed an E & M service in the morning to manage the patient's chronic conditions. Later in the afternoon, the patient cuts his hand while working in his garden. On the second visit of the day, the provider repairs the 2 cm laceration. The first service is appended with –CG. The second service is appended with -59. Total RHC services would be $325.00 The patient would be responsible for a $65 co-insurance payment. The RHC should receive two AIR payments.

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Preventative Services Guide

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

This CMS reference give examples of preventative services and indicates when the AIR is received and how the deductible and coinsurance amounts are applied.

The –CG modifier is appended if the only service provided is the preventative service. The –CG modifier if not needed for the IPPE but may be added. Preventative services provided on the same day as a qualifying medical visit are reported but are not bundled into the –CG line.

IPPE is the ONLY preventive service which will qualify for an additional AIR on the same DOS as a sick visit.

Preventive services should be tracked for cost-reporting.

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RHC Encounter: IPPE Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2021	1	200.00
0001	Total Charge				200.00

The physician performed IPPE (Welcome to Medicare) service on this date of service. No –CG modifier is required. The patient has no cost share for this visit because the deductible and co-insurance is waived.

Is the IPPE the same as a beneficiary's yearly physical?
No. The IPPE is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

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RHC Encounter: IPPE and Sick Visit on same date of service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2021	1	150.00
0521	IPPE	G0402	11/01/2021	1	200.00
0001	Total Charge				350.00

The physician performed IPPE ($200) and an E & M ($150) for a problem visit on the same date of service. The office visit is listed first with the -CG modifier. The patient has no cost share for the IPPE service because the deductible and co-insurance is waived. The co-insurance amount due for the sick visit is $30.00. The RHC will receive two AIR payments for this visit.

You should track all preventive services for cost-reporting purposes.

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RHC Encounter: IPPE with EKG Interpretation/Report as Part of IPPE

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2021	1	200.00
0521	EKG IPPE Interpret/Report	G0405	11/01/2021	1	100.00
0001	Total Charge				300.00

The RHC physician performed IPPE ($200) and also interpreted the EKG ($100) performed as part of the IPPE. Only the HCPCS codes for the two services are reported on each respective line. The clinic will receive one AIR rate but the coinsurance and deductible will be waived per HCPCS code.

You should track all preventive services for cost-reporting purposes.

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RHC Encounter: "Woman Well Visit" AWV and Other Screenings

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	AWV-Subsequent	G0439 CG	11/01/2021	1	150.00
0521	Breast/Pelvic	G0101	11/01/2021	1	100.00
0521	Pap Smear	Q0091	11/01/2021	1	50.00
0001	Total Charge				300.00

The patient received a subsequent AWV along with other preventive services on the same date of service. The –CG is appended to the AWV. There is no cost share for this visit. When performed alone, the AWV and the Breast/Pelvic Screening both reimburse at the AIR.

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Advanced Care Planning

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Sample-Billing.pdf

- As a standalone service, the AIR is paid.
- When provided on same date of service as AWV, the service is included in the one AIR payment.

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL4 6 Units	FL47 Total Charge
0521	Advance Care Planning	99497 CG	11/01/2021	1	150.00
0001	Total Charge				150.00

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Care Management

Beginning in 2021, RHC can now perform Principal Care Management which means the patient has only 1 condition which is managed. G0511 is used for both reporting CCM and PCM. RPM is NOT separately billable by RHCs and is considered incident-to care management. Reimbursement for G0511 in 2022 is $79.25 There is a 20% coinsurance amount or roughly $16.00.

Change in 2022:
TCM and CCM can be performed within the same 30-day period. Documentation should support both services.

RHC Care Management FAQ
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

RHC Care Management MLN
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf

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Example of CCM Billing

CCM Reported Alone

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	CCM	G0511	02/01/2021	1	75.00
0001	Total Charge				75.00

The –CG Modifier is NOT appended to G0511 because the service is paid under fee-for-service reimbursement. Deductibles and co-insurance apply. **The 2022 rate for G0511 is $79.25 The patient's coinsurance will be 20% of the allowable.**

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Example of CCM Billed with an Encounter

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213-CG	02/28/2021	1	100.00
0521	CCM	G0511	02/28/2021	1	75.00
0001	Total Charge				175.00

If CCM is billed with another RHC service, the charge for CCM is NOT added to the first line. The –CG modifier is only added on the first line. The clinic will receive the RHC all-inclusive rate for the office visit/encounter and the $66.77 for the CCM. The coinsurance will be $20.00 for the office visit and another $13.35 for the CCM (Total $33.35). It is important to explain to the patient the value of the CCM when enrolling them.

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Questions or Comments?

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