

# Rural Health Clinic Workshop

## Rural Health Clinic Billing

Wednesday, October 15, 2014  
10:30 a.m. – 11:30 a.m.



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# Overview of Today's Session

- RHC Background & Building Blocks
- Medicare Billing Basics
  - Rural Health Clinic (RHC) Services & Non-RHC Services
  - Noncovered Services
  - Payment for Services
  - Filing an RHC Claim
  - Review of Billing Policies
- Medicare vs. Medicaid Billing
- Appendix
  - FAQs, Acronyms, and Resources



# RHC Building Blocks

## What Is a Rural Health Clinic?

The rural health clinic certification is a designation that clinics providing primary care in certain rural, underserved areas can obtain from the Centers for Medicare & Medicaid Services (CMS), which provides an alternative, cost-based reimbursement system for treating Medicare and Medicaid beneficiaries.



# RHC Building Blocks

## How Are RHCs Paid?

RHCs are paid a flat rate for each *face-to-face, medically necessary encounter with an RHC practitioner* based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs (i.e., cost report) occurring at the end of the fiscal year.

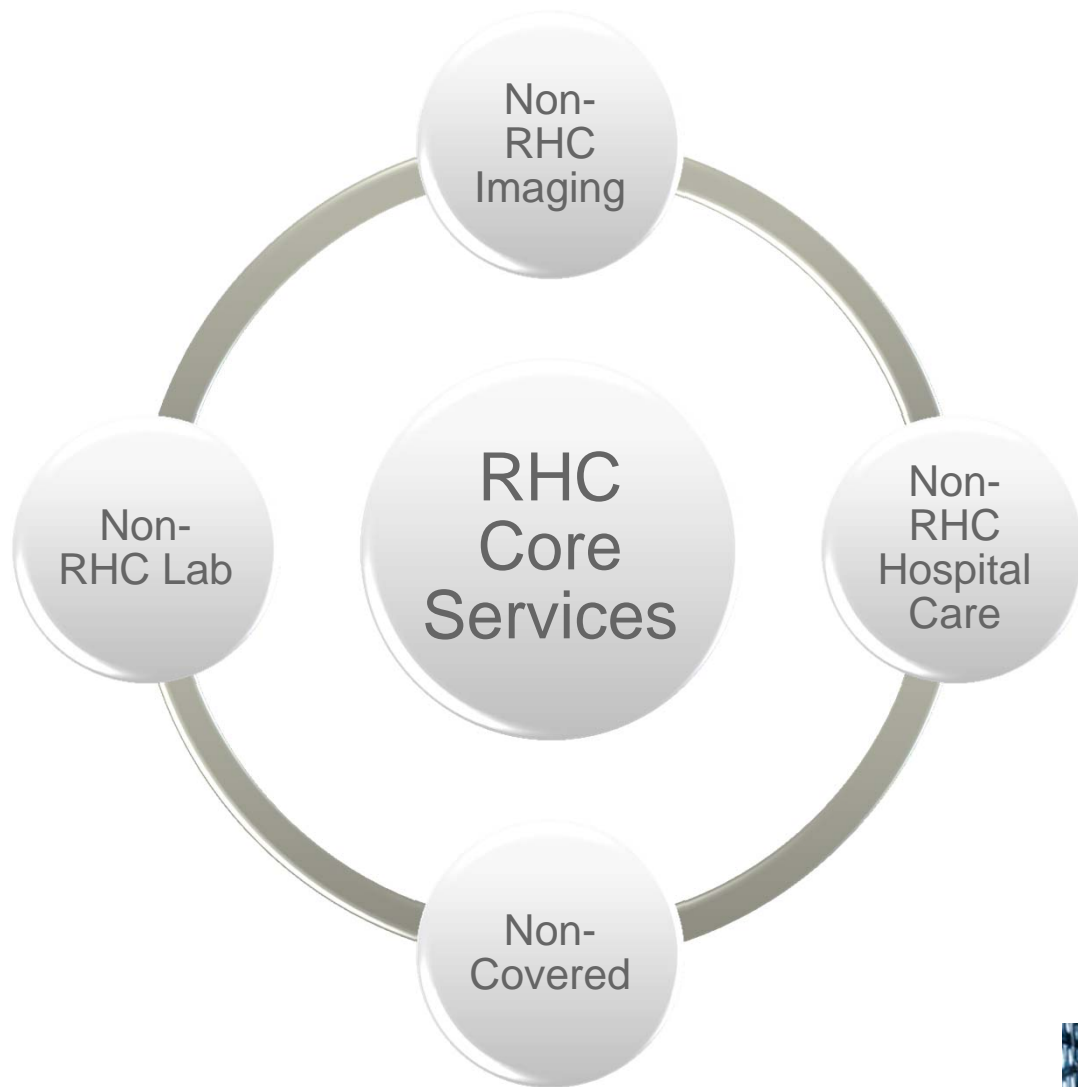


# RHC Building Blocks

**There are two types of RHCs; billing and payment are slightly different:**

1. Independent RHCs bill RHC services to one of five regional fiscal intermediaries/MACs.
2. Provider-based RHCs bill RHC services to the FI/MAC of the host provider (usually a hospital).





# RHC Services

- Physician services
- Services of nonphysician practitioners (NPP), which include physician assistants, nurse practitioners, and certified nurse midwives (does not include clinical nurse specialists)
- Services and supplies incident to Physicians and NPP
- Visiting nurse services to the homebound
- Clinical psychologist and clinical social worker services
- Services and supplies incident to clinical psychologist and clinical social workers
- Physician services for beneficiaries in Part A stay in SNF (including hospital swing bed) separately billable effective 1/1/05



# RHC: Physician Services

- Physician services = Professional services performed by a physician for a patient:
  - Diagnosis, therapy, surgery, consultation, and interpretation of tests (EKG, x-rays)
- Services performed at the clinic are payable only to the RHC:
  - Include RHC or patient's place of residence or implied place of residence (SNF, NF, or swing bed)
- Payment made under all-inclusive rate





# RHC: Incident to Services

Services and supplies are furnished incident to physician services:

- Furnished as an incidental, integral part of professional services
- Commonly rendered either without charge or otherwise chargeable
  - Cannot bill carrier or intermediary separately!
  - Costs are included in the cost report as part of the all-inclusive rate (AIR)
- Commonly furnished in a physician's office
- Furnished by a clinic employee (staff)
- Includes services of clinic staff (e.g., nurse, therapist, technician, or other aide):
- Supplies such as bandages and tongue depressors are included in the office visit as packaged services



# RHC: NP, PA, and CNM

Payment allowed for services furnished by NPPs in all areas and settings permitted under state licensure laws:

- NP, PA, and CNM services provided in RHC follow same guidelines as outlined for physician services above (Reimbursed at same rates as physician – no reduction based on type of provider!)
- Payment made under all-inclusive rate (AIR)



# RHC: Visiting Nurse Services

- Covered if service area considered a shortage of HH agencies
- Services rendered to homebound patients
- Patient furnished part-time/intermittent nursing care by RN, LPN, or licensed vocational nurse
- Needs to be an employee of RHC
- Services furnished under written plan of treatment:
  - Reviewed once every 62 days by supervising physician of RHC



# Non-RHC Services

- DME
- Ambulance services
- Diagnostic tests such as X-ray and EKGs
- Lab test (*although required for certification, must be able to perform six required tests in RHC*)
- Screening mammography services
- Prosthetic devices
- Services provided to hospital patients (**except those in a swing bed**)



# Non-RHC Services - Lab

## Required Lab Services That Must be Available as an RHC

- Chemical examinations of urine (CPT 81002)
- Hemoglobin (CPT 83026)
- Blood sugar (CPT 82962)
- Examination of stool specimens (CPT 82270)
- Pregnancy tests (CPT 81025)
- Primary culturing for transmittal to a certified laboratory

*Clinic must have the ability to perform these basic [CLIA waived] tests; however, they are billed as non-RHC services.*



# Non-RHC Services - Lab

## Lab performed by a CAH

- *Medicare Improvements for Patients and Providers Act of 2008* allows cost-based reimbursement for all laboratory services provided by any provider type (i.e., SNF, RHC, or other physician clinic) that is operated by the CAH regardless of where the lab specimen is collected (i.e., *patient does not have to be physically present in the CAH at the time the specimens are collected*).
- Went into effect for service dates on or after July 1, 2009.



# Non-RHC Services - Lab

## Billing Lab Services Performed in an RHC

- Independent RHC:
  - Bill all lab services (including the six basic required tests) to Part B carrier on CMS 1500
  - Excluding the lab draw procedure (CPT 36415)



# Non-RHC Services - Lab

## Billing Lab Services Performed in an RHC

Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see Section 1861(aa)(2)(G) of the Act and for FQHCs see Section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead, and personnel for these services must be adjusted out of the RHC or FQHC cost report. **This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.**

**MLN Matters Number MM8504, November 22, 2013**





# Non-RHC Services - Lab

## Billing Lab Services Performed in an RHC

- Provider-based RHC operated by a CAH:
  - For CAH lab services with dates of service beginning July 1, 2009, use 85X bill type to receive cost reimbursement for lab services



# Non-RHC Services - Lab

## Billing Lab Services Performed in an RHC

- Provider-based RHC operated by a PPS hospital:
  - Bill all lab services (including the six basic required tests for RHC COP) performed in RHC as reference lab to FI on Form UB-04 using hospital billing number
    - Again, bill under hospital main provider number (not RHC number!)
    - Bill type 14X
    - Revenue code 030X
    - CPT code required field
    - Fee schedule reimbursement



# Diagnostic Services

## Special Billing - Other Diagnostics Services

Example billing for EKGs:

- Part B service:
  - Bill technical component of EKG using 93005 (EKG) to Part B carrier or hospital FI
- RHC (professional) service:
  - Follow normal RHC billing if attending physician is also interpreting test; charge added (bundled) with office visit
  - Rev code 52x
  - Paid as RHC encounter



# Summary of Billing for RHC vs. Non-RHC Services

## RHC Billing Differences (Core Services)

Service	Independent	Provider-Based
RHC services (face-to-face encounter in RHC site of service).	Billed to Independent RHC Regional Fiscal Intermediary - RHC provider number on Form UB-04.	Billed to host Provider Fiscal Intermediary - RHC provider number on Form UB-04.



# Summary of Billing for RHC vs. Non-RHC Services

## RHC Billing Differences (Non-RHC Services)

Service	Independent	Provider-Based
Laboratory ( <b>excluding the draw procedure, e.g., CPT 36415</b> ).	Billed to Part B carrier - Existing group number on Form 1500.	Billed on hospital O/P claim type (14x, 13x, or 85x) on Form UB-04.
Other Diagnostic/Radiology - Professional component.	May be billed with encounter. If read by non-RHC provider, they will bill the carrier.	May be billed with encounter. If read by hospital radiologist, bill the carrier.
Other Diagnostic/Radiology - Technical component.	Billed to Part B carrier - Existing group number on Form 1500.	Billed on hospital O/P claim type (13x or 85x) on Form UB-04.
Non-RHC Professional Services (I/P, ER, other O/P services).	Billed to Part B carrier - Existing group number on Form 1500.	Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for O/P pro fees).



# Services Not Covered

Services never paid by Medicare include:

- General exclusions from Medicare (e.g., dental, cosmetic surgery, routine services)
- Not reasonable and necessary for:
  - Diagnosis
  - Treatment of illness or injury
  - Improved functionality of malformed limb
- Experimental services



# Payment Calculations

- Payments for covered RHC services by physician, PA, NP, CNM, CP, CSW, and visiting nurse are under an all-inclusive rate for each visit
- Each provider's interim rate is based on the all-inclusive rate per visit (determined based on the cost report)
- Established by your Medicare intermediary:
  - Determined by dividing total allowable cost by the number of total visits for RHC services
  - Rate may be adjusted during reporting period



# Payment Calculations

- The upper payment limit for RHC for 1/1/14 through 12/31/14 is \$79.80 per visit (based on the Medicare Economic Index, MEI, 0.8 percent increase over the 2013 rate of \$79.17)
  - However, no upper payment limit for RHCs that are provider-based to a hospital with less than 50 beds





# Charges to Beneficiaries

## Part B Deductible

- The \$147 Part B annual deductible applies to services covered under the RHC benefit for 2014

## Part B Coinsurance

- If the item or service is covered under the RHC benefit, the beneficiary is responsible for 20% of the customary charge
- If the service is not covered under the RHC benefit and is covered under Part B, the beneficiary is responsible for 20% of Medicare-approved charge (MFS)



# Payment Calculations

## RHC Payment Examples

- Customary charge for 99213 is \$110
- Assume Medicare fee schedule allowable is \$59
- Medicare encounter rate is \$128:
  - Limited to \$80 for independent RHC
  - No limit for provider-based RHC - Available beds < 50
- Deductibles have been met already



# Payment Calculations

## Comparison Between RHCs and Part B Payment Example

Description	RHC Amount (Independent)	RHC Amount (Provider-based)	Part B Amount
Customary Charge	\$110.00	\$110.00	\$110.00
Patient Copay	22.00	22.00	11.80
Medicare Pays	64.00	102.40	47.20
Total Payment	86.00	124.40	59.00
Contractual Adjustment	24.00	(14.40)	51.00



# Payment Calculations

**Does it matter how we code the visit if we get paid the same rate?**

- Patient payment is affected
- Medicare considers overcoding as a violation of the fraud and abuse regulations because of the additional reimbursement
- Medicare considers undercoding as a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic

**Conclusion: Yes, it Matters!**



# Filing an RHC Claim

- UB-04 (CMS Form 1450)
- Bill type 71x
- Revenue codes allowable 52x and 900 (*maximum unit of one per day*)
- No HCPCS required (*except for covered preventive services*)
- Separate RHC billing number (for each RHC)
- Only RHC services on RHC billing number
- Bill all non-RHC ancillary services SEPARATELY!
  - Independent - To Part B carrier using existing group number
  - Provider-based - Through the hospital provider number on 13x, 85x, or 14x type of bill (A-00-36 7/28/00)
- Non-RHC professional services billed to Part B carrier utilizing existing group number (or to FI/MAC under CAH Method II billing)



# Filing an RHC Claim

## RHC Bill Types (UB-04 claim form, 71X):

- 710 Claim with only non-covered charges
- **711 Original claim**
- 715 Late charge – adjustment to prior claim
- 717 Replacement claim – adjustment to prior claim
- 718 Void/cancel previous claim



# Filing an RHC Claim

## **RHC Revenue Codes - Effective July 1, 2006:**

- 0521 Clinic visit at RHC/FQHC
- 0522 Home visit by RHC/FQHC
- 0524 Visit by RHC/FQHC practitioner in Part A stay SNF
- 0525 Visit by RHC/FQHC practitioner in a NF or ICF or residential facility
- 0527 RHC/FQHC visiting nurse (must have special designation)
- 0528 RHC/FQHC visit other locations (i.e., scene of an accident)
- 0780 Telehealth services (Note: not an RHC service)
- 0900 Mental health visits

*Sometimes referred to as place of service with respect to RHC/FQHCs*



# Review of Billing Policies

## RHC Billing Tips

- Combine all charges on one line
- Always include unit/visit number with visit revenue code (e.g., 521 revenue code)
- CPT/HCPCS codes not required (except for preventive services); however, if used, must pass (Outpatient Code Editor) OCE edits
- Use only ICD-9 to describe diagnosis
- Always code to most specific detail code available





# Review of Billing Policies

## RHC Billing Tips

- NPI - Show appropriate identifier (assigned to the provider)
- Always include revenue code with total charges
- Can combine non-visit charges with visit charges:
  - Usually within 30 days
  - Bundle all charges with visit revenue code
- Should list actual charge on claim form—not reimbursement rate!



# Review of Billing Policies

## Mental Health Visit – Revenue Code 900

- Reduction in Mental Health Limitation - Mental health limitation is phased out effective 1/1/2010 per a memorandum dated 10/30/2009:
  - 2011 68.75% (Medicare pays 55%, patient pays 45%)
  - 2012 75.00% (Medicare pays 60%, patient pays 40%)
  - 2013 81.25% (Medicare pays 65%, patient pays 35%)
  - 2014 100% (Medicare pays 80%, patient pays 20%)



# Review of Billing Policies

## Mental Health Visit – Revenue Code 900

- Mental Health Visits Do Not Include
  - Initial psychiatric visits
  - Psychiatric testing
  - Psychiatric consultations
- These services are not subject to limitation and should be billed using 52X rev code



# Review of Billing Policies

## Mental Health Visit – 521 or 900 revenue code?

Service	CPT Code	Rev Code
Diagnostic (no medical)	90791	521
Diagnostic (w/ medical eval.)	90792	521
Psychotherapy (30 min)	90832	900
Psychotherapy (45 min)	90834	900
Psychotherapy (60 min)	90837	900
Psychotherapy with E&M	+90833/36/38	521
Psychotherapy for crisis	90839 (+90840)	0900
Family psychotherapy	90846/47/49	N/A
Group psychotherapy	90853	N/A
Other (pharmaceutical mgmt)	E&M codes	521



# Review of Billing Policies

## Home Health Visits

As a condition for payment, the Affordable Care Act (ACA) mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she or an allowed NPP has had a face-to-face encounter with the patient.

- Must occur within 30 days of start of care unless seen within 90 days.
- Documentation must be present with starts of care on or after 1/01/11.
- Certifying physician can “hand off” care.
- Face-to-face encounter could be through telehealth in approved site.

(Refer to MLN Matters SE1038 for more details.)



# Review of Billing Policies

## Hospice Care

The general requirement for hospice care is that if the patient is terminally ill (defined as life expectancy of 6 months or less), they can elect to receive hospice benefit. When doing this, the beneficiary gives up the right to receive any other care from a Medicare provider (including RHC/FQHCs).

However, if the beneficiary does need Medicare services for a condition completely unrelated, they should be able to bill for that service as an RHC service.

**Use condition code 07:** Treatment of Non-terminal Condition for Hospice Patient. The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.



# Review of Billing Policies

## Special Billing - Telehealth Services

Telehealth services (originating site) are non-RHC services. Originating site will receive separate payment. Coinsurance and deductible apply.

RHC (originating site):

- This is the only service that may be included on an RHC bill (bill type 71X) with another RHC service (e.g., Rev. Code 521)
- Bill Telehealth service under Rev. Code 0780 with HCPCS Q3014
- Requires HCPCS code Q3014 (Reimbursement ~ \$25.00)



# Review of Billing Policies

## Special Billing - Telehealth Services

Physician service (distant site):

- Bill as if the patient was with you “face-to-face”
- Payment made based on current fee schedule for service provided as if the patient was with provider





# Review of Billing Policies

## Special Billing - Flu/PPV

- Flu and pneumococcal vaccines have “special” treatment for cost-based reimbursement
- Do not file claims for flu/PPV
- Requires maintaining a log with the patient’s name, HIC number, and date of service. *Hint: Automate!*
- Reported and paid separately on the RHC cost report



# Review of Billing Policies

## Special Billing - Preventive Services

Effective for dates of service on or after January 1, 2011, Medicare beneficiaries receive an annual wellness visit (AWV), with a personalized prevention plan service (PPPS). The two HCPCS codes:

- G0438 – Annual wellness visit, includes PPPS, first visit
- G0439 - Annual wellness visit, includes PPPS, subsequent visit



# Review of Billing Policies

## Special Billing - Preventive Services

G0438/G0439 are paid under the RHC all-inclusive rate.

- G0438 (initial visit) is a once-in-a-lifetime benefit; cannot be billed within 12 months after effective date of Medicare coverage (should be preceded by IPPE).
- G0438 cannot be submitted within 12 months of IPPE (Welcome to Medicare Visit, G0402) or G0439 (AWV, subsequent visit).



# Review of Billing Policies

## Special Billing - Preventive Services

(Medicare Learning Matters SE 1039)

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the Initial Preventive Physical Examination (IPPE) or “Welcome to Medicare Visit.”

To ensure coinsurance and deductible are not applied, detailed HCPCS coding must be provided for preventive services.

The ACA also waives the deductible for planned colorectal cancer screening tests that become diagnostic.



# Review of Billing Policies

## Special Billing - Preventive Services

If covered preventive services are provided as part of RHC encounter, charges for the preventive services must be deducted from the total charge for calculating deductible and coinsurance.



# Review of Billing Policies

## Special Billing - Preventive Services

To ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052X series with the approved preventive service HCPCS code and the associated charges.

For example, the service lines should be reported as follows:

<u>Line</u>	<u>Revenue Code</u>	<u>HCPCS Code</u>	<u>DOS</u>	<u>Charges</u>
1	052X		01/01/2011	100.00
2	052X	<i>Preventive Service Code</i>	01/01/2011	50.00



# Review of Billing Policies

## Special Billing - Preventive Services

Example billing for ECG component of the IPPE is as follows:

- Part B service:
  - Bill technical component of ECG using G0404 (ECG for IPPE) to Part B carrier or hospital FI/MAC
- RHC (professional) service:
  - Follow normal RHC billing if attending physician is also interpreting test; charge (G0405) added (bundled) with the preventive service line (G0402)
  - Rev code 52x
  - Paid as RHC encounter



# Review of Billing Policies

## Special Billing - Multiple Visits

Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day at a single location constitute a single visit.

Exception: When one of the following conditions exist:

- (a) After the first encounter, the patient suffers illness or injury requiring additional treatment.
- (b) The patient has a medical visit and a clinical psychologist or clinical social worker visit.





# Review of Billing Policies

## Special Billing - Noncovered Services

### Option 1:

- Entire episode not covered:
  - Not required unless requested by patient
  - Use condition code 20 - If patient disagrees and wants Medicare to decide
  - Use condition code 21 - Patient wants denial for other insurance coverage
- Bill Type 710
- Charges listed as noncovered



# Review of Billing Policies

## Special Billing - Noncovered Services

### Option 2:

- Bill entire noncovered service to Part B on CMS 1500 claim form
- Will result in a better “cross-over” to supplemental plans



# Medicare vs. Medicaid Billing

## **Billing for RHC services for Medicaid varies by state:**

-Some states require that RHC services are billed on a 1500 while others recognize billing on a UB04.

-Oregon includes lab and diagnostic services in the RHC rate; therefore, these services are not billed separately.

-Oregon recognizes RNs as RHC practitioners. These visits are paid at the RHC rate.

-Oregon RHC Administrative Rulebook:

<http://www.oregon.gov/oha/healthplan/Policies/147rb040414.pdf>



# Medicare Bad Debt

- ✓ Medicare bad debt reimbursement (Part A deductibles and coinsurance only)
  - Not paid by the patients as a reasonable/standard collection effort for 120 days from the date of initial bill to patient has been made. (CMS is now insisting that if turned over to outside collection agency, account cannot be claimed until returned from collection agency.)
  - Denials by Medicaid as secondary payor as long as actually billed and denied – immediate.
  - Documented charity care write-offs – immediate.



# Appendix



# Frequently Asked RHC Billing Questions

Patient seen at one RHC then referred to another related RHC for a medically necessary visit on the same day

✓ Two Billable RHC Visits or One RHC Visit?

ANSWER - Two RHC visits

Each RHC has a separate provider number; therefore, each visit is separately billable provided the second visit is clearly medically necessary.



# Frequently Asked RHC Billing Questions

Patient is seen by an RN for a coumadin screening

✓ Billable RHC Visit?

ANSWER – No

A face-to-face encounter with a practitioner did not occur. The charge may only be combined with a previous or subsequent face-to-face encounter. The RHC will only be paid an additional co-insurance of 20% of charges since Medicare does not recognize it as an RHC encounter.



# Frequently Asked RHC Billing Questions

Patient seen by a physician for coumadin screening

✓ Billable RHC visit?

ANSWER – Only if physician involvement is medically necessary.

If not medically necessary for provider involvement, handle like RN visit on previous slide.





# Frequently Asked RHC Billing Questions

Patient is seen by an RN for coumadin screening clinic during non-RHC hours

✓ Billable RHC visit?

ANSWER – No

✓ Billable as non-RHC service?

ANSWER – Yes

All services provided during non-RHC hours are billable to the Part B carrier as non-RHC services.



# Frequently Asked RHC Billing Questions

Patient is seen by a physician who performs a scope during RHC hours.

✓ Billable RHC visit?

ANSWER – Yes

✓ Billable as a non-RHC service?

ANSWER – No

Although the physician may be paid more from the Part B carrier (depending on independent vs. provider-based RHC status), the service was performed in the RHC during RHC hours and is considered by Medicare to be a face-to-face encounter that **must** be billed to the Medicare intermediary as an RHC visit.



# Frequently Asked RHC Billing Questions

What happens if a minor surgical procedure is performed at the same time as an office visit?

✓ Billable as a second RHC visit?

ANSWER – No

These charges would be “bundled” and submitted as one line item.

In addition, the follow-up visits for dressing change or suture removals would only be billed as an encounter if there is a medically necessary reason documented that an RHC provider could only perform the follow-up.



# Frequently Asked RHC Billing Questions

What about a follow-up visit for surgeries performed outside the RHC (e.g., by a surgeon in the hospital) and within the global period?

✓ Billable as an RHC visit?

ANSWER – Depends

If the surgeon bills globally, then answer is: No.

If the surgeon bills with a modifier -54 (surgery only), the answer is: Yes. The RHC can bill the follow-up encounter separately if the follow-up is medically necessary requiring a provider to perform the service.

This method will take some coordination between the hospital-based procedure and the plan for follow-up care in the RHC.



# Frequently Asked RHC Billing Questions

## Visiting Specialists

- ✓ Can an RHC offer visiting specialist services?

ANSWER – Yes

- ✓ Is the visiting specialist service a billable RHC visit?

ANSWER – Depends

Any qualified provider (MD, DO, or NPP) can see patients in the RHC.

The only requirement is that the RHC must be engaged in providing primarily primary care services during the operating hours of the clinic. This is interpreted to mean primary care services must be a majority of the services offered, i.e., 51 percent of the operating hours.



# Frequently Asked RHC Billing Questions

## Visiting Specialists (continued)

There are primarily two scenarios for visiting specialists:

1. A specialist rents space from the RHC periodically and may bring his own staff (nursing) and does his own billing.
2. A specialist comes to the RHC periodically and sees RHC patients during the RHC hours of operation. The billing is done by the RHC.



# Frequently Asked RHC Billing Questions

## Visiting Specialists (continued)

### Scenario 1

A specialist rents space from the RHC periodically and may bring his own staff (nursing) and does his own billing.

#### Treatment:

The RHC would carve out the cost of the space and remove all associated costs as non-RHC services on the cost report. Result would be that none of the cost related to the specialist is included in the all-inclusive rate computed for RHC services.



# Frequently Asked RHC Billing Questions

## Visiting Specialists (continued)

### Scenario 2

A specialist comes to the RHC periodically and sees RHC patients during the RHC hours of operation. The billing is done by the RHC.

#### Treatment:

Bill as RHC service – no carve-out is necessary. In addition, the visiting specialists would be treated as a purchased professional service and not subject to the productivity screens on the cost report.





# Frequently Asked RHC Billing Questions

- ✓ If an RHC provider has a face-to-face encounter in the office, and then later admits the patient to the hospital (and separately documents this service), can the clinic bill both the RHC encounter (to Part A) and a hospital admission (to Part B)?

ANSWER – Depends on the FI/MAC

Some FI/MACs follow CPT Manual rules (See 2012 Edition), which basically say that when a patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g., hospital ER, observation status, physician's office, nursing facility), all E&M services provided in conjunction with the admission are considered part of the initial hospital care.



# Frequently Asked RHC Billing Questions

As a result of clarification of the 3-day/1-day payment window provisions for outpatient services treated as inpatient services for professional services of clinics owned by a hospital, the following rules are being followed by some FI/MACs (per CMS Change Request 7142\*, Dated: 04/04/2011):

- ✓ If there is a separate and distinct RHC encounter at a free standing (independent) RHC prior to the admission-related visit, a separate visit may be billed to the FI/MAC.
- ✓ If the RHC is provider-based (wholly owned and/or operated by the hospital), all services provided on the date of admission must be combined and billed with the inpatient claim.

***This continues to be a gray area...What about CAHs (3-day window does not apply?)***

*\*Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PL 111-192, Section 102)*



# List of Acronyms

*AIR – all inclusive rate*

*AWV – annual wellness visit*

*CCN – CMS certification number*

*CNM – certified nurse midwife*

*CP – clinical psychologist*

*CSW – clinical social worker*

*DSMT – diabetes self-management training*

*EKG - electrocardiogram*

*FQHC – Federally qualified health center*

*FTE – full time equivalent*

*HHA – home health agency*

*HHS – Health and Human Services*



# List of Acronyms (continued)

*HPSA - Health Professional Shortage Areas*

*IPPE – initial preventive physical exam*

*MAC – Medicare Administrative Contractor*

*MEI – Medicare Economic Index*

*MNT – medical nutrition therapy*

*MUA - Medically-Underserved Area*

*NCD – national coverage determination*

*NP – nurse practitioner*

*PA – physician assistant*

*RHC – rural health clinic*

*RO – regional office*

*USPSTF – U.S. Preventive Services Task Force*



# Resources

## CMS Online Manuals:

- Pub 100-4, Chapter 3, Section 30 - Inpatient Part A Hospital Manual
- Pub 100-4, Chapter 4, Section 250 - Part B Hospital (including Inpatient Hospital Part B and OPPS)
- Pub 100-4, Chapter 6, Section 20 - SNF Inpatient Part A Billing
- Pub 100-4, Chapter 9 - RHC/FQHC Manual
- Pub 100-4, Chapter 16, Sections 30.3 and 40.3.1
- Laboratory Services from Independent Labs, Physicians & Providers

## Other:

- Medicare Prescription Drug Improvement & Modernization Act of 2003
- Medicare Improvements for Patients and Providers Act of 2008
- CMS Quick Reference Information: Preventive Services  
[https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS\\_QuickReferenceChart\\_1.pdf](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf)
- CMS Rural Health Clinic Center: <http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>
- Medicare Billing Information Chart for Rural Providers: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralChart.pdf>



# Questions



Thank you!



# Speaker Information

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