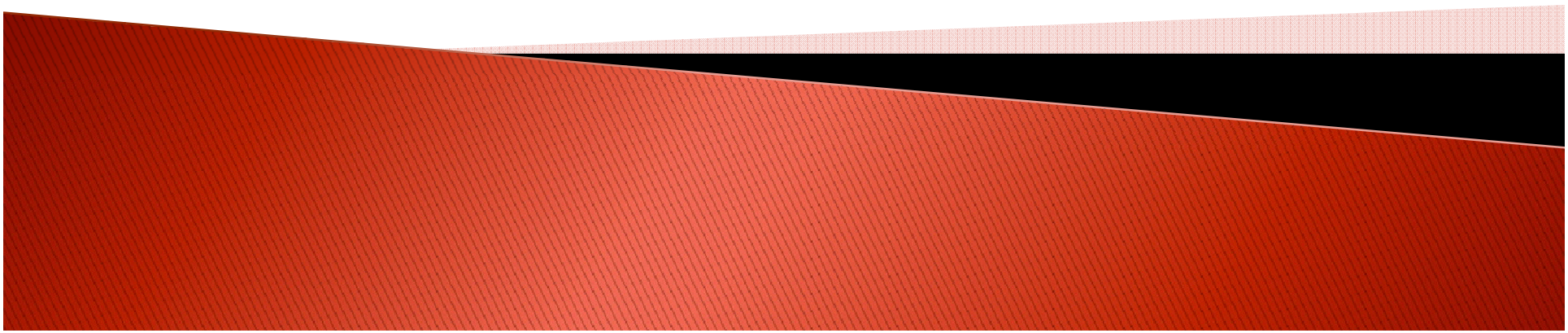
RHC BILLING 101

2013



OBJECTIVES

- Participants will understand the billing differences between Provider Based and Independent RHC Technical billing.
- Participants will understand how to appropriately bill professional and technical components.
- Participants will understand the challenges of RHC billing and managing the Accounts Receivable.

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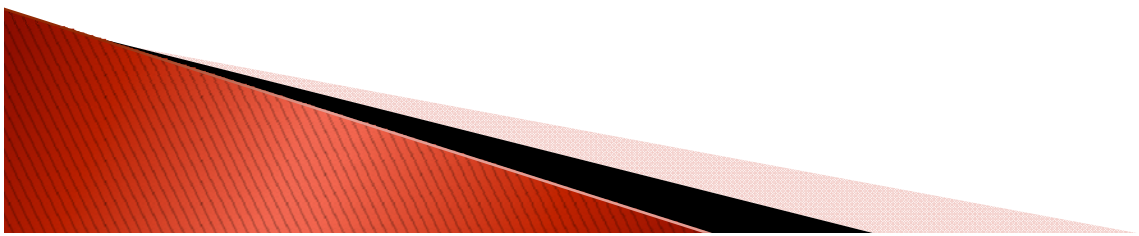
WHAT IS A RHC?

- A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.



INDEPENDENT VS PROVIDER BASED

- Independent RHC are generally private
  - Professional billing is submitted under CLINIC Part A number.
  - Technical billing is submitted under CLINIC Part B number. This can be billed under the group, but each provider must be credentialed with Medicare Part B if they are seeing patients.
- Provider based RHC is owned and directed by the hospital, nursing facility, or home health agency.
  - Professional billing is submitted under CLINIC Part A number
  - Technical billing is submitted under HOSPITAL Part A number

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RHC LOCATIONS

- The clinic (office)
- Home visit (the home of the patient)
- Nursing Home
- Scene of an accident

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RHC ENCOUNTER

- Encounters with (1) more than one health professional; and (2) multiple encounters with the same health professional which takes place on the same day and at the same location, constitutes a single visit. *Exceptions will be addressed later in presentation.*
- The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC service is rendered.

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RHC ENCOUNTERS ARE NOT

- Non medical necessity services
- Non covered services
  - Lab tests/results only
  - Dressing change
  - Refill of prescriptions
  - Administration of injection only
- Completion of claim forms
- Care plan oversight
- 99211 is NOT an RHC encounter. If the provider is billing this level they are most likely undercoding

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SLIDING FEE PROCESS

- If this process is offered in your clinic setting you must:
  - Post in the patient area that the service is offered
  - Offer to all patients
  - Have an application system in place with policy
  - Understand the process
  - Be current in the poverty guidelines and their application for use.

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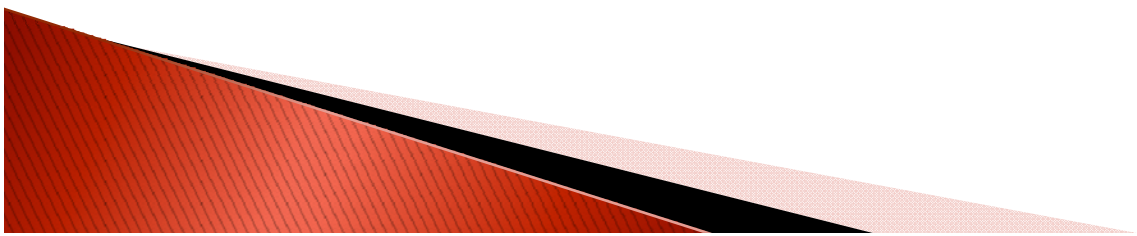
COMMERCIAL AND MEDICAID RHC BILLING



NON MEDICARE/NON MEDICAID

- You will submit your commercial, workers comp, and auto claims as you always have. These are submitted on 1500 claim forms.
- You will bill your self pay services as you always have through your statement services.
- You may still turn accounts over to collections
  - Have a process
  - Have policy

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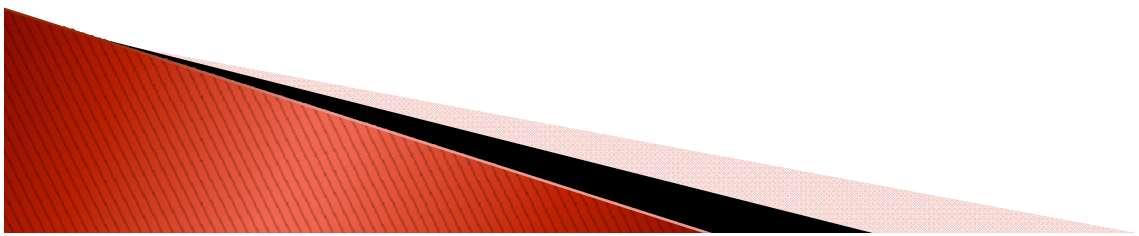
MEDICARE RHC BILLING



BILLING GUIDELINES

- All billing is subject to CMS guidelines.
- Be certain that your credentialing/enrollment processes are correct and current.
- Be sure that each provider's NPI numbers are attached to the services rendered and that the NPPES website has current information.
- Be sure that the clinic NPI number has the correct taxonomy codes including Rural Health Clinic.
- Midlevel providers need to have their own Medicare Part B billing numbers
- Know your carriers and if the midlevel needs to bill under the supervising physician or if they can be credentialed as a provider

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REVENUE CODES

- The following Revenue Codes are used for Medicare Part A billing on the UB 04 format:
  - 0521 Clinic visit at RHC by qualified provider
  - 0522 Home visit by RHC provider
  - 0524 Visit by RHC provider to a Part A SNF bed
  - 0525 Visit by RHC provider to a SNF, NF or other residential facility (non-Part A)
  - 0527 Visiting Nurse service in home health shortage area
  - 0528 Visit by RHC provider to other non-RHC site (scene of accident)
  - Revenue code 0900 from both RHCs and FQHCs when billing for services subject to the Medicare outpatient mental health treatment limitation, and revenue code 0780 when billing for the telehealth originating site facility fee.

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COMINGLING

- Commingling is being paid twice from Medicare for the same service(s) and is considered fraud.
- Since you are billing incident-to-services with the professional component to Medicare Part A as an RHC you cannot bill the same incident-to-services to Medicare Part B to receive a second payment

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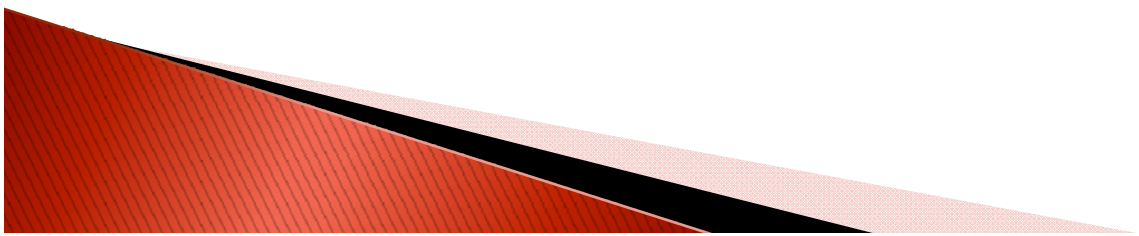
NON RURAL HEALTH SERVICES

- These services are billed to:
  - Medicare Part B as FFS (fee for service) for Independent RHC
  - Medicare Part A under the main entity for Provider-Based
    - Diagnostic testing (technical component)
    - X-ray
    - EKG
    - Laboratory services
  - Medicare Part B for both Independent or Provider Based
    - Professional services done in the hospital



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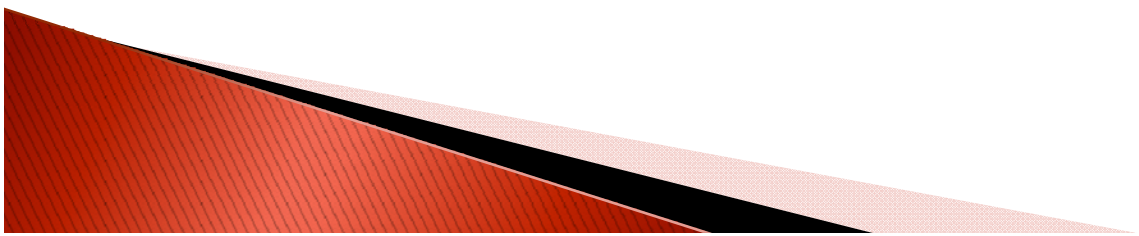
MEDICARE PART A BILLING

- File in the UB 04 format
- Type of bill 711 for RHC and 771 for FQHC
- Enter actual charges, NOT THE ENCOUNTER RATE.
  - The charges must be rolled into 1 line item with the correct revenue code EXCEPT for G0402, G0438, G0439
- Co-insurance/deductible is based on the total charge of professional services rendered.
- Bill only one Medicare encounter per day for services rendered in the clinic
- Must have a medically-necessary diagnosis
- A mental health visit AND an RHC encounter are payable on the same day.
- Timely filing limits have changed to one year from the date of service.



BILLING OFFICE VISITS

- Established Patient
- New Patient
- Independent RHC submits the encounter under the CLINIC Medicare Part A number on the UB form
- Provider Based RHC submits the encounter under the CLINIC Medicare Part A number on the UB form

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LABORATORY

- All Independent RHC lab services are billed to Medicare Part B using the clinic Medicare Part B number and filed in the 1500 claim format.
- This includes venipuncture.
- Use CLIA waived modifiers QW on Part B claims.
- All Provider Based RHC lab services are billed to Medicare Part A using the hospital Medicare Part A number and filed in the UB 04 format.

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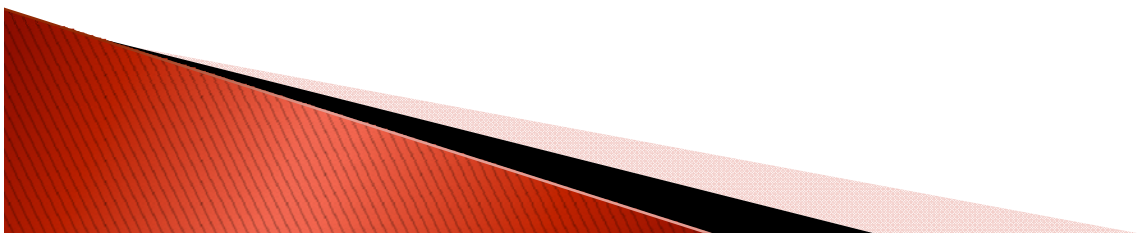
MEDICARE EKG

- The professional component (interp and report) 93010 is bundled into the RHC encounter and billed inclusive on the UB form to Medicare Part A for both Independent and Provider Based RHC.
- The technical component 93005 is billed as fee for service to Medicare Part B 1500 claim format using the clinic Medicare Part B number for the Independent RHC and to Medicare Part A UB 04 claim format using the hospital Medicare Part A for the Provider Based RHC.



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RADIOLOGY

- The professional component is bundled into the RHC encounter.
  - Know if the professional piece is contracted by a radiologist not included in the RHC.
  - Know if the contracted radiologist is billing for the reading.
- For Independent RHC the technical component is billed as fee for service to Medicare Part B on a 1500 claim form using the clinic Medicare Part B number.

INJECTIONS

- Injections and immunizations are only billed to Medicare and Medicare HMOs if there is a valid face-to-face encounter with an approved provider.
- If you have a face-to-face encounter within 30 days prior or after the date of the injection/immunization, your may bundle the injection/immunization service into the encounter and bill to Medicare and Medicare HMOs.

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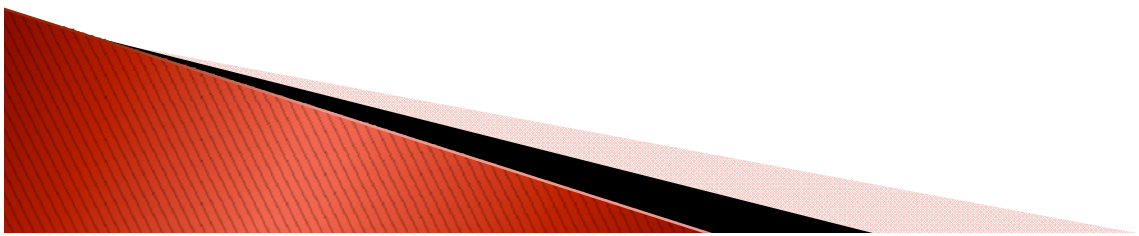
PROCEDURES

- Procedures performed on the same day as an RHC encounter will be bundled and ONE RATE will be paid for the entire encounter.



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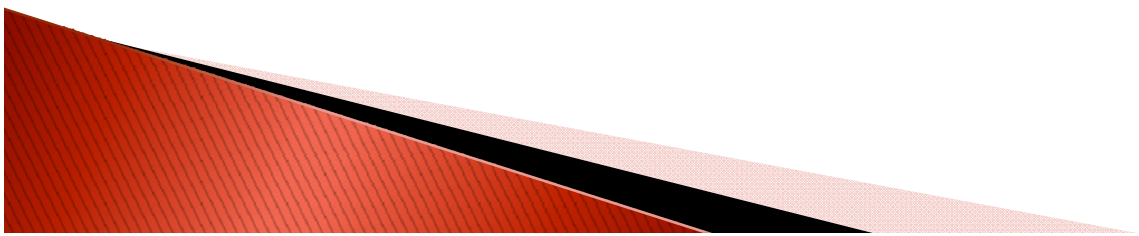
FLU/PNEUMOVAX

- These injections are covered under the RHC program.
- Regular Medicare services are NOT to be billed on a claim.
- A log needs to be kept for these injections and they are submitted on the cost report. They will be paid at annual cost report reconciliation.
  - Date of service
  - Patient name
  - Patient Medicare Number
- Medicare HMOs are to be billed on a HCFA 1500 with the administration code. Use Medicare billing CPT codes for Flu/pneumo. (G code series)



WELCOME TO MEDICARE

- This is payable once per lifetime
- The service must be rendered within twelve months of the patient becoming eligible for Medicare or if they are enrolled in Medicare and they have NOT had their welcome visit.
- The co-insurance/deductible are not applicable to this service
- Only one payment is made for this RHC encounter.

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WELCOME TO MEDICARE

- For an Independent RHC all diagnostic screenings are billed to Medicare Part B.
- Codes G0402must be billed on their own claim line and must have the CPT code on the UB04 claim form. If other services are performed on the same day and they meet the requirement of separately identifiable face-to-face encounter, they will be bundled together on their own line item separate from the G codes listed and they will not need CPT codes on the UB 04 form but will be in the revenue line item.
  - G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
  -

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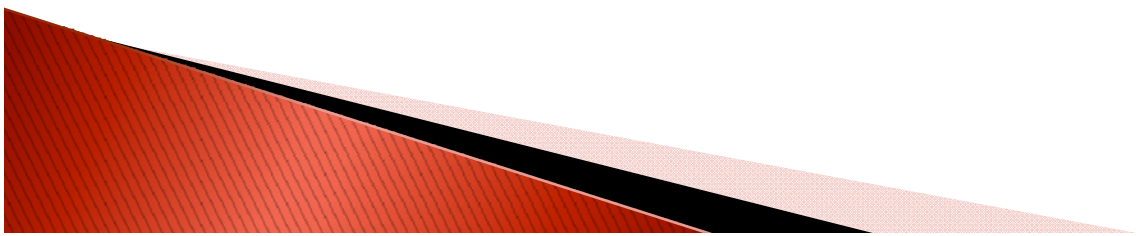
ANNUAL WELLNESS VISIT

- Annual wellness is NOT a physical.
- Medicare DOES NOT pay for the wellness exam, ie, 99397
- G0439
  Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

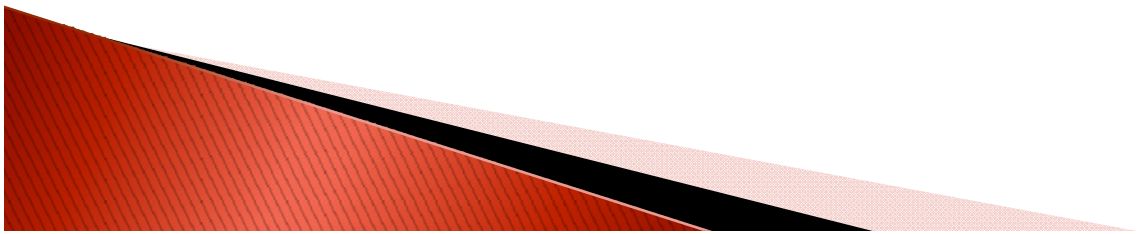


ANNUAL WELLNESS VISIT

- The initial annual wellness visit (AWV) includes taking the patient's history; compiling a list of the patient's current providers; taking the patient's vital signs, including height and weight; reviewing the patient's risk factor for depression; identifying any cognitive impairment; reviewing the patient's functional ability and level of safety (based on observation or screening questions); setting up a written patient screening schedule; compiling a list of risk factors, and furnishing personalized health services and referrals, as necessary. Subsequent annual wellness visits (AWV) include updating the patient's medical and family history, updating the current provider list, obtaining the patient's vital signs and weight, identifying cognitive impairment, updating the screening schedule, updating the risk factors list, and providing personalized health advice to the patient.

ANNUAL WELLNESS VISIT

- G0438 Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
- G0439 Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
- G0438, G0439 must be billed on their own claim line and must have the CPT code on the UB04 claim form. If other services are performed on the same day and they meet the requirement of separately identifiable face-to-face encounter, they will be bundled together on their own line item separate from the G codes listed and they will not need CPT codes on the UB 04 form but will be in the revenue line item.



IN PATIENT HOSPITAL SERVICES

- Independent RHC In-Patient services are billed to Medicare Part B on a 1500 claim form
- Some MACs will cover the In-Patient claim AND an office encounter on the same date. Know your MAC and what their payment guidelines are for this component.
- EXAMPLE: If your MAC will cover both you **may** have the following example.
  - Office visit and inclusive services billed to Medicare Part A on UB format
  - In-Patient services billed to Medicare Part B on 1500 format.

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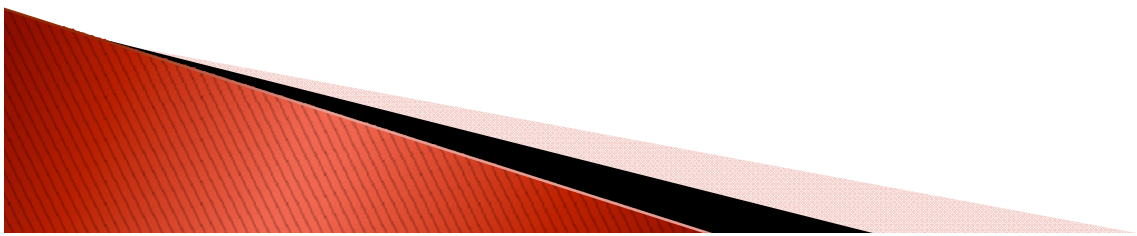
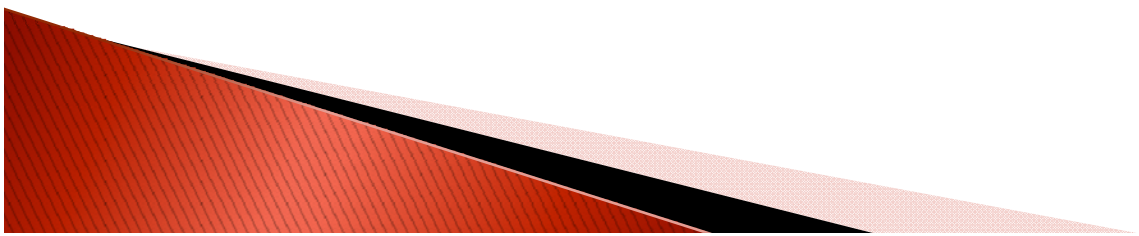
NURSING HOME SERVICES

- Nursing home services (including SNF) are billed to Medicare Part A on a UB form.



FINANCIAL INFORMATION

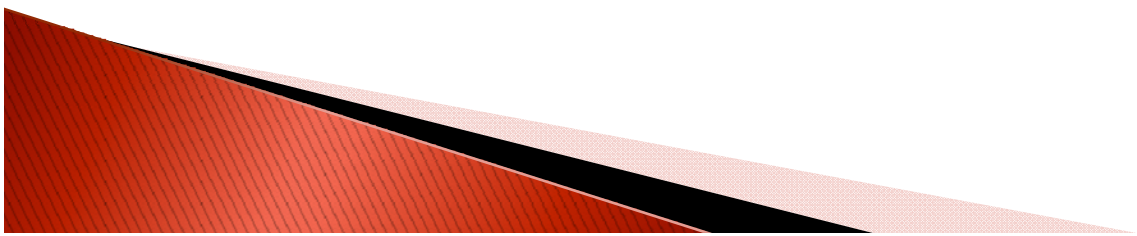


MEDICARE COPAYS/DEDUCTIBLES

- The effect on payment is an increase in the charge, and in the co-insurance.
- RHC services deductible is based on billed charges. Non-covered expenses do not count toward the deductible.
- The cost for incident-to-services are included in the cost report, but they are not payable on the claims.
- EXAMPLE: The patient has an office visit for $65.00 and an injection for $40.00. There will be one line item of $105.00 on the UB form with revenue code of 521. The patient (or secondary) will be responsible for $21.00 which is the 20% co-insurance

PAYMENT POSTING

- Medicare will pay 80% of the RHC encounter rate.
- The patient/co-insurance will be responsible for 20% of the charge.



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MEDICARE SECONDARY PAYER

- Collect patient health insurance or coverage information at EACH patient visit.
- Tools can be found on the CMS website:
  - http://www.cms.gov/manuals/downloads/msp105c03.pdf
- Bill the primary payer before billing Medicare, as required by the Social Security Act.

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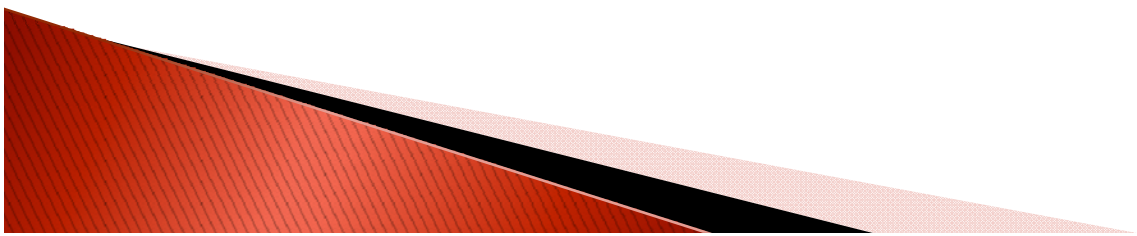
SECONDARY BILLING AFTER MEDICARE

- 20% of charges may not be equal to 20% of the encounter rate (if the charges are not equal to the encounter rate)
- Coinsurance is established on the 20% of the allowed amount.
- Do not write off the account with primary payer to $0.00. Bill the patient/secondary 20%.



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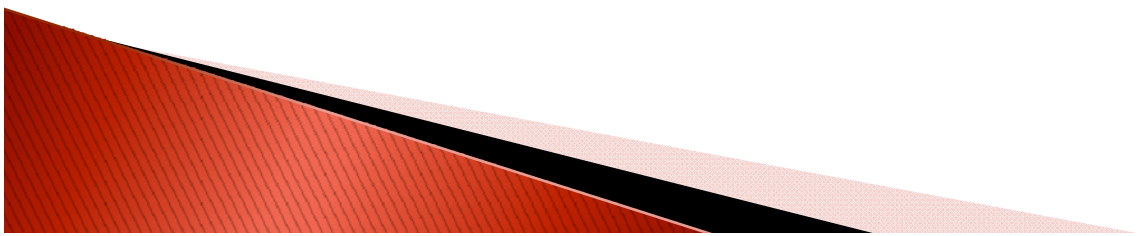
MEDICARE BAD DEBT

- RHCs are allowed to claim bad debts in accordance with 42 CFR 413.80. RHCs may claim unpaid deductible. The RHC must establish that reasonable efforts were made to collect these co-insurance amounts in order to receive payment for bad debts. If the RHC co-insurance or deductible is waived, the clinic may not claim bad debt amounts for which it assumed the beneficiary's liability.
- Reasonable attempts must be made to attempt to collect the bad debt. Trail to show statements/billing in a routine pattern for 120 days.
- Only services rendered during RHC effectiveness qualify to be written off for Medicare Bad Debt.
- Medicare Bad Debt is reported in the year it was written off.
- Any denials by Medicaid as secondary payer as long as claim was actually billed and denied
- Documented charity write-offs

OTHER REPORTS



OTHER REPORTS

- Credit Balance Reports
  - Due 30 days after the end of each fiscal quarter
  - Report over-payments from Medicare
  - No payments will be made if you do not complete this report
- CMS billing audit reports
  - CMS may ask for 25 patients specific billing for a date of service and the office notes to support the billing.
  - An adjudicator reviews and decides if the service was a medical necessity.
  - Monies can be taken back by Medicare. There is an appeal process through the adjudicator.

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QUESTIONS /ANSWERS

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