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Part A Fall 2024 Virtual Conference:
Keeping Compliant with Medicare Starts With You
November 12th, 14th, and 19th

Rural Health Clinics – What You Need to Know!

11/19/24

NGSMU
NGS Medicare University

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Objective

After today's session, attendees will understand how to properly bill the different types of RHC services to Medicare and know where to go for more information.

Today's Presenters

- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Mimi Vier

Agenda

Billing Basics

Billing Preventive Services

Other RHC Services

RHC Top Errors

Resources and References

Q&A

Billing Basics

RHC Visit Definition

- Encounter between patient and physician, NP, PA, CNM, CP or CSW, during which allowed RHC service(s) furnished
  - Medically necessary medical visit
  - Mental health visit
  - Qualified preventive health visit

RHC Qualifying Visit List (QVL)

- QVL used as guide to services which generally qualify as stand-alone billable visits
  - Typically E&M type of services or screenings for certain preventive services
- Medically necessary service not included on QVL can be billed as stand-alone visit if:
  - Meets Medicare coverage requirements
  - Within scope of RHC benefit
  - Not furnished incident to physician's service

RHC Bill Types

- TOB = 71X
  - 710 = nonpayment/zero claim (all charges are noncovered)
  - 711 = admit through discharge
  - 717 = claim adjustment
  - 718 = claim cancel
- DOS cannot overlap calendar years
  - Split billing periods that overlap calendar year
    - Reference: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100A

RHC Qualified Visit Revenue Codes

Code	Description
0521	Clinic visit
0522	Home visit
0524	Visit for beneficiary in covered Part A SNF stay
0525	Visit for beneficiary in noncovered Part A SNF stay (or other residential facility)
0527	Visiting nurse service at beneficiary's home when in HH shortage area
0528	Visit to other non-RHC site (scene of accident)
0780	Telehealth
0900	Psychological services provided by CP, CSW

Reporting Qualified Visit HCPC Code

- Claims and adjustments must include modifier CG on qualified visit line
  - Reported with medical and/or HCPCS code representing primary reason for medically necessary face-to-face visit
  - Must include bundled charges for all services subject to coinsurance and deductible
- Qualified visit line must include visit charge and total charges for all incident to services provided during visit
  - Coinsurance based on Total Charges on visit claim line
  - 0001 Totals line must calculate accurately
  - Payment generated based on billable visit revenue code

Report All Services Provided During Visit

- RHCs required to report appropriate HCPCS code for each service on separate claim line along with revenue code
  - Also applies to RHCs exempt from electronic reporting under Code of Federal Regulations Section 424.32(d)(3)
  - Additional claim lines do not generate additional reimbursement
  - All other billing requirements still apply

Report All Services Provided During Visit

- Claim lines for services/supplies furnished “incident to” visit should report
  - Appropriate revenue code
    - RHCs can report incident to services using all valid revenue codes except 002X–024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X–072X, 080X–088X, 093X, 096X–310X
  - Applicable CPT/HCPCS code
  - One unit
  - Charges that apply to service

2024 Update – Incident to

- Behavioral health services can be furnished under general supervision of physician (or other practitioner)
  - Services provided by auxiliary personnel incident to services of physician (or another practitioner)
- Effective date 1/1/2024, implementation date 10/14/2024
  - Revision to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 40.3 (CMS Change Request 13493)

Counting Visits

- One visit (one unit)
  - Visits with more than one practitioner on same day
  - Multiple visits with same practitioner on same day
- Applies regardless of
  - Length or complexity of visit
  - Number/type of practitioners seen
  - Subsequent visit scheduled or not
  - Initial visit related or not to subsequent visit

Billing for Two Visits

- Illness/injury occurs after initial visit requiring diagnosis/ treatment on same day
  - Primary visit billed with CG modifier
  - Subsequent medical visit billed with
    - 052X revenue code
    - Qualifying visit HCPCS code and modifier 59
    - One unit
    - Total charges associated with visit
- Medical visit and mental health visit same day
  - Both lines billed with CG modifier
- IPPE and separate medical or mental health visit on same day
  - Do not report CG modifier on IPPE line

2024 Update – Counting Visits

- Separate payment can be made for IOP service and medical visit on same day
  - Both lines billed with CG modifier
- Payment made at IOP rate when mental health visit and IOP service on same day
  - Mental health visit considered packaged
- Effective date 1/1/2024, implementation date 10/14/2024
  - Revision to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 40.3
    - CMS Change Request 13493

Billing for Three Visits

- IPPE, separate medical and mental health visit on same day
  - Do not report CG modifier on IPPE line

Reporting Multiple Qualified Visits

- Report claim line and incident to line(s) for each qualifying visit
  - Only one line has CG modifier unless mental and medical health visit
- Total charges report on qualifying visit claim line must include associated incident to charges
- All-inclusive rate (AIR) generated for each qualifying visit claim line
- Coinsurance applies to each qualifying visit claim line (20% total charges)

Billing Preventive Services

Preventive Services

- Rural Health Clinic (RHC) Preventive Services Chart
- Paid as stand-alone visits if no other service furnished on same day
- Considered as one single visit if furnished on same day as another medical visit
  - Exception - Two visits may be billed if IPPE visit occurs on same day as another billable visit
- Most preventive services do not have coinsurance or deductible applied, except:
  - Prostate Cancer Screening
  - Glaucoma Screening
  - Screening Pap Test

When Preventive Service Is Qualified Medical Visit

- Approved preventive service is qualifying medical visit when only service provided on DOS
  - Revenue code 052X with preventive service CPT/HCPCS code
  - One unit
  - Associated charges
- AIR payment generated
  - Coinsurance waived based on CPT/HCPCS

Coinsurance and/or Deductible Waived

- Approved preventive service on same day as qualifying medical visit and coinsurance/deductible waived
  - Qualified medical visit line
    - Appropriate revenue code
    - Qualified visit HCPCS code with CG modifier
    - One unit
    - Bundled total charges except for preventive service charges
      - Ensure coinsurance does not include preventive service costs
  - Preventive service line
    - Revenue code 052X
    - Preventive service CPT/HCPCS code
    - One unit
    - Charges for preventive service only

Coinsurance and/or Deductible Not Waived

- Approved preventive service on same day as qualifying medical visit and coinsurance/deductible NOT waived
  - Qualified medical visit line
    - Appropriate revenue code
    - Qualified visit HCPCS code with CG modifier
    - One unit
    - Bundled total charges including preventive service charges
- Include preventive service charges in qualifying visit total charges
  - Coinsurance (20%) applies to total charges on qualifying visit line

Vaccines

- COVID-19, influenza and pneumococcal vaccines and administration
  - Coinsurance and deductible do not apply
  - Not submitted on RHC claims
  - Paid through cost report process
- Hepatitis B vaccination
  - If provided with qualified visit, report as incident to service
    - Coinsurance applicable
    - Payment included in qualified visit
  - If vaccine/administration only service provided, do not submit claim
    - Paid through cost report process

SDOH Risk Assessments

- Effective 1/1/2024
- SDOH risk assessments billed using HCPCS G0136
  - Must be provided in conjunction with qualifying visit, including an E&M visit or AWV
- Not paid separately
- Cost-sharing
  - When provided with AWV, no deductible/coinsurance applied
  - When provided with other visits, cost sharing applies
- MLN Matters® *MLN9201074 - Health Equity Services in the 2024 Physician Fee Schedule Final Rule*

Other RHC Updates

Telehealth: Originating Site

- Exception through 12/31/2024 - all patients can get telehealth wherever they're located
  - No geographic restrictions on originating site but RHCs must be in qualifying area
- RHCs serving as telehealth originating sites
  - Bill separately, no other visit reported
    - Revenue code 0780
    - HCPCS Q3014
    - Originating site facility fee charges
  - Subject to Part B deductible and coinsurance

Telehealth: Distant Site

- Exception through 12/31/2024 - all providers eligible to bill Medicare for professional services can provide distant site telehealth
  - Can provide telehealth from any distant site location, including their home, while working for RHC
  - Can provide any distant site-approved telehealth under MPFS
- Do not include cost of visit on claim or in cost report

MFT and MHC Services

- Services coverable in RHC
  - Effective date 1/1/2024, implementation date 10/14/2024
- Statutorily authorized to furnish services for diagnosis and treatment of mental illnesses only
- References:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13
    - Sections 10.1, 30.1, 40, 50.1, 50.3, 150, and 160
  - MLN Matters® *MM13331 - Provider Enrollment Changes to the Medicare Program Integrity Manual*

IOP Services

- Medicare allows coverage and payment of IOP services
  - Includes group therapy with physicians or psychologists or other mental health professionals to extent authorized under state law
- Payment not based on RHC AIR
  - Paid at rate determined for "Intensive Outpatient (three services per day)" for hospital-based IOPs
- Effective date 1/1/2024, implementation date 10/14/2024
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
    - Chapter 6, Section 70.4
    - Chapter 13, Sections 250 & 251 (CMS Change Request 13493)

In-Person Mental Health Visits

- Effective 1/1/2025, in-person mental health service (without use of telecommunications technology) required
  - Within six months prior to furnishing mental health service via telecommunications
  - At least every 12 months while beneficiary receiving services furnished via telecommunications technology
    - For diagnosis, evaluation, or treatment of mental health disorders
    - Exception – physician/practitioner and patient agree that risks and/or burdens outweigh benefits associated with furnishing in person service
      - Reason(s) for this decision must be documented in patient's medical record
- Revision to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 170

CCM Services Updates

- Separately billable initiating visit (E&M, AWV, or IPPE) with RHC primary care practitioner required prior to beginning CCM
  - Must occur no more than one year prior to beginning CCM
  - Do not need to discuss CCM during the initiating visit
- Before furnishing, obtain consent from beneficiary
  - Written or verbal
  - Can be obtained by auxiliary staff under general supervision of RHC primary care practitioner or billing practitioner
- Effective 1/1/2024, implementation date 10/14/2024
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 230.2.1

CCM Consent Documentation Requirements

- Document beneficiary
  - Advised about availability of CCM services
  - Consents to obtain CCM services from RHC
  - Gives permission to consult with relevant specialists
  - Informed that
    - Cost-sharing (e.g., deductible and coinsurance) may apply for both in person and non-face-to-face services provided
    - Only one practitioner/facility can furnish and be paid for CCM services during each calendar month
    - They can stop CCM services at any time, effective end of that calendar month

General Care Management Updates

- Additions coverable services list in CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13
  - Remote Patient Monitoring (RPM) - Section 230.2.5
  - Remote Therapeutic Monitoring (RTM) - Section 230.2.6
  - Community Health Integration (CHI) - Section 230.2.7
  - Principal Illness Navigation (PIN) - Section 230.2.8
  - PIN Peer-Support (PIN-PS) - Section 230.2.9
- Effective date 1/1/2024, implementation date 10/14/2024
  - CMS Change Request 13493

RPM Services

- Minimum of 20 minutes of qualifying non-face-to-face RPM services furnished during calendar month, including
  - Collection, analysis, and interpretation of digitally collected physiologic data
  - Development of treatment plan
  - Managing of beneficiary under treatment plan
- RHCs also paid for
  - Initial set-up
  - Beneficiary education on using equipment that stores physiologic data for RPM services

RTM Services

- Minimum of 20 minutes of qualifying non-face-to-face RTM services furnished during calendar month, including
  - Remote monitoring of respiratory system and musculoskeletal status
  - Therapy adherence
  - Therapy response
- RHCs also paid for
  - Initial set-up
  - Beneficiary education on using equipment that stores physiologic data for RTM services

CHI Services

- Minimum of 60 minutes of qualifying non-face-to-face CHI services furnished during calendar month, including
  - Coordination of care
  - Facilitation of access to services
  - Communication between settings to address SDOH need(s) that may interfere with or present barrier to diagnosis or treatment

PIN Services

- Minimum of 60 minutes of qualifying non-face-to-face PIN services furnished during calendar month, including
  - Health care navigation as part of treatment plan for serious, high-risk disease
    - Expected to last at least 3 months
    - Places beneficiary at significant risk of
      - Hospitalization or nursing home placement
      - Acute exacerbation/decompensation
      - Functional decline
      - Death

PIN-PS Services

- Minimum of 60 minutes of qualifying non-face-to-face PIN-PS services furnished during calendar month, including
  - Treatment of high-risk behavioral health conditions

General Care Management Services Billing and Payment

- Bill using G0511
  - Can report multiple services on same claim as long as clinical staff minutes do not overlap
- Payment
  - Weighted average of national non-facility PFS payment rate
    - Utilization of base code for service furnished
    - Any applicable add-on codes used in same month
    - Any base code reported alone in month when general care management HCPCS code G0511 on claim
      - Alone or with other payable services
  - Rate for HCPCS code G0511 updated annually based on PFS amounts for base codes
  - Costs reported in non-reimbursable section of cost report
    - Not used to determine RHC AIR

General Care Management Services Base Codes

- Used to calculate weighted average payment rate for G0511
  - CCM - 99487, 99490, 99491
  - PCM - 99424, 99426
  - CPM - G3002
  - General BHI - 99484
  - RPM - 99453, 99454, 99457, 99091
  - RTM - 98975, 98976, 98977, 98980
  - CHI - G0019
  - PIN - G0023
  - PIN-PS - G0140
- Does not include add-on code pairs or codes that describe additional minutes

RHC Top Errors

April – June 2024

Jurisdiction 6

Denials	Rejections	RTPs
39928	U5233	34963
5WEXC	38200	39910
59132	39934	U5065

Jurisdiction K

Denials	Rejections	RTPs
5WEXC	U5233	39910
39928	38200	34963
-	39929	E0401

Denial Reason Code 39928

- Each line of charges on this claim has been denied by medical review
- Avoiding/Correcting this error
  - Determine line level denial codes for each line of claim
    - Claim page 2 (MAP 1712) and F11 to MAP171D
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - Review current National Government Services LCDs and Billing and Coding Articles
  - If you disagree with denial, you have the right to appeal

Denial Reason Code 5WEXC

- Claim does not qualify for Medicare payment due to principal diagnosis code supplied
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - Review current National Government Services LCDs and Billing and Coding Articles
    - Look for typos and transposed numbers
  - If additional medical circumstances exist or more specific diagnosis code appropriate, indicate when submitting appeal

Denial Reason Code 59132

- TOB 71X with HCPCS code G0108 or G0109 present (NCD 40.1)
- Provider-liable
- Avoiding/Correcting this error
  - Review claim for typos and transposed numbers
  - DSMT cannot be billed by RHCs
    - CMS RHC Preventive Services Chart

Rejection Reason Code U5233

- Services on claim fall within or overlap MA HMO enrollment period
- Avoiding/Correcting this error
  - Verify admission date, from, and through dates on claim
  - Compare admission date, from, and through dates on claim to MA HMO entitlement dates
  - Determine if billed correctly and take appropriate action

Rejection Reason Code 38200

- Claim exact duplicate of previously submitted claim
  - MBI number
  - TOB (all three positions of any TOB)
  - Provider number
  - DOS
  - Total charges (0001 revenue line)
  - Revenue code, HCPCS and modifiers (if required by revenue code file)
- Avoiding/Correcting this error
  - All additions and/or corrections to processed claims must be adjustment claims, not new claims
  - Before submitting claim, ensure has not been previously submitted
  - Review remittance advice or use self-service tools

Rejection Reason Code 39934

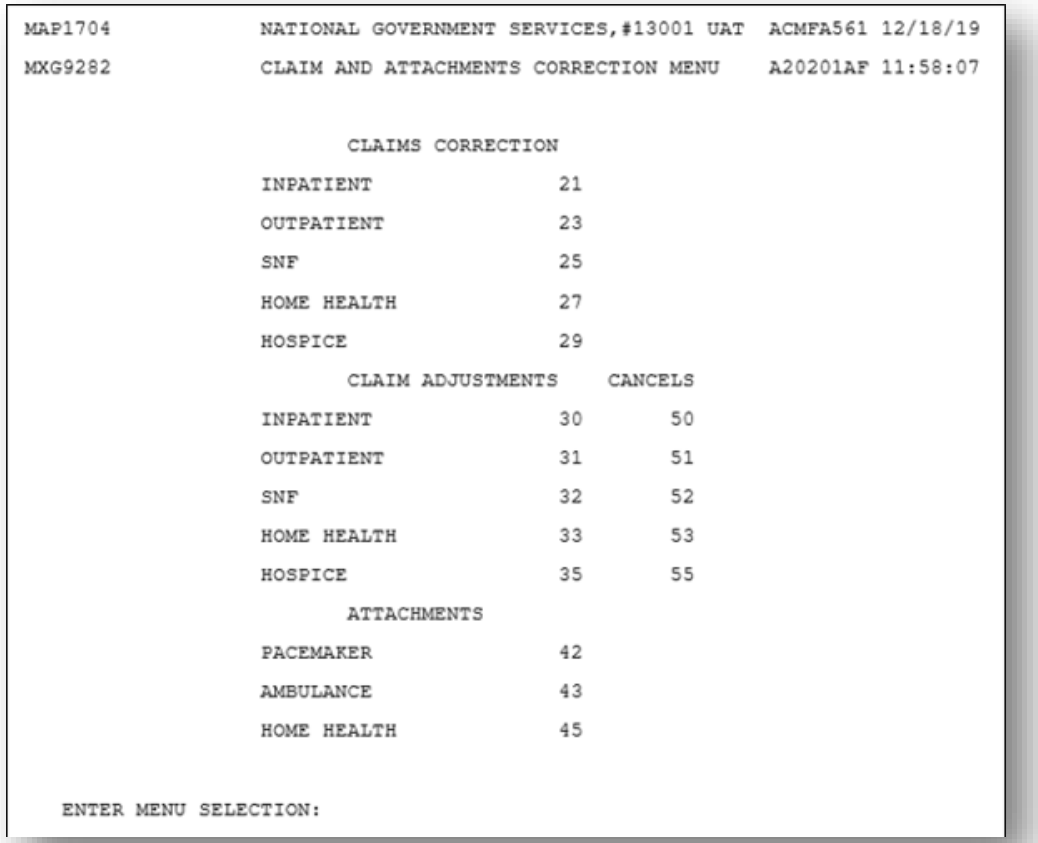
- All revenue code lines on claim denied as noncovered and one or more lines denote beneficiary liability
- Avoiding/Correcting this error
  - Verify line level rejection information to determine rejection for each claim line
    - Line level reason code(s) appear on the right view (PF11) of claim page 2 (MAP171D)
  - When appropriate, make corrections and submit new claim

Rejection Reason Code 39929

- Each line of charges on this claim rejected and/or rejected and denied
- Avoiding/Correcting this error
  - Verify line level rejection information to determine rejection for each claim line
    - Line level reason code(s) appear on the right view (PF11) of claim page 2 (MAP171D)
  - When appropriate, make corrections and submit new claim

RTP Tips

- Check RTPs routinely
  - Daily, every other day or weekly, based on claim volume
- RTPs not considered "received" by Medicare
  - Must be resubmitted before passes timely filing period
- Review and correct RTPs in FISS DDE Claims Correction submenu
  - Option 03 from FISS DDE Main Menu



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                          CLAIMS CORRECTION
                  INPATIENT                21
                  OUTPATIENT               23
                  SNF                      25
                  HOME HEALTH              27
                  HOSPICE                  29
                         CLAIM ADJUSTMENTS     CANCELS
                  INPATIENT                30        50
                  OUTPATIENT               31        51
                  SNF                      32        52
                  HOME HEALTH              33        53
                  HOSPICE                  35        55
                         ATTACHMENTS
                  PACEMAKER                42
                  AMBULANCE                43
                  HOME HEALTH              45


   ENTER MENU SELECTION:
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RTP Reason Code 34963

- One of the following applies:
  - Attending physician on Claim Page 05 invalid or not present in PECOS Enrolled Physicians file (Type C Records)
  - Attending physician NPI present on PECOS Enrolled Physicians file but first four digits of last name do not match
  - Through DOS on claim equal to or greater than Termination Date on PECOS Enrolled Physician Inquiry screen
- Avoiding/Correcting this error
  - Review PECOS to ensure information correct, update if necessary
  - Verify billing
  - If appropriate, correct attending physician information on claim and resubmit (PF9)

RTP Reason Code 39910

- Modifier CG required on qualifying visit line on TOB 71X
- Avoiding/Correcting This Error
  - Modifier CG must be reported on the line representing primary reason for medically necessary face-to-face visit
    - Claims and adjustments must include modifier CG on only one line
    - Exception – medical and mental health visit on same day (both lines must have modifier CG)
  - Ensure modifier CG on revenue code 52X or 900 as appropriate
  - If appropriate, correct claim and resubmit (PF9)

RTP Reason Code U5065

- Claim From Date prior to MBI effective date on CWF crosswalk file
- Avoiding/Correcting this error
  - Check/verify beneficiary's entitlement dates in CWF
  - Verify MBI number
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code E0401

- TOB either
  - Invalid
  - Inconsistent with provider number (PTAN)
  - Inappropriate when billing revenue code 403
- Avoiding/Correcting this error
  - Verify TOB, PTAN and revenue codes billed on claim
  - If appropriate, correct and resubmit (PF9)

Resources and References

CMS References - General

- CMS Rural Health Clinics Center
- RHC Reporting Requirement FAQs
- MLN® Booklet: *Information for Rural Health Clinics*
- Rural Health Clinic (RHC) Preventive Services Chart

CMS Resources

- CMS Internet-Only Manual Publications:
  - 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
  - 100-04, *Medicare Claims Processing Manual*, Chapter 9, Rural Health Clinics/ Federally Qualified Health Centers
  - 100-04, *Medicare Claims Processing Manual*, Chapter 18, Preventive and Screening Services

Other Resources

- AMA CPT® (Current Procedural Terminology)
- National Uniform Billing Committee website
  - NUBC Official UB-04 Data Specifications Manual
  - Annual fee
  - Providers also receive updates throughout the year
- U.S. Preventive Services Task Force Website
  - Provides Grade A and B preventive services

NGS Resources

- Revenue codes and HCPCS codes files available in FISS DDE
- NGS website
  - Upcoming training events
  - Medicare updates and educational materials
  - Contact information for
    - Provider Contact Center
    - IVR
    - Written inquiries
  - NGSConnex
  - Medicare University

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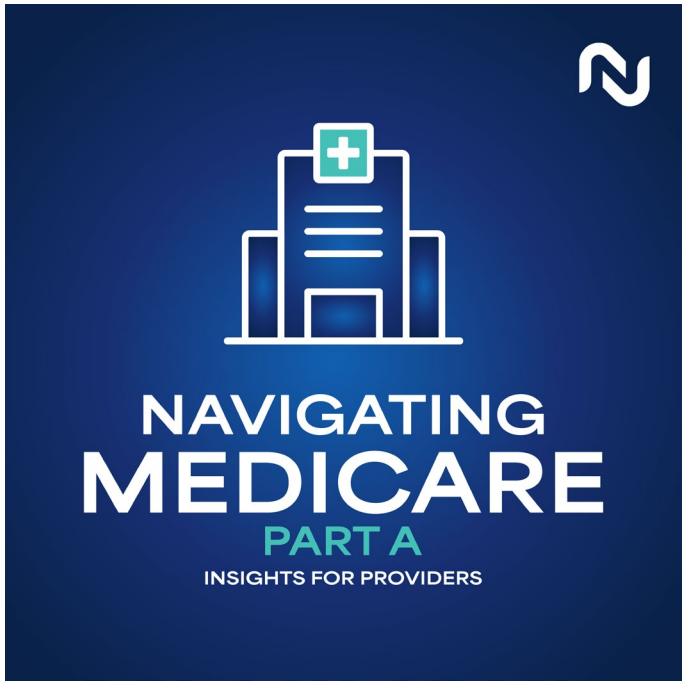

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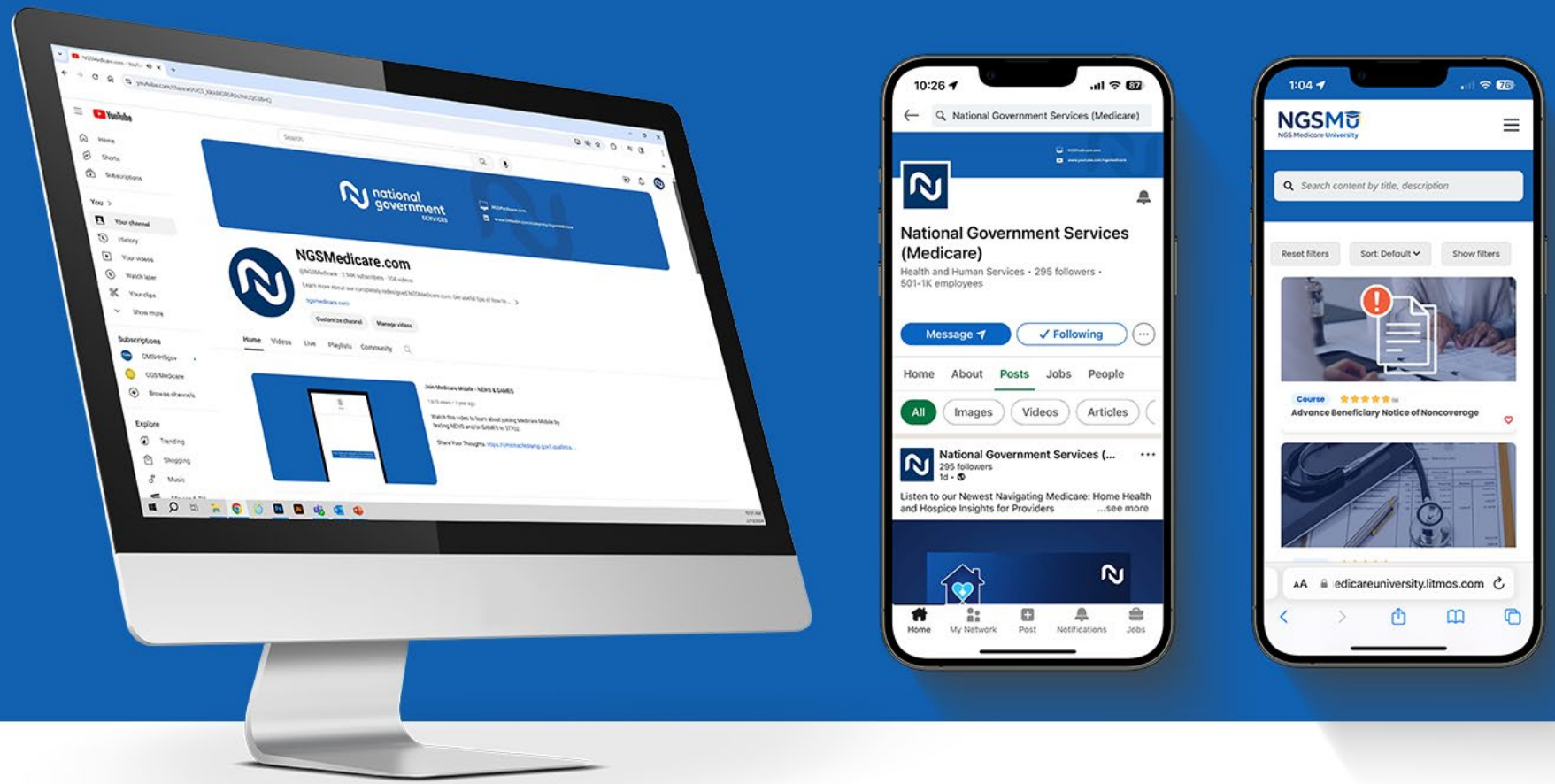

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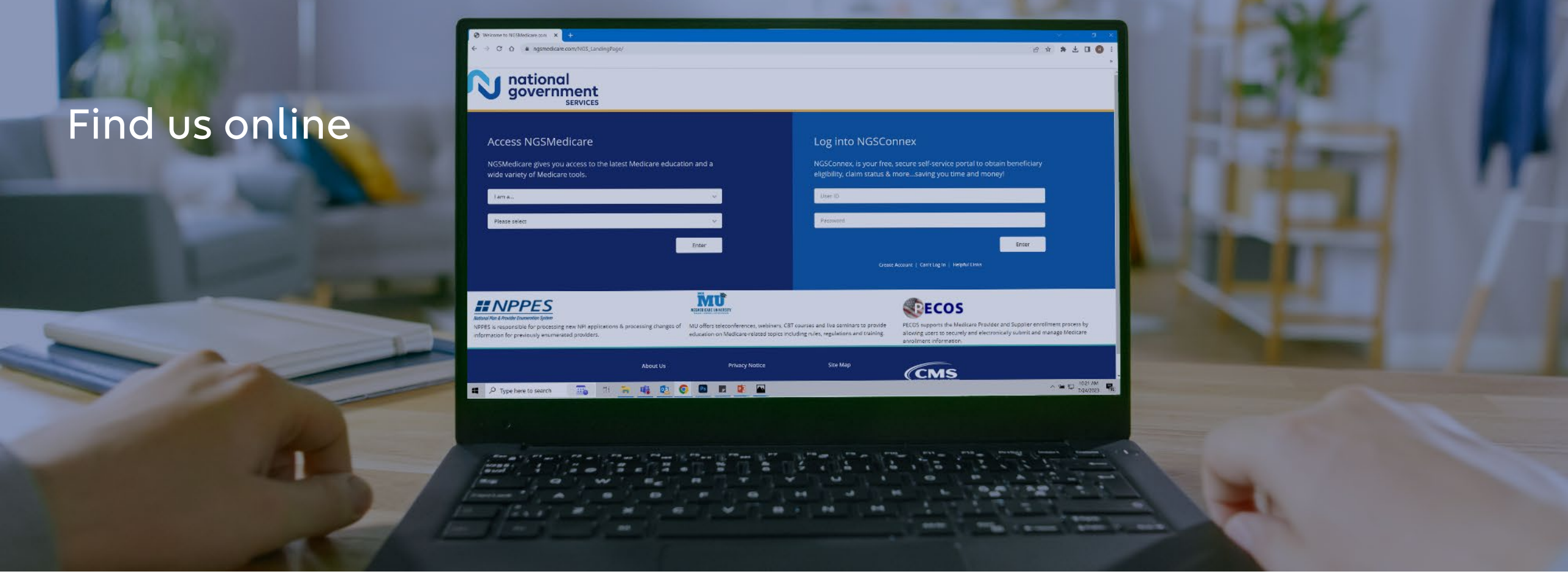

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