

Rural Health Clinic Billing Basics

7/30/2024

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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

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Agenda

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[Billing Preventive Services](#)

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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 evaluation and management (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

Notes for Upcoming Claim Examples

- HCPCS codes and associated charges used in examples are for illustration purposes only
- Examples assume that all coverage criteria have been met
- All other coding requirements (diagnosis, condition, occurrence, value codes, etc.) and claim elements apply

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 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

Claim Example: Reporting Qualified Medical Visit

- Claim generates AIR payment
 - Deductible applies
 - Coinsurance applies
 - 20% total charges on qualified visit line

Revenue Code (FL 42)	HCPCS/CPT (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG	07/30/2024	1	\$115
0001				\$115

Claim Example: Reporting Qualified Mental Health Visit

- Claim generates AIR payment
 - Deductible applies
 - Coinsurance applies
 - 20% total charges on qualified visit line

Revenue Code (FL 42)	HCPCS/CPT (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
0900	90834 CG	07/30/2024	1	\$170
0001				\$170

Claim Example: Reporting Qualified Medical Visit with Incident to Services

- Claim generates one AIR payment
 - Deductible applies
 - Coinsurance applies
 - 20% total charges on qualified visit line

Claim Example: Reporting Qualified Medical Visit with Incident to Services

Revenue Code (FL 42)	HCPCS/CPT (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG (\$115)	07/30/2024	1	\$205
0300	36415	7/30/2024	1	\$55
0636	90746	7/30/2024	1	\$25
0771	G0010	7/30/2024	1	\$10
0001				\$295

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/inquiry 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

Billing for Three Visits

- IPPE and 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
- AIR generated for each qualifying visit claim line
- Coinsurance applies to each qualifying visit claim line (20% total charges)

Claim Example: Reporting Multiple Qualified Medical Visits

- Claim generates two AIR payments
 - Deductible applies
 - Coinsurance applies
 - 20% total charges on each qualified visit line

Revenue Code (FL 42)	HCPCS/CPT (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG	07/30/2024	1	\$115
052X	99214 59	7/30/2024	1	\$95
0001				\$210

Billing Preventive Services

Preventive Services

- Preventive services paid as stand-alone visits if no other service furnished on same day
- Except for IPPE, preventive services furnished on same day as another medical visit considered one single visit
 - 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

Preventive Services

- [Rural Health Clinic \(RHC\) Preventive Services Chart](#)

Preventive Service	HCPCS
Alcohol Screening and Behavioral Counseling	G0442, G0443
AWV	G0438, G0439
Glaucoma Screening	G0117, G0118
IPPE	G0402
IBT for Cardiovascular Disease	G0446
IBT for Obesity	G0447

Preventive Services (continued)

Preventive Service	HCPCS/CPT
Lung Cancer Screening with LDCT	G0296
Prostate Cancer Screening	G0102
Screening for Depression	G0444
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling	G0445
Screening Pap Test	Q0091
Screening Pelvic Exam	G0101
Smoking and Tobacco Cessation Counseling	99406, 99407

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

Claim Example: Reporting Preventive Service as Qualified Medical Visit

- Claim generates one AIR payment
 - Deductible waived
 - Coinsurance waived

Revenue Code (FL 42)	HCPCS/CPT (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	G0101 CG	07/30/2024	1	\$35
0001				\$35

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

Claim Example: Reporting Preventive Service and Qualified Medical Visit

- Claim generates one AIR payment
 - Deductible applies
 - Coinsurance (20%) applies to charges on qualified medical visit line

Revenue Code (FL 42)	HCPCS/CPT (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG (\$115)	07/30/2024	1	\$115
052X	G0101	07/30/2024	1	\$35
0001				\$150

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

Social Determinants of Health (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 AWW
- Not paid separately
- Cost-sharing
 - When provided with AWW, no deductible/coinsurance applied
 - When provided with other visits, cost sharing applies

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

Other RHC Services

General Care Management

- Effective 1/1/2024, bill general care management code G0511 for
 - Remote physiologic monitoring (RPM)
 - Remote therapeutic monitoring (RTM)
 - Community health integration (CHI)
 - Principal illness navigation (PIN)
 - PIN-peer support (PIN-PS)

Billing Advanced Care Planning (ACP) as Element of AWW

- Report claim line for qualifying visit
 - Revenue code 052X with AWW qualifying visit HCPCS code G0438 or G0439
 - One unit with total charges for qualifying visit (only)
- Report claim line for ACP
 - Revenue code 052X with CPT code 99497
 - One unit with total charges for ACP
- 0001 Totals line must calculate appropriately

Billing ACP as Stand-Alone Encounter

- Report claim line for ACP
 - Revenue code 052X with CPT code 99497
 - Reported with CG modifier if only preventive services furnished and ACP primary reason for visit
 - One unit and total charges for ACP
- 0001 Totals line must calculate appropriately
- Generates separate MPFS payment

Transitional Care Management (TCM) Billing

- TCM guidelines
 - Only one health care professional may report TCM services
 - One TCM visit covered per beneficiary per post-discharge period
 - Services provided not in post-op global period
 - Subject to Part B coinsurance
- If TCM visit occurs same day as another billable visit, generally only one visit billed
 - As of January 1, 2022 can bill TCM and general care management services for same patient during same time period
 - RHC must meet requirements for billing each code

Billing for TCM Services

- DOS = day face-to-face visit takes place
- Revenue code = 0521
- Qualifying visit HCPCS codes
 - 99495 for moderate-complexity decision making
 - 99496 for high-complexity decision making
- One unit
- Total Charges
- 0001 total charges

General Care Management Services

- Can only bill once per month per beneficiary
 - Do not bill if other care management services are billed for same time period by any practitioner or facility
 - Except TCM for DOS on/after January 1, 2022
- Can be billed alone or on qualifying visit claim
- Line item reporting - HCPCS code G0511
 - Do not apply modifier CG to these services
- Coinsurance and deductible applied

Principal Care Management Services

- PCM services describes comprehensive care management services of single high-risk disease or complex condition
 - Bill G0511 (general care management) for PCM services, either billed alone or other payable services
 - Payment rate includes PCM HCPCS G2064 and G2065
 - [CR 12252](#)
 - [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Section 230.2](#)

Psychiatric Collaborative Care Model (CoCM)

- Can only bill once per month per beneficiary
 - Do not bill if other care management services are billed for same time period by any practitioner or facility
- Can be billed alone or on qualifying visit claim
- Line item reporting - HCPCS code G0512
 - Do not apply modifier CG to these services
- Coinsurance and deductible applied

Global Surgeries

- Surgical procedures furnished in RHC included in AIR
- Surgical procedures furnished at other locations, follow global billing guidelines
 - Bill for visit during global period if visit for service not included in global package
 - [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12](#) Section 40 and 40.1

Telehealth: Originating Site

- Exception through 12/31/24 - 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 12/31/24 - 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

Virtual Communication Services

- Can be billed alone or with other payable services
- Submit claim with HCPCS code G0071
- RHC face-to-face requirement waived
- Medicare coinsurance and deductible apply
- [Virtual Communication Services in Rural Health Clinics \(RHCs\) and Federally Qualified Health Centers \(FQHCs\) Frequently Asked Questions](#)

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

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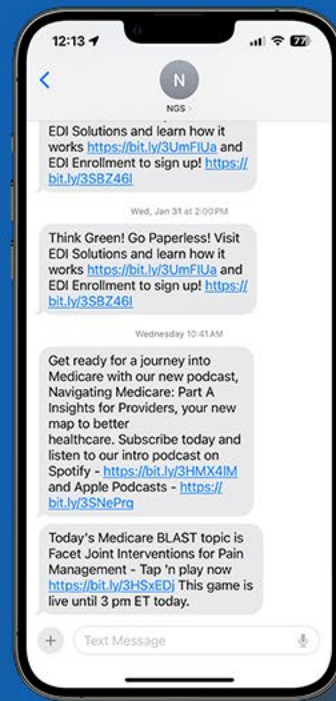
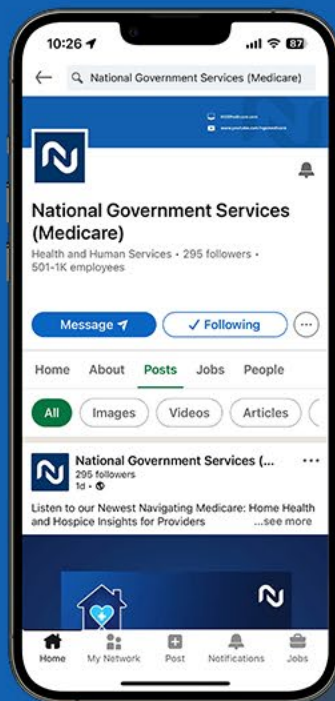
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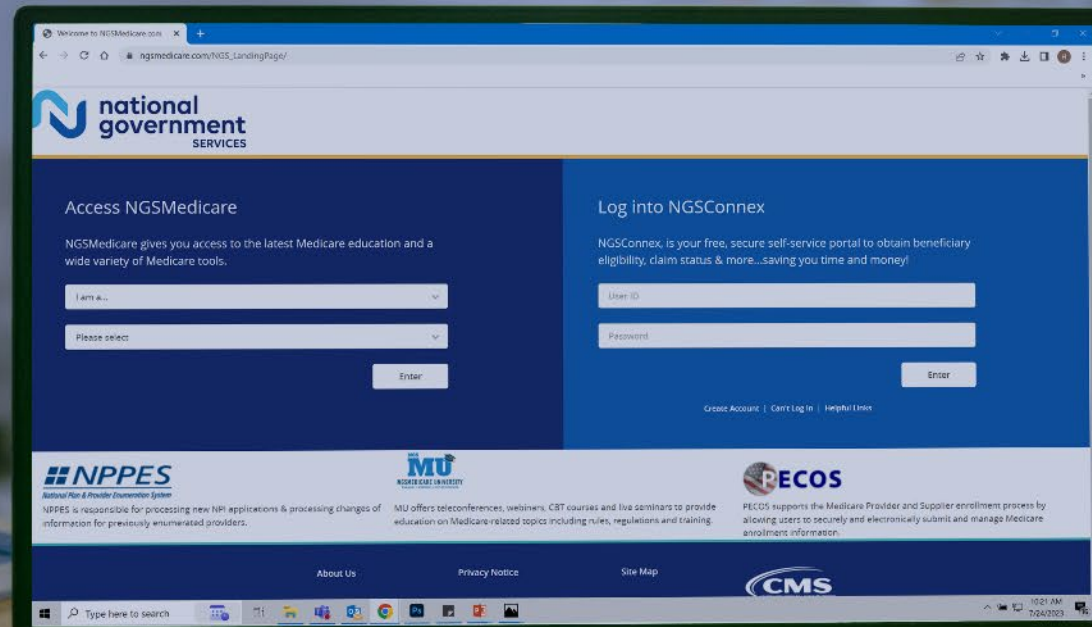
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