

RHC Billing 101 v.2019

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What is an RHC?

- ✓ A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.
- ✓ 51% of Clinic Services must be Primary Care (FP,IM,OB,Ped).
- ✓ The purpose of the RHC program is improving access to primary care in underserved rural areas.
- ✓ The clinic must be staffed at least 50% of the time with a midlevel practitioner.

(Rural Assistance Center FAQ)

RHC Regulations and Interpretive Guidelines

Social Security Act Section 1861(aa)(2)(K)

[42 CFR §405.2402](#) (Basic Requirements)

[42 CFR Part 491, Subpart A](#) (Conditions for Participation!)

[State Operations Manual](#) – Appendix G (Surveyor Guidance)

Accreditation Organization Standards:

- ✓ [AAAASF](#)
- ✓ [The Compliance Team](#)

The RHC Encounter Rate

The Current RHC maximum encounter rate CY 2019 is **\$84.70**. (for independent/freestanding RHCs or PBRHCs ineligible for an uncapped rate).

“In general, the all-inclusive rate (AIR) for an RHC or FQHC is calculated by the MAC/FI by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation.”

(Medicare Benefit Policy Manual. Chapter 13. Section 70.)

RHC Productivity Standard

1 FTE Physician – 4,200 Visits

1 FTE NP or PA – 2,100 Visits

If the RHC or FQHC has furnished fewer than expected visits based on the productivity standards, the MAC/FI substitutes the expected number of visits for the denominator and use that instead of the actual number of visits.

(Medicare Benefit Policy Manual. Chapter 13. Section 70.4.)

RHC Rate and Cost Reporting

- ✓ The RHC Encounter Rate is set via the RHC Cost Report.
- ✓ Provider-based Clinics file as part of the hospital cost report.
- ✓ Costs must appropriately allocated and tracked for the RHC space and personnel.
- ✓ Provider FTEs should be measured via formal time study.
- ✓ Only time spent in the RHC counts.
- ✓ Medical Director, Physician, PA, NP, Nursing FTEs have a major impact on cost reporting.
- ✓ Laboratory Expenses must be allocated and reclassified appropriately. (RHC vs. Non-RHC)

Independent RHCs

- ✓ Independent RHCs are generally private physician offices or hospital clinics whose parent is > 50 beds.
- ✓ RHC encounters are paid using the current RHC cap.
- ✓ Independent RHCs must file an annual cost report, which is due 5 months after the end of each fiscal year.
- ✓ Failure to file timely cost reports can result in full refunds of RHC payments.

Provider-Based RHCs

Provider-based RHCs (PBRHC) are those owned by a parent entity such as a hospital, nursing facility, or home health agency.

- ✓ PBRHCs owned by a ***hospital*** with 50 beds or less qualify for an uncapped RHC rate.
- ✓ PBRHCs whose parent entity is greater than 50 beds have the same cap as independents.
- ✓ PBRHCs rate is set under the parent entity's cost report.
- ✓ Claims are billed to the MAC which services the parent entity.

Medicare Fees (Patient Charges)

“RHCs and FQHCs must charge Medicare beneficiaries the same rate that non-Medicare beneficiaries are charged.”

(Medicare Benefit Policy Manual. Chapter 13. Section 80.)

Medicare Payments

“In general, Medicare pays 80 percent of the RHC or FQHC’s all-inclusive rate, subject to a per-visit payment limit. The beneficiary in an RHC must pay the deductible and coinsurance amount.”

(Medicare Benefit Policy Manual. Chapter 13. Section 80.)

RHC Claims - Medicare Part A

The Centers for Medicare and Medicaid Services administers Rural Health Clinics payments under Medicare Part A. RHC services are a Part B (Physician Service) benefit, but our reimbursement structure is Medicare Part A.

Medicare Part B (FFS)

In the RHC world, the term 'Medicare Part B' typically indicates those claims which will continue to be paid 'fee-for-service' and billed on a CMS-1500 under the Medicare Physician Fee Schedule (MPFS) payment structure.

RHC claims are NOT paid based on the Medicare Fee Schedule. Non-RHC services are those that may be paid outside of the RHC Benefit.

Medicare Advantage Plans

Medicare Advantage plans are considered commercial payers for RHC purposes and cost reporting purposes.

- ✓ Most of these will pay your RHC encounter rate and follow Medicare RHC reimbursement.
- ✓ RHC services should be submitted on a CMS-UB04;
- ✓ Non-RHC services *may* be submitted on a CMS-1500.
- ✓ Pneumococcal and Influenza injections should not be reported on the RHC Cost Report.

Rural Health Clinics and MIPS

Medicare Part A reimbursement for claims submitted on a CMS-UB04 is NOT subject to MIPS negative/positive payment adjustments at present.

Any non-RHC/non-FQHC billing which is submitted on a CMS-1500 WILL be subject to MIPS adjustments.

Qualified RHC Providers

An RHC encounter can be billed for the following providers:

- ✓ Physicians (MD, or DO)
- ✓ Nurse Practitioners
- ✓ Physician Assistants
- ✓ Certified Nurse Midwives
- ✓ Chiropractor, Dentist, Optometrist, Podiatrist

Behavioral Health Providers

Medicare RHC providers are:

- ✓ Clinical Psychologist (PhD)
- ✓ LCSW
- ✓ LCPC or CPC is not payable by Medicare

(Check with your own state to see if LCPC or CPC are eligible – in most states they are not)

Rural Health Services

- ✓ Physicians' services, as described in section 100;
- ✓ Services and supplies incident to a physician's services, as described in section 110;
- ✓ Services of NPs, PAs, and CNMs, as described in section 120;
- ✓ Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 130;
- ✓ Clinical Psychologist and Clinical Social Worker services, as described in Section 140;
- ✓ Services and supplies incident to the services of CPs and CSWs, as described in Section 150; and
- ✓ Visiting nurse services to the homebound as described in Section 180.

(Medicare Benefit Policy Manual Chapter 13)

Incident-to Services Defined

- ✓ Incident-to services are considered covered **and paid** under the RHC.
- ✓ They must be bundled with the RHC encounter. They are not separately billable or payable.
- ✓ Services that do not occur on the same date as the encounter can be bundled if they occur 30 days before or after.
- ✓ The effect on payment is an increase in the charge, and therefore in the co-insurance.
- ✓ The cost for these services are included in the cost report, but are not separately payable on claims.

Non-Rural Health Services

- ✓ “RHCs and FQHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit.
- ✓ If these services are authorized...the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service.
- ✓ RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.”

(Medicare Benefit Policy Manual Chapter 13; Section 60)

Non-Rural Health Services

Certain services are not considered RHC or FQHC services either because they 1) are not included in the RHC or FQHC benefit, or 2) are not a Medicare benefit. Non-RHC/FQHC services include, but are not limited to:

Medicare excluded services	Ambulance services
Technical component of an RHC or FQHC service	Prosthetic devices
Laboratory services	Body Braces
Durable medical equipment	Practitioner services at certain other Medicare facility
Telehealth distant-site services	Hospice Services
Group Services	

Diagnostic Testing and Lab: Independent

The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.

- ✓ The technical component of these tests are billed to the Medicare Part B carrier using the fee-for-service provider number.
- ✓ All lab services are also billed to the Part B carrier.

Diagnostic Testing and Lab: Provider-Based

The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.

- ✓ The technical components for X-Ray, EKG, ultrasounds, etc. are billed to the FI using the hospital CCN number.
- ✓ Lab services are also billed to the FI using the hospital CCN number.

RHC Locations

RHC visits may take place in:

- ✓ the RHC or FQHC,
- ✓ the patient's residence (including an assisted living facility),
- ✓ a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
- ✓ the scene of an accident.

(Medicare Benefit Policy Manual. Chapter 13. Section 40.1)

Never a RHC Location

RHC Visits may never take place in:

- ✓ an inpatient or outpatient department of a hospital, including a CAH, or
- ✓ a facility which has specific requirements that preclude RHC or FQHC visits (e.g., Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.)

(Medicare Benefit Policy Manual. Chapter 13. Section 40.1)

The RHC Encounter is:

“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.”

(Medicare Benefit Policy Manual. Chapter 13. Section 40.)

Qualifying Visits

Medical Services RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

RHC Qualifying Visit List

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

RHC Services – Claim Form

- ✓ RHC Services are submitted on a CMS-UB04 claim form.
- ✓ The electronic format is ANSI837-Institutional.
- ✓ Type of Bill is “711” for an original claim.
- ✓ All services must be reported using the appropriate revenue code.
- ✓ All claims must have a qualifying visit denoted with a “CG” Modifier.
- ✓ Incident-to services must be reported on the claim, but bundled with the qualifying visit.

Revenue Codes

- 0521 All Clinic Visits and Professional Services by qualified RHC 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 non-SNF bed,
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 an accident)
- 0250 Pharmacy (Does not need the HCPCS)
- 0300 Venipuncture
- 0636 Injection/Immunization
- 0780 Telehealth
- 0900 Behavioral Health

CG Modifier

“...beginning on October 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible.” (Med Learn Matters SE1611)

“If only preventive services are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the medically necessary face-to-face visit and the bundled charges.”

Multiple Encounters

“Encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit, regardless of the length or complexity of the visit or whether the second visit is a scheduled or unscheduled appointment.”

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

Multiple Encounters are allowed when:

- ✓ The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (2 visits), or
- ✓ The patient has a medical visit and a Behavioral Health visit on the same day (2 visits), or
- ✓ The patient has his/her IPPE and a separate medical and/or Behavioral health visit on the same day (2 or 3 visits).

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

RHC Use of Modifiers -59 and -25

Modifier-59 indicates that separate conditions on the same treated are unrelated. This is used only a subsequent illness or injury on the same day as another visit. Modifier-25 in an RHC is interchangeable with -59!

Modifier-59 and -25 indicate two encounters. -25 is different in an RHC. Modifier 25 or 59 is only on the SECOND line item UB-04 on a claim form.

RHC Pro Tip: Modifier-25 is NOT used to distinguish an Evaluation and Management Service from a procedure.

CG Modifier? Subsequent Illness or Injury

Q13. Is modifier CG reported when a subsequent medically necessary visit that qualifies as a separate payment occurs on the same day as an earlier medically-necessary visit?

A13. No.

Q14. Should modifier CG and modifier 25 or modifier 59 be reported on the same service line together to indicate a subsequent medically necessary visit that qualifies as a separate payment?

A14. No.

Medicare Preventive Services (MPS)

“RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits (where applicable) have not been exceeded.

The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B.”

Preventive RHC Services

RHC services also include certain preventive services. These include:

- ✓ Welcome To Medicare Visit (G0402)
- ✓ Annual Wellness Visit/Subsequent Annual Wellness (G0438/G0439)
- ✓ Medicare-covered Preventive Services (DMST is NOT eligible as an RHC Visit!)
- ✓ Influenza, Pneumococcal (Medicare Cost Report – **Medicare** Flu/Pneumo Only)
- ✓ Care Management Services (G0511/G0512)
- ✓ Virtual Communication Services (G0071)

(Medicare Benefit Policy Manual Chapter 13)

Preventive Services and Same Day Billing

“RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the [Certain Preventive Services] when they are performed on the same day.” MLN SE1039

The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.

Preventive Services and Stand-Alone Encounters

All other preventive services are 'stand-alone' encounters. If a "Stand Alone" encounter is the only service rendered on a particular date of service, then it will be paid at the AIR. If it is furnished on the same day as another medical visit, it is not a separately billable visit.

The beneficiary coinsurance and deductible may be waived, depending on the service rendered.

Telehealth

- ✓ RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report.* (***State rules vary!!**)
- ✓ This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract.

Telehealth

- ✓ Report on UB04 with Q3014. (app. \$23.17)
- ✓ Can accompany an E/M service or be reported alone.
- ✓ 'Remote' physician bills an E/M code with modifier.

Chronic Care Management becomes Care Coordination

CCM services furnished on or after January 1, 2018: CCM services can be billed by adding the general care management G code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

For CCM services furnished between January 1, 2016 and December 31, 2017: CPT code 99490 ONLY applies to these old claims. 99490 is dead.

G0511: General Care Management Services

G0511: General Care Management Services

- ✓ Billed alone or with other payable services on a RHC or FQHC claim
- ✓ This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.
- ✓ Payment for G0511 is set at the average of the 3 national non-facility PFS payment rates for the CCM (CPT code 99490 and CPT code 99487) and general BHI (CPT code 99484).
- ✓ The *current payment rate is \$61.37* for FY2018.
- ✓ The rate is updated annually based on the PFS amounts and coinsurance applies.

Effective January 1, 2019: Virtual Communication

RHCs can receive payment for Virtual Communication Services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient who has had an RHC billable visit within the previous year.

- ✓ The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and -
- ✓ The medical discussion or remote evaluation ***does not lead*** to an RHC visit within the next 24 hours or at the soonest available appointment.

Virtual Communication Services - Payment

G0071 (Virtual Communication Services) is billed either alone or with other payable services.

Payment for G0071 is set at the PFS national average of the non-facility payment rate for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services).

For 2019, the payment amount for code G0071 will be **\$13.69** (average of HCPCS codes G2012 and G2010).

G2010: Virtual Communication Services

Virtual Check-In: Brief Communication Technology-based Service:

- ✓ by a physician or other qualified health care professional;
- ✓ provided to an established patient;
- ✓ not originating from a related E/M service provided within the previous 7 days;
- ✓ nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment;
- ✓ 5-10 minutes of medical discussion.

G2012: Virtual Communication Services

Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward):

- ✓ including interpretation with follow-up with the patient within 24 business hours
- ✓ not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

RHC - CMS Resources

Virtual Communication FAQ

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>

State Operations Manual Appendix G (Updated 1.2.18)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

Provider-Based Rules (42 CFR 413.65)

<https://www.law.cornell.edu/cfr/text/42/413.65>

RHC - CMS Resources

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Benefit Policy Manual- Chapter 15 Other Services

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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