RHC Claim Detail v.2019

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RHC Services: Claims

Reporting Services

Beginning on April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with a revenue code on their Medicare claims. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services.

HCPCS Reporting – Medicare!

HCPCS Reporting, QVL, CG Modifiers and all of the RHC billing requirements which changed on April 1, 2016…Only Affects Medicare RHC Claims!

This does not affect commercial or State Medicaid RHC billing requirements!

Qualifying Visits – Medical Services

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.

Total Qualifying Visit Line

- ✓ Medicare does not adjudicate RHC claims based on the 0001 Total Charge amount.
- ✓ Medicare adjudicates RHC claims using the Qualifying Visit Line.
- ✓ The qualifying visit line should be the sum of all RHC charges subtracted by any preventive services.

Expanded QVL

CMS has expanded the Qualifying Visit List on multiple occasions. The full list can be found at:

RHC Qualifying Visit List

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

QVL After October 1, 2016

"…a qualifying visit list [will] serve as a guide to services that generally qualify as stand-alone billable visits. The HCPCS reporting requirements have not changed what is considered a RHC stand-alone billable visit, which is typically evaluation and management type of services or screenings for certain preventive services."

Encounter Billing – October 1, 2016

"…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)

CG Modifier

"RHCs should report modifier CG on one line with a medical and/or Behavioral health HCPCS code that represents the primary reason for the medically necessary face-to-face visit.

Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs) (Revised 10-14-16)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf

CG Modifier – Preventive Services

"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."

Billing Example #1: Office Visit Only

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	4/2/2017	1	$ 100.00
0001	Total Charge				$ 100.00

An established patient is seen and a qualifying visit of 99213 for $100 is generated. The applicable coinsurance and/or deductible shall be based upon $100.

Medicare will pay the encounter at 80% of the AIR. The patient will be responsible for $20.00 in co-insurance.

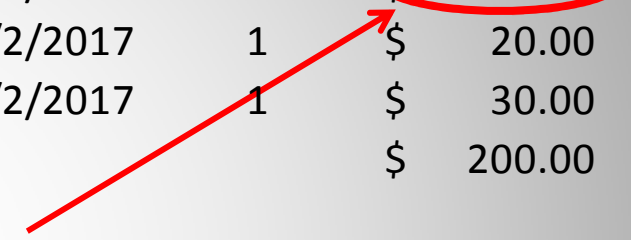
Billing Example #2: Medical Services Plus Ancillary

Service	Charge
99213	$100.00
96372	$20.00
J1885	$30.00
Total Charges	$150.00

A Medicare beneficiary is seen for 99213 for a charge of $100. A Toradol injection (J1885) for $30 was performed.

Billing Example #2: Medical Visit plus Ancillary

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 150.00
0636	Injection Admin	96372	4/2/2017	1	$ 20.00
0636	Toradol	J1885	4/2/2017	1	$ 30.00
0001	Total Charge				$ 200.00



The charge amount for Toradol ($30.00) and the administration ($20.00) will be added to the 99213 ($100) for a qualifying visit line of $150.00. The total charge line is inaccurate.

Service Detail

Service detail lines can be reported as $.01 or greater. The additional services lines CAN be reported as $.01. This eliminates artificial inflation of revenue, adjustments, and AR.

Billing Example #2: Alternative Method Medical Visit plus Ancillary

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 150.00
0636	Injection Admin	96372	4/2/2017	1	$ 0.01
0636	Toradol	J1885	4/2/2017	1	$ 0.01
0001	Total Charge				$ 150.02

The Toradol charge amount ($30.00) plus $.01, the injection administration (20.00) plus $.01 are bundled with the $100 charge on the 99213 qualifying visit line. Medicare will use the line with the qualifying visit code (99213) to determine the total charge and calculate co-insurance.

Bundled Services – Different Dates

"The RHC can combine incident to services furnished on a different date of service on one claim as long as they are furnished in a medically appropriate period and are incident to the service being billed. Incident to services should not be reported with modifier CG."

Billing Example #3: Bundled Injection/Different Dates

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 120.00
0636	Allergy Injection	95115	4/2/2017	1	$ 20.00
0001	Total Charge				$ 140.00

The Allergy injection charge amount ($20.00) for the line item is bundled with the $100 charge on the 99213 qualifying visit line. Medicare will use the line with the qualifying visit code (99213) to determine the total charge and calculate co-insurance.

Billing Example #3: Bundled Injection/Different Dates

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 120.01
0636	Allergy Injection	95115	4/2/2017	1	$ 0.01
0001	Total Charge				$ 120.02

The charge amount for the allergy Injection ($20.00) plus $.01 will be added to the 99213 ($100) for a qualifying visit line of $120.01.

Billing Example #4: Medical Services Plus EKG

A Medicare beneficiary is seen for 99213 for a charge of $100. A EKG (93005/93010) for $75/$30.

Service	Charge
99213	$100.00
93005 EKG-TC	$45.00
93010 EKG-PC	$30.00
Total Charges	**$175.00**

Billing Example #4: Medical Visit plus EKG

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
521	OV Est 3	99213 CG	4/2/2017	1	$ 130.00
521	EKG-PC	93010	4/2/2017	1	$ 30.00
001	Total Charge				$ 160.00

The EKG-PC charge amount is bundled with the 99213 on the RHC claim. A 93005 will be billed to Medicare Part B/FFS under the physician/group (IRHC) or Hospital P-TAN (PBRHC).

Billing Example #4: Alternative Medical Visit plus EKG

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
521	OV Est 3	99213 CG	4/2/2017	1	$ 130.01
521	EKG-PC	93010	4/2/2017	1	$ 0.01
001	Total Charge				$ 130.02

The charge for the EKG-PC ($45.00) is bundled with the 99213 charge ($100.00) on the RHC claim. The EKG-PC is reported as a $.01 line item. A 93005 will be billed to Medicare Part B/FFS under the physician/group (IRHC) or Hospital P-TAN (PBRHC).

Claim Example #5: Behavioral Health Services

Behavioral Health Services RHCs shall report one service line per Behavioral Health encounter/visit with revenue code 0900 and a qualifying Behavioral Health visit from the RHC Qualifying Visit List.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min	90836 CG	4/2/2017	1	$ 120.00
0001	Total Charge				$ 120.00

Claim Example #6: Sick Visit and Behavioral Health

Modifier CG should be reported once per day for a qualified medical visit (revenue code 052x) and/or once per day for a qualified Behavioral Health visit (revenue code 0900).

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	4/2/2017	1	$ 220.00
0900	Rx Management	90832CG	4/2/2017	1	$ 120.00
0001	Total Charge				$ 340.00

Billing Example #7: Office Visit and Preventive w. Ancillary

An established patient is seen and a qualifying visit of 99213 for $100 is generated. A breast/pelvic exam was performed for $75.00. A venipuncture was taken for $20.00.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 120.00
0521	Breast/Pelvic	G0101	4/2/2017	1	$ 75.00
0300	Venipuncture	36415	4/2/2017	1	$ 20.00
0001	Total Charge				$ 215.00

The charge for the pelvic exam should NOT be bundled in the 99213 line since there will be no co-insurance applied to the preventive service. The $20.00 venipuncture charge will be bundled with the 99213 charge for $100.00.

Billing Example #7: Office Visit and Preventive w. Ancillary

An established patient is seen and a qualifying visit of 99213 for $100 is generated. A breast/pelvic exam was performed for $75.00. A venipuncture was taken for $20.00.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 120.01
0521	Breast/Pelvic	G0101	4/2/2017	1	$ 75.00
0300	Venipuncture	36415	4/2/2017	1	$ 0.01
0001	Total Charge				$ 195.02

The charge for the pelvic exam should NOT be bundled in the 99213 line since there will be no co-insurance applied to the preventive service. The $20.00 venipuncture charge will be bundled with the 99213 charge for $100.00.

Billing Example #8: Medical Services Plus Procedure

A Medicare beneficiary is seen for 99213 for a charge of $100. A minor surgical procedure (11100) for $150 was performed.

Service	Charge
99213	$100.00
11100	$150.00
Total Charges	**$250.00**

Billing Example #8: Medical Visit plus Procedure

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 250.00
0521	Procedure	11100	4/2/2017	1	$ 150.00
0001	Total Charge				$ 400.00

The laceration repair charge of $150.00 is bundled with the $100.00 office visit charge. The $400 total charge is irrelevant.

Billing Example #8: Alternative Method Medical Visit plus Procedure

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2017	1	$ 250.01
0521	Procedure	11100	4/2/2017	1	$ 0.01
0001	Total Charge				$ 250.02

Medicare will use the line with the qualifying visit code (99213) to determine the total charge and calculate co-insurance.

Billing Example #9: Procedure only

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Procedure	11100 CG	4/2/2017	1	$ 150.00
0001	Total Charge				$ 150.00

Billing Example #10: IPPE Only

An established patient is seen for the “Welcome to Medicare Visit” or IPPE. (G0402) is the only service performed.

Service	Charge
G0402	$200.00
Total Charges	**$200.00**

“Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim.”

RHC Reporting Requirement FAQ

Billing Example #10: IPPE Only

The IPPE was the only service performed. The CG modifier when The G0402 does NOT need billed.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	4/2/2017	1	$ 200.00
0001	Total Charge				$ 200.00

**Make sure and report preventive charges on your Cost Report!!

Billing Example #11: IPPE plus Office Visit

An established patient is seen for a COPD. The patient has just enrolled with Medicare and is eligible for the "Welcome to Medicare Visit" or IPPE (G0402). An established patient visit is billed treating the COPD in addition to the IPPE.

Service	Charge
G0402	$200.00
99213	$100.00
Total Charges	**$300.00**

Billing Example #11: IPPE plus Office Visit

"Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service." RHC Reporting FAQ

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient III	99213CG	4/2/2017	1	$ 100.00
0521	IPPE	G0402	4/2/2017	1	$ 200.00
0001	Total Charge				$ 300.00

Billing Example #12: Well Woman Exam

An established patient is seen for a "well woman exam". Medicare does not recognize 99381-99387. A subsequent annual wellness visit (G0439) is performed for $175, in addition to a breast/pelvic exam (G0101) for $75.00. A pap spear (Q0091) for $50.00 is also rendered.

Service	Charge
G0439	$175.00
G0101	$75.00
Q0091	$50.00
Total Charges	**$300.00**

Billing Example #12: Well Woman Exam

Medicare does not pay a well-woman exam (99381-99387). Each component will be billed instead. An annual or subsequent wellness visit (G0438/G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091).

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Subsq AWV	G0439 CG	4/2/2017	1	$ 175.00
0521	Breast/Pelvic	G0101	4/2/2017	1	$ 75.00
0521	Pap Smear	Q0091	4/2/2017	1	$ 50.00
0001	Total Charge				$ 300.00

Each charge is listed individually. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

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)

Modifier 59 OR Modifier 25

Either Modifier-59 *OR* Modifier-25 may be used when there are two encounters on the same day.

Modifier-59 indicates that separate conditions being treated are totally unrelated.

Modifier-59 Example

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 4	99214 CG	7/26/2018	1	$ 340.00
0521	Laceration	12002 59	7/26/2018	1	$ 200.00
0001	Total Charge				$ 540.00

Modifier-59 and Modifier-25

Either Modifier-59 *OR* Modifier-25 may be used when there are two encounters on the same day.

Modifier-59 indicates that separate conditions being treated are totally unrelated.

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.

Treatment Plans or Home Care Plans

Treatment plans and home care oversight provided by RHC or FQHC physicians to RHC or FQHC patients are considered part of the RHC or FQHC visit and are not a separately billable service.

(Medicare Benefit Policy Manual. Chapter 13)

Transitional Care Management

TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

TCM services are billable only when furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), skilled nursing facility, or community Behavioral Health center.

Transitional Care Mgmt

TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

99495/99496 Transitional Care Management

CPT Code 99495

Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)

CPT Code 99496

Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)

TCM Claim Example

TCM Service - No Other Services to Report

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	TCM	99495CG	4/2/2016	1	$ 150.00
0001	Total Charge				$ 150.00

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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