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REVENUE CYCLE MANAGEMENT IN THE RHC

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INDIANA RURAL HEALTH ASSOCIATION

Indiana Rural Health Association

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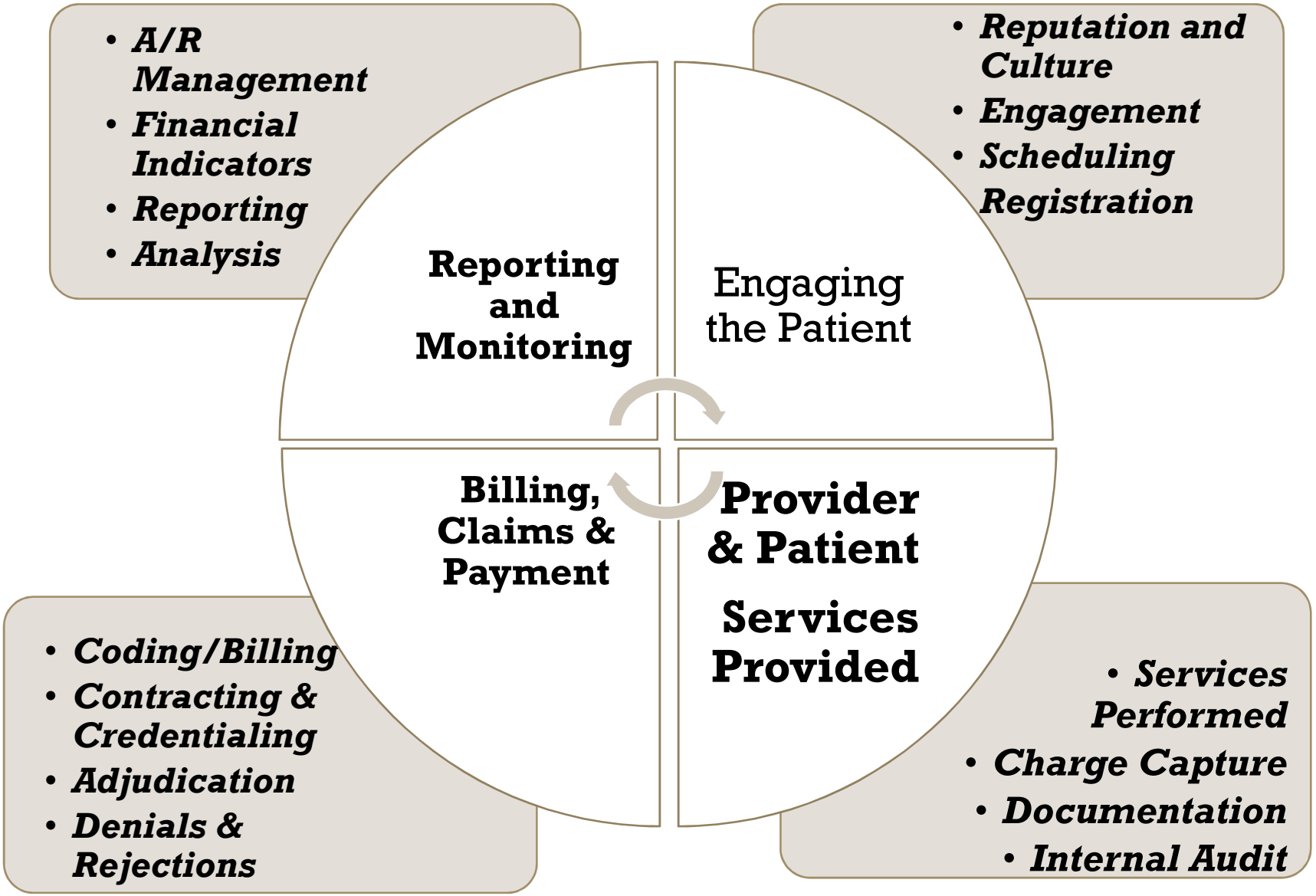
Revenue Cycle: All of the administrative and clinical processes which represent the "life cycle" of a patient account from engagement through payment resolution for an encounter, an episode of care or a series of recurring encounters.

The inter-related functions, when executed efficiently, result in the maximum reimbursement in the shortest amount of time (A/R days). A weakness in any of the individual processes can directly effect the overall revenue cycle performance.

We tend to think of RCM as after the fact, back-end functions when in fact most of our opportunities for optimizing revenue cycle performance and maximizing reimbursement are found early in the revenue cycle.


• A/R Management
• Financial Indicators
• Reporting
• Analysis
• Reputation and Culture
• Engagement
• Scheduling
Registration
Reporting and Monitoring
Engaging the Patient
Billing, Claims & Payment
Provider & Patient
Services Provided
• Coding/Billing
• Contracting & Credentialing
• Adjudication
• Denials & Rejections
• Services Performed
• Charge Capture
• Documentation
• Internal Audit

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PATIENT ENGAGEMENT & THE PATIENT EXPERIENCE

I. The Patient Visit

II. Clinical Workflow

PRE-APPOINTMENT ENGAGEMENT: HOW'S YOUR REPUTATION?

- In your Community?
- With your Patients?
- With your Employees?

Excellent - Great

MEH!

Less than Good

- If your reputation is less than excellent, you need to take deliberate action to rebrand your RHC and create a culture that rewards employees and values patients.

- Disgruntled employees can have a worse effect on culture and reputation than dissatisfied patients. You don't want either!

- Know your community and seek to serve its needs.

- Be visible in the community.

- It's not your grandfather's clinic any longer so don't keep doing the same wrong things over and over again. Change for the better.

WHAT YOUR PATIENTS ARE REALLY THINKING?

Didn't I fill out this same paperwork last month?

I have been waiting over an hour. Isn't my time valuable, too?

What will I owe for today's visit? They don't always know.

I could have been in and out already at the Walgreens on 10th Street by now.!

Seeing Your Clinic from your Patient's Point of View

- Ease of Scheduling
- Paperwork or Process Burden
- Redundancy
- Staff Attitude
- Wait Times (front & back)
- Convenience
- Do I feel welcomed and appreciated?
- Did I receive quality of care?

WHAT KIND OF PATIENT IS OUT THERE?

Is it the medicare patient with multiple comorbidities?

Probably not We either have them or we can't move them.

Is it those who can't travel very far due to either lack of $ or lack of capacity?

Probably not We probably have them due to our location or they are not going to come due to their limitations.

Is it the loyal baby boomer?

Probably not We already have them and if we don't they are too loyal to change.

WELL, WHO IS OUR TARGET MARKET?

The younger and more mobile patients…oh no! They don't exist.

The younger and more mobile crowd are not patient therefore they are not PATIENTS…they are CONSUMERS.

WHAT ARE THE CHARACTERISTICS OF THESE CONSUMERS/PATIENTS?

1. They have grown up with a smart phone at their disposal.
2. Face to Face engagement is not a driving issue with them.
3. Texting is their preferred means of communication.
4. They have grown accustom to longer commutes for work, for entertainment, and for a better variety of goods and services.

WHAT ARE THE CHARACTERISTICS OF THESE CONSUMERS/PATIENTS? CONTINUED

5. They want things on their timetable, the news, shows, playlists. They want to speak things into existence ("Alexa, turn on the lights and give me the weather.")

6. References and resumes are not as important as Reviews. Social media lets them know who to choose.

7. They don't look at a TV schedule and adjust their E-schedule to watch a certain show. They watch what they want and when they want it.

WHAT ARE THE CHARACTERISTICS OF THESE CONSUMERS/PATIENTS? CONTINUED

8. Like their handheld GPS, they have options and they are always considering how to overcome delays.

9. They do not tolerate bad processes, they expect to key in their name once.

10. Due to dwindling commerce in rural America, they are probably commuting to work in a larger community.

11. Wages aren't rising as fast as costs, so their time is at least as valuable as anyone at the clinic.

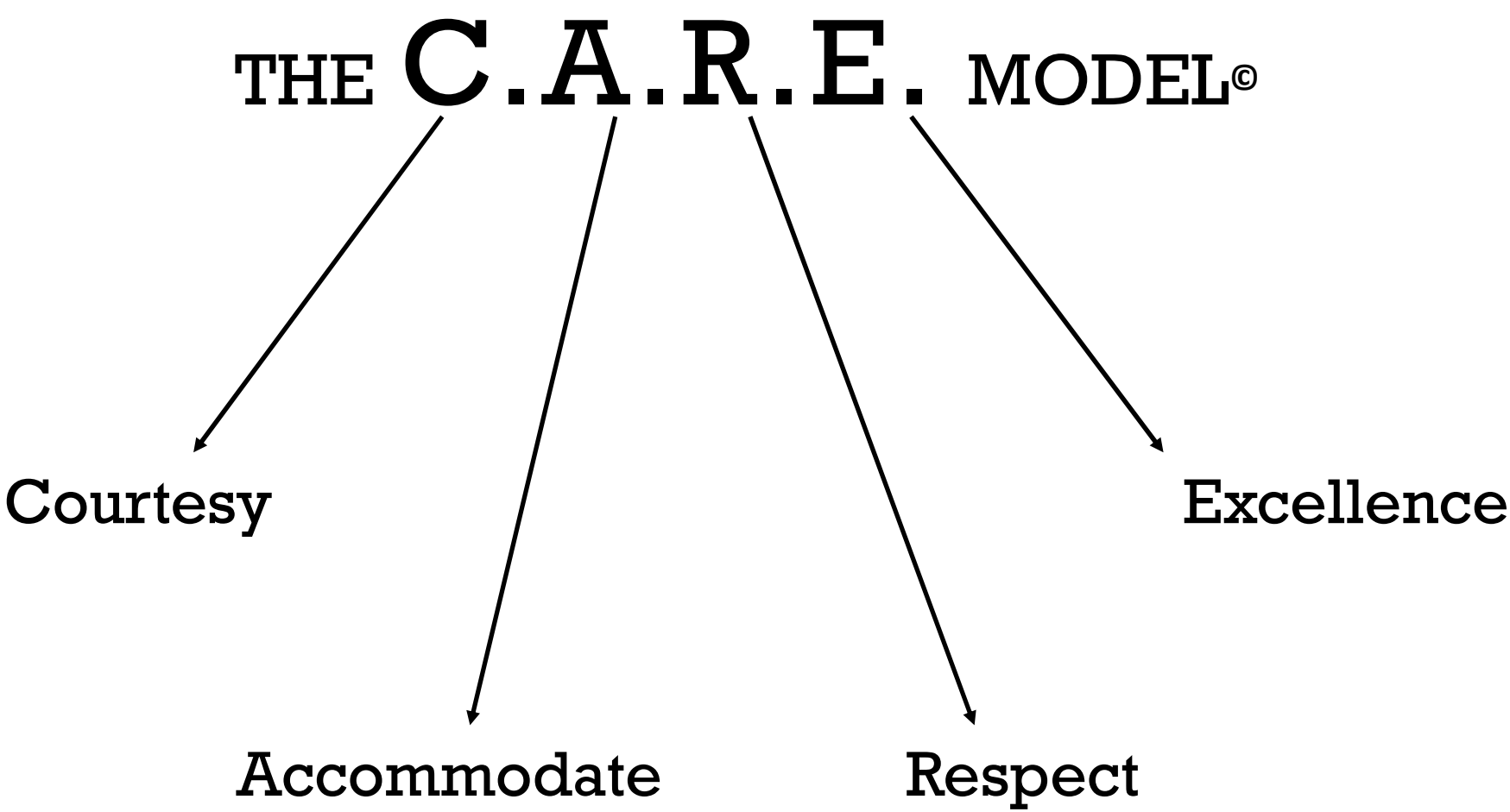
Who are your patients?

Know the demographic profile of your community or service area:

- Age
- Gender/Sex
- Income
- Education Attainment
- Average Commute Time
- Household status
- Competition/Referral Base

The success of any business or industry is to attract and retain consumers. This is no different in health care. Our patients are our consumers, our customers!

DO PATIENTS NEED US MORE THAN WE NEED THEM? OR DO WE NEED PATIENTS MORE THAN THEY NEED US?



Customer Service Model – C.A.R.E.

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WHO COMES 1ST?

THIS IS CLOSER TO THE SIGN WE NEED

Patients come First and everyone else is second!

Patients/Customers can recognize disrespect better than we can!

- Ease of Scheduling; Same day appointments
- **Well-trained, welcoming, dedicated, unburdened front desk staff**
- Customer service and excellence
- Minimize Paperwork and Redundant Processes
- Give them something they can't get at the "doc-in-box". Give them something they do get there.
- Clear, non-retaliatory, communication about financial practices and patient responsibility.

Engaging patients through EHR and Patient Portals

Richard Frankel, PhD, Professor at University of Indiana School of Medicine, has created the acronym **(POISED)** for a model providers can use to enhance patient engagement when using laptops or tablets in the exam room.

Information about his model and a longer article published in JAMA can be found at these links.

http://news.medicine.iu.edu/releases/2015/11/frankel-exam-room-computing.shtml

https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2473626

Frankel's POISED Model

•Prepare - review electronic medical record before seeing patient.

•Orient - spend 1 to 2 minutes in dialogue with the patient explaining how computer will be used during the appointment.

•Information gathering - don't put off data entry as patients may question how seriously their concerns are being taken if physician does not enter information gleaned from patient into computer from time to time.

•Share - turn the computer screen so patients can see what has been typed signaling partnership and also serving as a way to check that what is being entered is what was said or meant.

•Educate - show a graphic representation on the computer screen of information over time, such as patient's weight, blood pressure or blood glucose, so it can become basis for conversation reinforcing good health habits or talking about how to improve them.

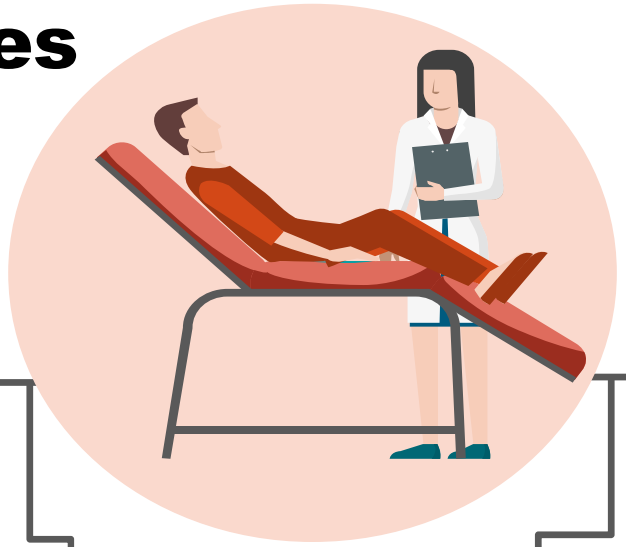
•Debrief - Exam room computers provide ideal opportunity to use "teach back" or "talk back" format for doctor to assess the degree to which recommendations are understood by the patient and correct as necessary.

Educating and Engaging Patients through Technology

- Registration Kiosks
- Sign-in Tablets
- Electronic signatures for consents
- Understanding visit summaries
- Patient Portals
- Understanding electronic transmission of claims
- Understanding electronic medical records
- Being practical while embracing HIT

Understanding Your Work Processes

- Encounter or Visit
- Service Provided
- Assess/Treat
- EHR/Clinical Documentation
- Redundancy



Marketing

Patient Engagement

Registration

Front Desk is Key

Coding

Charge Capture

Payor Contracting

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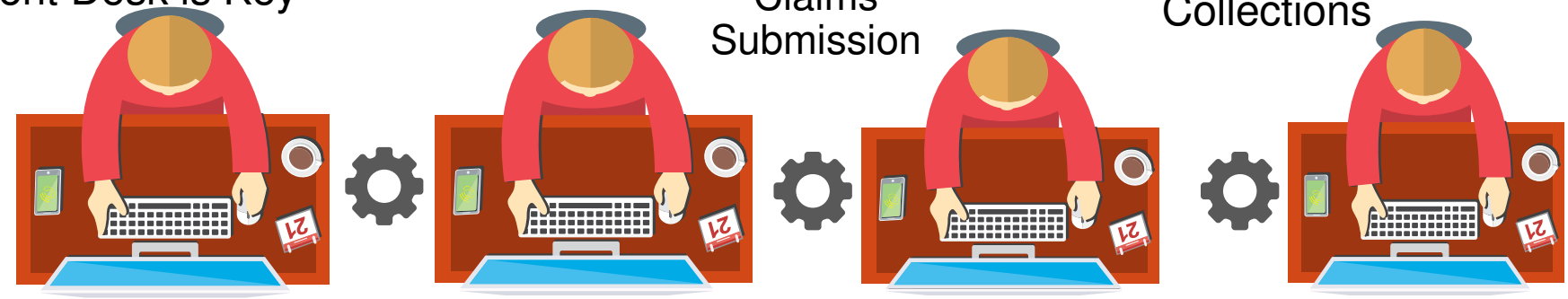
Claims Submission

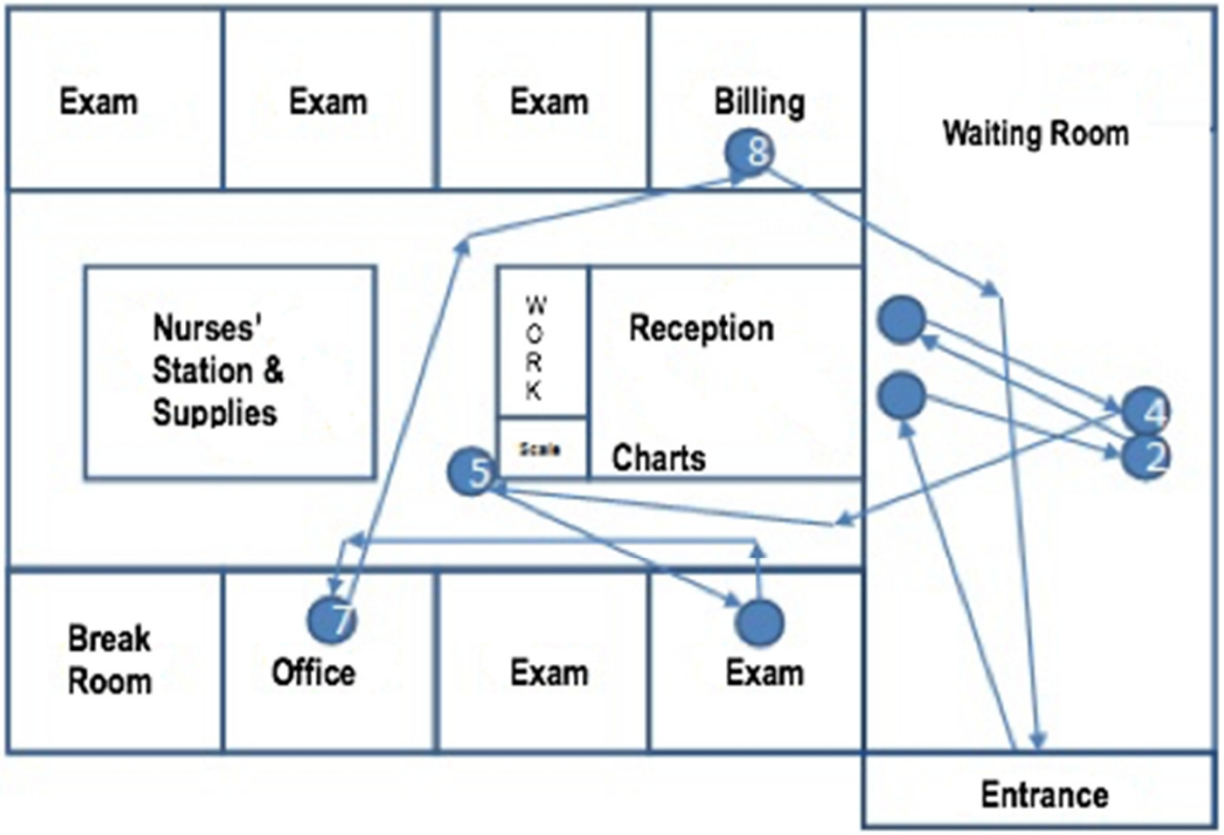
Rejection/ Denial Management

Collections



Quality and Performance Improvement

Use Tools to Gain Understanding



	Step	Begin	End	Activities	Elapsed Time
1	Arrive	2:25	2:25	Sign in	0
2	Wait	2:25	2:30		5
	Check-in	2:30	2:33	Ins. card, co-pay, updates	3
4	Wait	2:33	2:40		7

Spaghetti Mapping

Follow the motion to identify areas for improvement; eliminate redundancy; ensure charge capture; and streamline processes for both patients and staff.

PATIENT ACCESS/REGISTRATION

COMMON ROADBLOCKS IN PATIENT ACCESS/REGISTRATION

- Not having the right people in those roles
- Staff not adequately trained or don't have the tools they need
- Establishing medical necessity or getting authorization prior
- Incomplete/poorly designed forms/duplicated info
- Patient demographics not verified.
- Health plan not verified. It's worth the $ to get verification add-on to your system.
- Registration errors/omissions.
- Payer tables not well maintained—too messy to pick correct one.
- Secondary Medicare Payer questionnaire
- Third-party liabilities/Workers Comp determination

UPFRONT/POS COLLECTIONS

- Make sure your staff is knowledgeable about how different health plans are structured.
- Understand High Deductible Plans and off-setting HSA and MSAs.
- Have a financial counselor or supervisor available to discuss payment options. Protect your patient access staff from confrontation.
- Verify coverage and deductibles in advance. Use system tools to reduce on- phone time or bottlenecks.
- Train staff to be casual but direct about the patient's anticipated cost share of the service.
- Good customer service does not mean we are too nice to take care of business.

COMMON ROADBLOCKS IN CHARGE CAPTURE

- Workflow inefficiencies
- Poorly designed templates or forms
- Illegible notes
- System limitations and security matrix problems
- Visits not Reconciled
- Missed Charges (who enters what?)
- Other Charge Errors
- Charges for services not performed; wrong service captured.
- Late Charges
- Chargemaster/Fee schedule errors

DOCUMENTATION ERRORS

- Services Performed but Not Documented/Captured
  - Lab
  - Injections
  - Nursing Services
  - Provider Services
- Order not on chart/ Telephone Orders
- Chief Complaint not addressed or Diagnosis is inconsistent with CC.
- Discrepancies in the Record (gender/laterality/HPI & Exam)
- Diagnosis Sequencing is incorrect
- Diagnoses coded that were not addressed/related to visit.
- Lab results not on chart or reviewed
- Poorly Designed or Written Notes/Templates
- **Inadequate EHR Mastery**
- **Unsigned or Incomplete Records (30 day?)**
- **Bills on hold for provider review/finalization.**

ERRORS IN CLAIMS PROCESSING

- ✓ **Payers not set up correctly in your system**
- ✓ Providers/provider numbers not set up correctly in your system
- ✓ Incomplete Credentialing or Provider Enrollment
- ✓ NUBC Guidelines Not Followed
- ✓ Missing Condition Codes
- ✓ Bypassing Billing Edits (adding -59)
- ✓ Clearinghouse/Software Problems/EDI Issues
- ✓ Submitting Duplicate Claims
- ✓ Missing or incomplete patient information
- ✓ Claim submitted to wrong payer
- ✓ Use of non-specified codes
- ✓ Conflicts with payer's business rules
- ✓ Payers do make mistakes

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RHC BASICS AND MEDICARE BILLING

IT'S ALL ABOUT THE ENCOUNTER !

RHC visits (encounters) are medically necessary face-to-face medical or mental health visits or qualified preventive visits between the patient and a physician, NP, PA, CNM, CP, or CSW during which a qualified RHC service is furnished.

Qualified preventive and screening services may also be standalone RHC visits.

Citations:

IOM, Medicare Policy Benefit Manual, Chapter 13, Section 40

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf

FACE-TO-FACE, ONE ON ONE (PHYSICIAN, NP, PA or LCSW↑)

+

MEDICALLY NECESSARY

+

LEVEL 2 OR HIGHER Requires a Provider*

=

RHC ENCOUNTER (Billable)

* Or a procedure on QVL or Preventive Service or TCM or ACP

CPT® 99211 VISITS ARE NOT BILLABLE STANDALONE MEDICARE RHC ENCOUNTERS.

- An incident-to service which occurs subsequent to an RHC encounter may be bundled with an otherwise billable visit within 30 days provided there is appropriate clinical documentation of the service.
- An injection only visit does not meet the definition of a RHC encounter and cannot be billed as a standalone visit.

Citation: https://med.noridianmedicare.com/web/jfa/education/event-materials/rhc-qa

PROVISION OF SERVICES

- No services can be provided without a RHC provider being in the clinic.
- A provider must be in the RHC during all posted patient care hours.
- Patients should not be roomed in advance of a provider's arrival.
- No patient care services can be performed without a provider present.
- Visits must be medically necessary to be billable Medicare/Medicaid encounters:
  - No medication refill only visits without continued E & M.
  - No lab result visits only when labs are normal
  - No injection only visits (allergy shots, ABX, etc.)
  - Suture removal or bandage change without additional face to face
  - Services can be bundled into another RHC encounter

RHC CORE SERVICES

- RHC services are professional services including evaluation & management services, procedures typically performed in a medical office, preventive service and RHC encounters taking place in other qualified settings.
- Technical components of diagnostic services, including lab are not RHC core services and are not reimbursed by the all-inclusive rate (AIR).
- Venipuncture is included in the AIR.
- 51% Primary Care; See 42 CFR 491.9 and SOM, Appendix G.

RHC REQUIRED LAB TESTS

The RHC provides basic laboratory services essential to the immediate diagnosis and treatment of the patient, including:

(i) Chemical examinations of urine by stick or tablet method or both (including urine ketones);

(ii) Hemoglobin or hematocrit;

(iii) Blood glucose;

(iv) Examination of stool specimens for occult blood;

(v) Pregnancy tests; and

(vi) Primary culturing for transmittal to a certified laboratory.

Citation:
42 CFR 491.9

REIMBURSEMENT

- RHCs can be Independent or Provider-Based.
- RHCs are paid an all-inclusive rate by Medicare (CMS) through claims filed with the MAC.
- Independent RHCs are capped for 2018 at $83.45. (1.4% over the 2017 capped rate of $82.30).
- Provider-based RHCs with parent entity < 50 beds are not capped. Bed count is not licensed beds, but is determined by available beds as defined by CMS.
- The AIR is adjusted annually based on the cost report data calculation.
- Medicaid rates are adjusted each year and are set based on services & area.

Rate Calculation

Total Allowable Costs to Provide RHC Services

$$\frac{\text{Total Allowable Costs to Provide RHC Services}}{\text{\# of Visits that meet the Encounter Definition}} = \text{RHC Rate}$$

PATIENT DEDUCTIBLE AND COINSURANCE

- The Part B Deductible amount for the current calendar year is applied to RHC Visits. Pts with Part A only not covered.
- $183.00 for 2017 & 2018
- Co-insurance = 20% of total visit charges –not the Medicare Fee-for-service Allowable.
- Medicare remit will be 80% of the RHC AIR. The cost share will be 20% of charges.
- At the first of each calendar year, the first RHC claim for the patient may reflect a negative payment if the encounter rate is less than the deductible, because Medicare expects the RHC to collect the Part B deductible amount.

RHC FEDERAL REGS & GUIDANCE

42 CFR § 491
https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part491.pdf

CMS Policy Benefit Manual, Chapter 13
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

CMS Claims Processing Manual, Chapter 9
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

State Operations Manual, Appendix G
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

WHAT IS APPENDIX G?

- It is sub-regulatory guidance; an interpretive guide for state surveyors.
- A 90-page document; expanded from previous version that had 24 pages.
- New instructions to surveyors with stricter requirements to evidence the survey J-tags.
- J-tags are renumbered.
- Gives surveyors instructions to interview patients, staff and providers on policies and roles.

FOR EXAMPLE:

- Surveyors are instructed to observe medical services being performed (be in exam room).
- Requires more physician/medical director involvement.
- Review of biomedical equipment inspections to be included in annual program evaluation.
- Emergency kit contents defined.
- Medical records/review of records/program evaluation redefined.

KNOW 42 CFR §491

- Take surveyor back to CRF
- Appendix G is interpretive guidance—not the law.
- Some provisions expected to be rewritten—to correct overstepping.
- Some items in proposed RHC Modernization Act.
- Review your policies and procedures.

RHC MEDICARE BILLING

UB-04 RHC BILL TYPES

Bill Type	Type of Service	Comment
711	RHC Covered Services; or mixed covered/non-covered	For example: covered services with a B-12 injection
710	All charges are non-covered; claim is sent to trigger denial	Condition Code 21
717	Adjusted Claims	Replacement of Prior Claim; Comment on reason
718	Cancelled Claims	Void already processed claim.

RHC BILLING BY TYPE MATRIX

Type of RHC	Encounter Professional Services RHC Service	CLIA Lab Performed in RHC	Other Technical Components (non-RHC)	Professional Services Outside RHC Hours*
Independent or Freestanding	Part A UB-04	Part B Form 1500	Part B Form 1500	Part B Form 1500
Provider-Based	Part A UB-04	Billed to MAC by Parent hospital TOB 141/131 for PPS hospital; CAH: 851.	Billed to MAC by Parent hospital TOB 131 for PPS hospital; CAH:851	Billed to MAC as a professional service or CAH Method II Billing.

* Don't double-dip; don't bill Part B for RHC services; don't pick & choose.

RHC BILLING TYPE EXAMPLE

Mary presents to ABC Rural Health Clinic, with symptoms of a lower respiratory infection. The provider orders an in-house chest x-ray to confirm the diagnosis. During the ROS and exam, the provider also suspects that Mary may have a UTI. An in-house UA (one of the required RHC tests) is also performed. Mary also receives one unit of Rocephin IM.

*Red is provider-based RHC.

Service	Billed On	Provider #	Reimbursed
E & M Service for office visit (99214)	UB-04	RHC Number	Encounter Rate AIR
Rocephin (J0696)	UB-04	RHC Number	Encounter Rate AIR
Urinalysis	1500/ UB-04	Part B Group # if independent; Hospital # if provider-based	PFS, Lab Fee Schedule
X-ray (Technical Component Only)	1500/UB-04	Part B Group #; Hospital # if provider-based	PFS, OPPS or % of charges.

REVENUE CODES CPT® & HCPCS® CODES

Revenue Codes are 4-digit number (the leading zero is sometimes omitted) that indicates the place or type of service the patient received. When the revenue code is correlated to a CPT®/HCPCS®, the payer can determine the appropriateness of the service based on where it was provided.

CPT ®/HCPCS ® Codes are five characters in length and can be numeric or alphanumeric. Level I HCPCS codes are identical to the AMA CPT codes and are used to report professional and technical services. Level II HCPCS codes begin with a letter and are used to report supplies and other services. For example J codes for drugs or G codes for Medicare services. Category II CPT codes are used to report outcomes and data measure.

REVENUE CODES: PLACE OF SERVICE

Revenue Code	Description
0521	Clinic Visit by a member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at SNF (includes swingbeds)
0525	Visit by a RHC practitioner to a member in a Part B SNF or Nursing Facility or other residential facility
0528	Visit by a RHC practitioner to other non RHC site (e.g., scene of accident)

For Medicare claims only.

REVENUE CODES FOR CPT/HCPCS® BILLING

Revenue codes are used in institutional billing to reflect the place of service and to validate the service performed in that place of service.

All Revenue codes **EXCEPT** the following are allowed for RHC billing:

002X-024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X-072X, 080X-088X, 093X, 096X-310X

Some common allowed Revenue codes in addition to 52x might include:

0250: Pharmacy (no J code)
0636: Drugs with J code
0300: Venipuncture
0420, 0430, 0440: PT/OT/ST
0780: Telemedicine site
0900: Behavioral Health

QUALIFYING VISIT LIST

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

Codes in black type could be billed as qualifying standalone services for dates of services and processing between 4/1/2016 and 9/30/2016.

Codes in red type could be billed as qualifying standalone services for process dates after 10/1/2016 when used with the CG modifier.

ALL QVL codes can now be appended by –CG.
QVL is not exclusive list.

RHC BILLING AFTER 10/1/2016

- CPT/HCPCS® Level Codes are reported for ALL services that are provided.
- Revenue Codes are reported for each CPT/HCPCS® Code.
- ALL Charges are totaled and reported on the line with the ***qualifying visit code*** for that encounter. This is the "pay" line.
- The qualifying visit code/pay line is designated by the **CG modifier**. All charges are rolled up to this line item. This line is either the E & M code or the code which is most closely related to the chief complaint.
- All other line items must include a charge amount of ≥ $.0.01. The amount may be your actual charge or the penny amount.
- The total line (0001) will NOT equal the total for all charges. It will appear overstated. Coinsurance is calculated from the total charges line and not the total line.
- After 10/1/2016 (processing date), all qualifying visit codes should be billable as standalone codes. The CG modifier will trigger the AIR.

THE –CG "PAY" LINE

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.

A RHC visit must include one of the services listed on the RHC Qualifying Visit List. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the CMS RHC center webpage. The code appended with –CG should be the service most related to the reason for the visit.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf

MORE ON THE –CG MODIFIER

- The –CG Modifier is appended to the first CPT® line item on a claim for which the all-inclusive rate (RHC rate) will be paid. There may be one or more line items on the claim. The –CG modifier is only applied to the first service reported.
- All charges are combined on the first line item with the -CG modifier. **That line is used to calculate the deductible and co-insurance lines.**
- Other lines are reported at the full charge or at .01.
- The total line will appear overstated.
- The –CG modifier is not required to be appended to any preventive service or any service which is reimbursed differently. For example, care management, breast screening, etc.

RHC CLAIM EXAMPLES

Note: Codes and Prices in Examples for demonstration purposes only and are not intended to suggest specific methodologies or clinical scenarios.

RHC ENCOUNTER WITH E & M ONLY

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est Pt III	99213 CG	11/01/2017	1	100.00
0001	Total Charge				100.00

Provider performed an E & M service ($100.00) for a problem which required no lab, no ancillary or incidental services or other non-RHC services. The patient responsibility is $20 and the MAC will reimburse 80% of rate if the deductible has been met.

RHC Encounter with In-Office Procedure Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	I & D Abscess	10160 CG	11/01/2017	1	150.00
0001	Total Charge				150.00

Provider performed a simple I & D ($150.00) during this encounter. No other services were provided. The supplies and local anesthesia would be integral to the procedure. The patient would be responsible for a $30 co-insurance payment.

RHC Encounter with Multiple Services # 1

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/1/2017	1	250.00
0521	I & D Abscess	10160	11/1/2017	1	150.00
0001	Total Charge				400.00

Provider performed an E & M service ($100) and an in-office procedure ($150.00) during the same visit. The supplies and local anesthesia would be integral to the procedure. The patient would be responsible for a $50.00 co-insurance payment. The total 001 line appears overstated.

RHC Encounter with Multiple Services # 1- Alternative Method

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2017	1	250.00
0521	I & D Abscess	10160	11/01/2017	1	.01
0001	Total Charge				250.01

Provider performed an E & M service ($100) and an in-office procedure ($150.00) during the same visit. The supplies and local anesthesia would be integral to the procedure. Additional service items are reported ≥ .01. The patient would be responsible for a $50.00 co-insurance payment. The total 001 line appears overstated. Using this method depends on your PM/EHR and your facility's method for tracking charges.

RHC Encounter with Multiple Services #2

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2017	1	190.00
0521	Inj Admin	96372	11/01/2017	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2017	2	50.00
0001	Total Charge				255.00

Provider performed an E & M service ($125) and an abx injection ($15 + $50) during the same visit. Also, a UA and an x-ray were performed in the RHC. Total RHC services would be $190.00. The patient would be responsible for a $38.00 co-insurance payment. The total 001 line appears overstated. ***Lab and x-ray services would be billed separately under the appropriate method for the type of RHC.***

RHC Encounter with Multiple Services #2

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2017	1	190.00
0521	Inj Admin	96372	11/01/2017	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2017	2	50.00
0001	Total Charge				255.00

Provider performed an E & M service ($125) and an abx injection ($15 + $50) during the same visit. Also, a UA and an x-ray were performed in the RHC. Total RHC services would be $190.00. The patient would be responsible for a $38.00 co-insurance payment. The total 001 line appears overstated. ***Lab and x-ray services would be billed separately under the appropriate method for the type of RHC.***

RHC Encounter: Office Visit & EKG

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2017	1	145.00
0521	EKG- Prof	93010	11/01/2017	1	20.00
0001	Total Charge				165.00

Provider performed an E & M service ($125) and an EKG tracing/TC ($40) and interpretation/PC ($20) during the same visit. The RHC provider read the EKG. Total RHC services would be $145. The patient would be responsible for a $29.00 co-insurance payment. The total 001 line appears overstated. Additional service lines could be reported ≥ 0.01. ***The technical component of the EKG ($40) would be billed separately under the appropriate method for the type of RHC.***

RHC Encounter: Mental Health Visit Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Psych Eval	90791 CG	11/01/2017	1	200.00
0001	Total Charge				200.00

Provider performed an Psychiatric Diagnostic Evaluation ($200) on the date of service. Total RHC services would be $200. The patient would be responsible for a $40.00 co-insurance payment.

RHC Encounter: Medical Visit and Mental Health Visit on Same Date of Service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV New	99204 CG	11/01/2017	1	175.00
0900	Psych Eval	90791 CG	11/01/2017	1	200.00
0001	Total Charge				375.00

The physician performed an sick visit ($175) and the behavioral health provider performed a psych eval ($200) on the same date of service. Both services would be reported separately with the –CG modifier. Total RHC services would be $375.00. The patient would be responsible for a $40.00 co-insurance payment. Medication management for behavioral health if it were incidental-to the medical visit would not be a separately billable mental health visit.

MODIFIERS -59 OR -25

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has an injury and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit code, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

This is an unconventional use of -59 and is only used in this way, unique to RHC billing of multiple visits on the same date of service.

Use of modifiers (-59, -25) other than the -CG modifier on Medicare claims with multiple services may trigger an incorrect overpayment.

Multiple Encounters on Same Date of Service Different Problems

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est	99213 CG	11/01/2017	1	175.00
0521	Laceration	12001 59	11/01/2017	1	150.00
0001	Total Charge				325.00

The physician performed an E & M service in the morning to manage the patient's chronic conditions. Later in the afternoon, the patient cuts his hand while working in his garden. On the second visit of the day, the provider repairs the 2 cm laceration. The first service is appended with –CG. The second service is appended with -59. Total RHC services would be $325.00 The patient would be responsible for a $65 co-insurance payment. The RHC should receive two AIR payments.

WELLNESS VISITS

Medicare wellness visits and screening visits and Commercial wellness visits are not typically the same services. Make sure that providers understand the requirements for each service as defined by the payer. For example, the Medicare AWV is not a physical exam at all although it does require that the provider perform the service in the RHC. Medicare does not reimburse for routine services (i.e., annual physical or yearly check-up). However, most Medicare patients have chronic comorbidities which require ongoing, periodic management.

PREVENTATIVE SERVICES GUIDE

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

This CMS reference give examples of preventative services and indicates when the AIR is received and how the deductible and coinsurance amounts are applied.

The –CG modifier is appended if the only service provided is the preventative service. The –CG modifier if not needed for the IPPE but may be added. Preventative services provided on the same day as a qualifying medical visit are reported but are not bundled into the –CG line.

IPPE is the ONLY preventive service which will qualify for an additional AIR on the same DOS as a sick visit.

Preventive services should be tracked for cost-reporting.

RHC Encounter: IPPE Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2017	1	200.00
0001	Total Charge				200.00

The physician performed IPPE (Welcome to Medicare) service on this date of service. No –CG modifier is required. The patient has no cost share for this visit because the deductible and co-insurance is waived.

Is the IPPE the same as a beneficiary's yearly physical?
No. The IPPE is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

RHC Encounter: IPPE and Sick Visit on same date of service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2017	1	150.00
0521	IPPE	G0402	11/01/2017	1	200.00
0001	Total Charge				350.00

The physician performed IPPE ($200) and an E & M ($150) for a problem visit on the same date of service. The office visit is listed first with the -CG modifier. The patient has no cost share for the IPPE service because the deductible and co-insurance is waived. The co-insurance amount due for the sick visit is $30.00. The RHC will receive two AIR payments for this visit.

You should track all preventive services for cost-reporting purposes.

RHC Encounter: IPPE with EKG Interpretation/Report as Part of IPPE

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2017	1	200.00
0521	EKG IPPE Interpret/Report	G0405	11/01/2017	1	100.00
0001	Total Charge				300.00

The RHC physician performed IPPE ($200) and also interpreted the EKG ($100) performed as part of the IPPE. Only the HCPCS codes for the two services are reported on each respective line. The clinic will receive one AIR rate but the coinsurance and deductible will be waived per HCPCS code. Use the G-code when EKG is performed as part of IPPE.

You should track all preventive services for cost-reporting purposes.

EKG Billing in Rural Health Clinics

Code	Description	RHC UB-04	Independent RHC Part B	PBRHC Hospital side
93000	EKG, 12 Lead with interpretation/report	NO	NO	NO
93005	EKG, 12 lead, tracing only	NO	YES	YES
93010	EKG, 12 lead, interpretation and report only.	Maybe*	NO	Maybe*

* Depends on the provider who does the interpretation and the report.

Medicare Annual Wellness Visit

- Is NOT a routine physical exam.
- Must include certain components
- Is payable as a stand-alone RHC visit when it is the only service performed
- Is not payable as a separate service when performed on the same day of service as other medical or screening services.

Is the AWV the same as a beneficiary's yearly physical?
No. The AWV is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

RHC Encounter: "Woman Well Visit" AWV and Other Screenings

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	**AWV-Subsequent**	G0439 CG	11/01/2017	1	150.00
0521	Breast/Pelvic	G0101	11/01/2017	1	100.00
0521	Pap Smear	Q0091	11/01/2017	1	50.00
0001	Total Charge				300.00

The patient received a subsequent AWV along with other preventive services on the same date of service. The –CG is appended to the AWV. There is no cost share for this visit.

CARE MANAGEMENT

RHC Care Management FAQ

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

RHC Care Management MLN

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf

New HCPCS Codes G0511 and G0512 effective 01/01/2018; 99490 is not a valid code for RHC billing of CCM after 01/01/2018. For 2019, there will be a new G-code for care management services provided by the physician or NPP.

Transitional Care Management (TCM) is also billable at the all-inclusive rate.

EXAMPLE OF CCM BILLING

CCM Reported Alone

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	CCM	G0511	02/01/2018	1	75.00
0001	Total Charge				75.00

The –CG Modifier is NOT appended to G0511 because the service is paid under fee-for-service reimbursement. The RHC will receive $62.28. Deductibles and co-insurance apply. The patient will have a cost share. These amount are for 2018.

EXAMPLE OF CCM BILLED WITH AN ENCOUNTER

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213-CG	02/28/2018	1	100.00
0521	CCM	G0511	02/28/2018	1	75.00
0001	Total Charge				175.00

If CCM is billed with another RHC service, the charge for CCM is NOT added to the first line. The –CG modifier is only added on the first line. The clinic will receive the RHC all-inclusive rate for the office visit/encounter and the $62.28 for the CCM. The coinsurance will be $20.00 for the office visit and another $12.48 for the CCM (Total $32.48). It is important to explain to the patient the value of the CCM when enrolling them.

ADVANCED CARE PLANNING

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

- As a standalone service, the AIR is paid.
- When provided on same dos as AWV, the service is included in the one AIR payment.

Hospice Patients

When providing RHC services to a Hospice Patient for an acute condition or injury not related to the hospice admitting diagnosis:

- Use Condition Code 07
- Use the diagnosis code which relates to the visit. Do not use the terminal illness as the diagnosis.

MEDICARE FLU AND PNEUMOCOCCAL SHOTS

- RHCs do **NOT** bill Medicare for Flu or Pneumococcal Immunizations on claims.
- CPT codes for administration and for the vaccine are never included in the claim detail. Can be set up as zero charge/no bill for tracking.
- Prevnar 13 immunizations are included.
- Charges for Flu and Pneumococcal Injections are not included in the total encounter charge.
- RHCs must keep a log with Patient's name, HIC, date of immunization, etc. Some EMR and PM systems will generate log; if not, must be manual.
- The immunizations are directly reimbursed on the Medicare Cost Report at the end of the year. RHC must report cost of administration, vaccine and number of immunizations.
- Medicare Advantage Plans/Medicare HMOs **are** billed for these immunizations. However, make sure your contracts have provisions for additional reimbursement. The costs of these immunizations are not included on the regular Medicare cost report.

HOME HEALTH CERTIFICATIONS AND CARE PLAN OVERSIGHT

110.2 - Treatment Plans or Home Care Plans

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Except for comprehensive care plans that are a component of *authorized care management services (see section 230)*, 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.

Part B should not be billed for Care Plan Oversight.

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REVENUE CYCLE MANAGEMENT AND REPORTING

VI. A/R Management and Rev Cycle Team Players
VII. Credit Balance Reporting
VIII. Payment Processing
IX. Patient Billing
X. Reporting and Monitoring

Identifying Your Team

Give them a seat at the table.

Lead by Example...Not by Authority

- Recognize Individual Strengths, Knowledge and Skills
- Leave Personal Agendas Outside the Door
- Strive for a Common Goal or Outcome. Be missional.
- Seek Performance and Process Improvement
- Incentivize In a Way that Strengthens Your Team

- Prevent Silo-ing!
- Encourage Collaboration
- Reward Problem-solving and creativity
- No one gets thrown under the bus!
- Zero tolerance for blame-shifting
- Accountability and Responsibility

- Maintain community engagement.
- Timely and Clear Statements
- Create Buy-In
- Positive patient-staff-community relationships
- Help patients overcome doubts about technology
- Remember that the patient is our customer. Know your community demographics.

Look for real fixes instead of Band-aids!

- Gain Feedback from Players
- Prevent Individual Work-arounds
- Go back to where the “fail” happened
- Re-engineer the process until it works better

WHAT TO DO IF YOU OUTSOURCE SOME OF YOUR RCM?

PROS & CONS OF OUTSOURCING RCM IN RURAL HEALTHCARE

Pros

- Skill and Workforce Gaps
- Health Information Technology
- Standardized Processes
- Economy of Scale
- Objective

Cons

- Loss of Local Workforce
- Moving Processes farther from the Knowledge Base
- Loss of Staff Engagement/Buy-in
- Loss of Control
- “Rural” is different

- Enter 3rd party relationships with clear expectations
- Establish and maintain clear communication
- Expect routine phone calls, reports, and collaboration.
- Don’t let the tail wag the dog!
- Evaluate performance
- Maintain local staff involvement and buy-in!

FINANCIAL PERFORMANCE METRICS

Basic Revenue Cycle Metrics

Accounts Receivables: Total amount of all outstanding patient account balances; May include total charges for accounts not yet paid or adjusted yet; May include both insurance balances or patient responsibility balances.

A/R Days: A calculation of how long it takes on average to collect one day's revenue. The calculation can be based on either gross or net amounts of revenue. Before EDI and EFT, we could expect this payment window to be 45-60 days, but now we can expect a much shorter time period for clean claims. Know your norm and the norm for each payer. Look for red flags.

DNFB: The total of gross charges/patient revenue which has not been released or finalized to drop a bill because of errors or deficiencies.

Aging: Account aging represents the outstanding account receivable amounts assigned to aging bucket based on how many days have elapsed since the original date of service. The aging can represent both insurance balances and patient balances.

Bad Debt: Accounts receivable amounts which have been determined to be uncollectable.

Basic Revenue Cycle Metrics

Contractual Adjustments: The difference between the gross charge and the amount we have agreed to receive for the service based on contracts or agreements with a payer.

Other Adjustments: Amounts adjusted off of the gross charge for reasons other than contractual adjustments. The posting categories should be set up and used in a way that helps us identify problems, trends, and internal or external issues.

Payments: Amounts posted which represent cash payments from either the patient or a 3rd party.

Credits: Amounts posted which reduce the balance but do not represent a transaction from a direct payment source.

Credit Balance: The result of posting more adjustments, payments and credits which exceed the dollar amount of gross charges. The credit balance may represent a true overpayment or can result from posting errors.

RHC PRODUCTIVITY REPORTING

FTE Monitoring Analysis of providers' hours (hours available for seeing patients) by the hour, day, and week. Common errors on cost reports because FTEs are not closely monitored.

Very seldom should we see whole number FTEs

~~2.0~~ more like 1.78

Encounters by Providers Encounters need to be captured instead of visits. CMS defined encounters need to be measured against the productivity standards for each type of provider. Keep encounters by provider even though the aggerate number is used as the test number on the cost reports.

Illustration:

Provider Type	FTE	Encounters	Prod. Std
Physicians	0.62	2,050	2,604(.62*4,200)
N/Ps	1.43	3,825	3,003(1.43*2,100)
Totals		5,875	5,607

Physicians didn't meet their productivity standard but the N/Ps did meet their standard and in the aggerate productivity standard was met.

COLLECTIONS/PAYMENTS

- **Errors in posting payments and adjustments.**
- **Adjustment and Payment Categories Misleading.**
- **Posting guidelines, checks & balances, and benchmarks.**
- **Errors created by electronic posting of remittance advices.**
- Failure to reconcile A/R activity in system to daily cash reports, actual deposits, and EFTs. Use your system reports and tools.
- Not collecting co-pays, deductibles and co-insurance amounts at the time of service.
- Not having established, written financial policies.
- Not enforcing or following up with payment plans.
- Not sending statements in a timely manner.
- Transparency and Communication with Patients.

PAYMENT POSTING & COMMON ERRORS

- If the 80% of the AIR is more than the total charges billed, the RHC will end up with a payer debit contractual adjustment. Some systems make this adjustment as an "other" adjustment and some allow you to enter a debit C/A.
- Adjustments and credits not correctly applied to the adjustment type.
- Not leaving the patient's co-insurance as a patient balance due when the AIR payment is more than the total claim amount.
- Errors resulting from electronic posting errors.
- Waiving deductibles or coinsurance.

Payments and Collections

- **Establish and Communicate clear objective expectations when contracting with 3rd parties for billing, A/R and Collection Services.**

- Have written financial policies for collection processes, for bad debt write-off and cost report treatment of bad debt. All financial classes must be managed using the same guidelines.

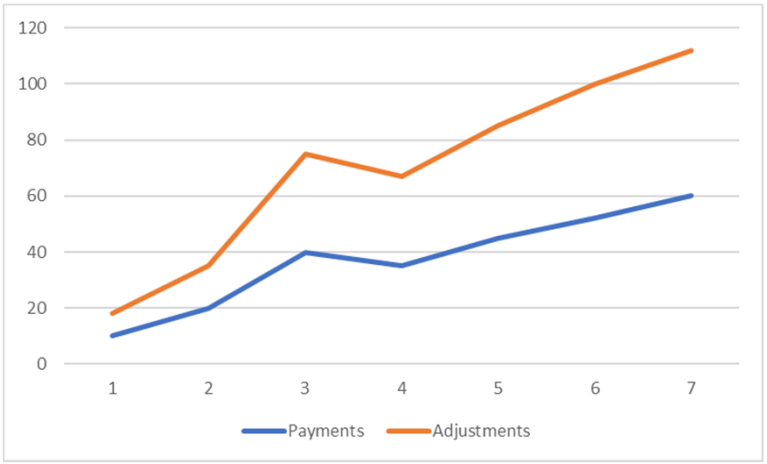
- Pull A/R back from collections for cost reporting.

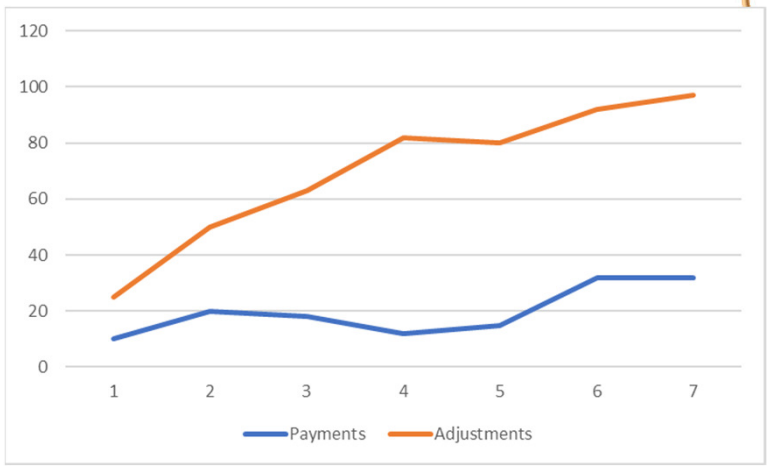
- Investigate credit balances in a timely manner to determine if the amount was created by a posting error or if an overpayment was received. Resolve credit balances as quickly as possible. Only report true credit balances.

- Strive to have a clean A/R.

- The older it is—the harder it is to resolve, if at all!

Typically, there is a proportionate relationship between total charges, payments and adjustments. If adjustments are up when payments are down, this is a red flag. Any change in the overall % of adjustments relative to other posting activity should be investigated.





To the extent that you can, have adequate segregation of duties for internal control (checks and balances).

CREDIT BALANCE REPORTING

CMS Form 838 is used to report credit balances on a quarterly basis. The certification form must be completed, signed, and submitted whether or not there are credit balances to report. Report only Medicare credit balances which indicate that Medicare actually overpaid on the claim. Don't use the credit balance report to make claim adjustments. Verify that CMS did overpay before including on form.

Fax to WPS at (608)223-7550 or mail to:

Indiana
WPS GHA Part A
MSP Department
P.O. Box 8602
Madison, WI 53708-8602

Quarter Ending	Due Date
March 31	April 30
June 30	Jul 30
September 30	October 30
December 31	January 30

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS838.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5084.pdf

Questions?
Comments?
Something to Share?

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