Rural Health Clinic Billing Medicare/Medicare Advantage

Hawkeye AAHAM 9/16/2021

Speaker

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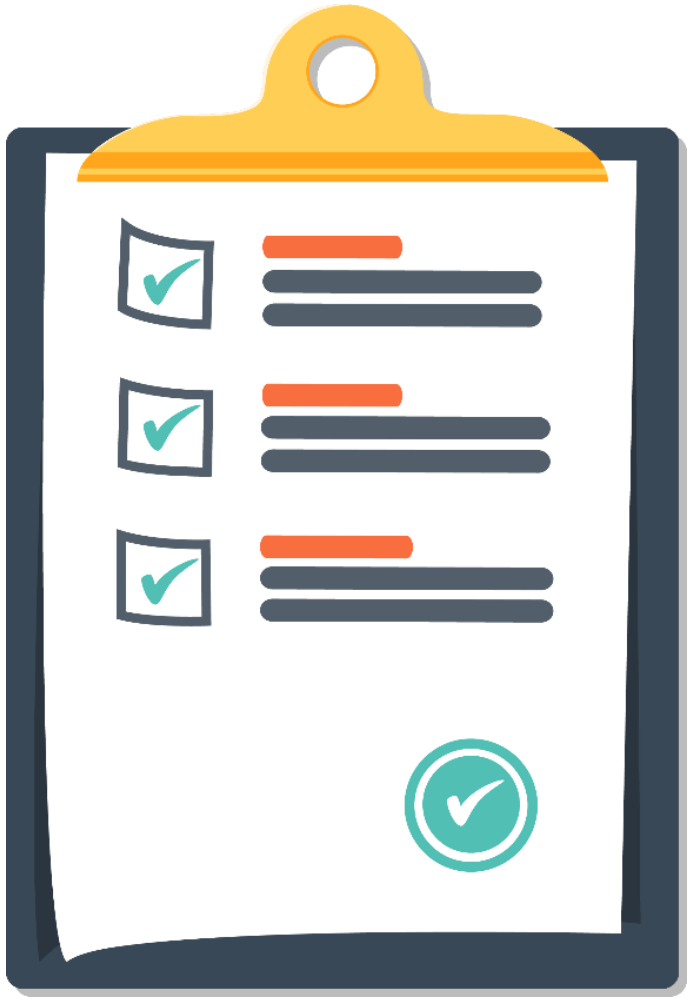
Learning Objectives



- Review Reimbursement for RHC
- Discuss RHC rule's and regulations
- Discuss Telehealth Reimbursement & Denial Trends
- When You Can vs. When You Should Bill for Telehealth Services
- Follow Up Strategies for Telehealth-related Denials

Medicare

- Medicare provides health insurance to Americans 65 and older, and younger people with certain disabilities and other health conditions.
  - Eligible the 1st day of the month in which you turn 65 years old
  - ESRD – End Stage Renal Disease
  - ALS – Lou Gehrig's disease
- Largest Health Program in the United States
- Funded by the Federal Government (and you!)

Medicare Part A

- Participant does not pay for this part of Medicare
- Eligible at 65 for the most part
- Covers:
  - Hospital Inpatient Stays
  - Skilled Nursing Facility (SNF) Stays (Swing Bed) – Following a 3 day hospital stay
  - Home Health Care (some)
  - Hospice
  - Lifetime Reserve Days = 60

Medicare Part A Coverage

- Inpatient Stay
  - Day 1-60: deductible $1484.00 per spell of illness
  - Day 61-90: coinsurance is 25% of current year deductible or $352.00 per day
  - Day 91-150: lifetime reserve days – 50% of current year deductible or $704.00 per day
- SNF Care (Swing Bed)
  - Day 1-20: no coinsurance or deductible
  - Day 21-100: 1/8 of current inpatient deductible for $176.00 per day
- Home Health
  - No coinsurance/deductible
- Durable Medical Equipment (DME)
  - 20% coinsurance-allowable
- Hospice
  - No Coinsurance or Deductible

Medicare Part B

- Eligible at age 65 years old
  - Pay a monthly premium (average $148.50)
- Services Covered
  - Practitioner Fees
  - Outpatient hospital services
  - Ambulatory Surgery Centers (ASC)
  - Durable Medical Equipment (DME)
  - Some Home Health

Medicare Part B Coverage

Medical Services

- Deductible $203.00 (2021) per year.
- Coinsurance is 20% of approved charges
  - For CAH Part B claims (851) the 20% is based on charged amount not allowed amount

Clinical Lab Services

- No deductible or coinsurance due

Home Health Care

- No deductible or coinsurance due

DME

- 20% coinsurance

Medicare Part C

- Medicare Advantage
  - Replaces traditional fee for service
  - Many times, Medicare Advantage plans include better benefits
  - Premiums are often lower than cost of regular Medicare plus a supplement
  - 5 types of Medicare Advantage plans
    - HMO's
    - PPO's
    - Private fee for service
    - Special need plans
    - Medicare Medical Savings Accounts

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Medicare Part D

- Covers prescription medications
  - Patients pay a monthly premium
  - Patients owe copays and deductibles

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Helpful Medicare References

CMS.gov
Centers for Medicare & Medicaid Services

- ✓https://www.cms.gov/Medicare/Medicare – General Site
- ✓https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index - Lab Fee Schedule
- ✓https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index – Physician Fee Schedule
- ✓https://www.cms.gov/Outreach-and-Education/Outreach-and-Education - Outreach and Education
- ✓https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html - Preventative Services
- ✓https://www.wpsgha.com/wps/portal/mac/site/home

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Rate Sheet

Provider	Component	OLD	NEW
A	Inpatient Per Diem	2,975.15	2,989.70
B	CAH - Outpatient Percentage	0.71	0.70
C	Swing Bed Per Diem	2,071.97	2,014.09
D	RHC – All Inclusive Rate	231.23	253.77
E	RHC – All Inclusive Rate	207.97	207.97

Rural Health Clinics

- Established by the **Rural Health Care Services Act of 1977**

- Assist rural communities where a shortage of physicians exists.
- Utilize non-physician practitioners (NPP) to independently provide primary care.
  - Nurse Practitioner (NP), physician assistant (PA), and clinical nurse midwife (CNM)

- Location, location, location!
  - Must be located in a non-urbanized area determined by the U.S. Census Bureau.
    - https://factfinder.census.gov
  - Must be located in a federally designated area where a shortage of health services exists
    - Designation must have come within the previous four years.
      - Primary Care Health Professional Shortage Area (HPSA), either geographic or population-group
      - Medically Underserved Area (MUA)
      - Governor-Designated and Secretary-Certified Shortage Area

Rural Health Claims

Key Fields

- Type of Bill (TOB)
  - **0710** = non-payment/zero claim that contains only non-covered charges (when no payment from Medicare is anticipated)
  - **0711** = admit through discharge (original claim)
  - **0717** = replacement of a prior claim (used to correct a previously submitted claim)
  - **0718** = void prior claim (used to cancel a previously submitted claim.

Key Fields (cont.)

- Revenue Codes
  - Qualifying visit line reported with revenue code 052x and/or 0900
    - For example:
      - **0521** Clinic visit in RHC
      - **0900** Mental health treatment/services
  - Also report other medically necessary services with the most appropriate revenue code that describes service being performed
    - For example:
      - **0300** Venipuncture
      - **0730** EKG Interpretation
    - Additional revenue lines with HCPCS code(s) and charges are informational only.

Rural Health Claims

Key Fields (cont.)

- HCPCS code
  - Required for qualifying visit
  - Also, for any services provided incident to qualifying visit, if a code exists.
- Service units = 1
  - Represents a single visit that is paid an AIR, regardless if other services are provided during the same visit (e.g., injection and drug)
  - Multiple visits with more than one RHC practitioner on the same day, represent a single visit and are only payable as one qualifying visit
    - Applies regardless of the length or complexity of visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related to the subsequent visit.
    - There are exceptions (discussed later)

Rural Health Clinic Claims: Charges

- Total charge reported on the qualifying visit line includes the qualifying visit and all items or services provided incident to the visit
  - Each additional line must include a charge
  - Payment for the additional lines is bundled into the AIR
  - CMS will accept additional service lines reported with charges equal to or great than $0.01
- *Total line (**0001 revenue code**)* is the sum of all charges reported on the claim.
  - Includes the charges for qualifying visit and additional lines
  - AIR payment is only based on the qualifying visit line(s)
  - Total line (**0001 revenue code**) is not adjudicated

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Rural Health Clinic Claims: Key Modifiers

- Modifier -CG (policy criteria applied)
  - Required to identify the qualifying visit eligible for AIR payment(s)
  - -CG line includes the total charge for the qualifying visit and other medically necessary services.
  - -CG line will trigger deductible and coinsurance, except for certain preventive services
  - -CG only reported once per date of service for a medical or preventive visit (**revenue code 052X**) and/or once per date of service for a mental health visit (**revenue code 0900**)

- Modifier -25
  - Subsequent visit is distinct or independent from an earlier visit furnished on the same day
  - Usually reported on E/M code (e.g., **99213-25**)

- Modifier -59
  - Subsequent visit was distinct or independent from an earlier visit furnished on the same day
  - Usually reported on procedure code (e.g., **12001-59**)

- Modifiers -25 and -59 are interchangeable in an RHC

Multiple Qualifying Visits and Multiple AIRs

- Medical visit and mental health visit
  - Medical visit (**revenue code 052X**) on the same day as a mental health visit (**revenue code 0900**)
    - Modifier –CG is reported on *both* qualifying visit lines
    - Modifier -25 or -59 are not reported on either line
    - Both qualifying visits would be paid as separate AIR
- Initial preventive physical examination (IPPE)
  - Separate medical visit (**revenue code 052X**) and/or mental health visit (**revenue code 0900**) on the same day as IPPE
    - Modifier –CG is reported on *both* qualifying visit lines
    - Do not report modifier –CG with IPPE
    - Modifier -25 or -59 are not reported on any line in this scenario
    - Both qualifying visits and IPPE would be paid as separate AIR

Qualifying Visit

Qualifying Visit defined

- Medically necessary **face-to-face** visit
  - Qualifying medical visit is typically an evaluation and management (E/M) type of service, procedure, or certain preventative services
    - Reported with revenue code **052X**
  - Qualifying mental health visit is typically a psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis
    - Reported with revenue code **0900**

Qualifying Visit defined (cont.)

- May include transitional care management (TCM) when all the coverage requirements are met
  - Must be furnished **within 30 days** of the date of the patient's discharge to "home" from hospital, outpatient observation, partial hospitalization, SNF, or community mental health center
  - Communication with the patient or caregiver by direct contact, telephone, or electronic media must start **within 2 business days** of discharge
  - A face-to-face visit must occur **within 14 days** of discharge with moderate-complexity decision-making (**99495**); **OR**
  - A face-to-face visit must occur **within 7 days** of discharge with high-complexity decision-making (**99496**)

RHC Example(s)

4 TOB	711	29 Accident State		Covered Days	
6 Stmt From	1/4/2021	12 Admission Date	Show Calendar	Non-Covered Days	
6 Stmt Thru	1/4/2021	13 Admission Hour		Co-Insurance Days	
EPSDT Code	EPSDT Cc	14 Admission Type	3	Lifetime Reserve Days	
		15 Admission Source	1	7 Reserved	
		16 Discharge Hour			
		17 Discharge Status	01		
		IDE #	IDE #		

UB CODING

SERVICE/CHARGE DATA

SERVICES / CHARGES

Line	42 Rev Coc	44 HCPC	44 Rat	M	M	M	M	45 Service Date	46 Units	47 Total Charge	48 Non-Covere		
1	0521	99213		CG				1/4/2021	1	$129.10		Details	

CLAIM TOTALS

RHC Reimbursement

CHARGES:		PAYMENT DATA:			
		0.00	=DRG	0.00	=RIEM RATE
129.10	=REPORTED	0.00	=DRG AMOUNT	0.00	=MSP RIM PAY
0.00	=NON-COVERED	0.00	=DRG OPER	0.00	=PROFCOMPONENT
0.00	=DENIED	0.00	=DRG CAPITAL	0.00	=ESRD AMOUNT
129.10	=COVERED	0.00	=OUTLIER( )	129.10	=HCPCS AMOUNT
DAYS/VISITS:					
		228.84	=ALLOWED AMT		
0.00	=COST REPT	0.00	=CASH DEDUCT	0.00	=G/R AMOUNT
0.00	=COVD/UTIL	0.00	=BLOOD DEDUCT	0.00	=INTEREST
0.00	=NON-COVERED	25.82	=COINSURANCE	0.00	=CONTRACT ADJ
0.00	=COVD VISITS	0.00	=PAT REFUND	0.00	=PER DIEM AMT
0.00	=NCOV VISITS	0.00	=MSP LIAB MET	203.02	=NET RIEM AMT
TOTAL PATIENT LIABILITY: 25.82				0.00	=COPAY

CLAIM LEVEL:

GROUP	CODES	AMOUNT	DESCRIPTION

REMARK CODES: MA01

SERVICE LINE LEVEL:

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOWED	GC	RSN	AMOUNT
0521	20210104	99213		CG	1	129.10	228.84			203.02
								CO	94	(99.74)
								PR	2	25.82

- AIR = 253.77
- Patient responsibility
  - 20% of total charges (minus any deductible owed)
  - Total Charges = 129.10
    - 129.10 – Deductible (0)= 129.10
    - 129.10 x 20% = 25.82
    - Total OWED = 25.82
- Medicare Responsibility
  - 80% of AIR (minus any deductible owed)
    - 253.77 – 0 = 253.77
    - 253.77 x .80% = 203.02
- TOTAL = 228.84

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RHC Example(s)

4 TOB	711	29 Accident State		Covered Days	
6 Stmt From	1/6/2021	12 Admission Date	Show Calendar	Non-Covered Days	
6 Stmt Thru	1/6/2021	13 Admission Hour		Co-Insurance Days	
EPSDT Code	EPSDT Cc	14 Admission Type	3	Lifetime Reserve Days	
		15 Admission Source	1	7 Reserved	
		16 Discharge Hour			
		17 Discharge Status	01		
		IDE #	IDE #		

UB CODING

SERVICE/CHARGE DATA

SERVICES / CHARGES

Line	42 Rev Coc	44 HCPC	44 Rat	M	M	M	M	45 Service Date	46 Units	47 Total Charge	48 Non-Covere	
1	0521	99214		CG	25			1/6/2021	1	$1,060.28		Details
2	0521	20610		RT				1/6/2021	1	$0.01		Details
3	0636	J3301						1/6/2021	8	$0.01		Details

RHC Reimbursement

CHARGES:

1060.30	=REPORTED
0.00	=NON-COVERED
0.00	=DENIED
1060.30	=COVERED

DAYS/VISITS:

0.00	=COST REPT
0.00	=COVD/UTIL
0.00	=NON-COVERED
0.00	=COVD VISITS
0.00	=NCOV VISITS

PAYMENT DATA:

0.00	=DRG
0.00	=DRG AMOUNT
0.00	=DRG OPER
0.00	=DRG CAPITAL
0.00	=OUTLIER( )
415.07	=ALLOWED AMT
57.69	=CASH DEDUCT
0.00	=BLOOD DEDUCT
200.52	=COINSURANCE
0.00	=PAT REFUND
0.00	=MSP LIAB MET

0.00	=RIEM RATE
0.00	=MSP RIM PAY
0.00	=PROFCOMPONENT
0.00	=ESRD AMOUNT
1060.30	=HCPCS AMOUNT
0.00	=G/R AMOUNT
0.00	=INTEREST
645.23	=CONTRACT ADJ
0.00	=PER DIEM AMT
156.86	=NET RIEM AMT
0.00	=COPAY

TOTAL PATIENT LIABILITY: 258.21

CLAIM LEVEL:

GROUP	CODES	AMOUNT	DESCRIPTION

REMARK CODES: MA01 M15 MA18

SERVICE LINE LEVEL:

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOWED	GC	RSN	AMOUNT
0521	20210106	20610		RT	1	0.01	0.00			0.00
								CO	97	0.01
0521	20210106	99214		CG 25	1	1060.28	415.07			156.86
								CO	45	645.21
								PR	2	200.52
								PR	1	57.69
0636	20210106	J3301			8	0.01	0.00			0.00
								CO	97	0.01

- AIR = 253.77
- Patient responsibility
  - 20% of total charges (minus any deductible owed)
  - Total Charges = 1060.30
    - 1060.30 – Deductible 57.69 = 1002.61
    - 1002.61 x 20% = 200.52
    - Total OWED = 258.21
- Medicare Responsibility
  - 80% of AIR (minus any deductible owed)
    - 253.77 – 57.69 = 196.08
    - 196.08 x .80% = 156.86
- TOTAL = 415.07

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RHC Qualifying Visits – Fun Facts

- Flu vaccine and Pneumovax vaccine(s) and administration should not be billed on the RHC claims – hospital gets paid via the cost report.

- Shingles Shot – these are not paid by Medicare and are excluded from coverage. They can be billed on the claim with a GY modifier.
  - THESE charges should not be included in total charges.

- Labs should not be billed on the claim (these can be billed on the 851 claim with hospital NPI).

Other Payers

- Medicare Advantage – follow Medicare guidelines
- Commercial – No special billing payment and billing will depend on contract
- Medicaid – Follow state rule(s)

Telehealth Vs. Telemedicine

Telehealth refers to a broad range of technologies and services to provide patient care and improve the healthcare delivery system as a whole.

Telemedicine is a subset of telehealth that refers solely to the provision of health care services and education over a distance, through the use of telecommunications technology. Telemedicine involves the use of electronic communications and software to provide clinical services to patients without an in-person visit.

Telehealth before 1135 Waivers (March 5, 2020)

Medicare

- Originating site (where the patient is located)
  - A County outside a Metropolitan Statistical Area (MSA); or
  - A Rural Health Professional Shortage Area (HPSA) in a Rural Census Tract; and
  - Be in a specific Eligible site:
    - Physician and Practitioner Offices
    - Critical Access Hospitals
    - Rural Health Clinics
    - Federally Qualified Health Centers
    - Hospital-based or CAH-based Renal Dialysis Centers
    - Skilled Nursing Facilities
    - Community Mental Health Centers
    - Renal Dialysis Facilities

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Telehealth before 1135 Waivers (March 5, 2020)

Distant Site – Medicare does not provide a definition of where a distant provider site is, but it does limit the type of provider who can provide a service. However, CMS has stated that providers cannot be located out of the country when providing services via Telehealth.

Those providers include:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurse Midwives
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Clinical Psychologists and Clinic Social Workers
- Registered dietitians or nutrition professionals

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Covered Services before Waivers

CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420–G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	G0108–G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2–11 years of age	90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12–19 years of age	90969
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	90970
Individual and group medical nutrition therapy	G0270, 97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436, G0437, 99406, 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396, G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444

Covered Services cont.

Service	HCPCS/CPT Code
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160, 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839, 90840
Prolonged preventive services	G0513, G0514

Service	HCPCS/CPT Code
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438

References

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327
- Telemedicine Toolkit (AHIMA) – Available to members of AHIMA

March 6, 2020 - New Normal?

- Most payers have relaxed guidelines and regulations
- We now have Telehealth, Check-ins and e-Visits
- Patient financial responsibilities are waived if COVID-related

Terminology

Telehealth

Audio & Video

Virtual Check-in or telephone evaluation & management

Audio only

e-Visit

Patient Portal, Secure Email, HIPAA compliant text messages

Medicare & Medicare Advantage

Rural Health Clinics/FQHC

- July 1st, 2020 – through end of COVID-10 PHE
  - Use G2025, you will be paid $99.45 (no CG required)
  - https://www.cms.gov/files/document/se20016.pdf
  - https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

Claim Requirements for RHC's Telehealth

Table 1. RHC Claims for Telehealth Services from January 27, 2020, through June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95 (optional)

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Claim Requirements for RHC No Cost Share

Claims Examples:

Table 5. RHC Claims for Telehealth Services from January 27, 2020, through June 30, 2020, when cost sharing is waived:

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG, CS (required) 95 (optional)

Table 6. RHC Claims for Telehealth Services with cost sharing waived starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CS (required) 95 (optional)

Virtual Check-in Evaluation and Management Services

- Audio –Only Telephone E&M services 99441,99442,99443 = G2025 in the RHC setting
- Provider must provide at least 5 minutes of telephone E&M service to patient
- You cannot bill for these if they originate from a related E&M service provided within the previous 7 days or lead to an E&M within the next 24 hours or soonest available appointment

Virtual Communication- online Digital E&M Services

- CPT code 99421 (5-10 minutes over a 7-day period)
- CPT code 99422 (11-20 minutes over a 7-day period)
- CPT code 99423 (21 minutes or more over a 7-day period)
- G0071 can be used in the RHC setting – Reimbursement is 23.73
- These are non-face-face-to-face, patient-initiated, digital communications using a secure patient portal.

Top Denials

Eligibility

Place of Service(s), Modifiers Incorrect

Code not on the Approved List

Questions?

Contact Information

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