STROUDWATER

RURAL HEALTH CLINIC BILLING TRANSITION

Amy Graham, Principal

AGENDA

- Background
- Goal of the Project
- Differences Between RHC and Physician Billing
- Claim Form Components
- Clinic Visit Claim Examples
- Outcomes
- Q&A

BACKGROUND

BACKGROUND

- New York 47-bed acute-care hospital with a Skilled Nursing Facility and multiple successful physician practices
- The decision had been made by executive leadership to transition the designation of several of the physician practices from stand-alone entities to hospital-based (provider-based) practices including some with the CMS Rural Health Clinic (RHC) designation for those that qualified
- Multiple starts and stops in the project

WHY DID THEY WANT THE RHC DESIGNATION?

- The Rural Health Clinic designation is a program that entities can leverage as part of effective primary care strategy to address market changes to help ensure the long-term viability of hospitals and other organizations in a rural healthcare setting
  - It is not without risk
  - Refusing to adapt is also not without risk
- Like any new venture, there are challenges to navigate for achieving RHC certification
- Can lead to significant positive financial impacts while providing needed primary care access in rural communities served

RHC CERTIFICATION AND BILLING STEPS

- Location requirements
- Financial feasibility assessment
- RHC application
- Initial approval
- Survey process
- Successful survey
- Recommendation for approval
- CMS approval
- Medicare provider letter receipt
- Rate determination
- Successful RHC claim submission

REIMBURSEMENT

- Medicare reimburses a flat All-Inclusive Rate (AIR) for RHC services
- Payment limit per visit based on national statutory limits:
  - Calendar Year (CY) 2023 = $126.00
  - Calendar Year (CY) 2024 = $139.00
  - Medicare Administrative Contractors (MACs) calculate the payment limit per visit for “Grandfathered” RHCs increased by 4.6% in 2024
- Medicare Part B deductible and coinsurance rates apply. This means that once patients meet their Part B deductible, Medicare pays 80% of the AIR and the patient pays the remaining 20%.
- For certain preventive services like the Annual Wellness Visit (AWV) and the Initial Preventive Physical Exam (IPPE), Medicare will pay the full AIR and patients do not have a co-pay
- Non-RHC services paid on the allowed amount for the service

RHC QUALIFYING VISITS (QV)

- An RHC visit is defined as 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 an RHC practitioner during which time one or more RHC services are furnished
- Over 400 CPT/HCPCS codes can be considered Qualifying Visits (QV)
  - Note: Distant site telehealth and chronic care visits do not require a patient and provider in the same place to perform the service, so these *are not* QV services

NON-RHC SERVICES – (NOT CONSIDERED A QV)

"Incident to" nurse visit only services

Distant site telehealth and chronic care visits do not require a patient and provider in the same place to perform the service

Charges may be included on the claim associated with a qualifying visit if performed up to 30 days from the date of the reportable encounter

- Suture removal
- Dressing changes
- Injections
- Blood pressure monitoring
- Medical Nutritional Therapy (MNT)
- Diabetes Self Management Training (DSMT)

Technical component (TC) of diagnostic tests (e.g., Taking X-rays is considered a TC)

- Separately reportable as non-RHC services by the reading physician if not resulted by the servicing provider and billed on 1500 form

MULTIPLE VISITS ON SAME DAY

- Visits with more than one RHC practitioner on the same day, or multiple visits with the same RHC practitioner on the same day, count as a single visit, *except when*:
  - Patient returns to the RHC for diagnosis or treatment of an injury or illness that happened after the initial visit; for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the RHC
  - Patient has a qualified medical and mental health visit on the same day
  - Patient has an IPPE and a separate medical or mental health visit on the same day

TYPES OF VISITS FROM AN RHC

Medicare – Qualifying Visit (RHC)

Medicare – Non-Qualifying Visit (non RHC)

Commercial

Billing Rules

GOAL OF THE PROJECT

PROJECT GOAL

Transition designation of clinic entities: from stand-alone physician practices to hospital-based physician practices

INITIAL FINDINGS

Initial project team did not include all the correct members

Outsourced organizations did not view the situation with a sense of urgency

A limited number of people had a full understanding of the RHC guidelines

Needed to educate everyone on the RHC Billing Rules

The Project Goal needed to be reevaluated

CHALLENGES ENCOUNTERED

Multiple leadership teams at the physician practices

Practices at various stages of transition

Disparate EHR and billing platforms

Not using a consistent fee schedule

Two separate teams were responsible for the physician and hospital revenue cycle (RCM) functions

Certain RCM functions are outsourced to multiple entities

PROJECT GOALS

INITIAL PROJECT GOALS

- Transition designation of clinic entities: from stand-alone physician practices to hospital-based physician practices

ACTUAL PROJECT GOALS

- Focus became RHC-related
- Identify Qualifying Clinics
- Determine stage in the conversion process
- Expand team from a single person to representatives from:
  - Clinic Operations
  - Credentialing
  - Billing Companies
- Train project team in RHC billing basics
- Determine status of billed claims for the Clinic that has received the RHC designation

DIFFERENCES BETWEEN RHC AND PHYSICIAN BILLING

THE WHY WAS THE KEY MESSAGING

Reimbursement for the Clinic would improve

Professional billing would change dramatically

BILLING WOULD FOLLOW PAYORS' RULES

Government

- Specific guidelines apply for Medicaid/Medicare
- Distinction made between RHC and non-RHC services
- Medicare bill Professional services on UB-04 form
- Medicare bill Technical services on 1500 and non-RHC services on 1500 form
- Medicaid bill services based on specific state rules

Commercial

- Each payor is unique
- No distinction made for services provided
- Bill Professional services on 1500 form
- Bill Technical services on 1500 form

A July 2022 article from Becker’s Healthcare stated

“Twenty-two percent of revenue cycle leaders who manage their inpatient RCM outsource some of their *outpatient or ancillary RCM services,* according to a study conducted by the Healthcare Financial Management Association.”

https://www.beckershospitalreview.com/finance/22-of-revenue-cycle-leaders-are-outsourcing-outpatient-services-survey-says.html

WHAT DOES THIS MEAN IN PLAIN LANGUAGE?

- RHC billing could be considered outpatient billing
- It is only a portion of services
- Not all claims are RHC claims
- Not all claims are clinic claims
- These claims may be outsourced to a third-party billing company

CLAIM FORMS ARE DIFFERENT

UB04

HCFA 1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CLAIM FORM COMPONENTS

CHARGE FORM COMPONENTS

CODE SET	IDENTIFY	RHC Billing on UB04	Clinic & Tech Billing on 1500
CPT	Procedures, services, drugs, combo services	✓	✓
HCPS	Procedures, services, drugs, combo services, supplies, DME	✓	✓
Revenue Code	Location, provider, type or procedure	✓	
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	✓	✓
Type of Bill	4-digit code representing the place of service, type of service and billing stage. Leading number is a zero	✓	
Place of Service	2-digit code identifying the location of the provider, or type of service		✓
ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM.	✓	✓

CHARGE FORM COMPONENTS

CODE SET	IDENTIFY	RHC Billing on UB04	Clinic & Tech Billing on 1500
CPT	Procedures, services, drugs, combo services	✓	✓
HCPS	Procedures, services, drugs, combo services, supplies, DME	✓	✓
Revenue Code	Location, provider, type or procedure	✓	
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	✓	✓
Type of Bill	4-digit code representing the place of service, type of service and billing stage. Leading number is a zero	✓	
Place of Service	2-digit code identifying the location of the provider, or type of service		✓
ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM.	✓	✓

REVENUE CODES

4-digit codes (leading zero) that categorize the type of service or product delivered, describe where the service took place and/or who performed or is billing the service (professional or technical)

All procedure codes billed on a hospital UB-04 (or electronic 837i) must be paired with a revenue code

Revenue code/procedure code pairing must make sense, must follow National Uniform Billing Committee guidelines, and must be acceptable to payors

Revenue code-HCPCS mismatches are automatic denials in many cases

RHC REVENUE CODES

Revenue Code	Revenue Category
0300-0319	Lab
0320-0329	Diagnostic Radiology
0400-0409	Other Imaging Services
0521	Clinic Visit by member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
0525	Visit by RHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
0523	Visit by RHC practitioner to other non RHC site (e.g., scene of accident)
0900	Behavioral Health Treatments/Services

CHARGE FORM COMPONENTS

CODE SET	IDENTIFY	RHC Billing on UB04	Clinic & Tech Billing on 1500
CPT	Procedures, services, drugs, combo services	✓	✓
HCPS	Procedures, services, drugs, combo services, supplies, DME	✓	✓
Revenue Code	Location, provider, type or procedure	✓	
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	✓	✓
Type of Bill	4-digit code representing the place of service, type of service and billing stage. Leading number is a zero	✓	
Place of Service	2-digit code identifying the location of the provider, or type of service		✓
ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM.	✓	✓

RHC QUALIFYING VISIT MODIFIER

The primary service is considered the qualifying visit

CG modifier required for the line considered the qualifying visit

Report charges associated with preventative med services on a separate line

Report all charges on the service line with the qualifying visit CPT code, minus any charges for preventive services

RHC & CLINIC VISIT – MODIFIER EXAMPLE

Commercial

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. S01.01XA B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER
10	18	22				22		99215	25	1	350	00			NPI	123456
10	18	22				22		12001		1	245	00				0

Use 25 modifier

Dollars reported as charged

Medicare

4 TYPE OF BILL: 711

3a PAT. CNTL # | b. MED. REC. # | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME | 9 PATIENT ADDRESS | 10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0521	Established Patient Visit Level 5	99215CG	10102022	1	595 00	
0521	Simple Repair scalp less than 2.5 cm	12001	10102022	1	01	

Use CG modifier, no modifier 25

Sum the dollars on a single line

CHARGE FORM COMPONENTS

CODE SET	IDENTIFY	RHC Billing on UB04	Clinic & Tech Billing on 1500
CPT	Procedures, services, drugs, combo services	✓	✓
HCPS	Procedures, services, drugs, combo services, supplies, DME	✓	✓
Revenue Code	Location, provider, type or procedure	✓	
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	✓	✓
Type of Bill	4-digit code representing the place of service, type of service and billing stage. Leading number is a zero	✓	
Place of Service	2-digit code identifying the location of the provider, or type of service		✓
ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM.	✓	✓

TYPE OF BILL

- Required on a UB-04
- Serves a similar function as the place of service on a physician bill (HCFA 1500), except each number provides a separate piece of information

TYPE OF BILL – EXAMPLES

First Digit	• Leading zero. Ignored by CMS
Second Digit = Type of facility	• 1 - Hospital • 2 - Skilled Nursing • 3 - Home Health • 7 - Clinic (RHC) • 8 - CAH
Third Digit = Type of care	• 1 - Inpatient or clinic • 2 - Inpatient Part B, Hospital based clinics, Hospice, Home Health • 3 - Outpatient • 5- Special Facilities (CAH)
Fourth Digit = Sequence of this bill in this episode of care. Referred to as a "frequency" code	• 1 - Admit to Discharge initial claim • 7 - Adjustment claim • 8 - Cancel claim • 0 - No payment

PLACE OF SERVICE

- Required on HCFA 1500 form
- Two-digit code specifying the entity where the services were rendered
- Must match the address and zip entered in the service location to avoid denials of claims

TYPE OF BILL VS PLACE OF SERVICE CLAIM EXAMPLE

UB Type of Bill 711	HCFA 1500
7 - Clinic (Type of Facility)	11 Office
1 - RHC (Type of Care	22 Outpatient Hospital
1 - (First or final bill)	21 Inpatient Hospital

UB-04 Form

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL: 711 | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 | 8 PATIENT NAME a | 9 PATIENT ADDRESS a

1500 Form

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE: 22 | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # | NPI

CHARGE FORM COMPONENTS

CODE SET	IDENTIFY	RHC Billing on UB04	Clinic & Tech Billing on 1500
CPT	Procedures, services, drugs, combo services	✓	✓
HCPS	Procedures, services, drugs, combo services, supplies, DME	✓	✓
Revenue Code	Location, provider, type or procedure	✓	
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	✓	✓
Type of Bill	4-digit code representing the place of service, type of service and billing stage. Leading number is a zero	✓	
Place of Service	2-digit code identifying the location of the provider, or type of service		✓
ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM.	✓	✓

UB-04 DIAGNOSIS CODING

Diagnoses are not specific to a single line, but apply to the entire claim

Must complete box 70 Diagnosis "Reason for Visit"

Additional diagnoses must be sequenced

UB-04 EXAMPLE

1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME a
b
9 PATIENT ADDRESS a
b c d e
10 BIRTHDATE
11 SEX
ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 CODE OCCURRENCE SPAN FROM THROUGH
36 CODE OCCURRENCE SPAN FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a b c d
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ___ OF ___
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P. REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67 A B C D E F G H
I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI QUAL
LAST FIRST
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
77 OPERATING NPI QUAL
LAST FIRST
80 REMARKS
81CC a b c d
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

HCFA-1500 DIAGNOSIS CODING

Used to bill all services to commercial payors

Used to report Medicare Part B "technical" services and RHC services

Requires Diagnosis codes specific to each line of service

HCFA-1500 EXAMPLE

PICA PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

OUTPATIENT DIAGNOSES REPORTING

Report the full diagnosis code to the highest level of specificity for the diagnosis shown to be reason for the outpatient services

Report symptom in absence of finding addressed in the provider note

Do not report suspected

Do not report rule out

Reading physician must always report finding if applicable

Report reason for encounter (Z code) for encounters with no symptoms or findings

HISTORY CODES

Personal History Codes

- Relevant to treatment options
- Relevant to reason for visit, example: cough
  - Do not report personal history of contraception Z92.0 range
  - Report
    - History of nicotine dependence – Z87.891 if applicable
    - History of tuberculosis – Z86.11 if applicable

Almost always relevant

- Personal history of cancer, malignant neoplasms (leukemia, lymphoma)
- Personal history of falling – Z91.81

Family history

- Risk factors relevant to visit
- Screening services

CODE FIRST

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology

Sequence underlying condition (etiology) first and manifestation second

Codes that have in the code title, "in diseases classified elsewhere," are never permitted to be first listed or principal diagnosis codes

- Use in conjunction with underlying condition
- Code underlying condition first

"use additional code" – Two codes required to fully describe a single condition that affects multiple body systems

Sequencing should be etiology/manifestation

CLINIC VISIT CLAIM EXAMPLES

MEDICARE WELLNESS AND FOLLOW-UP APPOINTMENT

Services Provided

- G0439 Annual Wellness Visit (AWV), PPS Subsequent Visit*
- G0442 annual alcohol screening*
- G0444 annual depression screening*
- 99214 (follow chronic disease management)
- 93000 (report of new onset palpitations)

*Preventive service as defined by Medicare

MEDICARE WELLNESS AND FOLLOW-UP APPOINTMENT

Medicare Wellness and Follow-Up Appointment

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		711
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME a | 9 PATIENT ADDRESS a

b | b c d e

10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38
Medicare Part A
address
city, st zip

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0521	AWV, PPPS, Subseq visit	G0439	03/31/2022		190.00		
2	0521	Annual alcohol screen 15 min	G0442	03/31/2022		28.00		
3	0521	Depression Screen annual	G0444	03/31/2022		40.00		
4	0521	office Est Pt 30-39 min	99214CG	03/31/2022		164.00		
5								

Wellness Visit
UB-04 Form

If this was an Initial Preventive Physical Exam (IPPE) it would count as two separate visits

Ancillary Services on 1500 form

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | 20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. I50.21 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03	31	22				72		93000		A	70 00			NPI	
2																

SINUSITIS – SHOULDER PAIN - INJECTION

Services Provided

- 99213 dx sinusitis
- 20610 shoulder pain
- J1030 injection methylprednisolone

SINUSITIS – SHOULDER PAIN - INJECTION

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL: 711

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a | b | 9 PATIENT ADDRESS a | b | c | d | e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

Medicare Part A
address
city, st zip

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a
b
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED C
0521	office Est Pt 20-29 min	99213CG	03/31/22		623.00	
0521	ARTHROCENTESIS ASPIR&/INJ	20610	03/31/22		.01	
0636	Methylprednisolone 40 mg inj	J1030	03/31/22		.01	

Prices were reduced to $0.01 for all "incident to services" and original charge amounts summed on line 1

Revenue Code related to service was reported

THERAPEUTIC INJECTION FOR CONTRACEPTIVE AND PREGNANCY TEST

Services Provided

- 96372 therapeutic injection for contraceptive (patient's own meds)
- 81025 urine pregnancy test

THERAPEUTIC INJECTION FOR CONTRACEPTIVE AND PREGNANCY TEST

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 0uh9	B. z32.00	C.	D.
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	03	31	22				72		96372		A	140 00			NPI	
2	03	31	22				72		81025		B	25 00			NPI	
3															NPI	
4															NPI	

N OR SUPPLIER INFORMATION

No Qualifying Visit was performed – Bill on 1500 form

OUTCOMES

WITH EDUCATION, THE TEAM BECAME ENGAGED

Developed a list of all physician practices

- Determined RHC eligibility
- Documented the stage in the RHC designation process

Team was willing to make the appropriate changes

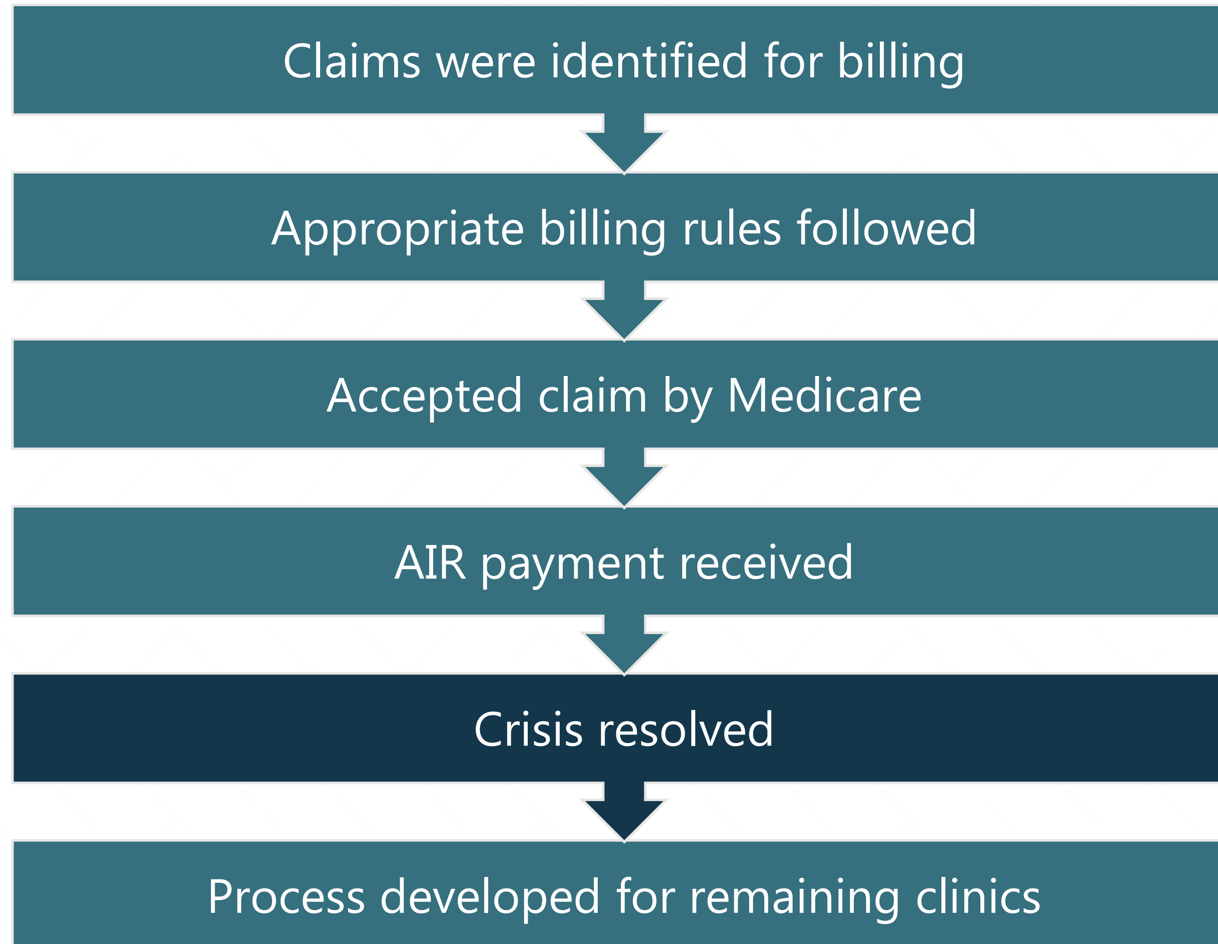
- Clinic visits adjusted to reflect Qualifying Visit (QV) services
- Coordination with hospital medical records systems
- Billing rules established

We encountered an emergency

EMERGENCY IDENTIFICATION & RESOLUTION

- Through the development of the list of facilities, one RHC was identified as receiving designation 10 months prior and HAD NOT yet billed a claim to Medicare
  - The designation was received prior to the change in the reimbursement rate
  - If an accepted claim was not received, the designation would be lost
- Why was this a problem?
  - Differences in reimbursement rates
  - Potential for entire enrollment process needing to be completed again
- The team quickly jumped into action

RESOLUTION



WHAT WE LEARNED

Understand

Understand the importance of an engaged team to facilitate the billing transition

Demonstrate

Demonstrate improved understanding of specific billing rules required for a Rural Health Clinic as compared to traditional clinic billing

Identify

Identify the repercussions of failing to use the RHC billing number for almost 12 months and nearly relinquishing it, with potentially devastating reimbursement consequences

Q&A

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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