BUILDING BLOCKS OF RURAL HEALTH CLINIC BILLING:

INTRODUCTION TO MEDICARE BILLING

Kentucky RHC Summit

July 28,2023

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TYPES OF RURAL HEALTH CLINICS

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RHC Ownership

- **For profit/proprietary**
- **Non-profit**
- **Governmental entity/hospital district/county/municipality**
- **Any legal entity structure allowed in the state**

Provider-based

- Owned by a hospital, SNF, or home health agency
- Under the **same EIN** as the parent organization
- **Different NPI** for RHC from parent organization
- Qualifies for 340B child site
- M-series on parent entity's cost report
- Grandfathered higher rate ≤ 2020

Independent

- Independently owned by a provider, group or private entity
- OR has a different EIN from another related entity
- **Different NPI for RHC** from other practice locations under the same EIN
- Files a separate cost report
- Subject to annual upper payment limits

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RHC CMS Certification Numbers (CCN)

RHCs can be either **independent** or provider-based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (A/B MAC). They are assigned a CMS Certification Number (CCN) in the range 3800-3974 or 8900-8999.

Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH)), skilled nursing facility (SNF), or a home health agency (HHA). They are assigned a CCN in the range 3400-3499, 3975-3999, or 8500-8899.

CCN is another term for PTAN

Provider Enrollment FAQs on NPI and CCN/PTANs

Medicare Billing Numbers

41. What is a CCN?

A CMS Certification Number (CCN) is assigned to Part A facilities for billing and administrative purposes and identifies them in Medicare claims and other transactions (including cost reports for those providers that are required to file Medicare cost reports). ***The CCN is equivalent to a Provider Transaction Access Number (PTAN).***

National Provider Identifier (NPI)

1. When are subpart NPIs recommended?

A. CMS encourages all providers to obtain subpart NPIs in a manner similar to how they receive CMS Certification Numbers (CCNs) (i.e., a ***"one-to-one relationship").***

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/2019_National_Provider_Enrollment_Conference_FAQs.pdf

RHCs and Identity Crisis Myths

MYTH #1: An RHC is the just a medical practice that is paid differently. Nothing really changed when the clinic became an RHC.

TRUTH: The clinic is now a CMS-certified healthcare facility. *It became something new*. An RHC is subject to regulatory compliance and standards that medical offices are not.

MYTH #2: A PBRHC is a department of the parent hospital or entity.

TRUTH: CMS certifies an RHC as a separate type of facility from the parent entity. Although the PBRHC must fall under the general management of the parent organization, the RHC has different certification and accreditation standards because it is subject to different conditions of certification. The RHC also has different Emergency Preparedness requirements. Louisiana does have a licensing option that does treat the RHC as a department of the hospital, but this is the only exception. CMS does not consider a PBRHC to be a department of the parent organization.

MYTH #3: An RHC is just a medical office in a rural location. There are no other requirements.

TRUTH: RHCs must meet local requirements as being in a rural, non-urbanized area. RHCs must also be in a Primary Care HPSA or MUA.

RHC REIMBURSEMENT, CODING AND BILLING BASICS

Distinctives of Medicare and Medicaid RHC coding and billing
Cost-based Reimbursement

Main things to master in RHC Billing

- Understanding how RHC cost-based reimbursement works
- Understanding how RHCs are paid
- Understanding what is a standalone billable service
- Understand the claim formats
- Understanding Medicare Split Billing
- Understanding the –CG Modifier and Roll Up
- Understanding how face to face encounters are reported
- Understanding other coding rules and modifier use
- Understanding the billing exceptions

Cost-based Reimbursement Methodology

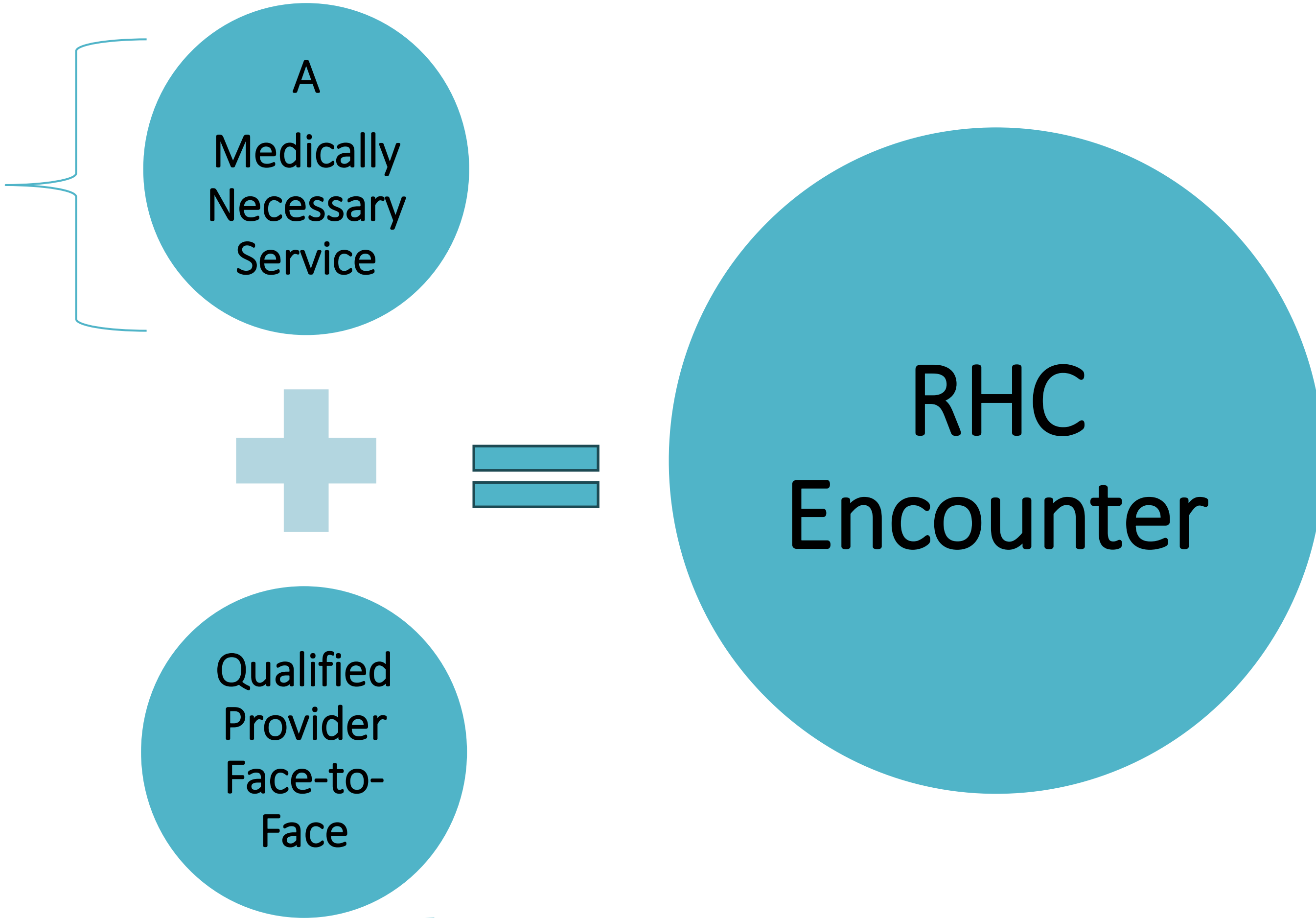
Part B medical offices are reimbursed at an allowable fee schedule amount, the Medicare Physician Fee Schedule (MPFS), for each reportable CPT/HCPCS code.

New RHCs will need to start thinking differently about how they are paid for performing services in the RHC setting.

RHCs are reimbursed per encounter based on a cost report calculation that is made every year. RHCs are paid each year based on what it actually costs them to provide care on a per encounter basis. The lesser or the actual cost or the current year's upper payment limit is used as the payment rate for the next year. That amount becomes the all-inclusive rate or AIR for all qualifying RHC services.

Total Allowable Costs ÷ Total Qualifying Visits = All-Inclusive Rate (AIR)

Medicare LCD/NCD Covered Services



Reimbursement for an encounter is based off the All-Inclusive Rate which is calculated each year on the cost report.

CMS reimburses 80% of the AIR after the deductible is met and there is an additional patient responsibility amount/coinsurance which is 20% of the total charges.

Mental Health encounters may be furnished via telehealth beginning 2022 are considered face to face.

- Qualified RHC providers include:
  - Physicians
  - NPs
  - PA’s
  - CNM
  - Clinical Psychologists
  - Licensed Clinical Social Workers
  - Dentists (Medicaid and in addition to a primary care provider on duty; Considered to be a specialist.
  - Podiatrists (not the only provider on duty); Considered to be specialist.
  - Chiropractors (not the only provider on duty); Considered to be specialist.
- Ancillary and support staff: RHCs may employ support staff and staff that perform incident-to or other administrative or clinical tasks. Nurse visits may be covered benefits but are not standalone billable services for Traditional Medicare.
- Specialists may be RHC providers. In most cases, the specialist should be contracted or employed by the RHC and the RHC bills for all specialist services to prevent mixing RHC and non-RHC services.

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Mental Health Providers

- In 2024, Medicare will begin enrolling professional counselors and marriage & family therapists as qualified Medicare provider types.
- These providers will also be approved for providing mental health services in the RHC.
- Some Medicaid programs already recognize these other mental health professional as RHC providers under their state plans.
- Mental health telehealth is considered an RHC encounter; however, primary care must be the main service performed in aggregate.

Rural Health Clinic Qualifying Visit List (RHC QVL)

(8-01-16)

The RHC QVL is intended as guidance for RHCs beginning to report HCPCS codes. It consists of frequently reported Healthcare Common Procedure Coding System (HCPCS) codes that qualify as a face-to-face visit between the patient and an RHC practitioner and it is not an all-inclusive list of stand-alone billable visits for RHCs. More information on what is considered a RHC visit is included in the "RHC Visits" section of this guidance.

Medical Services

HCPCS Code	Short Descriptor
10081[1]	*Drainage of pilonidal cyst*
10120[1]	*Remove foreign body*
10121[1]	*Remove foreign body*
10140[1]	*Drainage of hematoma/fluid*
10160[1]	*Puncture drainage of lesion*
11000[1]	*Debride infected skin*
11010[1]	*Debride skin at fx site*
11011[1]	*Debride skin musc at fx site*
11042[1]	*Deb subq tissue 20 sq cm/<*
11055[1]	*Trim skin lesion*
11056[1]	*Trim skin lesions 2 to 4*
11057[1]	*Trim skin lesions over 4*
11100[1]	*Biopsy skin lesion*
11200[1]	*Removal of skin tags <w/15*
11300[1]	*Shave skin lesion 0.5 cm/<*

Evaluation & Management Services

99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq

Approved Preventive Health Services

HCPCS Code	Short Descriptor
99406[4]	*Behav chng smoking 3-10 min*
99407[4]	*Behav chng smoking > 10 min*
G0101	Ca screen; pelvic/breast exam
G0102[5]	Prostate ca screening; dre
G0117[5]	Glaucoma scrn hgh risk direc
G0118[5]	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

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

RHC CLAIM FORMATS AND BILL TYPE

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RHC Medicare Coding, Billing and Reimbursement Basics

Claim Format and Reimbursement

- RHCs bill Medicare as a Part A Institutional provider.
- RHCs submit an 837I electronic claim which is known as a UB-04 paper claim for RHC services and encounters.
- RHCs are reimbursed per encounter in contrast to fee-for-service medical offices which are reimbursed per CPT code or per service performed.
- RHC use a bill type 71x. Each facility type has a unique, specific bill type.

RHC Element	
Electronic Claim Format	837I
Paper Claim Equivalent	UB-04
Type of Reimbursement	Per Encounter/AIR Rate

Each institutional facility has a unique Bill Type. For RHCs, the bill type family is 071x. The field is four characters long but the leading zero is ignored.

Bill Type	Used for
0711	Original claims for RHC encounters
0710	To file non-covered charges for a denial so that secondary payer can then be billed
0717	To correct a claim
0718	To cancel a claim

Type of Bill, FL 4

This four-digit alphanumeric code gives three specific pieces of information. The first digit is a leading zero. CMS ignores the first digit. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular benefit period. It is referred to as a "frequency" code.

Code Structure

1st Digit – Leading Zero
CMS ignores the first digit

2nd Digit - Type of Facility
7 - Special facility (Clinic)

3rdDigit - Classification (Special Facility Only)
1 – Rural Health Clinic
7 – Federally Qualified Health Centers

4th Digit – Frequency	**Definition**
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
1 - Admit Through Discharge Claim	This code is used for a billing for a confined treatment.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or "new" bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

https://www.cms.gov/regulations-and guidance/guidance/manuals/downloads/clm104c09.pdf

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1 ABC Rural Health Clinic
1234 Main Street
My Town, KY 40000

2 Not Required

3a PAT. CNTL # Unique Provider ID for Patient
b. MED. REC. #

4 TYPE OF BILL 0711

5 FED. TAX NO. 999999999

6 STATEMENT COVERS PERIOD FROM 07 01 23 THROUGH 07 01 23

7

8 PATIENT NAME a John Doe
b

9 PATIENT ADDRESS a 5678 Happy Place
b Any Town c KY d 40000 e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18–28	29 ACDT STATE	30
01/01/1957	M			9	9		01	Used rarely as needed		

31–34 OCCURRENCE CODE / DATE: Occurrence Codes used only situational (MSP)

35–36 OCCURRENCE SPAN CODE / FROM / THROUGH: Not used

37

38

39–41 VALUE CODES CODE / AMOUNT: a Used for MSP Claims
b

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	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	RHC Encounter Clinic	99214 CG	07 01 23	1	225.00			1
2	0521	Injection Administration	96372	07 01 23	1	25.00			2
3	0636	Ketorolac tromethamine, per 15 mg	J1885	07 01 23	4	60.00			3
4									4
5									5
6									6
7									7

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50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	RHC RHC NPI
A Medicare Contractor	Health Plan ID	Y	Y	Not Required		57	
B 1234 Please Pay Lane						OTHER	
C Someplace, KY 40000						PRV ID	

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Insured Nme	18	Patient's MBI	if applicable	If applicable
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A Not usually necessary for Medicare RHC claim	Needed for correction or cancellation	
B	Needs condition code above, D-0 to D-9	
C		

66 DX: M1612 | I10 | 68

69 ADMIT DX: N/A | 70 PATIENT REASON DX: not used for RHC | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

Not used for RHCs

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI Ind Provider NPI	QUAL Optional
LAST Doe	FIRST Jane	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS: Only if needed to explain situation

81CC			
a	B2	marital status optional	
b	B3	261QR1300X	RHC taxonomy
c			
d			

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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CODE SETS USED IN RHCS

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- RHCs use the HCPCS/CPT® codes for procedural coding. All provider types use these codes. CPT® codes are Level 1 HCPCS codes which are maintained by the American Medical Association. Level 2 codes are the alpha-numeric codes used to report drugs, supplies and temporary or governmental codes.

- There are several RHC-specific HCPCS codes (Level 2) to report services. These codes are for telehealth, virtual communication services and care management services. These RHC-specific Medicare codes are used in place of the regular codes which describe the same or similar services. These unique codes are tied to RHC-specific reimbursement.

- RHCs use ICD-10-CM for diagnosis coding. Providers should always code to the highest degree of specificity in the clinical documentation.

- Quality measure reporting for Medicare CANNOT currently be claims-based. These Category 2 codes create a bill type error. The claim will reject or if they do process, the quality measures are not attributed to the provider. This is a challenge as more RHC are entering into APMs.

- RHCs also use Revenue codes on Medicare claims to indicate the type or place of service.

- RHCs also use condition codes, occurrence codes and value codes on the UB-04 claim to submit supplemental information needed for claims processing. These are used in specific situation and not generally.

Examples of Code Sets

Code Set	Use	Examples
HCPCS Level 1 or CPT® Codes	To report evaluation & management services and procedures	99214 (E & M code); 17000 (Destroy pre-malignant lesion); 99495 (TCM); 81003 (urinalysis); 93005 (EKG tracing)
HCPCS Level 2 Codes	To report drugs, separately billable supplies, temporary codes, governmental payer codes and RHC specific codes	J0696 (Rocephin/250); G0238 (AWV), G0511 (RHC CCM); Q0911) Pap Smear Collection
Revenue Code (leading zero)	To report the type or location of the service. Used for all Part A facility types.	0521 (RHC Clinic); 0522 (RHC Home encounter); 0636 (J code drugs); 0300 (Venipuncture); 0900 (behavioral health
ICD-10-CM 3-7 characters	Used to a report signs, symptoms, diseases, conditions or the reason for the encounter (diagnosis codes)	I10 (Hypertension); J01.09 (acute sinusitis, unspecified; R05.3 (chronic cough); Z00.129 (routine child screening w/no abnormal find)
Condition Codes, Value Codes, & Occurrence Codes	Used to report supplemental information need to process claim.	Condition Code 07 for hospice patient being seen for non-hospice; Value Codes and Occurrence codes for MSP.

Main Revenue Codes for RHC Encounters

One of these revenue codes must be on the claim. Additional revenue codes can be used for drugs, venipunctures and supplies.

Location	Revenue Code	Comments
Within the RHC Certified Space	521 (Clinic)	Most common type of encounter
In the patient's home, assisted living or other residential setting	522 (Home, assisted living)	Must be a qualified RHC provider unless in a designated home health shortage area.
In a Part A skilled nursing facility or swingbed	524 (District part SNF or Swing bed)	Documentation must also be in RHC medical record
In a Part B nursing facility	525 (Nursing home)	Documentation must be in the RHC medical record and must include a treatment consent.
Other location (scene of an accident)	528 (Rarely used)	Qualified RHC provider provides a face-to-face encounter when responding to an accident.
Behavioral Health	900 (All)	Mental health services

MEDICARE SPLIT BILLING

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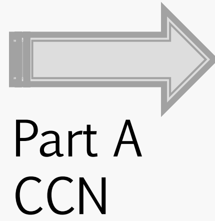
RHC Medicare Coding, Billing and Reimbursement Basics

The RHC Encounter and Split-Billing

- RHCs "split-bill" for Medicare separating RHC encounters and non-RHC services into two claims.
- This is because the clinic's AIR or all-inclusive rate is calculated for RHC services only. There is a specific definition of an RHC encounter. These services are billed using the 837I/UB-04 claim format.
- Other technical components of service which are not included in the AIR are separately reimbursed by split-billing.
- There are regulations and CMS guidance which determines which charges can be split-billed and how.
- RHC practice management/EHR systems must be able to generate both 837I/UB-04 claims and 837P/1500 claims. Sometimes new RHCs have to upgrade or change systems.

Pays AIR



Part A CCN

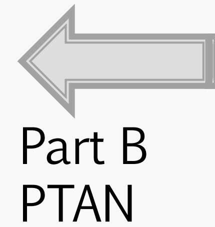
Medicare Split Billing Independent RHC

RHC UB-04 Claim

- E & M codes
- Procedure Codes
- Injection Administration
- Venipuncture
- J Codes
- Professional Interpretation

Part B Claim

- POC Waived Tests
- Imaging Done in RHC
- EKG Tracing
- Any Technical Component of a service done in the RHC



Part B PTAN

Pays a fee schedule amount

- You should not bill professional procedures to Part B for increased reimbursement.
- You should NOT have a separate “treatment” room in your RHC.
- Do not include the six required tests on the RHC UB Medicare Claim.
- The six tests are billable to Part B.

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Pays AIR

RHC Part A
CCN
RHC NPI

Medicare Split Billing PBRHC

PBRHCs are NOT billed as departments of the hospital. CAH Method II billing does not apply to RHC professional services.

Pays as an outpatient hospital claim

Caution: Only One Hospital OP Claim per date of Service per patient. For RHCs who are on different systems, this can be challenging.

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Type of RHC	Encounter Professional Services RHC Service	CLIA Lab Performed in RHC	Other Technical Components Performed in RHC- EKG, X-ray, Imaging	Professional Services Outside RHC Hours- Hospital Services
Provider-Based **Hospital Owned**	Part A UB-04 Using the RHC NPI And Parent Entity EIN	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.
Independent	Part A UB-04 Using RHC NPI and RHC EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B 1500 using the NPI assigned to your Part B PTAN and your EIN.	Part B Professional Group PTAN to which the provider is linked.

UNDERSTANDING THE –CG MODIFIER

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RHC Medicare Coding, Billing and Reimbursement Basics

-CG Modifier and Roll up of Charges

- RHCs also use a specific modifier on claims to indicate that a qualifying encounter has occurred. This modifier is –CG.
- All claims must include one –CG line. There are rare exceptions in which more than one line can be appended with the –CG modifier. An example would be whenever a medical encounter and a mental health encounter occurred on the same date of service for the same patient.
- The RHC Qualifying Visit List was published by CMS as a reference to which CPT/HCPCS® qualify as standalone encounters.
- All of the charges for RHC services performed at the encounter are reported by line item on the claim.
- However, all of the charges must be summed up to the –CG line. Only the –CG line processes.

Revenue Codes and CPT/HCPCS codes are listed for each line item.
The –CG Modifier is appended to the QVL code.
Only the –CG line will be processed.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	Description Optional	99214 CG	110119	1	190 00		
0521		96372	110119	1	15 00		
0636		J0696	110119	2	50.00		
001	PAGE 1 OF 1	CREATION DATE	120519	TOTALS	255 00		

99214 = $135.00
96372 = $ 15.00
J0696 = $ 50.00
Total = $190.00
Summed and rolled up to –CG line

Charges Appears Overstated

-CG Modifier FAQ Document

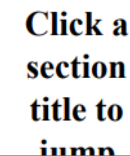
Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

Sections

- Reporting Modifier CG
    - Reporting Modifier CG with Preventive Services
    - Reporting Modifier CG with Medical and/or Mental Health Services
    - Other Modifier CG Questions



https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/rhc-reporting-faqs.pdf

Other Modifiers

- RHC claims to traditional Medicare will <u>**not**</u> typically use Modifier -25 or Modifier -59
- Educate coders and providers on the use of RHC modifiers. Modifier use on Medicare claims does **NOT** follow conventional coding.
- -25 and -59 can create erroneous overpayments.
- -59 is only used to report the second unrelated RHC encounter that occurs on the same date of service. This visit is unrelated to the first visit and is unscheduled or not anticipated.
- Claim example on another slide.

SERVICES BILLED ON THE UB-04 WHICH DO NOT REQUIRE A FACE-TO-FACE

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Exceptions to Face-to-Face Encounter

- Care Management and Care Coordination Services (G0511)
  - CCM or PCM or CPCM
  - BHI
  - Psychiatric CoCM
- Virtual Communication Services
  (G0071)
- Medical Telehealth Reported under G2025
- These services are not reimbursed at the AIR. They are reimbursed at a composite FFS amount with RHC specific HCPCS Codes. These allowable amount are updated annually.
- No –CG Modifier if the services does not pay the AIR.

2023 RHC Rates for Non-encounter services

HCPCS Code	CY 2023 Payment Rate
G0511	$77.94 Chronic Care (20 min), Principle Care (30 min), Behavioral Health Integration (20 min), Chronic Pain Management (30 min)-
G0512	$146.73 Psychiatric Coordination of Care
G0071	$23.72 (1/1/2023 - 5/11/2023); $13.22 (5/12/2023 - 12/31/2023)
G2025	$98.27 Medical Telehealth

CLAIMS EXAMPLES

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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	07/01/2023	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	07/01/2023	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

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 **CG**	11/1/2022	1	250.00
0521	I & D Abscess	10160	11/1/2022	1	150.00
0001	Total Charge				400.00

Charges are rolled up or summed to the –CG line. Only this line is processed. Deductible and coinsurance amounts are calculated from this line only.

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.

The –CG line is the "encounter" line. Everything is calculated from it.

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	11/01/2022	1	250.00
0521	I & D Abscess	10160	11/01/2022	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 by .01. Using this method depends on your PM/EHR and your facility's method for tracking charges.

RHC Encounter with Multiple Services #2

Make sure the units are correct on injectables.

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2022	1	150.00
0521	Inj Admin	96372	11/01/2022	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2022	2	50.00
0001	Total Charge				215.00

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	11/01/2022	1	145.00
0521	EKG- Prof	93010	11/01/2022	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 technical component of the EKG ($40) would be billed separately under the appropriate method for the type of RHC.***

EKGs 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.

Home Encounter
Face to face with qualified RHC provider

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0522	Home visit	99341 CG	11/01/2022	1	200.00
0001	Total Charge				200.00

CPT Codes in the 99341-99350 range are compatible with the 522 revenue code. These codes are new with changed descriptions and new E & M coding guidelines for 2023. Clinical documentation for the RHC professional service should be in the RHC medical record. The RHC must have a complete medical record and consent to treat on record for the patient.

Swing Bed Encounter
Face to face with qualified RHC provider

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0524	SNF Prof Service	99305 CG	11/01/2022	1	200.00
0001	Total Charge				200.00

CPT Codes in the 99304-99306 and 99307-99310 range are compatible with the 524 and 525 revenue codes. New E & M guidelines for nursing home services were established in 2023. Clinical documentation for the RHC professional service should be in the RHC medical record. The RHC must have a complete medical record and consent to treat on record for the patient. The SNF facility or hospital record is the facility record and not the RHC record. You must have clinical documentation for any reported encounter.

Nursing Home Encounter
Face to face with qualified RHC provider

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0525	Nursing Home	99309 CG	11/01/2022	1	200.00
0001	Total Charge				200.00

CPT Codes in the 99304-99306 and 99307-99310 range are compatible with the 524 and 525 revenue codes. New E & M guidelines for nursing home services were established in 2023. Clinical documentation for the RHC professional service should be in the RHC medical record. The RHC must have a complete medical record and consent to treat on record for the patient. The nursing facility chart is the facility record and not the RHC record. You must have clinical documentation for any reported encounter.

RHC Encounter: In- Person 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	11/01/2022	1	200.00
0001	Total Charge				200.00

Provider performed a 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	11/01/2022	1	175.00
0900	Psych Eval	90791 CG	11/01/2022	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. No roll-up.** Total RHC services would be $375.00. The patient would be responsible for a $75.00 coinsurance.

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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	11/01/2022	1	150.00
0521	IPPE	G0402	11/01/2022	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 for the problem 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. **No roll-up. The RHC will receive two AIR payments for this visit.**

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

Sick Visit with AWV

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Sick Visit	99213 CG	11/01/2022	1	100.00
0521	**AWV-Subsequent**	G0439	11/01/2022	1	150.00
0001	Total Charge				250.00

- ***-CG goes on the E & M for the follow-up of chronic conditions***
- ***AWV is reported on a separate line and NOT rolled up because there is no coinsurance and deductible on the preventive service.***
- ***The AIR is paid. Only one AIR is paid.***
- ***The patient coinsurance is $20 for the 99213.***

Questions/Discussion

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 25 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. Patty currently serves on the Board of NARHC.