



# Part II: Advanced RHC Billing



# Advanced Billing Overview

- The following areas will be discussed:
  - Injections and Minor Surgical Procedures
  - Carve-Outs: RHC vs. Non-RHC services
  - Visiting Specialists in an RHC
  - Charging the patient
  - Telemedicine
  - Mental Health Billing and Payments
  - Medicare as Secondary Payor



# Injections and Surgical Procedures

- ▶ When performed during RHC hours, injections are incident to an encounter.
- ▶ Likewise, in the absence of carve-outs, surgical procedures are definitely an encounter.
- ▶ RHC services can only be billed FFS with significant administrative adjustment and ***extreme caution***. (Commingling)



# Minor Surgical Procedures

- ▶ Minor surgical procedures performed in the RHC, during RHC hours, must be billed as encounters.
- ▶ Follow-up visits for dressing changes, or suture removal can only be billed as encounters if there is a medically-necessary, documented reason and it is performed by an RHC provider.



# Office Visit and Surgical Procedure

- ▶ If an office visit is performed during the same visit as a minor surgical procedure, the clinic will only have one encounter to bill.
- ▶ These should be bundled and submitted as one line item.



## Follow-Up Visits as RHC Encounters

- ▶ Follow-up visits (for example) ***can be*** billed as RHC encounters if they are medically-necessary and performed by an RHC provider.
- ▶ Follow-up visits for surgeries performed outside the RHC and within the global billing period are **NOT** billed as encounters.



# Carve Outs

Some services can be carved out of the Rural Health Clinic.

A 'Carve-Out' is an accounting adjustment which removes particular costs from the cost report.

Once services are 'carved-out', they can be billed FFS.



## Carve outs and Non-RHC services

- ▶ Non-RHC services such as lab, diagnostic imaging, and hospital services are 'carved-out' of the RHC cost report by statute.
- ▶ There is no need to establish non-RHC hours to bill these fee-for-service.



## Carve-Outs and RHC services

- Any physician or NP services (including incident-to) are considered RHC services.
- It is never acceptable to bill RHC services (direct services or incident-to) to Medicare Part B (FFS) during RHC clinic hours...unless an appropriate carve-out is performed.
- Opinions on this vary.



## Non-RHC Hours

- ▶ To carve-out services that are normally performed in the RHC, non-Rural Health Clinic hours must be established.
- ▶ All costs associated with non-RHC hours are 'carved-out' of the cost report.
- ▶ All services provided during non-RHC hours are billed to Medicare Part B (FFS).



# Carve-Out Methodology

- Use time studies to assess the personnel component to a services cost.
- Reclassify all associated costs of a particular item; personnel, overhead, space.
- Don't do this yourself – talk it over with your accountant and cost report guru.



# Critical Test for Carve-Outs

Does it pass the smell test? If something feels wrong, it probably is.

No Financial Triage.



## Visiting Specialists in an RHC

Any qualified provider (MD, DO, NP, PA) can see patients in an RHC.

The only stipulation is that the RHC must provide primary care services fifty-one percent of operating hours. (FP, IM, Peds, OB)



# Two Scenarios for Visiting Specialists

Scenario #1: A specialist rents space from the RHC one morning per week, brings his own staff, and does his own billing.

Configuration: The RHC carves out the cost of the space and removes all associated costs from the cost report.



## Visiting Specialists

Scenario #2: A general surgeon comes to the RHC once per week. She sees RHC patients and they are billed as RHC encounters.

Configuration: In-patient surgeries should be billed with modifier 54 (surgery only). Follow-up visits can then be billed as encounters.



# Advanced Beneficiary Notice (ABN)

- An ABN is used for services that Medicare otherwise pays for, but may not be covered in this instance.
- This may not be used as blanket coverage, but only per incident.
- It must be given to the patient PRIOR to rendering the service.



## New ABN Rules

Effective March 1, 2009, the ABN-G and ABN-L are no longer be valid; and notifiers must begin using the revised Advance Beneficiary Notice of Non-coverage (CMS-R-131).



# Advanced Beneficiary Notice\*

## 50.3.2 - Voluntary ABN Uses

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).

The ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

- Personal comfort items;
- Routine physicals and most screening tests;
- Others...

[www.cms.gov/BNI/Downloads/RevABNManualInstructions.pdf](http://www.cms.gov/BNI/Downloads/RevABNManualInstructions.pdf) (See pg.5)

[www.trailblazerhealth.com/Publications/Training%20Manual/abn.pdf](http://www.trailblazerhealth.com/Publications/Training%20Manual/abn.pdf)



# Charging the Patient

- ▶ A Medicare claim for Type of Bill 710 can be submitted for a non-payment/zero claim (claim with only non-covered charges) in order to produce a denial for secondary.



## B-12 Shots

Are now self-administered, so are excluded from Medicare. These patients can be charged.



# Missed Appointments

As long as all patients are charged in the same manner, it is acceptable to charge Medicare patients for missed appointments.



# Mental Health Services

- Mental Health Services performed by a qualified provider are billed using revenue code 900.
- Diagnostic services are paid as an encounter.
- Therapeutic services are subject to a limitation which is being phased out.



# Mental Health Payment Limitation

Period	Limitation %	Medicare Pays/ Pt. Pays
Through Dec. 31, 2009	62.5%	50% / 50%
Jan. 1, 2010 – Dec. 31, 2011	68.5%	55% / 45%
Jan. 1, 2012 – Dec. 31, 2012	75%	60% / 40 %
Jan. 1, 2013 – Dec. 31, 2013	81.5%	65% / 35%
Jan. 1, 2014 – onward	100%	80% / 20%



# No Limitation for Diagnostic Visits

The following types of diagnostic services would be exempt from the limitation:

- **Psychiatric testing** - this refers to use of actual testing instruments such as intelligence tests;
- **Psychiatric consultations** - evaluation made by a physician or non-physician for purposes of preparing a report for the attending physician; or
- **Initial psychiatric visits** - evaluation made by a physician who will test the patient.



## MH RHC Payment: Step 1 – Pt. Portion

**Beneficiary Responsibility:** The beneficiary is responsible for at least 31.5 percent of the all-inclusive rate for psychiatric therapy services. Additionally, the beneficiary is responsible for the coinsurance and any unmet deductible that is based on the remaining 68.5 percent of the reasonable charges.



# MH Payment: Step 2 – Pt. Portion

The patient's liability is a two-part calculation as follows:

**Part 1** - 68.5% limitation:

Multiply the charges for revenue code 0900 by 31.5%.

**Part 2** - Deductible and coinsurance calculation:

1. Multiply charges for revenue code 0900 by 68.5% to **calculate recognized charges**.
2. For RHCs, apply any portion of recognized charges necessary toward the deductible, if it is applicable and has not yet been fully satisfied.
3. Multiply remaining recognized charges by 20% to calculate coinsurance.



## MH Payment: Step 3 - Medicare

Total beneficiary liability for RHCs is 31.5 percent of revenue code 0900 charges plus 20 percent of recognized charges (coinsurance) plus any unmet deductible (as calculated from recognized charges.)



## MH Payment: Step 4 – Total Pmt

- 1 - Subtract the 31.5 psychiatric liability (plus for RHCs any amount applied toward the deductible) from the clinic's/center's all-inclusive payment rate.
- 2 - Multiply the remainder by 80%.



# MH Payment Example (No Pt. Ded.)

	Amount	Description
90801 Revenue Code 900	\$ 120.00	Therapeutic MH Visit
RHC Rate	\$ 76.34	Clinic RHC Encounter Rate
Psych. Limitation	\$ 37.80	Charge multiplied by 31.5%
Recognized Charges	\$ 82.20	Charge multiplied by 68.5%
Total Patient Liability	\$ <b>54.24</b>	Limitation plus 20% of recognized charge
Medicare Portion	\$ 38.54	RHC Rate minus Psych. Limitation
Remainder	\$ <b>30.83</b>	Medicare Portion times 80%
Total Clinic Payment	\$ <b>85.07</b>	Medicare Remainder plus Pt. Liability



# Telemedicine

- ▶ Telemedicine services are the only additional line items that can be include on the RHC claim.
- ▶ These are considered non-RHC services, so an encounter rate will not be paid.



# Telehealth Services

- Consultation
- Office Visits
- Individual Psychotherapy
- Psychiatric Diagnostic Interview Exam
- Pharmacological Management
- Neurobehavioral Status exam
- Individual Medical Nutrition Therapy



## Telemedicine – RHC Location

- The RHC is the 'originating' site.
- The RHC will add line a line item to the RHC claim with Revenue Code 0780 and HCPCS code Q3014.
- Payment for this service is \$23.36



## Telemedicine – Remote Site

- The remote site is where the physician is assessing the patient via video link.
- The claim will be submitted fee-for-service using the appropriate evaluation and management code for the level of service rendered.
- Billed as if the patient was at the remote site.



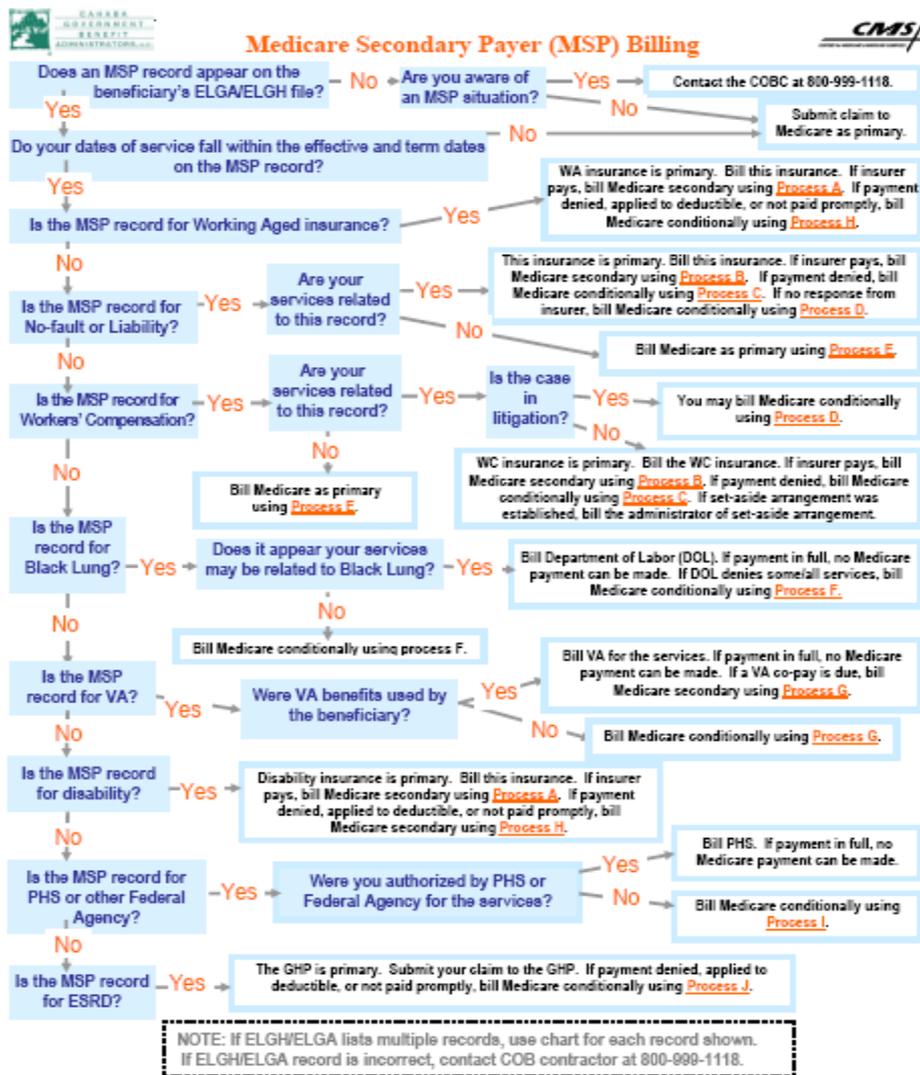
# Medicare as Secondary Payor (MSP)

Medicare Secondary Payer is the term used when Medicare is not the source of primary payment.

MACs, Providers, Patients, and Attorneys all have responsibilities to ensure Medicare does not pay when another primary source of payments exist.



# MSP Flow Chart





# MSP Questionnaire

RHCs (and all Medicare providers) must have a mechanism for documenting that there is no payor primary to Medicare at each visit!

An updated MSP questionnaire must be on file and updated annually in the clinic. Most MACs allow an electronic copy to be on file.

The clinic must have a system for documenting that MSP questions have been asked prior to ***every*** visit.



# MSP – Working Aged

**Process A: Working Aged or Disability insurance is primary. Billing Medicare secondary.**  
 Submit your claim to the primary insurance. After receiving payment from the primary insurance, you may bill Medicare secondary using the following instructions.

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instructions (**NOTE: Bill all other fields as usual**)
1	VALUE CODES	FL 39-41	Enter the value codes "12" to indicate Working Aged insurance, or "43" to indicate Disability insurance and the amount you were paid by the primary insurance. Enter value code '44' and amount if you are contractually obligated to accept an amount less than the total charges as your payment in full. Bill any other value code as usual.
3	CD	N/A	Enter payer code "A" if working aged or "G" if disability on line A. Enter payer code 'Z' on line B.
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on ELGA) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your provider number for the primary payer (if known), on line A.
4	REMARKS	FL 65	Enter the employer's name and address that provides the primary insurance.
5	INSURED NAME	FL 58	Enter the Insured's name (the name of the employee that carries the working aged/disability insurance) on line A. Enter the beneficiary's name on line B.
5	SEX	N/A	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	DOB	N/A	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	REL	FL 59	Enter the code for the patient's relationship to the insured on line A. (See "MSP Billing Codes" below.)
5	CERT-SSN-HIC	FL 60	Enter the primary payer's policy number (if available on ELGA) on line A. Enter the beneficiary's HIC number on line B.
5	GROUP NAME	FL 61	Enter the group name or plan through which the insurance is provided on line A (if known).
5	INS GROUP NUMBER	FL 62	Enter the insurance group number of the plan through which the insurance is provided on line A (if known).
6	1# INSURERS ADDRESS, CITY, ST, ZIP	N/A	Enter the insurance company's address, city, state and zip (as it appears on ELGA).



# MSP Code References

## Excellent MSP Reference – Cahaba

[https://www.cahabagba.com/part\\_a/education\\_and\\_outreach/educational\\_materials/quick\\_msp.pdf](https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_msp.pdf)



# Submission of MSP Claims

The best way to get these claims paid (assuming all the fields are correct!) is:

- ANSI 837 claims
- PC-Ace

Your software vendor must be able to produce a valid 837 claim for submission.



# RHC Resources

NARHC List-Serve – just remember, it's public.

CMS Rural Center - [www.cms.gov/center/rural.asp](http://www.cms.gov/center/rural.asp)

HRSA RHC/FQHC Comparison:

<http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf>



# CMS Websites - [www.cms.gov](http://www.cms.gov)

MedLearn Catalog -

[www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf](http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf)

Medicare Claims Processing Manual – Chapter 9

[www.cms.gov/manuals/downloads/clm104c09.pdf](http://www.cms.gov/manuals/downloads/clm104c09.pdf)

CMS Medicare Secondary Payor Manual:

[www.cms.gov/manuals/downloads/msp105c03.pdf](http://www.cms.gov/manuals/downloads/msp105c03.pdf)

Preventive Services -

[www.cms.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf)



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