RHC Basics & Billing 101

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Agenda

Back to the Basics
- What is a Rural Health Clinic?
- What are the requirements to be a RHC?
- Independent vs. Provider-Based RHCs?

RHC Billing
- What qualifies as a RHC encounter?
- How is RHC billing different?
- How do I bill for RHC services?

Taking it to the Next Level
- Tomorrow at 11:00am with Janet Lytton
  - TCM, CCM, ACP, Care Management
  - In depth into non-RHC Services and incident-to
Established in 1977 by The Rural Health Clinic Services Act:

• Enacted to address an inadequate supply of physicians serving Medicare patients in rural areas.
• Enacted to increase the use of non-physician practitioners (NPs and PAs) in rural areas.
What is a RHC?

“Facilities that are engaged primarily in providing services that are typically furnished in an outpatient clinic.”

Section 1861(aa)(2) of the Social Security Act
Currently, there are more than **4000** RHCs nationwide providing primary care and preventive health services to patients in rural and underserved areas.
RHC Participation Requirements – Location

- Must be located in a non-urbanized area (determined by U.S. Census Bureau)
- Must be located in an area designated within the last 4 years by the Health Resources and Services Administration (HRSA) as one of the following types of Federally designated or certified shortage areas:
  1. Primary Care Geographic Health Professional Shortage Area (HPSA)
  2. Primary Care Population-Group HPSA
  3. Medically Underserved Area (MUA)
  4. Governor-designated and Secretary-certified shortage area
RHC Participation Requirements – Services

- Have arrangements with one or more hospitals to furnish medically-necessary services that are not available at the RHC
- Have available drugs and biologicals necessary for treating emergencies
- Services provided must be at least 51% primary care
- Directly furnish routine diagnostic and laboratory testing including the following six required laboratory tests on site...
RHC Participation Requirements – Labs

• Six Required Laboratory Tests to Provide On-site:
  1. Chemical examination of urine by stick, tablet method, or both
  2. Hemoglobin or hematocrit
  3. Blood sugar
  4. Examination of stool specimens for occult blood
  5. Pregnancy tests
  6. Primary culturing for transmittal to a certified laboratory
RHC Participation Requirements – Staffing

• Must employee at least one NP or PA
• Have an NP, PA, or CNM working at least 50% of the time the RHC operates
• Note: You can have Specialists in a RHC
RHC Participation Requirements – Miscellaneous

- Must have a quality assessment a performance improvement program (QAPI)
- Must post days and hours of operation
- Cannot be a rehabilitation agency or a facility that is primarily for the treatment of mental disease
- Cannot be a Federally Qualified Health Center (FQHC)
- Must meet other applicable State and Federal requirements
Two types of RHCs:

Independent (free-standing)

Provider-Based
Independent RHC

- Free-standing clinics owned by a provider or a provider entity
  - Majority are physician owned
- CMS Certification Number (CCN) Range:
  - xx3800 – xx3974
  - Xx8900 – xx8999
- Receive capped reimbursement rate of $83.45 (CY 2018)
- Different billing rules for technical components of lab and diagnostic services
Provider-Based RHC

- Owned and operated as an essential part of a hospital (including CAHs), skilled nursing facility (SNF), or home health agency (HHA) participating in the Medicare Program

- CMS Certification Number (CCN) Range:
  - xx3400 – xx3499
  - xx3975 – xx3999
  - xx8500 – xx8899

- Receive reimbursement based on actual cost*, also known as the RHC all-inclusive rate (AIR)
  - *Hospital must be under 50 beds or reimbursement is capped the same as a free-standing RHC ($83.45)

- Different billing rules for technical components of lab and diagnostic services
“A RHC visit is 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 a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered.”

CMS Internet Only Manual 100-02, Chapter 13
What is NOT a RHC Encounter?

- Visits only for medication refills
- Visits only for lab results
- Visits only for injections (i.e. allergy)
- Suture removal or dressing change without an additional face-to-face visit
- Visits billed using CPT code 99211 (nursing visit)
Claim Form, Bill Types & Place of Service

- RHC services are billed on a CMS-1450 (also known as a UB-04 form)
- RHCs should use Place of Service (POS) code 72
- These are the common bill types (TOBs) used on RHC claims:
## Independent vs. Provider Based RHC Billing

<table>
<thead>
<tr>
<th>Encounter for RHC Service(s)</th>
<th>CLIA Lab in RHC</th>
<th>Technical Component (Non-RHC Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill to Part A on UB-04</td>
<td>Bill to Part B on CMS-1500</td>
<td>Bill to Part B on CMS-1500</td>
</tr>
</tbody>
</table>

### Independent RHC

- Bill to Part A on UB-04
- Billed to MAC by Parent Entity
  - PPS Hospital: TOB 141/131
  - CAH: TOB 851
- Billed to MAC by Parent Entity
  - PPS Hospital: TOB 131
  - CAH: TOB 851

### Provider-Based RHC
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Clinic visit by a member to RHC</td>
</tr>
<tr>
<td>0522</td>
<td>Home visit by RHC practitioner</td>
</tr>
<tr>
<td>0524</td>
<td>Visit by RHC practitioner to member in a covered Part A stay at a SNF</td>
</tr>
<tr>
<td>0525</td>
<td>Visit by RHC practitioner to member in a non-Part A SNF, NF, ICF, or other residential facility</td>
</tr>
<tr>
<td>0527</td>
<td>RHC visiting nursing services to a member’s home in a Home Health Shortage Area</td>
</tr>
<tr>
<td>0528</td>
<td>Visit by RHC practitioner to another non-RHC site (i.e. scene of an accident)</td>
</tr>
<tr>
<td>0900</td>
<td>Mental health visit</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>0250</td>
<td>Pharmacy – drug with no J-code</td>
</tr>
<tr>
<td>0300</td>
<td>Venipuncture</td>
</tr>
<tr>
<td>0636</td>
<td>Drugs with detailed HCPCS J-code</td>
</tr>
<tr>
<td>0780</td>
<td>Telemedicine originating site</td>
</tr>
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</table>
RHC Claim Details

• RHCs are required to line-item, detail code for all services provided during the RHC visit
  • Include HCPCS codes for all services performed during that visit

• The first line of the RHC claim should be the HCPCS code for the qualifying visit
  • Modifier CG should be attached to identify the qualifying visit
  • Modifier CG signals to Medicare which line to use when calculating applicable coinsurance and deductible
RHC Claim Details

- Charges for all services provided during the visit should be “rolled up” to the first line of the claim
- Except for charges for qualifying preventive health services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>HCPCS Code</th>
<th>Amount</th>
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<tbody>
<tr>
<td>521</td>
<td>RHC Visit</td>
<td>99213-CG</td>
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<td>521</td>
<td>Procedures</td>
<td>28610</td>
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<tr>
<td>636</td>
<td>Drug</td>
<td>J3499</td>
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</tr>
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</table>
Qualifying Visit List (QVL)

- Last updated **August 1st, 2016**

**QVL consists of “frequently reported HCPCS codes that qualify as a face-to-face visit between the patient and an RHC practitioner…”**

“…**NOT** an all-inclusive list of stand-alone billable visits for RHCs.”

- [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf)
Claim Example #1

RHC Encounter – E/M Office Visit Only

- Scenario: RHC Provider completed a level-3 E/M office visit. Charge for the visit is $100.00. No additional work (incident-to or non-RHC services) were required.

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Office Visit – Established Pt III</td>
<td>99213 CG</td>
<td>10/25/2018</td>
<td>1</td>
<td>$100.00</td>
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<tr>
<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$100.00</td>
</tr>
</tbody>
</table>
Claim Example #2

RHC Encounter – Procedure Only

• Scenario: RHC Provider completed a simple I&D in the office. Charge for the visit is $150.00.

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>I&amp;D Abscess</td>
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<td>Total Charge</td>
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<td></td>
<td></td>
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</table>
Claim Example #3a

RHC Encounter – E/M Office Visit and Procedure

• Scenario: RHC Provider completed a level-3 E/M office visit and a simple I&D in the office. Charge for the E/M visit is $100.00 and for the procedure is $150.00.

<table>
<thead>
<tr>
<th>FL42</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
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</thead>
<tbody>
<tr>
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<tr>
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<td>Total Charge</td>
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<td></td>
<td></td>
<td>$400.00</td>
</tr>
</tbody>
</table>
Claim Example #3b

RHC Encounter – E/M Office Visit and Procedure

- Scenario: RHC Provider completed a level-3 E/M office visit and a simple I&D in the office. Charge for the E/M visit is $100.00 and for the procedure is $150.00. Additional charges are reported with $0.01

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Office Visit – Established Pt III</td>
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<td>$250.00</td>
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<td></td>
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</table>
**Claim Example #4**

### RHC Encounter – E/M Office Visit and Injection

- Scenario: RHC Provider completed a level-4 E/M office visit and gave the patient a Rocephin injection. Charge for the E/M visit is $150.00, for the administration is $12.00 and for the drug is $45.00.

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
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<th>FL46 Units</th>
<th>FL47 Total Charge</th>
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<tr>
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<td>$12.00</td>
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<td>0636</td>
<td>Rocephin, 250 mg</td>
<td>J0696</td>
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<td>$45.00</td>
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<td>0001</td>
<td>Total Charge</td>
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<td></td>
<td></td>
<td>$264.00</td>
</tr>
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</table>
Preventive Health Services

• When billing for preventive health services, DO NOT include charges for those services in the “roll up” to the qualifying visit line
• Medicare pays for qualifying preventive health services at 100%
• Coinsurance and deductible do not apply for qualifying preventive health services.
• **Resource:** United States Preventive Services Task Force (Grade A or B)
• **Resource:** Rural Health Clinic Preventive Services Chart
  [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf)
**Claim Example #5**

**RHC Encounter – E/M Office Visit and Preventive**

- **Scenario:** RHC Provider completed a level-4 E/M office visit. While in the office, the provider completed the patient’s IPPE. Charge for the E/M visit is $150.00, and for the IPPE is $195.00.

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Office Visit – Established Pt IV</td>
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<td>10/25/2018</td>
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<td>$150.00</td>
</tr>
<tr>
<td>0521</td>
<td>IPPE</td>
<td>G0402</td>
<td>10/25/2018</td>
<td>1</td>
<td>$195.00</td>
</tr>
<tr>
<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$345.00</td>
</tr>
</tbody>
</table>
Non-RHC Services

• RHCs may “furnish certain services that are beyond the scope of the RHC benefit”. These are considered “Non-RHC Services”

• Non-RHC services are billed separately to the appropriate MAC under the payment rules specific to that service.

• All cost associated with non-RHC services (i.e. space, equipment, supplies, facility, overhead, personnel) should be removed from the cost report.
Claim Example #6

**RHC Encounter – E/M Office Visit and EKG**

- Scenario: RHC Provider completed a level-3 E/M office visit. While in the office, the provider also did an EKG. Charge for the E/M visit is $100.00, and for the professional fee for the EKG is $25.00.

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Office Visit – Established Pt III</td>
<td>99213 CG</td>
<td>10/25/2018</td>
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<td>$125.00</td>
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<td>0521</td>
<td>EKG, interpretation and report</td>
<td>93010</td>
<td>10/25/2018</td>
<td>1</td>
<td>$25.00</td>
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<tr>
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<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$150.00</td>
</tr>
</tbody>
</table>
Claim Example #6

RHC Encounter – E/M Office Visit and EKG

- In this scenario, the technical component of the EKG (a non-RHC service) is billed differently depending on whether the RHC is independent or provider-based:

  **Independent RHC**
  - Bill HCPCS code 93005 (EKG, tracing only) to Part B on CMS-1500

  **Provider-Based RHC**
  - Parent entity will bill HCPCS code 93005 (EKG, tracing only) to MAC
### Claim Example #7

#### RHC Encounter – Mental Health Visit Only

- **Scenario:** RHC Provider completed psychiatric diagnostic evaluation with a patient. Charge for the visit is $200.00.

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>Psychiatric diagnostic evaluation</td>
<td>90791 CG</td>
<td>10/25/2018</td>
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<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$200.00</td>
</tr>
</tbody>
</table>
Multiple Visits on the Same Day

• In general, encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day count as a single RHC visit and will only receive one AIR payment.

• “This applies regardless of the length or complexity of the 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 or unrelated to the subsequent visit.”
  • Resource: CMS IOM 100-02, Chapter 13, Section 40.3

• However, there are a few specific exceptions...
Multiple Visits on the Same Day – Exceptions

• Exceptions are for the following circumstances **only**:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC). In this situation only, the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits.

- The patient has a qualified medical visit and a qualified mental health visit on the same day (2 billable visits).

- The patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits).
Claim Example #8

RHC Encounter – Medical Visit & Subsequent Visit, Same Day

- Scenario: RHC Provider completed a level-4 office visit with a patient who has diabetes. Later in the day the patient fell and came back to the RHC to be seen. Charge for the first medical visit is $150.00 and for the subsequent visit is $100.00

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Office Visit – Established Pt IV</td>
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<td>10/25/2018</td>
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<td>0521</td>
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<td>10/25/2018</td>
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<td>Total Charge</td>
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<td></td>
<td></td>
<td>$250.00</td>
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</tbody>
</table>
Claim Example #9

RHC Encounter – Medical Visit & Mental Health Visit, Same Day

- Scenario: RHC Provider completed a level-3 office visit with a patient and a mental health provider in the same office completed a psychiatric diagnostic evaluation on the same day. Charge for the medical visit is $100.00 and for the mental health visit is $200.00

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
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<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
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<tbody>
<tr>
<td>0521</td>
<td>Office Visit – Established Pt III</td>
<td>99213 CG</td>
<td>10/25/2018</td>
<td>1</td>
<td>$100.00</td>
</tr>
<tr>
<td>0900</td>
<td>Psych eval</td>
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<td>10/25/2018</td>
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<td>$200.00</td>
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<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$300.00</td>
</tr>
</tbody>
</table>
**Claim Example #10**

**RHC Encounter – IPPE, Medical Visit, & Mental Health Visit, Same Day**

- Scenario: RHC Provider completed a patient’s IPPE. While they were in the office, they were seen for their hypertension. The patient also saw a mental health provider who had a 30 minute psychotherapy session. Charge for IPPE is $195.00, for the medical visit is $150.00, and for the mental health visit is $220.00.

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
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<th>FL47 Total Charge</th>
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<td>$150.00</td>
</tr>
<tr>
<td>0521</td>
<td>IPPE</td>
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<td>10/25/2018</td>
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<td>$195.00</td>
</tr>
<tr>
<td>0900</td>
<td>Psychotherapy, 30 m</td>
<td>90832 CG</td>
<td>10/25/2018</td>
<td>1</td>
<td>$220.00</td>
</tr>
<tr>
<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$565.00</td>
</tr>
</tbody>
</table>
Coinsurance & Deductible

• Coinsurance is equal to 20% of the total charges submitted on the RHC claim.
  • It is not the Medicare allowable amount
  • Calculated from the qualifying visit line, as identified by the CG modifier

• Coinsurance and deductible are waived for qualified preventive health services

• The Part B deductible is applied to RHC visits. Patients who only have Medicare Part A coverage are not covered.
  • Part B Deductible for 2018 = $183.00
Coinsurance Calculation – Example #1

RHC Encounter – E/M Office Visit Only

<table>
<thead>
<tr>
<th>FL42</th>
<th>FL43 Description</th>
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<td>$100.00</td>
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<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$100.00</td>
</tr>
</tbody>
</table>

- Coinsurance = 20% of $100.00
- Coinsurance is **$20.00**
Coinsurance Calculation – Example #2

RHC Encounter – E/M Office Visit and Procedure

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Office Visit – Established Pt III</td>
<td>99213 CG</td>
<td>10/25/2018</td>
<td>1</td>
<td>$250.00</td>
</tr>
<tr>
<td>0521</td>
<td>I&amp;D Abscess</td>
<td>10160</td>
<td>10/25/2018</td>
<td>1</td>
<td>$150.00</td>
</tr>
<tr>
<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$400.00</td>
</tr>
</tbody>
</table>

- Coinsurance = 20% of $250.00
- Coinsurance is **$50.00**
**Coinsurance Calculation – Example #3**

### RHC Encounter – E/M Office Visit and Preventive

<table>
<thead>
<tr>
<th>FL42 Rev Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS Code</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Office Visit – Established Pt IV</td>
<td>99214 CG</td>
<td>10/25/2018</td>
<td>1</td>
<td>$150.00</td>
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<tr>
<td>0521</td>
<td>IPPE</td>
<td>G0402</td>
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<tr>
<td>0001</td>
<td>Total Charge</td>
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<td></td>
<td></td>
<td>$345.00</td>
</tr>
</tbody>
</table>

- **Coinsurance = 20% of $150.00**
- **Coinsurance is $30.00**
- **Coinsurance is waived for the IPPE.**
Influenza & Pneumococcal Vaccines

- RHCs are reimbursed for flu and pneumococcal vaccines, and their administration, through the cost report.
- DO NOT report flu and pneumococcal vaccines, nor their administration on the RHC claim.
- You should have a mechanism in place for tracking vaccines and their administration in order to accurately reconcile these on your cost report.
  - Keep a log with patient’s name, DOB, insurance information, date of immunization, at a minimum.
Non Covered Services

• Non covered services are not considered medically-necessary, therefore not covered by the RHC benefit, nor any Medicare benefit.

• The RHC should complete an Advance Beneficiary Notice of Non-Coverage (ABN) for all non covered services.

• Submit these charges using TOB 710.

• Payment for charges associated with non covered services is the responsibility of the patient.
ABN Requirements

• The ABN notifies Medicare beneficiaries that a particular service is non-covered, or that Medicare may deny payment for a particular service. In these cases, the patient is responsible for the charges.

• The ABN should be given to patients before they receive the service.
  • If it is given to them after they receive the service, it is not valid, and the RHC may be liable for any amounts Medicare does not pay. You may not bill the patient for those services.

• The ABN must include a *reasonable estimate* for the cost of the service to be provided.
  • “Reasonable estimate” is defined as within $100 or 25% of the total cost, whichever is greater.
Taking RHC Billing to the Next Level

Tomorrow at 11:00am with Janet Lytton

RHC Advanced Billing

• Learn which revenue codes to use
• Learn how to handle Part D drugs
• Learn how to bill for TCM, CCM, ACP
• Learn how to bill preventive care, non-RHC, & incident to services
Questions?