RHC BILLING OVERVIEW 2023

OREGON OFFICE OF RURAL HEALTH

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RHC BILLING V.2023: PRESENTATION OBJECTIVES

- ✓ RHC Services, Definitions/Basics, Incident to Services
- ✓ RHC Locations and Providers, RHC Services, Non-RHC Services
- ✓ Incident-to Services
- ✓ Claim Form, Charges, Revenue Codes, Types of Bill
- ✓ Surgeries, Injections, Specialists, Global Billing, Multiple Encounters

WHAT IS AN RHC?

A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.

51% of Clinic Services must be Primary Care (FP, IM, OB, Ped*)

The purpose of the RHC program is improving access to primary care in underserved rural areas.

* Subject to interpretation

RURAL HEALTH CLINIC (RHC) PAYMENT LIMIT PER-VISIT

Over an 8-year period is as follows:

- ✓ In 2021, after March 31, at $100 per visit;
- ✓ In 2022, at $113 per visit;
- ✓ In 2023, at $126 per visit;
- ✓ In 2024, at $139 per visit;
- ✓ In 2025, at $152 per visit;
- ✓ In 2026, at $165 per visit;
- ✓ In 2027, at $178 per visit;
- ✓ In 2028, at $190 per visit.

January 1, 2021 and After

All newly enrolled RHCs (as of January 1, 2021, and after), both independent and provider-based, to a national payment limit per-visit.

PROVIDER-BASED RHCS: *NOT OUTPATIENT DEPARTMENTS*

42 eCFR 413.65 (a)(2):

For purposes of this part, the term “department of a provider” does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC.

WHERE DO WE SEND MEDICARE RHC CLAIMS?

Type of RHC	Encounter Visit Incident-To/PC	CLIA Lab	Diagnostic	Hospital Professional Services
Independent	Part A/ UB-04 RHC CCN RHC NPI RHC EIN	Part B* Form 1500	Technical Components Part B*/1500	Part B* Form 1500 Medicare Group
Provider Based	Part A UB-04 RHC CCN	Billed by Parent Hospital – UB04 Hospital CCN	Billed by Parent Hospital – UB04 Hospital CCN	Part B* Form 1500 Medicare Group

WHERE DO WE SEND MEDICARE RHC CLAIMS?

Type of RHC	Medicare RHC	Medicaid/ Medicaid MCO	Medicare Advantage	Commercial
Independent	Part A/UB04 RHC CCN RHC NPI RHC EIN	MCO => POS 72 RHC NPI RHC EIN RHC NPI	Some Pay RHC rates => UB04 Bill 1500 for all others. RHC EIN	Part B/1500 POS => 11 Non-RHC NPI RHC EIN
Provider Based	Part A/ UB-04 RHC NPI RHC CCN HOSPITAL EIN	MCO => POS 72 RHC NPI Hospital EIN	Same as Above HOSPITAL EIN	Part B/1500 POS => 11 Non-RHC NPI HOSPITAL EIN

EXPANDED RHC PROVIDERS

LPC/LMFT EXPANSION

MEDICARE QUALIFIED RHC PROVIDERS: 2023

An RHC encounter can be billed for the following providers:

- ✓ Physicians (MD, or DO)
- ✓ Nurse Practitioners
- ✓ Physician Assistants
- ✓ Certified Nurse Midwives
- ✓ Chiropractor, Dentist, Optometrist, Podiatrist
- ○ Clinical Psychologist (PhD)
- ○ LCSW

EXPANDED BEHAVIORAL HEALTH PROVIDERS: 2023 CMS FINAL RULE

Therefore, CMS is finalizing the proposal to add an exception to the direct supervision requirement under our "incident to" regulation at 42 CFR 410.26 to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner (NPP), rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel, such as LPCs and LMFTs, incident to the services of a physician (or NPP).

CONSOLIDATED APPROPRIATIONS ACT 2023 H.R.2617

(MARRIAGE AND F AMILY T HERAPIST SERVICES; MARRIAGE AND FAMILY T HERAPIST; MENTAL HEALTH COUNSELOR SERVICES, MENTAL H EALTH COUNSELOR —The term ‘marriage and family therapist services’ means services furnished by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the marriage and family therapist is legally authorized to perform under State law of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service.

MEDICARE RHC -FQHC PROVIDERS 2023 (CMS FINAL RULE FY2023)

Medicare RHC -FQHC Providers 2023	
Physician	Podiatrist
Physician assistant	Psychologist
Advanced practice registered nurse (SA – Only if employed by clinic/group)	Optometrist
Clinical Psychologist	General Supervision:
Clinical Social Worker (AJ)	Licensed clinical addiction counselors
Dentist	Licensed marriage and family therapists
Chiropractor	Licensed mental health counselors

MEDICARE RHC -FQHC PROVIDERS 2024 (H.R. 2617)

Medicare RHC -FQHC Providers 2024	
Physician	Podiatrist
Physician assistant	Psychologist
Advanced practice registered nurse (SA – Only if employed by clinic/group)	Optometrist
Clinical Psychologist	Approved RHC Providers 2024:
Clinical Social Worker (AJ)	Licensed clinical addiction counselors
Dentist	Licensed marriage and family therapists
Chiropractor	Licensed mental health counselors

MEDICARE RHC LOCATIONS

RHC visits may take place in:

- the RHC or FQHC,
- the patient's residence (including an assisted living facility),
- a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
- the scene of an accident.
- Hospice (effective 1.1.2022!)

(Medicare Benefit Policy Manual. Chapter 13. Section 40.1)

NEVER AN RHC LOCATION

RHC Visits may never take place in:

- ✓ an inpatient or outpatient department of a hospital, including a CAH, or
- ✓ a facility which has specific requirements that preclude RHC or FQHC visits (e.g., Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.)

(Medicare Benefit Policy Manual. Chapter 13. Section 40.1)

THE RHC ENCOUNTER IS:

"An RHC or FQHC 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 or FQHC services are rendered."

(Medicare Benefit Policy Manual. Chapter 13. Section 40.)

RHC ENCOUNTER DEFINITION:

A visit is a face-to-face encounter between an RHC client and a physician, PA, NP, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit.

§ 405.2463 WHAT CONSTITUTES A VISIT

A mental health visit is a face-to-face encounter, or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio only interactions in cases where the patient is not capable of, or does not consent to, the use of technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder…

MENTAL HEALTH VISITS FURNISHED USING TELEHEALTH

Beginning January 1, 2022, RHC mental health visits will include visits furnished using interactive, real-time telecommunications technology.

This change will allow RHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, *including audio-only visits* when the beneficiary is not capable of, or does not consent to, the use of video technology.

CMS Rural Health Clinic Center

IN-PERSON VISITS - DELAYED

"Section 4113 of the CAA, 2023 delayed the in-person requirements under Medicare for mental health services furnished through telehealth under the PFS and for mental health visits furnished by RHCs via telecommunications technology. **For RHCs, in-person visits will not be required until January 1, 2025,** if the PHE ends prior to that date."

CMS Rural Health Clinic Center

BEHAVIORAL HEALTH CLAIMS VIA TELEHEALTH

"RHCs should bill Revenue code 0900, along with the appropriate HCPCS code for the mental health visit along with modifier CG. Use modifier 95 for services furnished via audio and video telecommunications and use modifier FQ for services that were furnished audio-only."

CMS Rural Health Clinic Center

BEHAVIORAL HEALTH => TELEHEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min	90832 CG 95	01/01/2022	1	$ 120.00
0001	Total Charge				$ 120.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Audio-Only Pt 30 Min	90832 CG FQ	01/01/2022	1	$ 120.00
0001	Total Charge				$ 120.00

RHC SERVICES

50.1 - RHC Services

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHC services include:

- ✓ Physicians' services, as described in section 110;
- ✓ Services and supplies incident to a physician’s services, as described in section 120;
- ✓ Services of NPs, PAs, and CNMs, as described in section 130;
- ✓ Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 140;
- ✓ CP and CSW services, as described in section 150;
- ✓ Services and supplies incident to the services of CPs, as described in section 160; and
- ✓ Visiting nurse services to patients confined to the home, as described in section 190.
- ✓ Certain care management services, as described in section 230.
- ✓ Certain virtual communication services, as described in section 240.

RHC SERVICES

50.1 - RHC Services

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHC services also include certain preventive services (see section 220 – Preventive Health Services). These services include:

- Influenza, Pneumococcal, Hepatitis B vaccinations;
- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.

190.2 - REQUIREMENTS FOR FURNISHING VISITING NURSING SERVICE

RHCs and FQHCs are paid for visiting nursing services when G0490 is on an RHC or FQHC claim and all of the following requirements are met:

190.2 - REQUIREMENTS FOR FURNISHING VISITING NURSING SERVICE

Visiting Nurse Requirements:

- ✓ *The patient is considered confined to the home* as defined in section 1835(a) of the Act and the Medicare Benefit Policy Manual, Chapter 7:
- ✓ The RHC or FQHC is located in an area that has a shortage of home health agencies*;
- ✓ The services and supplies are provided under a written plan of treatment;
- ✓ Nursing services are furnished on a part-time or intermittent basis only; and
- ✓ Drugs and biological products are not provided.

HOME HEALTH SHORTAGE AND PHE

During the PHE, all HPSAs were determined to be Home Health Shortage Areas. This has not been extended.

INCIDENT-TO SERVICES DEFINED

- ✓ Incident-to services are considered covered ***and paid*** under the RHC.
- ✓ They must be bundled with the RHC encounter. They are not separately billable or payable.
- ✓ Services that do not occur on the same date as the encounter can be bundled if they occur “within a medically reasonable timeframe”, before or after the encounter.
- ✓ The effect on payment is an increase in the charge, and therefore in the co-insurance.
- ✓ The cost for these services are included in the cost report, but are not separately payable on claims.

PROVISION OF INCIDENT-TO SERVICES

Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service.

Direct supervision does not mean that the physician must be present in the same room…the physician must be in the RHC or FQHC and immediately available.

(Medicare Benefit Policy Manual. Chapter 13. Section 110.1)

EXAMPLES OF NON-ENCOUNTER – NO MEDICAL NECESSITY

- ✓ Injections
- ✓ Suture Removal
- ✓ Dressing Changes
- ✓ Prescription Services
- ✓ Blood Pressure Monitoring

VENIPUNCTURE

"Although RHCs and FQHCs are required to furnish certain laboratory services…laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit." (MLN Matters® MM8504)

QUALIFYING VISITS

Medical Services RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

RHC Qualifying Visit List

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

QUALIFYING VISIT LINE CHARGE (052X) VS TOTAL CHARGE (0001)

RHC QVL FAQ: THE BEST RHC BUNDLING RESOURCE!

- ✓ Medicare does not adjudicate RHC claims based on the 0001 Total Charge amount.
- ✓ Medicare adjudicates RHC claims using the Qualifying Visit Line.
- ✓ The qualifying visit line should be the ***sum of all RHC charges minus any preventive services***.

Total Charges WILL be reported as allowed charges on remits, BUT:

Patient Co-Insurance/Deductible amounts are based on the Qualifying Visit Line.

RHC SERVICES – CLAIM FORM

- ✓ RHC Services are submitted on a CMS-UB04 claim form.
- ✓ The electronic format is ANSI837-Institutional.
- ✓ Type of Bill is “711” for an original claim.
- ✓ All services must be reported using the appropriate revenue code.
- ✓ All claims must have a qualifying visit denoted with a “CG” Modifier.
- ✓ Incident-to services must be reported on the claim, but bundled with the qualifying visit.

REVENUE CODES

The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid revenue codes *except* 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x- 088x, 093x, or 096x-310x. RHCs should report the most appropriate revenue code for the services being performed. (MLN 9269)

REVENUE CODES

0521	All Clinic Visits and Professional Services by qualified RHC provider;
0522	Home visit by RHC provider;
0524	Visit by RHC provider to a Part A SNF bed;
0525	Visit by RHC provider to a non-SNF bed, NF or other residential facility (non-Part A);
0527	Visiting Nurse service in home health shortage area
0528	Visit by RHC provider to other non-RHC site (scene of an accident)
0250	Pharmacy (Does not need the HCPCS)
0300	Venipuncture
0636	Injection/Immunization
0780	Telehealth
0900	Behavioral Health

MEDICARE FEES (PATIENT CHARGES)

"RHCs and FQHCs must charge Medicare beneficiaries the same rate that non-Medicare beneficiaries are charged."

(Medicare Benefit Policy Manual. Chapter 13. Section 80.)

MEDICARE PAYMENTS

"In general, Medicare pays 80 percent of the RHC or FQHC's all-inclusive rate, subject to a per-visit payment limit. The beneficiary in an RHC must pay the deductible and coinsurance amount."

(Medicare Benefit Policy Manual. Chapter 13. Section 80.)

CG MODIFIER

"…beginning on October 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible." (Med Learn Matters SE1611)

"If only preventive services are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the medically necessary face-to-face visit and the bundled charges."

BILLING EXAMPLE: CG MODIFIER

An established patient is seen and a qualifying visit of 99213 for $100 is generated. The applicable coinsurance and/or deductible is calculated using $100.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	08/02/2022	1	$ 100.00
0001	Total Charge				$ 100.00

BILLING EXAMPLE: INCIDENT-TO SERVICES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	8/2/2022	1	$ 150.00
0636	Injection Admin	96372	8/2/2022	1	$ 20.00
0636	Toradol	J1885	8/2/2022	1	$ 30.00
0001	Total Charge				$ 200.00

- ✓ J1885 ($30.00) and 96372 ($20.00) are bundled with 99213 ($100) on the qualifying visit line.
- ✓ The total QVL Charge is $150.00; the sum of all services reported on the claim.
- ✓ The total charge line (0001) is inflated due to duplicating the injection/admin charges from the detail lines.

“ALTERNATE METHOD” FOR REPORTING SERVICE DETAIL

Service detail lines can be reported as $.01 or greater. The additional services lines CAN be reported as $.01. This eliminates artificial inflation of revenue, adjustments, and AR.

The CG Modifier-QVL line is used to calculate total charges for co-insurance/deductible calculations.

"ALTERNATE METHOD" SERVICE DETAIL REPORTING

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	8/2/2022	1	$ 150.02
0636	Injection Admin	96372	8/2/2022	1	$ 0.01
0636	Toradol	J1885	8/2/2022	1	$ 0.01
0001	Total Charge				$ 150.04

- ✓ The Injection and Medication Charges ($20.00/$30.00) are added to the 99213 qualifying visit line.
- ✓ The detail lines are reported as $.01.
- ✓ The total charges are no longer falsely inflated.

BUNDLED SERVICES – DIFFERENT DATES

"…services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe." (MBPM 13; Section 120.3)

Do NOT span dates on the "Admit From" and "Admit Through" dates. This will cause other claims submitted within those dates to reject.

BILLING EXAMPLE: BUNDLED INJECTION/DIFFERENT DATES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	08/02/2022	1	$ 180.04
0636	Allergy Injection	95115	08/02/2022	4	$ 0.04
0001	Total Charge				$ 180.08

Four weekly allergy injections @ $20.00 each were provided. An Office Visit occurred on 4.2.2020.

- ✓ Four allergy injections are bundled with the $100 charge on the 99213 qualifying visit line.
- ✓ Medicare will use the line with the qualifying visit code (99213) to determine the total charge and calculate co-insurance.

BILLING EXAMPLE: OFFICE VISIT PLUS VENIPUNCTURE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 3	99213 CG	08/02/2022	1	$ 125.01
0521	Venipuncture	36415	08/02/2022	1	$ 0.01
0001	Total Charge				$ 125.02

- ✓ An office visit and a venipuncture are performed.
- ✓ The venipuncture ($25.00) is bundled with the office visit charge ($100.00).
- ✓ Venipuncture must be bundled and submitted with a valid RHC encounter.
- ✓ If a medically-necessary encounter is not performed, a stand-alone venipuncture cannot be billed.
- ✓ It is recommended that these are ***posted, zero-charged, and NOT submitted on a claim.***

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.
- ✓ 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.

VISITING SPECIALISTS IN AN RHC

- ✓ Any qualified provider (MD, DO, NP, PA) can see patients in an RHC.
- ✓ RHC must provide primary care services fifty-one percent of ***total provider hours***. (FP, IM, Peds, OB)
- ✓ Specialists can be integrated into the RHC.
- ✓ Commercial and Medicaid enrollment should be assessed.
- ✓ All services rendered within the four walls of the

BILLING EXAMPLE: PROCEDURES ONLY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Procedure	11100 CG	08/02/2022	1	$ 150.00
0001	Total Charge				$ 150.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Procedure	99213CG	08/02/2022	1	$ 650.01
0521	Wound Rpr < 2.5 cm	12031	08/02/2022	1	$ 0.01
0001	Total Charge				$ 650.02

BILLING EXAMPLE: OFFICE VISIT PLUS PROCEDURE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 3	99213 CG	08/02/2022	1	$ 280.00
0521	Joint Injection	20610	08/02/2022		$ 0.01
0001	Total Charge				$ 280.01

- ✓ An office visit is performed in addition to a joint-injection at the same visit.
- ✓ The joint injection ($180.00) is bundled with the ($100.00) office visit charge.
- ✓ These should be bundled and submitted on the same encounter.
- ✓ The joint injection is on the QVL; if performed independently it is paid at the AIR.

GLOBAL BILLING

Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services.

The RHC is paid based on its all-inclusive rate and is not subject to the Medicare global billing requirements.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements.

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

MULTIPLE ENCOUNTERS ARE ALLOWED WHEN:

- ✓ The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (2 visits), or
- ✓ The patient has a medical visit and a Behavioral health visit on the same day (2 visits), or
- ✓ The patient has his/her IPPE and a separate medical and/or Behavioral health visit on the same day (2 or 3 visits).

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

BEHAVIORAL HEALTH SERVICES

Behavioral Health Services performed by a qualified provider are billed using revenue code 900.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Rx Management	90832CG	08/02/2021	1	$ 120.00
0001	Total Charge				$ 120.00

BEHAVIORAL HEALTH QUALIFIED VISITS

HCPCS	Short Description
90791	Psych Diagnostic Evaluation
90792	Psych Diag Eval w/Med Srvcs
90832	Psytx Pt/Family 30 minutes
90834	Psytx Pt/Family 45 minutes
90837	Psytx Pt/Family 60 minutes
90839	Psytx Crisis Initial 60 min
90845	Psychoanalysis

CLAIM EXAMPLE: SICK VISIT AND BEHAVIORAL HEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	04/02/2020	1	$ 220.00
0900	Rx Management	90832CG	04/02/2020	1	$ 120.00
0001	Total Charge				$ 340.00

Modifier CG should be reported once per day for a qualified medical visit (revenue code 052x) and/or once per day for a qualified Behavioral health visit (revenue code 0900).

NOTE: Limited number of scenarios that require TWO CG Modifiers!

NON-RHC SERVICES

NON-RURAL HEALTH SERVICES

"RHCs and FQHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit.

If these services are authorized…the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service.

(Medicare Benefit Policy Manual Chapter 13; Section 60)

MEDICARE TECHNICAL COMPONENTS AND LAB: NON-RHC SERVICES

“These services may be billed separately to the A/B MAC by the facility). (The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner or furnished incident to an RHC or FQHC visit).”

“… laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report.”

NON-RURAL HEALTH SERVICES

Non-RHC/FQHC services include, but are not limited to:

List of Non-RHC Services	
Medicare Excluded Services	Ambulance Services
Technical Components	Prosthetic Devices
Laboratory Services	Body Braces
Durable Medical Equipment	Practitioner Services At Certain Other Medicare Facility
Telehealth Distant-site Services	Hospice Services
Group Services	

NON-RURAL HEALTH SERVICES

Non-Rural Health Services can be billed to the fee-for-service carrier (or hospital MAC). These services include:

- ✓ Diagnostic testing - X-Ray, EKG, etc.
- ✓ Laboratory services – except Venipuncture!
- ✓ Professional services rendered in the hospital

TECHNICAL COMPONENTS AND LAB: NON-RHC SERVICES

All lab and technical components are billed to the Medicare Part B MAC – NOT Part A.

The technical component of these tests are Non-RHC services, billed fee-for-service.

CAHs receive cost-based reimbursement.

Independents and PPS hospitals are paid on a fee schedule.

DIAGNOSTIC TESTING AND LAB: INDEPENDENT

The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.

- ✓ The technical component of these tests are billed to the Medicare Part B MAC using the fee-for-service provider number.
- ✓ All lab services are also billed to the Part B MAC.

DIAGNOSTIC TESTING AND LAB: PROVIDER-BASED

The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.

- ✓ The technical components for X-Ray, EKG, ultrasounds, etc. are billed to the MAC using the hospital CCN number.
- ✓ Lab services are also billed to the FI using the hospital CCN number.

PROVIDER-BASED DIAGNOSTIC CLAIMS - CAH

PBRHC owned by CAH: Billed using *parent's CCN*, payment is cost-based.

LAB:	TOB 851/Rev Code 300/UB04
RAD-TC:	TOB 851/Rev Code 320/UB04
EKG-TC:	TOB 851/Rev Code 730/UB04

PROVIDER-BASED DIAGNOSTIC CLAIMS - PPS

PBRHC owned by **PPS**: Billed using ***parent's CCN***, payment is based on the Medicare Fee Schedule.

Lab:	TOB 141/Rev Code 300/UB04
Rad-TC :	TOB 141/Rev Code 320/UB04
EKG-TC:	TOB 141/Rev Code 730/UB04

PROFESSIONAL COMPONENTS: DIAGNOSTIC TESTING

The professional component for X-Ray, EKG, and diagnostic testing is bundled with the RHC encounter.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
521	OV Est 3	99213 CG	08/02/2022	1	$ 155.00
521	EKG-PC	93010	08/02/2022	1	$ 30.00
521	Venipuncture	36415	08/02/2022	1	$ 25.00
001	Total Charge				$ 210.00

PROFESSIONAL COMPONENTS: DIAGNOSTIC TESTING

The professional component for X-Ray, EKG, and diagnostic testing is bundled with the RHC encounter.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
521	OV Est 3	99213 CG	08/02/2022	1	$ 155.02
521	EKG-PC	93010	08/02/2022	1	$ .01
0521	Venipuncture	36415	08/02/2022	1	$ .01
001	Total Charge				$ 155.04

HOSPITAL SERVICES

- ✓ Physician services at the hospital are billed to the Medicare Administrative Contractor for fee-for-service reimbursement.
- ✓ If the parent-entity is a Critical Access Hospital (CAH) using option II billing – out-patient hospital services are billed to the parent's MAC.

RHC - CMS RESOURCES

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

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