RHC Coding & Billing: The Fundamental Concepts

Oregon Office of Rural Health

March 4, 2025

inQuiseek Consulting

The Fundamental Concepts of RHC Billing

- Understanding the RHC Reimbursement Model
- Understanding the RHC Encounter definition
- Understanding Medicare Deductibles and Coinsurance in an RHC
- Understanding the Bill Format for Medicare Claims
- Understanding the –CG Modifier/-CG Roll-up
- Understanding Split Billing
- Understanding Modifier Use
- Understanding Medicare Immunization in an RHC
- Understanding Telehealth in the RHC

RHC Reimbursement, Cost Reporting Basics, Coding and Billing

Cost-based Reimbursement Methodology

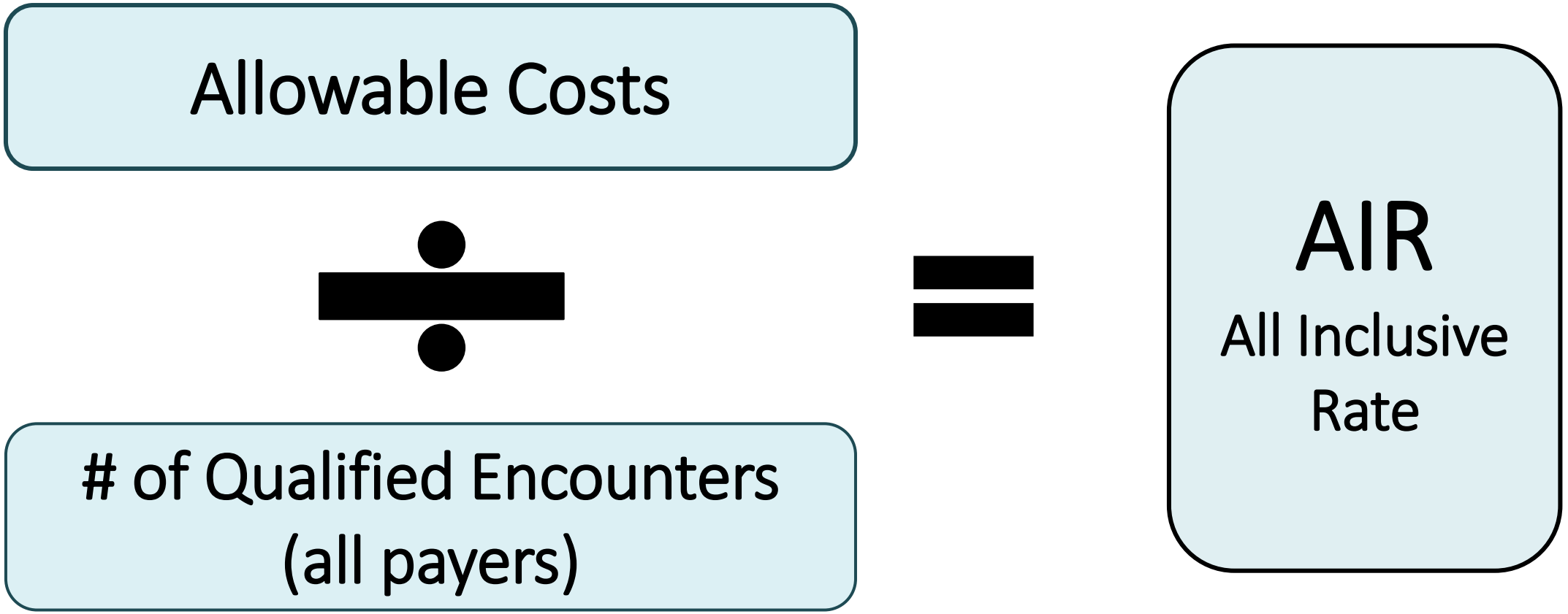
- For traditional Medicare and Medicaid, RHCs are paid based on a cost-based methodology.
- RHCs are paid per encounter for RHC services.
- For traditional Medicare, the All-Inclusive rate (AIR) is calculated on the cost report annually.
- For Medicaid, a base rate is increased annually by an inflation factor.
- Some non-RHC services may be paid using a fee-for-service methodology.

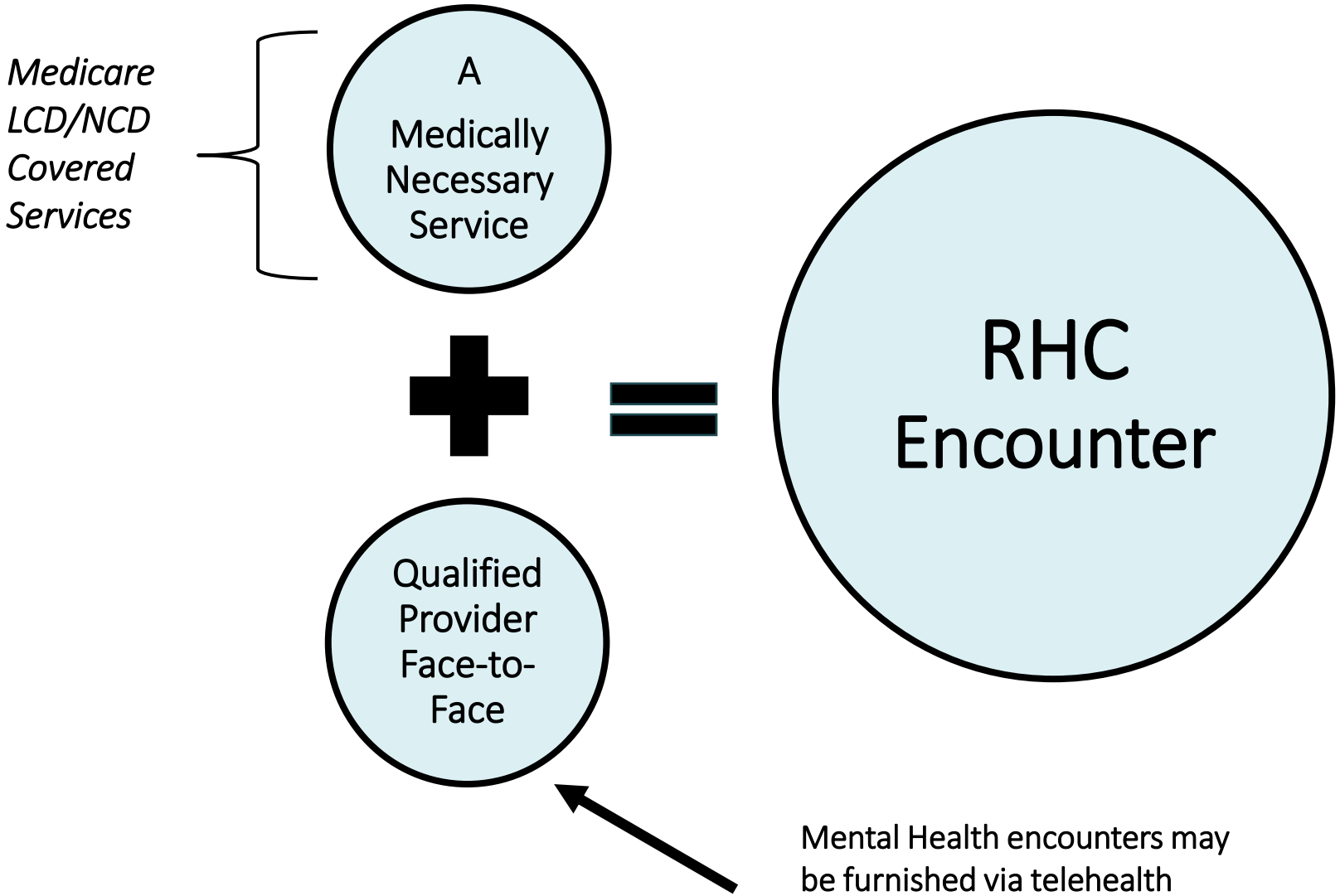
Medicaid Reimbursement Methodologies

One of these cost-based methodologies is typically used for Medicaid Reimbursement:

- **First year full cost report** is used as the RHC base rate. That rate is adjusted for inflation based on the MEI each year. Texas and Mississippi, for example
- **Proximity rate**: The RHC is paid per encounter based on what other RHCs with similar services are reimbursed. RHCs may be paid based on geographic location based on a state methodology. (Tennessee) This may be an average, a per clinic rate or a fixed amount. Louisiana uses a proximity rate-setting methodology.
- **Actual costs** per state Medicaid cost report. Some CAHs, for example.
- **Matches Medicare AIR rate** each year. Oklahoma, for example.
- **Wrap Payment**: The RHC is paid fee-for-service by the MCOs and then there is a monthly or quarterly supplemental payment made to make the RHC whole on the per encounter rate. Tennessee and Florida, for example.

Medicare AIR Calculation





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.

These services when done alone do not qualify as a standalone billable Medicare or Medicaid services, but they are still a good use of resources. The direct expense of these services are allowable costs in the AIR calculation.

Nurse Visits 99211
Immunization/Injection Only Visits
Blood Pressure Checks

Upper Payment Limits (AIR) for clinics after 2020 and for independent clinics prior to 2020

- **2021**: $100 per visit
- **2022**: $113 per visit
- **2023**: $126 per visit
- **2024**: $139 per visit
- **2025**: $152 per visit
- **2026**: $165 per visit
- **2027**: $178 per visit
- **2028**: $190 per visit

The lesser of the actual cost per visit from the cost report OR the UPL for the calendar year.

Established provider=based RHCs (before 2020) receive a grandfathered AIR that increased each year by a MEI. Their AIR is the lesser of actual cost per visit or their grandfathered AIR.

Traditional Medicare Reimbursement

Total Charges for Encounter	415.00			
(E & M Service, Injection, procedure)				
AIR $152 for 2025 Independent Clinic				
MAC pays .80% of AIR	121.60			
.8 x 152				
			$204.60	
Coinsurance After Deductible	83.00		Total Reimbursement	
20% of total Charges				
.2 x $415				

Changes to Credit Balance Reporting

- All institutional Providers must report true credit balances on patient accounts which have resulted from Medicare overpayments.
- Beginning in December 2024, the reporting is done only when credit balances are present.
- Previously, Credit Balance Reports (CMS 838) were due whether there was a credit balance or not.
- Credit balances are reported when Medicare has over-paid or Medicare paid as primary when it should have been secondary.
- Research credit balances. Do not report credit balances from patient overpayments or from posting errors.
- Reports can be faxed or reported through your MAC's portal.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0600

MEDICARE CREDIT BALANCE REPORT
CERTIFICATION PAGE

The Medicare Credit Balance Report is required under the authority of sections 1815(a), 1833(e),1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

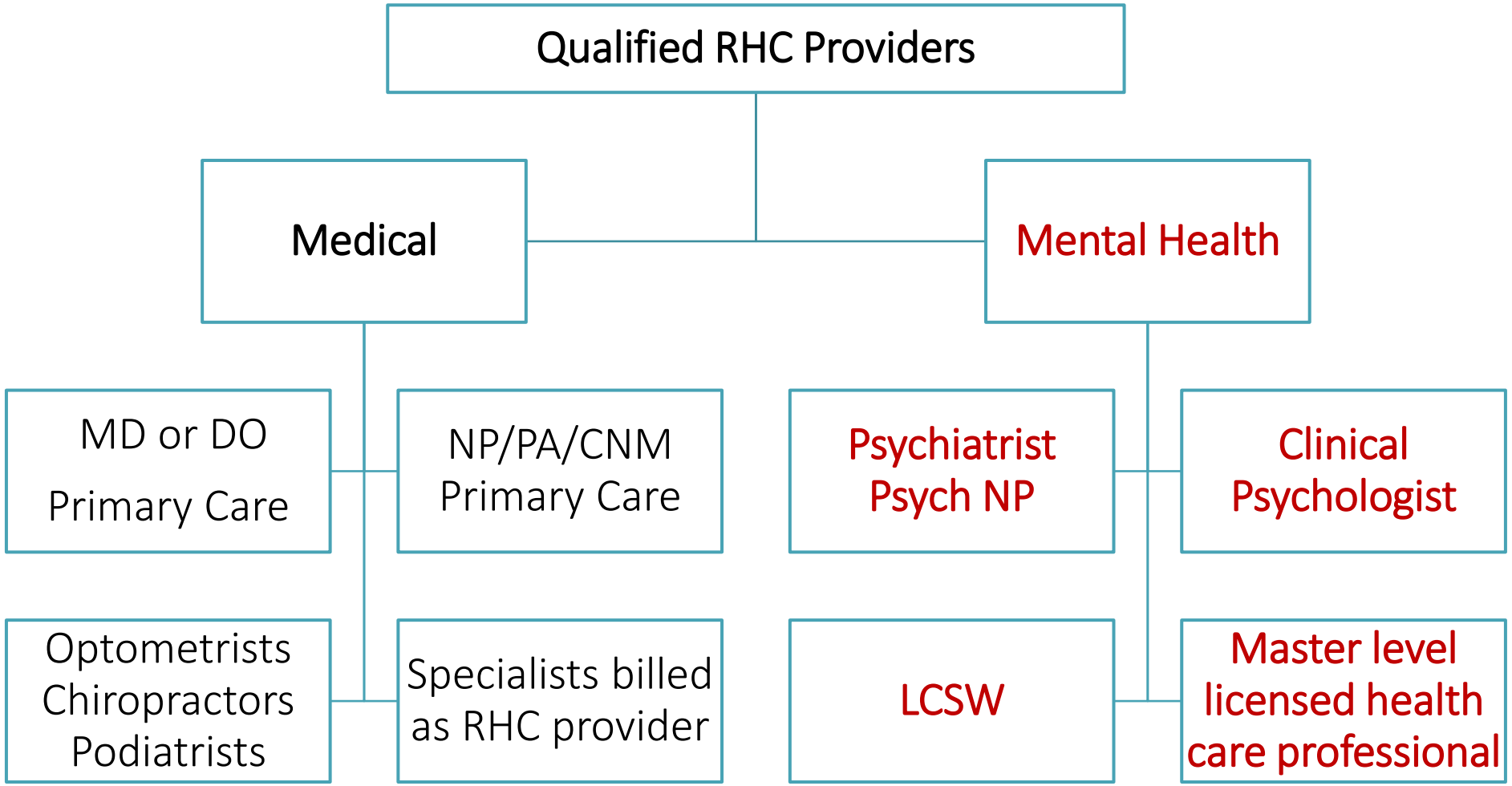
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by:

Provider Name	Provider 6-Digit Number

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

RHC Providers and Qualifying Visits


Qualified RHC Providers
Medical
Mental Health
MD or DO
Primary Care
NP/PA/CNM
Primary Care
Psychiatrist
Psych NP
Clinical
Psychologist
Optometrists
Chiropractors
Podiatrists
Specialists billed
as RHC provider
LCSW
Master level
licensed health
care professional
Must still have primary care providers
available and present in the clinic

Printed Copy is not updated for 2021 changes to E & M codes

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 Medicare Claim Basics

Institutional Claim 837I

UB-04

Bill Type 71x

711: regular claim

710: for non-covered services

717: Adjusted claim

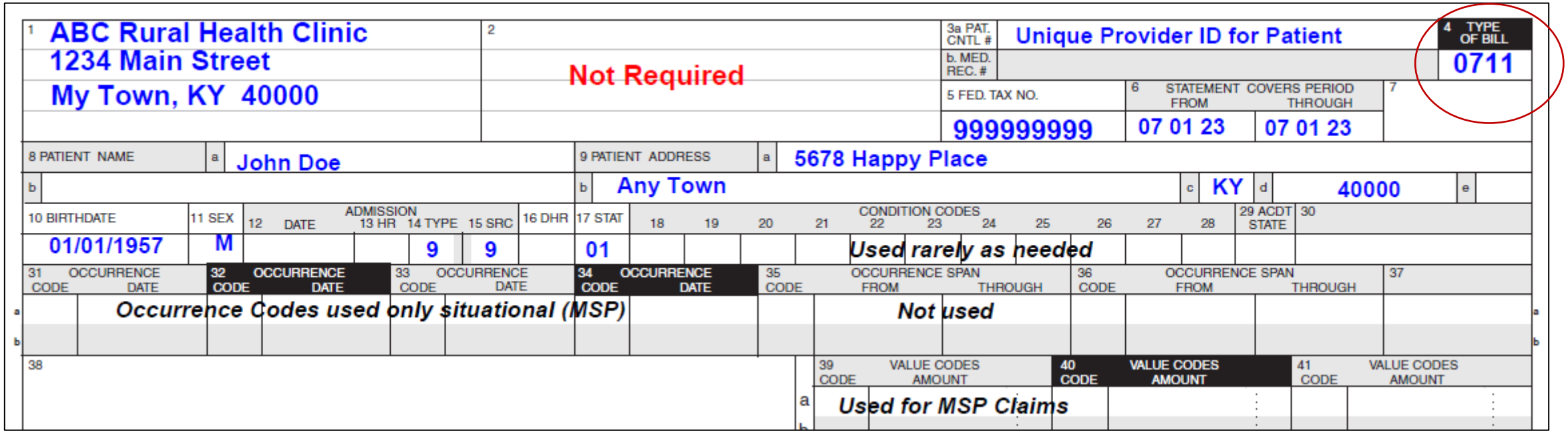
718: Cancelled claim

Cat 2 Quality codes can go on the UB-04

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12941	**Date: October 31, 2024**
	Change Request 13817

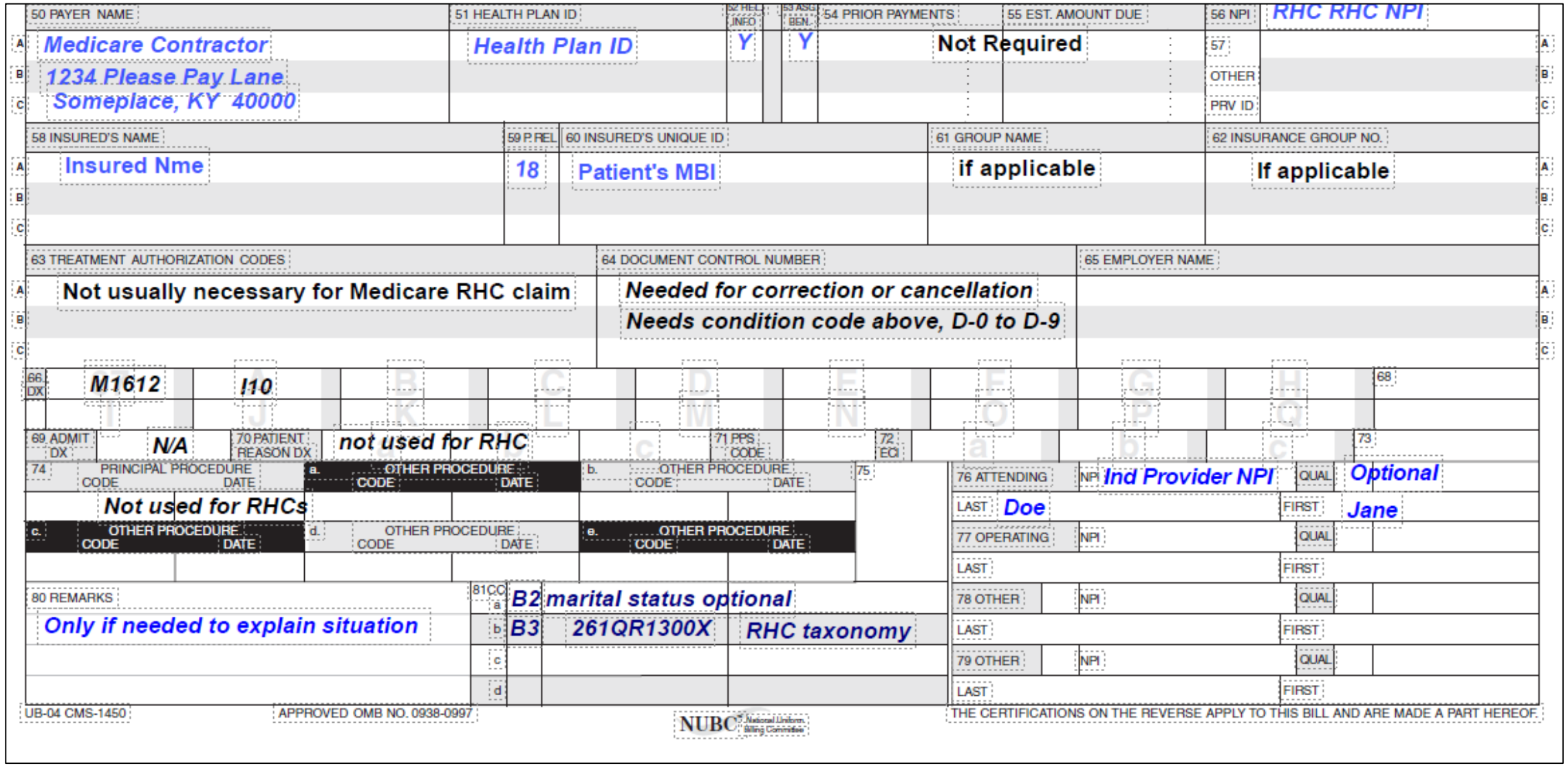
SUBJECT: Updates to Allow Category II Codes to be Submitted on Rural Health Clinic (RHC) Claims

https://www.cms.gov/files/document/r12941otn.pdf


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
9 PATIENT ADDRESS
a
5678 Happy Place
b
Any Town
c
KY
d
40000
e
10 BIRTHDATE
01/01/1957
11 SEX
M
12 ADMISSION DATE
13 HR
14 TYPE
9
15 SRC
9
16 DHR
17 STAT
01
18 19 20 21 22 23 24 25 26 27 28
CONDITION CODES
Used rarely as needed
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
Occurrence Codes used only situational (MSP)
35 OCCURRENCE SPAN CODE FROM THROUGH
Not used
36 OCCURRENCE SPAN CODE FROM THROUGH
37
a
b
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
Used for MSP Claims
b

	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

- Revenue Codes required
- Description Optional
- CPT/HCPCS® required for all service lines
- One date of service
- Units
- Customary Charge (do not set all E & M charges at the AIR)


50 PAYER NAME
Medicare Contractor
1234 Please Pay Lane
Someplace, KY 40000
51 HEALTH PLAN ID
Health Plan ID
52 REL INFO
Y
53 ASG BEN
Y
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
Not Required
56 NPI
RHC RHC NPI
57 OTHER
PRV ID
58 INSURED'S NAME
Insured Nme
59 P REL
18
60 INSURED'S UNIQUE ID
Patient's MBI
61 GROUP NAME
if applicable
62 INSURANCE GROUP NO.
If applicable
63 TREATMENT AUTHORIZATION CODES
Not usually necessary for Medicare RHC claim
64 DOCUMENT CONTROL NUMBER
Needed for correction or cancellation
Needs condition code above, D-0 to D-9
65 EMPLOYER NAME
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
Not used for RHCs
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
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
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

- The RHC is the billing provider (facility) for UB-04
- Use RHC NPI in FL 56
- Individual Provider is *Attending Provider* in FL 76
- Two additional individual NPIs can be reported
- RHC Taxonomy Code in FL 81CC, B3
- No reassignment of benefits required for Part A claims

Revenue Codes By Encounter Location

RHC
521

Home
522

Revenue Code by Encounter Location

Swingbed or SNF
524

Accident Scene
528

Nursing Home
524 or 525

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

Other Common Revenue Codes

Revenue Code	Type of Service
300	Venipuncture
636	J Code Injectable Drugs
250	General Pharmacy
780	Originating Site Telehealth (Q3014)

RHC Encounter in Clinic

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	07/01/2024	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 encounter occurred within the four walls of the RHC (rev code 521). If the deductible has been met, the MAC will pay 80% of the AIR and the patient coinsurance will be $50 or 20% of the total charges on the –CG line.

E & M Coding Guidelines changes in 2021 and again in 2023. Levels are now determined by EITHER medical decision-making OR time.

Home Encounter
Face to face with qualified RHC provider
Not a nurse visit

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0522	Home visit	99341 CG	11/01/2024	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 and beyond. 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 or SNF 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	11/01/2023	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	11/01/2024	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.

Mental Health Services	
HCPCS Code	**Short Descriptor**
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

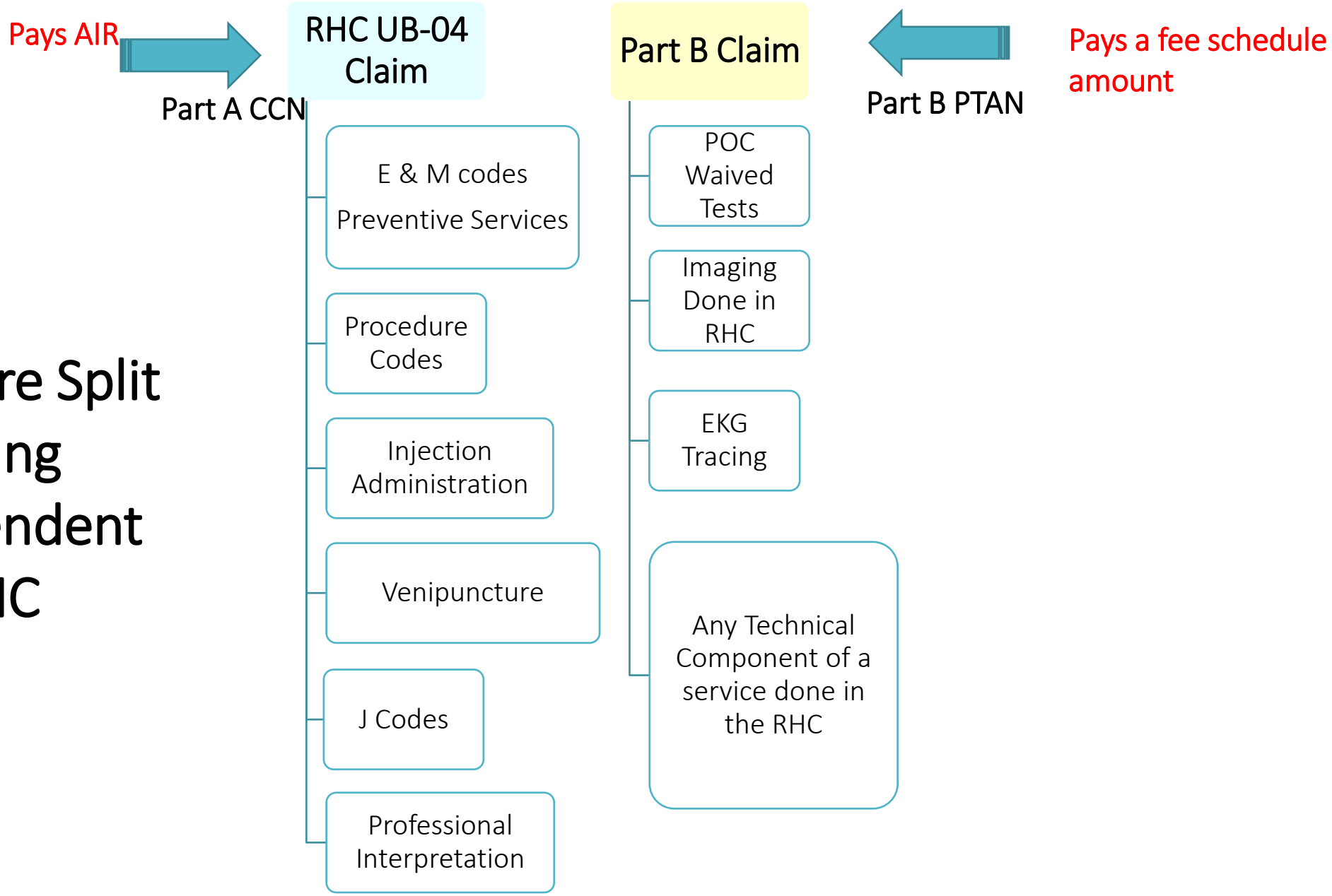
RHC Encounter: In- Person Mental Health Visit Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Psych Eval	90791 CG	11/01/2024	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. This claim example represents a behavioral health visit occurring in the RHC. See other examples of mental health telehealth. Mental health provider will have a mental health individual taxonomy code.

RHC Medicare Split Billing

Medicare Split Billing Independent RHC



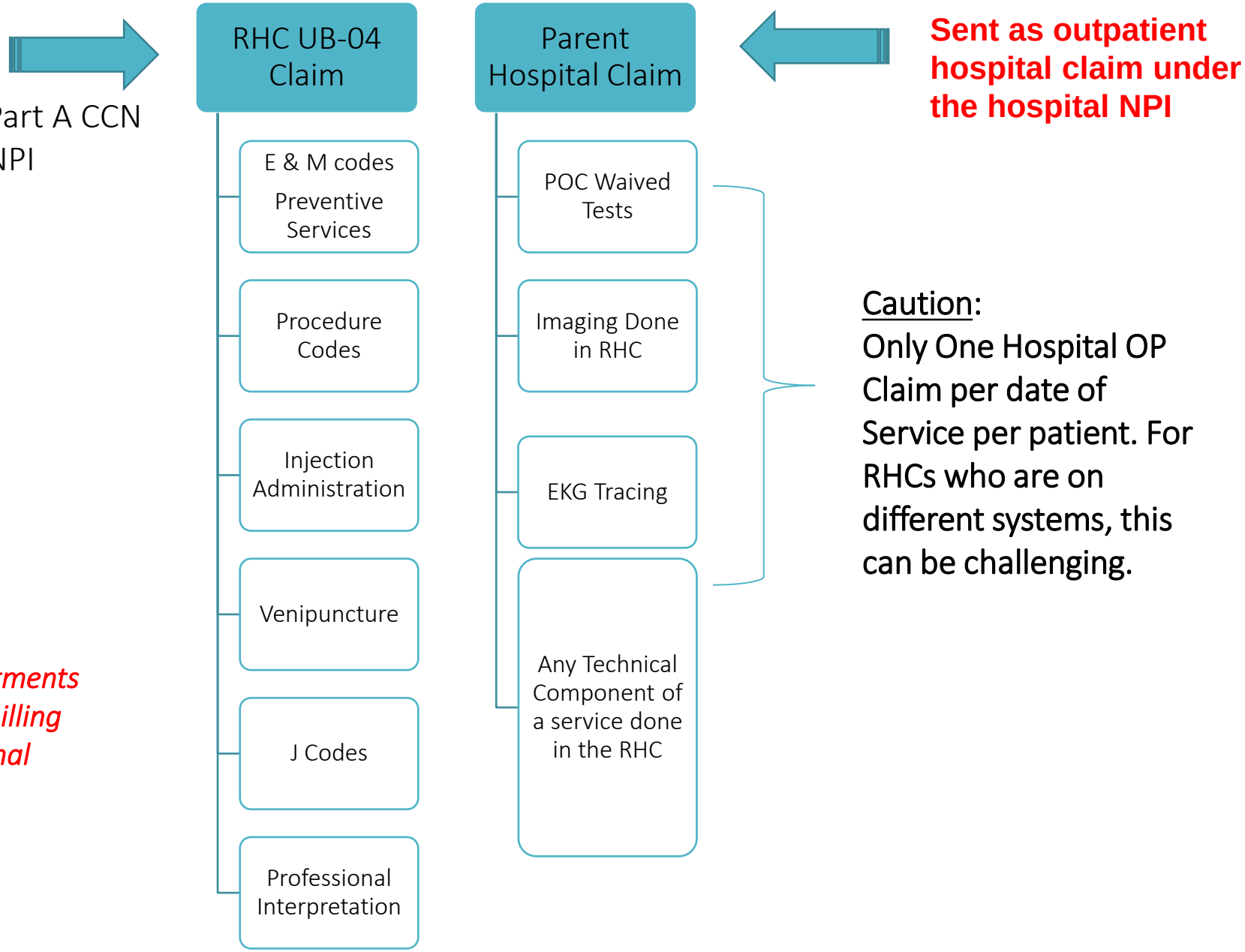
- **You should NOT bill procedures or injections to Part B for increased reimbursement. RHC Hours versus Non-RHC Hours. Pros and Cons.**
- **You should NOT have a separate "treatment" room in your RHC that is used to carve out or redirect payment for procedures.**
- **Do NOT include required tests* on the RHC UB Medicare Claim. Do not include other waived tests on the RHC UB Medicare Claim.**
- **The four(4) required tests are billable to Part B along with other Point of Care testing done in your office.***
- **Pass-through lab billing is a compliance issue.**

* 2025 PFS final rule reduced the required test to four(4) instead of six(6). Make sure your state now agrees with the federal guidance.

Medicare Split Billing PBRHC

Pays AIR

RHC Part A CCN
RHC NPI



Sent as outpatient hospital claim under the hospital NPI

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

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

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 Novitas by Parent hospital TOB 141/131 for PPS hospital; CAH: 851.	Billed to Novitas by Parent hospital TOB 131 for PPS hospital; CAH:851	Billed to Novitas 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.

Regular 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. EKGs done as an optional part of the IPPE preventive visit are reported differently.

EKG Coding with Welcome to Medicare Exam

IPPE Coding

The four HCPCS codes used to report IPPE services and ECG screenings are:

- G0402 – IPPE is a face to face visit. Service is limited to a new beneficiary during the first 12 months of Medicare enrollment.
- G0403 – Electrocardiogram (ECG) performed as a screening for the IPPE (with interpretation and report)
- G0404 – ECG performed as a screening for the IPPE (tracing only without interpretation and report) Technical Component
- G0405 – ECG performed as a screening for the IPPE (interpretation and report only) Professional Component

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	11/01/2024	1	145.00
0521	EKG- Prof	93010	11/01/2024	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.***

The –CG Roll-up

Still one of the most common RHC billing errors in claim set-up and reporting.

- One –CG per claim with one exception. If a medical and mental health encounter on the same day, each qualifying visit will have a –CG.
- -CG is amended to the qualifying visit code with either a 52x or 900 revenue code.
- All RHC line items charges roll up to the –CG line.
- The –CG line will be the only line that processes.
- The deductible and co-insurance will normally be calculated from the –CG line.
- NO labs roll up to the –CG line. These always split bill.
- -CG NOT used for services which do not pay the AIR.

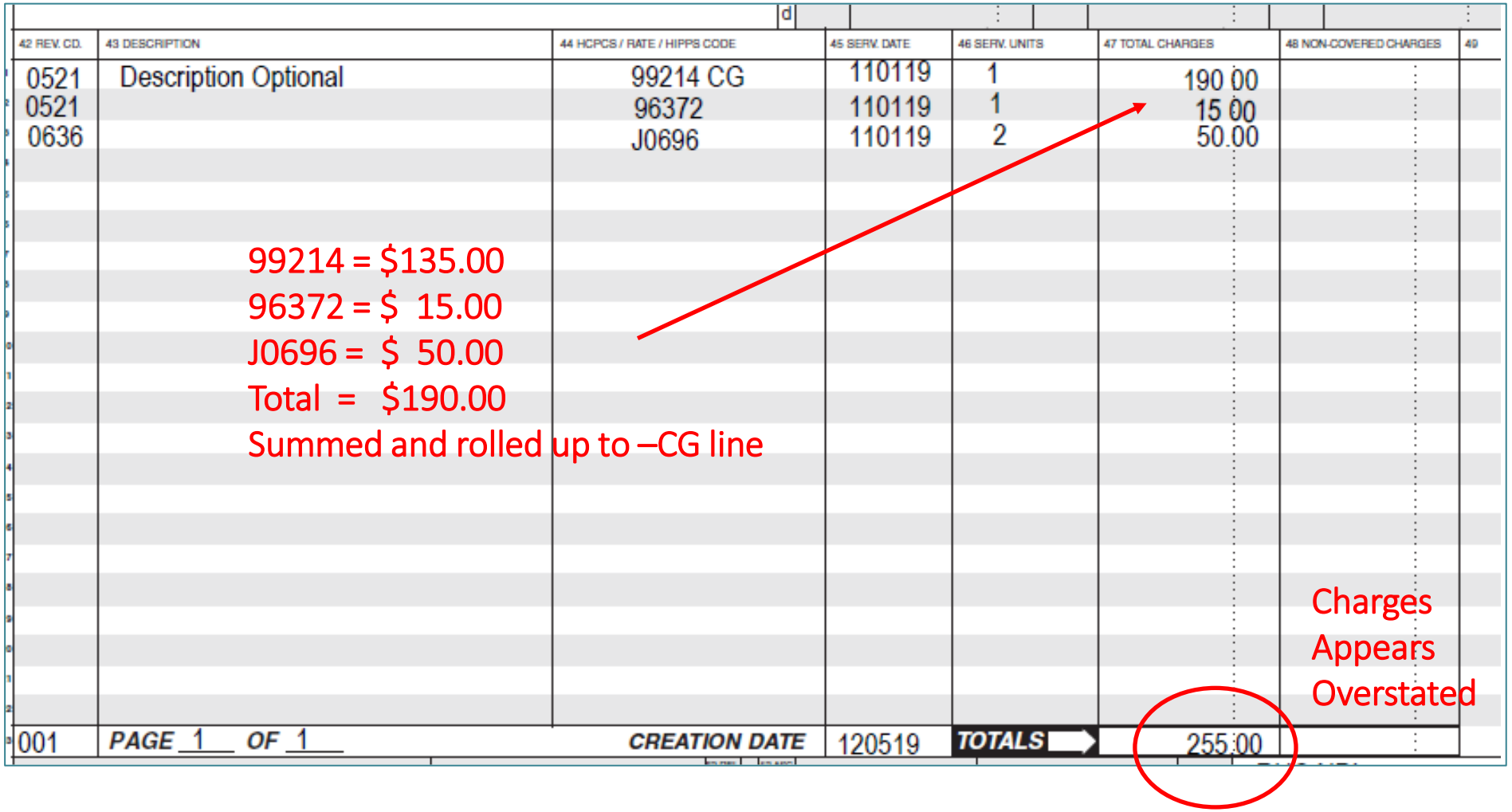
RHC Encounter with Multiple Services #2

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est IV	99214 CG	11/01/2023	1	190.00
0521	Inj Admin	96372	11/01/2023	1	15.00
0636	Rocephin, 250 mg	J0696	11/01/2023	2	50.00
0001	Total Charge				255.00

Make sure the units are correct on injectables.

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.***

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.



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: 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	11/01/2024	1	175.00
0900	Psych Eval	90791 CG	11/01/2024	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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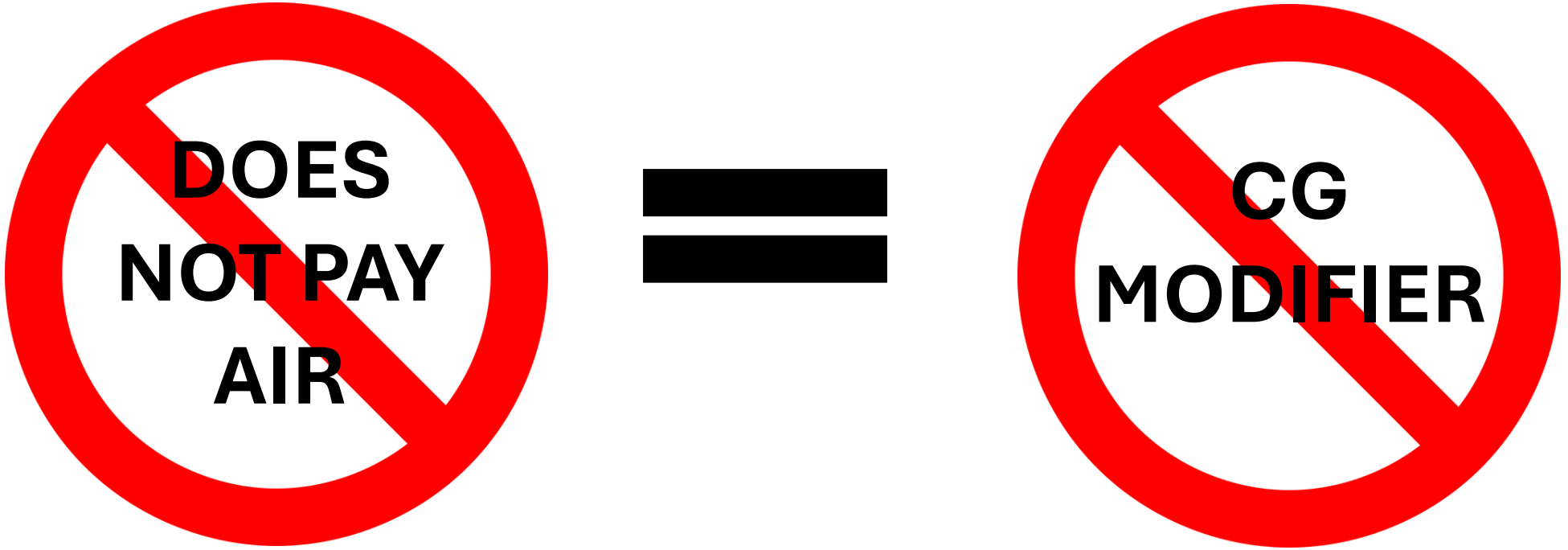
When is –CG not used?

- Not used on any service which:
  - Is report on the UB-04 claim
  - But, does not reimburse at the AIR.

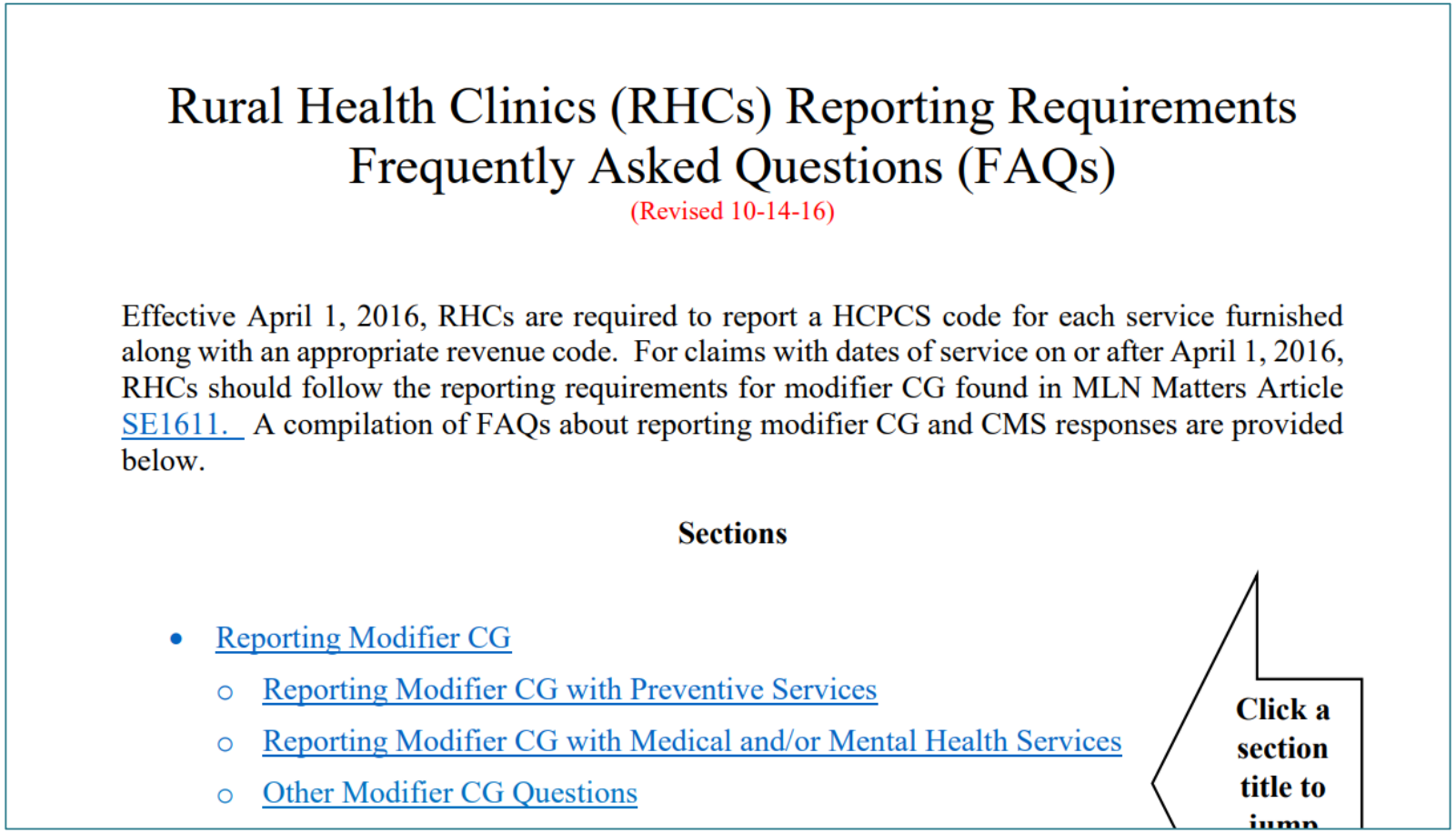
- Includes:
  - **Medical Telehealth (G2025)**
  - **Virtual Communication (G0711)**
  - **Care Management Services (G5011, G5012)**

- Any service which pays a consolidated fee schedule amount instead of the AIR.

If the services does not pay the all-inclusive RHC encounter rate, then no CG modifier is needed on the traditional Medicare claim.



-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

Click a section title to jump

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

Do you have a billing problem or an EHR Problem?

Other Modifiers

RHC claims to traditional Medicare will **not** 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

Exceptions to Face-to-Face Encounter

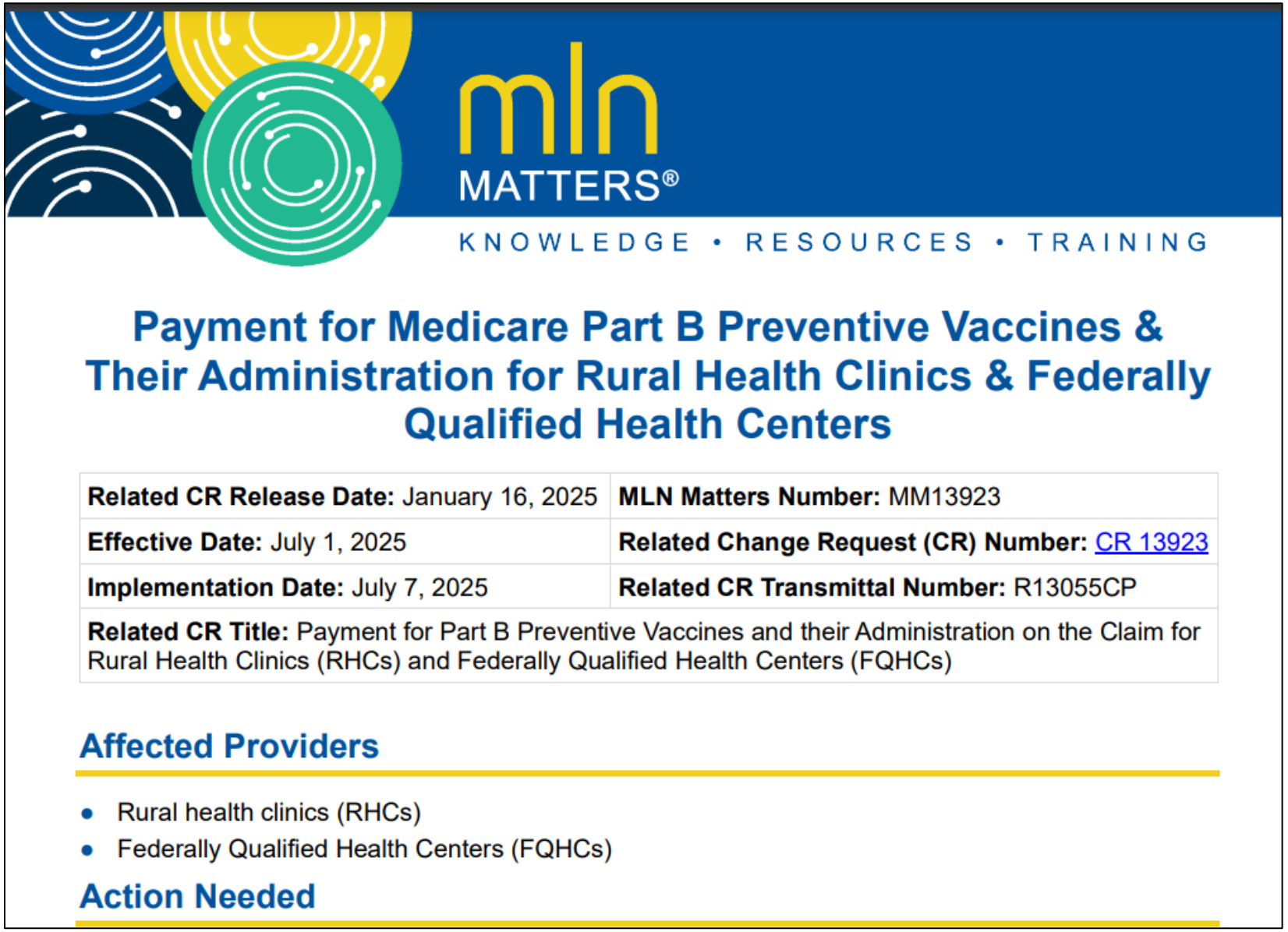
Billed on UB-04

- Care Management and Care Coordination Services
- 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.
- Not counted in visits; expenses are carved out of allowable costs for cost-reporting.
- No –CG Modifier if the services does not pay the AIR.

Traditional Medicare Immunizations

Approved vaccines to be paid at the time of service beginning mid-year 2025, but still reconciled on the Cost Report

- Immunizations that are Part B approved preventive services (Flu, Pneumonia, COVID and Hep B) will be paid at the time of administration based on the regular reimbursement for those vaccines.
- The actual cost of administering the vaccines will be reconciled on the cost report through a settlement process.
- The vaccines are not expected to be able to reported on the UB-04 claim until July1, 2025.
- The changes are being made to give relief to RHCs so that at least partial reimbursement prior to cost report settlement.



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Payment for Medicare Part B Preventive Vaccines & Their Administration for Rural Health Clinics & Federally Qualified Health Centers

Related CR Release Date: January 16, 2025	**MLN Matters Number:** MM13923
Effective Date: July 1, 2025	**Related Change Request (CR) Number:** CR 13923
Implementation Date: July 7, 2025	**Related CR Transmittal Number:** R13055CP
Related CR Title: Payment for Part B Preventive Vaccines and their Administration on the Claim for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	

Affected Providers

- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

Action Needed

https://www.cms.gov/files/document/mm13923-payment-medicare-part-b-preventive-vaccines-their-administration-rural-health-clinics.pdf

Traditional Medicare Immunizations

- Influenza, Pneumococcal, and COVID immunizations are not reported on the UB-04 claim for traditional/RW&B or Medicare **prior to midyear 2025**. Do not report them. Do NOT report them with a zero or .01 charge.
- These are reimbursed through the cost reporting process.

  Invoices

  Logs

  # of total private stock immunizations

  # of Medicare immunizations

  Set charge not to drop on the claim

- Do NOT report Medicare Advantage immunizations on the cost report. This was done the first year of COVID but they are not included now.

Traditional Medicare immunizations will be reportable on claims around July 2025 for an interim payment. They will still be cost-settled.

- Except for Hep B which is reported on the UB-04 claim, all other adult immunizations are Part D Pharmacy Benefits.
- If you use a 3rd party vaccine management or biller, please let your cost report preparer know.
- Commercial coverage of adult immunizations may vary among payers.

Telehealth Definitions

Distant Site versus Originating Site

Audio/Video/Two-Way Synchronous

The provider is usually at their practice location or another appropriate location.

Patient is usually at home or another appropriate location. When a hospital or clinic hosts a patient for a telehealth service with a distant site provider, **the hosting facility is the originating site.**

Originating site is defined by CMS as where the patient is located during the telehealth encounter or consult.

Provider is at the distant site away from the patient usually their practice location

Patient is at home or another facility

Distant site is defined by CMS as the telehealth site ***where the provider or specialist is "seeing" the patient at a distance.***

Originating Site Requirements

CAHs and RHCs

Social Security Act, Section 1834, Payment for Telehealth

C) Originating site.—
(i)[173] In general.—Except as provided in paragraph (5), (6), and (7), the term "originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—
(I) in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));
(II) in a county that is not included in a Metropolitan Statistical Area; or
(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.
(ii) Sites described.—The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.
(II) A critical access hospital (as defined in section 1861(mm)(1)).
(III) A rural health clinic (as defined in section 1861(aa)(2)).
(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).
(V) A hospital (as defined in section 1861(e)).
(VI) A hospital-based or critical access hospital- based renal dialysis center (including satellites).
(VII) A skilled nursing facility (as defined in section 1819(a)).
(VIII) A community mental health center (as defined in section 1861(ff)(3)(B))
(IX)[174] A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).
(X)[175] The home of an individual, but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).

Distant Site Requirements

Patient is **at home** or another originating site

Provider is in **their practice location** or their home (12/31/2024)

Before and After the PHE

- CAHs and RHCs are statutorily excluded from being distance site providers though the Social Security Act.
- During the PHE, temporary emergency orders allowed these provider types to perform telehealth/telemedicine services.
- These flexibilities and waivers have been extended to RHCs through 12/31/2024.
- The 2025 MPFS proposed rule would extend some of these flexibilities into 2025 if finalized. 03/03/2025

What is the billing location for the provider when the provider is at home?

Through 12/31/2024:

In response, CMS finalized, through CY 2024, that we would continue to permit a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

"We are therefore proposing that through CY 2025 ***we will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home."***

--2025 Physician Fee Schedule Proposed Rule, page 61,633.

Situation	Originating Site	Distance Site	What is billed?
Patient is at home and the provider is at their own clinic	Patient's Home	Provider's Clinic	The provider or their clinic bills a distance site telehealth service
Patient is at the CAH or RHC but the provider is at an outside office	CAH or RHC	Outside provider's location	The facility where the patient is being hosted bills an originating site telehealth service
Provider is at home and the patient is at home	Patient's Home	Provider's normal practice location	The provider or their clinic bills a distance site telehealth service unless the rule changes.
Patient is in a nursing home and the provider is at their normal practice location.	Skilled Nursing Facility	Provider's normal practice location	The provider or their clinic bills a distance site telehealth service.

Medicare Medical Telehealth

Only Until 04/01/2025 unless there is additional Congressional action.

Telecommunication Services in RHCs and FQHCs

We are finalizing a policy clarification to continue to allow direct supervision via interactive audio and video telecommunications and to extend the definition of "immediate availability" as including real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025. We are also finalizing a policy to allow payment, on a te ry basis, for non-beha health visits furnished via telecommunication technology under th gy that has be r these services during and after the COVID-19 PHE through Dece cifica ed policy, RHCs and FQHCs can continue to bill for RHC and munication technology by reporting HCPCS code G2025 on the claim, g audio-only communications technology through December 31, 2025. For pay health visits furnished via telecommunication technology in CY 2025, we amount based on the average amount for all PFS telehealth services on t e for those services reported under the PFS.

We are finalizing a continued policy to de person visit requi mental health services furnished via communication technology by s and FQHCs to benefici s in their homes until January 1, 2026.

The American Relief Act, 2025 changed the telecommunication "through" date from 12/31/2025 to 3/31/2025. Same change was made for in-person requirement for mental health services.

Telemedicine: Medical & non-Medical

The PHE telemedicine flexibilities will be extended through 03/31/2025

RHCs will continue to report all approved telemedicine services under G2025.

The consolidated fee schedule amount for G2025 will be determined by averaging all of the fee schedule allowables for all approved telehealth services.

Refer to the Approved Telehealth Services list to determine if a service can be audio only or not. Audio only is determined by a constraint on the patient's side.

Providers will be able to continue performing telemedicine services from home. Services will be reported from the provider's regular practice location.

Non-medical telehealth/mental/behavioral telemedicine encounter will continue to reimburse the AIR. The in-person requirement is also being waived through 03/31/2025.

RHC Distant Site Medical Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	05/15/2022	1	100.00
0001	Total Charge				100.00

Optional

Effective January 1, 2025, the payment rate for distant site medical telehealth services is $94.45. This is a composite fee schedule amount. G2025 is reported on the UB-04 claim.

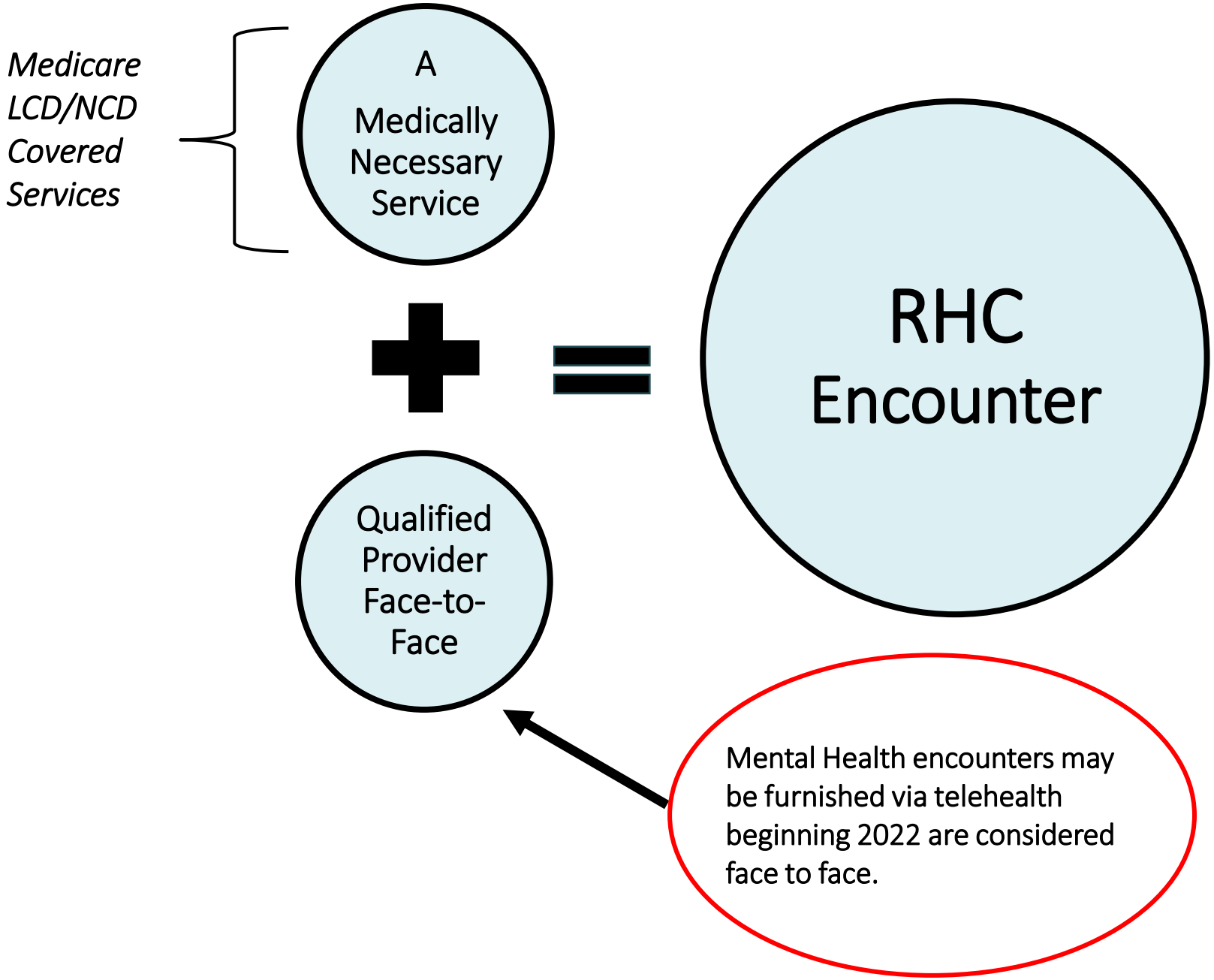
Add the -CS Modifier if G2025 is reporting a preventive service that would not be subject to deductible and coinsurance.

No –CG Modifier since this does not reimburse at the AIR. Not an encounter.

This distant site service is available to RHCs through **March 31, 2025.** Unless there is new guidance or legislation distant site telehealth will end on this date.

Medicare Mental Health Telehealth

“Permanent”



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 Telehealth Example

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other qualifying mental health visit payment code)	95 (audio-video) or FQ or 93 (audio-only) CG (required)

Mental Health Services	
HCPCS Code	**Short Descriptor**
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

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ or 93for audio only
- Is an encounter; pays at the AIR, is reported on the cost report.

This MLN matters stated that in-person visits is delayed until 1/1/2025 but PL 118-158 revised the date to 3/31/2025

Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE22001 Revised

Related Change Request (CR) Number: N/A

Article Release Date: May 23, 2023

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

What's Changed: We revised this Article to show a legislative change about in-person visits and added modifier 93 for reporting audio-only mental health visits. Substantive changes are in dark red on pages 1-2.

Questions or Discussion

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