Oregon Office of Rural Health

Billing for Rural Health Clinics

September 28, 2016
Today’s Agenda

• Rural Health Clinic Overview
• Rural Health Clinic Services
• Non-RHC Services
• Payment for Services
• Filing an RHC Claim
• RHC HCPCS Reporting Requirements
• Recent Events
• Oregon Medicaid Considerations

Katie Jo Raebel, CPA, Senior Manager
Rural Health Clinic Overview
What is an RHC?

RHC certification is a designation from the Centers for Medicare & Medicaid Services (CMS) to clinics providing primary care in certain rural, underserved areas, which provides an alternative, cost-based reimbursement system for treating Medicare and Medicaid beneficiaries.
How Are RHCs Paid?

RHCs are paid a flat rate for each *face-to-face encounter* based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs (i.e., cost report) occurring at the end of the fiscal year.
Cost-based reimbursement is determined on the average cost per visit. A visit is defined as a medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker and a patient.

In general, if there is no “visit,” there is no RHC payment (exceptions for flu/pneumo vaccines).
What Is Different About RHC Billing?

RHC services are billed and reimbursed by Medicare (and Medicaid in some states) under an all-inclusive payment rate regardless of the type of practitioner (physician vs. midlevel) or the complexity of services performed (99212 vs. 99215, E/M vs. surgical procedure).

RHC services are billed to Medicare on the UB-04 claim format instead of the CMS 1500 form often used for billing physician services.

CPT/HCPCS codes are now reported for Medicare RHC billing purposes effective April 1, 2016 (more about this later).
There are two types of RHCs; cost reporting and billing for some services is slightly different for each:

- Independent RHCs submit an RHC cost report to one of five regional fiscal intermediaries (transitioning to MAC).
- Provider-based RHCs submit an RHC cost report as a subset of the host provider (usually a hospital).
RHC Services
## RHC Billing Differences (Core Services)

<table>
<thead>
<tr>
<th>Service</th>
<th>Independent</th>
<th>Provider-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHC services (face-to-face encounter in RHC site of service).</td>
<td>Billed to Independent RHC Regional Fiscal Intermediary - RHC provider number on Form UB-04.</td>
<td>Billed to host Provider Fiscal Intermediary - RHC provider number on Form UB-04.</td>
</tr>
</tbody>
</table>
## RHC Billing Differences (Non-RHC Services)

<table>
<thead>
<tr>
<th>Service</th>
<th>Independent</th>
<th>Provider-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory (excluding the draw procedure, e.g., CPT 36415).</td>
<td>Billed to Part B carrier - Existing group number on Form 1500.</td>
<td>Billed on hospital O/P claim type (14x, 13x, or 85x) on Form UB-04.</td>
</tr>
<tr>
<td>Other Diagnostic/Radiology - Professional component.</td>
<td>May be billed with encounter. If read by non-RHC provider, they will bill the carrier.</td>
<td>May be billed with encounter. If read by hospital radiologist, bill the carrier.</td>
</tr>
<tr>
<td>Other Diagnostic/Radiology - Technical component.</td>
<td>Billed to Part B carrier - Existing group number on Form 1500.</td>
<td>Billed on hospital O/P claim type (13x or 85x) on Form UB-04.</td>
</tr>
<tr>
<td>Non-RHC Professional Services (I/P, ER, other O/P services).</td>
<td>Billed to Part B carrier - Existing group number on Form 1500.</td>
<td>Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for O/P pro fees).</td>
</tr>
</tbody>
</table>
RHC Services

- Physician services

- Services of nonphysician practitioners (NPP), which include physician assistants, nurse practitioners, and certified nurse midwives (does not include clinical nurse specialists)

- Services and supplies incident to Physicians and NPP

- Visiting nurse services to the homebound

- Clinical psychologist and clinical social worker services

- Services and supplies incident to clinical psychologist and clinical social workers

- Physician services for beneficiaries in Part A stay in SNF (including hospital swing bed) separately billable effective 1/1/05
RHC: Physician Services

- Physician services = Professional services performed by a physician for a patient:
  - Diagnosis, therapy, surgery, consultation, and interpretation of tests (EKG, x-rays)

- Services performed at the clinic are payable only to the RHC:
  - Include RHC or patient’s place of residence or implied place of residence (SNF, NF, or swing bed)

- Payment made under all-inclusive rate

*Note: Bill the carrier (or FI/MAC) for physician services furnished to beneficiaries in a place of service other than RHC*
Services and supplies are furnished incident to physician services:

- Furnished as an incidental, integral part of professional services
- Commonly rendered either without charge or otherwise chargeable
  - Cannot bill carrier or intermediary separately!
  - Costs are included in the cost report as part of the all-inclusive encounter rate
- Commonly furnished in a physician’s office
- Furnished by a clinic employee (staff)
- Includes services of clinic staff (e.g., nurse, therapist, technician, or other aide):
  - Example: Medicare-covered drug administration (see PM A-01-49 CR1600 4/5/01)
- Supplies such as bandages and tongue depressors are included in the office visit as packaged services
RHC: NP, PA, and CNM

Payment allowed for services furnished by NPPs in all areas and settings permitted under state licensure laws:

- Payable if no other facility or provider charges
- No separate payment made for ordering or referring services
- NP, PA, and CNM services provided in RHC follow same guidelines as outlined for physician services above (Reimbursed at same rates as physician – no reduction based on type of provider!)
- Payment made under all-inclusive rate
RHC: Visiting Nurse Services

- Covered if service area considered a shortage of home health agencies
- Services rendered to homebound patients
- Patient furnished part-time/intermittent nursing care by RN, LPN, or licensed vocational nurse
- Needs to be an employee of RHC
- Services furnished under written POT:
  - Reviewed once every 62 days
    by supervising physician of RHC
Preventive Services in the RHC
See Medicare Learning Matters MM7079

Effective for dates of service on or after January 1, 2011, Medicare beneficiaries receive an annual wellness visit (AWV), with a personalized prevention plan service (PPPS). The two HCPCS codes:

- G0438 – Annual wellness visit, includes PPPS, first visit
- G0439 – Annual wellness visit, includes PPPS, subsequent visit
Preventive Services in the RHC

See Medicare Learning Matters MM7079

- G0438/G0439 are paid under the RHC all-inclusive rate.

- G0438 (initial visit) is a once-in-a-lifetime benefit; cannot be billed within 12 months after effective date of Medicare coverage (should be preceded by IPPE).

- G0438 cannot be submitted within 12 months of IPPE (Welcome to Medicare Visit, G0402) or G0439 (AWV, subsequent visit).
See Medicare Learning Matters SE1039

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the Initial Preventive Physical Examination (IPPE) or “Welcome to Medicare Visit.”

To ensure coinsurance and deductible are not applied, detailed HCPCS coding must be provided for preventive services.

The ACA also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

Professional component of covered preventive service billed as RHC encounter on TOB 71x using 052x revenue code along with the HCPCS code of G0402.
In response to several recent inquiries, CMS has determined that the screening pelvic and clinical breast examination, Healthcare Common Procedure Coding System (HCPCS) code G0101, is a billable visit when furnished by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) practitioner to an RHC or FQHC patient.

To avoid any delays in payment until the system is updated, providers should follow the guidance in the Preventive Services Chart on the RHC center pages. Submit adjustments for any claims with G0101, rejected on or after January 1, 2014, to your Medicare Administrative Contractor, using this billing guidance.
Preventive Services in the RHC

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Except for IPPE, all preventive services furnished on the same day as another medical visit constitute a single billable visit. If an IPPE visit occurs on the same day as another billable visit, two visits may be billed.

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Code</th>
<th>Long Description</th>
<th>Paid at the AIR</th>
<th>Eligible for Same Day Billing</th>
<th>Coinsur./Deduct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Preventive Physical Exam (IPPE)</td>
<td>G0402</td>
<td>Initial preventive physical examination; face-to-face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment.</td>
<td>Yes</td>
<td>Yes</td>
<td>Waived</td>
</tr>
</tbody>
</table>
Preventive Services in the RHC

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Except for DSMT/MNT, all of the preventive services listed below may be billed as a stand-alone visit if no other service is furnished on the same day.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Annual Wellness Visit</td>
<td>G0438</td>
<td>Annual wellness visit, including PPPS, first visit</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
<tr>
<td>Annual Wellness Visit</td>
<td>G0439</td>
<td>Annual wellness visit, including PPPS, subsequent visit</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
</tbody>
</table>
## Preventive Services in the RHC

See [http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html](http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html)

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<tr>
<td>Screening Pelvic Exam</td>
<td>G0101</td>
<td>Cervical or vaginal cancer screening; pelvic and clinical breast examination</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>G0102</td>
<td>Prostate cancer screening; digital rectal examination</td>
<td>Yes</td>
<td>No</td>
<td>Not Waived</td>
</tr>
</tbody>
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## Preventive Services in the RHC

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<tr>
<td>Glaucoma Screening</td>
<td>G0117</td>
<td>Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist</td>
<td>Yes</td>
<td>No</td>
<td>Not Waived</td>
</tr>
<tr>
<td>Glaucoma Screening</td>
<td>G0118</td>
<td>Glaucoma screening for high-risk patient furnished under the direct supervision of an optometrist or ophthalmologist</td>
<td>Yes</td>
<td>No</td>
<td>Not Waived</td>
</tr>
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</table>
## Preventive Services in the RHC

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<tr>
<td>Screening Pap Test</td>
<td>Q0091</td>
<td>Obtaining screen pap smear</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
<tr>
<td>Alcohol Screening and Behavioral Counseling</td>
<td>G0442</td>
<td>Annual alcohol screen; 15 minutes</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
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<tr>
<td>Alcohol Screening and Behavioral Counseling</td>
<td>G0443</td>
<td>Brief alcohol misuse counsel</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
<tr>
<td>Screening for Depression</td>
<td>G0444</td>
<td>Depression screen annual</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
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<tr>
<td>Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling</td>
<td>G0445</td>
<td>High intensity behavioral counseling STD; 30 min</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
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## Preventive Services in the RHC

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<tr>
<td>Intensive Behavioral Therapy for Cardiovascular Disease</td>
<td>G0446</td>
<td>Intensive behavioral therapy for cardiovascular disease</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
<tr>
<td>Intensive Behavioral Therapy for Obesity</td>
<td>G0447</td>
<td>Behavioral counseling for obesity; 15 min</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
</tbody>
</table>
## Preventive Services in the RHC

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<th>Eligible for Same Day Billing</th>
<th>Coinsur./Deduct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking and Tobacco Cessation Counseling</td>
<td>99406* (*G0436 discontinued 10/1/2016)</td>
<td>Tobacco-use counseling; 3-10 min</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
<tr>
<td>Smoking and Tobacco Cessation Counseling</td>
<td>99407* (*G0437 discontinued 10/1/2016)</td>
<td>Tobacco-use counseling; &gt;10 min</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
</tbody>
</table>
## Preventive Services in the RHC

See [http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html](http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html)

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<tbody>
<tr>
<td>Lung Cancer Screening with Low Dose Computed Tomography</td>
<td>G0296</td>
<td>Visit to determine LDCT eligibility</td>
<td>Yes</td>
<td>No</td>
<td>Waived</td>
</tr>
</tbody>
</table>
Preventive Services in the RHC

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Sample Billing for Preventive Services

Eligible preventive services (identified above) shall be paid based on an RHC’s AIR when submitted as shown in the following example on a 71X TOB with revenue code 052X.

<table>
<thead>
<tr>
<th>42 Rev Code</th>
<th>44 HCPCS/RATES</th>
<th>45 SERV DATE</th>
<th>46 SERV UNITS</th>
<th>47 Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Blank or Valid HCPCS code</td>
<td>10/01</td>
<td>1</td>
<td>$120.00</td>
</tr>
<tr>
<td>0521</td>
<td>G0101</td>
<td>10/01</td>
<td>1</td>
<td>$  50.00</td>
</tr>
<tr>
<td>0001</td>
<td>Total</td>
<td></td>
<td></td>
<td>$170.00</td>
</tr>
</tbody>
</table>
Pneumococcal and Influenza Vaccines

See CMS Publ. 100-02, Chapter 13, Section 210.1.1

Pneumococcal and influenza vaccines and their administration are paid at 100 percent of reasonable cost. When an RHC practitioner (physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the cost of the vaccines and administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should not be reported on an RHC claim when billing for RHC services, and the beneficiary pays no Part B deductible or coinsurance for these services.
Hepatitis Vaccines

See CMS Publ. 100-02, Chapter 13, Section 210.1.2

Hepatitis vaccines and their administration are included in the RHC visit and are not separately billable. The cost of the vaccines and administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the RHC provides.
Non-RHC Services

Non-Covered Services
Non-RHC Services

- DME
- Ambulance services
- Diagnostic tests such as X-ray and EKGs
- Lab test (although required for certification, must be able to perform six required tests in RHC)
- Screening mammography services
- Prosthetic devices
- Services provided to hospital patients (except those in a swing bed)
Non-RHC Services - Lab

Required Lab Services That Must be Furnished as an RHC

• Chemical examinations of urine
• Hemoglobin
• Blood sugar
• Examination of stool specimens
• Pregnancy tests
• Primary culturing for transmittal to a certified laboratory
• Clinic must furnish these basic [CLIA waived] tests; however, they are billed as non-RHC services
Lab performed by a CAH

- Medicare Improvements for Patients and Providers Act of 2008 allows cost-based reimbursement for all laboratory services provided by any provider type (i.e., SNF, RHC, or other physician clinic) that is operated by the CAH regardless of where the lab specimen is collected (i.e., patient does not have to be physically present in the CAH at the time the specimens are collected).

- Went into effect for service dates on or after July 1, 2009.
Billing Lab Services Performed *in* an RHC

- Independent RHC:
  - Bill all lab services (including the six basic required tests) to Part B carrier on CMS 1500
  - Excluding the lab draw procedure (CPT 36415)
Billing Lab Services Performed *in* an RHC

Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see Section 1861(aa)(2)(G) of the Act and for FQHCs see Section 330(b)(1)(A)(i)(II) of the PHS Act), 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 Number MM8504, November 22, 2013
Billing Lab Services Performed *in* an RHC

- Provider-based RHC operated by a PPS hospital:
  - Bill all lab services (including the six basic required tests for RHC COP) performed in RHC as reference lab to FI on Form UB-04 using hospital billing number
  - Again, bill under hospital main provider number (*not RHC number!*)
  - Bill type 14X
  - Revenue code 030X
  - CPT code required field
  - Fee schedule reimbursement
Services Not Covered

Services never paid by Medicare include:

- General exclusions from Medicare (e.g., dental, cosmetic surgery, routine services)

- Not reasonable and necessary for:
  - Diagnosis
  - Treatment of illness or injury
  - Improved functionality of malformed limb
  - Experimental services
Payment for Services
Payment Calculations

• Payments for covered RHC services by physician, PA, NP, CNM, CP, CSW, and visiting nurse are under an all-inclusive rate for each visit

• Each provider’s interim rate is based on the all-inclusive rate per visit (determined based on the cost report)

• Established by your Medicare intermediary:
  − Determined by dividing total allowable cost by the number of total visits for RHC services
  − Rate may be adjusted during reporting period
Payment Calculations

• The upper payment limit for RHC for 1/1/16 through 12/31/16 is $81.32 per visit (based on the Medicare Economic Index, MEI, 1.1 percent increase over the 2015 rate of $80.43)

  However, no upper payment limit for RHCs that are provider-based to a hospital with less than 50 beds
Charges to Beneficiaries

Part B Deductible

• The $166 Part B annual deductible applies to services covered under the RHC benefit for 2016

Part B Coinsurance

• If the item or service is covered under the RHC benefit, the beneficiary is responsible for 20% of the customary charge

• If the service is not covered under the RHC benefit and is covered under Part B, the beneficiary is responsible for 20% of Medicare-approved charge (MFS)
Payment Calculations

RHC Payment Examples

- Customary charge for 99213 is $120

- Assume Medicare fee schedule allowable is $70

- Medicare encounter rate is $160:
  - Limited to $80 for independent RHC
  - No limit for provider-based RHC - Available beds < 50

- Deductibles have been met already
## Payment Calculations

### Comparison Between RHCs and Part B Payment Example

<table>
<thead>
<tr>
<th>Description</th>
<th>RHC Amount (Independent)</th>
<th>RHC Amount (Provider-based)</th>
<th>Part B Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customary Charge</td>
<td>$120.00</td>
<td>$120.00</td>
<td>$120.00</td>
</tr>
<tr>
<td>Patient Copay</td>
<td>24.00</td>
<td>24.00</td>
<td>14.00</td>
</tr>
<tr>
<td>Medicare Pays</td>
<td>64.00</td>
<td>128.00</td>
<td>56.00</td>
</tr>
<tr>
<td>Total Payment</td>
<td>88.00</td>
<td>152.00</td>
<td>70.00</td>
</tr>
<tr>
<td>Contractual Adjustment</td>
<td>32.00</td>
<td>(32.00)</td>
<td>50.00</td>
</tr>
</tbody>
</table>
Does it matter how we code the visit if we get paid the same rate?

• Patient payment is affected
  
  − Medicare considers overcoding a violation of the fraud and abuse regulations because of the additional reimbursement
  
  − Medicare considers undercoding a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic

Conclusion: Yes, it Matters!
Filing an RHC Claim
Filing an RHC Claim

- UB-04 (CMS Form 1450)
- Bill type 71x
- Revenue codes allowable 52x and 900 (maximum unit of one per day)
- CPT/HCPCS required beginning April 1, 2016
- Separate RHC billing number (for each RHC)
- Only RHC services on RHC billing number
- Bill all non-RHC ancillary services SEPARATELY!
  - Independent - To Part B carrier using existing group number
  - Provider-based - Through the hospital provider number on 13x, 85x, or 14x type of bill (A-00-36 7/28/00)
- Non-RHC professional services billed to Part B carrier utilizing existing group number (or to FI/MAC under CAH Method II billing)
Filing an RHC Claim

RHC Bill Types (UB-04 claim form, 71X):

- 710  Claim with only non-covered charges
- 711  Original claim
- 715  Late charge – adjustment to prior claim
- 717  Replacement claim – adjustment to prior claim
- 718  Void/cancel previous claim
Filing an RHC Claim

RHC Revenue Codes - Effective July 1, 2006:

• 0521 Clinic visit at RHC/FQHC
• 0522 Home visit by RHC/FQHC
• 0524 Visit by RHC/FQHC practitioner in Part A stay SNF
• 0525 Visit by RHC/FQHC practitioner in a NF or ICF or residential facility
• 0527 RHC/FQHC visiting nurse (must have special designation)
• 0528 RHC/FQHC visit other locations (i.e., scene of an accident)
• 0780 Telehealth services (Note: not an RHC service)
• 0900 Mental health visits

Sometimes referred to as place of service with respect to RHC/FQHCs
Special Billing - Telehealth Services

Telehealth services (originating site) are non-RHC services. Originating site will receive separate payment. Coinsurance and deductible apply.

RHC (originating site)

- This is the only service that may be included on an RHC bill (bill type 71X) with another RHC service (e.g., Rev. Code 521)
- Bill Telehealth service under Rev. Code 0780 with HCPCS Q3014
- Requires HCPCS code Q3014 (Reimbursement ~ $25.00)
Review of Billing Policies

Special Billing - Telehealth Services

Physician service (distant site):

• Bill as if the patient was with you “face-to-face”

• Payment made based on current fee schedule for service provided as if the patient was with provider
Healthcare Common Procedure Coding System Requirement for Rural Health Clinics
Purpose of RHC HCPCS Reporting Requirements

- Compliance with national coding standards and requirements.
- Collect data on RHC services to better inform policies.
- Increase accuracy of RHC claims processing.
Rollout Timeline

July 15, 2015: Physician Fee Schedule (PFS) Proposed Rule published (80 FR 41943)

Nov. 16, 2015: PFS Final Rule published (80 FR 71088)

Feb. 1, 2016: Medicare Learning Network (MLN) 9269 published

Feb. 10, 2016: MLN 9269 reissued

Feb. 29, 2016: MLN 9269 reissued

Mar. 23, 2016: MLN 9269 reissued

Apr. 1, 2016: RHCs are required to report HCPCS coding
Example 1: Patient comes to the RHC for a routine medical visit and venipuncture on March 31, 2016.

Example 1a: Patient comes to the RHC for a routine medical visit and venipuncture on April 1, 2016.

Example 2: Patient comes to the RHC for medical and preventive health services.

Example 4: Patient comes to the RHC for a routine medical visit and simple wound repair.

Example 9: Patient comes to the RHC for wound repair only.
Disclaimer

This presentation contains information on HCPCS reporting for RHCs. It is not a legal document. Participants are encouraged to review the specific statutes, regulations, and other materials regarding billing requirements.

This presentation contains billing and payment examples. The UB-O4 sample, HCPCS codes, revenue codes, and the associated charges used in the slides are for illustrative purposes only and should not be used as a guideline for billing or setting rates.

The examples use the following fictional charges for illustrative purposes only:

- 99213 = $8.00
- 90834 = $8.00
- G0101 = $7.00
- 12002 = $7.00
- G0117 = $7.00
- 36415 = $5.00
- 90863 = $5.00
- 69200 = $5.00
Previous RHC Reporting Guidelines

For services furnished through

*March 31, 2016,*

RHCs are not required to report any specific HCPCS codes when billing for RHC services.
Patient comes to the RHC for a routine medical visit and venipuncture on March 31, 2016

Example is for illustrative purposes only

<table>
<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>REV. CODE</th>
<th>HCPCS</th>
<th>CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/31/2016</td>
<td>0521</td>
<td>99213</td>
<td>$8.00</td>
</tr>
<tr>
<td>03/31/2016</td>
<td>0300</td>
<td>36415</td>
<td>$5.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHARGE TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>$13.00</strong></td>
</tr>
</tbody>
</table>
Example 1 - UB-O4 Claim

Patient comes to the RHC for a routine medical visit and venipuncture on **March 31, 2016**

*Example is for illustrative purposes only*

<table>
<thead>
<tr>
<th>UB-O4 CLAIM EXAMPLE</th>
<th>EXAMPLE RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CLAIM COINS</td>
</tr>
<tr>
<td></td>
<td>$2.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>42 Rev. CD.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS / RATE / HIPPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGE</th>
<th>48 NON-COVERED CHARGES</th>
<th>49 COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0521</td>
<td>*</td>
<td>*</td>
<td>03/31/2016</td>
<td>*</td>
<td>$13.00</td>
<td>1 Paid at the AIR</td>
</tr>
<tr>
<td>2</td>
<td>0001</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>$13.00</td>
<td>2</td>
</tr>
</tbody>
</table>

* Field intentionally left blank
New RHC HCPCS Reporting

Qualifying Visit Service Line (Revenue code 052x or 0900)

- Report charges for all services furnished during the encounter minus charges for preventive services.
- Charges represent the amount that will be used to access coinsurance and deductible.

Additional Service Line(s)

- Report each additional service furnished with the most appropriate revenue code with charges $0.01 or greater.

Some charges are displayed twice

- On the line with the qualifying visit and on the service line for the specific service.
Example 1a – Patient’s Account

Patient comes to the RHC for a routine medical visit and venipuncture on

*April 1, 2016*

*Example is for illustrative purposes only*

<table>
<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>REV. CODE</th>
<th>HCPCS</th>
<th>CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2016</td>
<td>0521</td>
<td>99213</td>
<td>$8.00</td>
</tr>
<tr>
<td>04/01/2016</td>
<td>0300</td>
<td>36415</td>
<td>$5.00</td>
</tr>
</tbody>
</table>

**CHARGE TOTAL** $13.00
Example 1a – UB-04 Claim

Patient comes to the RHC for a routine medical visit and venipuncture on **April 1, 2016**

*Example is for illustrative purposes only*

### UB-04 CLAIM EXAMPLE

<table>
<thead>
<tr>
<th>42 Rev. CD.</th>
<th>43 DESCRIPTION / HIPPS CODE</th>
<th>44 HCPCS / RATE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGE</th>
<th>48 NON-COVERED CHARGES</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 0521</td>
<td>*</td>
<td>99213</td>
<td>04/01/2016</td>
<td>1</td>
<td>$13.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>2 0300</td>
<td>*</td>
<td>36415</td>
<td>04/01/2016</td>
<td>1</td>
<td>$5.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>3 0001</td>
<td>*</td>
<td></td>
<td></td>
<td>*</td>
<td>$18.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

### EXAMPLE RESULTS

| CLAIM COINS | $2.60 |

### COMMENTS

1. Paid at the AIR
2. Medicare assigns CARC 97
3.

* Field intentionally left blank

Centers for Medicare and Medicaid Services
Patient comes to the RHC for a routine medical visit and venipuncture on April 1, 2016.

Example is for illustrative purposes only

Report the most appropriate HCPCS code from the qualifying visit list on the 0521 service line.

Charges subject to coinsurance and deductible are reported on the 0521 service line.

- Same as it is today.
- Office visit $8.00 + Venipuncture $5.00 = $13.00
Example 1a – Additional Line(s)

Patient comes to the RHC for a routine medical visit and venipuncture on

*April 1, 2016*

*Example is for illustrative purposes only*

Additional service(s) are reported with the most appropriate revenue code(s) and HCPCS code(s).

- Payment for these lines are included in the all-inclusive rate (AIR) and will be assigned Claim Adjustment Reason Codes (CARC) 97.

  - CARC 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
Example 2 – Patient’s Account

Patient comes to the RHC for medical and preventive health services.

<table>
<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>REV. CODE</th>
<th>HCPCS</th>
<th>CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2016</td>
<td>0521</td>
<td>99213</td>
<td>$8.00</td>
</tr>
<tr>
<td>04/01/2016</td>
<td>0521</td>
<td>G0101</td>
<td>$7.00</td>
</tr>
<tr>
<td>04/01/2016</td>
<td>0300</td>
<td>36415</td>
<td>$5.00</td>
</tr>
</tbody>
</table>

**CHARGE TOTAL** | **$20.00**

**CHARGE TOTAL (Minus Preventives)** | **$13.00**
Example 2 – UB-04 Claim

Patient comes to the RHC for medical and preventive health services.

### UB-O4 CLAIM EXAMPLE

<table>
<thead>
<tr>
<th>42 Rev. CD.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS / RATE / HIPPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGE</th>
<th>48 NON-COVERED CHARGES</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 0521</td>
<td>*</td>
<td>99213</td>
<td>04/01/2016</td>
<td>1</td>
<td>$13.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>2 0521</td>
<td>*</td>
<td>G0101</td>
<td>04/01/2016</td>
<td>1</td>
<td>$7.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>3 0300</td>
<td>*</td>
<td>36415</td>
<td>04/01/2016</td>
<td>1</td>
<td>$5.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>4 0001</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>$25.00</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* Field intentionally left blank

### EXAMPLE RESULTS

| CLAIM COINS | $2.60 |

### COMMENTS

1. Paid at the AIR
2. Medicare assigns CARC 97
3. Medicare assigns CARC 97
4. Medicare assigns CARC 97
Patient comes to the RHC for a routine medical visit and simple wound repair.

### UB-O4 CLAIM EXAMPLE

<table>
<thead>
<tr>
<th></th>
<th>42 Rev. CD.</th>
<th>43 DESCRIPTION</th>
<th>44 HCPCS / RATE / HIPPS CODE</th>
<th>45 SERV. DATE</th>
<th>46 SERV. UNITS</th>
<th>47 TOTAL CHARGE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0521</td>
<td>*</td>
<td>99213</td>
<td>04/01/2016</td>
<td>1</td>
<td>$20.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>2</td>
<td>0521</td>
<td>*</td>
<td>12002</td>
<td>04/01/2016</td>
<td>1</td>
<td>$7.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>3</td>
<td>0300</td>
<td>*</td>
<td>36415</td>
<td>04/01/2016</td>
<td>1</td>
<td>$5.00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>4</td>
<td>0001</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>$32.00</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* Field intentionally left blank

### EXAMPLE RESULTS

| CLAIM COINS | $4.00 |

### COMMENTS

1. Paid at the AIR
2. Medicare assigns CARC 97
3. Medicare assigns CARC 97
Patient comes to the RHC for a wound repair only.

Note: CMS updated the RHC Qualifying Visit List on 3/24/16 with additional medically necessary services. RHC held claim and claim was received after 10/01/2016.
Billing or MA Questions: Contact your MAC

RHC Payment Policies: Corinne.Axelrod@cms.hhs.gov or Simone.Dennis@cms.hhs.gov

RHC Claims Processing:

Tracey.Mackey@cms.hhs.gov
Qualifying Visit List

QVL

- Intended as guidance for RHCs that are now reporting HCPCS codes
- It is not an all-inclusive list of stand-alone billable visits for RHCs
- RHCs should hold claims solely for billable visits shown in red (or procedures/RHC visits not on the list) until October 1, 2016
  - Note: If the patient has a visit on the QVL and a service not on the QVL on the same day, all services should be billed now and not held until October 1st
Additional October 1st Billing Items:

Modifier CG

- Beginning on October 1, 2016, MACs will accept modifier CG on RHC claims
  - Report modifier CG on one revenue code 52X or 900 service line, which includes all charges subject to coinsurance and deductibles
  - This modifier indicates which service line should receive the all-inclusive rate and be subject to deductibles and coinsurance
  - Additional service lines should be reported with charges greater or equal to $0.01
  - Additional service lines are for informational purposes only
Additional October 1\textsuperscript{st} Billing Items:

Additional Modifiers

- Beginning on October 1, 2016, MACs will accept modifier 25 or 59 when a patient, subsequent to the initial visit, suffers an illness or injury that was not present during the earlier visit and requires additional diagnosis or treatment on the same day.
Additional October 1st Billing Items:

Influenza and Pneumonia Injections

- Services to Medicare patients will continue to be paid on the Medicare cost report and should not be included on RHC claim forms.
Recent Events

Advanced Care Planning (ACP)

Effective January 1, 2016, Advanced Care Planning (ACP) will be a stand-alone billable visit in an RHC.

Per the 2016 Physician Fee Schedule Final Rule:

- RHCs furnish Medicare Part B services and are paid in accordance with the RHC all-inclusive rate system. Beginning on January 1, 2016, ACP will be a stand-alone billable visit in an RHC when furnished by an RHC practitioner and all other program requirements are met. If furnished on the same day as another billable visit, only one visit will be paid. Coinsurance and deductibles will be applied for ACP when furnished in an RHC. Coinsurance and deductibles will be waived when ACP is furnished as part of an AWV. Additional information on RHC billing of ACP will be available in sub-regulatory guidance.
Recent Events

Advanced Care Planning (ACP) (continued)

• CPT code 99497 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate; and

• An add-on CPT code 99498 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure).
## Advanced Care Planning (ACP) (continued)

### Sample Billing for ACP furnished by RHCs from January 1, 2016 through March 31, 2016

**ACP Furnished as a Stand-alone Billable Visit**

<table>
<thead>
<tr>
<th>42 Rev Code</th>
<th>44 HCPCS/RATES</th>
<th>45 SERV DATE</th>
<th>46 SERV UNITS</th>
<th>47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>521</td>
<td>99497</td>
<td>01/01/2016(^1)</td>
<td>1</td>
<td>$XX.XX(^2)</td>
<td>AIR</td>
<td>Yes</td>
</tr>
</tbody>
</table>

\(^1\) Any date of service on or after 1/1/2016  
\(^2\) Enter charge amount

**ACP Furnished as Part of an AWV**

<table>
<thead>
<tr>
<th>42 Rev Code</th>
<th>44 HCPCS/RATES</th>
<th>45 SERV DATE</th>
<th>46 SERV UNITS</th>
<th>47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>521</td>
<td>G0438 or G0439</td>
<td>01/01/2016(^1)</td>
<td>1</td>
<td>$XX.XX(^2)</td>
<td>AIR</td>
<td>No</td>
</tr>
<tr>
<td>521</td>
<td>99497</td>
<td>01/01/2016(^1)</td>
<td>1</td>
<td>$XX.XX(^2)</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

\(^1\) Any date of service on or after 1/1/2016 through 3/31/2016  
\(^2\) Enter charge amount
Recent Events

Chronic Care Management (CCM)

Effective January 1, 2016, RHCs are able to bill for Chronic Care Management (CCM) services when all CCM requirements are met.

See MLN Matters MM9234

RHCs can bill for CCM services when an RHC practitioner furnishes a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and initiates the CCM service as part of this visit.

Coinsurance and deductibles would apply as applicable to RHC claims. RHCs would continue to be required to meet the RHC Conditions of Participation and any additional RHC payment requirements.
Recent Events

Chronic Care Management (CCM) (continued)

RHCs cannot bill for CCM services for a beneficiary during the same service period as billing for transitional care management or any other program that provides additional payment for care management services (outside of the RHC AIR) for the same beneficiary.

The 2016 rate for CCM services in RHCs is $40.82.
Recent Events

Chronic Care Management (CCM) (continued)

In order to provide CCM services, the RHC physician, NP, or PA responsible for the patient’s care must fulfill the direct supervision requirements of the “incident to” rules. This means that any auxiliary staff performing CCM services must be located on site.

**Warning from NARHC**: You may be approached by CCM companies offering various products to help with CCM services. As such, we want to caution the RHC community to make sure that any CCM product they purchase complies with the “incident to” rules regarding direct supervision.
Recent Events

Chronic Care Management (CCM) (continued)

Billing Examples for CCM Services

The following examples are provided to assist RHCs and FQHCs in billing for CCM services:

### CCM Furnished as a Stand-alone Service

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied (when applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>52x&lt;sup&gt;1&lt;/sup&gt;</td>
<td>99490</td>
<td>01/01/2016&lt;sup&gt;2&lt;/sup&gt;</td>
<td>1</td>
<td>$XX.XX&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Based on the PFS national average non-facility payment rate</td>
<td>Yes</td>
</tr>
</tbody>
</table>

---

<sup>1</sup>Use the revenue code most appropriate for the service

<sup>2</sup>Any date of service on or after 1/1/2016

<sup>3</sup>Enter charge amount
**Recent Events**

**Chronic Care Management (CCM) (continued)**

**CCM Services Furnished with a Billable Visit**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied (when applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>52x¹</td>
<td>A FQHC payment code and a qualifying visit HCPSCS for FQHCs or A valid HCPSCS for a billable service for RHCs</td>
<td>01/01/2016²</td>
<td>1</td>
<td>$XX.XX³</td>
<td>FQHC Prospective Payment System (PPS) Methodology for FQHCs or All-inclusive rate (AIR) for RHCs</td>
<td>Yes⁴</td>
</tr>
<tr>
<td>52x¹</td>
<td>99490</td>
<td>01/01/2016²</td>
<td>1</td>
<td>$XX.XX³</td>
<td>Based on the PFS national average non-facility payment rate</td>
<td>Yes</td>
</tr>
</tbody>
</table>

¹Use the revenue code most appropriate for the service
²Any date of service on or after 1/1/2016
³Enter charge amount
⁴Coinsurance and/or deductible is waived when an approved preventive service is billed
Oregon Medicaid Considerations
Oregon Medicaid Considerations

RHC Rates

• Prospective rate that is set upon initial enrollment that is updated yearly by the Medicare Economic Index

  — Change in Scope

  ➤ Qualifying change of scope may qualify to increase the clinic’s rate (i.e. – addition of a service)

• In order for an RHC to be paid the RHC rate per encounter, the clinic must bill at least its RHC rate – the State has indicated that this is an acceptable practice.

  — Remember that at the beginning of each year the RHC rate is updated!
Oregon Medicaid Considerations

RHC Visits and Allowable Costs

• Oregon Medicaid RHC practitioners and RHC costs do not exactly mirror the Medicare regulations

  — Know what items are included/excluded in the RHC rate and what items the clinic cannot/can bill for separately

    ➤ i.e. – lab costs are included in the RHC rate in Oregon and cannot be billed separately

  — Oregon defines RHC practitioners differently than Medicare

    ➤ i.e. – RNs are considered RHC practitioners; therefore, their visits should be considered in the RHC rate building. In addition, their visits can be billed and paid at the RHC rate.
Oregon Medicaid Considerations

Oregon Medicaid Managed Care Visits

• RHCs are paid under the negotiated contract

• “Wrap” payment data is submitted (as often as quarterly) in order for the clinic to receive the difference between what the clinic was paid vs. what the clinic would have received if the visits were paid based on the Medicaid RHC rate per encounter.
Resources

CMS RHC website:

http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Oregon RHC website:

http://www.oregon.gov/oha/healthplan/Pages/fqhc-rhc.aspx
Resources

CMS Online Manuals:

- Pub 100-4, Chapter 3, Section 30 - Inpatient Part A Hospital Manual
- Pub 100-4, Chapter 4, Section 250 - Part B Hospital (including Inpatient Hospital Part B and OPPS)
- Pub 100-4, Chapter 6, Section 20 - SNF Inpatient Part A Billing
- Pub 100-4, Chapter 9 - RHC/FQHC Manual
- Pub 100-4, Chapter 16, Sections 30.3 and 40.3.1
- Laboratory Services from Independent Labs, Physicians & Providers

Other:

- Medicare Prescription Drug Improvement & Modernization Act of 2003
- Medicare Improvements for Patients and Providers Act of 2008
- CMS Quick Reference Information: Preventive Services
- United Government Services CAH Training Manual (available in PDF at) Noridian Administrative Services LLC
  www.noridianmedicare.com
Questions?
Thank you!
CPAs and Consultants
HEALTH CARE PRACTICE

wipfli.com/healthcare