RHC Billing 101 Q&A Follow-Up

General

Q: Where do you find out if you are a "Home Health Shortage Area"?

A: There is not a federal resource for home health shortage areas like there is for Health Professional Shortage Areas, etc. It is recommended that RHCs contact their State Department of Health or CMS Regional Office.

Billing

Q: If a patient has a qualified medical visit and a qualified mental health visit on the same day (2 billable visits), will both visits be paid? Will the All-Inclusive Rate be paid X2, for twice the AIR reimbursement? Or would there only be one AIR payment for the claim that included two billable visits?

- Can a medical visit and a mental health visit on the same day be billed on separate claims (if both have CG modifier) or do they need to be combined into one claim?
- Medical and mental health visits same day but different providers, how do you bill those?
- How would the individual providers names/NPIs be reported on the UB04 claim if being treated by two providers on the same day, with two billable RHC encounters (example Medical and Mental Health encounter same day)?

A: You will receive 2 All-Inclusive Rate payments, 1 for the medical visit and 1 for the mental health visit.

- This may vary by your billing system, but they should be paid as 2 AIRs whether they are on separate claims or combined into 1.
- RHCs bill as the facility NPI, not each individual provider NPI. The Medicare Claims Processing Manual, Chapter 9, Section 50 provides the following guidance:
    - FL 56 – National Provider Identifier: The RHC enters its own NPI. When more than one encounter/visits is reported on the same claim i.e., medical and mental health visits, please choose the NPI of the provider that furnished the majority of the services.
    - FL 76 – Attending Provider Name and Identifiers: The RHC/ enters the NPI and name of the attending physician designated by the patient as having the most significant role in the determination and delivery of the patient's medical care.

Q: Would a Vaccine Clinic be billable as an RHC?

A: For Medicare, you will not be billing these on a claim, you will need to be tracking them to include on your cost report (for COVID, flu and pneumococcal). Vaccinations alone do not count as an RHC encounter.

Q: Are all J-codes required to be on a 636-revenue code? Or can they be on a 521?

A: The revenue code specific to injectable medications is 636.

Q: RHCs typically bill charges on a UB-04. However, when a provider performs a procedure in the RHC Clinic that is NOT a qualifying visit (19083, a stereotactic breast biopsy, for example), but no visit occurred, should that procedure be billed out on a 1500 form? So long as those "non-RHC" charges do not exceed 49% of the office's total charges?

A: If your RHC provider is providing a medically necessary procedure in your RHC, that is billable as an RHC visit and should be billed accordingly. Avoid issues with co-mingling that can result from billing differently.

Q: Do you have any guidance on explaining the deductible to a Medicare patient when the negative payment appears to the patient like a payment?

A: I would show them the guidance directly from Medicare showing that they must meet their Part B deductible, and that Medicare applies that as charges which are incurred. The “payment” is actually a negative payment of a take back, as Medicare expects the RHCs to collect the patient’s owed deductible amounts.

Q: How are category II codes (quality codes) reported on an RHC claim?

A: Category II codes on RHC claims are either not recognized by the MACs or sometimes cause the claim to be fully denied incorrectly. If you need to report quality codes for participation in an ACO, etc. it will need to be done separately than via claims at this time.

Q: Can an RHC bill for Chronic Care Management services?

A: Yes! RHCs should bill the 99484, 99487, 99490, 99491, 99424, and 99425 codes as G0511 and will be reimbursed at $77.94 in 2023.

Q: Should nursing home visits be billed on a UB-04 or 1500?

A: If billed as RHC services, bill them on a UB-04 with appropriate revenue code (0524 or 0525).

Q: Is there a list of all procedure codes that are billable in the RHC?

A: The Qualifying Visit list is a good place to start, but this is not an entirely comprehensive list as it was last updated in 2016. Generally, a visit/procedure must be medically necessary, face to face, covered by Medicare, and with an eligible RHC provider it is billable.

Q: Can an E/M and a procedure code be billed together?

A: If your documentation supports both codes occurring, you should code accordingly and include on the same claim. However, you will only receive one All-Inclusive Rate payment. Your patient's co-insurance will increase as it is 20% of all charges.

Q: If you have multiple RHCs will you receive All-Inclusive Rate if there are visits in different clinics in the same day if you have a single shared tax ID?

A: Yes, because the clinics have different NPI numbers, and RHCs are separately certified.

Q: If an annual wellness (G0438), annual depression screening (G0444), and E/M charge (99213) are all performed on the same visit are they all separately payable?

- Would the depression screening be part of the AIR?

A: No – the RHC would receive one AIR payment for all services. The AWV and the annual depression screening are qualifying preventive services, so coinsurance and deductible are waived, so do not roll charges for these services into the qualifying visit/CG modifier line.

Q: Can you bill for a venipuncture in a PBRHC on a TOB 851 with the lab test or is it part of the All-Inclusive Rate?

- Should the venipuncture roll up to the qualifying line?

A: Venipuncture is part of the AIR. It should be included on the claim with the office visit the patient had that day, and the lab portion will be billed out separately. The venipuncture should roll up to the qualifying line.

Q: Should it matter if the line with the CG modifier is listed first on the claim?

A: No – how your system orders the claim does not impact adjudication of the claim so long as the CG modifier is present, and the charges roll up appropriately.

Q: When should RHCs use modifier 25?

A: Medicare has very specific rules about the use of modifier 25. In the RHC, it would only be used in instances of "subsequent illness or injury" where the patient has a second E/M visit on the same DOS. The modifier 25 would be attached to the second E/M, along with a CG modifier.

Q: If a colonoscopy or mammogram is billed as "non-RHC" will it be paid on the same day as an RHC billed provider visit?

A: A mammogram done in the RHC should not be billed as non-RHC as it is a qualifying preventive service. Payment for this service is included in the AIR if billed on the same day as another qualifying visit and is not separately payable. Medicare Benefit Policy Manual, Chapter 13, Section 220.1

A colonoscopy, if done in the RHC, would meet the definition of a RHC encounter, and if done on the same day as another qualifying visit, is not separately payable. Payment would be included in the AIR for the qualifying service.

Q: Are nurse visits (99211) ever captured/reported on the cost report?

- If an RHC performs a lot of 99211s, should they bill for them and just not be paid?

A: Yes, nurse visits can be captured on the cost report so long as the service represents an expense incurred by the RHC. A common misconception is that "captured on the cost report" implies that there is some sort of reporting or log required in order to report on the cost report. This is misleading – RHCs should make sure that they are reporting the cost associated for providing these services on your cost report. There is no separate reporting mechanism for such services.

Q: Is time spent traveling to home visits reimbursable on the cost report?

A: This is part of the RHC services and should be recorded as patient RHC time which is reimbursable on the cost report.

Q: You said that we had to bill all carriers the same rate. For example, we bill an office visit say 99213 at $110.00 to Medicare can we bill the same CPT 99213 to Medicare Plus Blue?

A: RHCs should charge all patients the same regardless of payer. So, your facility-specific charge for a 99213 should be the same for Medicare as it is for all other payers. Now – specific billing requirements for Medicare Advantage plans may vary according to each plan. Refer to your contract for specific billing requirements.

Q: We added an optometrist to one of our RHCs this year. Are we correct that Refraction services with CPT 92015 is not a qualifying RHC visit? How would you suggest we bill for refraction if not already bundled by the payor as part of the exam?

A: No, refraction is not covered by Medicare under Part B. It may be billable to Medicare Part C if the patient has that coverage.

Clarification on Radiology Services:

The professional component of imaging services is billable on the RHC claim if the interpretation and report was done by a RHC provider. You would report the appropriate x-ray HCPCS code in addition to the modifier 26 if there is not a specific HCPCS code for ONLY the professional component. Payment is included in the AIR for the qualifying visit. If done globally, you will split bill the service – professional component, with a modifier 26 on the RHC claim, and the technical component split out to the appropriate claim according to RHC type, with a TC modifier. RHCs do not bill the global HCPCS code as part of the service is considered a non-RHC service and is required to be billed outside of the RHC encounter.

Telehealth

Q: For patients who are located in a different state (on vacation or at an alternative home) receiving a telehealth visit- are we still ok to bill those if the Provider is not licensed in the state the patient is sitting?

A: According to the Center for Connected Health Policy (CCHP), "a provider typically needs to be licensed in the patient's state (the physical location of the patient.)" However, some states "have licenses or telehealth specific exceptions that allow an out-of-state provider to render services via telemedicine in a state where they are not located or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state)."

- Resources for licensing across state lines: Telehealth.hhs.gov

Q: Are non-mental health telehealth visits billable in the RHC?

A: Yes! Any of the services on this list (including several via audio-only) can be billed G2025 and will be reimbursed at $98.27 in 2023. RHCs should bill non-mental health telehealth visits

this way through December 31, 2024. For non-mental health telehealth to be extended past this date, it will require additional legislation to be passed by Congress. This should be billed as The CG modifier does not need to be included on these visits.

Q: Where do providers and/or patients need to be located during all telehealth visits?

A: At least through December 31, 2024, both patients and providers can be located anywhere, including their homes during telehealth visits. Telehealth visits must be done during RHC hours.

Q: Can the RHC bill as both the distant site and originating site?

A: RHCs are eligible to serve as both the distant site and originating site. While there is no explicit guidance to prohibit an RHC billing for both, a single entity is not intended to serve as both the distant and originating sites for the same encounter.

Q: We do Medicare Annual Wellness Visits by telehealth; do we need to bill the G0439 or the G2025?

A: This should be billed via G2025, as should all services done via telehealth found on this list at least through 12/31/2024.

Q: How would an RHC Medical visit using Telehealth (Audio-only or Audio-Visual) be reported when it's on the same day as an RHC Mental Health qualifying visit? Would it be G2025 under 521 revenue code (which is NOT considered a true RHC encounter, and is not paid the AIR) billed along with the MH code under 900 revenue code?

A: This is correct. For each visit, mental health telehealth and medical telehealth, RHCs must follow the separate billing guidance for each.

As a reminder, this resource is primarily for traditional Medicare billing. Medicaid billing varies by state, and Medicare Advantage and other commercial payor billing varies by contract.

These resources are prepared with the most available and updated information as of May 2023 and are subject to change. If your question was clinic-specific and not addressed here, or you need any further information please contact Sarah.Hohman@narhc.org.