Healthcare Common Procedure Coding System (HCPCS) Requirements for Rural Health Clinics (RHCs) Frequently Asked Questions

(4-27-16)

Q1: What has changed in RHC reporting beginning on April 1, 2016?

> **A:** Prior to April 1, RHCs were required to report HCPCS codes for a few services, such as certain preventive services eligible for a waiver of the deductible and/or coinsurance, services subject to frequency limits, and services eligible for payments in addition to the all-inclusive rate (AIR). Effective April 1, 2016, all RHCs are required to report the appropriate HCPCS code for each service furnished during the visit, along with the appropriate revenue code.

Q2: For services furnished through March 31, but billed after April 1, should those claims follow the new reporting requirements?

> **A:** No. The new reporting requirements are effective for services furnished on or after April 1, 2016. Claims for services furnished before April 1 should be billed under the previous guidelines, in which HCPCS codes were not required (except for preventive services eligible for a waiver of the deductible and/or coinsurance, services subject to frequency limits, and services eligible for payments in addition to the AIR).

Q3: What is the RHC Qualifying Visit List (QVL) and where is it located?

> **A:** The RHC QVL is intended as guidance for RHCs beginning to report HCPCS codes. It consists of frequently reported HCPCS codes that qualify as a face-to-face (one-on-one) visit between the patient and an RHC practitioner and it is not an all-inclusive list of stand-alone billable visits for RHCs. The QVL can be found directly using this link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf.

Q4: Should charges for all services furnished during the visit be reported on the qualifying visit service line?

> **A:** Yes. The charges for all services furnished during the visit should be reported on the qualifying visit line, minus charges for approved preventive services. Charges on the qualifying visit line represent the amount that will be used to assess the coinsurance and

deductible. When the claim processes, the qualifying visit service line will receive the AIR and will be subject to coinsurance and deductible.

Q5: What charges are reported on the additional service lines?

A: The additional service lines are for informational purposes only. Each service furnished during the visit should be reported with charges greater to or equal to $0.01. Contractors will package/bundle the additional service lines, which do not receive the AIR.

Q6: If preventive and non-preventive services are furnished, what charges are reported on the qualifying visit service line?

A: The charges for the visit should be reported on the qualifying visit line minus charges for approved preventive services.

Q7: If only preventive services from the RHC QVL are furnished, what charges should the RHC report on the qualifying visit service line?

A: If only preventive services are furnished during the visit, the RHC should report the charges for the approved preventive services on the qualifying visit service line.

Q8: Can more than one service from the QVL be reported on the claim from April 1, 2016 through September 30, 2016?

A: Yes.

Q9: How do RHCs report an E/M service and a medically-necessary service from the RHC QVL on a claim from April 1, 2016 through September 30, 2016?

A: From April 1, 2016 through September 30, 2016, RHCs should report the E/M service using the 052x revenue code with all the charges subject to coinsurance and deductible for the visit so that the charges for the visit should are rolled into the E/M service line. The medically-necessary service should be reported using the 052x revenue code with charges greater than or equal to $0.01. The E/M service line will receive the AIR and be subject to coinsurance and deductible.

Q10: Beginning on October 1, 2016, how do RHCs indicate which revenue code 052x and/or 0900 service line should receive the all-inclusive rate (AIR) and be subject to coinsurance and deductible?

> **A:** Beginning on October 1, 2016, the Medicare Administrative Contractors (MACs) will accept modifier CG (policy criteria applied) on RHC claims. RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line, which includes all charges subject to coinsurance and deductible for the visit. Modifier CG should only be used to indicate which revenue code 052x and/or 0900 service line should receive the all-inclusive rate (AIR) and be subject to coinsurance and deductible. Each additional service furnished during the visit should be reported with charges greater to or equal to $0.01. The additional service lines are for informational purposes only. The MACs will package/bundle the additional service lines, which do not receive the AIR.

Q11: What revenue codes are reported on RHC claims?

> **A:** The qualifying visit line should be reported with revenue code 052x or 0900. For additional lines, RHCs should report the most appropriate revenue code for the services being performed. All valid revenue codes are accepted except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, and 096x-310x. A complete list of revenue codes can be found in a National Uniform Billing Committee publication.

Q12: Does the order in which the RHC reports the claim lines matter?

> **A:** No, the order in which the RHC reports the claim lines does not matter because the lines are sorted in numerical order by revenue code and HCPCS code.

Q13: Can RHCs report modifier 25 for a subsequent visit with a RHC practitioner that is distinct and independent of an earlier visit?

> **A:** Beginning on October 1, 2016, RHCs can report modifier 25 or modifier 59 when the 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. Modifier 25 or modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. Modifier 59 or modifier 25 should be reported with medical services using revenue code 052x. This is the only circumstance in which these modifiers should be used.

Q14: When reporting a subsequent visit, can RHCs report modifier 59 with E/M codes?

A: Yes, RHCs can report modifier 59 with E/M codes. Beginning on October 1, 2016, RHCs will be able to report using modifier 59 or modifier 25.

Q15: Can RHCs report all modifiers?

A: Yes, RHCs can use any valid modifier. The system will accept up to five modifiers per service line.

Q16: When can RHCs report charges as 0.01 on a claim?

A: CMS requires that the charges for the visit be reported on the qualifying visit service line. CMS will accept additional service lines reported with charges greater than or equal to $0.01.

Q17: What charges are represented on the total line (0001 revenue code) and are charges for the additional service lines displayed twice?

A: Total line (0001 revenue code) is the sum of all of the charges reported on the claim. Charges for the additional service lines are displayed twice, once on the qualifying visit service line and on the line for the specific service.

Q18: Does Medicare pay based upon the charges reported on the qualifying visit line or the total charges (0001 revenue code) on the claim?

A: Medicare does not pay or adjudicate the total line (0001 revenue code). Payment is based on the qualifying visit line.

Q19: Can RHCs combine incident to services furnished on a different date of service from the qualifying visit on one claim? For example, an office visit is furnished on April 1 and venipuncture is furnished on April 4.

A: Yes, the RHC can combine incident to services furnished on a different date of service on one claim as long as they are furnished in a medically appropriate period and are incident to the service being billed.

Q20: Should RHCs report all services furnished on one UB-04 claim or break out certain services on a separate UB-04 claim?

A: RHCs should report all services furnished during the visit on one claim.

Q21: How do the HCPCS reporting requirements affect billing for technical components of a RHC service?

> **A:** Technical components of RHC service include diagnostic tests such as x-rays, electrocardiograms, and other tests authorized by Medicare statute or the National Coverage Determination process. The HCPCS reporting requirements do not change the billing for technical components of a RHC service. These services may be billed separately to the A/B MAC by the facility.

Q22: How do the HCPCS reporting requirements affect billing for Medicare covered vaccines and drugs and biologicals that are not usually self-administered?

> **A:** The HCPCS reporting requirements do not change the billing for these services. Medicare pays for the costs of influenza virus and the pneumococcal pneumonia vaccines and their administration through the cost report, and other Medicare-covered vaccines as part of the AIR. When covered vaccines or drugs not usually self-administered are reported on a RHC claim, they should be reported on a separate line with the most appropriate revenue code for the services being performed. RHCs should not report influenza and the pneumococcal pneumonia vaccines on the claim.

Q23: How do the HCPCS reporting requirements affect billing for laboratory tests?

> **A:** The HCPCS reporting requirements do not change the billing for laboratory tests, which are billed separately to the A/B MAC by the facility. This does not include venipuncture (HCPCS code 36415), which is included in the AIR.

Q24: How do the HCPCS reporting requirements affect billing for services with post-operative care?

> **A:** The RHC can only bill for post-operative services if the surgery that was performed elsewhere was not billed using a global surgery code and the services furnished qualify as a RHC billable visit. If the surgery was performed at another facility or office and was billed as a global surgery, than the RHC cannot bill for the post-operative services because payment for the post-operative services was included in the global payment and this would result in a duplicate payment. If the surgery was performed at the RHC and is one of the services on the RHC qualifying visit list, the RHC can bill for the visit.

Q25: How will the explanation of benefits (EOB) appear to the patient?

> **A:** The EOB will list all of the services on the claim. The EOB states that the Medicare approved amount may be less than what your provider actually charged. For some

patients, the RHC may need to explain that the RHC is not charging twice for the services that were furnished.

Q26: How will the remittance advice appear?

A: The remittance advice has two parts, summary and detailed lines. The remittance will show that the charges for the additional lines and that the payment is included in another line.

Q27: Should claims to Medicare as the secondary payer (MSP) follow the new reporting requirements?

A: Yes. All claims to Medicare should follow the new reporting requirements.

Q28: Are the coordination of benefits (COB) payers aware of the HCPCS reporting requirements?

A: Information on the HCPCS billing requirements has been made available to COB payers.

Q29: Where can I get additional information?

A: The following resources are available:

RHC Center Page - https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Technical Assistance Call Slides - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RHC-HCPCS-Requirements.ppt

MLN Matters MM9269 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf

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

Chapter 13 of the CMS Benefit Policy Manual - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Chapter 9 of the CMS Claims Processing Manual - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf