# Rural Health Clinics: Coverage and Billing

09/21/2021

# Today's Presenter

- Andrea Freibauer
  - Provider Outreach and Education Consultant
- Kim Thomas, CPC
  - Provider Outreach and Education Consultant

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# Objectives

- After today's session, attendees will be able to
  - Discuss coverage and requirements for RHC services
  - Properly bill RHC services to Medicare
  - Understand how RHC services are reimbursed
  - Know where to go for more information

# Agenda

- Background and Requirements
- Billing
- Reimbursement and Cost Reports
- Resources, Wrap-Up and Questions

# RHC Background and Requirements

# Background of RHC Program

- Established to address inadequate supply of physicians in underserved rural areas
  - Increased utilization of NPs and PAs
- Paid an AIR per visit providing
  - Primary health services
  - Qualified preventive health services

# Covered RHC Services

- Physician services
- Services and supplies furnished incident to physician's services
- NP, PA, CNM, CP and CSW services
- Services and supplies furnished incident to NP, PA, CNM, CP or CSW services
- Nursing visits to homebound individuals furnished by RN or LPN
  - When certain conditions met

# Did You Know

- Services, supplies, and drugs incident to covered RHC services covered if:
  - Furnished as incidental but integral part of physician/NPP professional services
  - Commonly rendered either without charge or included in RHC bill
- Not included
  - Supplies and drugs that must be billed to DME MAC or Part D

# Nursing Visits to Homebound Patients

- All of the following conditions must be met:
  - Patient homebound
  - RHC located in area with shortage of HHAs
  - Services provided under plan of treatment
    - Written and reviewed by physician, NP, PA, CNM, CP or CSW
  - Furnished on intermittent basis
  - Does NOT include drugs and biologicals

# Noncovered RHC Services

- Medicare exclusions (routine physicals, dental care, routine eye exams, hearing tests)
- Technical component of RHC services
- Laboratory services
  - **Note** - venipuncture included in AIR when furnished in RHC or incident to RHC service
- DME (crutches, hospital beds, wheelchairs)
- Ambulance services

# Noncovered RHC Services

- Prosthetic devices which replace all or part of an internal body organ
- Body braces
- Practitioner services furnished to inpatients/ outpatients of
  - Hospitals (including CAHs), ASCs, CORFs
- Telehealth services
- Hospice services

# RHCs Must

- Directly furnish routine diagnostic and laboratory services
  - Must furnish following six laboratory tests onsite
    - Urine chemical examination by stick and/or tablet method
    - Hemoglobin or hematocrit
    - Blood sugar
    - Examination of stool specimens for occult blood
    - Pregnancy tests
    - Primary culturing for transmittal to certified laboratory

# RHCs Must

- Have arrangements with one or more hospitals to furnish medically necessary services not available in RHC
- Have available drugs and biologicals necessary for treatment of emergencies
- Not concurrently be approved as FQHC
- Not be rehabilitation agency or facility primarily for mental health treatment

# Did You Know

- NPP services for RHC beneficiaries must be
  - Provided by RHC employee
  - Under general/direct physician supervision
  - Type of service legally permitted by state to furnish
  - Follow state guidelines, RHC policies
  - Covered when provided by physician

# RHC Reimbursement

- One AIR payment made for all professional services for each covered visit
  - AIR = Total allowable costs ÷ total number of visits
  - Based on reasonable costs reported on annual cost report
  - Includes all covered services provided (limited exceptions)
  - Updated annually based on update to cost report
  - Subject to maximum payment per visit

# Update: Per Visit Payment Limit

- RHC per visit payment limit based on Medicare Economic Index
  - Calendar Year 2021 = $87.52 (1.4% increase)
  - Update to the Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year 2021
  - CR12035
- Does not apply to RHCs integral and subordinate part of hospital with fewer than 50 beds

# RHC Reimbursement

- Subject to maximum payment per visit
- RHC paid 80% of AIR for each visit
  - Some preventive services paid 100% of cost
- Payment for approved preventive services included in AIR or reimbursed at annual cost settlement
- Certain services paid at Medicare PFS national average non-facility payment rate

# RHC Payment Limits

- Effective 4/1/2021
- CR12185
- Payment limits for RHCs restructured beginning 4/1/2021
  - Division CC, section 130 of Consolidated Appropriations Act of 2021(P. L. 116-260), signed December 27, 2020, updated §1833(f) of the Act

# RHC Payment Limits

- RHCs to receive increase in payment limit per visit over an eight-year period
  - Begins 4/1/2021
  - Prescribed increase amount for each year from 2021 through 2028
  - In subsequent years, limit updated by percentage increase in MEI applicable to primary care services furnished as of the first day of that year

# RHC Payment Limit Staged Increases

- 2021 (after March 31) = $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

# Provider Based (PB) RHCs - Exceptions

- Beginning 4/1/2021, PB RHC payment limit per visit established at amount equal to greater of:
  - Payment per visit amount applicable to PB RHC for services furnished in 2020 increased by percentage increase in CY 2021 MEI of 1.4 percent
    - Interim amount if MACs do not have final cost settled amount
  - Payment limit per visit applicable to non-PB RHCs
- PB RHCS must meet definition in section 1833(f)(3)(B) of the Act

# Provider Based (PB) RHCs - Exceptions

- After 2021, PB RHC payment limit per visit will be **greater** of:
  - Payment per visit amount applicable for services furnished in previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of that year
  - Payment limit per visit applicable to each year for non-PB RHCs

# PB RHCs

- PB RHCs that meet definition in section 1833(f)(3)(B) “grandfathered” into establishment of their payment limit per visit
  - PB RHC in hospital with fewer than 50 beds and enrolled in Medicare as of 12/31/2019 to receive payment per visit based on average allowable costs
- PB RHCs new as of 2020 subject to payment limit per visit applicable to independent RHCs

# Cost Report

- Submitted annually by provider for prior 12-month period
- Due no later than five months after end of cost reporting period
  - Upload via MCRef or send through US Mail
  - Failure to submit cost report may result in reduction/suspension of Medicare payments
- For more information, refer to the CMS Publication 15-2, *Provider Reimbursement Manual – Part 2*

# Cost Report

- Once submitted, NGS reviews and finalizes cost report
  - Determines payment rate and reconcile if overpayment or underpayment
    - Total allowable costs divided by number of actual visits
  - Reconciles interim payments and determine if adjustments needed
    - Flu/PPV vaccines, bad debt, etc.

# Beneficiary Cost Sharing

- Beneficiary pays deductible and 20% coinsurance amounts
  - Coinsurance based on Total Charges reported on visit line
  - Exception: Certain preventive services where coinsurance waived per ACA

# RHC Billing

# Timely Filing Guidelines

- One-year timely filing rule, based on date of service
  - THROUGH date used to determine timely filing for institutional claims containing span level DOS, i.e., “FROM” and “THROUGH” date span
- Effective for all Medicare claims
- Adjustment claims must also follow timely filing regulations

# Notes for Upcoming Claim Examples

- HCPCS codes and associated charges used in examples are for illustration purposes only
- Examples assume that all coverage criteria have been met
- All other coding requirements (diagnosis, condition, occurrence, value codes, etc.) and claim elements apply

# RHC Bill Types

- TOB = 71X
  - 710 = nonpayment/zero claim (all charges are noncovered)
  - 711 = admit through discharge
  - 717 = claim adjustment
  - 718 = claim cancel
- DOS cannot overlap calendar years
  - Split billing periods that overlap calendar year
    - Reference: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100A

# RHC Visit Definition

- Medically necessary, face-to-face medical or mental health or qualified preventive visit between patient and physician, NP, PA, CNM, CP or CSW during which RHC service furnished
- TCM service
- Certain LPN or RN visits to homebound patient
- Typically multiple encounters on same day with same RHC practitioner or more than one RHC practitioner constitute a single visit

# RHC Visit Locations

- RHC visits may take place in/at
  - RHC
  - Patient's residence
  - Assisted living facility
  - Medicare Part A skilled nursing facility
  - Scene of accident

# RHC Visit Locations

- RHC visits may NOT take place in
  - Inpatient or outpatient hospital department
  - CAH
  - Facility that excludes RHC visits (e.g. hospice, CORF)

# RHC Billable Visit Revenue Codes

| Code | Description |
|---|---|
| 0521 | Clinic visit |
| 0522 | Home visit |
| 0524 | Visit for beneficiary in covered Part A SNF stay |
| 0525 | Visit for beneficiary in noncovered Part A SNF stay (or other residential facility) |
| 0527 | Visiting nurse service at beneficiary's home when in HH shortage area |
| 0528 | Visit to other non-RHC site (scene of accident) |
| 0780 | Telehealth |
| 0900 | Psychological services provided by CP, CSW |

# RHC Qualifying Visit List (QVL)

- RHC Reporting Requirement FAQs
- To assist RHCs when HCPCS codes were first required to be on all claims, we posted a qualifying visit list to serve as a guide to services that generally qualify as stand-alone billable visits
  - The HCPCS reporting requirements have not changed what is considered a RHC stand-alone billable visit, which is typically evaluation and management type of services or screenings for certain preventive services
  - Q/A #12
- Reported with the CG modifier

# RHC Qualifying Visit List (QVL)

- Medically necessary service not included on QVL (which is a guide) can be billed as stand-alone visit if:
  - Meets Medicare coverage requirements
  - Within scope of RHC benefit
  - Not furnished incident-to physician's service

# Reporting Qualifying Visit HCPC Code

- Claims and adjustments must include modifier CG on one line
  - Reported on line with medical and/or medical HCPCS code that represents primary reason for medically necessary face-to-face visit
  - Must include bundled charges for all services subject to coinsurance and deductible

# Claim Example: Reporting Qualified Medical Visit

- Claim generates AIR payment
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on qualified visit line

| FL 42 Rev Code | FL 44 HCPC | FL 45 Service Date | FL 46 Service Units | FL 47 Total Charges |
|---|---|---|---|---|
| 052X | 99213 CG | 4/1/2020 | 1 | $115 |
| 0001 | | | | $115 |

# Claim Example: Reporting Qualified Mental Health Visit

- Claim generates AIR payment
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on qualified visit line

| FL 42<br>Rev Code | FL 44<br>HCPC | FL 45<br>Service Date | FL 46<br>Service Units | FL 47<br>Total Charges |
|---|---|---|---|---|
| 0900 | 90834 CG | 4/1/2020 | 1 | $170 |
| 0001 | | | | $170 |

# Report All Services Provided During Visit

- RHCs required to report appropriate HCPCS code for each service on separate claim line along with revenue code
  - Also applies to RHCs exempt from electronic reporting under Section 424.32(d)(3)
  - Additional claim lines do not generate additional reimbursement
  - All other billing requirements still apply

# Report All Services Provided During Visit

- Claim lines for services/supplies furnished "incident to" visit should report
  - Appropriate revenue code
    - RHCs can report incident to services using all valid revenue codes except 002X–024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X–072X, 080X–088X, 093X, 096X–310X
  - Applicable CPT/HCPCS code
  - One unit
  - Charges that apply to service

# Report All Services Provided During Visit

- Qualifying visit line must include visit charge and total charges for all incident to services provided during visit
  - Coinsurance based on Total Charges on visit claim line
  - 0001 Totals line must calculate accurately
  - AIR generated based on billable visit revenue code

# Claim Example: Reporting Qualified Medical Visit with Incident to Services

- Claim generates one AIR payment
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on qualified visit line

# Claim Example: Reporting Qualified Medical Visit with Incident to Services

| FL 42<br>Rev Code | FL 44<br>HCPC | FL 45<br>Service Date | FL 46<br>Service Units | FL 47<br>Total Charges |
|---|---|---|---|---|
| 052X | 99213 CG<br>($115) | 4/1/2020 | 1 | $205 |
| 0300 | 36415 | 4/1/2020 | 1 | $55 |
| 0636 | 90746 | 4/1/2020 | 1 | $25 |
| 0771 | G0010 | 4/1/2020 | 1 | $10 |
| 0001 | | | | $295 |

# Multiple Visits on Same Day

- Visits with more than one practitioner on same day = one visit (one unit)
- Multiple visits with same practitioner on same day = one visit (one unit)
- Applies regardless
  - Length or complexity of visit
  - Number/type of practitioners seen
  - Subsequent visit scheduled or not
  - Initial visit related or not to subsequent visit

# Multiple Visits on Same Day - Exceptions

- Illness/inquiry occurs after initial visit requiring diagnosis/treatment on same day (two visits billed)
  - Primary visit billed with CG modifier
  - Subsequent medical visit billed with 052X revenue code, qualifying visit HCPCS code and modifier 59, one unit, total charges associated with visit
- Medical visit and mental health visit same day (two visits billed)
  - Both lines billed with CG modifier
- IPPE and separate medical and/or mental health visit on same day (two or three visits billed)
  - Do not report CG modifier on IPPE line

# Reporting Multiple Qualified Visits

- Report claim line and incident to line(s) for each qualifying visit
  - Only one line has CG modifier unless mental and medical
- Total charges report on qualifying visit claim line must include associated incident to charges
- AIR generated for each qualifying visit claim line
- Coinsurance applies to each qualifying visit claim line (20% total charges)

# Claim Example: Reporting Multiple Qualified Medical Visits

- Claim generates two AIR payments
  - Deductible applies
  - Coinsurance applies
    - 20% total charges on each qualified visit line

| FL 42 Rev Code | FL 44 HCPC | FL 45 Service Date | FL 46 Service Units | FL 47 Total Charges |
|---|---|---|---|---|
| 052X | 99213 CG | 4/1/2020 | 1 | $115 |
| 052X | 99214 59 | 4/1/2020 | 1 | $95 |
| 0001 | | | | $210 |

# Billing RHC Preventive Services

# Approved Preventive Services

| HCPCS Code | Short Descriptor | Coinsurance/Deductible Waived? |
|---|---|---|
| G0101 | Ca screen; pelvic/breast exam | Yes |
| G0102 | Prostate ca screening; dre | No |
| G0117 | Glaucoma scrn hgh risk direc | No |
| G0118 | Glaucoma scrn hgh risk direc | No |
| G0296 | Visit to determ LDCT elig | Yes |
| G0402 | Initial preventive exam | Yes |
| 99406* | Tobacco-use consel 3–10 min | Yes |
| 99407* | Tobacco-use consel >10 min | Yes |
| G0438 | Ppps, initial visit | Yes |
| G0439 | Ppps, subseq visit | Yes |

# Approved Preventive Services

| HCPCS Code | Short Descriptor | Coinsurance/Deductible Waived? |
|---|---|---|
| G0442 | Annual alcohol screen 15 min | Yes |
| G0443 | Brief alcohol misuse counsel | Yes |
| G0444 | Depression screen annual | Yes |
| G0445 | High inten beh couns std 30 min | Yes |
| G0446 | Intens behav ther cardio dx | Yes |
| G0447 | Behavior counsel obesity 15 min | Yes |
| Q0091 | Obtaining screen pap smear | Yes |

# Billing Preventive Services

- Reporting approved preventive service with qualifying medical visit
  - On separate claim line report
    - Revenue code 052X
    - Preventive service CPT/HCPCS code
    - One unit
    - Associated charges
- Do not include preventive service charges in qualifying visit total charges
  - Ensure coinsurance does not include preventive service costs

# Claim Example: Reporting Qualified Medical Visit with Preventive Service

- Claim generates one AIR payment
  - Deductible applies
  - Coinsurance applies to nonpreventive claim lines
    - 20% total charges on qualified visit line

| FL 42 Rev Code | FL 44 HCPC | FL 45 Service Date | FL 46 Service Units | FL 47 Total Charges |
|---|---|---|---|---|
| 052X | 99213 CG ($115) | 4/1/2020 | 1 | $115 |
| 052X | G0101 | 4/1/2020 | 1 | $35 |
| 0001 | | | | $150 |

# Billing Preventive Services

- Reporting approved preventive service with qualifying medical visit when coinsurance/deductible are not waived
  - On separate claim line report
    - Revenue code 052X
    - Preventive service CPT/HCPCS code
    - One unit
    - Associated charges
- Include preventive service charges in qualifying visit total charges

# Billing Preventive Services

- Reporting approved preventive service as qualifying medical visit
  - When only services provided on DOS
    - Revenue code 052X
    - Preventive service CPT/HCPCS code
    - One unit
    - Associated charges
- AIR payment generated
  - Coinsurance waived based on CPT/HCPCS

# Claim Example: Reporting Preventive Service as the Qualified Medical Visit

- Claim generates one AIR payment
  - Deductible waived
  - Coinsurance waived

| FL 42<br>Rev Code | FL 44<br>HCPC | FL 45<br>Service Date | FL 46<br>Service Units | FL 47<br>Total Charges |
|---|---|---|---|---|
| 052X | G0101 CG | 4/1/2020 | 1 | $35 |
| 0001 | | | | $35 |

# Billing Hepatitis B Vaccine

- If vaccine/administration are only services provided, do not submit claim
- If provided with billable visit, report as incident-to services
  - Include vaccine/administration charges on CG modifier line total charges
- Coinsurance applicable
- Payment included in AIR

# Billing Influenza and Pneumococcal Pneumonia Vaccines

- Influenza and pneumococcal vaccines and administration not reported on RHC claims
- Coinsurance and deductible do not apply
- Payment made through cost report process

# COVID-19 Vaccines

- COVID-19 FAQs on Medicare Fee for Service Billing
  - Question/Answer #7 under Section BB. Drugs & Vaccines under Part B
    - FQHCs and RHCs are paid through the cost report process
- Available on the our website
  - Medicare Part A and B Billing for the COVID-19 Vaccine and Monoclonal Antibody

# Billing Guidelines – Other RHC Services

# Advanced Care Planning

- Optional element of AWV
  - Voluntary ACP = face-to-face service between physician and patient discussing advance directives
  - Considered preventive service when furnished on same day as AWV
  - Generates separate MPFS payment
    - Coinsurance waived

# ACP Billing Guidelines

- Billing as element of AWV
  - Report claim line for qualifying visit
    - Revenue code 052X
    - AWV qualifying visit HCPCS code G0438 or G0439
    - One unit
    - Total charges for qualifying visit (only)
  - Report claim line for ACP
    - Revenue code 052X
    - CPT code 99497
    - One unit
    - Total charges for ACP
  - 0001 Totals line must calculate appropriately

# ACP Billing Guidelines

- Qualifies as stand-alone encounter
  - Report claim line for ACP
    - Revenue code 052X
    - CPT code 99497
      - Reported with CG modifier if only preventive services furnished and ACP primary reason for visit
    - One unit
    - Total charges for ACP
  - 0001 Totals line must calculate appropriately
- Generates separate MPFS payment

# Transitional Care Management Services

- Services required during beneficiary's transition to community setting following discharge from inpatient hospital setting
  - 30-day period beginning date of discharge
- Physician/NPP accepts care of beneficiary post-discharge from facility setting without gap
  - Takes responsibility for beneficiary's care
- Medical/psychosocial issues require moderate-high/complexity medical decision making

# TCM Guidelines

- If TCM visit occurs same day as another billable visit, only one visit billed
- Subject to Part B coinsurance
- Does not apply to services provided in post-op global period
- One TCM visit covered per beneficiary per post-discharge period
- One health care professional may report TCM services

# Billing for TCM Services

- DOS = day face-to-face visit takes place
- Revenue code = 0521
- Qualifying visit HCPCS codes
  - 99495 for moderate-complexity decision making
  - 99496 for high-complexity decision making
- One unit
- Total Charges
- 0001 total charges

# Care Coordination Services

- Separate payment for care coordination services
  - Complex Chronic Care Management (CCM)
  - General Behavioral Health Integration (BHI)
  - Psychiatric collaborative care model (CoCM)
- Eligibility, coverage and documentation guidelines
  - MLN Matters® MM10175 Revised: *Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)*

# Care Coordination Services Billing

- Can be billed alone or on qualifying visit claim
- Line item reporting (no CG modifier on this line)
  - General Care Management services: HCPCS code G0511
  - Psychiatric CoCM services: HCPCS code G0512
- Coinsurance and deductible applied
- Can only bill once per month per beneficiary
  - Do not bill if other care management services are billed for same time period

# Principal Care Management Services

- PCM services describes comprehensive care management services of single high-risk disease or complex condition
  - Bill G0511 (general care management) for PCM services, either billed alone or other payable services
  - Payment rate includes PCM HCPCS G2064 and G2065
    - CR 12252
    - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 13, Section 230.2

# Telehealth Services

- RHC is originating site
  - Service is billed separately, no other visit reported
    - Revenue code 0780
    - HCPCS Q3014
  - Subject to Part B deductible and coinsurance
- RHCs not authorized to serve as distant site

# Global Surgeries

- Surgical procedures furnished in RHC included in AIR
- Surgical procedures furnished at other locations, follow global billing guidelines
  - Bill for visit during global period *if* visit for service **not** included in global package
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 40 and 40.1

# Virtual Communication Services

- RHCs virtual communication services
  - At least five minutes of communication technology-based or remote evaluation services furnished to patient who has had RHC billable visit within previous year
  - Medical discussion or remote evaluation must meet both of the following requirements
    - Condition not related to RHC service provided within previous seven days
    - Does not lead to RHC visit within next 24 hours or soonest available appointment

# Virtual Communication Services

- Can be billed alone or with other payable services
- Submit claim with HCPCS code G0071
- RHC face-to-face requirements are waived
- Medicare coinsurance and deductible apply
- For more information
  - Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions

# New and Expanded Flexibilities for RHCs and FQHCs During the COVID-19 PHE

- New and Expanded Flexibilities for RHCs and FQHCs During the COVID-19 PHE
  - SE20016
- Flexibilities extended for duration of current COVID-19 PHE
  - For additional information, please see RHC/FQHC COVID-19 FAQs

# Telehealth Distant Site Billing – RHC

- Claims submitted after 7/1/2020:
  - Payment rate of $92.03 when billed with G2025
  - Report G2025
  - Will not require CG modifier
  - 95 modifier (optional)
  - CS modifier (cost sharing waived) when appropriate
- Dates of service 1/1/2021
  - Payment rate of $99.45 when billed with G2025

# Resources and Wrap Up

# What You Should Do Now?

- Share this presentation with other internal staff members
- Develop/update any internal procedures or processes, as appropriate
- Review available references and resources for additional information
- Attend future NGS' training events

# CMS Rural Health Open Door Forum

- Free CMS teleconferences addressing RHC, FQHC and CAH issues
  - Rural Health Open Door Forum Mailing List Sign-Up
- For more information, registration and handouts
  - Rural Health Open Door Forum

# Resources

- CMS website
  - RHC Center
  - RHC Fact Sheet
  - RHC Preventive Services Chart

# Resources

- CMS Internet-Only Manuals (IOMs)
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manua*l, Chapter 9
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Preventive and Screening Services

# Resources

- CPT Standard Edition
  - Published by the American Medical Association
- FISS DDE providers have revenue codes and HCPCS codes files available for their reference

# Resources

- National Uniform Billing Committee website
  - NUBC Official UB-04 Data Specifications Manual
  - Annual fee
  - Providers also receive updates throughout the year
- U.S. Preventive Services Task Force Website
  - Provides Grade A and B preventive services

# Contact NGS

- Talk to live representative via the Provider Contact Center (PCC)
  - JK 888-855-4356 (TTY: 866-786-7155)
  - J6 877-702-0990 (TTY:  888-897-7523)
  - JK Available Monday–Friday: 8:00 a.m.–4:00 p.m. ET
    - Closed for training 2nd and 4th Friday from 12:00–4:00 p.m. ET
  - J6 Available Monday–Friday: 8:00 a.m.–4:00 p.m. CT
    - Closed for training 2nd and 4th Friday from 11:00 a.m. –3:00 p.m. CT

# Contact NGS

- Provider self-service using the IVR system
  - JK 877-567-7205
  - J6 877-309-4290
  - Available 24 hours per day, seven days per week
  - Menu options that require system access only available
    - Monday–Friday: 6:00 a.m.–7:00 p.m. ET
    - Saturday: 7:00 a.m.–3:00 p.m. ET

# Contact NGS

- Written inquiries
  - Via email through secure NGSConnex web portal
  - Via US Mail
    - Use Medicare Correspondence Request Form
    - JK providers mail to:
      - National Government Services, Inc.
        Attn: Provider Written General Inquiries
        P.O. Box 6189
        Indianapolis, IN 46206-6189

# Contact NGS

- Written inquiries
  - J6 providers mail to:
    - National Government Services, Inc.
      Attn: Provider Written General Inquiries
      P.O. Box 6474
      Indianapolis, IN 46206-6189

# Thank You

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?


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