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Rural Health Clinic Billing Basics

5/15/2025

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Objective

After today's session, attendees will understand how to properly bill the different types of RHC services to Medicare and know where to go for more information.

Today's Presenters

- Provider Outreach and Education Consultants
  - Andrea Freibauer

Agenda

- Billing Basics
- Billing Preventive Services
- Other RHC Services
- Resources and References
- Questions?

Billing Basics

RHC Visit Definition

- Medically necessary encounter where allowed RHC service(s) furnished in covered visit location
- Who can perform
  - Physician, NP, PA, CNM, CP, CSW, MFT or MHC
- Types of RHC visits
  - Medical
  - Mental health
  - Qualified preventive health visit

RHC Qualifying Visit List (QVL)

- QVL used as guide to services which generally qualify as stand-alone billable visits
  - Qualifying visits (QVs) typically E/M type services or certain preventive services
- Medically necessary service not included on QVL can be billed as stand-alone visit if
  - Meets Medicare coverage requirements
  - Within scope of RHC benefit
  - Not furnished incident-to physician's service

New for 2025

- MLNMatters® *MM13946: Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update*
- As of 1/1/2025:
  - Dental services that align with policies and operational requirements in physician setting
    - Considered QV and paid under RHC AIR even when furnished on same day as medical visit
  - Hepatitis B vaccines and their administration paid at 100% of reasonable cost
- As of 4/1/2025
  - CPT Category II codes allowed on RHC claims (quality reporting purposes)
- As of 7/1/2025
  - Bill and be paid for preventive vaccines/administration at time of service

Notes for Upcoming Claim Examples

- CPT/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 Qualified 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
0905	IOP

QV Line

- Claims and adjustments must include modifier CG on QV line
  - Reported with medical and/or HCPCS code representing primary reason for medically necessary face-to-face visit
  - Must include bundled charges for all services subject to coinsurance and deductible
- QV 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
  - Payment generated based on billable visit revenue code

Report All Services Provided During Visit

- RHCs required to report appropriate CPT/HCPCS code for each service on separate claim line along with revenue code
  - Also applies to RHCs exempt from electronic reporting under Title 42, Section 424.32(d)(3)
  - Additional claim lines do not generate additional reimbursement
  - All other billing requirements still apply

Incident To Services/Supplies

- 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

Counting Visits

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

Claim Example: Reporting Qualified Medical Visit

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

Revenue Code (FL 42)	CPT/HCPCS (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG	04/30/2025	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

Revenue Code (FL 42)	CPT/HCPCS (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
0900	90834 CG	04/30/2025	1	$170
0001				$170

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

Revenue Code (FL 42)	CPT/HCPCS (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG ($115)	04/30/2025	1	$205
0300	36415	04/30/2025	1	$55
0636	90746	04/30/2025	1	$25
0771	G0010	04/30/2025	1	$10
0001				$295

IOP Services

- IOP services billed with CC 92, revenue code 0905 and at least one code from List A Primary Services
- Counting visits
  - When furnished on same day as mental health visit, considered one visit
    - One payment made at IOP rate (mental health visit considered included)
  - When furnished on same day as medical visit, considered two visits
    - Both lines billed with CG modifier
    - Two different payments - AIR payment for medical visit and IOP rate for IOP visit

IOP References

- MLN Matters® *MM13264: Billing Requirements for Intensive Outpatient Program Services for Federally Qualified Health Centers & Rural Health Clinics*
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 250.1
- Intensive Outpatient Program

Billing for Two Visits

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

Billing for Three Visits

- IPPE and separate medical and mental health visit on same day
  - Do not report CG modifier on IPPE line

Reporting Multiple Qualified Visits

- Report claim line and incident to line(s) for each QV
  - Only one line has CG modifier unless medical and mental health visit or medical visit and IOP visit
- Total charges reported on QV claim line must include associated incident to charges
- AIR generated for each QV claim line
  - IOP payment for IOP visit
- Coinsurance applies to each QV 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

Revenue Code (FL 42)	CPT/HCPCS (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG	04/30/2025	1	$115
052X	99214 59	04/30/2025	1	$95
0001				$210

Billing Preventive Services

Preventive Services

- Paid as stand-alone visit when no other service furnished on same day
- Considered one single visit if furnished on same day as another medical visit (except for IPPE and preventive vaccines)
  - Two visits may be billed if occurs on same day as another billable visit
- Most preventive services do not have coinsurance or deductible applied, except
  - Prostate Cancer Screening
  - Glaucoma Screening
  - Screening Pap Test

Preventive Services

- Rural Health Clinic (RHC) Preventive Services Chart

Preventive Service	CPT/HCPCS Code
Alcohol Screening and Behavioral Counseling	G0442, G0443
AWV	G0438, G0439
Glaucoma Screening	G0117, G0118
IPPE	G0402
IBT for Cardiovascular Disease	G0446
IBT for Obesity	G0447

Preventive Services (continued)

Preventive Service	CPT/HCPCS Code
Lung Cancer Screening with LDCT	G0296
Prostate Cancer Screening	G0102
Screening for Depression	G0444
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling	G0445
Screening Pap Test	Q0091
Screening Pelvic Exam	G0101
Smoking and Tobacco Cessation Counseling	99406, 99407

When Preventive Service Is Qualified Medical Visit

- Approved preventive service is qualifying medical visit when only service provided on DOS
  - Revenue code 052X with preventive service CPT/HCPCS code
  - One unit
  - Associated charges
- AIR payment generated
  - Coinsurance waived based on CPT/HCPCS code

Claim Example: Reporting Preventive Service as Qualified Medical Visit

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

Revenue Code (FL 42)	CPT/HCPCS (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	G0101 CG	04/30/2025	1	$35
0001				$35

Coinsurance and/or Deductible Waived

- Approved preventive service on same day as qualifying medical visit and coinsurance/deductible waived
  - Qualified medical visit line
    - Appropriate revenue code
    - QV CPT/HCPCS code with CG modifier
    - One unit
    - Bundled total charges except for preventive service charges
      - Ensure coinsurance does not include preventive service costs
  - Preventive service line
    - Revenue code 052X
    - Preventive service CPT/HCPCS code
    - One unit
    - Charges for preventive service only

Claim Example: Reporting Preventive Service and Qualified Medical Visit

- Claim generates one AIR payment
  - Deductible applies
  - Coinsurance (20%) applies to charges on qualified medical visit line

Revenue Code (FL 42)	CPT/HCPCS (FL 44)	Service Date (FL 45)	Units (FL 46)	Total Charges (FL 47)
052X	99213 CG ($115)	04/30/2025	1	$115
052X	G0101	04/30/2025	1	$35
0001				$150

Coinsurance and/or Deductible Not Waived

- Approved preventive service on same day as qualifying medical visit and coinsurance/deductible NOT waived
  - Qualified medical visit line
    - Appropriate revenue code
    - QV CPT/HCPCS code with CG modifier
    - One unit
    - Bundled total charges including preventive service charges
- Include preventive service charges in QV total charges
  - Coinsurance (20%) applies to total charges on QV line

Social Determinants of Health (SDOH) Risk Assessments

- Effective 1/1/2024
- SDOH risk assessments billed using HCPCS code G0136
  - Must be provided in conjunction with QV, including an E&M visit or AWV
- Not paid separately
- Cost-sharing
  - When provided with AWV, no deductible/coinsurance applied
  - When provided with other visits, cost sharing applies

Billing ACP as Element of AWV

- Report claim line for QV
  - Revenue code 052X with AWV QV HCPCS code G0438 or G0439
  - One unit with total charges for QV (only)
- Report claim line for ACP
  - Revenue code 052X with CPT code 99497
  - One unit with total charges for ACP
- 0001 Totals line must calculate appropriately

Billing ACP as Stand-Alone Encounter

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

HIV PrEP - Counseling

- PrEP for HIV & Related Preventive Services
- Practitioners can bill for individual counseling when service performed in RHC
- Not separately billable when furnished on same day as another medical visit (packaged in RHC AIR payment)
- For claims with DOS on/after 9/30/2024, bill as stand-alone visit when only medical service provided
  - Physician or other qualified professional – bill HCPCS code G0011 with CG modifier
  - Auxiliary personnel – bill HCPCS code G0013 (packaged in RHC AIR PPS payment)

PrEP and Administration

- Bill using HCPCS code G0012
  - Can be billed alone or in addition to other services
- Paid separately according to Drugs Covered as Additional Preventive Services (DCAPS) fee schedule
  - 2025 ASP Drug Pricing Files
- RHCs don't have to enroll as "Part B pharmacy"

2025 Updates – Preventive Vaccines

- As of 1/1/2025, hepatitis B vaccines paid same as other Part B preventive vaccines
- As of 7/1/2025, RHCs can bill for all four types of Part B preventive vaccines and their administration at time of service
  - Coinsurance and deductible do not apply
  - Vaccine payment = 95% of AWP
  - Administration paid according to National Fee Schedule
- MLN Matters® *MM13923: Payment for Medicare Part B Preventive Vaccines & Their Administration for Rural Health Clinics & Federally Qualified Health Centers*

Preventive Vaccines – Billing

- COVID-19
  - Multiple vaccine codes to choose from
  - CPT code 90480 – administration
- Hepatitis B
  - Multiple vaccine codes to choose from
  - HCPCS code G0010 – administration
- Influenza/Flu
  - One per flu season (August–July) for all beneficiaries with Part B coverage
  - 2024–2025 vaccine codes
  - HCPCS code G0008 – administration
- Pneumococcal
  - Multiple vaccine codes to choose from
  - HCPCS code G0009 – administration

In-Home Vaccine Administration

- Additional payment when criteria met
  - Updated annually – approximately $40 for CY 2025
- Billing – include all three
  - Appropriate vaccine CPT code
  - Appropriate vaccine administration CPT/HCPCS code
  - HCPCS code M0201

Preventive Vaccines – Visits and Costs

- QV not required for administering pneumococcal, flu, hepatitis B, or COVID-19 vaccines
  - When performed on same day as QV, vaccine and administration receives separate payment
- Associated costs not included in determination of AIR rate and not subject to payment limit
- On cost report, annually reconcile payments received with actual vaccine/administration costs, including any in-home additional costs

Other RHC Services

Billing Care Coordination Services

- Effective for DOS on/after 1/1/2025, report individual CPT/HCPCS base codes and add-on codes for care coordination services
  - Except for Advanced Primary Care Management (APCM) services, can choose to continue to bill HCPCS code G0511 between 1/1/2025–7/1/2025
    - Must be on facility basis, not claim-by-claim or per beneficiary
- Can be billed alone or on QV claim
  - Do not apply modifier CG to these services
- Payment based on national nonfacility PFS payment rate
- Coinsurance and deductible applied
- MLN Matters® *13946: Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update*

CPT/HCPCS Coding for Care Coordination Services

- APCM – G0556, G0557, G0558
- General BHI – 99484, G0323
- CCM – 99437, 99439, 99487, 99489, 99490, 99491
- Community Health Integration (CHI) – G0019, G0022
- Chronic Pain Management (CPM) – G3002, G3003
- Principal Care Management (PCM) – 99424, 99425, 99426, 99427
- Principal Illness Navigation (PIN) – G0023, G0024
- PIN Peer-Support (PIN-PS) – G0140, G0146
- Remote Physiologic Monitoring (RPM) – 99453, 99454, 99457, 99458, 99474, 99091
- Remote Therapeutic Monitoring (RTM) – 98975, 98976, 98977, 98980, 98981

Transitional Care Management (TCM) Billing

- TCM guidelines
  - Only one health care professional may report TCM services
  - One TCM visit covered per beneficiary per post-discharge period
  - Services provided not in post-op global period
  - Subject to Part B coinsurance
- If TCM visit occurs same day as another billable visit, generally only one visit billed
  - As of 1/1/2022, can bill TCM and general care management services for same patient during same time period
    - RHC must meet requirements for billing each code

Billing for TCM Services

- DOS = day face-to-face visit takes place
- Revenue code = 0521
- QV CPT codes
  - 99495 for moderate-complexity decision making
  - 99496 for high-complexity decision making
- One unit

Psychiatric CoCM Services

- Can only bill once per month per beneficiary
  - Do not bill if other care management services are billed for same time period by any practitioner or facility
- Can be billed alone or on QV claim
- Report revenue code 052X with HCPCS code G0512
  - Do not apply modifier CG
- Coinsurance and deductible applied

Global Surgeries

- Surgical procedures furnished in RHC included in visit payment
- 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, Sections 40 and 40.1

Telehealth Extension Through 9/30/2025

- H.R.1968 - Full-Year Continuing Appropriations and Extensions Act, 2025 extended telehealth waivers until 9/30/2025
  - Pay claims through 9/30/2025 with the same flexibilities as 2024
  - All providers eligible to bill Medicare for professional services can provide distant site telehealth
  - Beneficiaries may continue to receive telehealth services at home
    - No geographic location restrictions
  - In-person mental health services requirement delayed until 1/1/2026
- Telehealth FAQ 4/9/2025
- List of Telehealth Services

Virtual Communication Services

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

Resources and References

CMS References – General

- CMS Rural Health Clinics Center
- RHC Reporting Requirement FAQs
- MLN® Booklet: *Information for Rural Health Clinics*
- Rural Health Clinic (RHC) Preventive Services Chart

CMS Resources

- CMS Internet-Only Manual Publications
  - 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
  - 100-04, *Medicare Claims Processing Manual*, Chapter 9, Rural Health Clinics/Federally Qualified Health Centers
  - 100-04, *Medicare Claims Processing Manual*, Chapter 18, Preventive and Screening Services

NGS Resources

- Revenue codes and HCPCS codes files available in FISS DDE
- NGS website
  - Upcoming training events
  - Medicare updates and educational materials
  - Contact information for
    - Provider Contact Center
    - IVR
    - Written inquiries

Other Resources

- AMA CPT® (Current Procedural Terminology)
- National Uniform Billing Committee (NUBC) website
  - NUBC Official UB-04 Data Specifications Manual
    - Annual fee
    - Providers also receive updates throughout the year
- U.S. Preventive Services Task Force (USPSTF) website
  - Grade A and B preventive services

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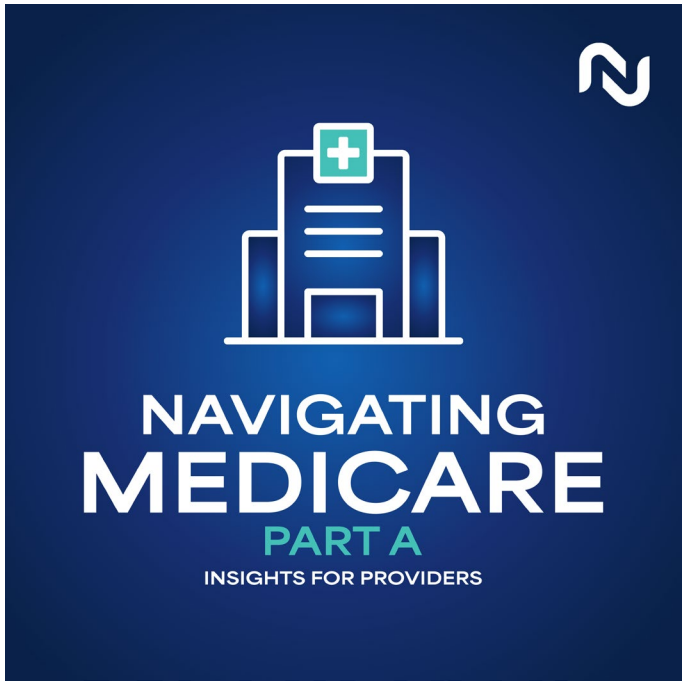

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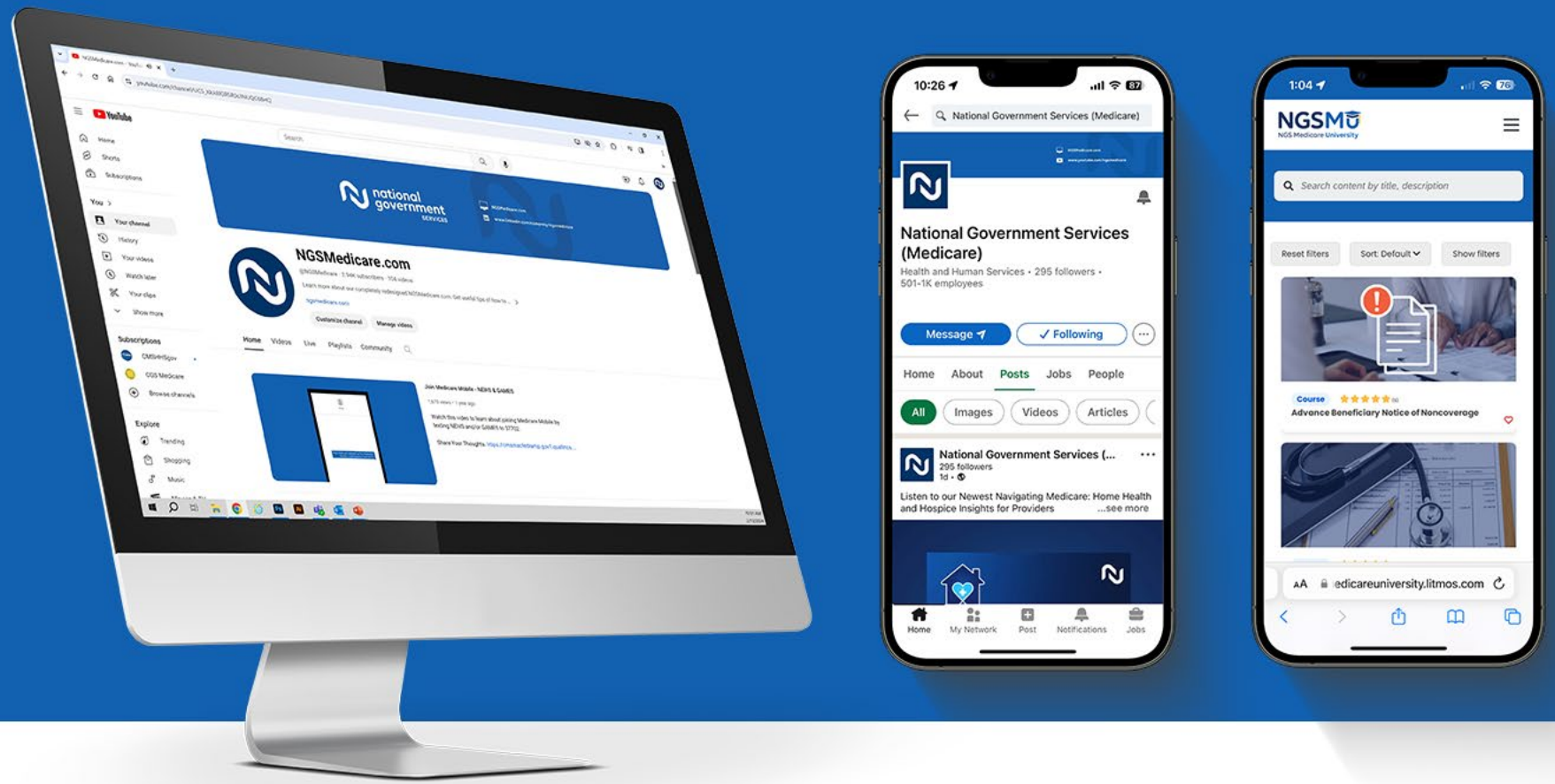

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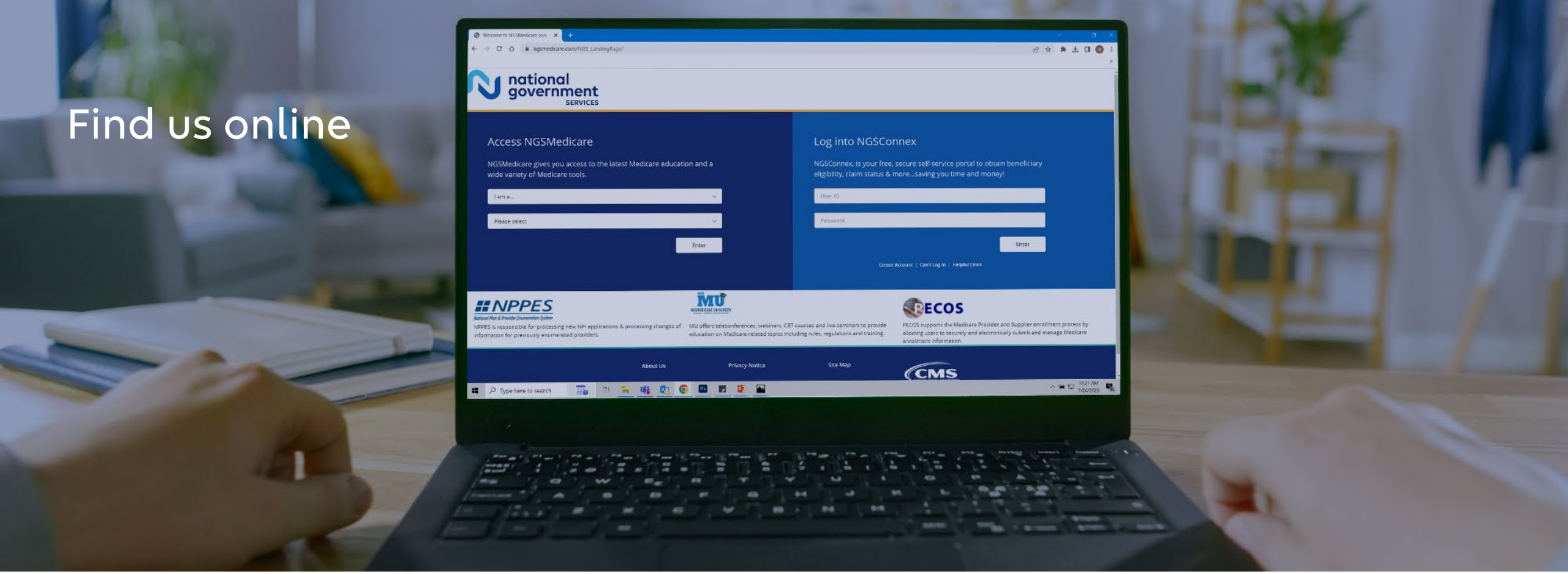

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