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Quality Outcomes Made Possible

June 2025

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# Rural Health Billing & Coding Workshop


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# Disclaimer

The information presented today is current as of today. As with any health care regulation, you should always verify that any references or resources are current and have not been replaced with more current guidance.

# RHC Basics and Key Resources

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- CMS Payment System
- CMS Manuals
- Encounters/Covered Services

# Payments

RHC’s receive an all-inclusive rate (AIR) per visit for qualified services

2025 $152.00

2026 $165.00

# Key Resources

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| CMS RHC Information | | |
|---|---|---|
| Name | Updated | Website |
| Medicare Claims Processing Manual, Chapter 9 | 6/7/2023 | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf |
| Medicare Benefit Policy Manual, Chapter 13 | 3/20/2025 | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf |
| Medicare Claims Processing Manual, Chapter 18 Preventative and Screening Services | 10/11/2024 | https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf |
| CMS Rural Health Clinics Center | | https://www.cms.gov/center/provider-type/rural-health-clinics-center |
| MLN006398 Information for Rural Health Clinics | Apr-25 | https://www.cms.gov/files/document/mln006398-information-rural-health-clinics.pdf |
| Rural Health Clinics Reporting Requirements FAQs | | https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf |
| RHC Qualifying Visit List | 8/1/2016 | https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/rhc-qualifying-visit-list.pdf |

# Chapter 9

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## Medicare Claims Processing Manual
### Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

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*(Rev. 12070, 06-07-23)*

**Transmittals for Chapter 9**

# Chapter 13

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## Medicare Benefit Policy Manual
### Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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*(Rev. 13133; Issued: 03-20-25)*

**Transmittals for Chapter 13**

# Chapter 13 con't

# Chapter 18

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## Medicare Claims Processing Manual
## Chapter 18 - Preventive and Screening Services

Close

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*(Rev. 12883; Issued: 10-11-24)*

**Transmittals for Chapter 18**

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BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

# Information for Rural Health Clinics

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# RHC FAQ's

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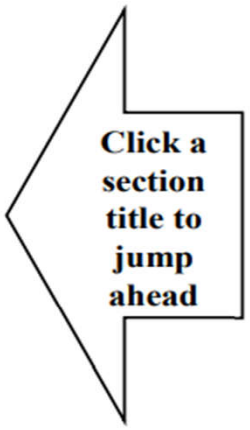
## Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

**Sections**





# Websites

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| Helpful Websites | |
|---|---|
| Name | Website |
| National Association of Rural Health Clinics | https://www.narhc.org/narhc/default.asp |
| National Rural Health Association | https://www.ruralhealth.us/ |
| | |
| Rural Health Information Hub | https://www.ruralhealthinfo.org/ |
| American Hospital Association Rural Hospitals | https://www.aha.org/advocacy/rural-health-services |
| CMS Critical Access Hospitals Center | https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/critical-access-hospitals-center |

# Medicare MAC websites

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Look at other Medicare MAC websites, some of them have great information for RHCs.

Facebook RHC groups are also a great resource.

# RHC Visit Definition

40 - RHC and FQHC Visits (Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24) An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, CSW, MFT or MHC during which time one or more RHC or FQHC services are rendered

Resource: Medicare Benefit Policy Manual, Chapter 13, Section 40

# Definition Expanded

Effective January 1, 2022, a mental health visit is a face-to-face encounter, or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder.

Resource: Medicare Benefit Policy Manual, Chapter 13, Section 40

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## 110.1 - Dental, Podiatry, Optometry, and Chiropractic Services

Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare statute, and qualified services furnished by physicians are billable visits in an RHC or FQHC. These practitioners can provide RHC or FQHC services that are within their scope of practice and not excluded from coverage (e.g., Medicare coverage of chiropractic services is limited to manual manipulation of the spine for a demonstrated subluxation).

An RHC or FQHC can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is a qualifying visit for RHCs or FQHCs and all other requirements are met. All services furnished must be within the state scope of practice for the practitioner, and all HCPCS codes must reflect the actual services that were furnished.

Resource: Medicare Benefit Policy Manual, Chapter 13, Section 110.1

# What services do RHC's provide

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- Preventative Services
- Care Coordination Services
- Transition of Care
- Routine diagnostic and lab services onsite
- Mental Health
- Dental
- Podiatry
- Optometry
- Chiropractors

**Not an inclusive list

# Are all visits qualifying encounters?

NO – The following are examples of visits that do not qualify for reimbursement as a RHC encounter:

- Nurse only visits (typically 99211)
- Visits for injections only
- Medication refills
- Suture removal
- Dressing change
- Lab results

# Coding and Documentation

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- Coding Basics
- CPT II Codes
- Chart Documentation

# Importance of Compliant Billing

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- Fraud prevention and legal compliance.
- Meeting medical necessity requirements.
- Compliance with regulatory requirements.
- Correct coding, modifier usage and claims processing.
- Proper documentation.
- Value-based reimbursement

# How do we capture the true condition of our patients?

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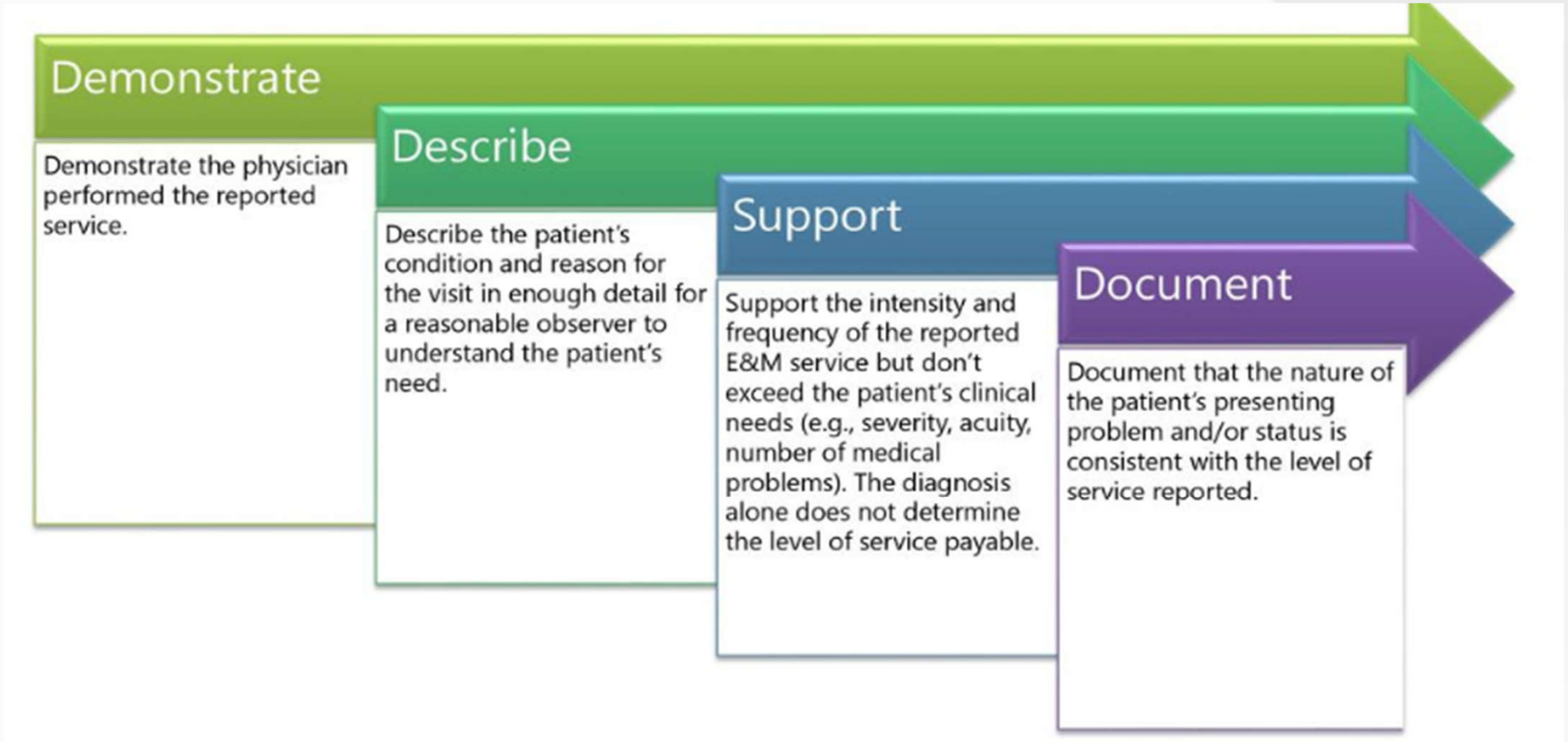

# Accurate Documentation

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- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
- Reduces risk management exposure
- Ensures appropriate reimbursement
- Supports compliance with federal and state laws

**YOU CAN ONLY BILL FOR WHAT THE DOCUMENTATION SUPPORTS**

# Documentation - Principles

The medical record should be complete and legible

The documentation of each patient encounter should include:

- Reason for the encounter (Chief Complaint) and relevant history, physical examination findings and prior diagnostic test results;
- Assessment, clinical impression or diagnosis;
- Plan of care
- Date and legible identity of the observer

# Documentation - Principles

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

Past and present diagnoses should be accessible to the treating and/or consulting physician.

Appropriate health risk factors should be identified.

The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

# Abbreviations

In 2004, the Joint Commission developed the "Do Not Use" list of medical abbreviations as part of the requirements for meeting the National Patient Safety Goal, which primarily addresses the effectiveness of communication between healthcare workers.

Further, the Joint Commission has banned the use of medical abbreviations in documents that pertain to patient rights, informed consent forms, discharge instructions, and all other documents that a patient and the family may receive from the healthcare institution.

To prevent any misunderstanding and jeopardize patient safety, the Joint Commission now requires healthcare institutions to develop a list of approved and not approved medical abbreviations. In addition, there should be a system or an audit process to ensure that there is compliance.

# E/M Services Guidelines

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History and exam no longer factor into code selection but must be performed as clinically appropriate for the visit.

Chief complaint needs to be documented to explain the medical necessity for the visit with the reason.

Providers select services based on total time OR medical decision making (MDM)

# Medical Necessity does not equal MDM

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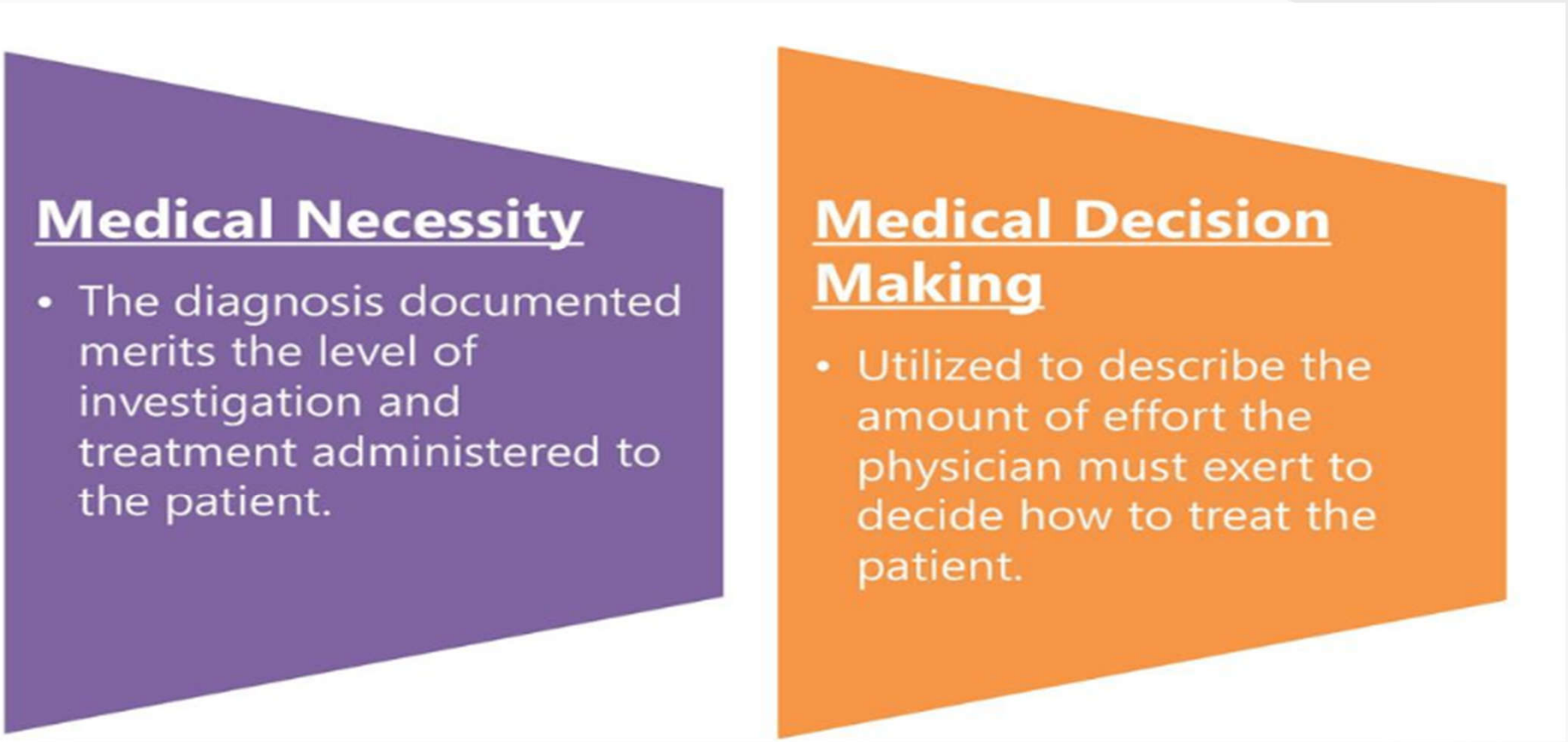

# Components of E/M Services

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- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of presenting problem
- Time

*Blue indicates the Key Components of E/M services

# Key Components

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# Chief Complaint (CC)

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CC is defined as a concise statement describing the symptom, problem, condition, diagnosis, or other factor that caused a patient to seek medical care. Simply stated, the chief complaint is a description of why the patient is presenting for healthcare services.

An easily identifiable chief complaint is the first step in establishing medical necessity for services rendered. The *1995* and *1997 Documentation Guidelines for Evaluation and Management (E/M) Services* specifically require, “The medical record should clearly reflect the chief complaint.” If the patient record does not reflect a chief complaint, the service is either:

1. A preventive service; or
2. Unbillable.

If the patient is returning for a follow up, the provider must likewise document the reason for the follow up, such as patient here for follow-up for HTN, COPD (rather than just ‘here for follow-up’).

# Brief and Extended HPI

**Brief** and **extended** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A **brief** HPI consists of one to three elements of the HPI.

> The medical record should describe one to three elements of the present illness (HPI).

An **extended** HPI consists of four or more elements of the HPI or the status of three or more multiple chronic conditions:

> The medical record should describe either four or more elements of the present illness (HPI) or associated comorbidities, or status of three or more multiple chronic conditions.

# Past, Family and/or Social History (PFSH)

The PFSH consists of a review of three areas:

- **Past history** (the patient's past experiences with illnesses, operations, injuries and treatments);
- **Family history** (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- **Social history** (an age appropriate review of past and current activities).

# PFSH – Con't

A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

A ***complete*** PFSH is of a review of **two or all three** of the PFSH history areas, depending on the category of the E/M service. ***A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient***. A review of two of the three history areas is sufficient for other services:

At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services - established patient.

At least one specific item from 4 of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services - new patient.

# Examination

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ systems(s).
- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system.

# Review of Systems (ROS)

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

# ROS – Con't

A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI:

> The patient's positive responses and pertinent negatives for the system related to the problem should be documented.

An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HP1 and a limited number of additional systems:

> The patient's positive responses and pertinent negatives for two to nine systems should be documented.

A ***complete*** ROS inquires about the system(s) directly related to the problem(s) identified in the HP1 plus all additional body systems:

> At least ten organ systems must be reviewed Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

# Exam – Con't

The extent of examinations performed and documented is dependent upon clinical judgement and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

***Specific*** abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented, A notation of "abnormal" without elaboration is **insufficient.**

Abnormal or ***Unexpected Findings*** of the examination of the **unaffected** or asymptomatic body area(s) or organ system(s) should be described.

A brief statement or notation indicating "negative" or "normal" is **sufficient** to document **normal findings** related to **unaffected** area(s) or asymptomatic organ system(s).

The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.

# Documentation - Diagnosis

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For each encounter, an assessment, clinical impression, or diagnosis should be document. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation. . For a presenting problem with an established diagnosis the record should reflect whether the problem is:

a) improved well controlled, resolving or resolved; or,

b) inadequately controlled, worsening, or failing to change as expected.

For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as 'possible", 'probable", or "rule out" (R/O) diagnoses.

# Level Selection by Total Time

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- When using total time on the date of an outpatient encounter, the time is a specific time range rather than an average time and there is no "rounding up."

- Total provider time on the day of the encounter includes the following:
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering tests, medications or procedures
  - Referring and communicating with other health care professionals
  - Documenting clinical information in the medical record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

# MDM vs Time – New Patient

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## New Patient

| Code | MDM | Time |
|---|---|---|
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *straightforward* medical decision making | 15 – 29 minutes of total time is spent on the day of the encounter |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *low* medical decision making | 30 – 44 minutes of total time is spent on the day of the encounter |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *moderate* medical decision making | 45 – 59 minutes of total time is spent on the day of the encounter |
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and *high* medical decision making | 60- 74 minutes of total time is spent on the day of the encounter |

# MDM vs Time – Established Patient

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## Established Patient

| Code | MDM | Time |
|---|---|---|
| 99212 | Office or other outpatient visit for the evaluation and management of an establisted patient, which requires a medically appropriate history and/or examination and *straightforward* medical decision making | 10 – 19 minutes of total time is spent on the day of the encounter |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and *low* medical decision making | 20 – 29 minutes of total time is spent on the day of the encounter |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and *moderate* medical decision making | 30 – 39 minutes of total time is spent on the day of the encounter |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and *high* medical decision making | 40- 54 minutes of total time is spent on the day of the encounter |

# MDM selection for services

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by 3 elements:

1. The number and complexity of problem(s) that are addressed during the encounter
2. The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter
3. The risk of complications and/or morbidity or mortality of patient management.

There are four types of MDM

♦ Straightforward ♦ Low ♦ Moderate ♦ High

* MDM does not apply to 99211

# MDM – Straightforward/Low

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| Elements of Medical Decision Making | | | |
|---|---|---|---|
| Level | Problem | Data | Risk |
| **Straightforward 99202/99212** | **Minimal**<br>• 1 self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| **Low 99203/99213** | **Low**<br>• 2 or more self-limited or minor problems;<br>**or**<br>• 1 stable chronic illness;<br>**or**<br>• 1 acute, uncomplicated illness or injury<br>**or**<br>1 Stable, acute Illness:<br>**or**<br>1 acute uncomplicated illness or inury requiring hospital inpatient or observation level of care | **Limited** (Must meet the requirements of at least 1 of the 2 categories)<br><br>**Category 1: Tests and documents**<br>**• Any combination of 2 from the following:**<br>• Review of prior external note(s) from each unique source;<br>• review of the result(s) of each unique test*;<br>• ordering of each unique test*<br>or<br>**Category 2**: Assessment requiring an independent historian(s) | **Low risk of morbidity from additional diagnostic testing or treatment**<br><br>Examples only:<br>Over the counter drugs management<br>Minor Surgery with no risk factors<br>PT/OT |

# MDM - Moderate

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| Elements of Medical Decision Making | | | |
|---|---|---|---|
| Level | Problem | Data | Risk |
| **Moderate 99204/99214** | **Moderate**<br>• 1 or more chronic illnesses with exacerbation, progression, side effects of treatment;<br>**or**<br>• 2 or more stable chronic illnesses;<br>**or**<br>• 1 undiagnosed new problem with uncertain prognosis;<br>**or**<br>• 1 acute illness with systemic symptoms;<br>**or**<br>• 1 acute complicated injury | **Moderate**<br>(Must meet the requirements of at least 1 out of 3 categories)<br>**Category 1: Tests, documents, or independent historian(s)**<br>**• Any combination of 3 from the following:**<br>• Review of prior external note(s) from each unique source;<br>• Review of the result(s) of each unique test;<br>• Ordering of each unique test*;<br>• Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br><br>Examples only:<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |

# MDM - High

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| Elements of Medical Decision Making | | | |
|---|---|---|---|
| Level | Problem | Data | Risk |
| **High**<br>**99205/99215** | **High**<br>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function | **Extensive** (Must meet the requirements of at least 2 out of 3 categories)<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>**• Any combination of 3 from the following:**<br>• Review of prior external note(s) from each unique source;<br>• Review of the result(s) of each unique test;<br>• Ordering of each unique test;<br>• Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | **High risk of morbidity from additional diagnostic testing or treatment**<br><br>Examples only:<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

# Presenting Problem

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**Minimal**

- A problem that may not require the presence of the physician or other qualified health professional, but service is provided under the physician's or other qualified health professional's supervision

**Self-Limited; Minor**

- A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance

**Low Severity**

- A problem where the risk or morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected

**Moderate Severity**

- A problem where the risk or morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment

**High Severity**

- A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment

# MDM Definitions

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**External:** External records, communications and/or test results from an external physician, other qualified health care professional or facility

**Independent historian(s):** An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historian(s) requirement is met.

**Independent Interpretation:** The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

**Social determinants of health:** Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

**Appropriate source:** An appropriate source in regard to the discussion of management or test interpretation includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

# MDM Definitions

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**Minimal Problem**: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision.

**Limited or minor problem**: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

**Stable, Chronic illness:** A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

**Acute, uncomplicated illness or injury**: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

# E/M 99211

- Can only be used for an established patient.
- Does not require a provider (Clinical Staff can render the service, preferably a nurse).
- Should not be billed based on time (ex. less than 5 minutes).
- Used to treat a minimally complex medical condition.

# 99211 vs 99212

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| Comparison | CPT Code 99211 | CPT Code 99212 |
|---|---|---|
| Visit Duration | 5 minutes | 10+ minutes |
| Service Provider | Nurse, physician assistant, or technician | Physician |
| Physician's Presence | Not required | Required |
| Patient's Condition | Minimally complex | Slightly more complex |
| Level of Medical Decision-Making | Basic | Straightforward to moderate |
| Documentation Requirements | Does not include specific key components, e.g., the patient's detailed history or examination | Includes specific key components, e.g., the patient's detailed history or examinations |

# Calculating MDM

- For CPT coding 2 of the 3 MDM elements need to be met or exceeded in order to select the level.

| Number of diagnoses or management options | Amount and/or complexity of data to be reviewed | Risk of complications and/or morbidity or mortality | Type of decision making |
|---|---|---|---|
| Minimal | Minimal or None | Minimal | ***Straightforward*** |
| Limited | Limited | Low | ***Low Complexity*** |
| Multiple | Moderate | Moderate | ***Moderate Complexity*** |
| Extensive | Extensive | High | ***High Complexity*** |

| Medical Decision Making | SF | LOW | MOD | HIGH |
|---|---|---|---|---|
| Number of Diagosis or Treatment | 1 | 2 | 3 | 4 |
| Amount and/or Complexity of Data to be Reviewed | 1 | 2 | 3 | 4 |
| Risk of Compilations, Morbidity, Mortality | Minimal | Low | Moderate | High |
| MDM Level = 2 out of 3 | | | | |

# Example

✓Patient presents with cough, congestion and body aches; no fever reported.
✓Ordered a rapid flu test and Covid 19 test
✓Tests were negative diagnosed with a cold and told to go home and rest and drink lots of fluids.

| Medical Decision Making | SF | LOW | MOD | HIGH |
|---|---|---|---|---|
| Number of Diagosis or Treatment | 1 | 2 | 3 | 4 |
| Amount and/or Complexity of Data to be Reviewed | 1 | 2 | 3 | 4 |
| Risk of Compilations, Morbidity, Mortality | Minimal | Low | Moderate | High |
| MDM Level = 2 out of 3 | **2** | **1** | | |

**MDM = Straightforward (99212)**

# Example

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✓Patient with worsening fatigue over the past several weeks along with complaints of headache and coldness to hands and feet. Discussed in length with patient's adult daughter as patient is unreliable due to advancing dementia.

✓Ordered a CBC

✓Patient is at low risk of morbidity from testing and treatment.

| Medical Decision Making | SF | LOW | MOD | HIGH |
|---|---|---|---|---|
| Number of Diagosis or Treatment | 1 | 2 | 3 | 4 |
| Amount and/or Complexity of Data to be Reviewed | 1 | 2 | 3 | 4 |
| Risk of Compilations, Morbidity, Mortality | Minimal | Low | Moderate | High |
| MDM Level = 2 out of 3 | | **2** | 1 | |

**MDM = Low (99213)**

# Example

✓Patient with stable chronic Hypertension and Hyperlipidemia presents for follow-up of chronic conditions. Patient doing well with no complaints.
✓No data ordered
✓HTN is well controlled on Lisinopril 10 mg; HL is well controlled on Rosuvastatin 10mg. Continue current treatment. Return to clinic in 6 months.

| Medical Decision Making | SF | LOW | MOD | HIGH |
|---|---|---|---|---|
| Number of Diagosis or Treatment | 1 | 2 | 3 | 4 |
| Amount and/or Complexity of Data to be Reviewed | 1 | 2 | 3 | 4 |
| Risk of Compilations, Morbidity, Mortality | Minimal | Low | Moderate | High |
| MDM Level = 2 out of 3 | **1** | | **2** | |

**MDM = Moderate (99214)**

# Example

✓Patient presents with worsening cough over the past several days, SOB & wheezing. Hx of COPD and has been hospitalized 3 times in the past year. Has been unresponsive to outpatient nebulizer as O2 sat < 89%.
✓No data ordered
✓Discussed directly admitting him to observation status, but patient refused. Follow up in clinic in 2 days but stressed to go to ED with worsening symptoms.

| Medical Decision Making | SF | LOW | MOD | HIGH |
|---|---|---|---|---|
| Number of Diagosis or Treatment | 1 | 2 | 3 | 4 |
| Amount and/or Complexity of Data to be Reviewed | 1 | 2 | 3 | 4 |
| Risk of Compilations, Morbidity, Mortality | Minimal | Low | Moderate | High |
| MDM Level = 2 out of 3 | **1** | | | **2** |

**MDM = High (99215)**

# CCVA Example

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✓Patient presents with congestion, ear pain, body aches, fever and fatigue for 2 days.

✓Provider orders rapid strep test and Flu and Covid Antigen

✓Tests are negative, diagnoses with viral upper respiratory tract infection, prescribed Loratadine-D

| Medical Decision Making | SF | LOW | MOD | HIGH |
|---|---|---|---|---|
| Number of Diagosis or Treatment | 1 | 2 | 3 | 4 |
| Amount and/or Complexity of Data to be Reviewed | 1 | 2 | 3 | 4 |
| Risk of Compilations, Morbidity, Mortality | Minimal | Low | Moderate | High |
| MDM Level = 2 out of 3 | 2 | 1 | | |

**MDM = Straightforward (99212)**

**CCVA coded 99211**

# New vs Established Patients

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- Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

- An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.
    - If you have changed practices and your patients follow you to the new practice, they are still considered established if you have seen them within three years.

# Coding basics

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- Don’t code “probable, suspected, questionable or rule out,”
- Code to the highest level of known specificity,
- Code reason for visit and/or your primary assessed condition first, and then……
- Code other chronic diseases if the patient receives active treatment for them or if it directly affects the primary/secondary diagnosis,
- Be sure to code any coexisting conditions affecting patient care at the time of the visit,
- And finally, identify which diagnoses should be “linked” to each diagnostic/therapeutic service, in order of importance for proper billing.

# CPT II codes

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## What are CPT Category II codes?

Current Procedural Terminology (CPT) Category II codes were developed by the American Medical Association (AMA) as a supplemental performance tracking set of procedural codes in addition to the Category I code set.

- Category I codes are used for tracking and billing for common procedures.
- Category II codes are intended to be used for measuring performance on quality metrics such as Healthcare Effectiveness Data and Information Set (HEDIS®).

| | | |
|---|---|---|
| Category II Codes are alphanumeric and consist of four digits followed by the letter 'F'. | Category II codes are **NOT** billing codes; they are used to track services on claims for performance measurement. | Category II codes are not to be used as a substitute for Category I codes. |

## What is the purpose of CPT II Codes?

Category II codes are intended to facilitate the collection of information about the quality of care delivered by coding a number of services or test results that support performance measures. It is anticipated that the use of Category II codes for performance measurement will decrease the need for record abstraction and chart review, thereby, minimizing the administrative burden on physicians and other health care professionals seeking to measure the quality of their patient care.

# CPT II codes

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## CPT Category II codes are arranged according to the following categories:

| Category | Code Range | Category | Code Range |
|---|---|---|---|
| Composite Measures | 0001F - 0015F | Therapeutic, Preventative or other interventions | 4000 - 4306F |
| Patient management | 0500 - 0575F | Follow-up or other outcomes | 5005F - 5100F |
| Patient history | 1000F - 1220F | Patient safety | 6005F - 6045F |
| Physical examination | 2000F - 2050F | Structural measures | 7010F - 7025F |
| Diagnostic/screening processes or results | 3006F - 3573F | | |

A list of most commonly used CPT II codes is provided on the following page.

# CPT II codes

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| HEDIS Measure | Description | CPT II Codes |
|---|---|---|
| Care for Older Adults (COA) | Pain Assessment | 1125F, 1126F |
| | Advance Care Planning (ACP) | 1123F, 1124F, 1157F, 1158F |
| | Medication Review | 1159F, 1160F |
| | Functional Status Assessment | 1170F |
| Comprehensive Diabetes Care (CDC) | No evidence of diabetic retinopathy | 2023F, 2025F<br>3072F (No evidence of retinopathy in the prior year exam) |
| | Evidence of diabetic retinopathy | 2022F, 2024F |
| | HbA1c Level | 3044F (<7%), 3051F (7% -8%), 3052F (8% - 9%), 3046F (> 9%) |
| | Urine Protein Tests | 3060F,03061F, 3062F |
| | Nephropathy Treatment | 3066F, 4010F |
| | Systolic <140 | 3074F, 3075F |
| | Systolic ≥ 140 | 3077F |
| | Diastolic < 80 | 3078F |
| | Diastolic 80 - 89 | 3079F |
| | Diastolic ≥ 90 | 3080F |
| Controlling High Blood Pressure (CBP) | Systolic <140 | 3074F, 3075F |
| | Systolic ≥ 140 | 3077F |
| | Diastolic < 80 | 3078F |
| | Diastolic 80 - 89 | 3079F |
| | Diastolic ≥ 90 | 3080F |
| Medication Reconciliation Post-Discharge (MRP) Transitions of Care (TRC) | Discharge medications reconciled with current medications in outpatient record. | 1111F |
| Prenatal and Postpartum Care (PPC) | Initial Prenatal Care Visit | 0500F |
| | Prenatal Flow Sheet Documented in record by first prental visit | 0501F |
| | Subsequent Prenatal Care Visit | 0502F |
| | Postpartum Visits | 0503F |
| Adult BMI | *See BMI chart for dx codes* | 3008F |

BMI Diagnosis Codes

| BMI | DX Code | BMI | DX Code | BMI | DX Code | BMI | DX Code |
|---|---|---|---|---|---|---|---|
| < 19 | Z68.1 | 26.0-26.9 | Z68.26 | 33.0-33.9 | Z68.33 | 40.0-44.9 | Z68.41 |
| 20.0-20.9 | X68.20 | 27.0-27.9 | Z68.27 | 34.0-34.9 | Z68.34 | 45.0-49.9 | Z68.42 |
| 21.0-21.9 | Z68.21 | 28.0-28.9 | Z68.28 | 35.0-35.9 | Z68.35 | 50.0-59.9 | Z68.43 |
| 22.0-22.9 | Z68.22 | 29.0-29.9 | Z68.29 | 36.0-36.9 | Z68.36 | 60.0-69.9 | Z68.44 |
| 23.0-23.9 | Z68.23 | 30.0-30.9 | Z68.30 | 37.0-37.9 | Z68.37 | 70+ | Z68.45 |
| 24.0-24.9 | Z68.24 | 31.0-31.9 | Z68.31 | 38.0-38.9 | Z68.38 | | |
| 25.0-25.9 | Z68.25 | 32.0-32.9 | Z68.32 | 39.0-39.9 | Z68.39 | | |

# Medicare vs Medicare Advantage

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## Medicare

- AWV – No sooner than 11 months from previous AWV
- Does NOT cover an annual physical
- Will NOT cover and AWV on the same date of service as an E/M visit

## Medicare Advantage

- AWV – anytime within the calendar year
- Does cover an annual physical in addition to the AWV
- Will pay for the AWV and an E/M visit on the same date of service

**You need to know what each MAP contract states for billing and payment information

# VA Medicaid MCO's

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## aetna
Aetna Better Health® of Virginia

**1-800-279-1878** | TTY: 711
AetnaBetterHealth.com/Virginia

**Adult vision and hearing**
- 1 eye exam, $250 for glasses or contacts per year
- 1 hearing exam, $1,500 for hearing aids, 60 batteries per year

**Healthy moms and kids**
- 300 free diapers, virtual baby showers, portable cribs, $25 monthly for mom and baby
- Free swim lessons
- Mobile app with 24/7 lactation and doula support
- $20 monthly for menstrual products
- Free yearly sports physicals

**Phone and online tools**
- Free smartphone, unlimited minutes, texts, data, 10 GB hotspot

**Wellness programs**
- MyActiveHealth management
- 12-week personalized weight management program
- Wellness rewards

**Other benefits**
- 30 free round-trip rides per year
- 14 meals after hospital stay
- GED certificate incentive
- Therapeutic shoes or inserts
- Windows, door alarms, Smart Alert app for Alzheimer's
- Free mattress, bedding, $150-$400 per year for carpet cleaning for asthma

## Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

**1-800-901-0020** | TTY: 711
anthem.com/vamedicaid

**Adult vision and hearing**
- 1 eye exam, up to $150 for glasses or contacts per year
- Adult hearing exam, $1,000 for hearing aids, 60 batteries per year

**Healthy moms and kids**
- 3 Baby Essential items (diapers, highchair, car seat, and more)
- Boys & Girls Club membership
- $35 Barnes & Noble card for books

**Phone and online tools**
- Free Safelink phone benefit
- Free Chromebook for high school seniors with 3.5 GPA

**Wellness programs**
- $120 for Weight Watchers (WW)®
- Up to $50 healthy rewards
- 24/7 physician video visits
- 1 pair insoles, 3 pairs of socks for those with diabetic neuropathy

**Other benefits**
- 12 rides per household per year to grocery store/food bank
- 14 meals after hospital stay
- $120 in GED testing vouchers
- $25 gift card for good grades
- $1000+ in coupon savings
- $20 gift card for doing health screener
- 2 items from assistive devices and wheelchair accessories catalog
- 2 items Asthma/COPD Catalog

## MOLINA HEALTHCARE

**1-800-424-4518** | TTY: 711
MolinaHealthcare.com

**Adult vision and hearing**
- 1 eye exam every other year, up to $100 for glasses or contacts per year

**Healthy moms and kids**
- Pregnancy supplies and mobile tools
- Baby showers quarterly per region
- Bicycle helmets for children
- Free yearly sports physicals

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, 4.5 GB data monthly

**Wellness programs**
- Up to $50 healthy rewards gift cards each year after health care activity

**Other benefits**
- 3 meals per day, up to 5 days delivered to home for member and 1 family member after hospital stay
- Online directory of community services and organizations
- SaveAround retail coupon book with over $2500 in savings.
- MyMolina mobile app access
- Backpack with supplies for foster children leaving foster care or adults with frequent or avoidable emergency room visits

## OptimaHealth
*Including the former Virginia Premier plan*

**1-800-881-2166** | TTY: 711
Northern VA Kaiser Permanente members:
1-855-249-5025
optimahealth.com/medicaid

**Adult vision and hearing**
- 1 eye exam, $100 for frames per year

**Healthy moms and kids**
- Maternal health programs and baby showers with up to $75 raffle gift
- 400 free diapers (restrictions apply)
- Grocery card for pregnant moms (restrictions apply)
- Free yearly sports physicals

**Phone and online tools**
- Free smartphone with 350 minutes, unlimited texts, 4.5 GB data monthly
- Free unlimited wireless, texts, minutes and hotspot (1 per household)

**Wellness programs**
- Up to $50 wellness rewards
- Weight management
- Financial wellness program
- Pedometer

**Other benefits**
- 24 free round-trip rides per year to grocery stores and more
- Up to 56 meals delivered to home after hospital stay
- Up to $275 for GED prep, test
- Up to $75 for college application help (restrictions apply)
- Free mattress cover, pillowcase for those with asthma
- Memory alarms, devices for dementia/memory loss

## UnitedHealthcare
Community Plan

**1-844-752-9434** | TTY: 711
uhccp.com/virginia

**Adult vision and hearing**
- 1 eye exam per year, glasses 2 years

**Healthy moms and kids**
- Up to $100 Healthy First Steps maternity program rewards
- Meals sent home after delivery
- Period underwear, those ages 11-49 who qualify
- Up to $100 vaccine incentives at Footlocker® up to age 18
- Boys & Girls Club membership
- Free yearly sports physicals, ages 5-18

**Phone and online tools**
- Free smartphone with unlimited minutes, texts, 10 GB hotspot monthly
- Self Care® app for stress, anxiety, depression support

**Wellness programs**
- Free gym membership to 300+ gyms and local YMCAs
- 14,000 free virtual fitness choices
- 13 Weight Watchers (WW)® vouchers
- Up to $50 healthy rewards

**Other benefits**
- 12 free round-trip rides to places of worship, grocery, DMV, DSS, library
- 14 meals delivered to home after hospital stay
- GED certificate assistance
- Housing application assistance
- Mattress cover for those with asthma

# VA MCO Maternal Health

CENEVIA HEALTH BUSINESS SERVICES

| aetna Aetna Better Health® | Anthem HealthKeepers Plus | MOLINA HEALTHCARE | Sentara Health Plans | UnitedHealthcare Community Plan |
|---|---|---|---|---|
| **Baby Matters**<br>**1-800-279-1878**<br>**TTY: 711** | **New Baby New Life**<br>**1-844-533-1994 – Option #2**<br>**TTY: 711** | **Healthy Beginnings**<br>**1-866-891-2320**<br>**TTY: 711** | **Welcoming Baby**<br>**1-844-671-2108**<br>**TTY: 711** | **Healthy First Steps**<br>**1-800-599-5985**<br>**TTY: 711** |
| **During Pregnancy**<br>• $25 each month to spend on over-the-counter items for yourself and baby through CVS Pharmacy®<br>• $50 Healthy Food Card- Every month for high-risk pregnant woman to buy healthy foods<br>• $50 Wellness Reward- For going to prenatal and postpartum visits<br>• 24/7 Get information on preparing for breastfeeding with live video chats | **During Pregnancy**<br>• $50 Healthy Reward for 1st prenatal visit<br>• Online support for your mental health during pregnancy (Twill)<br>• Women's Wellness and Recovery Program for women experiencing problems with drugs or alcohol (Empower)<br>• OB Concierge Care- a digital app to access resources and added benefits to support a healthy pregnancy<br>• 24/7 Online Medical Practice to improve maternal health outcomes (Pomelo) | **During Pregnancy**<br>• Up to $50 -Earn Rewards for healthy actions<br>• Pregnancy Celebration- Mom and baby goodies<br>• Baby Bundle- Get pregnancy supplies before birth<br>• Mother-to-Baby Connections program<br>• Online support offering Doula, pregnancy, and postpartum support (Mae)<br>• Telehealth programs for before and after pregnancy (Ouma) | **During Pregnancy**<br>• Up to $75 Reward- Receive reward with Maternal health & wellness programs<br>• $75 every quarter-Grocery card for pregnant women<br>• Healthy Savings Program - Discounted savings on healthy food, products & baby items<br>• Up to $35 - Healthy Member Incentive - For going to prenatal and postpartum visits | **During Pregnancy**<br>• Up to $50 in rewards, education & resources via Baby Scripts™ digital app<br>• Gestational Diabetes Healthy food box program<br>• Virtual prenatal care & education (Pomelo Care )<br>• Online support for your mental health (AbleTo)<br>• 24/7 live video chat with a doctor |
| **After Giving Birth**<br>• $25 each month to spend on over-the-counter items for yourself and your baby at CVS Pharmacy®<br>• $50 Wellness Reward- For going to prenatal and postpartum visits<br>• New Mom's Gift Box for those that participate in care management with their MCO during the month after giving birth<br>• Up to 300 size 1 baby diapers delivered to your home<br>• Free home-delivered meals for 7 days after leaving hospital<br>• 24/7 Breastfeeding help with live video chats | **After Giving Birth**<br>• $25 Healthy Reward for post-partum care visit<br>• Baby Essentials Catalog- Pick up to 3 items for you or your baby (car seats, baby carriers, diapers and more to choose from)<br>• Online support for your mental health during your pregnancy (Twill)<br>• Wellness and Recovery Program for women experiencing problems with drugs or alcohol (Empower)<br>• Home delivered meals after pregnancy- (Nourished Well offers dietician services)<br>• Online Medical Access Program to improve maternal health (Pomelo) | **After Giving Birth**<br>• Up to $50- Healthy Rewards Program<br>• After Delivery Celebration- Mom and baby goodies<br>• Baby Bundle- Get pregnancy supplies<br>• Mother to Baby Connections program<br>• Online support offering Doula, pregnancy, and postpartum support (Mae)<br>• Digital maternal telehealth programs for before and after pregnancy (Ouma) | **After Giving Birth**<br>• Up to 400 Free Diapers (size newborn to size 2)<br>• Home Delivered Meals – Up to 56 freshly prepared meals<br>• Free baby monitor or sleep sack with the Safe Sleep Program<br>• Up to $35 - Healthy Member Incentive - For going to prenatal and postpartum visits | **After Giving Birth**<br>• Up to 500 free diapers<br>• Up to $50 in rewards, education & resources via Baby Scripts™ digital app<br>• Meal delivery service after giving birth<br>• Free supply of absorbable menstrual undergarments<br>• 24/7 virtual breastfeeding support and education (Pomelo Care)<br>• Online support for your mental health (AbleTo) |

# RHC Billing

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- Claim Forms
- Type of Codes Reported
- Multiple Visits/Same Day
- Claim Examples
- Annual Wellness Visits
- Preventative Services
- Telehealth/Telephone Visits
- Virtual Communication
- Chronic Care Management Services

# Claim forms

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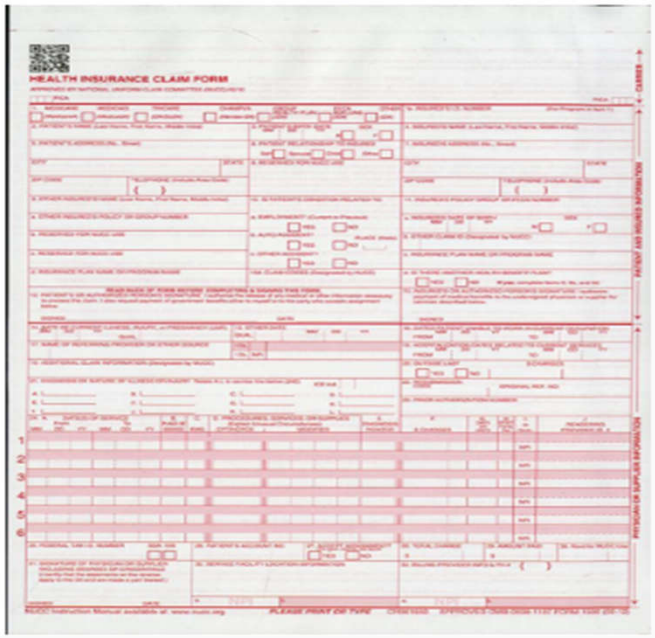
## CMS 1500

Used to submit claims to commercial and non-Medicare payers for Fee-for-Service payments




## UB

Used to submit claims to Medicare and most Medicare Advantage Plans payers for RHC services payable by the RHC AIR rate.

# Claim Details

RHCs are required to line-item, detail for all services performed during the visit, which includes any HCPCS codes for all RHC services, incident to services and applicable professional components performed during the visit.

All services should be reported with either their actual charge or a penny charge on lines other than the qualifying visit, with the charges rolled up to the qualifying line.
The exception is with qualifying preventative services, they should not be listed with a penny charge.

Payments received are 80% of AIR rate minus 2% sequestration, the patient is responsible for the 20% coinsurance when applicable.

# Qualifying Visit/Modifier CG

RHC claims must have a qualifying visit line, it identifies the primary reason for the encounter.

CG modifier identifies the qualifying visit, it tells Medicare what claim line to use to calculate applicable coinsurance and deductible.

Modifier CG needs to be reported on the RHC qualified visit code. Bundled services or preventative service needs to have the CG modifier, not both. All services should be reported on the claim with the qualified visit code.

CG not needed on IPPE

CG not needed on CCM services

**Note: Options for reporting non-RHC services that don't qualify for a payment is each organizations preference.

# RHC Revenue Codes

| | |
|---|---|
| 0521 | Clinic visit by a member to RHC |
| 0522 | Home visit by RHC practitioner |
| 0524 | Visit by RHC practitioner to member in a covered Part A stay at a SNF |
| 0525 | Visit by RHC practitioner to member in a non-Part A SNF, NF, ICF, or other residential facility. |
| 0527 | RHC visiting nursing services to a member's home in a Home Health Shortage Area |
| 0528 | Visit by RHC practitioner to another non-RHC site (i.e. scene of an accident) |
| 0900 | Mental health visit (both in person and via telehealth) |

# Other Revenue Codes in RHCs

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0250 Pharmacy – drug with no J-code
0300 Venipuncture
0636 Drugs with detailed HCPCS J-code
0780 Telemedicine originating site

# Multiple Visits – Same Day

**40.3 - Multiple Visits on Same Day**

(Rev. 13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where an RHC or FQHC patient has a medically necessary face-to-face visit with an RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

Exceptions are for the following circumstances only:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC). In this situation only, the FQHC would use modifier 59 on the claim to attest that the conditions being treated qualify as 2 billable visits;

- The patient has a medical visit and a mental health visit on the same day (2 billable visits)

Resource: Medicare Benefit Policy Manual, Chapter 13, Section 40

# Con't

- An IOP service and medical visit on the same day
- A dental visit and a medical visit on the same day;
- For RHCs only, the patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits); or Note: A mental health visit and IOP service may occur on the same day; however, if a mental health visit is furnished on the same day as IOP services, payment will only be made at the IOP rate, and the mental health visit will be considered packaged.

Note: A mental health visit and IOP service may occur on the same day; however, if a mental health visit is furnished on the same day as IOP services, payment will only be made at the IOP rate, and the mental health visit will be considered packaged.

Resource: Medicare Benefit Policy Manual, Chapter 13, Section 40

# Multiple visits on the same day

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## RHC's can only bill for 1 visit per day except for the following:

- ✓ Patient returns the same day for a separately identifiable reason.
- ✓ Patient has a medical and mental health visit on the same day.
- ✓ Patient has a medical and dental visit on the same day,
- ✓ Patient has IOP services same day as a medical visit.
- ✓ Patient has an IPPE and a separate medical or mental health visit on the same day.

# E/M visit only

Provider performs a level 3 E/M office visit. Charge for the visit is $100.00. No other services were required. The claim would have the Revenue code 0521 and the CG modifier. UB-04 Claim form would have the following:

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99213 CG | 12/05/2023 | 1 | 100.00 | 00.00 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 100.00 | | |

# Procedure only visit

Provider performs a simple I&D in the office. Charge for the visit is $150.00 UB-04 Claim form would have the following:

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, PROCEDURE | 10160 CG | 12/05/2023 | 1 | 150.00 | 00.00 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 150.00 | | |

# E/M visit and Procedure

Provider performs a level 3 E/M visit. The patient asks the provider to look at an abscess on their arm. The provider performed a simple I&D. Charge for the E/M is $100.00 and the procedure is $150.00. UB-04 Claim form would have the following: (Make note of the roll-up of charge amounts.

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99213 CG | 12/05/2023 | 1 | 250.00 | 00.00 | |
| 0521 | RURAL HEALTH CLINIC, PROCEDURE | 10160 | 12/05/2023 | 1 | 150.00 | 00.00 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 400.00 | | |

# Options for billing charge amounts

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Provider performed a level 4 E/M visit and gave the patient an injection. The charge for the visit is $150, the administration of the drug is $12.00 and the drug is $45.00. Here are two ways you can bill for these.

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99214 CG | 12/05/2023 | 1 | 207.00 | 00.00 | |
| 0521 | INJ ADMIN | 96372 | 12/05/2023 | 1 | 12.00 | 00.00 | |
| 0636 | ROCEPHIN | J0696 | 12/05/2023 | 1 | 45.00 | 00.00 | |
| 0001 | PAGE 1 OF 1 | CREATION DATE | 07/01/2023 | TOTALS | 264.00 | | |

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99214 CG | 12/05/2023 | 1 | 207.02 | 00.00 | |
| 0521 | INJ ADMIN | 96372 | 12/05/2023 | 1 | 0.01 | 00.00 | |
| 0636 | ROCEPHIN | J0696 | 12/05/2023 | 1 | 0.01 | 00.00 | |
| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 207.04 | | |

# E/M visit and Preventative

Provider performs a level 4 E/M visit and the provider completes the patient's AWV. The charge for the E/M is $150.00 and for the AWV $195.00.  Only one visit payment will be received.

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99213 CG | 12/05/2023 | 1 | 150.00 | 00.00 | |
| 0521 | PREVENTIVE SERVICE | G0439 | 12/05/2023 | 1 | 195.00 | 00.00 | |
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| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 345.00 | | |

# Medical Visit and Subsequent Visit

CENEVIA HEALTH BUSINESS SERVICES

Provider performs a level 4 E/M, patient later in the day fell and cut their leg and returns to the office to be seen again. Charge for the E/M is $150.00 and for the injury visit $100.00 UB-04 Claim form would have the following: (Two AIR payments would be received)

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99214 CG | 12/05/2023 | 1 | 150.00 | 00.00 | |
| 0521 | RURAL HEALTH CLINIC, PROCEDURE | 12001 CG, 59 | 12/05/2023 | 1 | 100.00 | 00.00 | |
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| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 250.00 | | |

# Medical Visit and Mental Health Visit

CENEVIA HEALTH BUSINESS SERVICES

Provider performs a level 3 E/M visit and the charge is $100.00. A mental health provider performs a psychiatric diagnostic evaluation on the same day with a charge of $200.00. UB-04 Claim form would have the following: (Two AIR payments would be received)

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99213 CG | 12/05/2023 | 1 | 100.00 | 00.00 | |
| 0900 | RURAL HEALTH CLINIC, MENTAL HEALTH | 90791 CG | 12/05/2023 | 1 | 200.00 | 00.00 | |
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| | | | | | | | |
| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 300.00 | | |

# Medical Visit, Mental Health Visit and IPPE

CENEVIA HEALTH BUSINESS SERVICES

Provider performs an IPPE and the charge is $195.00. While the patient is in the office, the provider addresses the patients medical issues and charges for a level 4 E/M visit and the charge is $150.00. The patient was also seen the same day by a mental health provider who charged $220.00. UB-04 Claim form would have the following: (3 AIR payments would be received)

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0521 | RURAL HEALTH CLINIC, OFFICE VISIT | 99214 CG | 12/05/2023 | 1 | 150.00 | 00.00 | |
| 0521 | PREVENTIVE VISIT | G0402 | 12/05/2023 | 1 | 195.00 | 00.00 | |
| 0900 | RURAL HEALTH CLINIC, MENTAL HEALTH | 90832 CG | 12/05/2023 | 1 | 220.00 | 00.00 | |
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| 0001 | PAGE 1 OF 1 | CREATION DATE | 12/05/2023 | TOTALS | 565.00 | | |

# Initial Preventative Physical Examination (IPPE)

CENEVIA
HEALTH BUSINESS SERVICES

The Initial Preventative Physical Examination (IPPE) is a face-to-face visit that occurs within the first 12 months of Medicare enrollment and once in a beneficiary's lifetime.

| | |
|---|---|
| Review the patient's medical and social history | AT Minimum, Collect this information: |
| | Past medical and surgical history |
| | Current medications, supplements and other substances |
| | Family history, including hereditary conditions |
| | Diet |
| | Physical activities |
| | Social activities |
| | Alcohol, tobacco and illegal drug use history |
| Review the patient's potential depression risk factors | Current or past experiences with depression |
| | other mood disorders |
| Review the patient's functional ability and safety level | Ability to perform activities of daily living |
| | Fall risk |
| | Hearing impairment |
| | Home and community safety, including driving when appropriate |

# Initial Preventative Physical Examination (IPPE)

CENEVIA
HEALTH BUSINESS SERVICES

| | |
|---|---|
| Exam | Height, weight, body mass index, blood pressure, balance and gait |
| | Visual acuity screen |
| | Other factors deemed appropriate based on medical and social history and current clinical standards. |
| End-of-life planning, upon patient agreement | End-of-life planning is verbal or written information you can offer the patient about: |
| | Their ability to prepare an advanced directive in case an injury or illness prevents them from making their own health care decisions. |
| | If you agree to follow their advance directive |
| | This includes psychiatric advance directives |
| Review current opoid prescriptions | For a patient with a current opiod prescription: |
| | Review any potential opioid use disorder risk factors |
| | Evaluate their pain severity and current treatment plan |
| | Provide information about non-opioid treatment options |
| | Refer to a specialist, as appropriate |

# Initial Preventative Physical Examination (IPPE)

CENEVIA
HEALTH BUSINESS SERVICES

| | |
|---|---|
| Screen for potential SUDs | Review the patient's potential SUD risk factors, and as appropriate, refer them to treatment. You can use a screening tool, but it is not required. |
| Educate, counsel, and refer based on previous components | Based on the results of the review and evaluation services from the previous components, provide the patient with appropriate education, counseling and referrals. |
| Educate, counsel, and refer for other preventive services | Include a brief written plan, like a checklist, for the patient to get: |
| | A once-in-a-lifetime screening electrocardiogram (ECG), as appropriate |
| | Appropriate screenings and other covered preventative services |

**IPPE services may not be furnished via telehealth**

# Initial Annual Wellness Visit (AWV)

CENEVIA
HEALTH BUSINESS SERVICES

The initial Annual Wellness Visit (AWV) occurs face-to-face afte the first 12 months of Medicare enrollment and at least 12 months after the IPPE, and once in the beneficiary's lifetime.

| | |
|---|---|
| Perform a Health Risk Assessment (HRA) | At minimum collect: |
| | Demographic Data |
| | Health status self-assessment |
| | Psychosocial risks, including, but not limited to, depression, life satisfaction, stress, anger, loneliness or social isolation, pain, suicidality and fatigue. |
| | Behavioral risks, including, but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety and home safety. |
| | Activities of daily living (ADL's), including dressing, feeding, toileting, and grooming; physical ambulation, including balance or fall risks and bathing; and instrumental ADL's including using the phone, housekeeping, laundry, transportation, shopping, managing medicaions and handling finances. |
| Establish the patient's medical and family history | Medical events of the patient's parents, siblings and children, including: Hereditary conditions that placed them at increased risk. |
| | Past medical and surgical history. |
| | Use of or exposure to medications supplements and other substances |
| Establish a current providers and suppliers list | Include current patient providers and suppliers that regularly provide medical care, including behavioral health. |

# Initial Annual Wellness Visit (AWV)

CENEVIA
HEALTH BUSINESS SERVICES

| | |
|---|---|
| Measure | Height, weight, body mass index and blood pressure. |
| | Other routine measurements deemed appropriate based on medical and family history. |
| Detect any cognitive impairments the patient may have | Assess cognitive function by direct observation or reported observations from the patient's family, friends, caregivers and others. |
| Review the patient's potential depression risk factors | Current or past experiences with depression. |
| | Other mood disorders. |
| Review the patient's functional ability and level of safety | Use direct patient observation, appropriate screening questions, or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the patient's: |
| | Ability to perform ADLs |
| | Fall risk |
| | Hearing Impairment |
| | Home and community safely, including driing when appropriate |
| Establish an appropriate patient written screening schedule | Base the written screening schedule on the: |
| | Checklist for the next 5-10 years |
| | Patient's HRA, health status ans screening history, and age-appropriate covered preventative services |

# Initial Annual Wellness Visit (AWV)

CENEVIA
HEALTH BUSINESS SERVICES

| | |
|---|---|
| Establish the patient's list of risk factors and conditions | Include: |
| | A recommendation for primary, secondary or tertiary interventions or report whether they are underway |
| | Mental health conditions, including depression, substance use disorgers, suicidality, and cognitive impairments |
| | IPPE risk factors or identified conditions |
| | Treatment options and associated risks and benefits |
| Provide personalized patient health advice and appropriate referrals to health education or preventative counseling services or programs | Include referrals to educational counseling services or programs aimed at: |
| | Community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including: |
| | Fall prevention, Nutrition, Physical activity, Tobacco-use cessation, Social engagement, Weight loss, Cognition |
| Provide advance care planning (ACP) services at the patient's discretion | ACP is a discussion between you and the patient about: |
| | Preparing an advance directive in case an injury or illness prevents them from making their own health care decisions |
| | Future care decisions they might need or want to make |
| | How they can let others know about their care preferences |
| | Caregiver identification |
| | Advance directive elements, which may involve completing standard forms |
| | We don't limit how many times the patient can revisit the ACP during the year, but cost sharing applies outside the AWV. |

# Initial Annual Wellness Visit (AWV)

| | |
|---|---|
| Review current opioid prescriptions | For a patient with a current opoid prescription |
| | Review any potential OUD risk factors |
| | Evaluate their pain severity and current treatment plan |
| | Provide information about non-opioid treatment options |
| | Refer to a specialist, as appropriate |
| Screen for potential SUDs | Review the patient's potential SUD risk factors, and as appropriate, refer them for treatment. You can use a screening tool, but it's not required. |
| Social Determinants of Health (SDOH) Risk Assessment | Starting in 2024, Medicare includes an optional SDOH Risk Assessment as part of the AWV. This assessment must follow standardized, evidence-based practices and ensure communication aligns with the patient's educational, developmental, and health literacy level, as well as being culturally and linguistically appropriate. |

**AWV services may be furnished via telehealth and billed with G2025. Patients may self-report vital signs if they have available the necessary equipment. Reimbursement for G2025 for 2024 is $95.29**

# Subsequent AWV

The subsequent Annual Wellness Visit (AWV) may occur annually 12 months after the initial or last AWV

Review and update the service elements of the previous AWV

**AWV services may be furnished via telehealth and billed with G2025. Patients may self-report vital signs if they have available the necessary equipment. Reimbursement for G2025 for 2024 is $95.29**

# Virtual Communication Services (VCS)

**G0071** = Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between Rural Health Clinics (RHCs) Federally Qualified Health Center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by a FQHC practitioner, occurring in lieu of an office visit.

**Purpose:** The purpose of VCS is to aid community/rural health providers who engage in "virtual check-ins" via phone and or the "store and forward" technique via a patient portal interpret images/audio submitted by patients for over 5 minutes for condition(s) unrelated to visits from previous 7 days and that do not result in an immediate visit.

**2024 reimbursement $13.32

# Telehealth Services

- FQHCs and RHCs can serve as Medicare distant site providers for non-behavioral/mental telehealth services through September 30, 2025. For an encounter furnished using interactive, real-time, audio and video telecommunications technology or for certain audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology services, payment to RHCs and FQHCs are subject to the national average payment rates for comparable services under the physician fee schedule (PFS) through December 31, 2025.
- Non-behavioral/mental telehealth services in Medicare can be delivered using audio-only communication platforms through September 30, 2025. Interactive telecommunications system may also permanently include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications, but the patient is not capable of, or does not consent to, the use of video technology.
- FQHCs and RHCs can permanently serve as a Medicare distant site provider for behavioral/mental telehealth services. Medicare patients can permanently receive telehealth services for behavioral/mental health care in their home. There are no geographic restrictions for originating site for Medicare behavioral/mental telehealth services on a permanent basis. Behavioral/mental telehealth services in Medicare can permanently be delivered using audio-only communication platforms. For FQHCs and RHCs, the in-person visit requirement for mental health services furnished via communication technology to beneficiaries in their homes is not required until January 1, 2026.

**G2025 Reimbursement for 2025 $96.87**

# New CCM services Codes

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**99490:** CCM services; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month $60.49

**99439:** CCM services; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) $45.93

If billed together total or monthly services $106.42

**99491:** CCM services; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month $82.16

**99437:** CCM services; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) $57.58

If billed together total or monthly services $139.74

# Complex CCM Services

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HEALTH BUSINESS SERVICES

**99487:** Complex CCM services; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month  $131.65

**99489:** Complex CCM services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)  $70.52

If billed together total or monthly services $202.17

# CCM Requirements

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- An initiating visit with the billing practitioner.
- Patient consent documented in chart (verbal or written)
- Documentation of time and furnished services ae essential.
- Comprehensive care plan, including a problem list, measurable goals, planned interventions, medication management and coordination with outside resources.
- At least 20 minutes of non-face-to-face clinical staff time per month for billing to occur.

# Patient scenario's

99490 20 mins

$60.49 x 200 patients per month = $12,098.00

X 12 months = $145,176.00

99491 30 mins

$82.16 x 200 patients per month = $16,432.00

X 12 months = $197,184.00

# Other CCM Services

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- Principal Illness Navigation
- Remote Therapeutic Monitoring
- Principal Care Management
- Chronic Pain Management
- Remote Patient Monitoring
- Behavioral Health Integration

# Vaccines

Beginning July 1, 2025 RHC's will be reimbursed for the following Part B vaccines and their administration:

- Pneumococcal
- Influenza
- Hepatitis B
- Covid-19

Payments will be made at the time of service with or without a qualifying visit.

*Bill on UB-04 to Part A

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# Questions?