CAPITOL ASSOCIATES

Moderator: Bill Finerfrock
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1:00 pm CT

Operator: Good day, ladies and gentlemen, and welcome to the "Rural Health Clinic Technical Assistance National Teleconference Series, the Basics of RHC Billing."

If you're listening to the teleconference on the phone and by computer, we ask that you please disconnect your phone line and listen on the computer only. You may submit questions online in the question box located to the left side of your screen. For those of you joining us by phone, instructions will be provided at that time for you to queue up for your questions. One final note, that today's call is being recorded.

And now I'd like to turn the conference over to Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, operator. And thanks, everyone, for participating in today's call. We're using, as you all know, a new format. We're using a webinar format. And we've been very pleased with the response thus far. Hopefully this will go well and this is something we can use going into the future. And we really are looking forward to today's presentation on the basics of rural health clinics billing.

My name is Bill Finerfrock, and I'm the executive director of the National Association of Rural Health Clinics, and I'll be the moderator for today's program. We have three presenters, actually, one presenter and two assistants who are going to help with questions. Our primary presenter is Robin Veltkamp, who is Vice President of Medical Professional and Consulting Services with Health Services Associates, and she'll be joined by Chris Christofferson, the Executive Vice President and CFO, and Julie Wiegand, VP of Medical Billing for Health Services Associates.

Rather than the traditional telephone-only format, which allows you to connect directly with your speakers, this format allows you to connect directly with the speakers via the Internet and watch the slides on your computer at your desk and also ask questions electronically through the question box on your screen. Because we recognize that not everyone has adequate Internet connections, we also will continue to make this available in an audio-only format.

There have been some questions about the slides. Those will be available on the Office of Rural Health Policy Web site, and we'll send that link out again. We had sent it out before, but we'll send that out again after the call so that folks can go back and download those slides and have them for the future.

The format today will be similar to our past calls, which consist of a 45-minute presentation, followed by questions and answers. And as I said, you can either – for those who are on

audio-only through a phone line will get instructions on that. Others can submit their questions in writing through the question box that's provided on your screen.

This conference call series webinar program is sponsored by the Health Resources and Services Administration Office of Rural Health Policy, in conjunction with the National Association of Rural Health Clinics. The purpose of this series is to provide rural health clinic staff with valuable technical assistance and RHC-specific information. Today's call is the 40th in the series, which began in late 2004. During that time, over 11,000 individuals have participated on this national teleconference series.

There is no charge, as you know for participation, and we appreciate everyone joining us. We're looking forward to today's presentation. And at this point, I'll turn it over to Robin, who will start our presentation and – it's all yours, Robin.

Robin Veltkamp: Thank you, Bill. And welcome, everyone.

As Bill mentioned, today we're going to be covering the basics of rural health care billing. We're going to be moving to basically the table of contents, and that is, we will be covering commercial and self-pay. We will be defining what RHC is. We will touch very briefly on Medicaid. And then we're going to spend most of our time in specified Medicare RHC billing guidelines, claim form completion, and payment posting.

On the, what I call, non-Medicare, non-Medicaid billing, this is your commercial world. And what I basically just want to put out at the beginning is some places, once they become a rural health clinic; they get the misunderstanding that everything that happens within the four walls of their clinic becomes rural health billing.

You will still have your commercial billing, and that will not change. You will still have workman's comp and auto claims. And those you will do as you've always done them. They will still be submitted on your 1500 claim format, and those you will not see billing changes because you are now an RHC.

Your self-pay services, you will always do those on your regular statements, and none of those will change. I do want to let you know you can still turn accounts over to collections. Just because you have become an RHC does not hinder you from doing that. But make sure that when you're doing your collections that you have a process in place, and make sure that you have collection policies in place to support the clinic and what they are doing.

If you are doing a sliding fee process, there are some requirements that you must do, and this process, if it is offered in your clinic setting, you need to make sure that you're posting in the patient area that the service is offered. And if you are going to offer this, it must be offered to all patients. That does include your insured patients. They may not qualify, but you do need to make sure that it is being offered.

Have an application system in place along with a written policy of the steps and processes that you use to maintain and administer your sliding fee process. Make sure your staff understands the process, especially those who are going to be offering it to the patients or those who will be processing the application itself.

And other key item is, be current in your poverty guidelines and understand how they are applied for use. Typically, when poverty guidelines come out, they are for a 2-year span, and so you want to make sure that you are using the most current poverty guidelines. And you can download those from the federal government Web site.

Let's get into basic RHC. What is an RHC? It is a rural health clinic. It is certified to receive special Medicare and Medicaid reimbursement. The purpose of this program is to improve access to primary care in underserved rural areas.

You are required to use a team approach. This team approach includes physicians, mid-level practitioners, such as nurse practitioners, physician assistants, certified nurse midwives. You can also use licensed social workers, psychologists, and these people are the ones that render and provide the services. One of the federal regulation requirements for an RHC is that the clinic must be staffed at least 50% of their operating patient care hours with a mid-level practitioner.

I know we have multiple people in this call, and I know that we have both provider and independent-based types of RHCs here today, and so I just want to differentiate right here,

from the very beginning, the difference between independent versus provider-based. A provider-based RHC are typically owned and directed by hospitals, nursing facilities, and home health agencies. Their professional billing is submitted under the clinic's Part A number and their technical billing is submitted under the hospital Part A number.

When you are an independent RHC – these are generally private practices – and their professional billing is submitted under clinic Part A number, and your technical billing is submitted under your clinic Part B number. Now, things can be grouped under your Part B group, but each provider, including mid-levels, must be credentialed with Medicare Part B if they're seeing patients.

One of the things I typically see is that the mid-levels are not enrolled in Medicare Part B, and they do not have their own Medicare Part B number. And what I've been told is they want to go under the supervising because of the 85% payment. In the rural health Part A world, you're getting your rate and the 85% on the mid-level, they're still going to get the rate, but they do need to be enrolled.

So, again, hospital, provider-based, the professional goes under the clinic Part A number in a UB format. The technical goes to hospital Part A number in a UB format. Independent professional goes under the clinic's Part A number in a UB format. And the technical goes to the clinic Part B number in a 1500 format. We will be breaking each of the basic Medicare components down from independent versus provider-based just to give you more clarity as we go through this presentation.

There are benefits of being in an RHC. And they receive special Medicare and Medicaid reimbursements. The Medicare visits are reimbursed based on allowable cost, and the Medicaid visits are reimbursed under the cost-based method or an alternative prospective payment system. And ordinarily, this results in an increase in reimbursement. RHCs may see improved patient flows through the utilizations of mid-level providers, as well as they can see more efficient clinic operations.

Reimbursement for the RHC is an interim payment through the clinic's fiscal year, and then it is reconciled at the end of the fiscal year through what is called cost reporting. The interim payment rate is determined by taking the total allowable cost for the RHC services, dividing that by the allowable RHC visits provided to the RHC patients receiving the core services.

Another keynote is all state Medicaid programs are required to recognize these RHC services. The states may reimburse RHCs under one of the two different methodologies that we mentioned in the earlier slide. Medicaid agencies may also cover additional services that are not typically considered RHC services, such as dental services. So if your state Medicaid program covers dental services, that will be in addition to them recognizing the basic RHC services.

What is an RHC encounter? You hear the word encounter frequently in what we call the RHC world, and what this term is, it's a visit. It is defined as the face-to-face encounter

between the patient and a physician, the mid-level, the clinical psychologist, or the clinical social worker, during which the RHC service is being rendered. And I have to emphasize this – this is a face-to-face with the provider. This is not a face-to-face with the nurse who is only going to be giving an injection. This is actually where the office notes are being developed and where they are seeing a provider for the RHC service.

Encounters with more than one health professional and multiple encounters with the same health professional take place on the same day and at the same location, they will constitute a single visit. Now, there are some exceptions to this, and I will be addressing those later in the presentation.

I want to review what RHC encounters are not. And this is very vital to understand. An RHC encounter is not one that covers what Medicare typically calls non-covered services. They are also not what Medicare calls non-medical necessity services. And I've listed some examples here in what is considered medical non-necessity services, and that if an injection only was given at that visit or if a dressing change was done or refill of prescriptions, lab tests or results only.

It is also not an encounter if you're completing a claim form, like a disability claim form or something that the provider is taking time. That is not an RHC encounter. RHC encounters are also not the care plan oversight. And one big key thing that must be understood is the CPT code, 99211; this is not an RHC encounter. This is typically what we have known in the billing world as a nurse visit, and if the provider is billing this level,

then the provider is most likely under-coding. You also cannot attach a 99211 to the injection to get that considered as an RHC encounter.

On the non-medical necessity services, I do encourage that as you are developing your office notes for those visits, whether it be the medical assistant, the nurse, or the provider themselves that complete the section of chief complaint, that is a very key item, and please make that as detailed, because that needs to show that it can be a stand alone medical necessity. Just putting RX refill does not merit a stand alone necessity or putting lab follow-up. If there is a lab follow-up for cholesterol make sure that the chief complaint is directing and showing the necessity of that visit.

There are different locations that are considered approved for RHC billing. And, of course, the typical one is the clinic or the office setting that is approved as an RHC location. If you are rendering home visits, one of your providers goes to the home of one of your patients, one of your Medicare patients, and they're doing the RHC services there. That is billable as an RHC.

Nursing home services is billable as an RHC. And a real difficult one, but at the scene of an accident, if your provider is at the scene of an accident and rendering RHC services, that is also considered a location.

Now, each of these have their own revenue codes that will direct the claim as to where the location of the services were rendered, and we'll get into those a little bit later. Rural health

services, there are the practitioner services, which are the physician, the nurse practitioner, physician assistant, certified nurse midwife, the clinical psychologist or social worker, also registered dietician or nutritional professionals for diabetes training services, and medical nutrition therapy.

Your rural health service will also include services and supplies incident to the practitioner services. These are not separately billable or payable. They are inclusive in the encounter, and that will be your injections, suture removal. And I want to put a caveat here, just to make sure that you understand, if the sutures were put in, for instance, at the emergency room, and the patient presents to the office, the suture removal is billable by the office.

But, again, inclusive is dressing changes, blood pressure monitoring, and covered drugs that are furnished by an incident-to-services of the practitioners for the RHC.

Non-rural health services, we have services that are called non-rural health, and they are going to be billed to Medicare Part B as a fee for service. They're going to go out on a 1500 format. And the items you're going to bill as non-rural health to Medicare Part B – and if you are provider-based, these will be under the hospital's Part A number. And if you're an independent, these are going to go under the clinic's Medicare group number for Part B on a 1500. And that is diagnostic testing, which is the technical component, and that would be for X-rays and EKG. This is the taking of the X-ray or the – running the test of the EKG. This is not the reading and the interpretation.

All lab services, including venipuncture, will be billed to Medicare Part B. And all professional services done in the hospital will be billed to Medicare Part B.

One thing I need to bring to your attention is what is called commingling, and this is being – when you are billing twice from Medicare for the same service. And I have to be very bold in saying that you have to understand, if you're doing this, this is considered fraud. And when this happens it is when you're billing incident-to services under the professional component to Medicare Part A, then you need to make sure that you're not billing those same components to Medicare Part B, because what you're trying to do in the commingling world is bill it out to both, and it has to be either/or.

Medicaid billing, that would be very difficult for us to really get into today, because Medicaid is a state program. And with the various states that we have, each state has their own method. They use their own formats. Some states use the 1500 format. Some require their billing on a UB-04 format. So what I can only do for you at this point with Medicaid specifically is to recommend you to go to your state government Web site, find the RHC department within your state Web site, and search for the rural health billing manual.

And some of the states are very explicit, and they will even take the different types of services rendered in the clinic and step you out exactly how to bill those out. But they will also tell you which format, if it's 1500 or UB, for your particular state.

Okay, let's get into some basic billing guidelines. All billing is subject to the CMS guidelines, so nothing is changed because you are RHC. You've always been subject to the CMS billing guidelines, and that remains.

Be certain that your credentialing and your enrollment processes are correct and current. Make sure things are enrolled with your state correctly, especially your Medicaid programs. Make sure that you understand if you are an independent or provider-based, so that when you're working with commercial carriers and Medicare Advantage plans, you have an understanding of what you're communicating to them as to what type of RHC you are.

Make sure that each of your provider NPI numbers are attached to the services and that the NPPES Web site has current information. And if you go to Google or Yahoo or whichever you put, if you put in NPPES and you pull up the Web site, you'll go through a couple of the different steps, and it will ask for the NPI number. I challenge you to take all of your different NPI numbers, including the clinic's numbers, and put them in and check them. Make sure the information is current.

Make sure that you have a taxonomy code for rural health attached to the clinic. Make sure that if you brought a new provider into your clinic that the change of address for their practice location has been updated into the NPPES system. And this is a very core piece that drives the communication between all of the carriers. And, again, mid-level providers need to have their own Medicare Part B billing numbers. Know your carriers. Know if your

mid-level needs to bill under the supervising physician or if they can be credentialed and billed under their own number.

Let's get to some of the formats. The Part A UB form, your Medicare Part A services is going to be in the UB-04 format and that is going to be provider-based or independent. It's going to all go to Medicare Part A in the UB format.

The type of bill is 711 and 771 for FQHCs. You're going to enter your actual charges. You have a fee schedule. Your clinic should only have one fee schedule. Whatever that CPT code is, that should be the charge that is universal for all of your patients, no matter what their payer is. You're going to enter the charges, not the encounter rate.

The charges must be rolled into a one-line item with the correct revenue code. So when your key entry person is putting in the CPT codes, they're going to key in all the services that are rendered. Your system is going to take all of those, and I call it that they're going to wrap into a one-line revenue item in the UB format. It's going to be assigned a revenue code. And it's going to be the total of all of those charges, but it's going to be on one line, even though they've entered the different CPT codes. There is an exception to this. And I've listed these with the (G0402, G0438, and G0439). Those will be listed out.

Your coinsurance and your deductible is based on the total charge of the professional services rendered. Bill only one Medicare encounter per day for the services rendered in the clinic. Make sure you have a medically necessary diagnosis. Again, follow-up, refill,

lab results; those are not considered medically necessary diagnoses. And if you have a mental health visit and an RHC encounter, they are payable on the same day. Another key item to understand is, know the timely filing limits and know that they have changed to be one year now.

These are the list of revenue codes. I'm not going to spend a lot of time in them, since you'll be able to print these slides off from the Web site. I recommend that you make sure that your system has the appropriate revenue codes attached to the appropriate CPT codes, so that if you're billing for nursing home, that it's lined up with the appropriate revenue code, or if you're doing home visits, that they are attached to the appropriate revenue code. I recommend that if you do these types of services, that you run some paper test and that you print off some UB formats and that you make sure the revenue codes are in alignment with the types of CPTs that you are billing for.

Office visits. Of course, you need to understand the difference between an established patient and a new patient. And a new patient is someone who has not had any records within your office or have services within the 3 years. And you will be using your different codes. You're still going to get your rate, but you need to be documenting and you need to be billing with the appropriate level code.

Provider-based RHC submits the encounter under the clinic Medicare Part A number in the UB format, and the independent submits the encounter under the clinic's Medicare Part A number on the UB form.

Labs. All independent RHC lab services are going to be billed to Medicare Part B using the clinic's Medicare Part B number, and you're going to file these in the 1500 claim format. Your provider-based RHC services are going to be billed to Medicare Part A using the hospital's Part A number, and those are going to be filed in the UB-04 format.

And I have to emphasize – this does include venipuncture. There has been some misunderstandings that venipuncture is a non-payable inclusive, and that is not true. You can bill for venipuncture. Also, when you're billing your Part B claims, make sure that you are using the appropriate QW modifier on any of your line items that are your CLIA waived test.

For EKGs, as many of you who have been in the coding and billing worlds, you will understand that there's three separate EKG codes. One is everything, the global code, and that one, if you are doing the tracing, the reading, and the interpretation; you are going to use that code in your commercial world and in your self-pay world and in your auto and workman's comp.

When you are in Medicare, you're not going to use that global code, and you're going to be using the 93010 for the professional component, which is the interpret and report, that's going to be included in with your office visit and the charge is going to be rolled into the revenue code. So you'll have your visit and your professional component, and you'll have

the total of that, but it will come out on one line and be billed to Medicare Part A on the UB format.

The technical component, 93005, is billed as fee-for-service to Medicare Part B using the clinic Medicare Part B number. Radiology, your professional component again, is bundled into the RHC encounter. It will increase the dollar amount on the UB form, but it will show up on one line UB format with the revenue code.

One thing that you need to make sure is if the professional piece is contracted by a radiologist, so you've contracted a radiologist to do your readings and their services, you need to know if they're part of the RHC or if they're doing their own billing, because you need to make sure somebody is capturing that component. And if he's contracted and, for instance, you're paying him so much to read, and he's not billing, then you are able to bill that as part of your professional.

The independent RHC, the technical component is billed as fee-for-service to Part B. And if you're provider based, the technical component is going to be billed under the Medicare provider Part A.

Injections. Injections and immunizations are only billed to Medicare and Medicaid HMOs if there is a valid face-to-face encounter with an approved provider. Where injections get to be complicated for the rural health world is if a patient comes in only for an injection. And a perfect example is, let's say I'm the Medicare patient and I come in for a B-12 injection, and

that's all I receive that day. That is not a billable, but you can hold that injection if you know I'm coming in within 30 days, and then that injection can be included in that office visit 30 days prior or after the date of the injection. And then that will be billed out.

Zostavax and hepatitis are considered covered, but they're not separately payable. These are also going to be bundled in with the RHC encounter and billed on the UB-04 format. One thing to note is the patient cannot be charged and they cannot be logged in the flu and pneumo logs.

Procedures performed on the same day as an RHC encounter are going to be bundled into one rate, and they will be paid for one encounter. So a perfect example is if I come in and I have a scheduled mole removal, and I show up with bronchitis, if the provider takes care of my bronchitis and completes the mole removal, in the fee-for-service world, you could put modifiers and you would be billing those out, but in the rural health world, you're going to include both of those, and you're going to get paid one rate.

Now, what you can do is if I'm scheduled for the mole removal and I arrive with the bronchitis, you can choose to treat my bronchitis – because you really don't want to do something invasive if there's an infection going on – and you can reschedule my mole removal. But if you choose to do them both on the same day, you will only be paid the one rate.

Flu and pneumo. These injections are covered under the RHC program. Regular Medicare services are not to be billed on a claim, so you're not going to send these to Medicare Part B. You're not going to include these in Medicare Part A. You're going to log then and you can either keep them on a paper log, or you can put them into your system so that they don't bill out, and then you can create your electronic log. And then these are going to be submitted on your cost report, and they will be paid at the annual cost report reconciliation.

Some key pieces of information as you're creating these logs or if you're putting them into your billing system, you need to be able to capture is the fact that you need to know the date of service, the patient's name, and the patient's Medicare number. And then those can be used in the cost report to capture your actual cost.

Now, Medicare HMOs are to be billed on a HCFA 1500, and you need to also bill for the administration and use the Medicare billing CPT codes for the flu and the pneumo, which is your G code series.

Welcome to Medicare. This is payable once per lifetime. The service must be rendered within 12 months of the patient becoming eligible for Medicare or if they've enrolled in Medicare and they have not had their welcome visit. This has changed since the initial Welcome to Medicare program.

The coinsurance and deductible are not applicable to this service. Only one payment is made for this encounter. And for an independent, all the diagnostic screenings are billed to Medicare Part B. And under the provider, all diagnostic screenings are billed under the main provider Medicare A on the UB format. Again, the G codes must be billed on their own claim lines, must have the CPT code on the UB-04 claim form, and if other services are performed on the same day and they meet the requirement of a separately identifiable face-to-face encounter, they're going to be bundled together in their lines from the G codes, and they will not need CPT codes on the UB-04. They're going to be part of that revenue line item.

And, again, when you can print off these slides, I've given the CPT definition of what these codes are and they tell you basically you know this is limited during the first 12 months or that they are an annual wellness and which code levels one is for an initial after and then one is for subsequent visits.

Inpatient services. The independent RHC inpatient services are billed to Medicare Part B on a 1500 claim form. As a provider based, they're going to be billed to Medicare Part B format. And you need to understand that (some MACs) will cover the inpatient claim and an office encounter on the same day. Some will not. You need to know your specific MAC and what their payment guidelines are for this component.

So some (MACs) will pay – for instance, if I come into the office and I'm seen and then I'm admitted, the admission is going to go to Medicare Part B and the office visit is going to go

to Medicare Part A, but some (MACs) do not recognize that, and so you need to understand what your (MAC) guidelines will allow you to do. If your (MAC) will cover both, again, your office visit will go to Part A and your inpatient will go to Part B.

Nursing home services are billed to Medicare Part A. This does include your SNF services, skilled nursing facility. Medicare co-pays and deductibles are effective and the effect on payment is an increase in the charge and the coinsurance. RHC services deductible is based on billable charges. Non-covered expenses do not count towards the deductible.

And I'm going to give you an example here where the cost for incident-to-services are included in the cost report, but they're not payable on the claims. So, for instance, the patient has an office visit for $65, and then they have an injection that's $40. On your UB-04 format, there's going to be one line item with one revenue code with the total of $105. The patient or secondary insurance is going to be responsible for $21, which is the 20% coinsurance.

In the fee-for-service world, you deal more with the allowables and the percentages based on the allowable. The co-pays and deductibles for RHCs is based on the total charges. On rare occasions, the clinic may be able to bill for two encounters on the same day to Medicare Part A. And a perfect example would be if I come in to the clinic in the morning, and I'm treated with bronchitis, and then later in the day, I come in and I fall and I have a wrist injury. Each of these would be considered their own encounter, and they can be billed separately on their own claim forms.

I will advise you that one will probably be rejected, but you can do an appeal, you can attach notes, and you can draft a letter, and get the reconsideration, and typically then you will receive payment on both of those items.

Also, the clinic can bill Medicare Part A and worker's comp or auto for services rendered on the same day. Now, there are some key instructions to this. And let's say, again, I'm here for a knee injury follow-up from an auto accident, and in the meantime, I've developed bronchitis. As long as the provider has two separate clinic notes and each note specifies the method of treatment for those two areas, you can bill my knee injury out to my auto insurance and you can bill my bronchitis out to my Medicare Part A.

Payment posting for rural health, if you've been in the fee-for-service world, the payment posting in rural health seems a little challenging at first, but Medicare is going to pay 80% of the rural health encounter rate, and then the patient or coinsurance is going to be responsible for the 20% of the charge. And many times, the rate is higher than what your CPT charge fee schedule is.

And so what you need to make sure that you do is when you post a payment, that if it comes down to zero, that you don't just say, well, we're at zero, we've got our money, that's good. You need to make sure that when you post the Medicare payment that the balance is still reflective of the 20% that is still owed by patient or secondary insurance.

Medicare secondary payer and I know this is a big question, I've seen it coming through listserv most of this week. You need to collect the patient health insurance or coverage information at each patient visit. Now, there is the long form, and there is the short form. I've seen the question about within 90 days. What you must do is have your initial documentation within the 90 days or you might be losing your payment, because Medicare has all these forms, and they make the patient's complete, and then they will reject until the patient has done their paperwork to align. And so this is what all of this is about, is just to show the alignment that everybody understands Medicare is secondary to a primary insurance.

I have listed a Web site here where the tools can be found on the CMS Web site. There's a great checklist. There's a lot of tools. And you can download the forms and everything.

Bill the primary payer before billing Medicare. And that is required by the Social Security Act. Sometimes what's going to happen, though, in the Medicare secondary world is, the patient hasn't communicated to Medicare that their status has changed. And so if Medicare is still saying the primary needs to pay and the patient no longer has that other primary, you need to work with the patient to get them to complete the Medicare paperwork on their part so that things get realigned as to who is the primary payer.

Secondary billing after Medicare, 20% of the charges may not be equal to 20% of the encounter rate. And the coinsurance is established on 20% of the allowed amount. And do

not write off the account to the primary payer to zero. Make sure that you're going for that 20% secondary or patient responsibility.

We also have what's called Medicare bad debt. Medicare RHCs are allowed to claim bad debts, and they may claim unpaid deductible, but the RHC must establish reasonable efforts and be able to show that reasonable efforts were made to collect the coinsurance amounts in order to receive payment for bad debt. If the RHC coinsurance or deductible is waived, the clinic may not claim bad debt amounts for which it assumed the beneficiary's liability.

You have to show reasonable attempts. You have to be able to show that you've attempted to collect this bad debt. And you need to have a trail that shows statements or billing in a routine pattern and that you've attempted for 120 days to collect. That doesn't mean every single day for 120. That is a statement once a month, up into the 120 days, and that you've attempted.

Only services rendered during RHC effectiveness qualify to be written off as Medicare bad debt. So if you're a new RHC, and let's say you became an RHC September of 2010, if you've had the services rendered in May of 2010, those are not going to be inclusive in that Medicare bad debt, because they were before you were deemed an RHC entity.

You will claim the Medicare bad debt in the year that you write it off. And any denials by Medicaid as a secondary payer, as long as that claim was actually billed and denied, you can claim that, and you can claim any documented charity write-offs.

I do want to bring up two other quick reports, and one is the credit balance report. You will get these. This is due 30 days after the end of each fiscal quarter. It's a simple one page, and you just need to complete what overpayments you've received from Medicare. And if you did not receive any overpayments, you just simply put the zero; finish completing the claim form, or the document, and getting that turned in. No payments will be made to you if you don't complete this form.

So it's not something that you can ignore. After like two quarters typically, sometimes three quarters at the most, your payments are going to be stifled, and you will be wondering what's happened, and usually it comes back to the fact that the credit balance report was not filed.

And as I mentioned earlier with medical necessity, CMS does conduct billing audit reports, and they may typically come and ask for 25 patients with specific billing dates. They want to see a copy of the billing, as well as a copy of the notes. Those go to an adjudicator, who reviews and decides if that service was medically necessary.

And many times I've seen where the adjudicator will look at the chief complaint, and if it says RX refill, they will stop there and say, this is not medically necessary and they are

going to take their money back, because this is not a medical necessity visit. So that is where you really need to make sure the chief complaint supports the rest of the note.

Many times you can appeal and you can have them look at what the provider has written, but the initial response will be this claim is denied and we want our money back. And they can take their money back, and then you have to go through an appeals process.

And now we will go to questions and answers, and I do see that there have been some questions forwarded.

Bill Finerfrock: Yes, we have quite a few questions, Robin. I don't know if you want to start with the ones that I've already sent you and work your way through or how – and, Chris and Julie, that's why I sent them ahead. You can give a chance that you can go ahead and think about it or go ahead and respond.

Robin Veltkamp: Okay. The first question is, explain the non-medical necessity services, lab tests, results only.

Again, this is, for instance, if I'm a high cholesterol patient and you run a cholesterol test. When I come back to the office, basically in my mind as a patient I'm coming back to find out what my test results are, but when you're documenting in the chief complaint, make sure that you're addressing that the lab tests are in regards to high cholesterol and not just

here to review lab results, because when you say lab results, the question basically comes out, for what?

So when you look at the chief complaint and training your medical people this, have them basically answer, RX refill for what, follow-up to what, and then that will help them put in what the reason of the visit is and help it become proven that it is a medical necessity visit.

Bill Finerfrock: Okay. We're going to have to try and work our way through as many of these as we can. What we'd like to do is, there are going to be a lot more questions than we're going to have time for, is perhaps submit those to Robin and to Julie and to Chris. And then what we can do is post those answers up on the ORHP Web site. So if we don't get to your question, we will try and get an answer and post it up on the ORHP Web site.

Robin Veltkamp: Okay.

Bill Finerfrock: Go ahead. Next was on nursing home patient.

Robin Veltkamp: Okay. Julie, do you want to take…

Julie Wiegand: Sure. The question is a nursing patient that has never been seen in the RHC, but was admitted ((inaudible)) under the care of the RHC physician, and if he ((inaudible)) patient – see the patient monthly ((inaudible)) is that considered an RHC patient and visit?

It is. There are some open to interpretation. The way I do the billing is that anything with regards to the nursing home is billed as an RHC visit. You must remember that if you're seeing a nursing home patient, the chart must be kept at the RHC. You can have a copy ((inaudible)) nursing home, but you must have the chart in the actual physical clinic.

Bill Finerfrock: Okay.

Robin Veltkamp: Okay. What is the difference between professional billing and technical billing? Basically, professional is what is the face-to-face with the provider. Technical is a lot of what the staff does, that is, taking the EKG, that's putting the leads on and running the report. It is actual snapping the films in radiology. It is the actual lab work. The professional component of that is reading those and interpreting those.

Bill Finerfrock: Okay, great. Next on the G codes?

Julie Wiegand: The next question is you have listed only three of the G codes that should be listed out. We thought that G0101 and Q0091 should also be listed and ((inaudible)) no coinsurance or deductible. The G0101 ((inaudible)) should be listed out on the UB-04, and it will not have deductible applied to it. You can also bill that along with the new codes, the G0438 and the G0439, as those are not really preventive care. They're kind of like an assessment, so you can build both those together or separate on their own line with the G codes.

However, the Q0091 is actually – goes to Medicare Part A. And that is similar to the collection of like a venipuncture. You're collecting the specimen, so that goes to Medicare Part B as a lab. I think that answers it. Robin?

Robin Veltkamp: Okay. Do you want to take the two on the revenue codes?

Julie Wiegand: For the revenue codes, is there anything that lists the procedure codes with the appropriate revenue ((inaudible)) the procedure codes aren't really linked to the CPT codes? You have to look at it as – it's where your place of service is. If you're in the office, it's going to be the 0521, so everything in the office, all the procedure codes are going to have that revenue code. If you're in a nursing home, you're going to have one of the two nursing home codes, et cetera. So it doesn't really link the two.

The only – I'm thinking that the question is, how do you decide whether or not it goes to Medicare Part B or Medicare Part A? That could be the question. And like Robin was saying, the professional component is going to go, and that is, again, the reading. It's going to go to Medicare Part A if you have ((inaudible)) if the patient comes in just to have their EKG done, what you would do is build a technical component to Medicare Part B, and the professional component – if there's no encounter, would be zeroed out or written off as not billable.

Bill Finerfrock: Okay.

Julie Wiegand: ((Inaudible)) answer that one. The next one.

Bill Finerfrock: Patients that get preventive services at no charge. I think you were just covering that.

Julie Wiegand: Yes, for Medicare patients ((inaudible)) preventative, you don't – let's see – you still use the same – again, the same revenue codes. The revenue code is not tied to the CPT code. So if you had a patient come in for a ((inaudible)) preventative care, the G0438, also the G0101, both of those would go on the UB-04, with the CPT code, G code on the form, and then all of the other services, if you had – and it has to be the patient came in for that ((inaudible)) an additional problem. It must be documented in the chart. Then you can also put on the code – on the form 0521 with all those services bundled up, so you could have a 99213 plus maybe an EKG or a reading of it or something like that.

So there would be three separate lines in that instance. There would be the G0438 with the code, a G0101, and then another line without any code, just the – no CPT code, just the revenue code.

Bill Finerfrock: Okay. All right.

Robin Veltkamp: This says our clinic is hospital-owned and has the hospital tax ID, so do venipunctures and the technical component of EKGs done in the office go on a UB-04 to Part A Medicare?

Yes. And I'm going to be honest with you. In some of the hospitals, the venipuncture, some of the hospitals do choose to include venipuncture as part of what they bill in their lab services, and they don't break out the specific venipuncture, because they'll get paid on the venipuncture, and sometimes that will lower their lab reimbursement. But it is to be billed as a provider based to Medicare Part A under the hospital's billing number for a provider-based clinic.

Bill Finerfrock: Can we just hold on a second? Operator, do we have folks from the – who are on the phone only who didn't – weren't able to get on the webinar who might want to ask a question?

Operator: They can press star 1 at this time if they have a question.

Bill Finerfrock: While we're waiting on that, why don't we go ahead and take the next written one, and then we'll see if there's anybody who had a call-in question?

Robin Veltkamp: Okay. We understand that Zostavax is a Part D service. How can that be bundled with an RHC service? And are you referring to the administration?

That's a very good question. Bill, this is one that I believe I would like to be able to give them a full written response, and so I would like to be able to do a little more investigation

on this, because I do not believe this is Part D, but I don't want to say that without further investigation for them.

Bill Finerfrock: Okay.

Julie Wiegand: I can answer – I can give a little insight to that, Robin.

Robin Veltkamp: Oh, okay.

Julie Wiegand: What some of our clinics are doing is having a patient go to the pharmacy, get their prescription, and bring it into the office. A lot of providers don't like that idea, because you're having the patient carry around the vaccine. They might not take care of it well. The way to actually do it correctly in an RHC world is bundle it, and it's considered (an instant to service). So it's an expensive service to have it in RHC, but that's the way it would be billed, is bundled up into an encounter.

Bill Finerfrock: Okay.

Robin Veltkamp: Okay. Thank you, Julie.

Bill Finerfrock: Operator, any questions on the phone?

Operator: We do. We have one question. Caller, your line is open.