RHC CLAIMS ISSUES AND 5010 REQUIREMENTS

Presented for:

Technical Assistance Conference Call

By:
Janet Lytton, Director of Reimbursement
Rural Health Development
P.O. Box 487, Cambridge, NE 69022
308-647-6455
RHDconsultJL@hotmail.com

Objectives

- ✓ Know the 5010 RHC Claim requirements
- ✓ Assure claims are submitted in the required format for 5010 compliance
- ✓ Assure preventive services are being billed correctly
- ✓ Know where to find the references used for billing

5010 RHC Claim Requirements

- ✓ All RHC demographics must match what has been submitted on the CMS 855A form.
  - ✓ Exact name of RHC
  - ✓ Exact address of RHC—no PO Box numbers allowed
  - ✓ 9 digit zipcode
  - ✓ Fed. Tax ID associated with RHC
  - ✓ NPI for that RHC
  - ✓ Taxonomy code for RHC = 261QR1300X

5010 RHC Claim Requirements

- ✓ All RHC billing is on the UB04 form
- ✓ There are specific FL (form locators) required for the RHC billing
- ✓ All requirements for claim submission are located in CMS manual 100-4 Ch 25 (manual on UB04) and CMS manual 100-4 Ch 9 (RHC claims)
- ✓ Medicare has a free software PCACE Pro 32
  - ✓ meets all requirements for clean submissions
  - ✓ claims can be sent directly to the Medicare payer
- ✓ Many Practice Management systems and clearinghouses are requiring more than needed

5010 RHC Claim Requirements

FL 1 = Name of Facility = required

Name

Street

City Zipcode

Phone Fax

FL 2 = not required

FL 3a = Patient control number = required

FL 3b = Med Rec # = situational

5010 RHC Claim Requirements

FL 4 = Bill Type = required

RHC = 0711

RHC claim for denial = 0710

must also have 21 cond code present

All charges listed would be noncovered

RHC adjustment claim = 0717

RHC cancel claim = 0718

0717 & 0718 require Doc. Contrl. Number

FL 5 = Fed Tax No. = Required xx-xxxxxxx

FL 6 = Statement from and through date

i.e. 012712 through 012712

5010 RHC Claim Requirements

FL 7 = not used

FL 8 = Patient name = required

FL 9 = Patient address = required

FL 10 = Birthdate = required

FL 11 = Sex = required

FL 12 = Admission Date = do not use for OP claim

FL 13 = Admission Hr = do not use for OP claim

5010 RHC Claim Requirements

FL 14 = Admission Type = required

RHC will most likely use

2 = urgent

3 = elective

9 = information not available

FL 15 = Source = required

RHC will most likely use

1 = nonhealthcare point of origin (hm)

5 = from ICF, SNF or ALF

9 = information not available

5010 RHC Claim Requirements

FL 16 = Discharge hour = not required, do not use on OP claim

FL 17 = Status (where discharged to) = required RHC will most likely use

- 01 = discharge to home or self care
- 03 = discharge to SNF
- 04 = discharge to custodial care facility

5010 RHC Claim Requirements

FL 18 – 28 = condition codes – rarely used

07 = claim for hospice pt for nonhospice Dx

21 = claim sent for denial purposes

some additional CC used for MSP billing; a reference guide from Cahaba is also attached

FL 29 = Accident state - not used

FL 30 = not used

FL 31 - 34 = Occurrence code & date = situational but normally not used; may be used in MSP

5010 RHC Claim Requirements

FL 35 – 36 = Occurrence span codes – not used in RHC

FL 37 = not used

FL 38 = Responsible Party – not required, usually the patient name and address defaults to here

FL 39 – 41 = Value Codes & Amount = only used in MSP situations

5010 RHC Claim Requirements

FL 42 = Revenue Code – required (face-to-face visit)

- 0521 = in office visit
- 0522 = home visit
- 0524 = SNF or SW bed resident on a Pt A stay
- 0525 = Nursing home visit
- 0527 = Visiting nurse visit in nonHHA area requires special designation by CMS
- 0528 = Other site, i.e. scene of accident
- 0900 = Behavioral Health Visit
- 0780 = Telehealth site fee
- 0001 = Total charges at bottom, not put in as line item, system will input

5010 RHC Claim Requirements

FL 43 = Description – not required for RHC claim

FL 44 = HCPCS/Rate/HIPPS Code – not required for RHC claim UNLESS a preventive service is performed, then the CPT Code of the preventive service is in this FL

FL 45 = Service Date – required for OP (will be same as from and through date)

FL 46 = Service Units – required = will be unit of 1 regardless of number of services performed, unless there are two allowable visits on same day

5010 RHC Claim Requirements

FL 47 = Total Charges – required = total charges for all services performed that day to include all OV E & Ms, procedures, Professional Components of tests, additional supplies, & Pt B drugs that are "bundled" in the 052X Revenue Code

FL 48 = NonCovered Charges – rarely used

If sending in for a denial, all charges are here

FL 49 = not used

1	2	3a PAT. CNTL #	4 TYPE OF BILL
RURAL HEALTH CLINIC		3333	
123 ANY STREET		b. MED. REC. # 3333	0711
ANYWHERE NE 666661234		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
3333333333 3333333334		47-0607118	011012 011012

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 123 AVENUE
b PATIENT, IMA	b SMALLTOWN c NE d 66666 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08101940	F			3	1		01													

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
PATIENT, IMA 123 AVENUE SMALLTOWN, NE 66666	a						
	b						
	c						
	d						

	42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	CLINIC VISIT BY MEMBER T		011012	1	132.50			1
2									2
3									3
4									4
5									5

1	2	3a PAT. CNTL #	4 TYPE OF BILL
RURAL HEALTH CLINIC 123 ANY STREET ANYWHERE NE 666661234 3333333333 3333333334		3333 b. MED. REC. # 3333	0711

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
47-0607118	011012	011012	

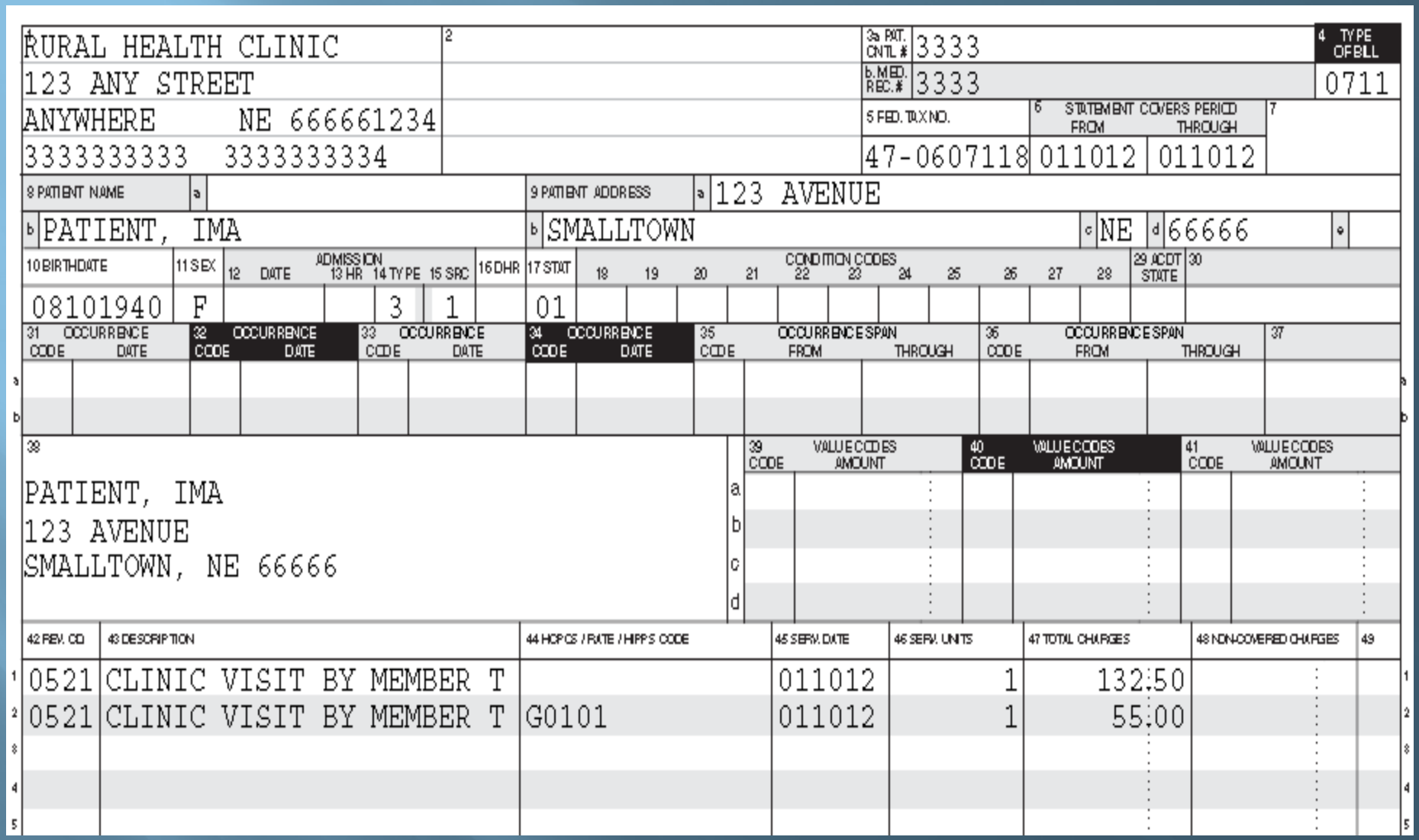
8 PATIENT NAME	9 PATIENT ADDRESS
a	a 123 AVENUE
b PATIENT, IMA	b SMALLTOWN c NE d 66666 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08101940	F			3	1		01													

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a															a
b															b

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
PATIENT, IMA 123 AVENUE SMALLTOWN, NE 66666	a					
	b					
	c					
	d					

	42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0521	CLINIC VISIT BY MEMBER T	G0402	011012	1	250.00		1
2								2
3								3
4								4
5								5



1	2	3a PAT. CNTL #	4 TYPE OF BILL
RURAL HEALTH CLINIC		3333	
123 ANY STREET		b. MED. REC. # 3333	0711
ANYWHERE NE 666661234		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
3333333333 3333333334		47-0607118	011012 011012

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 123 AVENUE
b PATIENT, IMA	b SMALLTOWN c NE d 66666 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
08101940	F			3	1		01													

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
PATIENT, IMA 123 AVENUE SMALLTOWN, NE 66666	a					
	b					
	c					
	d					

	42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0521	CLINIC VISIT BY MEMBER T		011012	1	132.50			1
2	0521	CLINIC VISIT BY MEMBER T	G0101	011012	1	55.00			2
3									3
4									4
5									5

5010 RHC Claim Requirements

FL 50 = Payer Name – required, i.e. Medicare

FL 51 = Health Plan ID – National Health Plan Identifier or the number Medicare has assigned

FL 52 = Release of Information – required – Usually "Y" – Yes patient signed statement for data release; also could be "I" – Informed consent to release data regulated by statute.

FL 53 = Assignment of benefits – required =

"Y" – payment to provider is authorized;

"N" – payment to provider is not authorized;

5010 RHC Claim Requirements

FL 54 = Prior Payments – left blank for regular RHC claim;

FL 55 = Est. Amount Due (from patient) – not required;

FL 56 = NPI = Billing Provider (RHC) NPI number

FL 57 = Provider ID of second and third payers if required

FL 58 – FL 62 = Required = Patient Insurance information; Insured name, Patient relation (18 self), Pt Medicare number or ins number; any applicable group name or group number

5010 RHC Claim Requirements

FL 63 = Treatment Authorization Code = not required for RHC claim; may be required for HMO or PPO claims when preauthorization is required.

FL 64 = Document Control Number = usually not required; Required for any adjustment or cancel claims, when adjustment or cancel is completed there must also be a Condition Code, D0 – D9, most used in RHC = D1 change to charges; or D5 cancel to correct HICN; D9 any other change;

5010 RHC Claim Requirements

FL 65 = Employer Name (of the insured) = not used on RHC claim;

FL 66 = Diagnosis of patient for the visit; some V-codes are appropriate as primary codes; list as many as provider addressed and also those that were considered in determining a treatment plan.

Just below FL 66 if claim is printed it defaults to "9" meaning use of ICD-9 codes

FL 68 = Not used

5010 RHC Claim Requirements

FL 69 = Admission Diagnosis = not required on OP claims

FL 70 = Patient reason Diagnosis = not required in the RHC

FL 71, FL 72, FL 73 = Not used

FL 74 = Principal Procedure codes & dates = Not used on OP claims, only IP claims

FL 75 = not used

5010 RHC Claim Requirements

FL 76 = Attending provider NPI, Last name, First name = Required

May also have another Qualifier number in "Qual"; could include: 0B State license number; 1G Provider UPIN; G2 Provider Commercial Number;

FL 77, FL 78, & FL 79 = Other providers = not used on RHC claim

FL 80 = Remarks = only used if need additional info to the payer. Must have a remark if claim is adjusted or canceled or two allowed visits on same day

5010 RHC Claim Requirements

FL 81CC a = this will show if there is a marital status for the patient, i.e. B2 S, marital status is not required

(If no marital status, then the second moves to first location)

FL 81CC b = This is the Taxonomy code for the Facility. This is Required. RHC = B3 (noting taxonomy code) 261QR1300X (taxonomy code)

5010 RHC Claim Requirements

Other Taxonomy codes that may be seen are:

CAH Clinic (this is not an RHC) = 261QC0050X
FFS Clinic = 261Q00000X
CAH = 282NC0060X
Acute Care Hospital = 282N00000X

0001	PAGE 1 OF 1	CREATION DATE	012712	TOTALS	132.50	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1760521926
A MEDICARE A FOR NEBRASKA	05401	Y	Y			57
B						OTHER
C						PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A PATIENT, IMA	18	555555555A		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX		A	B	C	D	E	F	G	H	68
25000	4011									
9	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75	76 ATTENDING NPI 1780629626 QUAL
				LAST PHYSICIAN FIRST SOLO
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE		77 OPERATING NPI QUAL
				LAST FIRST

80 REMARKS	81CC			78 OTHER NPI QUAL
	a	B2S		LAST FIRST
	b	B3 261QR1300X		79 OTHER NPI QUAL
	c			
	d			LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Other issues

Medicare negative reimbursements until Deductible is met:

At the beginning of each Calendar Year (CY), Medicare beneficiaries must meet the Part B deductible for outpatient services. In order for Medicare to render payment, the patient must first satisfy the $140 deductible. This can present a troubling issue for those unaware of the negative reimbursement policy that pertains to Rural Health Clinics (RHCs). If the billed amount on a claim is greater than the RHC's encounter rate **and** the patient still has an outstanding amount on his deductible, this will create a negative reimbursement as shown on the Medicare Remittance Advice (RA). The reason code that will appear on the RA will be 37206.

Other issues

Example that results in negative reimbursement:

Total Billed amount:	$186.00
Provider Reimb rate:	$ 64.78
Bene remaining deductible:	$100.00
Bene applicable copay:	$ 17.20

The beneficiary's responsibility will be $117.20 ($100 ded & $17.20 coins). Medicare's responsibility will show as -$35.22 (reimbursement rate minus ded).

www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=14751

Other issues

Medicare RHC Cost Report:

RHC cost reports will now require that the dollar amount of the preventive services that were billed as the separate line items with the CPT codes shown are to be disclosed on the annual cost report.

Medicare pays the RHC 80% of their rate of which there is to be no copay or deductibles associated with these services. In disclosing the amounts for the preventive services, Medicare will figure a cost settlement due for those amounts that were to be part of the RHC reimbursement.

References

Medicare Manuals:
http://www.cms.gov/Manuals/

Medicare Claims Processing Manual:
Medicare Manual 100-04

Chapter 9 = RHC claims processing

Chapter 25 = CMS 1450 date set (UB04 Claims)

UB04 Manual can be obtained at:
http://www.nubc.org/
(new manual unavailable until 7/12)

References

Medicare Preventive Services Quick Reference:

http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

Medicare Annual Wellness Visit Quick Reference:

https://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

Medicare Secondary Payer Quick Reference:

https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_msp.pdf

Questions ?