RHC Overview Coding and Billing: Getting Started

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Build a Foundation

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- Most business office and physician practice staff are trained internally by staff that may not have access to proper guidance
- Training may not be consistent or comprehensive
- Expectations are subject to interpretation
- **Standardized training manuals ensure all communication is consistent and thorough**

Acronyms/Abbreviations

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- RHC – Rural Health Center
- AIR – All Inclusive Rate
- COINS – Coinsurance, or patient responsibility after Medicare payment
- MPFS – Medicare Physician Fee Schedule
- TOB – Type of Bill. Required to describe location of service and bill sequence for hospital UB-04
- POS – Place of Service. Required on Professional 1500 bill

The Basics

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- Rural Health Center (RHC) is a CMS designation
- RHCs provides access to primary care in underserved areas
  - All state Medicaid required to recognize RHCs
  - Commercial payors make no distinction for RHCs
- Team approach
  - Physicians - MDs and DOs
  - Mid-levels (NP, PA, CNM)
  - Clinical psychologist
  - Dietician and diabetic educators- considered incident to in RHC
- At least 51% of the services provided must be primary care services
- At least 50% of the time, the clinic must be staffed with mid-levels
- Medicare reimbursement is based on an all-inclusive rate (AIR)
- Each provider must have there own NPI (National Provider Identifier) number

RHC Visits

- Visits can take place
  - In RHC
  - At the patient's residence (including an assisted living facility)
  - A Skilled Nursing Facility
  - At the scene of an accident
  - Virtual communication

Medicare Billing

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- Medicare retains private health insurer contractors (MACs) to process Medicare claims
- Rural Health Centers submit charges to a *Medicare Part A MAC*, but are paid through Part B
- Medicare beneficiaries must have Part B coverage at the time of service to qualify for RHC Medicare reimbursement
- RHC claims cannot overlap calendar years
- Primary services billed on a UB-04 form
- The technical component (diagnostic) is not considered RHC service
- Part B services should be billed on a UB-04 for provider based RHCs
- Bill Part B on 1500 for non-provider based services

Reimbursement

- Medicare reimburses a flat All Inclusive Rate (AIR) for RHC services
- Initial year AIR is an estimate provided by clinic
- Subsequent year AIRs established by CMS based on cost report
- Medicare pays 80% of AIR
- Patient is responsible for co-insurance and deductible of charged amount, minus charges associated with preventative medicine services
    - Care management and virtual services apply deductible at lesser of allowed amount or billed amount
- Non RHC services paid on allowed amount for the service

Qualifying Visit

- The primary service is considered the qualifying visit
- CG modifier required for the line considered the qualifying visit
- Report all charges on the service line with the qualifying visit HCPCS code, minus any charges for preventive services
- Report charges associated with preventative med services on a separate line

Non RHC E&M Services

- An RHC visit includes medically necessary medical or mental health visit, or a qualified preventive health visit. **The visit must include a face-to-face (one-on-one) encounter** between the patient and an RHC practitioner during which time one or more RHC services are furnished
- Effective January 1, 2019, virtual communication services are considered RHC services
- Distant site Telehealth and Chronic Care visits do not require a patient and provider in the same place to perform the service, so these are not RHC services
- Transitional Care requires a patient and practitioner visit during the month to satisfy requirements, therefore Transitional Care is considered an RHC visit

Non RHC E&M Services – Method II Billing

- Providers employed by Critical Access Hospitals can elect Method II billing
- Assign rights to CAH
- File written election MAC 30 days before start of cost reporting period
- Remains in effect until facility terminates Method II
- Bill Medicare on UB-04 form for the hospital
  - Appropriate professional Revenue Code
  - TOB 85X

Incident to Services – Nurse Visit

- "Incident to" nurse visit only services are not considered Qualifying Visits
- Charges may be included on the claim associated with a qualifying visit if performed up to 30 days from the date of the reportable encounter
  - Suture removal
  - Dressing changes
  - Injections
  - Blood pressure monitoring
  - Medical Nutritional Therapy (MNT) and Diabetes Self Management Training (DSMT)
- Cannot be billed as qualifying visit
- Can be included on the cost report

Ancillary Testing

- X-rays can be performed in RHCs
  - Taking X-rays is considered a technical component and is not part of an RHC visit.
  - Provider-based RHCs report taking of X-ray on the hospital billing form (UB-04).
  - Reading X-rays is a professional service.
    - Included in the RHC visit if the provider reads the X-ray during the face-to-face visit
    - Separately reportable as a non RHC services by the reading physician if not resulted by the servicing provider
- EKGs can be performed in an RHC
  - If the RHC provider reads the EKG, the reading is considered part of the professional service
  - Taking EKGs can be reported separately on a UB-04 for provider-based clinics
  - Report taking EKG on an HCFA 1500 for non-Method II or non-provider-based billing

Common Terms

Diagnosis code	Represents diseases, illnesses and injuries
CPT and HCPCS	Code set that is used to report medical, surgical, and diagnostic procedures and supplies and drug
Revenue Codes	Required on UB-04 to further define CPT or HCPCS into procedure categories, servicing provider or service type or location
Place of Service	2-digit code required on HCFA 1500 form
Type of Bill	4-digit service code required on UB-04. Leading digit is zero
EIN	Employer Identification Number: a unique **nine**-digit number assigned by the Internal Revenue Service (IRS) to business entities operating in the United States for the purposes of identification
Incident to services	Furnished under direct supervision as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness

Chargemaster Components

Item Number	Facility assigned mnemonic that is unique to one service line item
Item Description	Text Description of the CPT/HCPCS, truncated to the character requirement of the CDM while retaining all pertinent information from the CPT/HCPCS description
Revenue Code	4-digit code required on hospital bills categorizing the service performed. All CPTs/HCPCS are designated into Revenue Code categories
CPT/HCPCS	5-digit number or alpha-numeric code that describes in detail the service provided. CPTS and HCPCS are divided into limiting categories by product, type of service or body part examined.
Charge Amount	Fee assigned to service line item
Alternate CPT/HCPCS	Some CPTs and HCPCS overlap, and payors can determine which code is required for processing. Alternate CPT/HCPCS fields allow for one item number to be designated by payor to multiple code selections
Department	Numeric designation of servicing or expense area within the facility
GL Number	Numeric designation identifying the department within the General Ledger for accounting purposes

Charge Form Components

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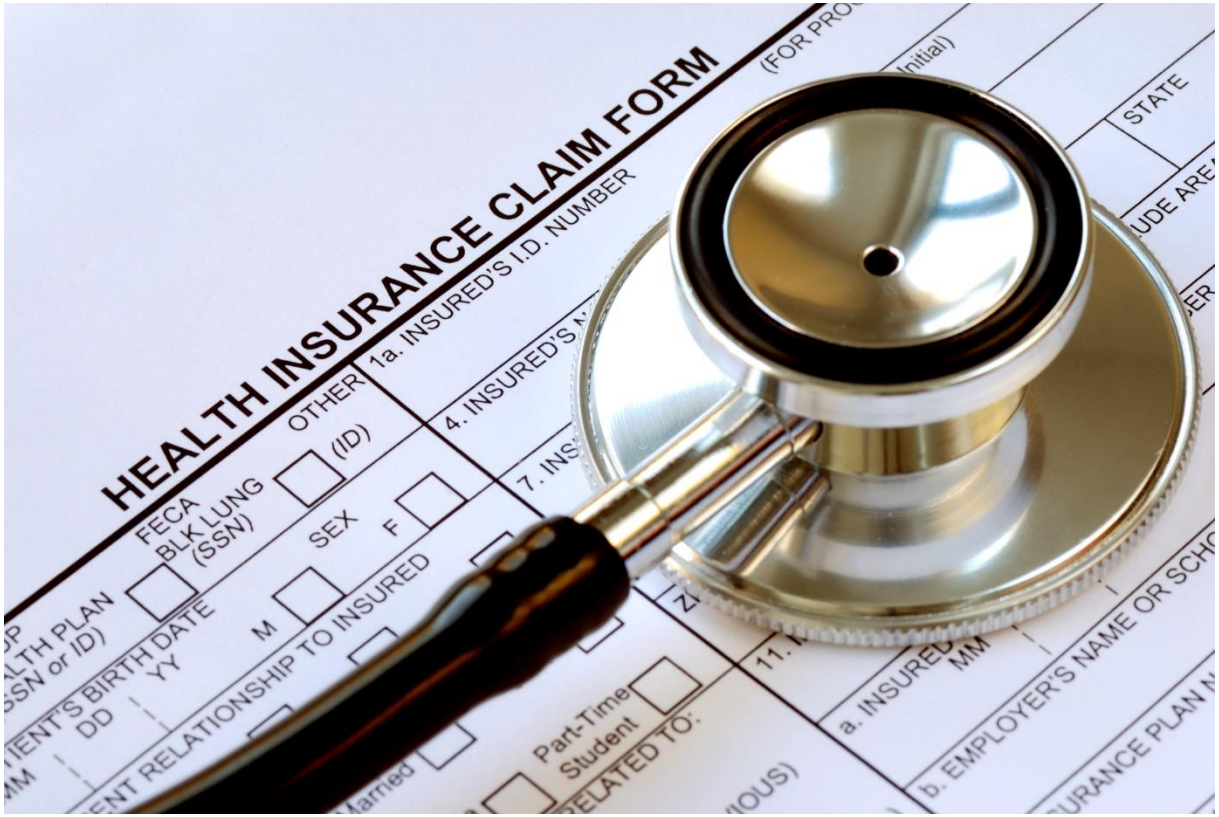
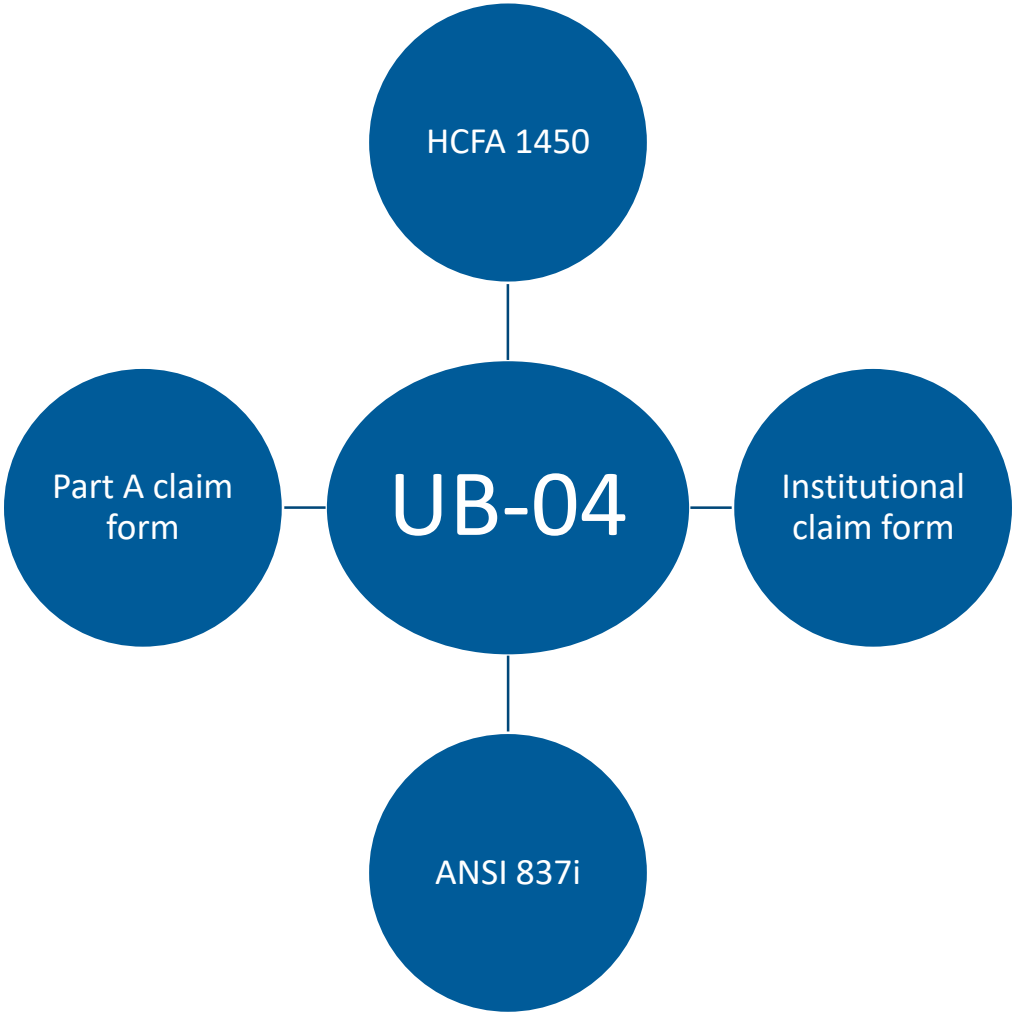
CODE SET	IDENTIFY	BILLING FORM	MAINTAINED BY
CPT	Procedures, services, drugs, combo services	1500 and UB-04	AMA
HCPS	Procedures, services, drugs, combo services, supplies, DME	1500 and UB-04	CMS, BCBS
Revenue Code	Location, provider, type or procedure	UB-04	NUBC
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	1500 and UB-04	AMA, CMS
ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM	1500 and UB-04	WHO
Type of Bill	4-digit code representing the place of service, type of service and billing stage. Leading number is a zero	UB-04	NUBC
Place of Service	2-digit code identifying the location of the provider, or type of service	1500	CMS, BCBS

Commercial vs Government Billing

- Specific guidelines apply for Medicare and Medicaid RHC services
- Commercial payors make no distinction between RHCs and physician practices
- HCFA 1500 form for professional services
- UB-04 for CAH Method II



UB-04 Claim Form



Revenue Codes

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- 4-digit codes (leading zero) that categorize the type of service or product delivered, describe where the service took place and/or who performed or is billing the service (professional or technical)
- All procedure codes billed on a hospital UB-04 (or electronic 837i) must be paired with a revenue code
- Revenue code/procedure code pairing must make sense, must follow National Uniform Billing Committee guidelines, and must be acceptable to payors
- Revenue code-HCPCS mismatches are automatic denials in many cases

RHC Revenue Codes

REVENUE CODE	REVENUE CATEGORY
0300	Lab
0521	Clinic visit by member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
0525	Visit by RHC practitioner to a member in a SNF, Nursing Facility (not in a covered Part A stay), Intermediate Care Facility or other residential facility
0527	RHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
0523	Visit by RHC practitioner to other RHC site (e.g., scene of accident)
0900	Behavioral Health Treatments/Services

Type of Bill

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First Digit	• Leading zero. Ignored by CMS
Second Digit = Type of facility	• 1 - Hospital • 2 - Skilled Nursing • 3 - Home Health • 7 - Clinic (RHC) • 8 - CAH
Third Digit = Type of care	• 1 - Inpatient or clinic • 2 - Inpatient Part B, Hospital based clinics, Hospice, Home Health • 3- Outpatient • 5- Special Facilities (CAH)
Fourth Digit = Sequence of this bill in this episode of care. Referred to as a "frequency" code	• 1- Admit to Discharge initial claim • 7- Adjustment claim • 8 - Cancel claim • 0 - No Payment

Type of Bill

SERVICE TYPE	BILL TYPE
RHC	71X
Outpatient Hospital	13X
Inpatient Hospital	11X
Critical Access Hospital	85X
Skilled Nursing Facility	21X

Status Codes

- Admission Status Codes
- Required on UB to explain how patient came to the visit
  - 1 - Emergency
  - 2 - Urgent
  - 3 - Elective
- Discharge Status Code
  - Used to report how or why patient ended visit
  - 01 - Discharged to home or self care
  - 02 - Discharged/transferred to short-term general hospital for Inpatient Care
  - 94 - Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

UB-04 Condition Codes

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- Used to adjust claims
  - D0 – Change Date of Service
  - D7 – Change Medicare from primary to secondary
  - D8 – Change Medicare from secondary to primary
  - D5 – Cancel a claim to correct the Medicare ID or provider number (only applicable on a xx8 type of bill)
  - D9 – Used for adjustments not described in any other condition codes. Remarks are required when using the D9 condition code to make a change.
- Condition Code and Type of Bill must describe adjustment type and reason
  - Type of Bill - Fourth digit of Type of Bill must represent bill frequency
    - 7 – Adjustment claim
    - 8 – Cancel claim
    - 0 – No Payment

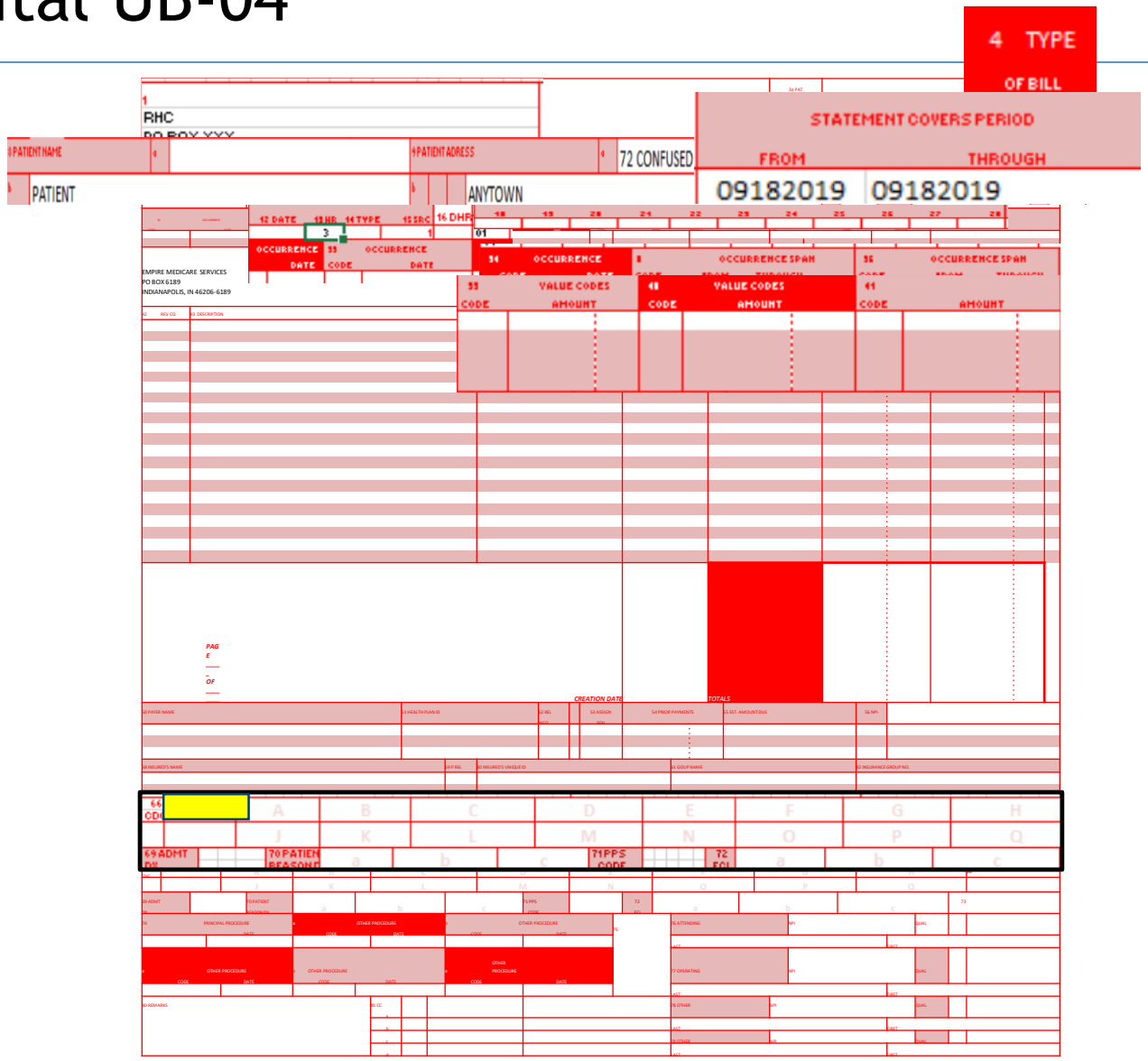
Value Codes

- Required when a value is required
- 14 - No-Fault, Including Auto/Other Insurance: That portion of a higher priority no-fault insurance payment, including auto/other insurance, made on behalf of a Medicare beneficiary, that the provider is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field to claim conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment.
- 44 - Amount Provider Agreed to Accept From Primary Payer When this Amount is Less than Charges but Higher than Payment Received (MSP due)
- 48 - Hemoglobin Reading: The latest hemoglobin reading taken during this billing cycle
- 49 - Hematocrit Reading: The latest hematocrit reading taken during this billing cycle

UB-04 Diagnosis Coding

- Diagnoses are not specific to a single line, but apply to the entire claim
- Must complete FL 70 Diagnosis reason for visit
- Additional diagnoses must be sequenced

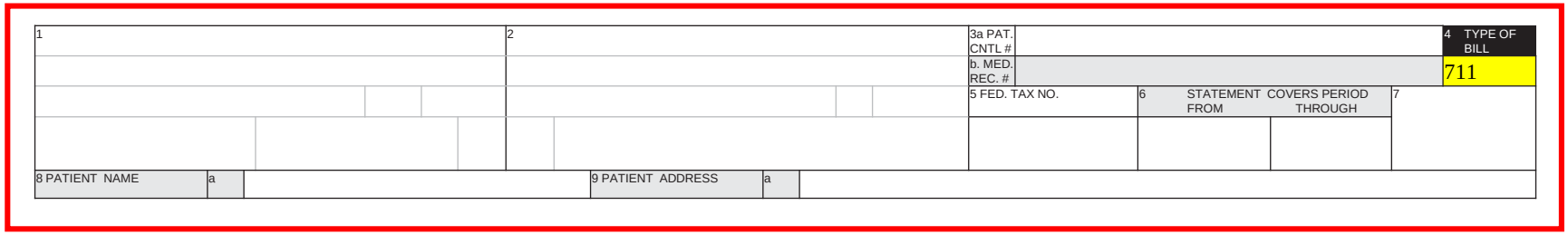
Hospital UB-04



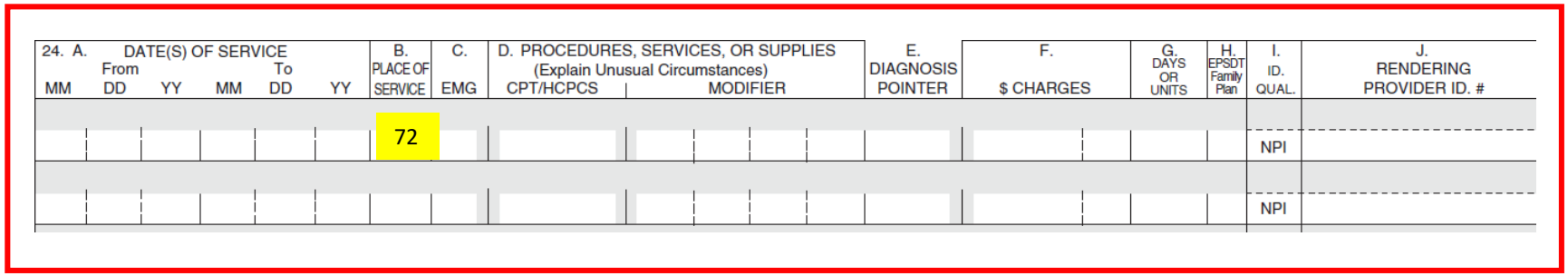
Type of Bill vs. Place of Service

UB Type of Bill 711	1500 Place of Service
711 - RHC	72 RHC
131 Outpatient Acute Hospital	22 Outpatient Hospital
851 – Critical Access Hospital	21 Inpatient Hospital

UB 04



1500 Form



Claim Form Examples

1. Point of Care Testing Performed and Resulted in RHC

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Point of care testing performed and resulted in RHC

Charges file to CAH service area on hospital billing for provider-based

Bill on a hospital UB-04

Coinsurance and deductible do not apply to outpatient labs in CAH

1. Point of Care Testing Performed and Resulted in RHC

- Example – Nurse only visit for PTT – No billable service performed in RHC
- Charges filed to CAH service area on hospital billing type of Bill 851
- Bill POC testing on hospital UB-04
- Coinsurance and deductible apply

HCPCS	CHARGES	PAYMENT	CO-INSURANCE
85730	$14.00	80% of reasonable cost	No coinsurance or deductible on CAH outpatient labs

1. POC Testing Hospital Claim

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1		3a PAT CNTL#		4 TYPE OF BILL
CAH PO BOX	2	B MED REC #		0851
		5 FED TAX NO	STATEMENT COVERS PERIOD FROM THROUGH	
			09182019 09182019	

8 PATIENT NAME		9 PATIENT ADRESS		
a		a	72 CONFUSED LANE	
b PATIENT		b ANYTOWN	c	d e

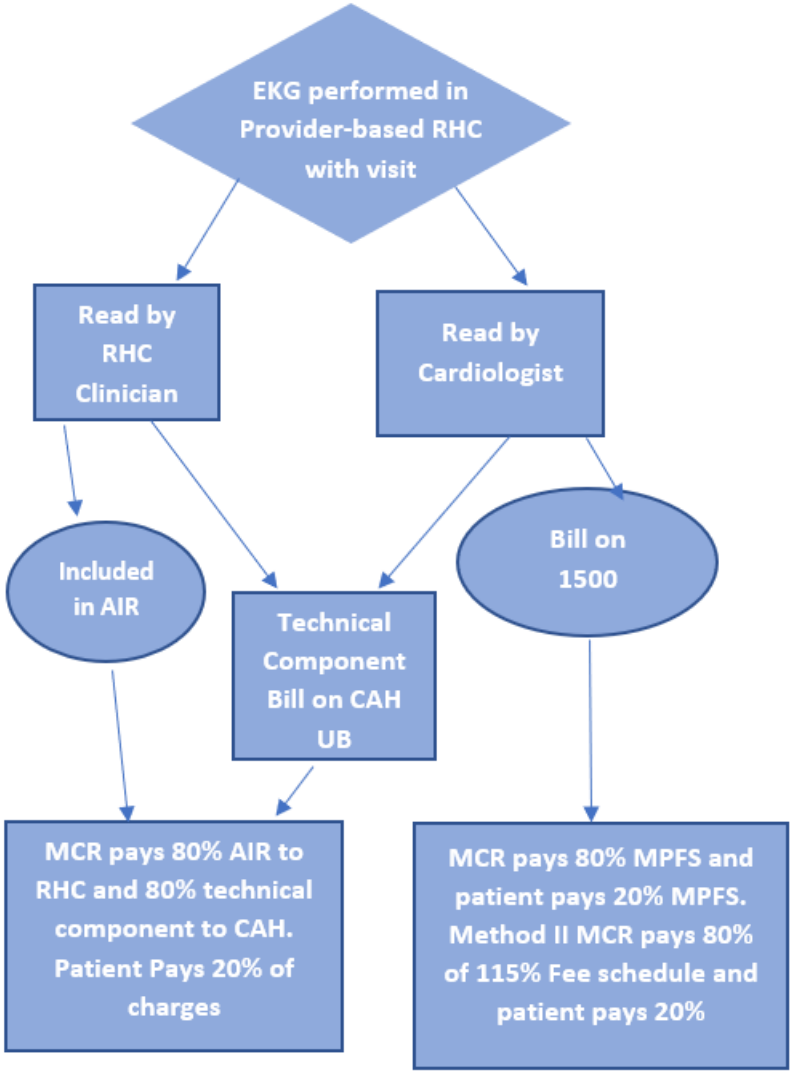
10 BIRTHDATE	11 SEX	12 ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
11241965	F		3		1		01													

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

MEDICARE MAC PO BOX		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 CODE	AMOUNT
	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
0301	PTT, PLASMA OR WHOLE BLOOD	85730	09182019	1	14.00		

EKG Performed



	Read by RHC Clinician	Read by MIB Cardiologist	Technical
Claim Type (form)	RHC UB-04	1500	CAH UB-04
Type of Bill (TOB) on UB-04 or Place of Service (POS) on 1500	TOB - 711	POS - 72	TOB - 851
HCPCS, Modifier	93010	93010	93005
Payment	Included in AIR (All inclusive rate)	80% MPFS (physician fee schedule)	80% reasonable cost
Coinsurance	20% of RHC charge	20% of MPFS	20% of charge

EKG Performed and Read by RHC Provider

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Performed at RHC

Reading included in visit

MCR pays AIR. Patient owes coinsurance based on charge

Provider-based technical component files to CAH service area for hospital billing on UB-04.

Self-Pay Balances will bill from hospital for technical and separate statement for RHC

EKG Performed and Read by RHC Provider

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RHC UB-04

1		3a PAT CNTL# REC #		4 TYPE OF BILL
RHC PO BOX	2	5 FED TAX NO	STATEMENT COVERS PERIOD FROM THROUGH	711
			09182019 09182019	

8 PATIENT NAME	a	9 PATIENT ADRESS	a	72 CONFUSED LANE
b PATIENT		b ANYTOWN	c	d e

10 BIRTHDATE	11 SEX	12 ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
11241965	F		3		1		01			

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

		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 CODE AMOUNT
MEDICARE MAC	a			
PO BOX	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
521	EST PATIENT VISIT LEVEL III	99213CG	9182019	1	125 00		
521	EKG	93005	9182019	1	100 00		

CAH UB-04

1		3a PAT CNTL# REC #		4 TYPE OF BILL
CAH PO BOX	2	5 FED TAX NO	STATEMENT COVERS PERIOD FROM THROUGH	0851
			09182019 09182019	

8 PATIENT NAME	a	9 PATIENT ADRESS	a	72 CONFUSED LANE
b PATIENT		b ANYTOWN	c	d e

10 BIRTHDATE	11 SEX	12 ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
11241965	F		3		1		01			

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

		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 CODE AMOUNT
MEDICARE MAC	a			
PO BOX	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
521	EKG	99213CG	09182019	1	125 00		

EKG Performed in RHC and Read by Non-RHC Cardiologist

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3 claims, RHC for visit, CAH for the technical component and Pro for reading

MCR pays 80% AIR for RHC visit 80% of CAH charge for technical component and 80% of MPFS for the cardiologist reading

Patient owes 20% of the total RHC charge, 20% of the total CAH charge and 20% of the MPFS for the cardiologist reading

RHC service and CAH technical component bill on UB-04s and reading bills on 1500

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1	2	3a PAT CNTL#	4 TYPE OF BILL
RHC PO BOX XXX		B MED REC #	0711
		5 FED TAX NO	STATEMENT COVERS PERIOD FROM 09182019 THROUGH 09182019

8 PATIENT NAME		9 PATIENT ADRESS				
b PATIENT		b ANYTOWN	c NY	d 13807	e	a 72 CONFUSED LANE

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
11241965	F		3		1		01			

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

		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
EMPIRE MEDICARE SERVICES PO BOX 6189 INDIANAPOLIS, IN 46206-6189	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
0521	EST PATIENT VISIT LEVEL III	99213CG	09182019	1	125.00		

1	2	3a PAT CNTL#	4 TYPE OF BILL
CAH PO BOX		B MED REC #	0851
		5 FED TAX NO	STATEMENT COVERS PERIOD FROM 09182019 THROUGH 09182019

8 PATIENT NAME		9 PATIENT ADRESS				
b PATIENT		b ANYTOWN	c NY	d 13807	e	a 72 CONFUSED LANE

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
11241965	F		3		1		01			

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

		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
EMPIRE MEDICARE SERVICES PO BOX 6189 INDIANAPOLIS, IN 46206-6189	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
730	EKG 12 LEAD TRACING ONLY	93005	09182019	1	125.00		

EKG with Visit Claim Forms

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HCFA - 1500

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												ICD Ind.		22. RESUBMISSION CODE		ORIGINAL REF. NO.			
A. I50.21			B.			C.			D.					23. PRIOR AUTHORIZATION NUMBER					
E.			F.			G.			H.										
I.			J.			K.			L.										

	24. A. DATES OF SERVICE						B.	C.	D.	PROCEDURES, SERVICES OR SUPPLIES		E.	F.	G.	H.	I.	J.
	FROM			TO			PLACE		(Explain Unusual Circumstances)			DIAGNOSIS		DAYS OR	EPSDT FAMILY	ID.	RENDERING
	MM	DD	YY	MM	DD	YY	OF	EMG	CPT/HCPCS	MODIFIER		POINTER	$ CHARGES	UNITS	PLAN	QUAL.	PROVIDER ID. #
1	9	18	19				72		93010	72		A	125 00			NPI	
2																	

RHC Sick Visit and Preventative Pelvic Exam Same Day

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- Deductible and co-insurance do not apply to preventative services
- Bill on RHC UB-04
- Report all charges on the line for qualifying “sick visit” with modifier CG
- Report preventative services on subsequent line
- Medicare will assess coinsurance/deductible on the total charges minus preventative med charges

Revenue Code	HCPCS	Modifier	Charges	Payment	Coinsurance
0521	99213	CG	$207.60	80% of AIR	20% non-preventative charges ($125.00)
0771	G0101		$82.60	Included in AIR	0.00

RHC Sick Visit and Preventative Pelvic Exam Same Day

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1	2	3a PAT CNTL#		4 TYPE OF BILL
RHC PO BOX XXX		REC #		0711
		5 FED TAX NO	STATEMENT COVERS PERIOD FROM	THROUGH
			09182019	09182019

8 PATIENT NAME	a	9 PATIENT ADRESS	a	72 CONFUSED LANE			
b PATIENT		b	ANYTOWN	c NY	d 13807	e	

10 BIRTHDATE	11 SEX	12 ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
11241965	F		3		1		01													

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

		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 CODE	AMOUNT
EMPIRE MEDICARE SERVICES	a						
PO BOX 6189	b						
INDIANAPOLIS, IN 46206-6189	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
0521	ICE OUTPATIENT 15 MIN	99213CG	09182019	1	207 60		
0771	PELVIC AND BREAST EXAM	G0101	09182019	1	82 60		

Example Non RHC Service

- Patient seen in a hospital for subsequent hospital visit
- Diagnosis acute systolic Congestive Heart Failure
- Medicare Method II – bill on UB
- Reimburses 115% Physician Fee Schedule
- Coinsurance and deductible applies

HCPCS	CHARGES	PAYMENT	CO-INSURANCE
99232	$175.00	80% of allowed amount	20% of allowed amount

Example Non RHC Service

UB-04 – Provider Based Method II

1		3a PAT CNTL#		4 TYPE OF BILL
LITTLE FALLS HOSPITAL PO BOX	2	REC #		0851

5 FED TAX NO	STATEMENT COVERS PERIOD FROM	THROUGH
	09182019	09182019

8 PATIENT NAME		9 PATIENT ADRESS					
a		a	72 CONFUSED LANE				
b PATIENT		b	ANYTOWN	c NY	d 13807	e	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
11241965	F		3		1		01	D7												

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

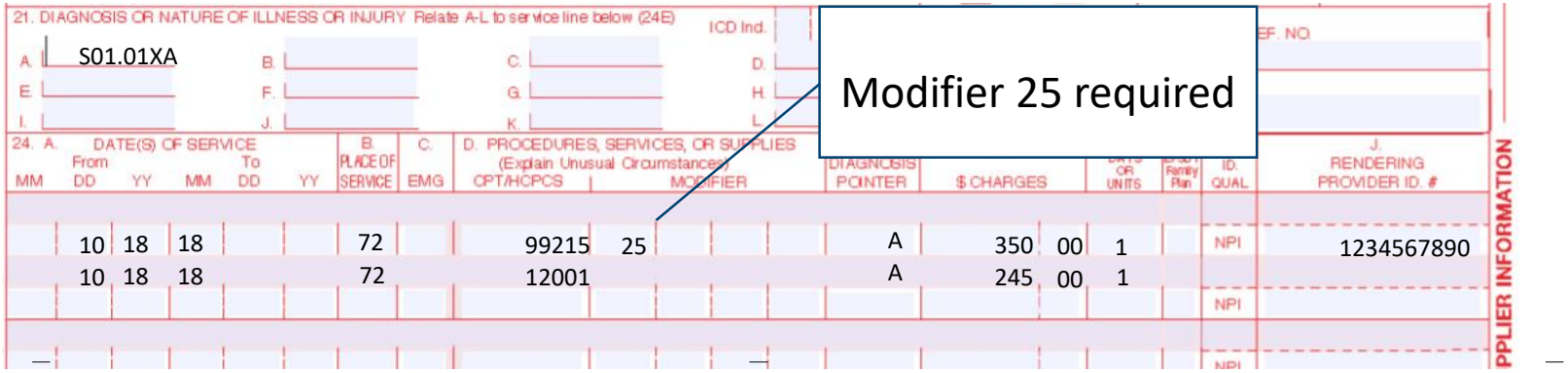
		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	AMOUNT
EMPIRE MEDICARE SERVICES	a						
PO BOX 6189	b						
INDIANAPOLIS, IN 46206-6189	c						
	d						

42 REV CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES	49
0987	SUBSEQUEBT HOSPITAL VISIT	99232	09182019	1	175 00		

RHC Clinic Visit Commercial Vs. Medicare

STROUDWATER Revenue Cycle Solutions

Commercial Insurance:



Medicare

1
RHC
PO BOX XXX

2

3a PAT CNTL#

4 TYPE OF BILL 0711

B MED REC #

5 FED TAX NO

STATEMENT COVERS PERIOD FROM 09182019 THROUGH 09182019

8 PATIENT NAME a PATIENT b

9 PATIENT ADRESS a 72 CONFUSED LANE b ANYTOWN c NY d 13807 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
11241965	F		3		1		01			

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

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 CODE AMOUNT

EMPIRE MEDICARE SERVICES
PO BOX 6189
INDIANAPOLIS, IN 46206-6189

Use CG modifier

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	ICE OUTPATIENT 15 MIN	99213	09182019	1	584 00		
0521	REPR SUPERF WND BODY ,2.5CM	12001	09182019	1	459 00		

Questions

References

- https://med.noridianmedicare.com/web/jea/topics/claim-submission/patient-status-codes
- https://med.noridianmedicare.com/web/jea/topics/claim-submission/condition-codes#claim-change
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
- https://learner.mlnlms.com/ContentDetails.aspx?id=74B97B9CBC7D49DAAA3FE271166054A7
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf
- https://healthplan.geisinger.org/documents/providers/ub04_instructions.pdf

Thank You

STROUDWATER
Revenue Cycle Solutions

- Stroudwater Revenue Cycle Solutions was established to help our clients navigate through uncertain times and financial stress. Increased denials, expanding regulatory guidelines and billing complexities have combined to challenge the financial footing of all providers.
- Our goal is to provide resources, advice and solutions that make sense and allow you to take action.
- We focus on foundational aspects which contribute to consistent gross revenue, facilitate representative net reimbursement and mitigate compliance concerns. Stroudwater Revenue Cycle Solutions helps our clients to build processes which ensure ownership and accountability within your revenue cycle while exceeding customer demands.
- **Contact us to see how we can help.**

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