

Rural Health Clinic, Overview & Guidelines

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Rural Health Clinic, Overview & Guidelines

This presentation is a global overview and will not cover all aspects, but will give a good overview.

Objectives

- Participants will understand the following:
 - RHC versus Non-RHC services
 - Billing guidelines for RHC services & non-RHC services
 - Components of E/M services, history, exam, MDM, time
 - Preventive services, coverage, billing guidelines
 - Documentation & billing requirements for RHC surgical procedures
 - Documentation & billing requirements for EKGs, radiology services
 - New 2013 updates

Rural Health Clinic

Encounters, Cost-based Reimbursement, RHC
Providers, RHC Place of Service, Claims
Submission Guidelines

Medicare Information RHCs

- Federal Register Section 491
- <http://www.cms.gov/Manuals/IOM/list.asp>
 - Policy Manual from CMS – specific attention to 100-2, Chpt. 13
 - Claims Processing Manual, 100-4, Chapter 9
 - NOTE: Policy Manual currently under revision

Sources of Information -Medicare

- <http://www.wpsmedicare.com/>
 - WPS Medicare

- <http://www.wpsmedicare.com/j5macpartb/policy/active/local/>
 - Coverage policies from WPS

Intro to RHCs

- Must be in a designated rural area according to the Census Bureau (approximately 3,950 nationwide)(Missouri has the most – 374)
- Must be in a designated shortage area
 - Ratio of primary care physicians to residents (1 per 3,500)
 - Number of residents 65 and older
 - Number of residents in which family income is below the poverty level (20%)
 - Infant mortality rate

RHC –the Concept

- Rural Health Clinic

- APPLICABLE TO MEDICARE & MEDICAID ONLY
 - Commercial payers do not see the RHC any differently than any other clinic – bill locator code “11” on the claim

Types of RHCs

- Free-standing-certified as an independent entity
 - Owned by group of physicians, nurse-practitioners, etc.
- Subject to regulations listed in certification requirements

Provider-Based

- Provider based-certified as part of a provider, e.g., a hospital
 - Physically located in close proximity of the provider where it is based, and both facilities serve the same patient population
 - Entity functions as a department of the provider
 - Operates under the same administrative personnel



Provider Based (cont.)

- Entity is held out to the public as part of the provider
- Entity and provider are financially integrated
- Entity reports its cost in the cost report of the provider where it is based

Key Certification Requirements for RHCs

- ❑ Clinic must be under the medical direction of a physician
- ❑ Must have a physician on staff who provides medical supervision at the clinic at least every two weeks
- ❑ Physician must be available by phone at all times
- ❑ **Must employ a non-physician practitioner who is on duty 50% of the time the clinic is open providing patient Services, off site visits do not count.**
- ❑ Must adhere to scope of licensure for State PA/NP supervision requirements state directed (each state has its own rules)

Key Certification Requirements (cont.)

- ❑ RHC must have written policies and procedures with physician involvement and be reviewed annually
- ❑ RHC must provide first response emergency care (even if a provider has not yet arrived)
- ❑ RHC must assure security of patient records (6 yrs) (must abide by state law if more stringent)
- ❑ RHC must have mechanism for an annual evaluation of the clinic's program

Key Certification Requirements (cont.)

- RHC must have arrangements to care for patients outside the clinic, e.g. hospital
- Must provide routine diagnostic tests:
 - Dipstick UA-81002
 - Occult Blood-82270 (requires 3 specimens)
 - Hematocrit/Hemoglobin-85014/85018
 - Fasting Blood Sugar-82962
 - Urine Pregnancy Test-81025
 - Obtain Cultures (no code)

Key Certification Requirements

- A physician, nurse practitioner, or physician's assistant must be available to furnish patient care services at all times during the clinic's regular hours of operation
 - **42 CFR Part 491.8**

 - **S&C 07-06**

Reimbursement Based on “Encounter” Cost

- Encounter
 - A face-to-face encounter (“visit”) between a physician or a mid-level during which a RHC/FQHC service is performed
 - Only one encounter allowed per day UNLESS subsequent to the first encounter the patient either suffers illness or injury requiring additional diagnosis or treatment

Cost Reimbursement

- Payment based on actual cost to perform services
- Cost divided by number of encounters to determine cost per encounter
- Cost report is filed
- Actual cost is compared to interim payment & adjustments are made

Encounter Reimbursement Limits

- **Government limits what an encounter may cost**
 - <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2595CP.pdf>
- **2013 upper limit rate is \$79.17 - 2012 was \$78.54; 2011 was \$78.07, 2010 - \$77.76, \$76.84 in 2009, \$75.63 2008, \$74.29 in 2007)**
- **NO cap if provider has less than 50 beds**

Services Subject to Co-Insurance and Deductible

- **All services subject to the Medicare coinsurance and deductible rules. The coinsurance is based on 20% of charges.**
 - **EXCEPTION: 2011 Preventive medicine services (most of them) waive co-insurance and deductibles**
- <https://www.cms.gov/transmittals/downloads/R864OTN.pdf>

Reimbursement (cont.)

- Payment is 80% of the established encounter rate
- Co-insurance=20% of billed RHC charges
 - Co-insurance not applicable to lab (2001)
 - Co-insurance and deductible not applicable to wellness covered services

- NOTE: A lab or TC of an x-ray or EKG are NOT RHC services and are not part of the 20% co-insurance
 - Lab has NO co-insurance
 - Part B Medicare co-insurance rules apply for the TC of x-rays and EKGS

Productivity Expectations

- Physicians
 - Government expectation- 4,200 encounters per year
- Mid-levels
 - Government expectation 2,100 encounters per year
 - NOTE: This is collectively determined, e.g. 1 FTE physician and 1 FTE NP together need 6,300 visits

Encounter Example RHC

- ❑ Total costs are \$275,000
- ❑ If physician saw 4,200 pt cost would be $\$275,000 / 4,200 = \65.47 per patient
- ❑ If physician saw 3,000 pts cost would be $\$275,000 / 3,000 = \91.67 (cap \$79.17)
- ❑ Payment would be limited to the cost if the provider had seen 4,200

Providers Who May Render Care for Reimbursement

Physicians, either M.D. or D.O.

- Non-physician practitioners included are:
 - Nurse practitioner
 - Physician's assistant
 - Certified midwife
 - Clinical social worker
 - Clinical nurse specialist
 - Clinical psychologist
- Visiting nurse (ONLY if so designated by CMS due to shortage)

Encounters with Auxillary Staff

- May attach services for up to 30 days
 - Bill with the date of the actual face-to-face encounter
- On line equal with revenue, use the date of the actual encounter
- May NOT submit a claim for a nurse service

- NOTE: Medicaid – check with the plan – each may be different concerning how to bill to the state plan

Encounters-No Face-to-Face

- Interpretation of results of tests or procedures which do **NOT** require a face-to-face contact between a physician/provider & the patient are **NOT** considered a reimbursable encounter
 - Reading an EKG or x-ray is **NOT** an encounter
 - Drawing blood is **NOT** an encounter

Encounters Face-to-Face But Not Medically Necessary

- Even if have face-to-face with a provider to
 - Draw blood
 - Render injection
 - Change a dressing
- AND it is not medically necessary for the NP, PA, or physician to see patient again for the condition, it may NOT be counted as encounter-MUST be INCIDENT TO service

Billing Two Encounters On Same Day of Service

- Only when patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment
 - Bill each service on the same UB-04 form
Medicare (new 2011) – two separate line items
 - Medicaid – check with each plan

New Billing Rules as of 2011

- When reporting multiple services on the same day that are unrelated, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon. (For RHC -59 not required)

- **Example B: Line**

□	Rev Code		DOS	Charges
□	1 0521	Office Visit	01/01/2012	150.00
□	2 0521	Office Visit	01/01/2012	450.00

- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1039.pdf>

3-Day Payment Window (Professional Services)

- *Q.32. Are rural health clinics (RHCs) or Federally qualified health centers (FQHCs) subject to the 3-day (or 1-day) payment window policy?*
- *A.32. No, the 3-day (or 1-day) payment window policy **does not apply** to RHCs or FQHCs. Medicare pays for RHC and FQHC services through an all-inclusive rate that incorporates payment for all covered items and services provided to a beneficiary on a single day by an RHC/FQHC physician or practitioner; and related services and supplies. It is not possible to distinguish within the all-inclusive rate the amount of the payment for any particular patient that represents the professional versus the technical portion. Given that the 3-day payment window policy does not include professional services, and that RHCs and FQHCs are paid an all-inclusive rate that includes payment for professional services, RHCs and FQHCs currently are not subject to the 3-day payment window policy.*
 - *<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/CR7502-FAQ.pdf>*

Place Of Service Covered

- Services **IN** the RHC
- Services performed away from the clinic such as nursing home rounds, home visits **IF**
 - Physician is an employee of the clinic/center
 - Compensation for physician includes agreement to render these services

Place Of Service Covered

- Covered services
 - Those rendered to the homeless
 - Those rendered to people in a shelter
 - May count these as encounters
 - May bill Medicare **IF** patient has coverage
- **NON**-covered services
 - Services rendered to those who are incarcerated
- Note: Services performed **IN** the hospital (except SNF) are **NOT** covered as RHC services (cost-reimb) and this time of the RHC physician must be carved out of the RHC cost report

“Incident to” Services & Supplies

- Covered if the service is:
 - An integral, although incidental, part of the physician’s plan of treatment
 - Of a type commonly furnished in a physician’s office
 - The ancillary personnel are employees of the physician (or both employees of the provider)
 - Furnished under DIRECT supervision of the ordering physician or mid-level

Incident to (cont.)

- ❑ NOT APPLICABLE TO NON-PHYSICIAN PRACTITIONERS IN A RHC
- ❑ Claims are submitted under the RHC provider number
- ❑ Non-physician practitioners in a RHC do not require direct supervision in order to see new patients and new conditions
 - Must be able to prove collaboration with a physician (document presence of physician at least once every two weeks)
 - Must adhere to scope of licensure of the state

Other Covered Services

- **Immunizations**
 - **Flu**
 - **Pneumonia**
- **Pays 100% for the serum & administration of the above**
 - **Neither co-insurance nor deductible apply**
- **NEVER put on claim-considered on cost report only (Medicare)**
- **Medicare Quick Reference Guide for immunizations**
- http://www.cms.hhs.gov/mlnproducts/downloads/qr_immun_bill.pdf

Immunizations (cont.)

- Hepatitis B-Patient must be at risk.
 - Billed as a part of the **RHC** claim (co-insurance and deductible no longer apply 2011)
 - Billed on a separate line item – dollar amount of the serum and the administration must **NOT** be included in the top encounter dollar amount
- Tetanus-Covered only with an injury and billed as a part of the RHC claim – co-insurance & deductible **ARE applicable**
- Immunoglobulin, rabies, etc., covered under the all inclusive rate when injury or direct exposure has occurred-bill as part of the RHC claim

Non-RHC Services (Still Covered by Medicare)

- ❑ TC of diagnostic tests such as x-rays/EKGs, Part B
- ❑ All laboratory tests (including the required RHC labs) performed on-site (bill as above)
- ❑ Screening mammography (bill to Part B)
- ❑ DME (bill to regional DME carrier)
- ❑ Ambulance services
- ❑ Services provided in a hospital setting (bill under physician's own provider # on a CMS 1500 form)

Non-RHC Services

Non-Covered Medicare Services

- ❑ Services not necessary or reasonable
- ❑ Routine foot care
- ❑ Hearing aids or eyeglasses
- ❑ Personal comfort items
- ❑ Cosmetic surgery
- ❑ Custodial care
- ❑ Preventive dental care including filling, removal or replacement of teeth
- ❑ Routine TB tests, hepatitis, tetanus

Evaluation & Management Services

**CPT -CURRENT PROCEDURAL TERMINOLOGY &
DOCUMENTATION SUPPORT**

ADDED Bonus, but not covered in this
section, go to page 76

Documentation- Why?

- Tracks physician's evaluation, plan, or treatment status over time
- Allows for communication to other providers
- Supports the services that are to be reimbursed by payers-thus the guidelines for documentation required for specific requests for reimbursement through code communication



<http://www.uhccommunityplan.com/assets/KS-Chapter16-PhysicianandFacilityStandardsandPolicies.pdf> United Healthcare Documentation Requirements, Chpt 16.8, pg 8,9

Documentation Timeliness

- WPS Medicare has stated “practitioners are expected to complete the documentation of services ‘during or as soon as practicable after it is provided in order to maintain an accurate medical record.’”
- May not submit a claim until there is documentation to support the service
- The 30-day rule may apply two ways
 - When the practitioner does not complete documentation within 30 days Medicare will not accept the documentation
 - When the documentation is completed but not signed within 30 days
- <http://www.wpsmedicare.com/j5macpartb/claims/submission/documentation-timelines.shtml>

CMS Defines Two Sets of Documentation Guidelines

- **1995 Guidelines** - generally more favorable to the physician
 - <http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf>

- **1997 Guidelines** – very specific in the exam component – requires a specific number of “bullets” (information about the system) to meet code criteria
 - <https://www.cms.gov/MLNProducts/Downloads/MASTER1.pdf>
- **Auditors must use whichever guidelines benefit the physician**

WPS Guide Concerning 1995 or 1997

- **Q17. Can the physician switch between the 1995 and 1997 E/M DGs within the body of one note? For example, could there be a documentation to support a 1997 history and a 1995 exam for the same service on the same note?**
- **A17. No, providers cannot use both the 1995 and the 1997 guidelines to document a single encounter. The 1995 and 1997 Documentation Guidelines offer only two differences. One is in the exam portion. The 1997 DG is much more extensive. Both documentation guidelines agree on the medical decision-making. The 1997 makes a small change in the History of Present Illness (HPI) section. The 1995 DG show an extended HPI is the documentation of 4 or more elements. The 1997 DG expand that statement to also include "or the status of at least 3 chronic or inactive conditions."**

CPT Coding

- Current Procedural Terminology, 4th Edition
cognitive
 - **Identifies all, procedural & material services provided to patients**
 - **Updated every year**

Components of E/M Documentation

- **7 components to E/M**
 - **History**
 - **Exam**
 - **Medical decision making**
 - **Counseling**
 - **Coordination of care**
 - **Nature of presenting problem**
 - **Time**

E/M KEY Components

- **3 KEY components**

- **History**

- **Exam**

- **Medical decision-making**

- **Per Medicare – “Medical necessity of a service is the overarching criteria for payment in addition to the CPT code requirements”**

TIME as Key Component

- **Exception: Time key component**
- **When over 50% of the face-to-face encounter is in spent in counseling or coordination of care, bill on TIME per average time defined by CPT**
- **Documentation requirement – must define**
 - **total time of visit and amount of**
 - **time spent in counseling/coordination of care,**
 - **nature of the counseling**

 - **Example: “visit time 40 minutes – spent 25 counseling the patient on his medications and the importance of compliance with treatment, consequences of non-compliance. Patient seems to understand importance.”**

TIME as Key Component

- **TIME – must be documented for time-based codes**
 - **Counseling dominates E/M**
 - **Discharge service – 99239**
 - **Critical care**

- **Exception: TIME is NOT pertinent to emergency department services unless the patient meets critical care criteria**

Chief Complaint Requirement

- ❑ **CHIEF COMPLAINT (CC)**
- ❑ The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.
- ❑ *!DG: The medical record should clearly reflect the chief complaint.*
- ❑ <http://www.cms.gov/MLNProducts/downloads/1995dg.pdf>

More Emphasis on Chief Complaint

- The chief complaint is the reason for the visit. Documentation for all E/M must include the chief complaint
- http://www.wpsmedicare.com/j5macpartb/resources/provider_types/2009_0526_emqahistory.shtml

1st Key Component

HISTORY-3 Elements

- **Documentation – chief complaint**
 - ***A chief complaint is indicated at all levels***
- **(1)-History of the presenting illness (HPI)-**
 - **Location – chest, arm, localized, diffuse**
 - **Quality- acute, sharp, crushing, improving**
 - **Severity- mild, immobilizing, scale 1 to 10**
 - **Duration- yesterday, 2 weeks, for years**
 - **Timing- off & on, constant, sporadic**
 - **Context- during exertion, after large meals**
 - **Modifying factors- applied heat, took OTC**
 - **Associated symptoms- also short of breath**
- **Physician must document the HPI**

Emphasis on HPI

- *The history portion refers to the subjective information obtained by the physician or ancillary staff. Although ancillary staff can perform the other parts of the history, staff cannot perform the HPI. Only the physician can perform the HPI.*
- http://www.wpsmedicare.com/j5macpartb/resources/provider_types/2009_0526_emqahistory.shtml

History – 2nd Element

- **(2)-Review of systems (ROS)** – *A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.*
- For purposes of ROS, the following systems are recognized:

Recognized Systems in ROS

- • 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

History – 3rd Element

- (3)-Past medical, family, social history
 - **Past Medical History** (the patient's past experiences with illnesses, operations, injuries and treatments);
 - Prior major illnesses and injuries
 - Prior operation
 - Current medications
 - Allergies (e.g. drug, food)
 - Age appropriate immunization status
 - Age appropriate feeding/dietary status

Past Social History

- **Past Social History** (an age appropriate review of past and current activities).
 - Marital status and/or living arrangements
 - Current employment
 - Occupation history
 - Use of drugs, alcohol, and tobacco
 - Level of education
 - Sexual history
 - Other relevant social factors

Past Family History

- **Past Family History** (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
 - WPS Medicare will not accept “noncontributory” or “negative”
 - “No known cardiac disease in parents” would be best or “unknown – patient is adopted” or “noncontributory due to the age of the patient”

History Level Dependent Upon How Much is Documented

- *Problem Focused*
 - 1-3 HPIs – chest pain x 3 days
- *Expanded Problem Focused*
 - 1-3 HPIs + 1 ROS – chest pain x 3 days. Also having abdominal pain
- *Detailed*
 - 4 HPIs, 2-9 ROS, 1 PFSH – chest pain off & on x 3 days, some SOB, also moderate abd pain, no nausea/vomiting, hx of anemia
 - *OR Status of 3 chronic conditions/illnesses (1997)*
- *Comprehensive*
 - 4 HPIs, 10 ROS, 2 PFSH (est pt) 3 PFSH new – severe chest pain for 3 hours with difficulty breathing, nausea/vomiting, blood in emesis, (must have 10 systems reviewed), hx of MI, smoker, father had MI at age 40.

Documentation Tips History

- Always define presenting problem
- “Follow up” must define condition
 - Avoid “here for med refills” as only HPI
- Document information pertinent to visit (OIG looking for same documentation across services) Caution: ROS – needs to correlate with rest of the note
- May reference info located elsewhere but must note date and location of the referenced information
- ROS- may define pertinent positive and negatives with “all other systems are reviewed and negative” OR “a 10/14-point ROS is negative”
- Avoid “all systems rev and negative” as the only ROS note -need system relating to presenting problem

Documentation Tips - of HX (cont.)

- Patient is comatose or incoherent – document attempt to obtain information and reason why unable to get hx components. NOTE: WPS Medicare expects the physician to get this information
- Avoid “see chart” for other information
- Avoid “see med list” when it is not up to date or documented
- Avoid “ROS reviewed and updated” without defining where the info is located
- Avoid “non-contributory”, “negative”, “unremarkable” in reference to PFSH
 - Acceptable “no known fm hx of cardiac disease” or “Negative for smoking”

2nd E/M Component – Exam 1995 Guidelines & 1997

- 1 body area or organ system=focused
 - 1997 1-5 bullets
- 2-7 body areas/organ systems briefly described=expanded
 - 1997 6-11 bullets
- 2-7 body areas/organ systems with at least one described in specific detail=detailed
 - 1997 12-17 bullets
- **8** or more body systems –comprehensive
 - 1997 2 bullets from 9 systems or all elements identified by a bullet from 9 organ systems or body areas

Exam Systems (1995)

- *For purposes of examination, the following **organ systems** are recognized:*
- • *Constitutional (e.g., vital signs, general appearance)*
- • *Eyes*
- • *Ears, nose, mouth and throat*
- • *Cardiovascular*
- • *Respiratory*
- • *Gastrointestinal*
- • *Genitourinary*
- • *Musculoskeletal*
- • *Skin*
- • *Neurologic*
- • *Psychiatric*
- • *Hematologic/lymphatic/immunologic*

Exam Body Areas (1995)

- *For purposes of examination, the following body areas are recognized:*
- • *Head, including the face*
- • *Neck*
- • *Chest, including breasts and axillae*
- • *Abdomen*
- • *Genitalia, groin, buttocks*
- • *Back, including spine*
- • *Each extremity*

Documentation Guidelines- Exam

- ❑ *DG: 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.*
- ❑ *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- ❑ *DG: 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).*
- ❑ *DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.*
- ❑ *<http://www.cms.gov/MLNProducts/downloads/1995dg.pdf>*

Documentation Tips- Exam

- Reference “GI” rather than “abdomen” especially when a template check system is utilized
- Reference “Lymph” system in describing the neck or may document each separately
- Reference “Musculoskeletal” rather than “back” or “extremities”
- Exam must include the system affected in the presenting problem
- Exam (except constitutional) must be performed by the physician – physician must reference vitals

3rd Component-E/M

Medical Decision Making

- 3 Elements to medical decision making
- **#1-Number of diagnoses & treatment options**
- **#2 Data ordered or reviewed**
- **#3-Risk of significant complications, morbidity and/or mortality**, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options
- (SEE TABLE of RISK)

Medical Decision Making – VERY Important to E/M Determination

- Medicare states that medical decision making is the overarching criteria for determining the level of E/M service.
- Medicare does not want to overpay for the services rendered and they do not want to underpay for the services that are rendered

Medical Decision Making (cont.)

- *Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services “unless” their presence significantly increases the complexity of the medical decision making.*

CPT 2011, page 9

Documentation for Medical Decision Making- Tips

- Assure that level of service selected meets medical necessity- MDM should be considered in selection of E/M
- Describe patients conditions to explain the complexity in coding high levels of service – think on paper



Determination of Level of Service

- ❑ What level of service was the history?
- ❑ What level of service was the exam?
- ❑ What level of service was the medical decision making? (2 of the 3 components of # of diagnoses, data, risk)

New vs. Established Patient

- New Patient-Patient has not been seen face-to-face for 3 years by provider or member of same specialty of same group
- Established patient-Patient has been seen by the provider or a member in the group within 3 years
 - Note: If a patient follows a provider to a new location, when they are seen in the new location they are “established” patients

Services Requiring Just Two of the Key Components

- These services require 2 components to meet or exceed the descriptor of the chosen CPT code
 - Established patient office visits
 - Subsequent hospital or SNF visits

Services Requiring Three of the Key Components

- These services require all 3 key components to meet or exceed the descriptor of the selected CPT code
 - New patient visits
 - Initial hospital visit
 - Initial SNF visit
 - ER visit
 - Consultation
 - Observation care

Consultations for Medicare Patients

- As of 2009 Medicare does not pay for consultations
- **Q6. Dr. A saw the patient in the ED and called in Dr. B for treatment. What does Dr. B bill?**
- A6. More than one physician may bill for an ED visit to the same patient during the same ED visit. Since Dr. B is called in to treat the patient, both physicians would bill an ED visit.
 - http://www.wpsmedicare.com/j5macpartb/resources/provider_types/2009_0713_emfacility.shtml

Transfer of Care

- *Transfer of Care – is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility ...before an initial evaluation*
 - *CPT 2013 Consultation section*

Patient Admitted from Office

- *Question 1: When the physician provides a direct admit from the office, can we bill an initial hospital visit even though the physician does not go to the hospital on that day?*
- *Answer: No. An initial hospital visit code is the first encounter with the patient as an inpatient in the hospital. Billing an initial hospital visit procedure code is not appropriate if the physician does not see the patient in the hospital. The physician would bill the office visit and then bill the initial visit code when he/she sees the patient in the hospital. If the physician sees the patient in the hospital on the same day as a visit in another site of service, only the initial hospital visit may be billed.*

■ http://www.wpsmedicare.com/j5macpartb/resources/provider_types/2009_0706_emfacility.shtml

RHC Office Encounter Same Day as Hospital Admission

- **From:** "Tanya.Hardiman@[WPSIC.com](mailto:Tanya.Hardiman@WPSIC.com)"
<Tanya.Hardiman@WPSIC.com>
To: Carolyn Duncan <rc_duncan@yahoo.com>
Sent: Wednesday, October 17, 2012 10:42 AM
Subject: Re: RHC visit same day as hospital visit

Carolyn,

We believe **both claims should be paid**. When you say you are not being reimbursed for both, how are you sending in the claims and which claim is being rejected? We are trying to see if this is a system issue and formulate how we will be addressing this question on the FAQ we are creating. Thanks!

Preventive Medicine

Per CPT, Medicare, Medicaid

Preventive Medicine Coverage Medicare

□ Entire list – see

- http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf (screening services)
- http://www.cms.hhs.gov/mlnproducts/downloads/qr_immun_bill.pdf (immunizations)
- http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf (IPPE)
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN90570_6.pdf (AWV)

Preventive Wellness Visit

□ CPT codes

- **99381-99387 Based on age for NEW patient**
- **99391-99397 – Based on age for ESTABLISHED patient**

□ Coverage:

- **Commercial – dependent upon patient contract**
- **Medicaid – Covered once a year for adults (check with the plan)**
- **EPSDT periodicity for 21 and under**
- **Medicare – CPT 99381-99397 NOT a covered service**

CPT Components to Preventive Medicine Services

- ❑ Age and gender appropriate history and examination
- ❑ Counseling/anticipatory guidance
- ❑ Risk factor reduction interventions
- ❑ Ordering of ancillary services: lab, radiology, other screening tests
- ❑ Immunization status age appropriate
- ❑ Instructions for follow up

Documentation Reason for Visit

- Reason for encounter should be for a wellness exam, routine check-up, well woman, or 6 month well child check
- It must be very clear per documentation – determines claim payment

Diagnosis Requirement

- Assessment-“V” code to represent wellness type
 - V70.0 General medical exam
 - V20.2 Well child health check
 - V72.31 Routine gynecological exam
- MUST have a wellness diagnosis to correlate with CPT 99381-99397 as PRIMARY diagnosis

Preventive Medicine and Incidental Finding

- ❑ IF during the preventive medicine exam a problem is encountered, but it does not need additional work-up, code the preventive medicine diagnosis first
- ❑ Code second the diagnosis to reflect the medical problem encountered
- ❑ Do NOT code an E/M as the first listed CPT code if the intent of the visit was for preventive care

Preventive Medicine with Significant Medical Treatment

- IF a significant problem is encountered during a preventive medicine visit the hx, exam, and medical decision making concerning the problem must be documented
- Commercial- Code BOTH the preventive medicine code & the E/M service
 - Attach modifier -25 to the E/M service
 - (Some payers may not recognize)
- Medicaid – Check with the plan

Preventive Medicine with Significant Medical Problem Medicare

- **IF perform non-covered physical & E/M, bill for both**
- **Subtract the covered service from the non-covered services – amount patient pays**
 - **Example:**
 - **99396 is \$100**
 - **E/M is \$60**
 - **Patient pays \$40**
- **http://www.wpsmedicare.com/j5macpartb/business/b_careout.pdf**

MEDICAID Preventive Care

- 99381-99397 – Used to report age appropriate preventive service to Medicaid
 - EPSDT (Early Periodic Screening, Diagnosis and Treatment)
 - EP modifier must be added to indicate a full screening was performed
 - NOTE: Check with each of the managed care Medicaid plans for guidelines

Medicaid Full EPSDT Documentation

- ❑ Must use either paper copy of the *Healthy Children and Youth (HCY) Screening Guide* and the *Lead Risk Assessment Guide* OR an electronic version of it as long as ALL components of the paper version are included
- ❑ Note, this may be different in your state, See notes from AFMC for more details

EPSDT (HCY) Documentation Requirements

- ALL components
 - Interval history
 - Unclothed physical exam
 - Anticipatory guidance
 - Lab/Immunizations
 - Lead assessment (6-72 months of age verbal, 12 & 24 months- blood lead)
 - Development personal – social and language
 - Fine motor/gross motor skills
 - Hearing
 - Vision
 - Dental

Medicare Coverage of Preventive Services

- ❑ Pneumococcal, influenza, and hepatitis B vaccine and administration;
- ❑ Screening mammography;
- ❑ Screening pap smear and screening pelvic exam;
- ❑ Prostate cancer screening tests;
- ❑ Colorectal cancer screening tests;
- ❑ Bone mass measurement;

Medicare Covered Preventive Services (Cont.)

- ❑ Screening for glaucoma; (optometrist or ophthalmologist)
- ❑ Cardiovascular screening blood tests;
- ❑ Diabetes screening tests;
- ❑ Ultrasound screening for abdominal aortic aneurysm (AAA); and
- ❑ HIV testing
- ❑ Tobacco cessation counseling
- ❑ Behavioral therapy for cardiovascular disease
- ❑ Counseling for alcohol misuse
- ❑ Screening for depression
- ❑ Behavioral Counseling for STDs with testing for the diseases
- ❑ Intensive behavioral therapy for obesity

E/M Preventive Services

- ❑ G0402 – IPPE (Welcome to Medicare)
- ❑ G0438 – AWV (Annual Wellness Visit)
- ❑ G0439 – Subsequent AWV
- ❑ G0101 – Well-woman exam
- ❑ G0447 – Obesity counseling (2012)
- ❑ G0444 – Depression counseling (2012)

IPPE Visit Reminder of Criteria

- G0402 – Initial Preventive Physical Exam
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf
- G0404 – EKG Technical Component
- G0405 – EKG Professional Component (not billable in a RHC)
- Very strict concerning the documentation
- <http://www.laoncologysociety.org/documents/clm104c12.pdf>
Medicare Claims Processing Manual Chapter 12, Section 30.6.1.1 page 36
- <http://www.aafp.org/fpm/2009/0100/fpm20090100p19-rt1.pdf> Encounter form developed for documentation of IPPE

Components to IPPE

- Initial Preventive Physical Examination components: (G0402) (Must be on the UB FL 44)
 - **Review of medical, family, and social hx** including illnesses, hospital stays, operations, allergies, injuries, treatment, meds, fm hx
 - **A list of providers and suppliers involved with caring** for the patient
 - Review of individual's **risk factors for depression**. Must use an approved screening instrument (suggest PHQ-2 instrument)
 - **Examination, ht, wt, BP, visual acuity, hearing impairment**, screen and other systems as appropriate
 - **Activities of daily living, fall risks, home safety**
 - Personalized **health advice as applicable** such as smoking cessation, physical activity, wt loss, nutrition
 - **Voluntary advance care planning**
 - **Handout - Plan for preventive work up**

AWV Medicare Preventive Services as of 2011

- Annual Wellness Visit (AWV) – G0438
 - Cannot be billed during first 12 months of Medicare eligibility- bill IPPE
 - Must be at least 11 months after IPPE
- Subsequent AWV – G0439
 - **MLN Matters® Number: MM7079**
- **Co-insurance and deductibles do NOT apply**
- Codes must go in FL 44 of the UB claim
- http://sitemaker.umich.edu/coding101/files/awn_and_ppps_cms_bulletin2010.12.pdf

Annual Wellness Visit – New as of 2011

- **G0438** – One time only benefit for Annual Wellness Visit
- *Acquire medical & family hx:*
 - Past medical and surgical hx
 - Use of or exposure to medications and supplements
 - Medical events in the patient's parents, siblings, or children that may be hereditary

Annual Wellness Visit

- *Review risk factors*

- Depression

- *Review functional ability & safety*

- Hearing impairment
- Ability to successfully perform activities of daily living
- Fall risk
- Home Safety

Annual Wellness Visit cont.

□ *Examination*

- Height, weight, BMI or waist circumference, BP & whatever the physician thinks
- List of current providers and suppliers that are regularly involved in providing medical care to the individual
- Detection of any cognitive impairment that the individual may have through direct observation and concerns raised by others

AWV (cont)

□ *Counsel Beneficiary*

- Establish a written screening schedule such as a check list for the next 5-10 years
- Determine patient's screening history
- List risk factors and conditions that need intervention
- Furnish advice and refer as appropriate
 - Weight loss
 - Physical activity
 - Smoking
 - Fall prevention
 - Nutrition

Subsequent Annual Wellness Visit

- **G0439** billed each year after the initial wellness visit – components same as initial AWV just updated
- See regs in Transmittal 2109, Dec 3, 2010.

Frequency Limitations

- ❑ IPPE – performed within the first 12 months of Medicare eligibility
- ❑ AWV – performed at least one year after the IPPE
- ❑ AWV subsequent visit – performed one year after initial AWV
- ❑ If patient had an IPPE, still bill the AWV initial visit
- ❑ No payment for AWV in first 12 months of Medicare eligibility – need IPPE

Medicare's Other Preventive Physical – Well Woman Exam

G0101-Allowed once every 2 years July 1, 2001,

allowed once every 2 years, CMS Transmittal 1823

- Must have 7 of these 11 components:
 - Inspection & palpation of breasts
 - Digital rectal exam including sphincter tone, presence of hemorrhoids, and rectal masses
 - Pelvic exam with or without collection of smears and cultures
 - External genitalia-general appearance, hair distribution, or lesions

G0101 (cont.)

- Urethral-masses, tenderness, scaring
- Bladder-fullness, masses, or tenderness
- Vagina-general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele
- Cervix-appearance, lesions or discharge
- Uterus-size, contour, position, mobility, tenderness, consistency, descent, or support
- Adnexa-masses, tenderness, organomegaly
- Anus and perineum
- Note: Breast exam now 1 of 11 components

G0101 (cont.)

- V72.31 – for a full GYN exam
- V76.2-for screening for malignant neoplasm, cervix
- V76.49-screening for malignant for patients who do not have a uterus or a cervix
- <http://www.cms.hhs.gov/Transmittals/downloads/R1541CP.pdf>

G0101 for High Risk

- May perform more than every 23 mo. IF
 - Early onset of sexual activity (under 16 yrs)
 - Multiple sex partners (five or more)
 - Hx of sexually transmitted disease
 - Fewer than 3 negative pap smears within the previous 7 years
 - DES-exposed daughters of women who took diethylstilbestrol (DES)
- Dx code-V15.89-personal Hx presenting hazards to health

New Medicare Covered Services – Depression Screening

- G0444 – (10/14/11) **Depression Screening** coverage for adults in the primary care setting
 - 15 minutes session – must document time
 - One session in a 12 month period
 - **NO coinsurance or deductible applicable**
 - Not separately payable with another encounter/visit on same day (part of encounter payment)
- http://www.integration.samhsa.gov/depression_screening.pdf

New Medicare Coverage for Obesity Behavioral Therapy

- G0447 – 11/29/11) Face-to-face behavioral counseling for *obesity*
 - BMI \geq 30 kg/m²
 - Dietary (nutritional) assessment; and
 - Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.
 - No co-insurance or deductible
 - <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253&>

Obesity Counseling 2012

- **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
- **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
- **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
- **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
- **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Intensive Behavioral Therapy for Cardiovascular Disease

- ❑ Intensive Behavioral Therapy (IBT) for cardiovascular disease (11/08/11)
- ❑ G0446 – 15 minutes face-to-face bi-annual – must be furnished by primary care physician
- ❑ **No co-insurance or deductible**
- ❑ Time **MUST** be documented in the encounter note

Counseling to Prevent Tobacco Use

- G0436 – Counseling 3-10 minutes
 - 2 attempts per year – each attempt includes 4 sessions – total 8 sessions year whether intermediate (3-10) or intensive (over 10)
- G0437 – Counseling greater than 10 minutes
 - Must document time
- **No co-insurance or deductible**

Counseling to Reduce Alcohol Abuse

- ❑ G0442 – Annual alcohol misuse screening, 15 minutes
- ❑ G0443 Brief face-to-face counseling for alcohol misuse 15 minutes (may do 4 times a year)
- ❑ **No co-insurance or deductible**
- ❑ Time **MUST** be documented

Sexually Transmitted Infections Screening and Counseling

- ❑ G0445 – High intensity behavioral counseling to prevent STI 30 minutes
- ❑ 2 sessions annually
- ❑ Time MUST be documented

Procedures & Other Services

Documentation Requirements
E/M & Procedure

Bonus, not covered in this session, jump to slide 128

National Correct Coding Initiative (NCCI)

- *If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.*
 - *<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/>*

Modifier 25 Example

- **May bill a separate E/M IF and only IF there is work above and beyond the normal pre-op service. Use -25 on E/M**
 - **E.g. Patient presents today with approximately 12 moles. Two of them bleed from time to time and both have changed in color. The physician evaluates the information, examines all of the moles and documents findings, and decides to remove the two giving problems. An E/M -25 and excision may be billed.**
 - **Evaluated on Wednesday and removed on Friday. May not bill visit on Friday**

Modifier 25 Example

- If there is work above and beyond that associated with the laceration repair, you may bill the E/M & the procedure
 - **E.g. Child has a bicycle accident striking his face on the pavement. He lacerates his chin. The physician probes for additional injuries associated with hitting the head on pavement as well as other injuries. A full neurological exam is performed. He/she then repairs the laceration.**

Documentation Lesion Removal

- ❑ **Location/area treated; size; activity of lesions, color, etc.**
- ❑ **Method of procedure (mini operative report) shave, excision, cryocautery, etc.**
- ❑ **Complications involved with the problem/adverse reaction/bleeding**
- ❑ **Wait until pathology is back to code**
- ❑ **Report size from margin to margin**
 - **Exception: shave removal – report size of lesion only**

NCCI Edits Pertaining to Lesions

- <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>
- **Biopsy of the lesion is included in the surgical removal of the lesion**
- **If repair is simple, it is included in the removal codes – if it is intermediate or complex, the repair may be billed in addition to the removal codes as long as the deficit is more than .5cm**
- **Debridement is included in the repair**
- **Note: An excisional biopsy references a “piece” of a lesion**
 - **Code 11100**

Documentation Laceration Repair

- Must define the repair procedure identifying simple, intermediate, or complex repair
 - **Simple –one layer closure**
 - **Intermediate- closure of subcutaneous layer and upper layer of skin**
 - **Complex- Extensive traumatic debridement, scar revision, more than layered closure**

Documentation of Laceration Repair

- ❑ Documentation must include LOCATION of the laceration, SIZE, and METHOD of repair,
- ❑ Steri-strips are a component of the E/M
- ❑ G0168 – adhesive of tissue – bill for Medicare
- ❑ Surgical repair to lacerations in the same part of the body are ADDED together to get the length of the laceration IF on the same body area (see CPT code defined) and same type (simple, intermediate, etc.)

Documentation Trigger Point Injections

- Trigger points are injections into the MUSCLE
- Dependent upon how many muscles injected (NOT dependent upon # of injections in a muscle)
 - 20552 if inject 1 or 2 muscles
 - 20553 if inject 3 or 4 muscles
- Bill for the serum (total units) injected
- NOTE: There is a LCD – assure have correct diagnosis to cover it
 - <http://www.wpsmedicare.com/j5macpartb/policy/active/index.shtml>

Documentation Joint Injections

- **Document a mini procedure note to define LOCATION, PROCEDURE (aspiration or injection)**
“The right knee was draped and prepped and a _____ needle was injected into the _____ of the knee. 80mg of DepoMedrol was injected. There was no bleeding-patient tolerated procedure well.
- **20600 aspiration OR injection small joint or bursa (fingers, toes)**
- **20605 aspiration OR injection intermediate joint or bursa (olecranon, wrist, elbow)**
- **20610 aspiration OR injection large joint or bursa (hip, shoulder, knee)**
- **20612 aspiration OR injection ganglion cysts**

Documentation Cerumen Impaction

- **69210 – Removal of cerumen- one of these must be present in the notes**
 - **Visual –cerumen impairs exam of portions of the auditory canal, tympanic membrane or middle ear**
 - **Qualitative- extremely hard, dry, irritative cerumen causing pain, or itching, or hearing loss, etc.**
 - **Inflammatory – associated with foul odor, infection or dermatitis**
 - **Quantitative – obstructive, copious cerumen that cannot be remove without magnification and multiple instrumentations requiring physician skills**

Documentation Cerumen Removal (cont.)

- Must be removed by the PHYSICIAN
- Must use an otoscope and instruments such as wax curettes or cup forceps and document what was used, the effort, time
- LAVAGE IS NOT BILLABLE whether performed by the nurse or the physician
 - *CPT Assistant, July, 2005, Page 14*

Interpretation & Report

- Must be similar to that prepared by a specialist in the field
- Must address findings, relevant clinical issues, and comparative data
- Considered to be a “review of data” which is a component of the medical decision making E/M if statements such as “fx of tibia” or “EKG is normal”
 - *Medicare Carrier’s Manual 15023*

Documentation for the Interpretation of an X-ray

- **Body of report should include:**
 - **Type of exam (e.g. A/P and lateral views of the chest)**
 - **Procedure and materials**
 - **Findings –precise anatomic and radiologic terminology**
 - **Clinical Issues**
 - **Comparative data**
 - **Impression**
 - *American College of Radiology: ACR Standard for Communication: Diagnostic Radiology*

Documentation of an EKG

- **EKGs should describe at least three of the following six elements:**
 - **Rate and rhythm**
 - **Axis**
 - **Intervals**
 - **ST segment changes**
 - **Comparison to prior tracings**
 - **Summary of clinical condition**
 - **Example: EKG-NSR, no ST changes, unchanged from prior EKG with no evidence of ischemia.**

EKG Report Determined by the Machine

- *A provider may use the computer-generated report as the basis of his/her interpretation and report of the test. However, a provider may only submit a claim for the professional component of this service when the situation meets certain qualifications. 1) There must be a notation of the physician's opinion of the computer decision - whether he/she agrees or disagrees. 2) If the physician disagrees with the computer decision or has additional information to supply, he/she must notate the disagreement or additional information. He/she can mark out or cross through the part he/she disagrees with, indicating the correct information. A common error seen in the computer-generated decision is that it indicates "RBBB" but the rhythm is actually a completely paced rhythm. We would expect to see something similar to "Disagree with RBBB. Completely paced rhythm with ventricular rate of 72; agree with rest." 3) The physician must sign his or her notation.*
- *http://www.wpsmedicare.com/j5macpartb/resources/provider_types/2010-1206-ekg-quest.shtml*

Transitional Care

- 99495 – Transitional Care Management Services
 - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
 - Medical decision making of at least moderate complexity during the service period
 - Face-to-face visit, within 14 calendar days of discharge

Transitional Care (cont)

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

Transitional Care RHC Visit

- The 99495 or 99496 MAY be billed as a RHC service with 0521 revenue center WHEN the **face-to-face visit occurs**
 - Will receive 1 encounter rate reimbursement
 - Attach all associated services to the face-to-face encounter

Telehealth Services

- Telehealth Services – covered in a RHC as the HOST site – the “**originating**” site
 - Billed on the UB 04 claim
 - May bill a face-to-face visit with a RHC provider on the same day as telehealth on the same claim
 - Paid an originating site facility fee
 - Billed with 0781 revenue code and Q3014 CPT in FL 44
- A RHC may not be a “distant site” which is the location of the practitioner rendering the telehealth communication

Key Element –Diagnosis Documentation

ICD-9 Diagnosis Guidelines

Bonus, not covered in this session.. Jump to page 137

ICD-9 Codes

- International Classification of Diseases-Ninth Edition (legislation requires ICD-10 by 2013)
- Guidelines found in the front of the ICD-9 coding book
- Identifies patient condition, illness, disease, syndrome or symptoms
- ICD-9 book divided in two parts:
 - **Alphabetic Index**
 - **Tabular list**

ICD-9 Coding Guide

- ❑ *For each encounter, an assessment, clinical impression, or diagnosis should be documented*
- ❑ **Code to highest level of specificity**
- ❑ **Avoid “suspect” “probable” “questionable”-list sign & symptoms for out-patient documents – perfectly appropriate to discuss thoughts on paper**
- ❑ *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.*

ICD-9 – Codes Guidelines (Out-patient)

- ❑ **Primary diagnosis must correlate with the reason for the encounter**
- ❑ **Primary dx should be acute problem of the day-not always most significant problem**
- ❑ **Secondary diagnosis-other problem treated or chronic problem affecting the treatment of the presenting illness**
- ❑ **Same diagnoses for the encounter should be included on the charge ticket for the claim**

Diagnoses for Diagnostic Orders

- For every test ordered there must be a diagnosis to support medical necessity that is *documented*
- Mandated by the Balanced Budget Act that diagnosis must be given at the time of the order
 - Follow NCDs
 - <http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx>
 - <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/downloads/manual201210.pdf> Follow LCDs
 - Follow LCDs
 - <http://www.wpsmedicare.com/j5macpartb/policy/active/local/>

Claim Submission RHC

UB-04 (CMS 1450) 5010 Format

RHC Claims Submission

- <https://www.cms.gov/transmittals/downloads/R1104CP.pdf>
 - Medicare instructions for filing a UB-04 claim form
- **Remember**-the RHC is only an RHC in the eyes of Medicare and Medicaid
- Bill Medicare services on a **UB-04** (CMS 1450)claim form
- Bill type 711
 - 7 means clinic
 - 1 means rural health
 - 1 means admit through discharge date

Additional Bill Types (Medicare)

- 710 = non-payment/zero claim (a claim with only noncovered charges)
 - Requires condition code 21
- 711 = Admit through discharge (original claim)
- 717 = Replacement of prior claim (adjustment)(requires a condition code to explain the reason)
- 718 = Void/cancel prior claim (cancellation)
 - Note: Both 717 and 718 must have the document control number from remittance advice

Revenue Codes as of July 1, 2006

- ❑ **0521 Clinic visit by beneficiary to the RHC**
 - ❑ **0522 Home visit by RHC practitioner**
 - ❑ **0524 Visit by RHC practitioner to a member in a covered Part A stay at a SNF**
 - ❑ **0525 Visit by RHC practitioner to a member in a SNF (not part A stay) , NF, ICF, or other residential facility**
 - ❑ **0527 RHC visiting nurse service to a beneficiary when in a home health shortage area**
 - ❑ **0528 Visit by RHC practitioner to other non RHC site (e.g. scene of accident)**
 - ❑ **0900 psychiatric visits**
 - ❑ If visit is to diagnosis or to treat medically should use 521
- Per Publication 100, Rev. 820, Issued:02-01-06, Effective: 07-01-06, Implementation: 07-03-06

Only One Other Revenue Code

- ❑ 0780 – Telehealth originating site facility fee is billed IN ADDITION to the 052X revenue code
- ❑ Must add Q3014 in FL 44 on the claim to indicate facility fee
- ❑ *Note-telehealth is NOT an RHC service. Use the Q3014 to report originating site facility fee

UB -04 Claims

- <http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf> MEDICARE
- <https://www.cms.gov/transmittals/downloads/R1104CP.pdf> Explains all the condition, value, occurrence, status codes needed on the claims



FL1-FL2-FL3 Provider & Patient Information (Red are required fields)

- ❑ FL1 Provider Name, city, state, and zip code, phone number (where service actually rendered) (required)
- ❑ FL2 Where payments to be sent
- ❑ FL3a Pt Control Number (Account Number) (required)
- ❑ FL3b Medical record number patient

FL4, FL5

- **FL 4 - TOB (required)**
 - First digit = 7 Clinic (type of facility)
 - Second digit = 1 Rural Health (bill classification)
 - Third digit = 1 admit thru discharge on same date (frequency of bill)

- **FL 5 – Federal Tax ID# (required)**

FL6-Statement Covers Period

- To report the beginning and ending dates of service for the entire period reflected on the bill. (NOT required)
 - For services rendered on a single day, both the “from” and “through” dates must be the same.
 - For RHC generally the same date except for “incident to” services.



FL 08-11 Patient Information

- ❑ FL 8 Patient name
- ❑ FL 9 Patient address
- ❑ FL 10 Patient birth date
- ❑ FL 11 Sex
- ❑ (All above required)

FL 12-14

- FL 12 – Admission date (do not use 5010)
- FL 14- Type of admission/visit (required)
 - 1 Emergency
 - 2 Urgent – patient seen first available time
 - 3 Elective – patient’s condition allowed adequate time to schedule visit

FL 15-17

- FL 15 –point of origin for admission (req)
 - 1(generally) patient self-referred
 - 5 patient came from ICF, SNF, ALF (use if physician doing NH visit)
 - 9 information is not available
- FL 17 – Status of patient at discharge (req)
 - 01 (generally) discharged to home or self-care
 - 03 discharged to a SNF
 - 04 discharged to assisted living or NH or independent care facility (ICF)

FL18-28 Condition Codes

(Sometimes)

- These codes are used to help determine patient eligibility and benefits and are used to administer primary or secondary insurance coverage. The most common are the following:
 - 02 Patient alleges work related
 - 07 Hospice pt being treated for non-hospice condition
 - 20 Patient request bill for non covered services
 - 21 Billing for Denial Notice (ABN issued)
 - 28 Pt and/or Spouse's EGHP is secondary
 - 29 Disabled Pt LGHP is secondary

FL31-34 Occurrence Codes

(sometimes)

- These codes are used to define a specific event relating to the bill that may affect payer processing. (e.g. liability & COB)
 - 05 Related to accident and there is no third party liability
 - 24 Date Insurance Denied (Use when filing Medicare secondary with date of primary EOB for deductible or denials)
 - 32 Used when ABN was issued

FL38-41

- FL 38 Address of where claim is being sent (not a required field)
- FL 39-41 Value Codes – MSP claims
 - 12 LGHP denied coverage – applying for conditional payment
 - 14 & 47 No fault or other liability insurance – applying to Medicare for conditional payment

FL42 (req) & 43 Revenue Codes and Descriptions

- ❑ Revenue Code (RC) that represents a specific service.
- ❑ 0521 Clinic visit by beneficiary to the RHC
- ❑ 0522 Home visit by RHC practitioner
- ❑ 0524 Visit by RHC practitioner to a member in a covered Part A stay at a SNF
- ❑ 0525 Visit by RHC practitioner to a member in a SNF (not part A stay) , NF, ICF, or other residential facility
- ❑ 0527 RHC visiting nurse service to a beneficiary when in a home health shortage area
- ❑ 0528 Visit by RHC practitioner to other non RHC site (e.g. scene of accident)
- ❑ 0900 psychiatric visits

FL 44 – HCPCS Codes

- **FL 44 – HCPCS code of the service/procedure provided.**
 - **(Not required for Medicare claims)**
 - **Exception: Preventive Medicine Services whose co-pay and deductible is waived (req)**
 - **“Bundled” services for RHC claims on line item with Rev 521 (Medicare) (except preventive services)**
 - **Applicable rev codes individually reported on UB to Medicaid- provider-based (req)**

FL 44 Medicaid Claim

- *Enter the CPT or HCPCS procedure code(s) and any applicable modifier.*
 - *If the service is a full or partial EPSDT/HCY screening, diagnosis code V20.2 must be shown as the primary dx in FL 67*
- Note: Medicaid makes this a required field

FLs 45-48 Revenue Dates, Units & Charges

- FL 45 Service Date (required)
- FL 46 Service Units (required)
- FL 47 Total Charges (required)

- FL48 – used only when filing claim for a denial (need condition code 20/21 and occurrence code 32)



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

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

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

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

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NONCOVERED 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

FLs 50-53 (all required)

- FL50 Payer name
 - Field A Primary Payer
 - Field B Secondary Payer
- Fl 51 Payer's Health Plan ID
- FL 52 Release of Information Certification Indicator
- FL53 Assignment of Benefits Certification Indicator
 - Y Yes-Benefits Assigned
 - N No-Benefits www.mwhc.net Not Assigned

FLs 56-62 (all required)

- FL 56 NPI or the Rural Health Clinic
- FL 57 – Provider ID of secondary payer
- FL 58 Insured's Name – Required
- FL 59 Patient's Relationship to Insured
 - Use 18 self
- FL60-62 Health Insurance Claim (HIC)-
Identification Number, or insurance number and
group number as applicable

FLs 64-81

- FL 64 Document Control Number used for an adjustment or cancel/void claim
- FL 66 Diagnosis codes applicable to the visit (list up to 9) (required)
- Fl 76 – Attending provider NPI last name, first name (required)
- FL 80 Remarks – additional information to communicate to payer
- FL 81CCb – Taxonomy code of RHC (RHC = 261QR1300X) (required)

CLAIM EXAMPLES

Wellness Visits

Claim Submission – Well Woman Medicare

- Medicare's descriptor is different:**
- G0101-Allowed once every 2 years as of July 1, 2001, HCFA Transmittal 1823, Feb. 2001 (must include G0101 in FL 44) separate line**
- If separate E/M list on TOP line item with 521 rev code**

Claim Submission – Well Woman Medicare (cont.)

- Q0091 –Preparation and conveyance of pap specimen to the lab (may bill for screening only paps but NOT for diagnostic) (must include Q0091 in FL 44 – separate line item**
- Line item of charges for E/M does NOT include the charge of preventive services that have waived co-insurance & deductible**

Instructions from Medicare

□ ***Basic RHC Billing for Preventive Services:***

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance and deductible. For example, if the total charge for the visit is \$150, and \$50 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on \$100 of the total charge.

□	Line	RevCode	HCPCS code	DOS	Charges
□	1	052X		01/01/2011	100.00
□	2	052X	Prev Service Code	01/01/2011	50.00

Example of Claim as 2011

FL 42	FL 43	FL 44	FL 45	FL 46	FL 47
0521	Limited OV		1/5/2011	1	\$ 70.00
	Well woman				
0521	exam	G0101	1/5/2011	1	\$ 70.00
	Prep of				
0521	specimen	Q0091	1/5/2011	1	\$ 40.00

MLN Matters Number: SE1039

- *The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate, coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. **Coinsurance and deductible are not applicable to the service line with the preventive service.***

Payment Exception-Additional Payment

- When an IPPE is performed in conjunction with an E/M, each will be billed on a separate line item. The G0402 will be needed in FL 44 for the IPPE....
- Separate payment for an encounter, in addition to the payment for IPPE will be made when they are performed on the same day.
- <http://www.cms.gov/MLNMArticles/downloads/MM6445.pdf>

Preventive Service & Treatment of Problem

- **IF** a problem encountered during a wellness visit is significant and is treated, bill both preventive medicine code and E/M code on separate line items (as discussed in previous slides)

Billing “Global” Services

- RHC Medicare
 - No global services exist
 - Bill each service for each day patient is seen
- Commercial insurance-global services must be tracked as encounters
 - Suggest 99024 (services rendered during a global period)
- If surgery performed in HOSPITAL by RHC physician
 - Add modifier -54 on CMS-1500 claim for the surgery

Billing OB Services

- ❑ Medicare patients - bill E/M that represents the service at time of each encounter plus any additional lab/service
- ❑ Bill the **delivery only code** (59409 or 59514 generally) for the delivery performed in the hospital to Medicare Part B & under the physician's own provider number
- ❑ Medicaid – check with each plan for billing guidelines

Billing Encounter + Lab

- Make the same entry for tracking charges for all payers
- For RHC
 - Medicare – provider based – bill all lab services under the **hospital's provider number**. This includes the lab services RHCs are required to perform for certification as a RHC
 - Must carve out associated costs for labs on the cost report

Flu & Pneumonia Shots

- ❑ **Do not send a claim for influenza or pneumonia (track on a log) considered on cost report (Medicare only)**
- ❑ **Log should include:**
 - **Beneficiary name**
 - **Beneficiary HIC#**
 - **Date of service**
 - **Type of injection received, e.g. influenza or pneumococcal**
 - May not count as visit if encounter for shot only
 - May not include \$ value of shots in visit
 - **Medicaid - Provider-based RHCS bill serum on pharmacy form at time of service**

Billing Immunizations

- Only medically necessary Hepatitis & Tetanus (Medicare – must have injury for tetanus) immunization payable under the encounter limitation in RHC
- NOTE: Co-insurance and deductibles **DO** apply (thus total charges all submitted under one line item combining all charges of the encounter under 0521) for **Tetanus** – use 90471 for the administration charge
- NOTE: Co-insurance and deductibles **DO NOT** apply for **Hepatitis** – bill as a separate line item on the UB. Bill administration with G0010 as separate line item on the UB.
 - (If only service is to receive the immunization, it is not billable as an encounter.

Billing Injections

- ❑ Must be attached to a face-to-face encounter (Medicare)
- ❑ \$ value of injection “collapses” into E/M code (Internally the actual HCPCS code should indicate the type of injection and \$ value)

Billing E/M & Procedure

- ❑ Document each service separately
- ❑ Report one line entry on claim with revenue code 521 and the dollar value of the E/M and procedure OR procedure only (billing guidelines for Medicare applicable in RHCs)
- ❑ May charge E/M for same diagnosis as the procedure **if** significant service above and beyond what is always performed for the procedure

Billing for X-rays and EKGs

- ❑ Medicare – the professional interpretation and report is rolled into the E/M service and billed on one line item under 0521
- ❑ The TC of the x-ray, e.g. 71020 TC is filed by the hospital. (part B if in a IRHC)
- ❑ The 93005 for the technical component of the EKG is filed by the hospital

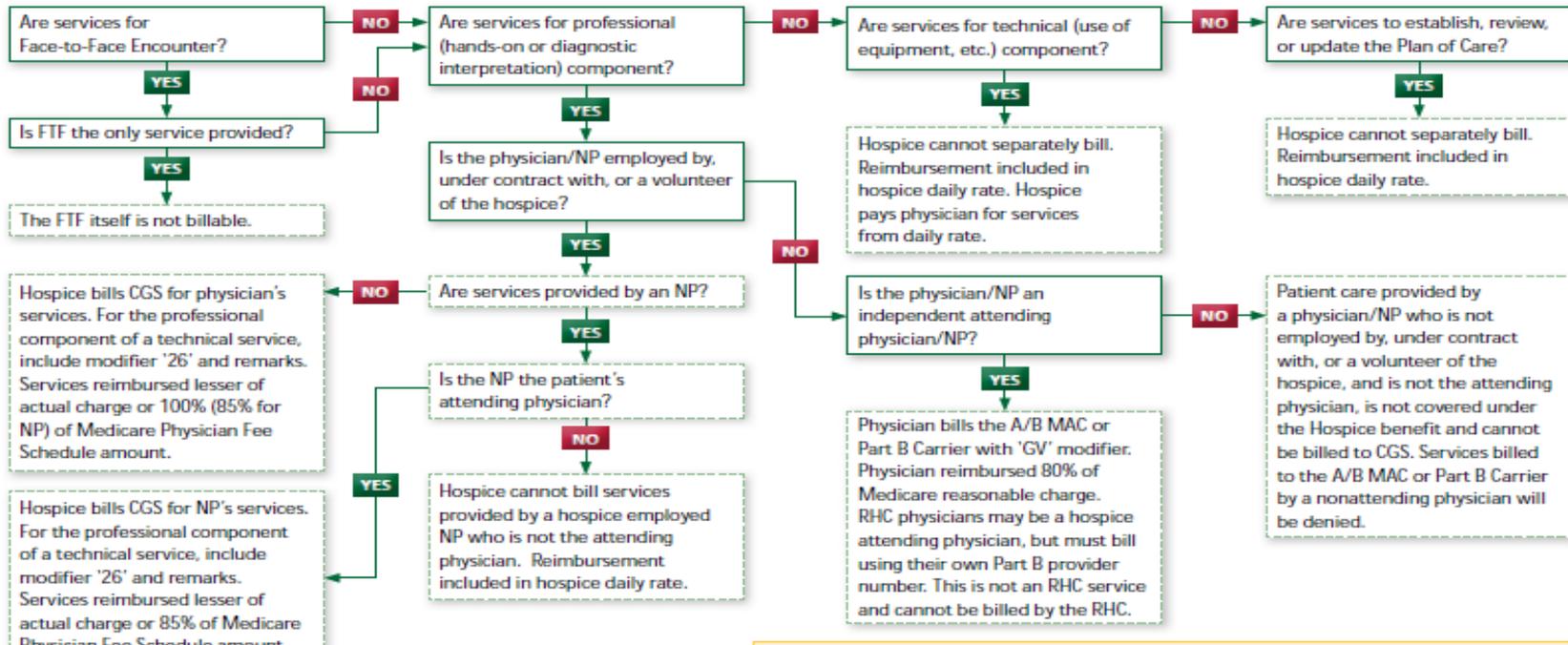
Hospice Patients Treated by RHC Physician/NP

- *Even though a beneficiary elects hospice coverage, he/she may designate and use an independent attending physician, who is not employed by nor receives compensation from the hospice for professional services furnished, in addition to the services of hospice-employed physicians. The professional services of an independent attending physician, who may be a nurse practitioner as defined in Chapter 9, that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered Medicare Part A hospice services.*
 - <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf>

Hospice and RHC Physician

http://www.cgsmedicare.com/hhh/education/materials/pdf/Physician_and_NP.pdf

Billing Hospice Physician and Nurse Practitioner (NP) Services (Related to Terminal Diagnosis)



RHC Attending Physician

Physician bills the A/B MAC or Part B Carrier with 'GV' modifier. Physician reimbursed 80% of Medicare reasonable charge. RHC physicians may be a hospice attending physician, but must bill using their own Part B provider number. This is not an RHC service and cannot be billed by the RHC.

Hospice (cont)

- Non-physician for hospice care and condition is non-hospice condition, physician is not “attending physician”
 - Condition code 07 is required
 - May bill as RHC claim
- IF non-hospice physician and condition IS related to hospice condition, BILL hospice
- IF non-hospice physician but designated as “attending physician” bill the carrier

Billing Non-Covered Services

Patient Request

- Patient asks that a non-covered service be submitted to Medicare
 - RHC – Bill type 710
 - Fill in FL 48 with total non-covered charges
 - Condition code 20 or 21
 - -20 patient requests to get a Medicare determination
 - -21 patient wants denial to submit to other insurance
 - Occurrence code 32

Posting RHC Payments

RHC Charge	Charge of total service submitted	\$110
Payment from patient	Deductible	\$0
Medicare pay rate	Determined from previous cost report	\$75
Medicare's net payment	\$75 less 20% co-insurance	\$60
Co-payment from pt/2nd ins	20% X total chg \$110	\$22
Total to be received all payers	\$60 + \$22	\$82
Medicare Adjustment	Diff of \$110 - \$82 is contractual adj	\$28

Posting Payment Greater Than Charge

RHC Charge	Charge of total service submitted	\$60
Payment from patient	Deductible	\$0
Medicare pay rate	Determined from previous cost report	\$75
Medicare's net payment	\$75 less 20% co-insurance	\$60
Co-payment from pt/2nd ins	20% X total chg \$60	\$12
Total to be received all payers	\$60 + \$12	\$72
Medicare Adjustment	Diff of \$60 - (\$72) is contractual adj	(\$12)

2013 Change

- Changes concerning drugs rendered as a component of the plan of care established by the physician
 - Must be billed by the physician
 - MLN Matters 7397 – *Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration “incident to” a physician service, such as refilling an implanted drug pump. These claims will be denied.*
 - *Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician’s office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered “incident to” a physician’s service and pharmacies may not bill Medicare Part B under the “incident to” provision.*
 - <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7397.pdf>
 - **Check with WPS Medicare for their interpretation before making changes**

Mental Health

- Limit for mental health for Medicare has been 62.5% since inception of Part B program.

New limits began 1/1/2010

- Jan 1, 2010 - Dec 31-2011 68.75%
- Jan 1, 2012 – Dec 31, 2012 75%
- Jan 1, 2013 – Dec 31- 2013 81.25%
- Jan 1, 2014 – forward 100%

New Mental Health Codes 2013- Diagnostic Evaluation

- 90791 – Psychiatric diagnostic evaluation performed by a non-physician (no medical services)
- 90792- Psychiatric diagnostic evaluation performed by a physician

New Psychotherapy Codes

- ❑ 90832 – 30 minutes (16-37 minutes)
- ❑ 90834 – 45 minutes (38-54 minutes)
- ❑ 90837 – 60 minutes (Not recognized by MO HealthNET)

- ❑ Time must be documented. *If the time is more than half the time of the code, the code may be used.*

- ❑ May NOT report psychotherapy of less than 16 minutes
- ❑ RHC regulations would require the patient to be present for the service

New ADD ON Codes when Psychotherapy is Added to E/M

- 90833 – 30 minutes of additional psychotherapy with E/M (code E/M separately)
- 90836 – 45 minutes of additional psychotherapy with E/M (code E/M separately)
- 90838 – 60 minutes of additional psychotherapy with E/M (code E/M separately)

- NOTE: Description has changed – now states time spent with the “*patient and/or family member*” – before stated “*with patient*”



New Crisis Codes

- 90839 – Psychotherapy for a patient in crisis first 60 minutes
- 90840 – add on code for each additional 30 minutes

Interactive Psychotherapy

- 90785 – interactive psychotherapy
 - Use as an add on code with psychiatric evaluation, the psychotherapy and psychotherapy add-on codes

Psychiatric Services Diagnostic Crosswalk

(American Academy of Child & Adolescent Psychiatry)



www.psychiatry.org

Psychiatric Services 2012 to 2013 Crosswalk

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY
WWW.AACAP.ORG

2012			2013		
Service	CPT Code	2013 Status	Service	CPT Code	Report with interactive complexity (+90785)
Diagnostic					
Diagnostic interview examination	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate
			Diagnostic evaluation with medical	90792	
Interactive diagnostic interview examination	90802	DELETED	Diagnostic evaluation (no medical)	90791	Yes
			Diagnostic evaluation with medical	90792	

Psychotherapy 2013 Crosswalk

(American Academy of Child and Adolescent Psychiatry)

Psychotherapy

Individual psychotherapy 20-30 min	90804, 90816	DELETED	Psychotherapy 30 (16-37*) min	90832	When appropriate
45-50 min	90806, 90818		45 (38-52*) min	90834	
75-80 min	90808, 90821		60 (53+*) min	90837	
Interactive individual psychotherapy 20-30 min	90810, 90823	DELETED	30 (16-37*) min	90832	Yes
45-50 min	90812, 90826		45 (38-52*) min	90834	
75-80 min	90814, 90828		60 (53+*) min	90837	

Psychotherapy with E/M Crosswalk

(American Academy of Child and Adolescent Psychiatry)

Psychotherapy with E/M (there is no one-to-one correspondence)					
Individual psychotherapy with E/M, 20-30 min	90805, 90817	DELETED	E/M plus psychotherapy add-on	E/M code (selected using key components, <i>not</i> time) and one of:	When appropriate
45-50 min	90807, 90819			+90833 30 (16-37*) min	
75-80 min	90809, 90822			+90836 45 (38-52*) min	
Interactive individual psychotherapy with E/M 20-30 min	90811, 90824	DELETED		+90838 60 (53+*) min	Yes
45-50 min	90813, 90827				
75-80 min	90815, 90829				

Psychotherapy Other Codes Crosswalk

(American Academy of Child and Adolescent Psychiatry)

Other Psychotherapy

(None)			Psychotherapy for crisis	90839, +90840	No
Family psychotherapy	90846, 90847, 90849	RETAINED	Family psychotherapy	90846, 90847, 90849	No
Group psychotherapy	90853	RETAINED	Group psychotherapy	90853	When appropriate
Interactive group psychotherapy	90857	DELETED			Yes

Other Psychiatric Services

Pharmacologic management	90862	DELETED	E/M	E/M code	No
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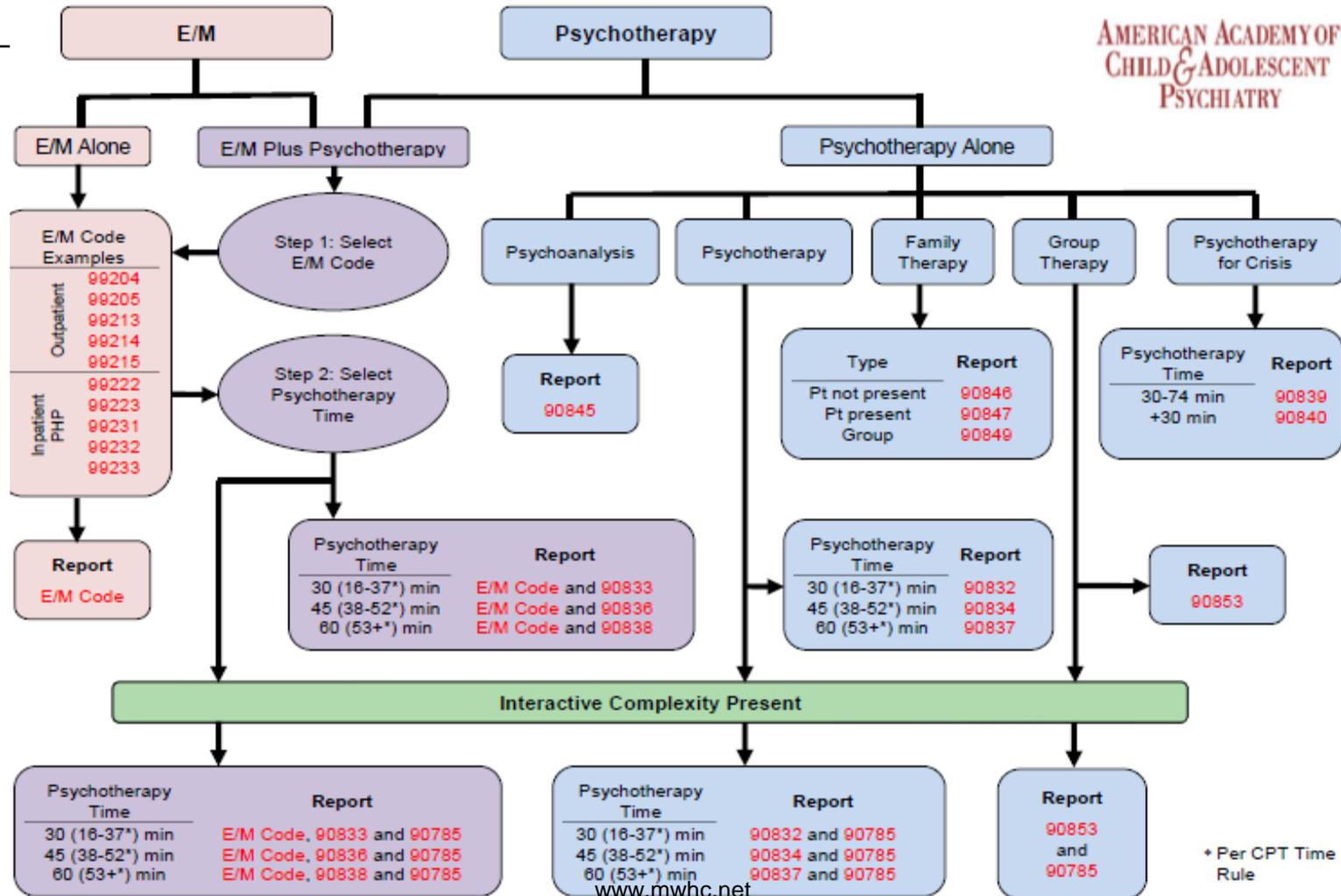
*Per CPT Time Rule

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www.hwws.net

E/M and Psychotherapy Coding Algorithm

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Documentation Templates

- <http://www.psych.org/practice/managing-a-practice/cpt-changes-2013/e-and-m-documentation-templates> from the American Psychiatric Association
- Note: Check with each of the Medicaid plans to determine what codes each recognizes

Upcoming 2014

- ICD-10 as of October 1, 2014
 - Assure software can accept 7 digits
 - Assure clearinghouse is ready
 - Begin NOW with discussion with providers
 - Take top 50 diagnosis codes currently billed by each provider
 - Define 2 or 3 each week with what the ICD-9 is now and what documentation will be required to report it in ICD-10
 - Budget for monies to devote to training staff and providers



Remember

- ❑ The patient's healthcare is priority
- ❑ The documentation to support everything that was billed is priority
- ❑ The success of the clinic depends on you!

References

- ★ UB04 Claim form screen print – Janet Lytton NARHC Technical Assistance Conference Call Handout 2/2/12
- CMS Internet Only Manual (IOM), Pub 100-04 Medicare Claims Processing, Chpt 9
- CMS (IOM) 100-2 Benefit Policy Manual Chpt. 13
- Websites as indicated in presentation
- American Academy of Child & Adolescent Psychiatry
- American Psychiatric Association
- Medicare MedLearn Matters credited in presentation
- Medicare Transmittals (referenced in presentation)
- WPS Medicare website as referenced



Thank You!

Questions or Comments?

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Please visit our web site at www.mwhc.net

This is a new site as of March 13, 2013 and has lots of resources and links. Visit us soon and tell us what you think. Sign up for our newsletters.



Thank You!

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If you would like to see a more in-depth presentation on billing for Certified Rural Health Clinics, presented in Arkansas, please contact me. We would be interested in affordable training and other needs you may have.

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