WEBINAR FOLLOW-UP QUESTIONS

Thank you for attending our webinar on March 9, 2016. In follow-up to that webinar, we have compiled the following summary of all attendee questions and answers received. Pertinent references have been provided if applicable.

ADVANCED CARE PLANNING (ACP)

1. If you furnish an evaluation and management (E/M) service on the same date as Advanced Care Planning (99497), do you report one encounter or two for the cost report?

   This would be counted as one encounter if both services are provided on the same date of service by the same provider.

2. How often can ACP be billed?

   CMS has not indicated how frequently ACP may be billed or covered.

3. Can ACP be performed/billed by an LCSW in a setting other than RHC?

   CMS has not excluded LCSWs from the list of eligible providers of ACP.

4. What if a physician is discussing ACP during hospital rounds? Can we bill for that in that setting?

   Yes. ACP may be performed in any setting. CPT code 99497 would be listed on the same CMS-1500 claim form as the other hospital professional service, i.e., subsequent hospital care. Documentation in the hospital medical record would need both services. A fee schedule payment would be received for both services.

RHC DETAILED BILLING

5. Do the new UB-04 billing rules go into effect for all claims submission prior to April 1 or only for claims with date of service April 1?

   The new billing criteria go into effect for claims with a date of service on and after April 1, 2016.

   Prior to April 1, 2016, the current billing criteria are still in effect. This billing change will impact only primary Medicare.

6. Will the new UB-04 billing rules apply to Medicare Advantage plans?

   No. The rules only apply to primary Medicare.

   We have provided some of the common revenue codes for procedures and supplies. A link to the Noridian Healthcare Solutions list of 2016 revenue codes has been provided for your reference.

   https://med.noridianmedicare.com/web/jea/topics/claim-submission/revenue-codes
RURAL HEALTH REIMBURSEMENT OPPORTUNITIES & UB-04 BILLING CHANGES FOR 2016

Revenue Code Service/Supply

- 0636 Injectable Drugs requiring detailed coding
- 0361 Minor Surgery
- 0761 Treatment Room
- 0521 Therapeutic Drug Administration (non-chemo)
- 0771 Vaccine Administration
- 0412 Inhalation/breathing treatments
- 0300 Laboratory blood draws/fingersticks
- 0521 Professional interpretation/diagnostic testing

7. **CPT procedure codes for joint injection and lesion removal are NOT listed as qualifying visits, so a procedure-only encounter will not meet criteria as a billable encounter?**

   Effective March 24, 2016, CMS released an update to the initial instruction and added some common, medically necessary in-office procedure codes to the list of “qualifying visits” eligible for encounter rate payment if performed as the sole, face-to-face service. This is not an all-inclusive list, so there will still be some “procedure-only” encounters that will be ineligible for encounter payment. Although the new instruction is effective April 1, 2016, payment will not go into effect until October 1, 2016, to allow CMS time to update their system. CMS has recommended holding procedure-only claims until October 1, 2016. Not all codes are on the list, and RHCs will need to evaluate what services will be eligible at this time and which ones won’t be eligible for payment and will need to be placed to allowable cost. The NARHC has compiled a list of additional service codes that are frequently performed and has submitted that information to CMS for consideration.

8. **Procedure 36415—I have been informed that you can’t bill to Medicare.**

   Per Medicare Benefit Policy Manual, Chapter 13, a blood draw, i.e., 36415, is considered as a professional service versus laboratory service in the RHC setting. If the blood draw is ordered and performed during a medically necessary, face-to-face encounter with a physician or non-physician practitioner, the CPT code and charge are listed separately on the clinic UB-04 and the charge rolled into the total charges. If performed outside of a medically necessary, face-to-face encounter, it is considered an incident to nurse-only service and not submitted on a separate UB-04. Rather, the cost is captured on the annual cost report.
9. Injections—if patient brings own medication with them to be administered, is the patient responsible for the administration or will Medicare pay for that? Example: patient brings Zostavax to be administered or if patient receives a TDAP and signs ABN that they will be responsible, will Medicare pay for the admin or should patient be responsible for admin also?

If the service is performed during a “nurse-only” visit, no claim is generated for Medicare or Medicaid. The cost of the administration is captured on the annual cost report. There is no charge from the RHC for the drug/medication if the patient brings the drug/medication with them. If this is a usually self-administrable medication, Medicare will not cover the expense, even if administered during a medically necessary, face-to-face visit with the physician or non-physician practitioner (for evaluation of other conditions or problems). NOTE: Some medications, such as Zostavax, may be covered under the patient's Part D pharmacy coverage and would be billed accordingly. Under Medicare coverage policies, administration of tetanus is not covered unless there is medical necessity. Therefore, the charge for both the tetanus vaccine and administration is patient responsibility.

10. Should different revenue codes be used for services other than an E/M code, or can we list 521 for everything? Under the new detailed billing guidance, different revenue codes will be listed for services furnished in addition to an evaluation and management service, mental health service or telehealth.

Please refer to answer No. 4 for additional information.

11. Can we still hold an initial claim and add a “nurse-only” drug/vaccine administration charge to the total charges if performed prior to or within 30 days of that encounter service?

Yes.

12. Will information be released to attendees if CMS changes the rules applicable to “procedure-only” encounter?

CMS released new instruction on March 24, 2016. CMS has added to the list of “qualifying visits” to include an initial selection of common, in-office procedures. This list is not all-inclusive, although the industry is compiling a list of codes to submit to CMS for consideration. Links to the updated instruction are provided below.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHCQualifying-Visit-List.pdf (Updated 3/24/16)

13. Do you use modifier 59 on all claims that have two QVLs that can be paid at the AIR, or is it specifically for two visits that occurred on the same day for different diagnosis?

CMS MLN Matters MM9269 (Revised March 23, 2016) states, “Billing for Multiple Visits on the Same Day – The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.”

14. For the procedure-only visits, can we bill them knowing they are not payable? But because on the cost report they meet the definition of a face-to-face with an eligible provider where decision making takes place, would they count as visits on the cost report?

Under the current CMS instruction, if the patient presents for a procedure-only visit and the service performed does not meet one of the CPT procedure codes listed as a “qualifying visit,” the visit is not eligible for billing to Part A and would not be counted on the annual cost report. The cost of performing the service would be eligible for inclusion in the allowable cost calculations on the annual cost report.

15. So this new billing process will be listing all lines like the hospital and like RHC bills Medicaid claims listing all services? Is this correct?

Yes. Effective for dates of service on or after April 1, 2016, all services performed during an eligible qualifying visit are separately listed on the UB-04 with the appropriate revenue code(s).

16. When you state April 1, does this mean all claims sent to CMS on or after April 1, or do you mean April 1 dates of service and previous to that date are billed according to the past rules?

The new billing criteria go into effect for services on or after April 1, 2016. Dates of service prior to April 1 are billed using the old billing criteria.

17. Do the lesion removal services become included in the cost report?

Based on the March 23, 2016, revised instruction, most of the lesion removal CPT codes have been added and would be eligible as a “qualifying visit” if performed as the sole service.
18. In the list of REV codes that CAN’T be reported, according to your handout, range 096x-310, was on that list. However, the examples that Medicare included had REV 310 with CPT 36415 included on the claim. Is this accurate?

The list furnished by NGS was from 2010, and some of the codes may be invalid for 2016 dates of service. Please refer to the following link for a 2016 list of eligible revenue codes. We recommend reporting RC300 for a blood draw.

https://med.noridianmedicare.com/web/jea/topics/claim-submission/revenue-codes

19. Can you send those additional lines with a zero or a .01 charge? Or must the line have a money amount attached?

Additional services lines must have the charge listed.

i. MLN Matters MM9269

20. Just to clarify, if I have a 99213 for $50 and a blood draw for $10 on my UB-04, I would have a line with the 99213 with charge of $60 and then a second line with the 36415 and $10?

Correct. The charge for the blood draw, i.e., additional service, rolls into the total charge(s) reported under the qualifying visit line, i.e., CPT 99213.

21. A “procedure-only” encounter will no longer meet criteria as a billable encounter. Does this mean that we do not bill it at all to Medicare, or do we still bill it and it is adjusted off the remit as not allowable?

Effective March 24, 2016, CMS updated the list of eligible qualifying visits to include some common in-office procedure codes. For any other “procedure-only” visit codes, the RHC would not generate a claim to Medicare and would include the cost of that service on the annual cost report.

22. Can a “procedure-only” visit be rolled to another qualifying visit claim within 30 days?

It is not our understanding that CMS will allow use of the 30-day rule for a professional service. Medicare Benefit Policy Manual, Chapter 13, Section 120.3, has allowed the 30-day rule for incident to services only. Specifically, “The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.”
23. If there is only one diagnosis with a procedure like a knee injection, are we able to still bill E/M so we can get paid for the visit? Or are we out of money just billing the procedure?

The usual CPT guidelines for billing an E/M in addition to a surgical/in-office procedure must be followed. By definition, use of modifier 25 requires that “on the day of a procedure, the patient’s condition required a significant, separately identifiable E/M service, above and beyond the usual pre- and post-operative care associated with the procedure or service performed.” National Correct Coding Initiative Manual, Chapter 11, Letter R, states that the “initial evaluation is always included in the allowance for a minor surgical procedure.” The surgical global period (0/10/90) for a defined therapeutic CPT code includes the usual preprocedural workup, so you would not always code an E/M with a minor procedure. For example, if the patient presents for a scheduled procedure and no other sign/symptom/condition requires evaluation, only the procedure code is assigned. There are scenarios where it is appropriate for the E/M to be billed separately. If the patient has presented for evaluation of a sign/symptom/condition that requires the physician or non-physician practitioner to do a full evaluation, and medical decision making determines what kind of treatment is best after evaluation, then documentation may support billing an E/M and a procedure code on the same date regardless if there is only one diagnosis. An E/M would also be supported if the physician is evaluating signs/symptoms/conditions unrelated to the reason for the procedure or for a significantly worsening condition that requires separate evaluation to determine if treatment should be continued or changed.

Each scenario will be distinct, and coding will depend on the medical record documentation of work performed.

Refer to the following Codapedia article for additional information:

http://codapedia.com/article_206_Modifier-25.cfm

24. Will 96372 (therapeutic, prophylactic or diagnostic injections) be billable and able to be rolled into the qualifying line item?

Yes. If a drug or vaccine administration (other than flu/pneumonia) is performed during a qualified visit, both the HCPCS (drug) or CPT (vaccine) code and the appropriate administration code should be listed. The total charges would be rolled into the qualifying line item and paid under the AIR.

25. How do you bill and get paid for a subsequent injection if you cannot bill it as a visit?

Refer to the updated list of eligible qualifying visit CPT codes. If the specific procedure code your provider is performing is NOT listed, then it will not be eligible for billing as a qualifying visit, but the cost of performing the service will be included as an “allowable cost” in the annual cost report. A “nurse-only” performed vaccine or drug injection does not meet criteria for a qualifying visit either now or for services on or after April 1. If the “nurse-only” injection is performed within a 30-day window of another qualifying visit with the physician or non-physician practitioner, the charges for the drug administration may be listed on the qualifying visit claim.
26. If managed care is considered same as commercial, why do they pay the RHC rate?

From a payment perspective, a Medicare or Medicaid managed care plan is required to pay a wraparound amount to ensure that no less than the RHC encounter rate is received. From a billing perspective, the initial claim generated is dependent on the primary payor. If the primary payor is an MCO, commercial guidelines are followed, i.e., CMS-1500. There may be varied instruction from the MCOs, so we always recommend obtaining specific claims filing instruction from your MCOs.

27. Should “procedure-only” patients be referred to the hospital to be performed there?

If the procedure is normally performed in the clinic setting, then it would not be medically necessary to move the procedure to the hospital setting. CMS has this issue under consideration and has already provided an updated list of procedures. Please refer to the updated list for additional information.