

RHC Common Claim Errors

Rural Health Clinic Technical Assistance Series Webinar

June 29, 2017

2:00 – 3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all lines have been placed in listen-only mode until the question-and-answer session. Today's call is being recorded. If anyone has any objections, you may disconnect at this time. I would now like to turn today's call over to Bill Finerfrock. Sir, you may begin.

Bill Finerfrock: Thank you operator and welcome everyone to today's rural health clinic technical assistance Webinar. Before getting into this I know we have a number of people who are only on audio-only.

So I do want to remind everyone that this Webinar is brought to you by the National Association of Rural Health Clinics and is supported by a cooperative agreement from the federal Office of Rural Health Policy, Health Resources and Services Administration.

It's intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and guest speakers. The contents of today's Webinar are solely the responsibility of the authors and don't necessarily represent the official views of HRSA so today's call I seem to have lost control here Wakina.

Wakina Scott: I can put you I can put the presentation up, thank you.

Bill Finerfrock: There we go, looks like it's all right so today's call is rural health clinic most common claim errors and our speaker today is Janet Lytton, Director of Reimbursement for Rural Health Development. Janet's contact information is there on the screen.

The purpose of the rural health clinic technical assistance series is to provide RHC staff with valuable assistance and RHC-specific information. Today's call is the 77th in the series which began in late 2004. During that time there have been over 20,000 combined participants on this national teleconference Webinar series.

There is no charge to participate as you know and we encourage you to refer others to the RHCTA program who might benefit from the information. Past Webinars and teleconference calls are posted on the Office of Rural Health Policies Website. You can go there to www.hrsa.gov/ruralhealth/policy/confcall/index.html.

There will be some opportunity for question at the end of Janet's formal presentation so I want to turn it over to Janet Lytton, our speaker today on common claims and billing errors for rural health clinics. It's all yours, Janet.

Janet Lytton: Thank you, Bill. Good afternoon, everybody that's on the telephone and on the Webinar itself. Today we're going to talk about some common claim errors for our rural health clinics and we're going to address those errors and hopefully on how to fix them.

There are issues still happening since we've had to be putting the CPT codes and the charges with the CG modifier and we're going to just address a few of

those, not all of them I am sure but we're going to try to do the most common ones.

So you may see Reason Code 38-200. This means it's an exact duplicate of a previously-submitted process claim is in the system. This happens for any paid claim and may only be adjusted or canceled and by paid claim they mean you may have a payment of zero and it would still be considered a paid claim.

Any denied claim may only be appealed so if you've got paid claims that weren't paid correctly or you received zero dollars, you're going to have to adjust that claim or you're going to have to cancel that claim and submit a new one.

Remember an adjustment claim is a 717 type of bill and if you need to cancel it, it's a 718 type of bill and this will be determined on your remittance advice if it is a paid claim or a denied claim. With all adjustments remember you must have a condition code and that's going to be your D codes. There is D0 through D9 and also an E0 which are possibilities for adjustments or cancels.

The cancel claim type of bill is a 718 and when doing either the adjustment or the cancel, you have to have the ICN number or the document control number for that claim that you are adjusting or canceling in field locator 64 and many of the remarks that you're putting in there for the D code that goes in the remarks side at the very bottom.

Then we have Reason Code 30905, no record of processing on original claim for this adjustment. We have to verify there are claim that you are wanting to adjust was in the finalized status. That finalized status it's going to have a

PB9997 with that claim and you're going to have to verify that before submitting an adjustment.

You have to verify that all of your field locators on that adjustment are identical to the original claim. If they are not identical from the health insurance claim number, the document control number and the first two digits of out type of bill which would be our 71 and our provider number, they'd have no idea on which claim to adjust.

So our remedy for that particular reason code, we have to know our status location of our claims. I would always suggest using the direct data entry system. Everybody that submits claims on a UV04 or for that matter the 1500s has a possibility and can access the direct data system in order to fix claims, adjust claims, cancel claims and basically look at your claims.

That has to be a process by applying to your (mac) and issuing certain paperwork. You have to have a connectivity in order to connect with the DDE. I use ability and it works quite well. I'm sure there may be other ones out there.

There's also eligibility lines and there's different methods of fixing claims through practice management systems so you need to know the status of your claims in order to do any of those adjustments or cancels.

If we're using the D9 condition code and we see a Reason Code 37541, you must enter a remarks field for the reason that you are requesting that adjustment. If there's more than one condition that applies to your adjustment, we list the first one on the list that we are fixing first and then we can list the other ones thereafter.

D9 for some (macs) not all of them require specific lingo in order to get that claim adjusted and I know that WPS is one of them that requires specific remarks for the D9 condition code. If you go on the WPS Website, you can pull-off the D9 remarks that are required for those particular different adjustments that you're going to be making.

For instance if it happens to be a modifier, you just put modifier. You don't put what modifier at all. If it happens to be condition code, that's all you put, condition code. If it happens to be the medical record number, that's what you put. If it happens to be the patient control number, you have to have patient control and then you have NBR.

So you can't spell-out the whole thing or you're going to get it thrown back at you as well so make sure look at your (macs) how they determine the D9 what they want to see on the claims in order to get that particular condition code to go through. Then we have Reason Code 30912. This is an adjust we're adjusting a claim that has already been adjusted.

You can't do an adjustment on another adjustment claim so we need to verify that you are using the correct document control number for the claim that you are adjusting and if the document control number is incorrect or incomplete, a new adjustment claim should be submitted with the correct document control number.

Adjustments are kind of tricky sometimes in that you have to specify exactly which claim that you are adjusting with that document control number and we have Reason Code 30919. This means that the original for this claim has been rejected as a duplicate.

Many times if we have a claim that has already been processed whether that is a zero pay or a paid claim or it's been denied, that we have to verify that we have the correct data service. You cannot submit a new claim in many of those instances.

You have to send the adjusted claim in order for that claim to process so make sure that you're tracking all of your claims to make sure that we're adjusting when we need to whether we're sending a new claim if we need to. There are many different things that we are looking for when we're looking at our claims and how to manage those claims.

The next reason code would be 39927. This was happening and I'm not sure if this has been updated but there was a problem with Revenue Code 0900. That is for our mental health services and all of these claims we're suspending. The (fiss) system it was a problem with it and the (mac) was aware of it but they weren't getting the claims paid.

So what they were asking is do not submit another claim or it's going to just sit there. It'll duplicate out and then they were going to update the system and it was going to process the claims that were in suspense on its own.

Now by all means continue to track those claims and make sure that they are being processed and keep your eye out to make sure that this 39927 has gotten a remedy in order to fix those claims. The common working file edits, we have the E9903. This was an issue for independent rural health clinic claims, type of bill 71X and it was containing revenue code 0780.

This is the telemedicine site fee that was erroring-out with this edit with the Q3014 and CMS was made aware of this and has instructed the (macs) to hold these claims until a new change request is implemented to correct the common working file E9903. Again make sure that you track those claims in order for those to be paid correctly.

For our remedies we want to hold-off submitting any additional claims with our 0780 until they do get this fixed and do not submit any more claims and then wait for an update for this in the very near future.

Now from the time I created this, there could be fixes already in the system. Again, look on your (macs) Website because it will tell you which edits have been fixed and which ones they are still working on. Then we have Reason Code 37187.

This code is on claims with type of bill 71X and it means that the HCPCS code builds with any revenue code in the 052X range with a single line for data service on or after April 1st, 2016 show the Remarks Code D0-97 on their remittance and a negative provider reimbursement.

What's happened with these claims is there has been no CG modifier or the HCPCS code is missing so make sure that you know what your system is putting-out electronically by reviewing those claims and making sure that the HCPCS codes are there with the CG modifier for our bundled line item of service.

So these claims have to be adjusted and cannot have another claim sent for that or it's going to error-out again as a duplicate so if you do have duplicate

claims that are showing-up in your errors, that means that you need to find the original claims and adjust those claims in order to get those claims paid.

I know of clinics that are still sitting out there from a year ago when we were submitting claims with the CG on them since October that still have claims that are not getting paid or haven't been paid and it's due to repeatedly sending claims and they're erroring-out as duplicates.

So make sure that you understand the rules and that claims are going-out of your system like they need to be. Then we have Reason Code 39001. This outpatient claim has been rejected because our records indicate the beneficiary is a member of an HMO or health maintenance organization.

By all means when you have Medicare patients come-in, they give you their cards but they give you the Medicare card, they may also give you a Humana card.

They may use the Aetna but they may have the Aetna HMO or the Humana HMO and you need to verify eligibility on each one of your Medicare patients before that claim is submitted and typically that eligibility is done prior to the patient even showing-up at the clinic.

So our remedy is we want to verify eligibility with the insurance coverage prior to the visit whether you look-up the eligibility if you have an eligibility check line.

If you put in their Medicare number and that patient comes-up, it will automatically immediately tell you if they're a member of an HMO and it will

give you the HMO's company name and address so you can verify that it's an HMO. Now is it wrong sometimes?

Yes, it is, it happens to be and then there and I don't have that number with me and I'm sorry, I was going to get it and I had forgotten. There is a common working file number that you and the beneficiary can call when they're in your office to get the information changed on the common working file and that is a process that sometimes it can be cumbersome but it does work.

I've sat-in with a beneficiary before and had to call them so make sure that you do that if it is in there incorrectly.

Bill Finerfrock: Janet?

Janet Lytton: Yes?

Bill Finerfrock: This is Bill. I'm just I'm curious on this one would the - on the HMO - would that be a Medicare Advantage? Is there a different code if it's a Medicare Advantage or that's a universal code that essentially is saying they're in a Medicare Advantage plan.

Janet Lytton: It will show a Medicare Advantage plan and that is all the PPOs, the HMOs and the private fee-for-service companies that are shown on the eligibility line when you access their Medicare eligibility.

Bill Finerfrock: So 39001 I guess the question is would it encompass not just the Medicare Advantage HMOs but the Medicare Advantage PPOs and private fee-for-service as well?

Janet Lytton: That is correct, yes.

Bill Finerfrock: Yes. My reason for asking to clarify is that if you went to the patient, let's say there were in a private fee-for-service or a PPO and they said well this code tells us that you're in an HMO. The patient may say well no, I'm not. I'm not in an HMO and so the terminology here may be important as well.

Janet Lytton: That's correct, Bill, yes, but I would definitely check that Medicare eligibility line and it will tell you which Medicare Advantage plan that they are with and those plans will include HMOs, PPOs and private fee-for-service companies that will be listed.

So then we have Reason Code C7010 and this is for a claim from and through dates that overlap a hospice election period and is not indicated as treatment of a non-terminal condition. Remember we as rural health clinics can only see those patients for their non-terminal conditions and when we do so, we have to submit our claims with a condition code of 07 in order to get those claims paid.

So if we do not submit that 07 condition code, we will receive this C7010 error code and at that point you're either going to have to adjust that claim by adding a condition code of 07 or if it was for that terminal illness that we saw those patients, we will not get paid for that claim nor is the patient liable for that particular claim.

Then we have Reason Code T5052. This is a common working file edit and it indicates that the beneficiary is not on file. This could be several different reasons. We need to verify the information on the beneficiary's Medicare

card and then when we do get the correct information, we must submit a new claim.

That information on their card has to be exactly their last name, first name, middle initial. Now I have been - you got to look at the card - because sometimes the card is actually different than what they actually have been going by out in the public or many times I've even seen it different on from their coinsurance plan and their Medicare card.

So it has to be exactly like it's on the Medicare card from the spelling. I've even had the Medicare card to have a misspelling on it but it has to be submitted. Now these people can change their card by contacting them, the Social Security office and they'll issue a new card with the new spelling and they'll have to submit verification of those differences.

But it's very important that we have all of the correct information as it is on the Medicare beneficiary card. Then we have some other claim errors. I don't have the numbers for those but many times we have claims that are submitted with the incorrect revenue code and HCPCS combination.

I understand at the beginning of time when we were asked to do rural health clinic line item billing and yes, there were some Webinars that were told that we could use the 521 for all of the codes that we do but that is not the case.

Our revenue code must match the CPT code that we are putting on our claim so any professional service and that's what our rural health clinic services are, the 521-52X revenue code would be in for any professional service.

There's a linkage between the HCPCS code and the revenue code. That's just like our 36415 is typically a lab. That's the only lab service that we are required to bill on our rural health clinic claims. That is a 0300 revenue code.

I do know recently that there was a Medicare payer that was saying that the 36415 is not coupled correctly with the 0300 revenue code. However, if you look at the it's either the change request 9269 or the FE1611 that I have listed below that it has the example of the venipuncture being put with the 0300 revenue code.

So if you have that case that's happening, refer those (macs) to those particular change requests and the FE1611 because it is exactly like that that CMS has put out so make sure you need to digest typically digest that CR9269 and the FE1611 because it will show you which revenue codes cannot be on a rural health clinic claim.

So it doesn't tell you the ones that can but it tells you the ones that which cannot so make sure that you know which ones that we're dealing with and you are dealing with on your claims. There are very few revenue codes typically that the rural health clinic is going to be using. I think I'm stuck. There it goes, well now it went way too far. Okay, let's see where we're at.

Bill Finerfrock: Yes, I think you went too far.

Janet Lytton: I'm hitting my button and it's not doing nothing. Is that where I am? I don't know what it's doing, Bill.

Wakina Scott: I can just try here for you.

Bill Finerfrock: You did that, we're going in the wrong direction. Go up, up, up.

Wakina Scott: There we go.

Bill Finerfrock: There, right there.

Janet Lytton: Mine didn't change.

Bill Finerfrock: You're still - it should say other claim reasons codes.

Janet Lytton: Yes, no. I'm on mine says 11, Number 11.

Bill Finerfrock: No, I wonder if your Internet, you're frozen.

Janet Lytton: Okay, what slide number is that?

Bill Finerfrock: You should be on 15, other claim reason codes.

Janet Lytton: Okay, I've got them printed here in front of me too. I'm going to state the slide number as I do them, okay?

Bill Finerfrock: Well, I'll move them for you then.

Janet Lytton: Okay, thank you. Okay, the next slide number is 15 and this is Reason Code 7NC21. This is the provider realizes services are non-covered level of care or excluded but request notice from Medicare or another payer. Now what this is, this is when we would bill our preventive physical, remember, the 9938X that is not considered covered under Medicare.

In order to get and if the patient requests you to bill that to Medicare, you are required to bill that to Medicare so you would bill it with the 711 type of bill and you would put a condition code of a 21 and then the claim thereafter will be the 521 revenue code, your 9938X code and then the total charge.

And that tells Medicare I know that this is not a paid claim but I need a denial for either the patient or their supplemental insurance so we have billed it correctly. At that point, you can bill the patient for that service as well.

Next slide is 16, other claim errors. We've got submitted claims with technical components on the claim or bundled codes such as the 93000 that's our EKG that is both the tracing and the interpretation and report and that should be split-out into the 93005 and also the 93010.

I've received copies of claims from clinics that they ask me well why isn't my EKG covered? Well, it would be but we have to have those split codes. Since Medicare now gets our codes with our 521 revenue code, that isn't correct with the 93000 so we have to have the 93010 which is the interpretation with that 521 revenue code.

Likewise, on Slide 17 it's going to include our technical component for our X-ray technical components between the EKG tracings, our (holter) monitoring placements, our ultrasound technical component and any service that has both a professional and technical must be split-billed.

Also if you remember when we do our IPPE exam that G0402, if we are choosing to do that EKG that may go with that IPPE, we cannot use the G0403. We must again split that apart, the technical component is the G0404

for the tracing only and the G0405 which is the interpretation and report. That G0405 would be on our rural health clinic claim with the G0402.

You can find all the preventive information on the CMS Website and it's at [cms.gov/medicare/prevention/preventiongeninfo](https://www.cms.gov/medicare/prevention/preventiongeninfo). That Website will show you an interactive tool that you can click on and you can click on each particular preventive service and it will give you billing instructions, coverage instructions, everything about that particular preventive service.

Very, very good site to have bookmarked for us in the clinics. Next slide is 18. We've got our qualifying visit codes. I cannot stress enough that each biller in your offices need to keep a list of that qualifying visit code list from our CMS Website.

That list is at the very bottom at that Website that's listed on this slide and each one of those visit codes that's listed when a CG modifier is with it can be as a standalone service for our rural health clinic services. It can be the only claim on the bill or the claim or it can be a part of many lines of that particular claim.

We need to make sure that each preventive service that we have on our claims is a separate line item as well. Those preventive services are not included in that CG modifier bundled line item service so you want to make sure those charges for those preventive services are not a part of that bundled line service.

If our entire claim is preventive services, you need to put a CG modifier on the main preventive service that brought the patient to your clinic. There are

no bundled line items when you have all preventive services. They're each going to be their preventive service and their specific charge for each.

Now we're still getting confused over the when do we get paid for more than one visit and that happens the only time you will get an additional payment for a preventive service with another rural health clinic service on the same day is the IPPE exam, the G0402 will be with either an ENM code or another procedure code all across the board.

Whenever that IPPE exam code is shown on a claim, you will receive a per diem payment for that code. If there's other services provided, you could receive as many as three visits for that one code depending on if there's medical, mental and the IPPE. I still see that happening as errors as well on claims.

Slide 19, this is our Internet sites that I've created this presentation from. I would encourage every one of you to look at each one of these sites and make sure that you definitely the preventive services site that (medlearn) matters 9269 or change request 9269 and the FE1611.

These are our basic rules of our billing for our rural health clinics and will help you curtail many of the errors that we're getting on our claims and going forward so with that I would be happy to take any of your questions.

Bill Finerfrock: Okay, operator, you want to give instructions for folks who are on the audio how they can ask questions and then we can also take questions in written form for those of you who are on the Webinar so operator?

Coordinator: Thank you. At this time if you'd like to ask a question, please press star 1 and please record your name when prompted.

Bill Finerfrock: And then for those of you who would like to ask a question via the Webinar, there is a chat box that you're aware on your screen it might appear but you can type-in your question there and we'll try and take questions from the phone callers as well as from the Webinar so why don't we give a minute, if you want to type-in a question for Janet, we'll try and queue some of those up and then move on?

Janet Lytton: While we're getting ready for the questions, just today I had an e-mail from a clinic that had a code on their claim that they had visited with their (mac) about and it is the G0372. This is a provider evaluation for a power mobility device for the patient. That claim is - or excuse me - that code is a code that CMS said is not to go on a rural health clinic claim.

I would hope that in the future that we don't have many of these types of codes but if any of you have codes like that and we need to be aware of it at the National Association so that we can research some of those codes because at this point there's CMS is saying that that's the only code that there is like that so with that said, let Bill or (Nathan) or even me send an e-mail and we'll try to get that research for you.

Bill Finerfrock: Operator, are we getting any questions through the phone lines?

Coordinator: Yes sir, thank you. Our first question comes from (Jan). Your line is open.

Bill Finerfrock: (Jan), you're up and let us know where you're from.

(Jan): Okay, this is (Jan), I'm from Dickinson County Healthcare System in Upper Michigan. I'm calling about to bill covered and non-covered services on the same claim. For example we have an OBGYN clinic that's rural health. Patients come and they get a complete physical.

We want to bill the G0101 and the Q code for their pelvic exam and pap collection but we'd also like to capture the services that are not covered which would be check a physical exam of their heart, lungs, ears, nose and throat. How would you bill both of those services on I know that you can't but how, I mean, how do you recommend that we handle those things?

Janet Lytton: That's an issue and that's been an issue since we started having to put all the codes on our claims. However, when you're doing a portion of a physical as the covered services with the 9938X code, you don't have a complete physical for the balance of those services that's being provided and with those balance of those services being provided, it would actually be an ENM code that would be assigned for those balance of services.

There is a section in the CMS guidelines actually the CMS regulations that state that as a bundled service-type provider which that's what a rural health clinic is, that any if any of the services provided are covered services, then the services that are non-covered are considered covered at that particular - that's not the exact words - but it's too much that same verbiage are considered covered.

So with that said, we have addressed CMS with this and I still seeing it be an issue; however, when you're billing that particular service, you do not use the physical code in order to bill it with the other G codes that you had assigned.

If they have other ailments involved, those ailments also need to go as the diagnosis on those claims and then perhaps those are the reasons that you are doing the other system body systems in the evaluations as well.

(Jan): Okay, so you don't see it an issue to change that 9938 whatever that's the preventive code and change that to an evaluation of management code?

Janet Lytton: No, no, I do not because you haven't done a full physical exam as the paid service because you've done the parts and pieces as the preventive services that you've just provided in those particular body systems.

(Jan): Okay.

Janet Lytton: Every system of the body is basically the preventive physical code.

(Jan): Okay, so then in essence the patient will end-up owing 20% of that balance of like the balance ...

Janet Lytton: Correct.

(Jan): ... that's on the 99213 or whatever you feel you should be ...

((Crosstalk))

Janet Lytton: Correct, that's correct.

(Jan): ... okay, okay.

Bill Finerfrock: All right?

(Jan): Okay, thank you.

Bill Finerfrock: Okay, we'll take a question or two from the chat box. First, (Christina Hamilton) asks CCM code 99490 I assume needs to have a CG modifier if billed alone on an institutional claim. We are an independent RHC.

Janet Lytton: The CCM code does not require a CG modifier because those are paid at the national Medicare physician fee schedule amounts. Those claims can go either in with a visit or they can go in alone but they do not have a CG modifier attached to them nor is that 99490 charge bundled with your ENM code if it is billed on the same claim as a visit.

Bill Finerfrock: Okay, next is the condition code for not work comp going to be D9 and in the remarks would we put not work comp related?

Janet Lytton: No. It wouldn't be a D9 but I don't know that one, Bill, I don't know what can do ...

Bill Finerfrock: Okay, that's fine, that's fine.

((Crosstalk))

Janet Lytton: ... you would be using.

Bill Finerfrock: I'll do another one. When a non-covered Medicare annual physical is performed on a patient along with a covered service in the same visit, these need to go on the same claim or split on two different?

Janet Lytton: Again, from the question that I just answered prior, if you're doing parts and pieces of a preventive physical and those services are covered, you don't have a physical code to be billed because you have not done all systems of the body as that physical code.

Again, you cannot submit two claims in one day so it has to be part of the covered services or it cannot be billed separately on split bills.

Bill Finerfrock: Okay, operator, we have some folks on the phone, take the next call on the phone?

Coordinator: Again next question comes from (Allie).

Bill Finerfrock: (Allie), you're up, where you calling from?

(Allie): Hi, I'm from (Bellen) Health in Northeastern Wisconsin.

Bill Finerfrock: Great. What can we do for you?

(Allie): I had a question Janet you had said that we have to make sure that the qualifying visits that we're billing are on the qualifying visit list. Me and an associate of mine had attended a Medicare boot camp in Southern Wisconsin in March and the presenter had said that the qualifying visit list was no longer ...

Janet Lytton: Updated?

(Allie): ... used as of January 1st.

Janet Lytton: Okay, I stand corrected. I did not know that.

Bill Finerfrock: Yes, the well let me clarify, I saw that on your slide too Janet, what CMS was realizing was that it was going to be a Herculean effort to try and keep that up-to-date and they were constantly finding additional codes and so forth.

So basically they have discontinued updating the list and essentially said anything that would be a medically-necessary visit that would have otherwise been covered by Medicare it meets all the RHC requirements would be covered as an RHC encounter whether it was on that list or not.

You still would have used the CG modifier but the lack of being on that list would not disqualify the visit from being covered so you still have to meet all of the requisite RHC requirements but don't allow the fact that a code might not be on that list to discourage from billing it as long as you meet all the other RHC billable visit requirements.

Janet Lytton: Okay, thank you. Thank you. I am glad that that's the way it is. I will caution you, make sure that if you're billing one of the standalone preventive services, those are to be specific for standalone so they can be standalone or they can be coupled with others. It can be either way so make sure that you understand that as well, thank you.

Bill Finerfrock: Yes, and the significance there is that on the preventive visits of course the beneficiary coinsurance is waived.

Janet Lytton: That's correct.

Bill Finerfrock: So another call from the phone line, operator?

Coordinator: Yes, we'll take our next question comes from (Robin).

Bill Finerfrock: Go ahead, (Robin), where you calling from?

(Robin): Hi, I'm from Boise, Idaho and actually the last caller asked the exact same question I was going to.

Bill Finerfrock: Okay, great.

(Robin): But we got our answer.

Janet Lytton: Great.

(Robin): Thank you.

Bill Finerfrock: Okay. There are - let me just - some people have asked about the slides. If you are on the Webinar and you want to get a hard copy on your screen, again on mine it's on the left-hand side but you should have a box that says file share and it says NARHC TA RHC most common, you can click on that and you should be able to download the slides there.

The slides are also on the NARHC Website and on the Office of Rural Health Policies' Website. We provided a link to those slides on the NARHC Website. If you got that, just go there and download them. If you still don't have them, contact me at info@narhc and I will send you the link to the slides.

We will have this call is recorded as well as the transcript and slides will be available on the NARHC Website in a few weeks once we're able to get

through all of the requisite reviews that we have to go through so that if you want to listen again, something you might have missed, a recording of it will be available in a few weeks.

Let me take a question here. If you're billing an office visit CPT 99213 and CPT 11300, do you have to roll-up the total to the 99213 line with the CG modifier or can they stand alone?

Janet Lytton: Any services that are on the CG modified line must be the bundled charge of all of the services with the exception of no preventive services.

Bill Finerfrock: Right.

Janet Lytton: So that's why the way Medicare assesses the copays and deductibles is through that CG modified line so we do not want any preventive services because most of them have no copays and no deductible so they cannot be bundled-in with that CG line but all other CPT codes must be bundled-in that line.

Bill Finerfrock: Okay.

Janet Lytton: And I know there's still systems out there that's not bundling that line item.

Bill Finerfrock: Okay, we need to do an adjustment to a claim that maybe has been submitted several times. Is there a way to find the correct ICN that is needed to do the adjustment?

Janet Lytton: That's when you could actually if you had access to the direct data entry system. It will show every time that claim has been submitted and you would

be able to tell by the receipt date exactly which one was your original claim so many times that direct data entry system helps you in that you know the timeline for the times that you've either submitted claims, you've adjusted claims or canceled claims.

So again that would probably be your best bet and look at your remittance advices perhaps. Go back and look at all of them to see within two weeks after you submitted the claim of the data service maybe and start looking there.

Bill Finerfrock: Okay, operator, a couple of questions from the phone lines?

Coordinator: Thank you. Our next question comes from (Janice). Your line is open.

Bill Finerfrock: (Janet), where you calling from?

(Janice): Hi, this is (Janice) from Cadillac, Michigan, the (munson) central billing office.

Bill Finerfrock: Okay.

(Janice): And my question may be partially answered. Bill, you gave us a contact. We were unable to get visual so we don't have the slides but we can get them out on our Website, if you wouldn't mind repeating them?

Bill Finerfrock: Yes, the it's hard to say it over the phone. If you send me an e-mail or anybody, I will send it to you because it's a rather complicated URL or ...

((Crosstalk))

(Janice): And it's info@nahrc?

Bill Finerfrock: Info@narhc.org.

(Janice): Okay, I got that and then Jan the original question brought-up a question in my mind, the 993 code with the G0101, it was my understanding so the total charge for the 993 code is \$197 so we carve-out the G0101 bringing both charges to the 197 and from what I'm understanding you're saying that we shouldn't be billing the 993 code, the preventive code?

Janet Lytton: No, the 9938X code should not be on a rural health clinic claim.

(Janice): But if the physical is for the rest of their systems, the G0101 is for the gynecological portion, correct, in the breast and cervical if they're doing all the other systems and the patient believes they're getting a physical, they're not expecting a copay on these so ...

Janet Lytton: What they expect and what they're going to get is going to be two different things.

(Janice): ... right.

Janet Lytton: Medicare does not pay for annual physicals so if they truly want the annual physical, then they're going to be paying for the whole thing and then if they are not and they do parts and pieces at the ENM code for their ailments and then the preventive services - the breast and pelvic and the gathering of the pap and all of those - as the G codes, then they would have the copay for the ENM portion and Medicare paying 100% of the preventive portions.

((Crosstalk))

(Janice): And you did mention the CMS regulations on that specific topic? You also mentioned a number of helpful sites that are preventive services, the 9269, the SE1611?

Janet Lytton: Yes.

(Janice): Is there a way like to get that information, you know, being on the call without any visual? It was hard for us to get any of that information so how do we easily gather that and give it to our billers?

Janet Lytton: Pull-off the slides that ...

(Janice): That Bill's going to send me?

Janet Lytton: ... yes, that Bill said ...

(Janice): All right.

Janet Lytton: ... and the one Website that I did say, the [cms.gov/medicare/prevention/preventionengeninfo](https://www.cms.gov/medicare/prevention/preventionengeninfo). That's the preventive services or if you go on the CMS Website and just do a search for preventive services, you'll be linked right to that site and that gives you an interactive tool to be able to click on each one of those services and it will give you all the coverage, the billing, all the information there is about those codes.

(Janice): All right, thank you so much.

Janet Lytton: You're welcome.

Coordinator: Thank you and our next question comes from (Sherry Barber). Your line is open.

(Sherry Barber): Yes, my question and we're very new to this so my question may sound dumb but anyways I need to know when we're billing for hospital inpatient/outpatient services, is that standalone charges and also for home health recerts and we do home visits also?

Janet Lytton: Your home visit would be a rural health clinic visit.

(Sherry Barber): Okay.

Janet Lytton: Your home health recertifications and certifications are not billable within the rural health clinic.

(Sherry Barber): Okay.

Janet Lytton: And any inpatient and outpatient services are billed to regular Medicare Part B or you have to look if you're part of a critical access hospital Method 2, the hospital will bill the outpatient portion of those services.

(Sherry Barber): Okay, so let me make sure I understand. Home visits can go under the rural health clinic billing side....

Bill Finerfrock: Can you clarify for me what you mean by home visit?

(Sherry Barber): We actually go to the home and see the patient.

Bill Finerfrock: So the physician and the PA and the nurse practitioner goes to the ...

(Sherry Barber): Yes.

Bill Finerfrock: ... okay, I just wanted to make it clear that that's what you meant by that.

(Sherry Barber): Yes, yes.

Bill Finerfrock: Okay.

(Sherry Barber): So and that's a standalone, it doesn't have to have, I mean ...

Janet Lytton: Correct.

(Sherry Barber): ... okay, yes, so standalone charge ...

Janet Lytton: That would be a 522 revenue code.

(Sherry Barber): ... okay, and then the home health certs and recerts that's being filed to Part B, is that right?

Janet Lytton: No, if it happens within the rural health clinic, it's not billable.

Bill Finerfrock: Right.

Janet Lytton: It's and that's one of those services that's considered a covered service but not billable because it does not require the face-to-face visit with a provider. It's a basically a paperwork issue.

(Sherry Barber): So, okay, so that one's not billable, recerts, certs and recerts?

Janet Lytton: Correct, correct.

Bill Finerfrock: Right, but just to clarify, the concept is that the nurse or the staff who are performing that service the space in which they're performing and all of the overhead are captured on your cost report so that you are being reimbursed for that service as part of your all-inclusive rate when you have a billable visit so it's not as though you're eating it, you're just simply building that into your cost-per-visit rate as opposed to having it as a billable visit.

(Sherry Barber): So home health, that goes under cost reports and the hospital goes to Part B, right?

Bill Finerfrock: Correct.

(Sherry Barber): Okay, thank you so much for that.

Janet Lytton: You're welcome.

Bill Finerfrock: Let me operator I'm going to take a couple of calls from the chat room here. we keep getting multiple denials for CPT 56605 biopsy because revenue code 521 stating that the revenue code is invalid but every other revenue code we find for this code are not RHC revenue codes. Is this not an RHC-billable service?

Janet Lytton: And if it can happen within a physician's clinic, it would be billable service and I know this is one of our issues Bill that I've been going around about because if they say that it's not coupled with the right revenue code, if it's a provider service it is coupled with the right revenue code so I don't know what to do about situations like that. I think we have to take it to CMS.

Bill Finerfrock: Okay, this was from (Andrea) and (Andrea) if you would send this to me at info@narhc.org and then we can try and look into it and see what's happening here. Next up here, we are getting 31686 error reason code and all of our value code amounts are correct. We don't have access to DDE. Can you explain this reason code further?

Janet Lytton: I don't know what that reason code means off the top of my head.

Bill Finerfrock: Okay.

Janet Lytton: My first question is what our value code amounts are correct. We very seldom use value codes on any of our rural health clinic claims unless this happens to be a Medicare secondary payer issue, there are very, very few times we use value codes so I'm not for sure what that 31686 means.

Bill Finerfrock: Okay, can she contact you directly?

Janet Lytton: Yes, she can e-mail me. I'll look it up after I get off to know what it is.

Bill Finerfrock: On the slides, the first slide with Janet's e-mail to contact her directly and she'll try and help you out. Next one I'll from the chat room before I go back to the phones, if we have a qualifying visit and a line item that may not be

covered and have an ABN signed, how does Medicare consider that line is payable if it is not rolled into the line with the QV qualifying visit?

Janet Lytton: Well, if it's a non-covered service by Medicare and they see that on your claim, I think at this point they're denying the claims.

Bill Finerfrock: Yes, that seems to be what's happening even though you're doing it in conjunction with a billable visit, if you're putting on there so we've had this recently with the home health certs where people are putting that onto the claim with a legitimate qualifying visit and the whole claim is being rejected and we've asked CMS to look into that, why that's happening.

Janet Lytton: Yes, and that's exactly what's happening with many claims of ...

((Crosstalk))

Bill Finerfrock: So when we get that clarified for folks, we will put that out on the list-serve as to what is being done there.

Janet Lytton: Okay.

Bill Finerfrock: Operator, take some calls from the phone? We're actually on 3:00. Janet, do you have a few more minutes?

Janet Lytton: Sure.

Bill Finerfrock: Or are you pressed for time?

Janet Lytton: No.

Bill Finerfrock: Wakina, can we keep going for a little while?

Wakina Scott: Yes.

Bill Finerfrock: Okay, operator?

Coordinator: Thank you. Our next question comes from (Lacey). Your line is open.

Bill Finerfrock: Go ahead, (Lacey).

(Lacey): Hi, I'm calling in reference to hospice patients. We are a provider-based rural health clinic in Kansas and when we turn-in a claim on a hospice patient and if the Condition 7 is left off, I noticed that I cannot go into the (fiss) system and add that. It doesn't even show the claim in (fiss).

Janet Lytton: No, it has to be appealed.

(Lacey): Okay. There's no other way to do it then?

Janet Lytton: No other way to do it.

(Lacey): Okay, because you can other condition codes on in (fiss).

Janet Lytton: I know, I know you can but I've even tried that so I know that it doesn't work so definitely.

(Lacey): Okay, that's all I had, thank you.

Janet Lytton: Yes.

Bill Finerfrock: Okay, operator?

Coordinator: Thank you. Our next question comes from (Laurie Weber).

Bill Finerfrock: Okay, (Laurie).

(Laurie Weber): Hi, we're from Manchester, Iowa and our (mac) is WPS and we've got a hand well about 15 claims that are approaching almost a year old and they've got error code of E51#6 and have you heard of that, Janet? Have you heard of that issue?

It's claims that have multiple lines on them and so we're rolling the charges all up onto the CG line and then putting a penny on the subsequent lines and just certain claims are not getting processed. Have you heard of that at all?

Janet Lytton: I haven't. Is it a certain line item that they're not liking the CPT code or something?

(Laurie Weber): We haven't identified one particular CPT code, no.

Janet Lytton: If ...

((Crosstalk))

(Laurie Weber): And it's sporadic, it's not on ...

Janet Lytton: If you would e-mail me a couple of those, scan them and e-mail a copy of those claims, I would be glad to look at it for you.

(Laurie Weber): Okay, we'd appreciate that, we'll do that.

Janet Lytton: Okay.

(Laurie Weber): Thank you.

Bill Finerfrock: Operator, anymore?

Coordinator: Thank you. Our next question comes from (Amanda).

Bill Finerfrock: Go ahead, (Amanda), where are you calling from?

(Amanda): I'm calling from Colorado and I was just hoping you could maybe touch on the 36415 the venipuncture, when it's billed with a visit if they're there for a visit, are we supposed to roll that up into the CG the first line item with the CG modifier and if they come-in just for a venipuncture, are we allowed to bill that?

Janet Lytton: Okay, first of all the claim with let's say a 99213 with a CG would be the charge for the 99213 and the line item for the 36415. That would be both of those charges rolled-up into that first line item with the CG. The second line item would be the 300 revenue code with the 36415 and whatever charge more than a penny would be for that code. You would receive one per diem for that example, okay?

(Amanda): But you do need to change the revenue code on the 36415 to 300?

Janet Lytton: 300, 0300 is the revenue code for the venipuncture.

(Amanda): And a charge of one penny?

Janet Lytton: One penny or more. I prefer doing your actual charges because without that, you'd have no statistics that are basically reliable so that's my preference.

Bill Finerfrock: Yes, this is a preference issue. Most people do a penny just because it drives a lot of folks crazy when the numbers don't add up or they're wildly different even though Medicare is ignoring the number at the bottom but it's more of a convenience to whatever you can put the correct number in there. You don't have to put a penny.

((Crosstalk))

Bill Finerfrock: Yes, Medicare won't allow it to be a zero charge claim line.

(Amanda): Right.

Janet Lytton: Correct now if you have the situation where they come-in for a venipuncture today and they happen to be seen tomorrow, that venipuncture can be bundled with tomorrow's visit.

(Amanda): Okay.

Janet Lytton: And just the claim is going to look just like the one I said previous, the data service on the claim is the date of the face-to-face service.

(Amanda): Okay.

Bill Finerfrock: Okay?

(Amanda): But you do roll - the charge for the venipuncture - you add into that first line item like your 213, your 99213, you add the cost of that visit plus the cost of your venipuncture and put that on the first line item with the CG modifier?

Janet Lytton: Correct.

(Amanda): Okay, that's what I needed to clarify. Thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: All right, I'm going to take some calls from the chat room. If a patient comes-in ...

Janet Lytton: Hey Bill?

Bill Finerfrock: ... yes?

Janet Lytton: I see one that I really I get this question all the time.

Bill Finerfrock: Okay, go ahead.

Janet Lytton: It says if a patient comes-in for their G0439 which is a subsequent annual wellness visit and has another service done at the same time or even by another provider, the CPT 99213 for example, can we bill both of them

together? Would you add CG to both charge items or just an AVS annual wellness visit or just the 99213?

That's only a one per diem payment service, both of those services in one day. The annual wellness visit would not have the CG modifier on it but the 99213 would have a CG modifier on it.

The line item for the 99213 would be the charge for the 99213. The subsequent line for the annual wellness visit would be the charge associated with the annual wellness visit. By all means, do not put a penny on there. Put the actual preventive service charge or you're not going to receive your additional copay through your cost report for that preventive service that was provided.

Bill Finerfrock: Okay. All right, yes, you read my mind. That's the question I was going to go to.

Janet Lytton: Oh, was it?

Bill Finerfrock: Yes, the next one I thought we'd take is if something is considered a non-covered service such as an annual exam or birth control device or injection for birth control purposes, is an ABN required?

Janet Lytton: An ABN is not required because this is a Medicare regulation that these are non-covered services. However, I always suggest giving an advanced beneficiary notice to the patient for them to understand that this service is going to be their bill to pay.

Bill Finerfrock: Yes, I think that's really important to make the distinction because you're right, you know, the technical it's not covered, therefore it doesn't require the ABN but that doesn't mean the patients understand that and sometimes the ABN is valuable just for your own I don't want to say protection but helps you down the road if the patient comes back and says oh wait a minute. I thought this was covered. I think it just avoids a lot of downstream issues.

Janet Lytton: I would agree, Bill.

Bill Finerfrock: So we'll go for a few more minutes. Operator, do we have more questions on the phone line?

Coordinator: Yes. Our next question comes from (Allie).

Bill Finerfrock: (Allie), you're up.

Coordinator: (Allie), your line is open.

(Kelly): It's (Kelly).

Coordinator: I'm sorry, go ahead, I apologize.

(Kelly): That's okay, I just wanted to make sure there wasn't someone out there named (Allie). I'm calling from Pulaski Memorial Hospital in Indiana and we are receiving denials when we bill the G0283 stating that the revenue code is invalid with the HCPCS code and we are billing (you) as 0521 rev code.

And we are being told every time we call, my provider is the one that bills for them and every time I call, they tell me that I need to be using a physical

therapy rev code, 042X and I don't feel that's correct because we're rural health, we're doing it in the office so it should be 0521.

Janet Lytton: G2083.

(Kelly): It's ultrasound.

Janet Lytton: Oh, that's electrical stimulation.

(Kelly): Yes.

Janet Lytton: That's one of those codes that regardless who provides it, it's a physical therapy code so with that said, again this is where they're looking at the CPT code to match the revenue code. A 420 is an appropriate code to be able to use on your rural health clinic claim. That doesn't say that a physical therapist did it. Any provider can do that particular code.

(Kelly): Okay, but just because it's considered physical therapy, it has to match the (rev code).

Janet Lytton: That's correct and I ...

((Crosstalk))

(Kelly): Okay, perfect. Thank you very much.

Janet Lytton: ... initially we were not told that that had to match that we could use 521. That's not true. That has not happened.

Bill Finerfrock: Okay.

(Kelly): Okay, thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: Yes, hope to see in Indiana this fall when the NARHC has their conference in Indianapolis. Operator, take another call from the phone line?

Coordinator: Thank you. Our next question comes from Sparta Hospital.

((Crosstalk))

Woman: What am I going to do?

Bill Finerfrock: Yes, go ahead and talk, your line's open. Where are you calling from?

(Beth): This is (Beth), I'm coming from the Sparta Community Hospital.

Bill Finerfrock: And you are located where?

(Beth): In Sparta, Illinois.

Bill Finerfrock: Great.

(Beth): Can you please explain (unintelligible) this is in a rural healthcare setting?

Janet Lytton: Okay, post-op services in a rural health clinic setting?

(Beth): Yes.

Janet Lytton: First of all if the procedure that was performed in perhaps in a hospital by a surgeon, you have to make sure and verify that that particular surgeon has billed with the procedure-only modifier which is a 54 modifier before you're able to bill a post-op service for that particular surgery that was performed.

If your service is provided in the rural health clinic to begin with, there are no global services within a rural health clinic so you would be billing the procedure code when it happens and then you would bill any subsequent medically-necessary visits after for the post-op checks.

(Beth): So saying that I would have to make sure that the provider doing the surgery has to bill with a modifier of 54?

Janet Lytton: That's correct. That means procedure only.

Bill Finerfrock: Right. Otherwise that surgeon is doing it as a global and Medicare is paying for a certain number of post-operative services in that fee that's paid to the surgeon. If you turn around and provide post-operative care, Medicare's position is hey wait a minute, we're paying twice. We paid the surgeon for that and now you're providing the care.

So that's why you have to verify that the surgeon didn't do global billing, otherwise Medicare is going to view your claim as a double billing for the same service that they've already paid for.

(Beth): All right, thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: Yes, for those of you who are online doing the Webinar, we have a slide up now. If you are not on the list-serve to get this information or you know someone who would like to be, there's information there on how you get onto the list-serve to get the announcements for these calls and other information relative to these Webinars and then also is a Web address listed there if you wish to listen to previous calls, previous Webinars, etcetera.

We'll be sending both of these out on the list-serve later today but for those of you who are on the Webinar, that information is up on your screen right now. Let me see, Wakina did we pretty well exhaust the Web room, the Web chat?

Wakina Scott: Yes, still up at the upper corner.

Bill Finerfrock: Okay.

Wakina Scott: But I think you may have addressed those questions.

Bill Finerfrock: All right, do we have one last call on the phone line operator and then we'll call it a day?

Coordinator: Yes, actually we do. Okay, we have a question from (Amanda). Your line is open.

(Amanda): Hello. I have ...

Bill Finerfrock: Where you calling from?

(Amanda): ... I'm calling from Henderson Healthcare Services in Henderson, Nebraska.

Bill Finerfrock: Okay.

(Amanda): I'm kind of doing a follow-up on another caller that has called-in with the error message E51#6 and that error reads-out a revenue code is shown but total charges for the revenue center is zero.

I have been dealing with this since last August and what's been happening on our end is I like if a patient comes-in and has a 11750 on one foot and one on the other foot, what's happening is when it's getting to Medicare is they're combining those lines so it's making one line two cents and another line is zero.

And they gave me a place to go look www.wpsgha.com, go to the topic tenor, claim, guides and resources and then pending reason codes to follow that because they're supposed to be fixing that and because they knew it was an issue.

I just got on there today and I cannot find that anymore so when I'm done with this, I am going to call them and see but I figured I would add that to who else was having that same issue because maybe that would help them out also but I do have one other question.

We have a patient that comes-in and has an allergy shot every couple of weeks. She's a Medicare patient and since it is a non-covered service, can we give or inform the patient about an ABN and can we bill them for that?

Janet Lytton: No, because it is not a non-covered service. It is a covered service but it is a non-billable service.

(Amanda): Okay.

Janet Lytton: Those are two different things so no, you have to understand that the cost for giving those injections even though you don't get to bill it to Medicare are still part of your cost report and your rate is based on based on your total cost.

So with that said, you've got two less visits going-in as your numbers of visits to dilute your rate whereas you're getting your costs ultimately so it's not that you're not getting paid. You're just getting it in an indirect manner.

(Amanda): Okay.

Bill Finerfrock: Okay?

(Amanda): Thank you.

Janet Lytton: And ...

Bill Finerfrock: Well, I think we need to be respectful of Janet's time and so forth and I want to thank everyone for participating in today's call. I know at one point we had nearly 400 people participating today either via the Webinar or audio and I think that's an indication of the value of these types of programs and the kind of interesting questions that people have.

I want to particularly thank Janet Lytton for her participation today. She really does a very nice job. She's been a speaker frequently at NARHC

conferences and always gets pretty high marks and really is a great resource so thank you Janet for your time today.

I want to ask everyone please encourage others that you know who may be interested in this series to register for the RHC technical assistance series and as I noted for those of you on the Webinar it's up on your screen.

We'll be sending that out again later today via the list-serve so you'll have that. If you know others you want to share this with, it'll also include the link to go back and look at older previous technical assistance calls.

We welcome your thoughts and ideas for future Webinars so if you have an idea that you'd like us to consider, please send it to info@narhc.org and put RHCA topic in the subject line. We're always interested in making sure that we offer programs that meet your needs so this is a very helpful way for us to know what's going on.

We do anticipate scheduling the next RHC technical assistance call will either be later in July or perhaps early August. We haven't set that yet. We will send-out notification when we get that setup to you and again we use the list-serve for that invitation. I want to thank everyone for your participation. This concludes today's call.

Janet Lytton: Thank you, Bill.

END