Rural Health Clinic Overview

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Published March 2012

108724

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Important

The information contained in this presentation was current as of February 2012 and can be found in the *Rural Health Clinic (RHC)* manual. All manuals can be downloaded from:

http://www.trailblazerhealth.com/Publications/Manuals/

CMS Web Site

http://www.cms.gov

Medicare Overview

Part A Services

Medicare Part A helps pay for medically necessary care for the following:

- Inpatient hospital care.
- Extended care services provided in a Skilled Nursing Facility (SNF)/Swing Bed (SB) after a hospital inpatient stay.
- Home health care.
- Hospice care.

Part B Medical Services

Medicare Part B helps pay for:

- Physicians' services.
- Outpatient hospital care.
- Diagnostic tests.
- Durable medical equipment.
- Ambulance services.
- Many other health services and supplies not covered by Medicare Part A.

Claim Filing Time

Claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service.

Common Working File (CWF):

- Medicare Part A and Part B benefit coordination and prepayment claims validation system.
- Once the claims are accepted by the CWF, they are stored in a beneficiary's file and forwarded to the National Claims History (NCH) file.

Hospice Care

The Hospice Medicare Benefit (HMB) is available under Part A if the beneficiary meets the following requirements:

- Entitled to Medicare Part A.
- Is terminally ill (six months or less life expectancy).
- Resides where the provider is certified to provide care.
- Elects the HMB.

Hospice Care (Cont.)

Claims for hospice patients are filed to the A/B Medicare Administrative Contractor (MAC) assigned exclusively for this process.

For a non-terminal-related condition:

- File to MAC.
- Use condition code 07.

2012 RHC Updates

The latest updates are listed below and can be found on the Rural Health Clinic (RHC) Web page under the “Notices” section:

http://www.trailblazerhealth.com/Facility Types/RHC/

- SE1205 – “Updating Beneficiary Information With the Coordination of Benefits Contractor.”
- MM7533 – “CY 2012 Medicare Rural Health Clinic and Federally Qualified Health Center Payment Rate Increases.”
- MM7633 – “Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse.”
- MM7636 – “Intensive Behavioral Therapy for Cardiovascular Disease.”
- MM7637 – “Screening for Depression in Adults.”
- SE1135 – “Guidance on Completing the CMS-855A Enrollment Form.”

RHC Policy and Billing

RHC Providers

Each clinic must have at least one supervising physician and one mid-level provider, such as:

- Nurse Practitioner (NP).
- Physician Assistant (PA).
- Nurse midwife.

Clinics may also have:

- Clinical psychologist.
- Clinical social worker.

RHC Certification

To comply with the required laws and codes, an RHC must:

- Have a supervising physician.
- Employ at least one mid-level provider.
- Be able to provide Clinical Laboratory Improvement Amendments (CLIA)-waived tests.
- Have written policies and procedures.
- Be able to provide first-response emergency care, including drugs.

RHC Certification (Cont.)

- Establish arrangements with providers and suppliers to furnish services not offered at the RHC.
- Assure the security of patient records.
- Receive an annual evaluation.
- Have policies and procedures for transferring patients in need of acute care.

RHC Services

The services offered in an RHC:

- Are the types of services that patients receive in a doctor's office or an outpatient or emergency room, such as physician diagnostic, treatment or consultation services.
- May also be provided by an NP, PA, certified nurse midwife, clinical psychologist or clinical social worker.

Covered Services

Services are covered if the following apply:

- Medically reasonable and necessary.
- Provided by physician or other practitioner allowed under state law to provide the service.
- Provided in accordance with the clinic’s policies, protocols and standing orders.

Non-RHC Services

Non-RHC services include:

- Durable Medical Equipment (DME).
- Ambulance services.
- Prosthetics and orthotics.
- Technical components of a diagnostic test.

Missed Appointments

- Policy must apply to all patients (Medicare and non-Medicare).
- Charge for a missed business opportunity can be billed to the patient.
- Charge for a missed business opportunity cannot be billed to Medicare.

Exclusions

General Medicare exclusions include:

- Not reasonable and necessary.
- No legal obligation to pay for or provide.
- Furnished or paid for by government entities.
- Routine services and appliances.
- Paid or expected to be paid under a Medicare Secondary Payer (MSP) provision.

Type of Bill

All charges submitted by an RHC will appear under Type of Bill (TOB) 71X. The third digit of the TOB is the bill frequency. This digit shows the nature or intent of the bill submitted:

• Non-payment	710
• Admit through discharge	711
• Adjustment	717
• Void	718

Coinsurance

Coinsurance is applied to RHC claims based solely on the billed amounts.

The patient owes 20 percent of the billed amount as coinsurance once the annual Part B deductible is met.

Negative Amount

Total billed amount	$186.00
Provider reimbursement rate	$ 64.78
Beneficiary's remaining annual deductible	$100.00
Beneficiary's coinsurance	$ 17.20

Beneficiary's responsibility will be $117.20 ($100 deductible and $17.20 coinsurance). Medicare's responsibility will show as -$35.22 (reimbursement rate minus deductible).

This example indicates that the beneficiary's deductible is more than what the provider reimbursement method would allow. The provider is receiving more than the reimbursement rate allowed by Medicare; therefore, a payment will not be received from Medicare. This will show as a negative amount on the provider's Remittance Advice (RA) with reason code 37206.

Split Billing

Split billing is required for RHCs:

- Must split bills for both the calendar year-end and the clinic's fiscal year-end.
- Assists in proper cost reporting information and correct calculations of Part B deductible amounts on the patient's statements.

Cost Report

- Due on or before the last day of the fifth month following the close of the RHC reporting period.
- Submit to the MAC showing the actual costs incurred and the total number of visits for services in the period.

Bad Debts

- Limited to Medicare deductible and coinsurance amounts that remain unpaid by the Medicare beneficiary.
- Must establish reasonable efforts were made to collect these deductible and coinsurance amounts.
- When deductible and coinsurance is waived by a clinic, that amount cannot be claimed as bad debt.

RHC Encounters

Requirements for an RHC encounter are:

- Face-to-face interaction between a physician, mid-level practitioner, Licensed Clinical Social Worker (LCSW) or Clinical Psychologist (CP), during which RHC services are rendered.
- A claim can only be generated when these requirements have been satisfied.

Encounter Rates for New Clinics

All new RHCs begin with an encounter rate equal to 75 percent of the current national capped amount.

A new clinic can submit an interim cost report showing data collected over the first three months of operation to justify a change in this percentage.

National Capped Amount

RHC providers are reimbursed per encounter on the basis of the calculated clinic-specific rate or the national capped amount, also known as the encounter rate:

- The national capped amount is indexed for inflation and can increase each year.
- Providers not currently reimbursed at the capped amount can file an interim cost report to request a correction on their rate.

National Capped Amount (Cont.)

RHC upper payment limit:

- Per visit has increased from $78.07 to **$78.54.** The 2012 RHC rate reflects a **0.6** percent increase over the 2011 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI).

Providers may reference CR 7533, Transmittal 2406, dated January 30, 2012, on the CMS Web site at:

http://www.cms.gov/Transmittals/downloads/R2406CP.pdf

Revenue Codes

RHCs use the following revenue codes:

- 0001 Total charges.
- 0521 Clinic visit in RHC.
- 0522 Home visit.
- 0780 Telehealth originating site facility fee.
- 090X Psychiatric services.

Revenue Codes (Cont.)

- 0524 Visit in a covered Part A stay in a SNF/SB.
- 0525 Visit in a non-covered SNF/SB or other residential facility.
- 0527 Visiting nurse service in home health shortage area.
- 0528 Visit to other non-RHC site (scene of accident).

HCPCS Requirements

RHCs are not required to report HCPCS codes on any line items billed with TOB 711.

Exceptions:

- Initial Preventive Physical Examination (IPPE) – HCPCS code G0402.
- Ultrasound screening for Abdominal Aortic Aneurysm (AAA) – HCPCS code G0389.
- Preventive services with grade B or better as determined by the U.S. Preventive Services Task Force (USPSTF).
- Telehealth originating site fee – HCPCS code Q3014.

Multiple Visits, Same Day

If the patient returns on the same day:

- For the same symptom, only one encounter should be billed. The amount billed should be increased to include the additional services.
- For an unrelated reason, a second encounter will be allowed when multiple diagnosis codes are used with remarks explaining the differences.
- If psychiatric services are rendered on the same day as an otherwise billable encounter (e.g., 052X and 090X), this will constitute two separate encounters.

Multiple Visits, Same Day (Cont.)

Field	Value
1	Provider Name; Street Address; City, State, ZIP Code; Telephone; Fax; Country Code
2	Pay-to Name; Street Address or Post Office Box; City, State, ZIP Code
3a PAT. CNTL #	Required
b. MED. REC. #	Recommended
4 TYPE OF BILL	0711
5 FED. TAX NO.	SubID XX-XXXXXXX
6 STATEMENT COVERS PERIOD FROM	MMDDYY
6 STATEMENT COVERS PERIOD THROUGH	MMDDYY
8 PATIENT NAME b	Patient Last, First, Middle Initial
9 PATIENT ADDRESS a	Street Address or Post Office Box
9 b / c / d / e	City / State / ZIP Code / Country Code
10 BIRTHDATE	MMDDCCYY
11 SEX	X
14 TYPE	X
17 STAT	XX
42 REV. CD.	052X
45 SERV. DATE	MMDDYY
46 SERV. UNITS	2
47 TOTAL CHARGES	168 75

Other form fields shown (blank): 7; 12 Admission Date; 13 HR; 15 SRC; 16 DHR; 18–28 Condition Codes; 29 ACDT State; 30; 31–34 Occurrence Code/Date; 35–36 Occurrence Span Code/From/Through; 37; 38; 39–41 Value Codes Code/Amount; 43 Description; 44 HCPCS / Rate / HIPPS Code; 48 Non-Covered Charges; 49.

Multiple Visits, Same Day (Cont.)

0001 PAGE 1 OF 1 CREATION DATE MMDDYY TOTALS → 168 75

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
Medicare		X				XXXXXXXXXX
						57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Beneficiary Last, First Name	XX	XXX-XX-XXXXX		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

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

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

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI XXXXXXXXXX	QUAL
LAST Last Name	FIRST First Name	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS	81 CC
	a
First diagnosis was for (define condition).	b
Second diagnosis was for (define condition).	c
Two visits, same day, not related.	d

Visiting Nurse Services

Visiting nurse services are covered as RHC services if:

- RHC has special certification from CMS to provide visiting nurse services because the RHC is located in an area where there is a shortage of home health agencies (as determined by CMS).

Psychiatric Coverage

All covered therapeutic services furnished by psychiatric providers are subject to the outpatient mental health limitation. This limitation does not apply to diagnostic services or pharmacological management.

Psychiatric Coverage (Cont.)

Effective January 1, 2010, the limitation will be phased out according to CR 6686:

- January 1, 2010 – December 31, 2011:
  - The limitation percentage is 68.75 percent.
  - Medicare pays 55 percent and the patient pays 45 percent.
- January 1, 2012 – December 31, 2012:
  - The limitation percentage is 75 percent.
  - Medicare pays 60 percent and the patient pays 40 percent.
- January 1, 2013 – December 31, 2013:
  - The limitation percentage is 81.25 percent.
  - Medicare pays 65 percent and the patient pays 35 percent.
- January 1, 2014:
  - The limitation percentage is 100 percent.
  - Medicare pays 80 percent and the patient pays 20 percent.

SNF/SB Care

SNF/SB coverage:

- Limited to physician, PA and NP services.
- RHC services are excluded from SNF/SB consolidated billing; this allows RHCs to bill these visits as off-site visits under revenue codes 0524 or 0525.

Preventive Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MEDICARE BILLING INFORMATION FOR RURAL PROVIDERS AND SUPPLIERS

ICN 006762 September 2011

QUICK REFERENCE RURAL BILLING CHARTS

							Preventive Services						
	Ambulance Services	Office Visits**	Hospital Services	Radiology and Diagnostics	Clinical Laboratory Tests	Supplies and Drugs	Screening Mammography Services and Pelvic Screening Exams	Cardiovascular Screening, Diabetes Screening, and Screening Pap Tests	IPPEs	Influenza and PPVs	HBVs	Colorectal and Prostate Cancer Screenings and BMMs***	Glaucoma Screenings
Rural Health Clinic	N/A	Bill FI or A/B MAC	N/A	**Provider based** **Professional component** Bill FI or A/B MAC **Technical component** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** **Professional component** Bill carrier or A/B MAC **Technical component** Bill carrier or A/B MAC using practitioner's ID number*	**Provider based** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Bill carrier or A/B MAC using practitioner's ID number*	RHCs receive no additional payment; costs included in encounter rate	**Provider based** **Professional component** Bill FI or A/B MAC **Technical component** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** **Professional component** Bill FI or A/B MAC **Technical component** Bill carrier or A/B MAC using practitioner's ID number*	**Provider based** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Bill carrier or A/B MAC using practitioner's ID number*	**Provider based** **Professional component** Bill FI or A/B MAC **Technical component of EKGs** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** **Professional component** Bill FI or A/B MAC **Technical component of EKGs** Bill carrier using practitioner's ID number*	Costs for vaccines included in cost report; no line items for vaccines are billed to FI or A/B MAC in addition to encounter	Effective 1/1/11, a separate line item for the vaccine must be billed to FI or A/B MAC RHCs receive no additional payment; costs included in encounter rate	**Provider based** **Professional component** Bill FI or A/B MAC **Technical component** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** **Professional component** Bill FI or A/B MAC **Technical component** Bill carrier or A/B MAC using practitioner's ID number*	**If and only if beneficiary has an otherwise covered encounter** Bill FI or A/B MAC **All provider types** No separable technical component

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Medicare Home Page » Specialty Services » Preventive Services

Preventive Services

Jump To: Notices | Publications | Upcoming Events | CMS Links | FAQs

TrailBlazer and CMS offer a variety of educational resources and products to promote national awareness of Medicare-covered preventive services and screenings and increase appropriate utilization and billing of these services.

The following preventive services and screenings are covered by Medicare when they meet certain eligibility and other limitations:

- Abdominal Aortic Aneurysm Screening.
- Adult Immunizations.
  - Influenza (Flu).
  - Pneumococcal Pneumonia Vaccine (PPV).
  - Hepatitis B Virus (HBV).
- Annual Wellness Visit (AWV).
- Bone Mass Measurements.
- Cancer Screenings.
  - Mammography.
  - Pap Test and Pelvic Exam.
  - Colorectal.
  - Prostate.
- Cardiovascular Screening.
- Diabetes Screening.
- Diabetes Self-Management Training (DSMT).
- Diabetes Supplies.
- Glaucoma Screening.
- High-Intensity Behavioral Counseling (HIBC) to Prevent Sexually Transmitted Infections (STIs).
- Human Immunodeficiency Virus (HIV) Screening.
- Initial Preventive Physical Exam (IPPE).
- Intensive Behavioral Therapy for Cardiovascular Disease.
- Intensive Behavioral Therapy for Obesity.
- Medical Nutrition Therapy (MNT).
- Smoking and Tobacco-Use Cessation Counseling Services.
- Screening for Depression.
- Screening for STIs.
- Screening and Behavioral Counseling Interventions to Reduce Alcohol Misuse.

Preventive Services

Beginning January 1, 2011, to ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052X series with the approved preventive service HCPCS code and the associated charges. For example, the service lines should be reported as follows:

Preventive Services (Cont.)

Line	Revenue Code	HCPCS Code	Date of Service	Charges
1	052X		01/01/2011	100.00
2	052X	HCPCS	01/01/2011	50.00

Preventive Services (Cont.)

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.

Preventive Services (Cont.)

Preventive services that receive a grade “B” or better as determined by the USPSTF are eligible for waiver of deductible and coinsurance.

Waiver of Deductible and Coinsurance for Preventive Services

The Patient Protection and Affordable Care Act (PPACA) allows for the waiver of coinsurance and deductible for some preventive services with dates of service on or after January 1, 2011.

Services	CPT/HCPCS Codes	2011 Coinsurance/Deductible
Initial Preventive Physical Examination (IPPE)	G0402	Waived
	G0403, G0404, G0405	Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Waived
Cardiovascular Disease Screening	80061, 82465, 83718, 84478	Waived
Diabetes Screening Tests	82947, 82950, 82951	Waived
Diabetes Self-Management Training (DSMT)	G0108, G0109	Not Waived
Medical Nutrition Therapy (MNT)	97802, 97803, 97804, G0270, G0271	Waived

Services	CPT/HCPCS Codes	2011 Coinsurance/Deductible
Glaucoma Screening	G0117	Not Waived
	G0118	Not Waived
Influenza Virus Vaccine	90655, 90656, 90657, 90660, 90662, Q2035, Q2036, Q2037, Q2038, Q2039, G0008, G9141, G9142	Waived
Pneumococcal Vaccine	90669, 90670, 90732, G0009	Waived
Hepatitis B Vaccine	90740, 90743, 90744, 90746, 90747, G0010	Waived
HIV Screening	G0432, G0433, G0435	Waived
Smoking and Tobacco Cessation	G0436, G0437	Waived
Annual Wellness Visit	G0438, G0439	Waived

Additional Provisions for Colorectal Screening Test and Related Services

Top Billing Issues

Top RTPs for RHC

Top Return to Provider (RTP) errors for RHCs:

- 32019 – Date of service after provider terminated.
- U5233 – Managed care billing error.
- 32200 – Flu billing error.
- 31577 – More than one unit shown with 052X.
- 30905 – An adjustment attempt with no original claim.
- 19201 – National Provider Identifier (NPI) missing.
- 39012 – Justification for timeliness error.
- 32078 – Invalid revenue code.
- 11701 – Type of admission missing.
- N5052 – Name/number mismatch.

All reason codes can be found on the Reason Code Search tool and include a resolution:

http://www.trailblazerhealth.com/Tools/ReasonCodeSearch.aspx

Technical Components

The technical component of a diagnostic procedure is reimbursed outside the encounter rate. An example is the creation of an X-ray film.

Provider-based and freestanding clinics bill this service differently.

Diagnostic Laboratory

All diagnostic laboratory services, including the six waived tests, are reimbursed outside of the encounter rate:

- Includes primary culturing for transporting to a certified lab.
- Provider-based and freestanding clinics bill these services differently.

CMS-1500 Claim Form

Bill on the CMS-1500 claim form for:

- Services rendered outside of the posted RHC hours.
- Services rendered at a hospital.
- Laboratory services for freestanding RHC.
- Technical components for freestanding RHC.

UB-04

Provider Name
Street Address
City, State, ZIP Code
Telephone; Fax; Country Code

Pay-to Name
Street Address or Post Office Box
City, State, ZIP Code

3a PAT. CNTL # Required
b. MED. REC. # Recommended

4 TYPE OF BILL 0711

5 FED. TAX NO. SubID
XX-XXXXXXX

6 STATEMENT COVERS PERIOD FROM THROUGH
MMDDYY MMDDYY

7

8 PATIENT NAME a
b Patient Last, First, Middle Initial

9 PATIENT ADDRESS a Street Address or Post Office Box
b City c State d ZIP Code e Country Code

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

MMDDCCYY X X XX

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
a b c d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521			MMDDYY	1	55 45		

UB-04 (Cont.)

0001 PAGE 1 OF 1 CREATION DATE MMDDYY TOTALS 55 45

50 PAYER NAME: Medicare
51 HEALTH PLAN ID
52 REL INFO: X
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI: XXXXXXXXXX
57 OTHER PRV ID

58 INSURED'S NAME: Beneficiary Last, First Name
59 P.REL: XX
60 INSURED'S UNIQUE ID: XXX-XX-XXXXX
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 9: XXXXX A B C D E F G H I J K L M N O P Q
67 (fields A–Q); 68

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

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI XXXXXXXXXX QUAL
LAST Last Name FIRST First Name
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81 CC a b c d

Telemedicine

Revenue code 0780 (telemedicine, general classification) is used to bill for the telehealth originating site facility fee. Telehealth originating site facilities' fees billed using revenue code 0780 are the only line items allowed on TOBs 71X that are not part of the RHC benefit.

These line items require use of HCPCS code Q3014 in addition to the revenue code (0780) to indicate the facility fee is being billed.

MSPQ

Medicare Secondary Payer Questionnaire (MSPQ):

- Quarterly for outpatient admission.
- Hard copy or online.
- No signature is needed.
- Retained for 10 years from date of service.

CR 6426:

- Instructed providers to use the CAS segment in the 837I when submitting MSP claims.
- Indicated that providers would not be able to submit MSP claims using Direct Data Entry (DDE) since the DDE process does not support the CAS segment adjustments as found in the 837.

MSP Billing

Description	Payment Indicator	Value Code
Working Aged	A	12
End Stage Renal Disease	B	13
Conditional Payment Request	C	All
Liability	D	14/47
Workers' Compensation	E	15
Disability	G	43
Federal Black Lung Program	H	41
Veterans Affairs	I	42

MSP Billing (Cont.)

1	2	3a PAT. CNTL #	Required	4 TYPE OF BILL
Provider Name	Pay-to Name	b. MED. REC. #	Recommended	0711
Street Address	Street Address or Post Office Box	5 FED. TAX NO. SubID	6 STATEMENT COVERS PERIOD FROM THROUGH	7
City, State, ZIP Code	City, State, ZIP Code	XX-XXXXXXXX	MMDDYY MMDDYY	
Telephone; Fax; Country Code				

8 PATIENT NAME a | 9 PATIENT ADDRESS a Street Address or Post Office Box

b Patient Last, First, Middle Initial | b City | c State | d ZIP Code | e Country Code

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

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
a	XX	25 00				
b						
c						
d						

Enter appropriate value code for type of other insurance.

Enter amount primary insurance paid.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521			MMDDYY	1	120 00		

MSP Billing (Cont.)

0001 PAGE 1 OF 1 CREATION DATE MMDDYY TOTALS 120 00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI XXXXXXXXXX
"X" Primary Insurance	XXXXXXXXXX	X				57 OTHER PRV ID
Medicare						

Replace X with appropriate payer ID code for primary insurance.

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Beneficiary Last, First Name	XX	XXX-XX-XXXXX	Insurance Name	Insurance Group Number
Beneficiary Last, First Name	XX	XXX-XX-XXXXX		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		Employer Name

66 DX: XXXXX A B C D E F G H 68

9 I J K L M N O P Q

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

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI XXXXXXXXXX QUAL
LAST Last Name FIRST First Name

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
Primary paid $25.

81 CC a b c d

Conditional Payment

Conditional payment:

- Value code and “0000.00” for payment.
- Occurrence code 24.
- “C” before primary insurance company name.
- Valid remarks:
  - Annual maximum.
  - Applied to deductible.
  - Pre-existing condition.
  - Forgoing lien; please pay conditionally (liability).
- Provider must wait 120 days before billing conditionally in liability cases.

Conditional Payment (Cont.)

1 Provider Name
Street Address
City, State, ZIP Code
Telephone; Fax; Country Code

2 Pay-to Name
Street Address or Post Office Box
City, State, ZIP Code

3a PAT. CNTL # Required
b. MED. REC. # Recommended

4 TYPE OF BILL 0711

5 FED. TAX NO. SubID XX-XXXXXXXX

6 STATEMENT COVERS PERIOD FROM MMDDYY THROUGH MMDDYY

7

8 PATIENT NAME a
b Patient Last, First, Middle Initial

9 PATIENT ADDRESS a Street Address or Post Office Box
b City c State d ZIP Code e Country Code

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

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
24	MMDDYY													

38

Occurrence code 24 is used for conditional payment.

Date must be 120 days greater than date of service, but less than date of bill.

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	XX	00		00		
b						

Enter appropriate value code for type of other insurance.

Do not show any amount; enter zeros.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521			MMDDYY	1	120 00		

Conditional Payment (Cont.)

0001 PAGE 1 OF 1 CREATION DATE MMDDYY TOTALS ➡ 120 00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	XXXXXXXXXX
"C" Primary Insurance	XXXXXXXXXX	X				57 OTHER PRV ID	
Medicare							

"C" represents conditional payment.

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Beneficiary Last, First Name	XX	XXX-XX-XXXXX	Insurance Name	Insurance Group Number
Beneficiary Last, First Name	XX	XXX-XX-XXXXX		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
		Employer Name

66 DX XXXXX A B C D E F G H 68

9 I J K L M N O P Q

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

74 PRINCIPAL PROCEDURE CODE DATE a. OTHER PROCEDURE CODE DATE b. OTHER PROCEDURE CODE DATE 75

c. OTHER PROCEDURE CODE DATE d. OTHER PROCEDURE CODE DATE e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI XXXXXXXXXX	QUAL
LAST Last Name	FIRST First Name	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS 81 CC a

Forgoing lien; please pay conditionally.

d

Enter comment on why the primary insurance did not pay.

Rural Health Clinic Overview

Thank you for attending.