



# MISSOURI RHC CODING BEST PRACTICES

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A photograph of a male doctor in a light purple shirt using a stethoscope to examine a female patient in a yellow top. The doctor is on the left, and the patient is on the right. The background shows a clinical setting with anatomical charts on the wall. A white horizontal bar with blue text is overlaid across the middle of the image.

# **RURAL HEALTH CLINIC (RHC): THE BASICS**

# What Is an RHC?

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





## Visits can take place

- In RHC
- At the patient's residence (including an assisted living facility)
- In a Medicare-covered Part A Skilled Nursing Facility
- At the scene of an accident

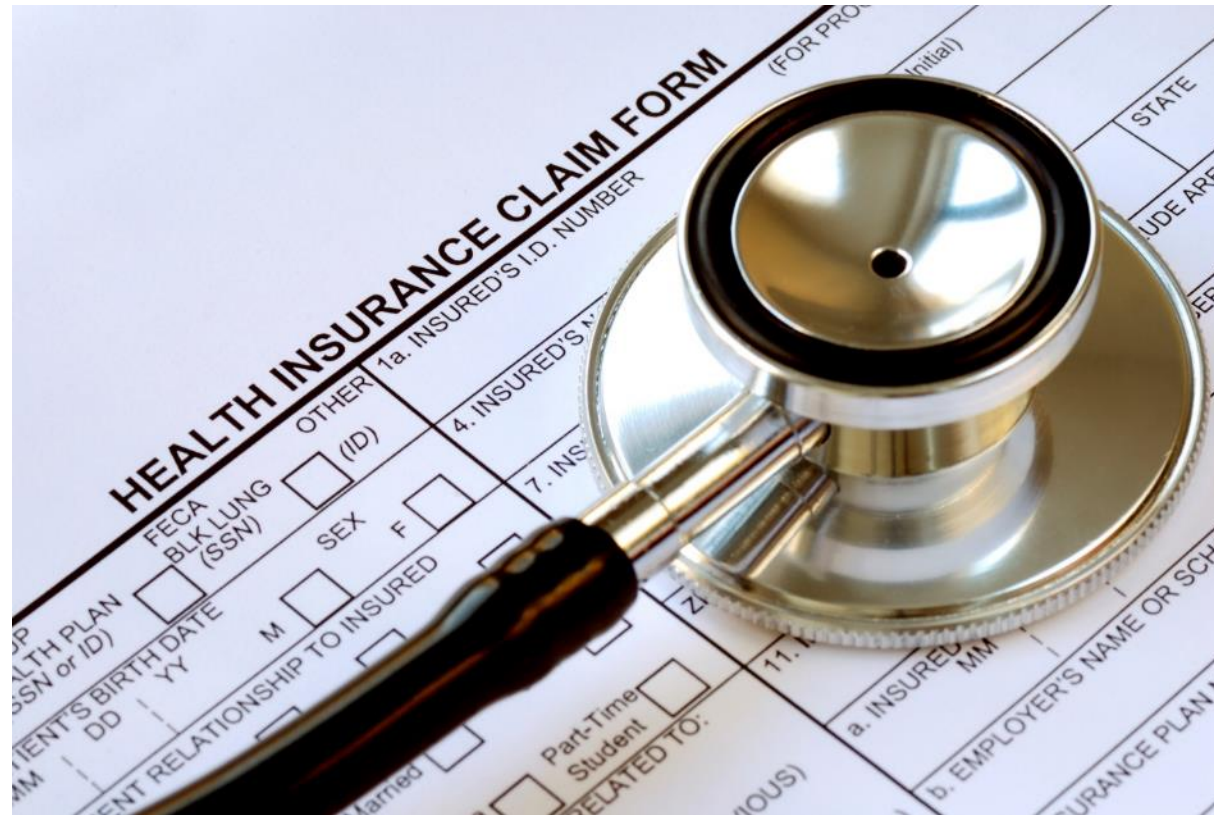
# Reimbursement

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

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

# Commercial vs. Government Billing

- Specific guidelines apply for Medicare and Medicaid RHC services
- Commercial payors make no distinction between RHCs and physician practices
- HCFA 1500 form for professional services
- UB-04 for CAH Method II
- Bill all Non-Medicare payors all applicable CPTs, HCPCS, modifiers and line item fees





A woman with dark curly hair, wearing a white lab coat, is sitting at a white desk in a bright office. She is looking at a laptop screen and has her hands on the keyboard. The desk is cluttered with various items: a blue stethoscope, a tablet, a blue folder, a small potted plant, and a black tray. The background shows a window with white blinds and a blue cabinet. The text "CLAIM FORM BASICS" is overlaid in the center of the image.

# CLAIM FORM BASICS

# Charge Form Components

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

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4-digit codes (leading zero) that categorize the type of service or product delivered, describe where the service took place and/or who performed or is billing the service (professional or technical)



All procedure codes billed on a hospital UB-04 (or electronic 837i) must be paired with a revenue code



Revenue code/procedure code pairing must make sense, must follow National Uniform Billing Committee guidelines, and must be acceptable to payors



Revenue code-HCPCS mismatches are automatic denials in many cases

# RHC Revenue Codes

Revenue Code	Revenue Category
0300-0319	Lab
0320-0329	Diagnostic Radiology
0400-0409	Other Imaging Services
0521	Clinic Visit by member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
0525	Visit by RHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
0523	Visit by RHC practitioner to other non RHC site (e.g., scene of accident)
0900	Behavioral Health Treatments/Services

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The primary service is considered the qualifying visit

CG modifier required for the line considered the qualifying visit

Report all charges on the service line with the qualifying visit HCPCS code, minus any charges for preventative services

Report charges associated with preventative med services on a separate line



# RHC Clinic Visit Commercial and Medicare

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												
A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.	
S01.01XA												
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOC PTINT												
MM	DD	YY	MM	DD	YY	PT	CD	CD	CD	CD	CD	CD
10	18	18				22	99215	25			1	350 00
10	18	18				22	12001				1	245 00

Modifier 25 required to signify procedure was the result of the visit for Commercial

1 PATIENT NAME	2 PATIENT ADDRESS	3a PAT. CNTRL #	3b MED. REC. #	4 TYPE OF BILL																	
				711																	
8 PATIENT NAME		9 PATIENT ADDRESS																			
10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30	
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37	38	39 VALUE CODES CODE	40 VALUE CODES AMOUNT	41	42	43	44	45	46	47	48	49	50	51	52
0521	Established Patient Visit Level 5			99215	CG	10102018		1	59500												
0521	Simple Repair scalp less than 2.5 cm			12001		10102018		1													

Use CG modifier, no modifier 25

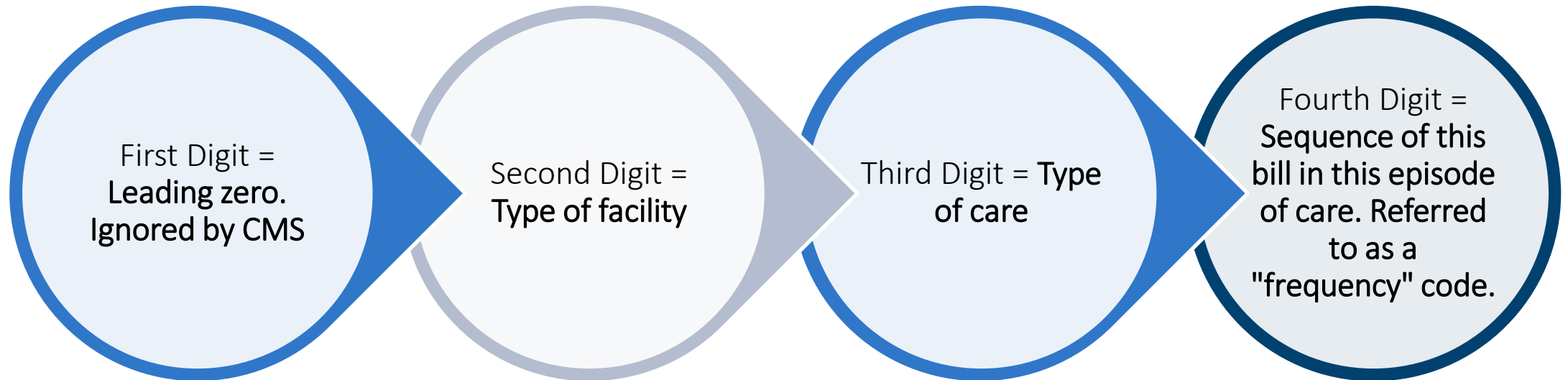
Sum the dollars on the line for the RHC visit

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# Type of Bill

- Required on a UB-04
- Serves a similar function as the place of service on a physician bill (HCFA 1500), except each number provides a separate piece of information



# Type of Bill - Examples

First Digit {

- Leading zero. Ignored by CMS

Second Digit =  
Type of facility {

- 1 - Hospital
- 2 - Skilled Nursing
- 3 - Home Health
- 7 - Clinic (RHC)
- 8 - CAH

Third Digit =  
Type of care {

- 1 - Inpatient or clinic
- 2 - Inpatient Part B, Hospital based clinics, Hospice, Home Health
- 3- Outpatient
- 5- Special Facilities (CAH)

Fourth Digit = Sequence of this bill in this episode of care. Referred to as a "frequency" code {

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

- 1- Admit to Discharge initial claim
- 7- Adjustment claim
- 8 - Cancel claim
- 0 - No Payment

- Required on HCFA 1500 form
- Two digit code specifying the entity where the services were rendered
- Must match the address and zip entered in the service location to avoid denials of claims

11 – OFFICE



21 – INPATIENT HOSPITAL



22 – OUTPATIENT HOSPITAL



# Place of Service vs. Type of Bill

UB Type of Bill 711	UB 1500
7 - Clinic (Type of Facility)	11 Office
1 - RHC (Type of Care)	22 Outpatient Hospital
1 - (First or final bill)	21 Inpatient Hospital

UB -04

1		2		3a PAT. CNTL #		4 TYPE OF BILL	
				b. MED. REC. #		711	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
8 PATIENT NAME		a		9 PATIENT ADDRESS		a	



1500 Form

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From	To													
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER						
						22								NPI	
														NPI	

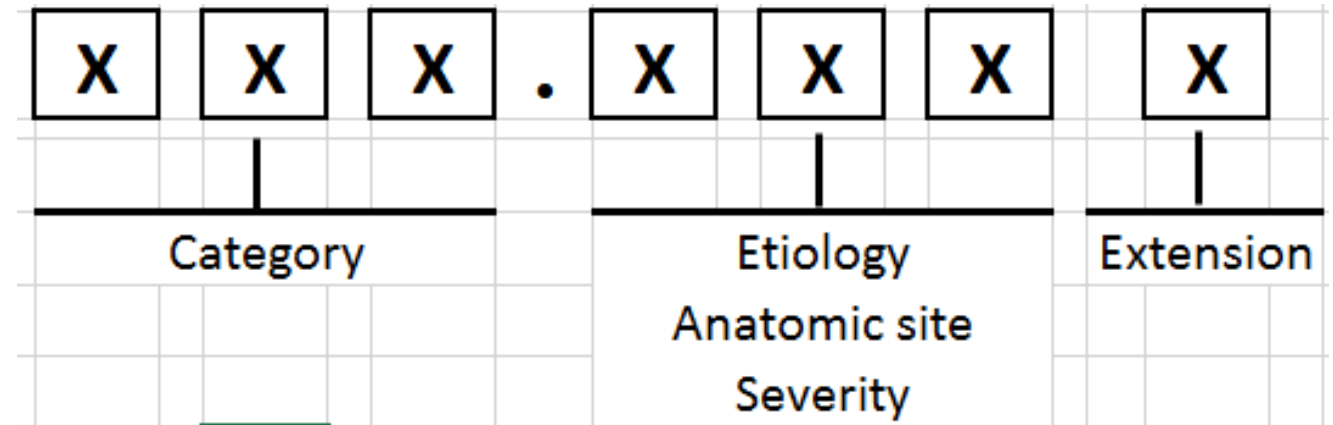


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# ICD-10 Code Structure

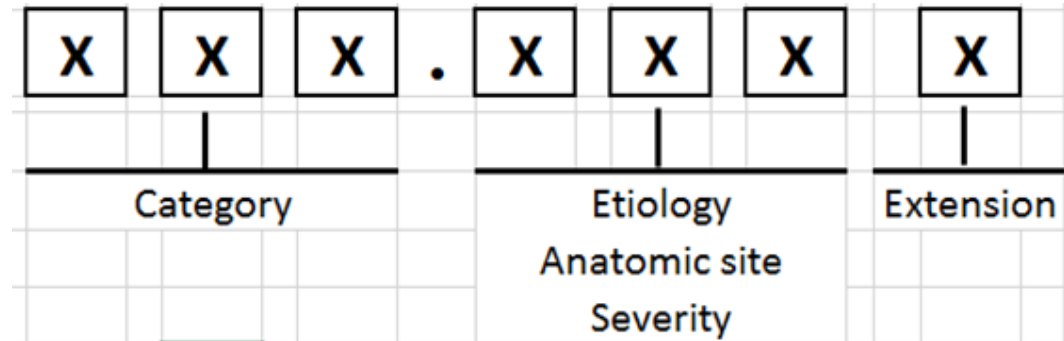
- First 3 characters represent category
  - May *rarely* be a complete code
- Next 3 characters provide detail on disease, condition, location, severity etc. Extra characters may be populated with X.
- Seventh character characterizes
  - Episode of care
    - Initial
    - Subsequent
    - Sequela – visit due to complication
  - Type of fracture
  - Fracture care
  - Complication of pregnancy





# 7<sup>th</sup> Character

Fracture of Shoulder and Upper Arm, Does not Require Gustilo Classifications	
A	Initial encounter for closed fracture
B	Initial encounter for open fracture
D	Subsequent encounter for fracture with routine healing
G	Subsequent encounter for fracture with delayed healing
K	Subsequent encounter for fracture with nonunion
P	Subsequent encounter for fracture with malunion
S	Sequela



Multiple Gestations	
0	not applicable or unspecified
1	fetus 1
2	fetus 2
3	fetus 3
4	fetus 4
5	fetus 5
9	other fetus



“and”

- interpreted as “and” or “or”

“Includes” notes

- Immediately appear under a three-character code title to further define, or give examples of, the content of the category

“with”

- “Associated with” or “due to”

+ or √

- Additional characters required

## BRACKETS [ ]

- Used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases
- Used in the Alphabetic Index to identify manifestation codes
- Sequence second

## PARENTHESES ( )

- Used in both the Alphabetic Index and Tabular List to isolate non-essential modifiers (supplemental words that do not affect the code assignment)

## COLON:

- Used in the Tabular List after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category

A photograph of a person's hands pointing at a document on a desk. The document features several colorful charts and graphs, including a pie chart and a bar chart. A laptop is open to the left, and a cup of coffee is in the foreground. The scene is lit with warm, golden light, suggesting a late afternoon or early morning setting. The text 'CODING TIPS AND TRICKS' is overlaid in a bold, black font across the center of the image.

# **CODING TIPS AND TRICKS**

Diagnoses are not specific to a single line, but apply to the entire claim

Must complete box 70 Diagnosis "Reason for Visit"

Additional diagnoses must be sequenced

# UB-04 Example

1		2		3a PAT CNTL # b. MED REC. #		4 TYPE OF BILL		
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH		
8 PATIENT NAME a			9 PATIENT ADDRESS a					
b		c		d		e		
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HRS 14 TYPE 15 SRC 16 DHR		
17 STAT		18 19 20 21 22 23 24 25 26 27 28						
29 ACCT STATE		30						
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		
35 CODE		36 OCCURRENCE SPAN FROM		37 THROUGH		38		
39 CODE		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT		
a		b		c		d		
43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERV. DATE		46 SERV. UNITS		
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50		
PAGE		OF		CREATION DATE		TOTALS		
51 HEALTH PLAN ID		52 REL INFO		53 ASST BEN		54 PRIOR PAYMENTS		
55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID		58		
59 P REL			60 INSURED'S UNIQUE ID			61 GROUP NAME		
62 INSURANCE GROUP NO.			63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX		67 A B C D E F G H		68		69		
70 PATIENT REASON DX		71 PPS CODE		72 ECI		73		
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 QUAL		
78 LAST		79 FIRST		80 LAST		81 FIRST		
82 OTHER NPI		83 QUAL		84 LAST		85 FIRST		
86 OTHER NPI		87 QUAL		88 LAST		89 FIRST		
90 REMARKS		91 CC a		92 b		93 c		
94 d		95		96		97		

Used to bill all services to commercial payors

Used to report Medicare Part B “technical” services and RHC services

Requires Diagnosis codes specific to each line of service

# HCFA-1500 Example

1. MEDICARE <input type="checkbox"/> (Medicare#)                    MEDICAID <input type="checkbox"/> (Medicaid#)                    TRICARE <input type="checkbox"/> (ID#DoD#)                    CHAMPVA <input type="checkbox"/> (Member ID#)                    GROUP HEALTH PLAN <input type="checkbox"/> (ID#)                    FECA (LUNG) <input type="checkbox"/> (ID#)                    OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID, NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY    STATE		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) CITY    STATE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.	
15. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY    QUAL. _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to C to service line below (24E) ICD Ind. _____		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
23. PRIOR AUTHORIZATION NUMBER _____		24. TABLE OF SERVICES	
25. FEDERAL TAX ID, NUMBER    SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov't, clinics, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____	
29. AMOUNT PAID \$ _____		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH # ( )		34. BILLING PROVIDER INFO & PH # ( )	



# Outpatient Diagnoses Reporting

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Report the full diagnosis code to the highest level of specificity for the diagnosis shown to be reason for the outpatient services

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Report symptom in absence of finding addressed in the provider note

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Do not report *suspected*

---

Do not report *rule out*

---

Reading physician must always report finding if applicable

---

Report reason for encounter (Z code) for encounters with no symptoms or findings

---



## Personal History Codes

- Relevant to treatment options
- Relevant to reason for visit, example: cough
  - Don't report personal history of contraception Z92.0 range
  - Report
    - History of nicotine dependence – Z87.891 if applicable
    - History of tuberculosis – Z86.11 if applicable
- Support reason for screening services

## Almost always relevant

- Personal history of cancer, malignant neoplasms (leukemia, lymphoma)
- Personal history of falling – Z91.81

## Family history

- Risk factors relevant to visit
- Screening services



**Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology**

Sequence underlying condition (etiology) first and manifestation second

If manifestation codes have in the code title, “in diseases classified elsewhere” are never permitted to be first listed or principal diagnosis codes

- Use in conjunction with underlying condition
- Code underlying condition first



**“use additional code” – Two codes required to fully describe a single condition that affects multiple body systems**

Sequencing should be etiology/manifestation

# Non RHC E&M Services

An RHC visit includes medically necessary medical or mental health visit, or a qualified preventive health visit. **The visit must include a face-to-face (one-on-one) encounter** between the patient and an RHC practitioner during which time one or more RHC services are furnished.

Effective January 1, 2019, virtual communication services are considered RHC services

Distant site Telehealth and Chronic Care visits do not require a patient and provider in the same place to perform the service, so these are not RHC services

Transitional Care requires a patient and practitioner visit during the month to satisfy requirements, therefore Transitional Care is considered an RHC visit



# Incident to Services – Nurse Visit

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



## X-rays can be performed in RHCs

- Taking X-rays is considered a Technical Component (TC) and is not part of an RHC visit.
- Provider-based RHCs report taking of X-ray on the hospital billing form (UB-04).
- Reading X-rays is a Professional service.
  - Included in the RHC visit if the provider reads the X-ray during the face-to-face visit
  - Separately reportable as a non RHC services by the reading physician if not resulted by the servicing provider

## EKGs can be performed in an RHC

- If the RHC provider reads the EKG, the reading is considered part of the professional service
- Taking EKGs can be reported separately on a UB-04 for provider-based clinics
- Report taking EKG on an HCFA 1500 for non-Method II or non-provider-based billing

# RHC Visit with X-ray

Taking of X-Ray Non RHC Service. Bill on 1500

Report Modifier TC for technical component only

24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			F.	G.	H.	I.	J.
From	To	MM	DD	YY	MM	DD	YY	EMG	PT/HPCS	MODIFI	PCINTER	\$ CHARGES	DAYS OR UNITS	EP/DT Family Plan	ID. QUAL	RENDERING PROVIDER ID. #			
10	18	18					22		71046	TC		1	45	00	NPI	1234567890			
															NPI				
															NPI				

PPLIER INFORMATION

Report RHC Visit On UB

3a PAT. CNTL #		4 TYPE OF BILL					
b. MED. SEC #		711					
5. STATEMENT COVERS PERIOD FROM		7. THROUGH					
26		29 ACDT STATE					
36 CODE		37					
40 CODE		41 CODE					
VALUE CODES AMOUNT		VALUE CODES AMOUNT					
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	Established Patient Visit Level 3		99213 10102018	1	59500		



# CLAIM FORM EXAMPLES



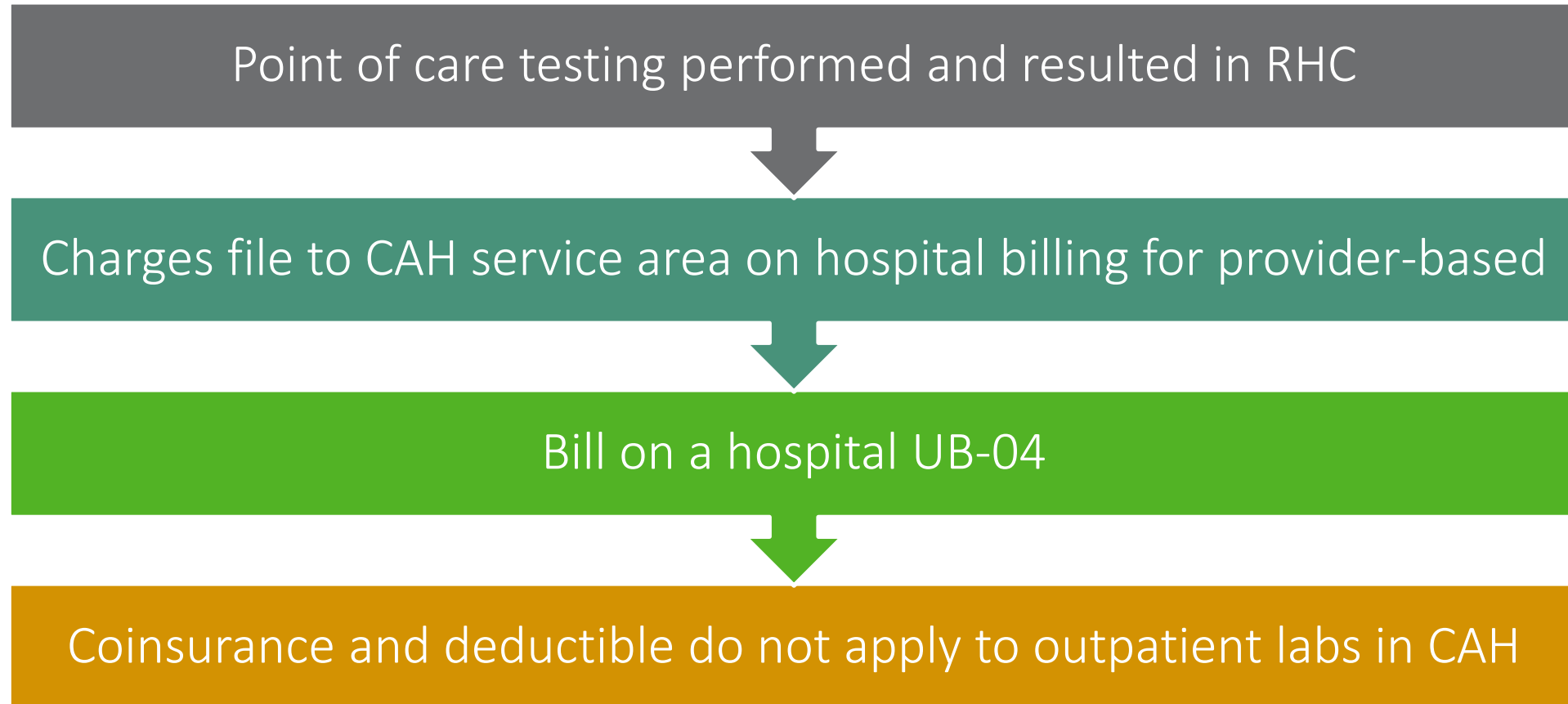
# 1. Point of Care Testing Performed and Resulted in RHC

## Example

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

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

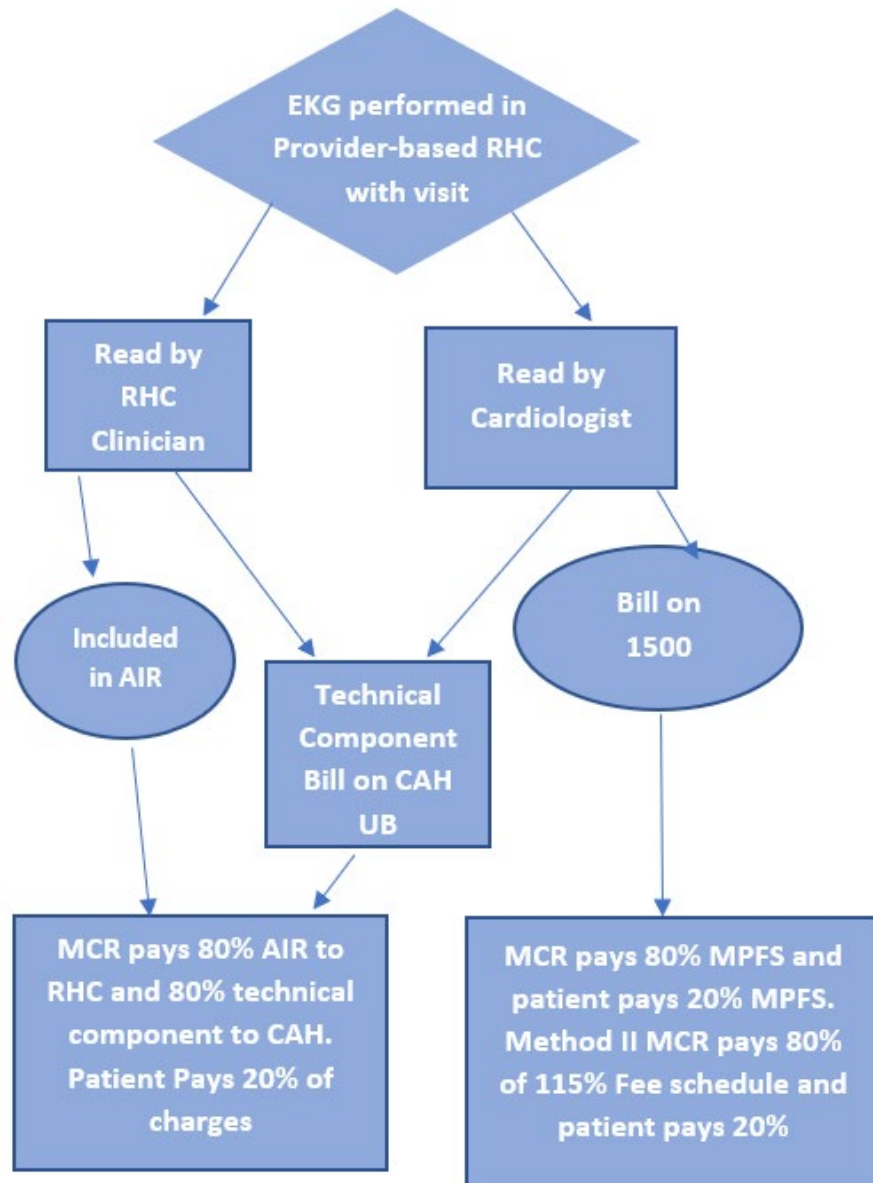
# 1. Point of Care Testing Performed and Resulted in RHC



# 1. Point of Care Testing Hospital Claim

1 CAH PO BOX												3a PAT												4 TYPE OF BILL 0851	
												B MED REC #													
												5 FED TAX NO												STATEMENT COVERS PERIOD FROM THROUGH 09182019 09182019	
8 PATIENT NAME a												9 PATIENT ADDRESS a 72 CONFUSED LANE													
b PATIENT												b ANYTOWN													
10 BIRTHDATE 11241965				11 SEX F		12 ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC				16 DHR		17 STAT		CONDITION CODES								29 ACDT		30	
						3				1		01													
31 OCCURRENCE CODE DATE			32 OCCURRENCE CODE DATE			33 OCCURRENCE CODE DATE			34 OCCURRENCE CODE DATE			35 OCCURRENCE SPAN CODE FROM THROUGH			36 OCCURRENCE SPAN CODE FROM THROUGH			37							
MEDICARE MAC PO BOX												39 VALUE CODES CODE AMOUNT			40 VALUE CODES CODE AMOUNT			41 AMOUNT							
												a													
												b													
												c													
												d													
42 REV CD. N				43 DES CRIP TIO				44 HCPCS/RATE/HIPPS CODE				45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES		48 NON COVERED CHARGES		49					
0301				PTT, PLASMA OR WHOLE BLOOD				85730				09182019		1		1400									

# EKG Performed



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

# EKG Performed and Read by RHC Provider

Performed at RHC

Reading included in visit

MCR pays AIR. Patient owes coinsurance based on charge.

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

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

# EKG Performed and Read by RHC Provider

1 RHC PO BOX		3a PAT		4 TYPE	
		CNTL#		OF BILL	
		REC #		711	
		5 FED TAX NO		STATEMENT COVERS PERIOD	
				FROM THROUGH	
				09182019 09182019	
8 PATIENT NAME		9 PATIENT ADDRESS			
PATIENT		72 CONFUSED LANE			
10 BIRTHDATE		11 SEX		12 ADMISSION	
11241965		F		13 DATE 14 TYPE 15 SRC	
16 DHR		17 STAT		CONDITION CODES	
3		1		01	
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE	
CODE DATE		CODE DATE		CODE DATE	
34 OCCURRENCE		35 OCCURRENCE		36 OCCURRENCE	
CODE DATE		CODE DATE		CODE DATE	
37 OCCURRENCE		38 OCCURRENCE		39 OCCURRENCE	
CODE DATE		CODE DATE		CODE DATE	
39 VALUE CODES		40 VALUE CODES		41 VALUE CODES	
CODE AMOUNT		CODE AMOUNT		CODE AMOUNT	
42 REV CD		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE	
521		EST PATIENT VISIT LEVEL III		99213CG	
				9182019	
				1	
				125.00	
521		EKG		93005	
				9182019	
				1	
				100.00	



1 CAH PO BOX		3a PAT		4 TYPE	
		CNTL#		OF BILL	
		REC #		0851	
		5 FED TAX NO		STATEMENT COVERS PERIOD	
				FROM THROUGH	
				09182019 09182019	
8 PATIENT NAME		9 PATIENT ADDRESS			
PATIENT		72 CONFUSED LANE			
10 BIRTHDATE		11 SEX		12 ADMISSION	
11241965		F		13 DATE 14 TYPE 15 SRC	
16 DHR		17 STAT		CONDITION CODES	
3		1		01	
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE	
CODE DATE		CODE DATE		CODE DATE	
34 OCCURRENCE		35 OCCURRENCE		36 OCCURRENCE	
CODE DATE		CODE DATE		CODE DATE	
37 OCCURRENCE		38 OCCURRENCE		39 OCCURRENCE	
CODE DATE		CODE DATE		CODE DATE	
39 VALUE CODES		40 VALUE CODES		41 VALUE CODES	
CODE AMOUNT		CODE AMOUNT		CODE AMOUNT	
42 REV CD		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE	
521		EKG		99213CG	
				09182019	
				1	
				125.00	

# EKG Performed in RHC and Read by Non-RHC Cardiologist

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

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

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

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

1 RHC PO BOX XXX		2		3a PAT CNTL#		4 TYPE OF BILL											
				B MED REC #		0711											
				5 FED TAX NO		STATEMENT COVERS PERIOD											
				09182019		09182019											
8 PATIENT NAME		9 PATIENT ADDRESS															
PATIENT		ANYTOWN NY 13807															
10 BIRTHDATE	11 SEX	12 ADMISSION		16 DHR		17 STAT		CONDITION CODES		29 ACDT	30						
11241965	F	12 DATE	13 HR	14 TYPE	15 SRC	18	19	20	21	22	23	24	25	26	27	28	STATE
			3		1												
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE		34 OCCURRENCE		35 OCCURRENCE SPAN		36 OCCURRENCE SPAN		37					
CODE	DATE	CODE	DATE	CODE	DATE	CODE	DATE	CODE	FROM	THROUGH	CODE	FROM	THROUGH				
EMPIRE MEDICARE SERVICES PO BOX 6189 INDIANAPOLIS, IN 46206-6189		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES		42		43		44					
		CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	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	EST PATIENT VISIT LEVEL III		99213CG		09182019		1 125.00										

1 CAH PO BOX		2		3a PAT CNTL#		4 TYPE OF BILL											
				B MED REC #		0851											
				5 FED TAX NO		STATEMENT COVERS PERIOD											
				09182019		09182019											
8 PATIENT NAME		9 PATIENT ADDRESS															
PATIENT		ANYTOWN NY 13807															
10 BIRTHDATE	11 SEX	12 ADMISSION		16 DHR		17 STAT		CONDITION CODES		29 ACDT	30						
11241965	F	12 DATE	13 HR	14 TYPE	15 SRC	18	19	20	21	22	23	24	25	26	27	28	STATE
			3		1												
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE		34 OCCURRENCE		35 OCCURRENCE SPAN		36 OCCURRENCE SPAN		37					
CODE	DATE	CODE	DATE	CODE	DATE	CODE	DATE	CODE	FROM	THROUGH	CODE	FROM	THROUGH				
EMPIRE MEDICARE SERVICES PO BOX 6189 INDIANAPOLIS, IN 46206-6189		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES		42		43		44					
		CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	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						
730	EKG 12 LEAD TRACING ONLY		93005		09182019		1 125.00										



# EKG with Visit Claim Forms

## HCFA - 1500

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)											ICD Ind.		22. RESUBMISSION					
													CODE		ORIGINAL REF. NO.			
A. 150.21			B.			C.			D.									
E.			F.			G.			H.			23. PRIOR AUTHORIZATION NUMBER						
I.			J.			K.			L.									
24. A.	DATES OF SERVICE					B.	C.	D. PROCEDURES, SERVICES OR SUPPLIES			E.	F.		G.	H.	I.	J.	
	FROM		TO			PLACE		(Explain Unusual Circumstances)			DIAGNOSIS			DAYS OR	EPSDT FAMILY	ID.	RENDERING	
	MM	DD	YY	MM	DD	YY	OF	EMG	CPT/HCPCS	MODIFIER	POINTER	\$ CHARGES		UNITS	PLAN	QUAL.	PROVIDER ID. #	
1	9	18	19				72		93010	72		A	125	100		NPI		
2																		

# Example Non RHC Service

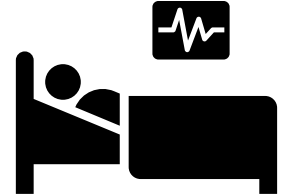
Patient seen in a hospital for subsequent hospital visit

Diagnosis acute systolic Congestive Heart Failure

Medicare Method II – bill on UB

Reimburses 115% Physician Fee Schedule

Coinsurance and deductible applies



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

# Example Non RHC Service

## UB-04 – Provider Based Method II

1 LITTLE FALLS HOSPITAL PO BOX												2												3a PAT CNTL# REC #		4 TYPE OF BILL 0851			
8 PATIENT NAME a												9 PATIENT ADDRESS a												5 FED TAX NO		STATEMENT COVERS PERIOD FROM 09182019		THROUGH 09182019	
b PATIENT												b ANYTOWN												c NY		d 13807		e	
10 BIRTHDATE 11241965			11 SEX F		12 ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC				16 DHR		17 STAT 01 D7		CONDITION CODES										29 ACDT STATE		30				
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											
EMPIRE MEDICARE SERVICES												a		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 AMOUNT											
PO BOX 6189												b																	
INDIANAPOLIS, IN 46206-6189												c																	
												d																	
42 REV CD		43 DESCRIPTION				44 HCPCS/RATE/HIPPS CODE				45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES		48 NON COVERED CHARGES		49											
0987		SUBSEQUETB HOSPITAL VISIT				99232				09182019		1		175.00															

# RHC Clinic Visit Commercial Vs. Medicare

## Commercial Insurance:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.													EF. NO.	
A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.			
S01.01XA														

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	(DIAGNOSIS) POINTER	\$ CHARGES	OR UNITS	Family Plan	ID. QUAL	J. RENDERING PROVIDER ID. #		
From	To	YY	MM	DD	EMG	(Explain Unusual Circumstances) CPT/HCPCS	MODIFIER						
10	18	18			72	99215	25			A	350 00 1	NPI	1234567890
10	18	18			72	12001				A	245 00 1	NPI	

PPLIER INFORMATION

Modifier 25 required

## Medicare

1 RHC PO BOX XXX										2										3a PAT		4 TYPE			
																				B MED REC #		0711			
																				5 FED TAX NO		STATEMENT COVERS PERIOD			
																						FROM THROUGH			
																						09182019 09182019			
8 PATIENT NAME										9 PATIENT ADDRESS															
PATIENT										ANYTOWN										NY		13807			
10 BIRTHDATE					11 SEX		12 ADMISSION			16 DHR		17 STAT			CONDITION CODES			29 ACDT		30					
11241965					F		3			1		01													
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE		34 OCCURRENCE		35 OCCURRENCE SPAN		36 OCCURRENCE SPAN		37													
CODE DATE		CODE DATE		CODE DATE		CODE DATE		CODE FROM THROUGH		CODE FROM THROUGH		CODE													
EMPIRE MEDICARE SERVICES PO BOX 6189 INDIANAPOLIS, IN 46206-6189																				39 VALUE CODES		40 VALUE CODES		41	
																				CODE AMOUNT		CODE AMOUNT		CODE AMOUNT	
42 REV		43 DESCRIPTION			44 HCPCS/RATE/HIPPS CODE			TOTAL CHARGES			48 NON COVERED CHARGES			49											
		0521 ICE OUTPATIENT 15 MIN			99213			09182019			1			584.00											
		0521 REPR SUPERF WND BODY ,2.5CM			12001			09182019			1			459.00											

Use CG modifier

# Useful Links

- [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_g\\_rhc.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf)
- <https://www.hrsa.gov/advisorycommittees/shortage/Meetings/20100922/rhcandfqhc.pdf>
- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf>
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf>
- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/CertandComplianceProcess.pdf>

A close-up photograph of a doctor's hands, wearing blue nitrile gloves, holding a small, rectangular wooden block. The block is split horizontally, with the word 'QUESTIONS' printed in bold, black, sans-serif capital letters on the top half and the word 'ANSWERS' printed in the same style on the bottom half. The doctor is wearing a white lab coat, and a stethoscope is visible around their neck. The background is softly blurred, showing the doctor's face and the white coat. A thin black horizontal line is positioned above the top edge of the wooden block.

**QUESTIONS**

**ANSWERS**



Amy Graham  
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(M) 561-628-0066

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- Strategic planning
- Master facility planning
- Hospital/RHC/FQHC financial analysis
- Access to capital options analysis
- Post-acute strategies
- Physician practice evaluations and valuations
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- Primary care options analysis
- Delivery system integration
- Clinical service planning
- Network development
- Affiliation strategy
- Physician contracting/compensation support

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