Texas Association of Rural Health Clinics

Quality Health Care for Rural Texas

RHC/FQHC
Rules Differ Per Payer

DON'T THINK ALL ARE LIKE MEDICARE!

Yes – Medicare & Medicaid deal with the AIR – but ONLY on some things

[redacted]

Let's not forget that there are many things you can and should bill Medicare Part B for

ALL INCLUSIVE RATE

- Services provided during Clinic Hours
- Services provided in the clinic
- Does not include clinical lab tests in house
- Does not include tech side of diagnostic tests
- Does not include services performed at hospital

ADDITIONAL $ ON MEDICARE

- Bill appropriately for what is done at the hospital
  - Both – Medicare and non Medicare
  - Make sure providers & biller are aware of what is billable
  - Don't violate incident-to rules –
    - If NP or PA sees patient in hospital – use their NPI – not physician
    - If NP or PA sees home patient – use their NPI – not physician
    - Both of these may be different per commercial carrier

Diagnostic Tests in the RHC/FHQC

- **Professional side is included in the AIR**
- **Technical side is separately billable to Medicare/Medicaid**
- **Example: ABI – ANKLE BRACHIAL INDEX – CODE 93922 – Austin, TX**
  - **GLOBAL: $91.33**
  - **PROF: $12.72 Included in AIR**
  - **TECH: $78.61 Part B Allowed**

Diagnostic Tests in the RHC/FHQC

- **Segmental ABI – CODE 93923 – Austin, TX**
  - **GLOBAL: $141.78**
  - **PROF: $22.63 Included in AIR**
  - **TECH: $119.15 Part B Allowed**
  - **1/3 of all ABIs are segmental due to occlusion**
  - **Average tech income is $105.24**

We refer everyone to hospital…

- No, you don't!
- Your providers only refer those that they are pretty certain have Peripheral Arterial Disease to the hospital for an ultrasound.
- Medicare said in PQRS, they wanted every patient with diabetes with any circulatory problems to have an ABI once a year.
- Two a day is an additional $54,784 per year

HOSPITAL WANTS DIAGNOSTICS

- Save your patients a trip to the hospital for the minor diagnostics, such as EKG, spirometer, ABI, etc.
  - Treat the patients the way you would want to be treated
  - By performing the minor diagnostics in house – you identify the more expensive needed diagnostics that can be ordered at the hospital
- Perform the diagnostics in your clinic that the hospital doesn't do – yet Medicare wants done

AUTONOMIC SYSTEM TESTING

- Very few hospitals perform –
  - Non certified personnel can complete
  - 10 minute non invasive test:
  - 3 CPT codes: 93922, 95921, 95923
  - Medicare – Austin, Texas
    - Global $329.31
    - Professional Included in AIR
    - Technical $184.72
  - Diabetes with autonomic neuropathy, Tachycardia, Orthostatic Hypotension, CRPS, Hyperhydrosis, etc.
  - 2 per day = $ $89,140 – Medicare annual income
  - 2 per day Non Medicare = $173,000 annual income

CHRONIC CARE MANAGEMENT

- **99490 – 20- Minutes per month – CCM $43.66 p/pt**
- **99487 - 60 minutes per month – CCM $96.13 p/pt**
- **Medicare Part B pays – not included in AIR**
- **January 2017 – Medicare allows RHC/FQHC to use a service with pass-through billing (only service that Medicare allows pass-through billing)**

ANNUAL WELLNESS VISIT

- NOT an annual physical
- Payable by Medicare and several commercial carriers including UHC, BCBS, AETNA and others
- Qualifies for AIR for RHC/FQHC
- Specific Requirements
  - Must be at least 11 full calendar months since previous AWV
  - Specific services must be performed
  - Patient must leave with printed Personalized Preventive Plan

ANNUAL WELLNESS VISIT

+ Specific Services Required:

- + Establish/update medical and family history
- + List current medical providers & all prescribed medications
- + Record vitals plus the BMI
- + Detect Cognitive Impairment
- + Provide printed PERSONALIZED screening schedule for 5-10 years
- + Furnish personalized health advice/referrals

ANNUAL WELLNESS VISIT

- Qualifies as visit under AIR – Medicare
- If testing is indicated, bring patient back for visit for results – AIR
- Commercial carries – typical income is over $270 if done properly
- How many Medicare patients x AIR?
- How many UHC, BCBS, Aetna x $270?

DETECT COGNITIVE

- **3 METHODS:**
- **Ask questions, draw clock – No code**
- **Cognitrax test – Codes 96103/96120**
- **CNS-VS test – Code G0505 (Used for a lot more than just AWVs)**

COMMON CODING ERRORS IN RHC/FQHCs

CODE 17000 & 17003

- 17000: Destruction, premalignant lesion; first lesion
- 17003: " ", second through 14th lesion; each
- 17004: " "; 15 or more lesions
- Most providers do not know that each lesion counts in the billing.

CODES 99238 - 99239

- Includes all E&M related services on day of discharge
- Includes time spent with patient, patient's family, coordinating care, dictating orders to nurses and dictating discharge to the hospital
- 99238: 30 minutes or less
- 99239: 31 minutes or longer

CODE 69209 & 69210

- 69209: Ear Irrigation – Impacted Cerumen – performed by MA, per ear
- 62910: Remove Impacted Cerumen with tool – Medical Provider – with magnification, one or both ears – Medicare (commercial is per ear)

4. EVERYONE DOESN'T USE THE SAME RULES AS MEDICARE

GLOBAL FEES

- Medicare includes all non-return-OR services in follow-up.
- CPT (Commercia)l says only "routine" post op care is bundled into the surgery
- Learn to use modifiers 79 and 24 properly

VENIPUNCTURE & HANDLING

- Medicare pays for 36415 (included AIR)
- Commercial carriers pay for 36415 and 36416 (most of them)
- Medicare doesn't pay for 99000
- 45% of commercial carriers pay for 99000

INCONVENIENCE FEES

- Medicare doesn't pay for 99050, 999052, 99054
- Some commercials do pay for them
- If it's for the convenience of the doctor – don't bill the inconvenience code
- 99050, 99052, 99054

CCI EDITS - OTHERS

- Medicare uses CCI edits
- Medicare sets standard of industry
- Make sure your clearinghouse is not scrubbing codes off that carriers would pay

NO SHOW FEES

- Medicare doesn't pay
- Medicare doesn't prohibit you billing patients for it – if that is your usual policy
- If no negative consequence – patients abuse you

TIMELY FILING

- Medicare is 1 year from DOS
- Commercial is whatever the patient's policy says – not the contract the carrier coerced you to sign
- Be willing to do what it takes (legally) to get the claims paid

STOP RECOUPMENTS

- LEARN ERISA
- ERISA APPLIES WHEN
  - INSURANCE PROVIDED BY EMPLOYER, AND
  - EMPLOYER IS NOT GOVERNMENT OR CHURCH
- MAKE CARRIERS PAY WHEN THEY DON'T WANT TO
- DISREGARD TIMELY LIMITS IN THE CONTRACTS
- MAKE CARRIERS FOLLOW THE FEDERAL LAW

QUESTIONS?

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