Texas Association of Rural Health Clinics

July 27, 2017

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Novitas Solutions Education

- This education contains specific contractor guidance for providers in Medicare Administrative Contractor (MAC):
  - Jurisdiction H (JH) includes: Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas
- If you are not a provider in JH please contact your Medicare contractor for specific guidance

Acronym List

Acronym	Definition
AIR	All Inclusive Rate
CARC	Claim Adjustment Reason Code
CCM	Chronic Care Management
CMS	Centers of Medicare & Medicaid Services
DDE	Direct Data Entry
EDI	Electronic Data Interchange
FAQs	Frequently Asked Questions
HCPCS	Healthcare Common Procedure Codes Services

More Acronym List

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Acronym	Definition
IPPE	Initial Preventative Physical Examination
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MREP	Medicare Remit Easy Print
MSP	Medicare Secondary Payer
NCD	National Coverage Determination
RARC	Remittance Advice Remark Codes
RHC	Rural Health Clinic

Today's Presentation

- Agenda:
  - RHC Billing Revisions
  - Chronic Care Management
  - RHC Updates
  - RHC Top Errors
  - Resources

- Objectives:
  - Identify and understand the current Medicare changes
  - Learn how to apply the new guidelines
  - Identify and utilize the educational resources and information

RHC Billing Revisions

Required Billing Updates for RHC

- Change Request # 9269:
  - Effective April 1, 2016
  - Implementation April 4, 2016
- Key Points:
  - RHCs are required to report the appropriate HCPCS code for each service line along with the revenue code and other codes as required
  - Payment for RHCs will continue to be made under the AIR when all of the program requirements are met
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf

Background

- Until March 31, 2016:
  - RHCs billing under the AIR system were not required to report HCPCS coding:
    - ✓ Required to report HCPCS codes when furnishing certain preventive services
- RHC Visit is defined as a medically necessary face-to-face encounter between a patient and a qualified practitioner during which time one or more RHC services are furnished:
  - Medical visit
  - Mental health visit
  - Qualified preventive health visit

April 1 Changes to RHC Billing

- Effective April 1, 2016, RHCs are required to report the appropriate HCPCS and revenue code for each service line
- Must include a qualifying visit
- Medical visit:
  - Typically evaluation and management type service
- Mental health visit:
  - Typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis

Line Item Billing (Beginning April 1, 2016)

- Required to report HCPCS codes with revenue code:
  - The professional component of qualified medical services are reported on a line item using revenue 052X (free-standing clinic), with qualifying RHC visit code
  - When an approved preventive health service is furnished, report it on an additional 052X service line with qualifying RHC visit code
  - Mental health services are reported on a line item using revenue code 0900 (mental health treatment services)

October 1, 2016 Billing

- Beginning on October 1, 2016, RHCs shall report the modifier CG on RHC claims and claim adjustments
- RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line per day, which includes all charges subject to coinsurance and deductible for the visit:
  - When a preventive health service is the primary service for the visit, RHCs should report modifier CG on the revenue code 052x service line with the preventive health service

Qualifying Visit

- An encounter must include a Qualifying Visit:
  - Total charges must be included on the qualifying visit line:
    - ✓ Minus any charge for approved preventive services
- Payment and any applicable coinsurance and deductible will be based on the qualifying visit line
- Update to Qualifying Visit list on March 24, 2016:
  - Items listed in red were added to list:
    - ✓ Not payable until October 1, 2016
- RHC Qualifying Visit List:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

RHC HPCS Reporting Requirements and Updates

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- Special Edition Article SE1611
- Key Points:
  - When a preventative service is the primary service for the visit, RHC's should report modifier CG on the revenue code 052x with the preventative health service
  - Coinsurance and deductible are waived for the approved preventative health services
  - Medicare will pay 100% of the AIR
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf

Special Edition Article SE1611

- Beginning on October 1, 2016, the MACs will accept modifier CG on RHC claims and claim adjustments
- RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line per day, which includes all charges subject to coinsurance and deductible for the visit
- Coinsurance is 20 percent of the charges:
  - Coinsurance and deductible will be based on the charges reported on the revenue code 052x and/or 0900 service line with modifier CG
  - RHCs will continue to be paid an all-inclusive rate (AIR) per visit

Claim Example 1: Medical Services

- Report one service line per encounter:
  - Report revenue code 052X
  - Report qualifying medical visit

Rev Code	HCPCS/ Modifier	Service Date	Units	Total Charges	Payment	Coinsurance Applied
052X	99213 CG	4/1/16	1	$76.40	AIR	Yes
0300	36415	4/1/16	1	$3.00	Included in AIR	No

Claim Example 2: Medical Service and Preventive Service

- The qualifying medical visit line should include the total charges for the visit:
  - Minus charge for approved preventive service
- Approved preventive service furnished with a medical visit:
  - Report the preventive service on an additional 052X line with the associated charges

Rev Code	HCPCS/ Modifiers	Service Date	Units	Total Charges	Payment	Coinsurance Applied
052X	99213 CG	4/1/16	1	$76.40	AIR	Yes
052X	G0101	4/1/16	1	$38.67	Included in AIR	No
0300	36415	4/1/16	1	$3.00	Included in AIR	No

Claim Example 3: Preventive Service Only Encounter

- Preventive service is the only qualifying visit:
  - Bill with 052X Rev Code

Rev Code	HCPCS/ Modifiers	Service Date	Units	Total Charges	Payment	Coinsurance Applied
052X	G0101 CG	4/1/16	1	$38.67	AIR	No
0001	*	*	*	$36.67	*	*

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Claim Example 4: Mental Health Service Encounter

- Report one service line per mental health encounter:
  - Report Rev Code 0900
  - Qualifying mental health visit

Rev Code	HCPCS/ Modifiers	Service Date	Units	Total Charges	Payment	Coinsurance Applied
0900	90834 CG	4/1/16	1	$110.63	AIR	Yes
0900	90863	4/1/16	1	$25.42	Included in AIR	No

Claim Example 5: Multiple Medical Services

- Report one service line per encounter with revenue code 052X:
  - Report the qualifying visit HCPCS code
- Each additional medical service should also be reported with revenue code 052X:

Rev Code	HCPCS/ Modifiers	Service Date	Units	Total Charge	Payment	Coinsurance Applied
052X	99213 CG	4/1/16	1	$183.32	AIR	Yes
052X	12002	4/1/16	1	$109.92	Included in AIR	No

Claim Example 6: Medical Services and Incident to Services

- Services and supplies furnished incident to a RHC visit are considered RHC Services:
  - Included in payment of the qualifying visit:
    - ✓ Are NOT separately payable as standalone services

Rev Code	HCPCS/ Modifiers	Service Date	Units	Total Charges	Payment	Coinsurance Applied
052X	99213 CG	4/1/16	1	$139.11	AIR	Yes
0300	36415	4/1/16	1	$3.00	Included in AIR	No
0636	90746	4/1/16	1	$59.71	Included in AIR	No
0771	G0010	4/1/16	1	$5.00	Included in AIR	No

Billing for Multiple Visits Same Day

- Multiple encounters on the same day constitute a single RHC visit, except for the following:
  - The patient suffers an illness or injury that requires additional diagnosis or treatment on the same day:
    - ✓ The subsequent medical service should be billed using a valid HCPCS code, revenue code 052X, and modifier 59:
      - ➢ Modifier 59 signifies that the conditions being treated are unrelated and services are provided at separate times of the day
  - The patient has a medical visit and a mental health visit on the same day
  - The patient has an IPPE and a separate medical and/or mental health visit on the same day:
    - ✓ IPPE is a once in a lifetime benefit and should be billed using HCPCS code G0402 and revenue code 052X

Modifier 59 Billing Example

- Report one service line per encounter with revenue code 052X:
  - Report the qualifying visit HCPCS code
- Report the second visit with revenue code 052X and modifier 59 for a visit that has a different DX from the first visit

Rev Code	HCPCS/ Modifiers	Service Date	Units	Total Charge	Payment	Coinsurance Applied
052X	99213 CG	4/1/16	1	$183.32	AIR	Yes
052X	99214 59	4/1/16	1	$109.92	AIR	No

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Chronic Care Management

Chronic Care Management (CCM) Services for RHC

- Change Request # 9234:
  - Effective: January 1, 2016
  - Implementation: January 4, 2016
- Key Points:
  - RHCs may receive an additional payment for the costs of CCM services that are not already captured in the RHC AIR for CCM services to Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months (or until the death of the patient), and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - CCM payment will be based on the Medicare PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC claim
- Reference:
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1576OTN.pdf

Chronic Care Management Services

- Beginning January 1, 2016, Medicare pays separately for code 99490, non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions
- References:
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1516.pdf

RHC Can Bill Chronic Care Management

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- RHC can bill for CCM when:
  - Practitioner furnishes a comprehensive E/M, AWV, or IPPE:
    - ✓ Prior to billing the CCM
    - ✓ CCM is initiated during the visit

Chronic Care Management Requirements

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- Must be a structured recording of:
  - Demographics
  - Problems
  - Medications/medication allergies
  - Creation of a structured clinical summary record
- A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care
- Access to care management services 24/7 that provides the beneficiary with a means to make timely contact with health care practitioners
- Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments

CCM Requirements

- RHCs would continue to be required to meet the RHC Conditions of Participation and any additional RHC payment requirements
- Comprehensive care plan is established implemented revised or monitored
- Providers must use Electronic Health Records (EHR):
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf
- Beneficiary must be receive notification and consent
- Patients must be given a written or electronic care plan
- Explaining how to revoke the service
- Informing the patient that only one practitioner can furnish and be paid for the service during a calendar month

Chronic Care Billing Requirements

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- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Can only be billed once per month/per patient and by only one physician
- RHCs cannot bill for CCM services for a beneficiary during the same service period as billing for transitional care management or any other program that provides additional payment for care management services (outside of the RHC AIR) for the same beneficiary

CCM Billing

- HCPCS 99490 without an encounter visit
- The face-to-face requirements are waived when CCM services are furnished to a RHC patient

Rev Code	HCPCS	Service Date	Units	Total Charges	Payment	Coinsurance Applied
052X	99490	4/1/16	1	$115.40	PFS national average non-facility payment rate	Yes
0001	*	*	*	$115.40	*	*

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CCM Billing With Visit

- HCPCS 99490 with an encounter visit
- The face-to-face requirements are waived when CCM services are furnished to a RHC patient

Rev Code	HCPCS/ Modifiers	Service Date	Units	Total Charges	Payment	Coinsurance Applied
052X	99213 CG	04/1/16	1	145.23	AIR	Yes
052X	99490	4/1/16	1	$115.40	Based on the PFS national average non-facility payment rate	Yes

CCM Payment

- Coinsurance and deductible will apply
- Payment is based on the fee amount, regardless of the charges

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RHC Updates

RHC Chapter 13 Updates and Revisions

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- Change Request # 9864:
  - Effective: March 9, 2017
  - Implementation: March 9, 2017
- Key Points:
  - Chapter 13 of the Medicare Benefit Policy Manual is being updated and revised for RHCs and Federally Qualified Health Centers (FQHCs):
    - ✓ Updates:
      - RHC owned by a Physician Assistant
      - Clinical Social Worker
    - ✓ Revised:
      - FQHC 2017 PPS base rate will be updated by the FQHC Market Basket
      - Graduate Medical Education in RHCs and FQHCs
      - Transitional Care Management (TCM) or Chronic Care Management (CCM)
      - Speech-Language Pathology Services
      - Co-payment for FQHC preventive services
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9864.pdf

RHC Chapter 13 Revisions

- Change Request # 9442:
  - Effective: February 1, 2016
  - Implementation: February 1, 2016
- Key Points:
  - New information:
    - ✓ RHC can count the time of a nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM)
    - ✓ Overview of requirements for payment of chronic care management in RHC
    - ✓ Lung cancer screening using low-dose computed tomography coverage requirements
  - Clarifying Information:
    - ✓ Use of Modifier 59
    - ✓ Payment for procedures
    - ✓ Description of ambulance services that are non-covered
    - ✓ Description of group services that are non-covered
    - ✓ Cost reporting requirements
    - ✓ Billable visits by dentists, podiatrist, optometrists, and chiropractors
    - ✓ Description of mental health visits, billing for mental health visits, and payment for medication management
    - ✓ Hepatitis C screening in RHCs
- References:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9442.pdf
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

RHC Chapter 9 Reorganization

- Change Request # 9397:
  - Effective: March 31, 2016
  - Implementation: March 31, 2016
- Key Points:
  - Chapter 9 of the Medicare Claims Processing Manual, Rural Health Clinics and Federally Qualified Health Centers, is being revised to include more comprehensive billing information
  - No new policies are being added
- Reference:
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3434CP.pdf

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RHC Top Errors

Top Errors

Reason Code	Error Message	Resolution
38200	No Medicare payment can be made because the statement covered period falls within or overlaps an enrollment period in a risk HMO	Verify the statement covered period Verify the patients eligibility Bill the claim to the beneficiaries HMO on file
38031	This outpatient claim is an exact duplicate to a previously submitted out- patient claim	Verify this patients claim history, an adjustment or appeal may need to be performed
U5233	No Medicare payment can be made because the statement covered period Falls within or overlaps an enrollment period in a risk HMO	Verify the from and through dates on the claim, if correct file to HMO

Top Errors Cont.

Reason Code	Error Message	Resolution
C7010	The edited outpatient claim has a from/through date that overlap a hospice election period	Related to the terminal illness: Bill the Hospice Unrelated to the terminal illness: Resubmit the claim to Medicare with the appropriate condition code 07
32402	Invalid revenue code for a HCPCS code reported or HCPCS is not valid for the date on which services were provided	Verify the revenue code billed Verify the HCPCS code billed Verify the “from” and “through” dates
34538	Claim submitted as Medicare primary and a positive Working Elderly record exists at CWF	Verify beneficiaries eligibility Working Aged file has been terminated: Submit adjustment stating ‘File is updated, Medicare is primary’ Working Aged file is valid and current: Bill primary payer Adjust claim to Medicare showing primary insurers payment

Claims Center

- Coding Guidelines:
  - Current Procedural Terminology and Healthcare Common Procedure Coding System
  - Modifiers
  - Institutional Billing
- Claim Access and Information:
  - Top Claim Submission Errors:
    - ✓ Monthly report for each state in our jurisdictions
  - Access Part A Claims and Eligibility Online:
    - ✓ Request Direct Data Entry Access into the Fiscal Intermediary Standard System (FISS)
    - ✓ FISS logon instructions, RACF ID and password rules, Resetting passwords
- Reference Materials:
  - UB-04 At A Glance
  - Bulletins and Claim Tips
  - Incentive Programs
  - FISS User Guide
  - Remittance, Advice and Reason/Remarks
- Reference:
  - http://www.novitas-solutions.com/webcenter/portal/Claims_JH/Claims

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Resources

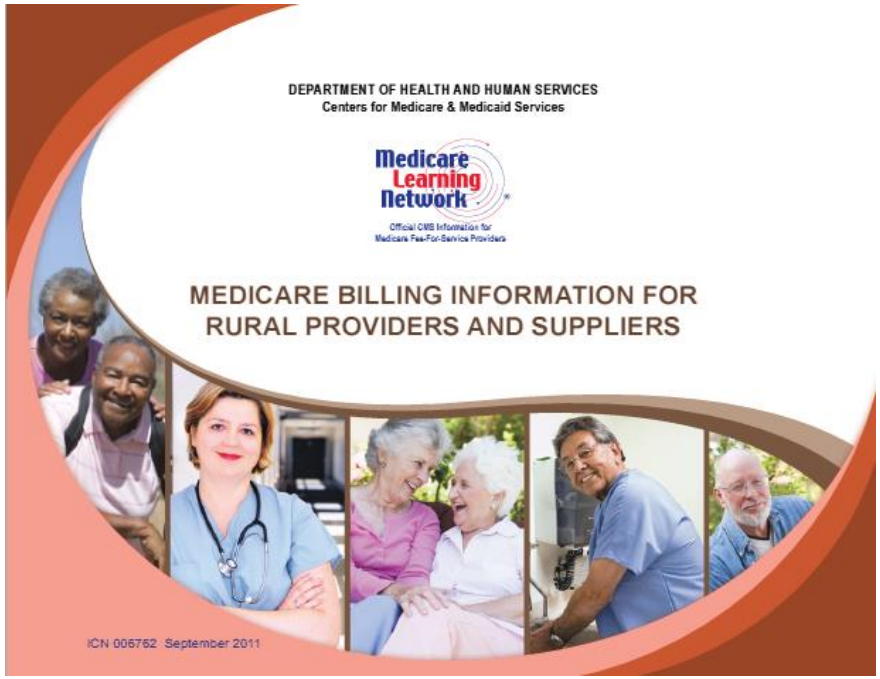
Novitas Resources

- Novitas website:
  - http://www.novitas-solutions.com
- RHC FAQs:
  - http://www.novitas-solutions.com/webcenter/portal/FAQs_JH

CMS Resources

- CMS website offers valuable resources:
  - Medicare Benefit Policy Manual 100-02, Chapter 13:
    - ✓ http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
  - Medicare Claims Processing Manual 100-04, Chapter 9:
    - ✓ http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
  - RHC Billing Guide (Special Edition SE1039):
    - ✓ http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1039.pdf
  - RHC Center:
    - ✓ http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html
  - CMS website:
    - ✓ http://www.cms.gov/
  - CMS FAQ's:
    - ✓ https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf

Medicare Billing Information For Rural Providers and Suppliers



- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralChart.pdf

Important Updates and Reminders

Join Our Email List Today

- Stay current with Medicare by receiving emails twice a week
- Available email lists (not all-inclusive):
  - Jurisdiction H
  - Part B Electronic Billing
  - Novitasphere Portal
  - ABILITY| PC-ACE
  - Medicare Remit Easy Print (MREP) Users
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00007968

Part A Publications

- Latest Part A News & Web Site Updates
- News Bulletins & Articles
- Monthly Medicare Part A Newsletters
- Novitas Solutions e-News
- Novitas Educational Tips and Tools (NETTs)
- Reference Manual
- http://www.novitas-solutions.com/webcenter/portal/Bulletins_JH/Publications

Part B Publications

- Latest Part B News and Web Site Updates
- News Bulletins and Articles
- Novitas e-News
- Quarterly Medicare Reports:
  - Medicare medical policy
  - Reimbursement updates
  - Specialty billing information
  - Claim reporting tips and more
- Published online at:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00025469

On-Demand Education

- Frequently Asked Questions
- Novitas Educational Tips and Tools (NETTs)
- Podcasts
- Educational Videos and Tutorials:
  - Watch and learn about the Medicare program and our website's features
- http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00082787

Centers for Medicare & Medicaid Services (CMS)

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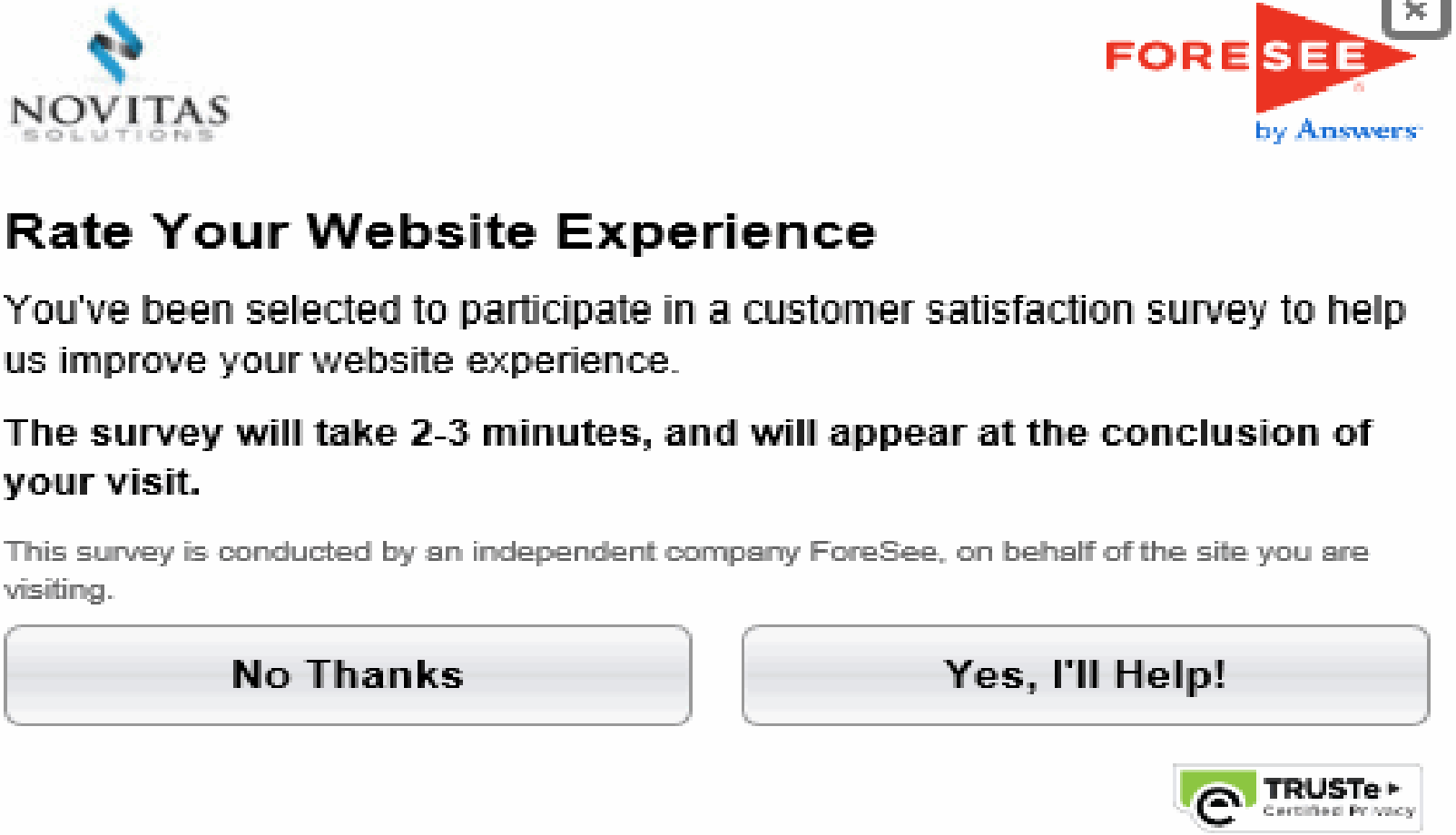
- CMS Internet Only Manuals (IOMs):
  - Offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives
- Medicare Learning Network (MLN) Matters Articles:
  - Your destination for health care professional education products
- Open Door Forums:
  - Provides an opportunity for live dialogue between CMS and the stakeholder community at large
- Quarterly Provider Updates:
  - Published quarterly for providers, suppliers, and the general public
- http://www.cms.gov/

Website Satisfaction Surveys



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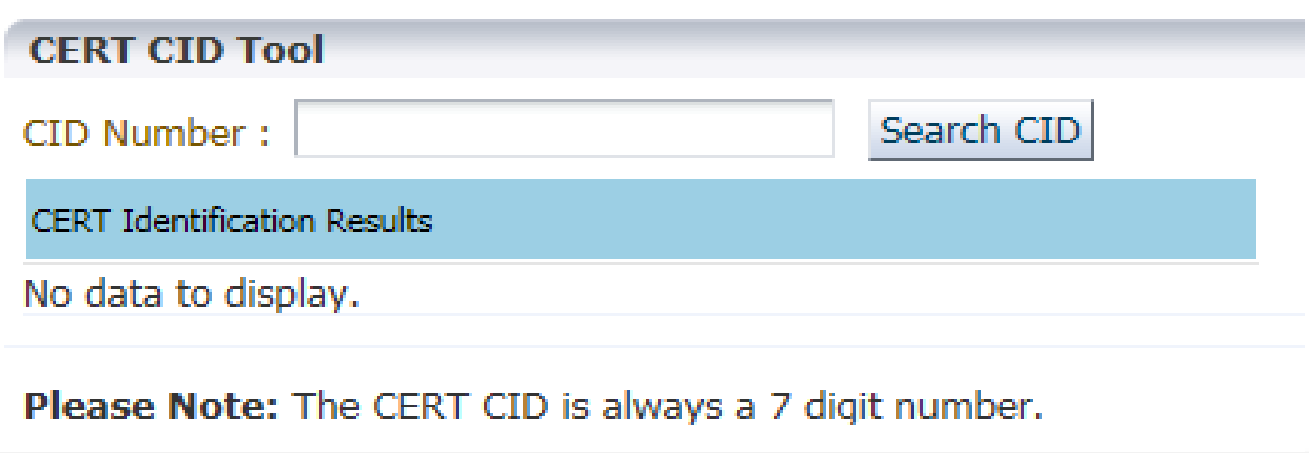
Comprehensive Error Rate Testing (CERT) Program

Comprehensive Error Rate Testing (CERT)

- Program developed by Centers for Medicare & Medicaid Services (CMS) to monitor the accuracy of claims processing
- Designed to protect the Medicare trust fund and determine error rates nationally and regionally
- Random audits conducted on a monthly basis
- AdvanceMed request medical records for claims selected as part of the monthly random sample
- Medical record documentation supporting claim must be returned in designated time frame
- http://www.novitas-solutions.com/webcenter/spaces/CERT_JH

CERT Identification Online Tool

- Provides status information for sampled claims using the Claim Identification Number (CID) where a decision has been made by the CERT contractor:
  - Claim in Error- CERT error was assessed or not
  - Status Date- last date that CERT updated/reviewed the case
  - Status Decision- where the claim is with the CERT Review Contractor
  - Appealed- if an appeal was initiated and the appeal status
  - Error Code- errors assessed



Medical Record Signature Reminders

- Categorized as “Insufficient Documentation” errors:
  - Missing signatures
  - Illegible handwritten signatures
  - Electronic signatures not dated
  - Attestation statements do not match the date of service
- Records must be signed and dated
- Include signature logs to determine handwritten signatures
- Complete attestation statements when records are not signed
- Do not add late signatures
- CMS Complying with Medicare Signature Requirements:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

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Self-Service Options

JH Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Customer Contact Center- 1-855-252-8782
- Provider Teletypewriter- 1-855-498-2447
- Self-Service Tools:
  - http://www.novitas-solutions.com/webcenter/portal/CustomerServiceCenter_JH/Self-Service+Tools
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - http://www.medicare.gov/index.html

Automated Claim Correction Using the IVR

- New feature for all Part B providers allowing an unlimited number of claims to be corrected using the IVR:
  - Adding, changing or deleting a modifier
  - Changing a primary diagnosis code
  - Changing an ordering/referring provider
  - Changing a procedure code (and billed amount)
  - Changing the quantity billed (and billed amount)
  - Changing a date of service
  - Completing a history correction
- Correct claims within one year of finalized date using the IVR
- Claims billed in error must be corrected using:
  - Return of Monies to Medicare Form
  - Part B Redetermination and Clerical Error Reopening Request Form
- Claim corrections not accepted via IVR may use:
  - Novitasphere
  - Part B Redetermination and Clerical Error Reopening Request Form

Automated Claim Correction Using the IVR Resources

- User Guide:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00086538
- Frequently Asked Questions:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00132381

Novitasphere

- Free, secure Web-based portal
- Part A – Access to Eligibility, Medical Review Record Submission, , Claim Submission with File Status, and Audit and Reimbursement Cost Reports Submission
- Part B - Access to Eligibility, Claim Information and Remittance Advice, Claim Submission with File Status, Electronic Remittance Advice (ERA), Claim Correction, Secure Messaging and a MailBox
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information:
  - http://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH/

Novitasphere Claim Correction Feature for Part B

- Common clerical errors can be corrected on finalized claims:
  - Number of services or units
  - Diagnosis code
  - Eligible modifiers
  - Procedure code
  - Date of service
  - Place of service
  - Billed amount
- Novitasphere Claims Correction Guide:
  - http://novitas-solutions.com/cs/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&dDocName=00086496&allowInterrupt=1

Summary

- RHC Billing
- Chronic Care Management
- RHC Updates
- RHC Top Errors
- Resources
- Stay up to date with the latest Medicare changes by visiting the Novitas Solutions website
- Be aware of CERT documentation request and respond appropriately
- Take advantage of the various self-service options available to the provider community

Thank you for your participation!