Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

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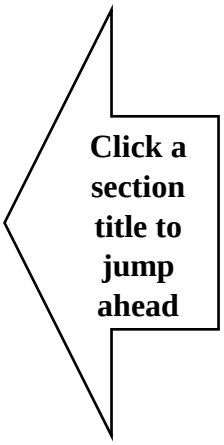

Reporting Modifier CG

Q1. When should modifier CG be reported?

A1. RHCs should report modifier CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit. This line should have the bundled charges for all services that are subject to coinsurance and the deductible (e.g., charges for all services furnished during the visit minus the charges for preventive services for which the coinsurance and/or deductible are waived).

If only preventive services are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the medically necessary face-to-face visit and the bundled charges.

Q2. Should claims for dates of service on or after April 1, 2016 be billed with modifier CG?

A2. Yes. These claims should follow the reporting requirements for modifier CG. Claims that have already been paid do not need to be resubmitted with modifier CG.

Q3. Is modifier CG used to report the line subject to coinsurance and deductible?

A3. Not necessarily. Coinsurance and deductible will be applied to the line reported with modifier CG as applicable. However, coinsurance and deductible will not be applied when modifier CG is reported with approved preventive services paid at 100 percent.

Q4. Should modifier CG be reported if there is only one service furnished as part of the billable visit?

A4. Yes. Modifier CG should be reported with the medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit.

Reporting Modifier CG with Preventive Services

Q5. Should modifier CG be reported if only preventive services are furnished during the visit?

A5. Yes. If only preventive services for which the coinsurance and/or deductible are waived are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the visit and the bundled charges.

Q6. If a medical service and a preventive service are furnished on the same day, should modifier CG be reported with both services?

A6. No. Modifier CG should be reported only with the medical service HCPCS code that represents the primary reason for the medically necessary face-to-face visit when medical and preventive services are furnished on the same day.

Q7. Is modifier CG reported with the initial preventive physical examination (IPPE) when it is billed alone or with other billable services on a claim?

A7. No. Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service.

Reporting Modifier CG with Medical and/or Mental Health Services

Q8. For a given date of service, how many times can a RHC report modifier CG for a qualified medical and/or qualified mental health visit?

> **A8.** Modifier CG should be reported once per day for a qualified medical visit (revenue code 052x) and/or once per day for a qualified mental health visit (revenue code 0900).

Q9. If a qualified medical service and a qualified mental health service are furnished on the same day, should modifier CG be reported on both lines?

> **A9.** Yes. Modifier CG should be reported on both the medical service line that represents the primary reason for the medical visit and on the mental health service line that represents the primary reason for the mental health visit.

Other Modifier CG Questions

Q10. Is modifier CG reported with Chronic Care Management (CCM) services when it is billed alone on the claim or with other billable services on a claim?

> **A10.** No, modifier CG should not be reported with the CCM HCPCS code. When CCM is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service.

Q11. Is modifier CG reported for medically-necessary visits in a Skilled Nursing Facility?

> **A11.** Yes, modifier CG is reported with the medical service HCPCS code that represents the primary reason for the medically necessary face-to-face visit.

Q12. Is there a list of services that qualify as stand-alone billable visits or will any service be paid as long as modifier CG is reported?

> **A12.** To assist RHCs when HCPCS codes were first required to be on all claims, we posted a qualifying visit list to serve as a guide to services that generally qualify as stand-alone billable visits. The HCPCS reporting requirements have not changed what is considered a RHC stand-alone billable visit, which is typically evaluation and management type of services or screenings for certain preventive services. We will monitor claims over the next several months to determine if the modifier is used appropriately, and will consider modifications to the payment system if necessary.

Reporting Modifier 25 or Modifier 59

Q13. Is modifier CG reported when a subsequent medically necessary visit that qualifies as a separate payment occurs on the same day as an earlier medically-necessary visit?

> **A13.** No. If an illness or injury that wasn't present during the first visit requires additional diagnosis or treatment on the same day (for example, a patient sees an RHC practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC), the RHC should report modifier 25 or modifier 59 on the line with the medical service that represents the primary reason for the subsequent visit and has the bundled charges for all services for the subsequent visit. Modifier 59 or modifier 25 should be reported with a medical service using revenue code 052x.

Q14. Should modifier CG and modifier 25 or modifier 59 be reported on the same service line together to indicate a subsequent medically necessary visit that qualifies as a separate payment?

> **A14.** No. Modifier 59 or modifier 25 should not be reported with modifier CG on the same line to indicate a subsequent medically necessary visit that qualifies as a separate payment.

Q15. Modifier 25 or modifier 59 are to be reported on the primary subsequent visit, but should it also be reported with the HCPCS code(s) for the services furnished during the subsequent visit?

> **A15.** No. Modifier 25 or 59 is reported only on the line that represents the primary reason for the subsequent visit.

Other Questions

Q16. Should RHCs continue to report other services furnished (in addition to the service that represents the primary reason for the visit) on the claim with an appropriate HCPCS code and charges greater than or equal to $0.01?

> **A16.** Yes. All services furnished should be reported with the appropriate HCPCS code. The bundled charges are reported with the line that represents the primary reason for the visit, and other services are reported with charges greater than or equal to $0.01.

Q17. Should RHCs report modifier CG for services furnished incident to a billable visit?

> **A17.** No, incident to services are listed on the claims with a charge greater than or equal to $0.01 and without modifier CG.

Q18. Can RHCs combine incident to services furnished on a different date of service from the qualifying visit on one claim? For example, an office visit is furnished on April 1 and venipuncture is furnished on April 4.

A18. Yes, the RHC can combine incident to services furnished on a different date of service on one claim as long as they are furnished in a medically appropriate period and are incident to the service being billed. Incident to services should not be reported with modifier CG.

Q19. What revenue codes are reported on RHC claims?

A19. The qualifying visit line should be reported with revenue code 052x or 0900. For additional lines, RHCs should report the most appropriate revenue code for the services being performed. All valid revenue codes are accepted except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, and 096x-310x. A complete list of revenue codes can be found in a National Uniform Billing Committee publication.

Q20. Does the order in which the RHC reports the claim lines matter?

A20. No. The lines are sorted in numerical order by revenue code and HCPCS code.

Q21. Should claims to Medicare as the secondary payer (MSP) follow the new reporting requirements?

A21. Yes. All claims to Medicare should follow the new reporting requirements.

Q22. Will secondary payers/coordination of benefits (COB) payers accept modifier CG?

A22. CMS has worked with our Coordination of Benefits Office to make them aware of the reporting requirement for RHC claims.

Q23. Should RHCs report all services furnished on one UB-04 claim or break out certain services on a separate UB-04 claim?

A23. RHCs should report all services furnished during the visit on one claim.

Q24. Does Medicare pay based upon the charges reported on the total charges (0001 revenue code) on the claim?

A24. Medicare does not pay or adjudicate the total line (0001 revenue code).

Q25. How do the HCPCS reporting requirements affect billing for technical components of a RHC service?

A25. Technical components of RHC service include diagnostic tests such as x-rays, electrocardiograms, and other tests authorized by Medicare statute or the National Coverage Determination process. The HCPCS reporting requirements do not change the billing for technical components of a RHC service. These services may be billed separately to the A/B MAC by the facility.

Q26. How do the HCPCS reporting requirements affect billing for Medicare covered vaccines and drugs and biologicals that are not usually self-administered?

A26. The HCPCS reporting requirements do not change the billing for these services. Medicare pays for the costs of influenza virus and the pneumococcal pneumonia vaccines and their administration through the cost report, and other Medicare-covered vaccines as part of the AIR. When covered vaccines or drugs not usually self-administered are reported on a RHC claim, they should be reported on a separate line with the most appropriate revenue code for the services being performed. RHCs should not report influenza and the pneumococcal pneumonia vaccines on the claim.

Q27. How do the HCPCS reporting requirements affect billing for laboratory tests?

A27. The HCPCS reporting requirements do not change the billing for laboratory tests, which are billed separately to the A/B MAC by the facility. This does not include venipuncture (HCPCS code 36415), which is included in the AIR.

Q28. How will the explanation of benefits (EOB) appear to the patient?

A28. The EOB will list all of the services on the claim. The EOB states that the Medicare approved amount may be less than what your provider actually charged. For some patients, the RHC may need to explain that the RHC is not charging twice for the services that were furnished.

Q29. Where can I get additional information?

A29. The CMS RHC Center Page (https://www.cms.gov/center/provider-type/rural-health-clinics-center.html) has the most current information on RHC payment and policies.