RHC 101

Wyoming Department of Health

May 2011

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OBJECTIVES

- GAIN AN UNDERSTANDING OF
  - WHAT IS AN RHC – COMPARED TO OTHER TYPES OF PRIMARY CARE PRACTICES
  - REQUIREMENTS
  - MEDICARE RULES – BASIC PAYMENTS
  - WYOMING MEDICAID
  - EHR INCENTIVE PAYMENTS
  - BASIC BILLING RULES

OBJECTIVES

- CHANGES ARE COMING
  - CMS
  - HPSA & MUA
- FINANCIAL ANALYSIS
- WHY DO YOU WANT TO BE ONE??
  - OR DO YOU??

- ANSWER YOUR QUESTIONS

Reimbursement for Primary Care Physician Services

- Rural Health Clinics (RHC)
- Provider based clinics
- Free-standing physician practices
  - Owned by hospital
  - Under contract with hospital

Which is Best?

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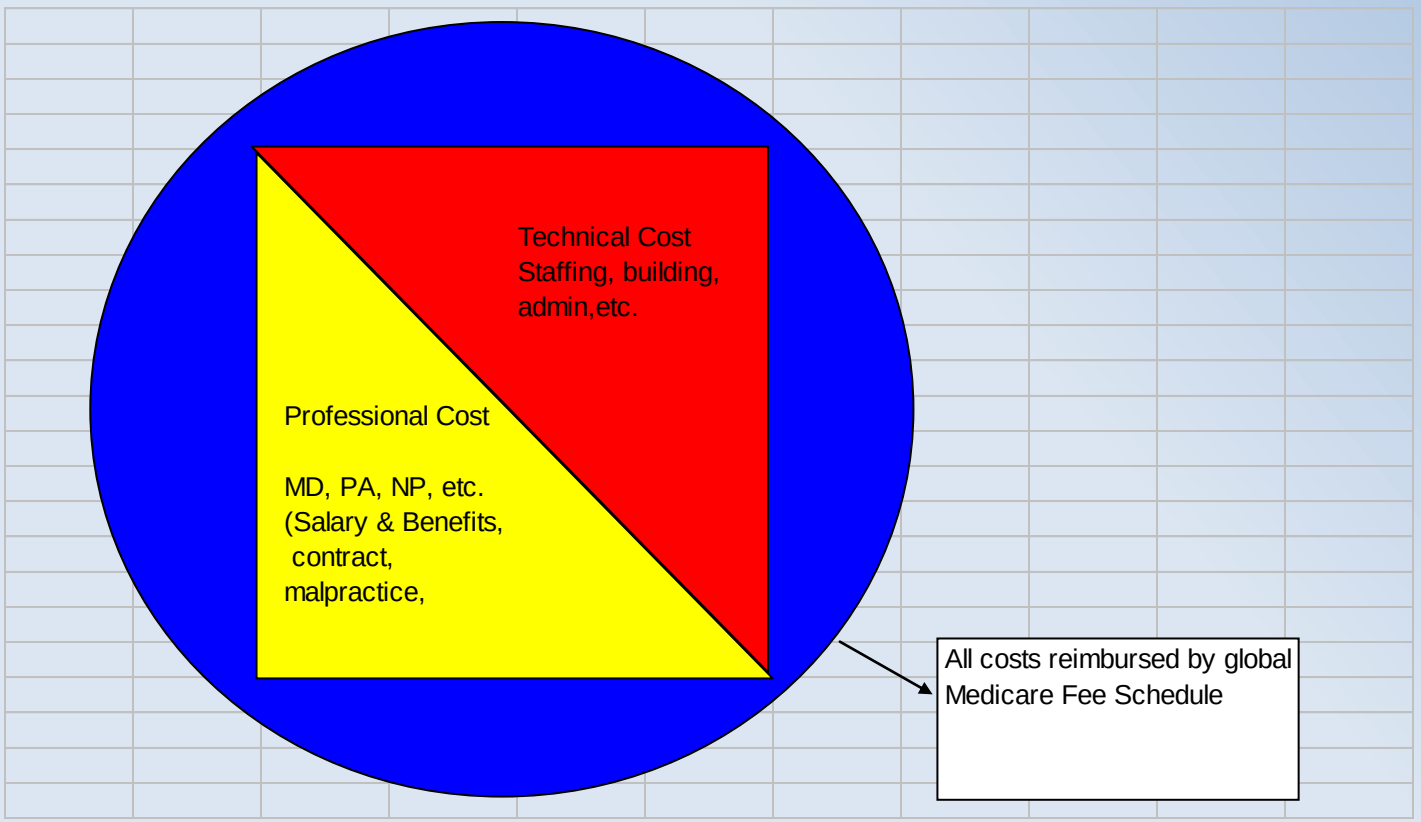
Freestanding Clinics

Freestanding Clinic Medicare Reimbursement

- **Technical and Professional Costs** paid on full RBRVS payment rate - also known as global Medicare fee schedule.
  - Medicare Fee Schedule (3 Parts)
    - 100% Work component
    - 100% Malpractice component
    - 100% Practice expense component

Freestanding Clinic Medicare Reimbursement



Rural Health Clinics

RHC General Requirements

- Must have mid-level practitioner at practice at least 50% of the time that the clinic is operating as an RHC
- Basic laboratory procedures are required to be able to be provided
- Must have written clinical protocols
- Must have annual evaluation

RHC General Requirements

- Must have written policies and procedures
- Subject to certification by Medicare
- Certification is “space-specific”
- Can be provider-based or freestanding

RHC Current Shortage Area Location Requirements

- HPSAs
  - Geographic Primary Care
  - Population-Group
- MUAs
- Governor's Designation
- Designation must be less than 3 years old.

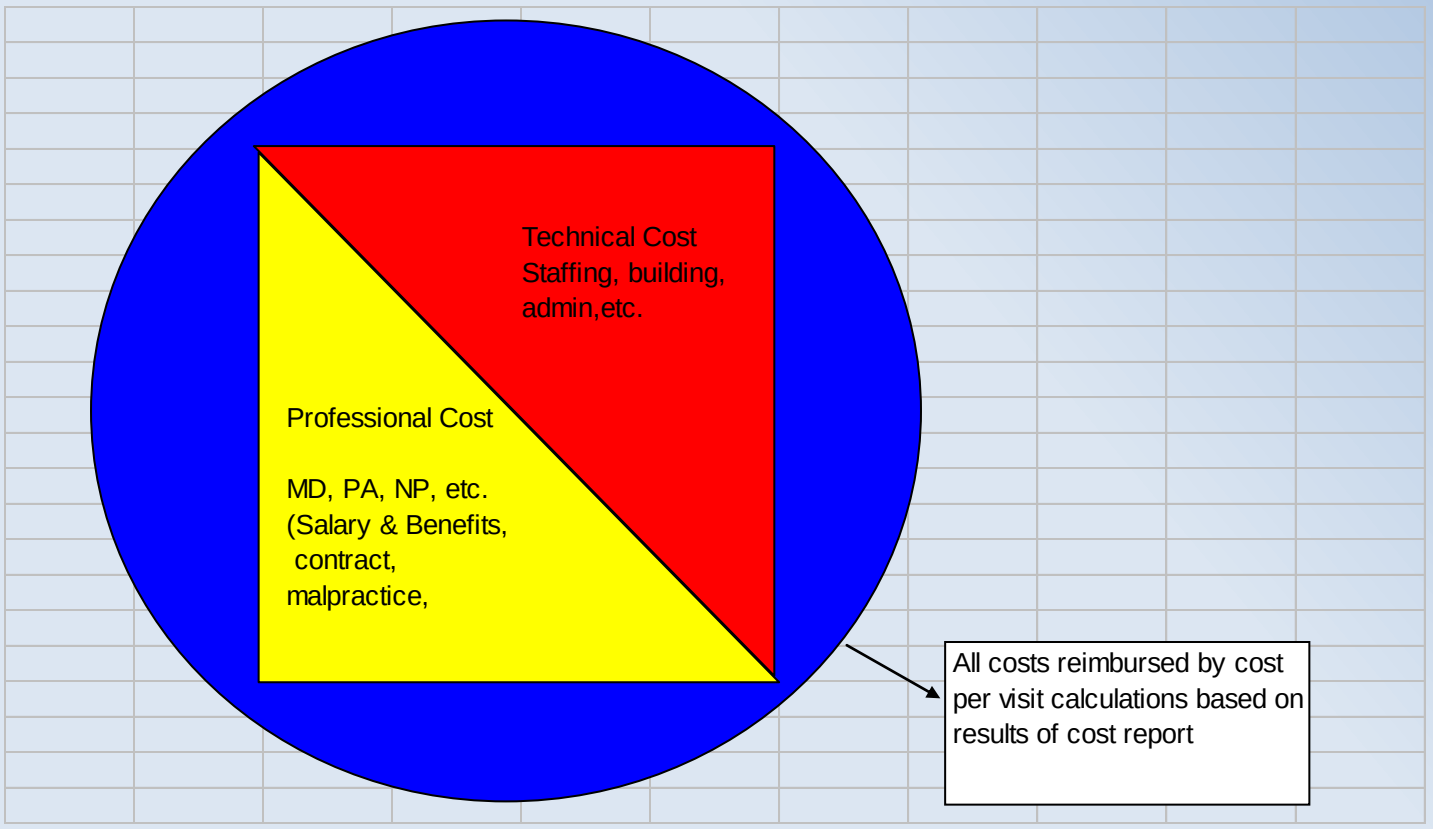
RHC Reimbursement

- Primary care visits - cost-based
  - All-inclusive cost per visit up to a limit
  - Subject to productivity standards that can reduce or limit reimbursement
    - 4,200 encounters per FTE for physician
    - 2,100 encounters per FTE for mid-level practitioner
    - Computation of FTEs – do not include
      - Office plus institutional time
      - Administrative time

RHC Reimbursement

- Inpatient Hospital visits - fee schedule
- SNF MD visit cost-based reimbursement
- Clinical laboratory-fee schedule:
  - Until 6/30/09 must be drawn in CAH space for cost
  - After 7/1/09 can be drawn in RHC space

RHC Clinic Medicare Reimbursement



Per Visit Cost Limits

- Updated Every January Based Upon Medicare Economic Index (Current year's increase was 1.8%)

- Limit 2011 = $78.07

Coinsurance Loss

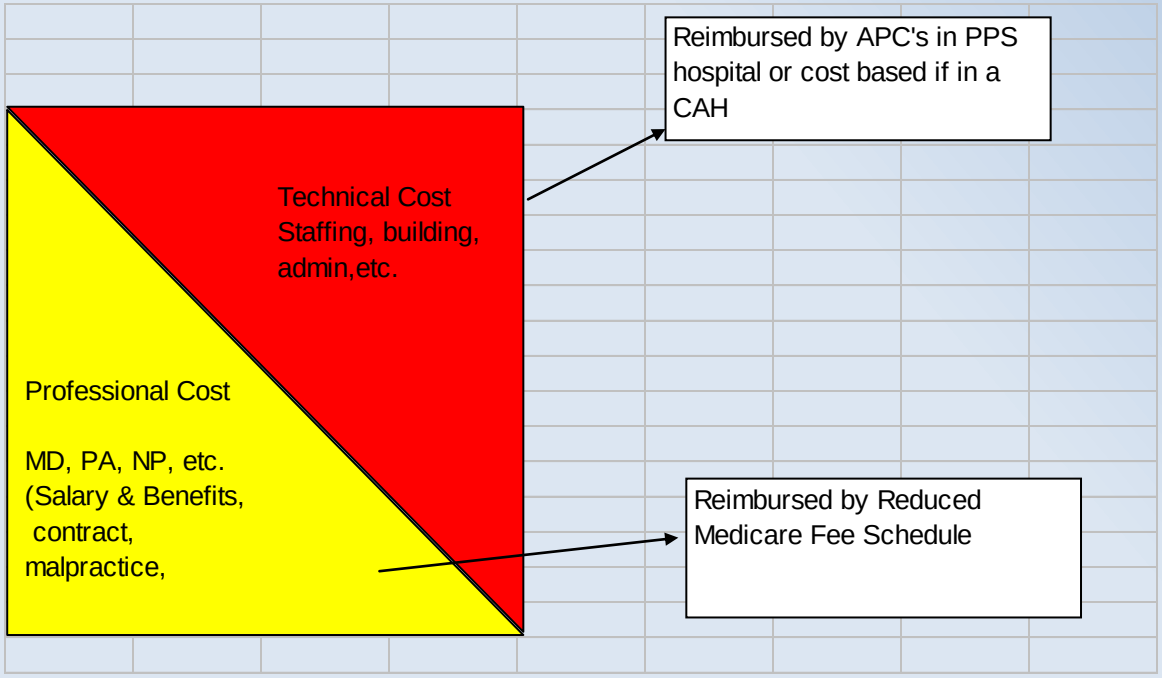
- Costs per visit is $100 (Coinsurance reduction on cost report is $20 - $100 time 80%)
- Charge per visit is $80 (Coinsurance billed to beneficiaries - $80 times 20% or $16 per visit)
- Loss is $4 per visit

Provider Based Clinics

Provider Based Clinic Medicare Reimbursement

- **Professional Component** paid on reduced RBRVS payment rate-also known as reduced Medicare fee schedule.
  - Medicare Fee Schedule (3 Parts)
    - 100% Work component
    - 100% Malpractice component
    - 50% Practice Expense component
- Plus, they receive a facility fee payment for the **Technical Component**.
  - Non CAH payment based on APC's
  - CAH payment based on allowable cost (no cost limitation)

Provider-Based Clinic Medicare Reimbursement



Disclosure

- Must disclose to Medicare beneficiaries that the clinic is provider-based
- If standard billing, must notify them that they will receive two explanation of benefits and have a different payment amount

Potential Advantages of Provider-Based Designation

- Potential significantly higher reimbursement. (Have to look at all payors in the aggregate)
- Increased coordination with hospital-physicians
- Increased clinical integration with hospital
- Greater flexibility in financing and efficiencies with admin or shared staff

Potential Disadvantages of Provider-Based Designation

- Increased costs related to hospital wage and benefit scales, more costly facilities, and less effective cost management.
- Increased billing complexities - negative impact from split billing for patients
- Patient coinsurance may be a big deal
- Decreased physician control of practice staff and accountability for finances and productivity

Provider Based Requirements

Provider- Based Attestation Process

- CMS regulation 413.65
  - Voluntary attestation process – we always recommend
  - Must demonstrate integration with the hospital
    - Clinical
    - Financial
    - Governance

Provider- Based Location Requirements

- Campus – within 250 yards of main hospital buildings
- Off campus – within 35 miles (except RHC)
- **CAUTION for CAH –**
  - CMS final OPPS rule FY 2008
  - Any new off-campus provider based location (except RHC) for CAH *must meet the CAH location requirements* – *consequence: loss of CAH designation!*

Case Study and Other Comparisons

Clinical Comparisons

	NON-RHC FREESTANDING CLINIC	RURAL HEALTH CLINIC		PROVIDER-BASED CLINIC
		FREESTANDING	PROVIDER-BASED	
RURAL	NONE	YES	YES	NO
HPSA/MUA	NONE	YES	YES	NO
MIDLEVEL HALFTIME	NONE	YES	YES	NO
PRODUCTIVITY	NONE	YES	YES	NO
LIMITATION ON SPECALIST	NONE	PRIMARY CARE MUST BE PREDOMINANT		NO
WITHIN HOSPITAL LICENSURE	NONE	NO	NO	YES
HOSPITAL CONSTRUCTION CODE	NONE	NO	NO	YES
MEDICARE REIMBURSEMENT	FEE SCALE WHICH IS NOT ADEQUATE LOWEST OPTION	COST UP TO $74.29	COST NO LIMIT (under 50 beds) COST UP TO $74.29 (over 49 beds)	FACILITY – COST +% (if CAH) FACILITY – PAC (if PPS) PHYSICIAN – FEE SCALE **PLUS**
HPSA BONUS	YES	NON RHC SERVICES ONLY	NON RHC SERVICES ONLY	YES
PSA BONUS	YES	NON RCH SERVICES ONLY	NON RHC SERVICES ONLY	YES
METHOD II BONUS	NO	NO	NON RHC SERVICES ONLY YES IF CAH ELECTED	YES IF CAH ELECTED
MEDICAID REIMBURSEMENT A	FEE SCALE USUALLY	PROSPECTIVELY SET	PROSPECTIVELY SET	FEE SCALE
MEDICAID REIMBURSEMENT B	FEE SCALE USUALLY	ALTERNATIVE METHOD	ALTERNATIVE METHOD	COST
MEDICAID REIMBURSEMENT C	FEE SCALE USUALLY	PROSPECTIVE RATE	ALTERNATIVE METHOD	FEE SCALE/COST
MEDICAID MANAGED CARE	FEE SCALE USUALLY	CONTRACT PLUS WRAPAROUND	CONTRACT PLUS WRAPAROUND	CONTRACT

CLINIC COMPARISON IN CAH

	Provider Based RHC	Provider Based Clinic	Free Standing RHC	Free Standing Practice
Billing	UB for RHC services; UB-CAH ancillary & 1500 for non-RHC services	UB for facility services & ancillary; 1500 for pro fees (unless Option II)	UB for RHC services; 1500 non- RHC	1500 for all
Payments	Cost for RHC portion; cost for CAH ancillary; fee schedule for non-RHC services	Cost for facility portion + reduced fee schedule for pro fee	Cost for RHC; fee for non-RHC	100% of fee schedule
Productivity & mid-level	Yes	No	Yes	No
Option II & HPSA	No	Yes	No	Yes

Payment Comparison for CPT 99213 - Office Visit

	Free Standing Practice 2011				Provider Based Clinic 2011				Rural Health Clinic		
	Charge	Medicare Non Facility	Patient Pay	Medicare Payment	Charge	Medicare Facility	Patient Pay	Medicare Payment	Charge	Patient Pay	Medicare Payment
Office visit	$ 100.00	$ 69.10	$ 13.82	$ 55.28							
Clinic charge (rev code 510)					$ 50.00		$ 10.00	$ 52.50			
Professional portion					$ 50.00	$ 48.64	$ 9.73	$ 38.91			
					$ 100.00		$ 19.73	$ 91.41			
RHC visit									$ 100.00	$ 20.00	$ 88.00

Assumptions:

Provider based clinic RCC	1.25
RHC visit cost	$ 110.00

SUMMARY - TOTAL PAYMENTS	
Free standing	$ 69.10
Provider based	$ 111.14
RHC	$ 108.00

ANY CAH

Analysis of Primary Care Clinic Options

	Existing Freestanding Clinic	Provider Based Clinic	Rural Health Clinic
Medicare:			
CAH reimbursement	-	161,861	(5,108)
Physician fee schedule - visits	126,588	92,588	-
Rural health clinic visits	-	-	232,344
Other fee schedule	32,303	-	-
	158,891	254,449	227,236
Medicaid:			
CAH reimbursement	-	142,271	3,414
Physician fee schedule - visits	95,085	69,460	-
Rural health clinic visits	-	-	208,577
Other fee schedule	28,991	-	-
	124,076	211,731	211,991
Total	282,967	466,180	439,227
Change from existing clinic		183,213	156,260

Wyoming Medicare 2011

HCPCS CODE		FACILITY PRICE	NON-FACILITY PRICE	HPSA 10%	PCIP 10%	TOTAL PAYMENT	EHR PAYMENT	TOTAL WITH EHR
99201	Office/outpatient visit new	$ 25.89	$ 41.18	$ 4.12	$ 4.12	$ 49.42	$ 30.89	$ 80.30
99202	Office/outpatient visit new	$ 49.05	$ 71.13	$ 7.11	$ 7.11	$ 85.36	$ 53.35	$ 138.70
99203	Office/outpatient visit new	$ 75.00	$ 103.20	$ 10.32	$ 10.32	$ 123.84	$ 77.40	$ 201.24
99204	Office/outpatient visit new	$ 126.80	$ 158.74	$ 15.87	$ 15.87	$ 190.49	$ 119.06	$ 309.54
99205	Office/outpatient visit new	$ 162.88	$ 197.54	$ 19.75	$ 19.75	$ 237.05	$ 148.16	$ 385.20
99211	Office/outpatient visit est	$ 9.19	$ 19.72	$ 1.97	$ 1.97	$ 23.66	$ 14.79	$ 38.45
99212	Office/outpatient visit est	$ 25.21	$ 41.52	$ 4.15	$ 4.15	$ 49.82	$ 31.14	$ 80.96
99213	Office/outpatient visit est	$ 49.39	$ 69.10	$ 6.91	$ 6.91	$ 82.92	$ 51.83	$ 134.75
99214	Office/outpatient visit est	$ 75.94	$ 102.45	$ 10.25	$ 10.25	$ 122.94	$ 76.84	$ 199.78
99215	Office/outpatient visit est	$ 107.27	$ 137.85	$ 13.79	$ 13.79	$ 165.42	$ 103.39	$ 268.81

Cost Reporting Issues between Types

- Freestanding Clinic
  - Treated as non-reimbursable cost center on cost report
- Provider-Based Clinic
  - Setup as clinic line on cost report
  - All professional cost and revenue excluded from calculations in cost report.
- Rural Health Clinic
  - Additional schedules need to be completed on cost report
  - Additional reporting/compilation of data required

Wyoming Medicaid for RHC

WY Medicaid - RHC

- PPS – prospective payment system
- PPS rate –
  - Established on 1999 - 2000 cost escalated annually
  - New RHC – average of the rates for the State then escalated annually

Children's Health Insurance Program

- CHIP
  - PPS rates mandated starting 10/1/2009

Summary of Clinic Scenarios-Which is the best scenario for my clinic?

- THAT ALL DEPENDS!
- To accurately determine most advantageous scenario, you have to calculate the financial impact provided the clinic details.

So What's an FQHC?

FQHC

- Grant funded (PHS Act Section 330)
- Purposes to provide access for vulnerable populations
- HRSA BPHC (Bureau of Primary Health Care) administers the grant program
- Major clinical focus
  - Providing primary care
  - Prevention
  - Education

RHC – FQHC Eligibility Criteria

	Comparison of Basic Eligibility Criteria	
Criteria	**Rural Health Clinic**	**Federally Qualified Health Center**
Location	Non-urbanized Area	N/A
Shortage Area	MUA, HPSA or Governor Designated Shortage Area	MUA or MUP
Corporate Structure	Unincorporated, public, nonprofit or for profit	Tax-exempt nonprofit or public.
Board of Directors	N/A	Required
Clinical Staffing	MLP required at least 50% of the time the clinic is open	No specific requirements.

Comparison of Required Scope of Services

Criteria	Rural Health Clinic	Federally Qualified Health Center
Primary Health Care Services	Required	Required
Primary Care for All Life-cycle Ages	Not Required	Required on-site or under arrangement
Basic Lab	Six specified tests required on-site, others required on-site or under arrangement	Required on-site or under arrangement
Emergency Care	First response capabilities required	Required on-site or under arrangement
Radiological Services	Required on-site or under arrangement	Required on-site or under arrangement
Pharmacy	Not Required	Required on-site or under arrangement
Preventive Health	Not Required	Required on-site or under arrangement
Preventive Dental	Not Required	Required on-site or under arrangement
Transportation	Not Required	Required by the site or under arrangement
Case Management	Not Required	Required on site or under arrangement
Dental Screening for Children	Not Required	Required on site or under arrangement
After Hours Care	Not Required	Required
Hospital/Specialty Care	Required by clinic staff or under arrangement	Required by clinic staff or under arrangement

Management & Finance: RHC & FQHC

Comparison of Management Criteria		
Criteria	**Rural Health Clinic**	**Federally Qualified Health Center**
Evaluation	Required annual evaluation of clinic operations	Required annual evaluation of clinic utilization
Compliance with Civil Rights Act	Required	Assurance required
Written Policies and Procedures	Required	Required
Sliding Fee Scale	Not Required	Required
Initial Application	Application forms and on-site survey	Application narrative and on-site survey (on-site survey is not mandatory for FQHCs or lookalikes at the time of application)
Recertification	On-site survey	Statement of compliance with program requirements
Management and Control Systems	Must demonstrate ability to manage cost-based reimbursement	Must provide written description of systems
Independent Financial Audit	Not Required	Required
Governance	No specific requirements	User-majority board of directors required

Comparison: OP Clinic, RHC & FQHC

Clinic Type	Reimbursement Basis		Cost Containment Mechanism	Cash Flow Mechanism
	Physician (Professional) Component	Facility Component		
Hospital Outpatient Clinic	Physician Fee Schedule	Outpatient Prospective Payment System (OPPS)	Set rates for all services	Individual Claims Submission and Payment
Provider Based RHC	100% of Reasonable Costs		Provider Productivity Screens.	All Inclusive Reimbursement Rate and Year End Cost Settlement
Independent RHC or FQHC	100% of Reasonable Cost		Provider Productivity Screens and All Inclusive Reimbursement Rate Caps	All Inclusive Reimbursement Rate and Year End Cost Settlement

Electronic Health Record Medicare & Medicaid Incentive Payments

Eligible Professionals

Who is an Eligible Professional?

- Doctor of:
  - Medicine or Osteopathy
  - Oral Surgery or Dental Medicine
  - Podiatric Medicine
  - Optometry
  - Chiropractor
- May be able to participate in either Medicare or Medicaid

EHR Incentive Payments - EP

- Physicians in hospital settings
  - Provider-based are eligible
    - **Ineligible** if 90% or more are inpatient or ED
    - Plus a 10% HPSA bonus (at least 50% of services)
- Rural health clinics/FQHC
    - Medicaid only – if more than 30% Medicaid and needy

EHR Incentive Payments - EP

- Physician payments made to the physician but can assign to employer
- Physicians may qualify for Medicaid payments
  - May switch between programs 1 time
  - Maximum payment = Medicaid schedule
- Medicaid – must adopt, implement, upgrade or demonstrate meaningful use in the first year

EHR Incentive Payments - EP

- Additional Medicaid EP:
  - Nurse practitioner
  - Certified Nurse mid-wife
  - Physician assistant in a PA-led RHC or FQHC

MAXIMUM EHR INCENTIVE FOR A MEDICARE EP - NOT PREDOMINANTLY IN A HPSA

Calendar year	First CY in which the EP receives an incentive payment				
	2011	2012	2013	2014	2015 and Subsequent Years
2011	$18,000				
2012	$12,000	$18,000			
2013	$8,000	$12,000	$15,000		
2014	$4,000	$8,000	$12,000	$12,000	
2015	$2,000	$4,000	$8,000	$8,000	$0
2016		$2,000	$4,000	$4,000	$0
Total	$44,000	$44,000	$39,000	$24,000	$0

MAXIMUM EHR INCENTIVE PAYMENTS FOR A MEDICARE EP - PREDOMINANTLY IN A HPSA

Calendar year	Year that an EP first receives the incentive payment for Medicare covered professional services furnished in a geographic HPSA				2015 and Subsequent Years
	2011	2012	2013	2014	
2011	$19,800				
2012	$13,200	$19,800			
2013	$8,800	$13,200	$16,500		
2014	$4,400	$8,800	$13,200	$13,200	
2015	$2,200	$4,400	$8,800	$8,800	$0
2016		$2,200	$4,400	$4,400	$0
Total	$48,400	$48,400	$42,900	$26,400	$0

MEDICAID EP POTENTIAL PAYMENTS

Calendar year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Medicaid Threshold 30%

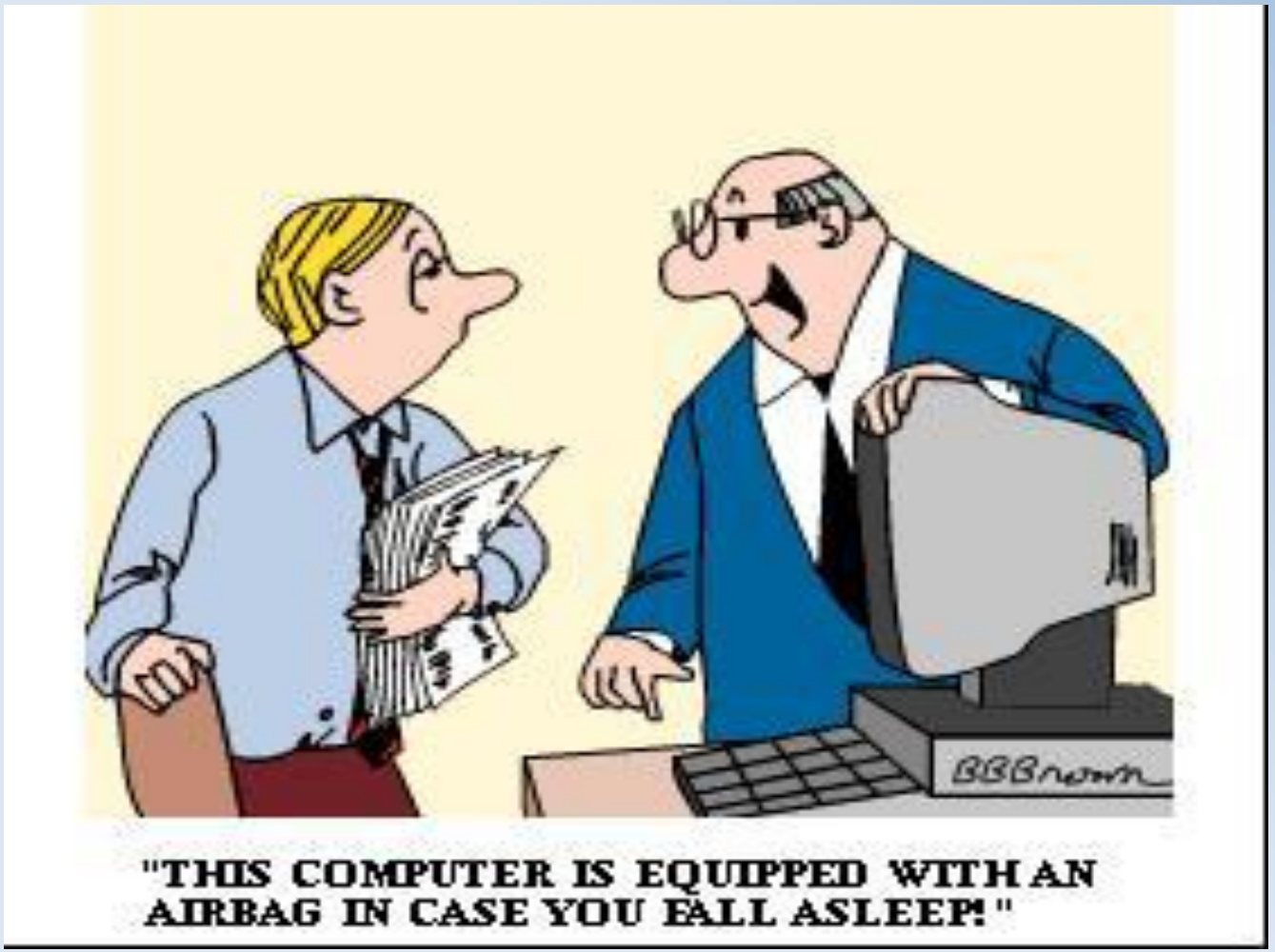
- Count encounters for:
  - Medicaid paid regular & managed care
  - Dual eligible patients
  - See AL definitions on website
- RHC/FQHC also count “needy”
  - CHIP
  - Uncompensated care
  - Sliding fee scale

Help & More Information

- Wyoming Regional Extension Center

- CMS:

  http://www.cms.gov/EHRIncentivePrograms


"THIS COMPUTER IS EQUIPPED WITH AN AIRBAG IN CASE YOU FALL ASLEEP!"

RHC Stuff

RHC Location Requirements

- Currently apply only to new RHCs
  - The RHC must be in a non-urbanized area, as defined by the U.S. Census Bureau, and
  - The RHC must be in an area that has been designated or certified by the Secretary within the previous 3 years as having an insufficient number or needed health care practitioners.
- Don't know? - Call the WY SORH.

Commingling – What Is It?

- The sharing of RHC space, staff, supplies, records, and other resources with an on-site Medicare Part B provider or Medicaid fee-for-service provider operated by the same RHC practitioner(s)

When It May Be Prohibited

- When it leads to duplicate Medicaid or Medicare reimbursement
- When used to select patient encounters for enhanced Part B billing

When It May Be Allowable

- When it doesn't lead to duplicate Medicaid or Medicare reimbursement
- When it isn't used to select patient encounters for enhanced Part B billing

Examples

- An RHC that is part of a multi-purpose clinic that houses other entities in the non-RHC space

- Hospital-based RHC that shares it's practitioners with the hospital emergency department

Physical Plant and Environment

- The clinic is maintained with appropriate State and local building, fire, and safety codes. This means that you must have a yearly inspection

Types of Services – Covered and Non-Covered

Types of Services - Covered and Non-Covered

- The services provided at a rural Types of Services - Covered and Non-Covered health center can be divided into four categories:
    1. Face-to-face encounters (or "visits").
    2. RHC services incident to a face-to-face encounter. These services are not directly billed but are reimbursed through the cost report. Incidental services are typically provided by non practitioners under general physician/extender supervision, although practitioners (particularly therapists who are directly employed by the RHC) frequently also provide incidental services.

Types of Services - Covered and Non-Covered

3. Non RHC services. RHCs can provide Part B covered services that do not fall within their congressional mandate. Examples include physician services to hospital inpatients and physical therapy by contracted therapists. Non RHC services are not reimbursed under the all inclusive rate; rather, they must be billed separately to the appropriate carrier.
4. Non-covered services. Non-covered services may be provided and billed directly to RHC patients. However, in no instance can Medicare beneficiaries be billed for services that would be covered under Medicare.

Covered Services

- The services offered in a Rural Health Clinic (RHC) are the type of services that patients receive in a doctor's office, an outpatient clinic or emergency room. Such services are physician's diagnostic, treatment or consultation services.
- The services may also be provided by a nurse practitioner, physician's assistant, certified nurse midwife, clinical psychologist or clinical social worker.

Covered Services

- Services are covered in an RHC if the following apply:
  - Medically reasonable and necessary.
  - The service is provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical social worker or clinical psychologist who is employed by or receives compensation from the clinic.
  - If not provided by a physician, the service is provided under the general supervision of the physician.

Covered Services

- The service is provided in accordance with the clinic's policies, protocols, standing orders or any physician's medical orders for patient care and treatment.
- If not provided by a physician, the service is permitted by state law for the nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist or clinical social worker to provide the service.
- If not provided by a physician, the service would be covered by Medicare if performed by a physician.

Non-covered Services

- Services not covered in an RHC as clinic services but may be covered under other Medicare benefits include:
  - Durable Medical Equipment (DME) (whether rented or sold) including iron lungs, hospital beds used in the patient's home, wheelchairs, etc.
  - Ambulance services.
  - Prosthetic devices, which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care, and the replacement of such devices.

Non-covered Services

- Leg, arm, back and neck braces and artificial legs, arms, and eyes, including replacements if required, because of a change in the patient's physical condition.
- Physical, speech or occupational therapy with a therapist not employed by the RHC.
- Screening mammography.
- Technical components of diagnostic tests.

Contracted non-physician diagnostic or therapeutic services are also excluded from RHC coverage.

Non-covered Services

- Custodial care.
- Cosmetic surgery.
- Charges by immediate relatives or members of household.
- Dental services.
- Paid or expected to be paid under a Medicare Secondary Payer (MSP) provision.

Or,

- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital.

Non-covered Services

- Visits for the sole purpose of obtaining or renewing a prescription, in which the need was previously determined (so that no examination of the patient is performed), are not covered services.
- Time used in completion of claim forms.
- Care-plan oversight is not allowed by either Part A or Part B for RHC providers

Services “Incident To”

- Services and supplies incident to an RHC practitioner’s (physician, physician's assistant, nurse practitioner, nurse midwife and clinical psychologist) professional services are covered as RHC services as long as the services and supplies are:
  - Furnished as an incidental, although integral, part of an RHC Practitioner’s services.
  - A type commonly furnished either without charge or included in the RHC’s bill.
  - A type commonly furnished in a physician’s office.
  - Services provided by *clinic employees* that are furnished under the direct and personal supervision of an RHC practitioner.
  - Furnished by a member of the clinic or staff who is an *employee* of the clinic.

Supervision

- Coverage is limited to situations where there is direct supervision of the clinic staff performing the service.
  - Direct and personal supervision does not mean that the RHC practitioner must be present in the same room.
  - The practitioner must be on the premises and immediately available to provide assistance and direction throughout the time the clinical staff is performing services.
  - If no mid-level or physician is on the premises; auxiliary staff may not provide any medical services.

Services for Lab Tests

- Lab tests
  - An encounter expressly for the purpose of obtaining blood for lab tests does not constitute a medically necessary face-to-face visit even if a face-to-face contact with the provider is made. To be considered as a face-to-face visit, there must be some additional medically necessary evaluation or management component.

Services without Visit Requirement

- For services that do not qualify as a billable *visit*, the usual charges for the services are added to those of the appropriate (*generally* previous) *visit*. RHCs use the date of the *visit* as the single date on the line item.

Medical Necessity

- Medical Necessity:
  - Situations in which the provider of the service (e.g. the person giving an injection) may be a qualified practitioner and the service (e.g. the injection) may be medically necessary but it is not medically necessary to have the practitioner re-examine the patient to deliver the service.
  - It is the physician/extender services that are medically unnecessary; using physician/extenders for services routinely performed by ancillary staff does not create additional reimbursable face-to-face encounters

Services to Others

- Medicare and Others
  - If you provide to others, must provide to Medicare beneficiaries
- Non Rural Health
  - Can't move patient back and forth to get reimbursement- allergy injection example

Providers of Service

Providers of Service

- Physicians
- Non-physician practitioners

NP/PA Other Locations

- Full-time and part-time nurse practitioners, physician assistants (including nurse midwives) who are employees of an RHC or who are compensated by the clinic for providing services furnished to the clinic's patients in locations other than at the clinic, may furnish services to clinic patients at the clinic or in other locations, such as the patient’s home.
- These services are RHC services and are reimbursable only to the clinic.
- Clinic patients include individuals who receive services at the clinic facility or services provided elsewhere.
- These costs are included in the costs of the RHC.

Non-Physician Practitioners

- Clinical Psychologist
  - Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and regulation.
  - Services and supplies furnished incident to a CP's services are covered if the requirements that apply to services incident to a physician's services, as described by CMS, are met and they are furnished by an employee of the RHC. To be covered, these services and supplies must be:
    - Mental health services that are commonly furnished in CPs' offices;
    - An integral, although incidental, part of professional services performed by the CP; and
    - Performed under the direct personal supervision of the CP, i.e., the CP must be physically present and immediately available.
-

Non-Physician Practitioners

- Clinical Social Worker
  - RHC services include the services provided by a clinical social worker, an individual who:
  - Possesses a master or doctor's degree in social work.
  - Has performed at least two years of supervised clinical social work; and, is either licensed or certified as a clinical social worker by the state in which the services are performed.
  - Or,
  - In the case of an individual in a state that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, Skilled Nursing Facility (SNF) or clinic.

Basic Billing & Reimbursement

RHC Billing and Reimbursement

- Provider Based billing to MAC
- Billing on CMS 1450 (UB or electronic equivalent)
- Services billed at your set charges, not expected reimbursement

RHC Billing and Reimbursement

- Medicare & Medicaid Reimbursement:
  - All inclusive rate current upper payment limit
  - Exceptions in provider based with less than 50 beds
  - Other exceptions: Vaccines, lab, etc.
- Patient Portion:
  - Deductibles
    - Based on incurred- your billed charge
  - Co-Pays
    - 20% co-insurance based on incurred- your billed charge

RHC Billing and Reimbursement

- Bill Types
  - RHC Bill Type 71X
  - Third digit:
    - 710 non payment/zero
    - 711 Admit through DC
    - 717 Replacement
    - 718 Void/cancel

RHC Billing and Reimbursement

- **0521** Clinic visit by member to RHC/FQHC
- **0522** Home visit by RHC/FQHC practitioner
- **0524** Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
- **0525** Visit by RHC/FQHC 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/FQHC Visiting Nurse Service(s) to a member's home when in a home health shortage area
- **0528** Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident) Charges for the interpretation of diagnostic tests performed by RHC staff (physician or midlevel) are included with the charges for the encounter under revenue code 52X.

RHC Billing and Reimbursement

- Dates of Service
  - A single date should be reported on a line item, not a range
- Reporting Units
- Non-visit day services
  - For services that do not qualify as a billable encounter, the usual charge for the services are added to those of the appropriate (previous or subsequent) encounter.

Specific Services

Technical Components

- Technical services/components associated with professional services/components performed by provider-based RHCs are billed by the base-provider on the TOB *for the base-provider* and submitted to the FI

Specific Services

- Lab Services
  - UA
  - Hemoglobin or Hematocrit
  - Blood Sugar
  - Stool for occult blood
  - Pregnancy
  - Primary culturing for transmittal to certified lab

Lab Follow-up Clinics

- Lab Follow-up Clinics*:*
  - Visits to lab-based follow-up clinics generally do not demonstrate a need for physician/extender face-to-face discussion of results other than in the two or three visits following diagnosis. Exceptions are expected to demonstrate a well-documented and unique need for the face to face interaction. The routine use of a visit to discuss lab results is not medically necessary.

Preventive Services

- Preventive Services:
  - Unless specifically covered by statute, primary preventive services are not covered and are additionally not considered to be medically necessary for the diagnosis or treatment of disease. Screening tests are not medically necessary for diagnosis when used for screening; they are only considered medically necessary when used in the diagnosis or exclusion of suspected disease.

Preventive Services

- Preventive services therefore include:
  - medical social services,
  - most nutritional assessments,
  - preventive health education,
  - prenatal and postpartum care,
  - routine physicals (including well child care),
  - immunizations,
  - eye and ear screening,
  - family planning,
  - routine screening procedures (urine dipstick, stool guaiac, serum cholesterol, weight and BP),
  - risk assessment (including undirected history taking and physical exam to ascertain risks), and
  - thyroid screening, among others

Preventive Services –Exception!

- Welcome to Medicare Physical :
  - The specific guidance regarding RHC billing is:
    - RHCs should follow normal billing procedures for RHC services.
    - Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at the same location constitutes a single visit.

Preventive Services

- Welcome to Medicare Physical
  - The technical component of the EKG performed at a provider-based RHC is billed on the applicable TOB and submitted to the MAC using the base provider number and billing instructions.
  - RHCs use revenue code 052X. RHCs do not have to report additional line items when billing for preventive and screening services on TOBs 71x. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC services must be reported on the revenue code line for the encounter, 052x, or 0900.

Pneumococcal and Influenza

- Influenza/Flu and Pneumonia Vaccines should not be submitted to MAC on a UB-92 claim form. Instead, when submitting your year end cost report , include a listing of those vaccines administered to your Medicare patients. The listing should include the following information:
  1) The patients Name and Medicare number.
  2) The date of service.
  3) The type and cost of each immunization.

  DO NOT, however, include vaccines administered to patients covered under the new Medicare Advantage plans on your listing to MAC. You should bill each respective Medicare plan for those services.

Injections

- Injections
  - A visit solely to receive an injection does not constitute a medically necessary face-to-face visit if the need for the injection was previously determined. This is true even if a face-to-face contact is made. [CMS Pub 100-4, 12-§200, RHC 27-406, CMS Pub 100-4, 17-§20, PIM 83-2.4.3.1]

Allergy Shots

- Allergy shots
  - A visit solely to receive an allergy shot does not constitute a medically necessary face-to-face visit even if a face-to-face contact is made. The allergy shot is generally administered by ancillary personnel and represents a service that is incident to a prior physician visit. However, if the patient has an adverse reaction that necessitates a physician/extender evaluation (and that examination, assessment and plan is appropriately documented), the encounter may then be appropriately billed as a face-to-face visit.

Dressing Changes

- Dressing changes
  - There may be instances when a caretaker is unable to adequately perform dressing changes or where the level of complexity of the care requires the skills of a nurse. These dressing changes do not constitute medically necessary face to face visits solely because the service was provided by a physician/extender if similar services could be provided by nurses or other designated office staff. Except in the special case of visiting nurse services, medical necessity for a face to face encounter is based on:
    1. The need for a physician/extender to monitor the underlying wound at a frequency that does not differ from the usual patterns of utilization in an office or outpatient clinic OR
    2. An exacerbation or complication that would trigger an examination in those environments OR
    3. Sharp debridement requiring the skills of a physician/extender.

Prescription Services

- Prescription Services
  - Writing or refilling prescriptions and services such as intermittently dispensing medications (oral or injectable) to psychiatric patients or drug abusers and counting/filling pill dispensers for disabled or demented beneficiaries do not require a face to face evaluations in the typical outpatient setting.
  - Thus the need for a prescription refill or medication disbursement will not contribute to establishing medical necessity for the face to face encounter. These are covered services, but are incidental to the underlying physician/extender examination and treatment.

Hospice

- Services related to the terminal illness of a hospice patient cannot be billed as RHC services. If the RHC physician is the hospice patient's attending physician, these hospice-related services can be reimbursed by the hospice service to the physician. RHC physicians and practitioners can bill, as an RHC, only the services that are not related to the terminal condition of a hospice patient

Mental Health

- The beneficiary co-pay is 45% of the all-inclusive rate for psychiatric therapy services.

- Beginning 1/1/2012 it reduces to 40%
- Beginning 1/1/2013 – 35%
- Beginning 1/1/2014 – 20%

Off Site/Other Services

- Nursing Facilities
- Home Visits
- Domiciliary Visits
- Hospital Visits
- Hospice Visits
- Visiting Nurse Services
- Telehealth Services
- Family Consultations

Medical Record Requirements

Medical Record Requirements

- Each page of the medical record must be assignable to a specific patient by some form of identification, either a complete patient name or a unique medical record number.
- Each face to face encounter documented in the medical record must include the date on which the encounter occurred or, in the case of multiple visits on a single day, the date and time of the visits.
- Each face to face encounter documented in the medical record must end with the signature of the provider who personally performed the face to face visit.
- The provider signature may be appended to the medical record in any of several formats

Changes are Coming ??

RHC Proposed Rules

- Proposed Rules Issued June 27, 2008
- Comments made in August, 2008
- Under consideration currently
- Issuance of final and effective date ????
- *Issue by June 27, 2011 or start over*

RHC Proposed Rules (Continued)

- HPSAs
  - Geographic Primary Care
  - Population-Group
- MUAs
- Governor's Designation
- Automatic HPSAs - **ELIMINATED**

RHC Proposed Rules (Continued)

- Location Requirements
  - **New** RHCs Must Have had shortage Area Designation Within the Last 3 Years before Seeking Designation
  - **Existing** - must have been redesignated within 3 years… If no longer in shortage area RHC could lose designation unless RHC Can Meet Certain Exceptions

RHC Proposed Rules (Continued)

- Possible exceptions
  - Essential Provider
  - Sole community provider
  - Major community provider
  - Specialty clinic
  - Extremely rural community

RHC Proposed Rules (Continued)

- Read the proposed rules – especially if you believe you have a problem
  - More information on National Rural Health Association (NRHA) site:
    - www.ruralhealthweb.org

HPSA/MUA negotiated rule making

- More than 130 hours, only three decisions to date made, we need to make 12 decisions in total.

- Members have requested an extension until October to finish (suppose to finish by July, but have not even begun impact testing or weighting yet).

Resources


Home computers are the perfect thing for women who don't feel that
Men provide them with enough frustration!!

Resources

- CRHC – Rural Health Clinic Toolkit
- HRSA – Starting a Rural Health Clinic – A How to Manual
- CMS – Cost reporting – Pub. 27 – RHC & FQHC Manual
- CMS – Benefit Policy Manual, Pub 100-02, Chapter 13 – RHC/FQHC Services
- CMS – Claims Processing Manual, Pub 100-04, Chapter 9

Resources

- NRHA – National Rural Health Association – RHC Constituency Group
  www.ruralhealthweb.org
- NARHC - National Association of Rural Health Clinics - www.narhc.org

Questions?

Class Dismissed