

Understanding Rural Health Clinics & Provider-Based Clinics



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Overview of the Rural Health Clinic (RHC) Programs

- ✓ Medicare reimbursement may be as much as 250% more than the reimbursement for other clinics.
- ✓ Cost of physician recruitment and retention is improved because the financial viability of the clinic is improved.
- ✓ Physician compensation can be increased.
- ✓ Recruitment fees may be recouped in part from Medicare.



RHC Requirements

- ✓ Rural
- ✓ HPSA or MUA within four year requirement (formerly three year)
- ✓ Midlevel practitioner 50% of clinic hours
- ✓ Nonprofit or for-profit organization



Requirements for Rural Health Status

- ✓ The clinic must be in a rural area as designated by the Bureau of Census.



Requirements for Rural Health Status

- ✓ The area must be designated by the Secretary of HHS as a medically underserved area (MUA) or a health care shortage area (HPSA)
 - ✓ Types of HPSA
 - ✓ Geographic (population-to-physician ratio greater than 3,500 to 1)
 - ✓ Low income
 - ✓ Migrant seasonal farm worker
 - ✓ Homeless
 - ✓ Governor designated



Requirements for Rural Health Status

- ✓ Loss of HPSA/MUA does not automatically terminate the rural health clinic status.
- ✓ Rural health clinic status may be revoked because of a failure to meet MUA or HPSA requirements. Once an area is no longer eligible for MUA or HPSA designation all rural health clinics must be re-evaluated by CMS to determine if rural health care status will continue. The CMS evaluation process is still being developed.



Requirements for Rural Health Status

- ✓ HPSA is valid for four years
- ✓ We encourage all RHCs to request renewal of HPSA six months prior to expiration date –

THE BURDEN IS ON YOU
TO MAKE THE REQUEST



Requirements for Rural Health Status

- ✓ Must have midlevel practitioner on the premises available to see patients 50% of the time the rural health clinic is open (use posted clinic hours)



Requirements for Rural Health Status

- ✓ The clinic must have the policies and procedures as described by the federal government in place and functioning. The state has no additional requirements.
- ✓ The clinic building must be physically fit. The requirements are similar to the hospital building survey requirements.



Requirements for Rural Health Status

- ✓ For certification, the clinic must:
 - Complete the application.
 - Normally an on-site survey 30-90 days after requested (survey may be delayed upon request); however, the survey may be delayed for an extended period of time due to quotas.
 - Inspections of both the policies and procedures and of the physical plant must be conducted.



Requirements for Rural Health Status

- ✓ If the clinic does not pass the initial survey, the survey team will resurvey within a year or two.
- ✓ If the clinic passes the survey, they will receive written notification from the state, a copy will be sent to the Medicare Region X office, and a copy will be sent to the Medicaid Rate Section.



Recertification and Termination

- ✓ Recertification of the rural health clinic is on an annual basis; however, the State is shorthanded and most resurveys occur every three to five years.
- ✓ Termination can occur if:
 - The clinic no longer meets requirements.
 - The clinic is not in substantial compliance with agreement.
 - The clinic changes ownership.



Services Available Through a Rural Health Clinic

- ✓ Services available through a rural health clinic are physician services and services incident to physician services.
- ✓ Similar services can be provided by the following:
 - Physician's assistants
 - Clinical psychologists
 - Nurse midwives
 - Nurse practitioners
 - Clinical social workers
- ✓ Visiting nurses and medical supplies (other than drugs and biologicals) to a homebound (permanently or temporarily) patient in the area where there is a shortage of home health agencies - a shortage exists if the Secretary of Health and Human Services determines that a shortage exists.



Required Written Policies and Procedures

The following is a list of requirements for a rural health clinic:

- ✓ Supervision and guidance of midlevel practitioners (including PA and ARNP) by a physician with a minimum of one on site visit every two weeks.
- ✓ Agreement with one or more outside physicians or policies governing designated physicians employed by the clinic for periodic supervision and guidance of services provided by midlevel practitioners including preparation of medical orders for care and treatment as may be necessary, availability of referral and consultation for patients as necessary, and advice and assistance in the management of medical emergencies.



Required Written Policies and Procedures

- ✓ Clinical records on all patients must be maintained and must include the following information:
 - Identification and social data
 - Consent form
 - Pertinent medical history
 - Assessment of medical status and health care needs
 - A brief summary of each episode, disposition, and instruction to the patient
 - Records of physical examinations, diagnostic and laboratory results, and consultation finding
 - Physician orders, reports of treatment and medication, and other information to monitor patient progress



Required Written Policies and Procedures

- ✓ Records must be confidential and safeguarded against loss, destruction, and unauthorized use.
- ✓ Written policies and procedures govern the use and removal of records and releases of information.
- ✓ Records must be retained for six years after the last date of entry.
- ✓ Agreements with one or more hospitals for referral and admission of patients requiring inpatient service.
- ✓ Written policies developed with the advice of and periodic review by a group of professional personnel including one or more physicians and one or more midlevel practitioners.



Required Written Policies and Procedures

- ✓ Physicians and midlevel practitioners must be responsible for execution of the policies.
- ✓ The clinic must provide routine diagnostic services.
- ✓ The clinic must provide clinical laboratory services, including:
 - Chemical examination of urine by stick or tablet
 - Blood glucose levels
 - Hemoglobin or hematocrit
 - Examination of stool specimen
 - Pregnancy tests
 - Primary culturing for transmittal to a certified lab
- ✓ Drugs and biologicals for life threatening emergencies must be available



Required Written Policies and Procedures

- ✓ There must be prompt access to additional diagnostic services from the facility for treatment of emergency cases.
- ✓ The appropriate procedures for storing, administering, and dispensing any drugs and biologicals must be followed.
- ✓ A midlevel must be able to furnish patient care 50% of the time the clinic is operating.
- ✓ The clinic building must be constructed, arranged, and maintained to insure access to and safety of patients. The clinic must also provide adequate space.
- ✓ Provider-based clinics must have an agreement with related provider as if that provider is not related.
- ✓ Each location must be certified separately.



Required Written Policies and Procedures

- ✓ There must be a preventative maintenance program.
- ✓ The staff must be trained to handle emergencies.
- ✓ Exit signs must be in appropriate locations.
- ✓ The clinic has to be under the direction of a physician
- ✓ Policies and procedures concerning lines of authority and responsibilities must be in place.
- ✓ The names and addresses of the owners, the person principally responsible for directing the clinic's operations, and the medical director must be displayed.

*This list is not all-inclusive.
Additional policies and procedures are required.*



Scope and Type of Programs Currently in Operation

- ✓ Freestanding clinic operated by a public hospital district
- ✓ Hospital-based clinic operated by a public hospital district:
 - Clinic located miles away from the hospital
 - Clinic located adjacent to the hospital
 - Clinic located within the hospital (area must be segregated from other departments within the hospital).
 - Clinic located adjacent to the emergency room. ER coverage provided by clinic staff during clinic hours. All nonemergency patients are referred the adjacent clinic. This eliminates ER physician coverage.



Provider-Based Versus Freestanding Clinics

- ✓ Provider-based clinics are an integral and subordinate part of a hospital, nursing home, or home health agency participating in the Medicare program. The clinic is operated with other departments under common licensure, governance, and professional supervision.
- ✓ Clinics not fitting this description are independent.



Medicare and Medicaid Reimbursement

Medicare and Medicaid reimbursement differs depending on whether the clinic is provider-based or independent.

✓ **Provider-Based Clinics**

Medicare reimbursement is on a reasonable cost basis as determined by the provider's Medicare cost report, unless the provider has more than 50 beds. If this is the case, the provider is reimbursed as an independent clinic.



Medicare and Reimbursement

✓ Independent Clinics

Medicare reimbursement is the lesser of cost or cost per visit limit (\$78.07 in 2011 and \$77.76 for 2010). Final reimbursement is based on the clinic's year-end cost report.

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Medicare Reimbursement

- ✓ RHCs provide both
 - RHC services
 - Non-RHC services



Medicare Reimbursement

- ✓ RHC services (billed to intermediary on UB04) include:
 - Office visits
 - All nursing home visits
 - Home visits
- ✓ Physician and midlevel services are reimbursed at the same rate



Medicare Reimbursement

- ✓ Non-RHC services (billed to Part B carrier on 1500 {freestanding} or may be billed by the hospital on UB04 {provider-based}) include:
 - Services provided in the hospital
 - Acute care visits
 - Operating room procedures
 - Emergency room services
 - Lab (performed in the clinic), X-ray (tech comp), EKG (tech comp)



Medicare Reimbursement

- Rural Health Clinic Services Visit (billed to Part A intermediary) include:
 - Anything incident to physician services unless specifically excluded
 - Incident to includes
 - Supplies
 - Drugs
 - Injections other than flu and pneumonia
 - Other professional services provided by RHC practitioners such as EKG and radiology read fees



Medicare Reimbursement

- Rural Health Clinic Services Visit Exclusions
(billed to Part B carrier, if freestanding)
(billed to Part A intermediary under Hospital provider number, if provider-based)
 - All laboratory services
 - X-ray (technical component)
 - EKG (technical component)
 - Bone density scan (technical component)
 - DME items



Medicare Reimbursement

- Provider-based RHC Laboratory Services
 - Prior to July 1, 2009 – 14X bill type – paid based on fee scale
 - After June 30, 2009 – 85X bill type – paid based on cost plus one percent



Medicare Revenue Codes

- When billing the Part A intermediary
 - Combine all charges on one line
 - Avoid using non-RHC revenue codes such as supply and pharmacy codes
 - CPT codes are option and not recommended by CMS



Medicare Reimbursement

- Non-RHC Reimbursement (2011)

– 99212	\$ 40.91	
– 99213	\$ 68.10	most common
– 99214	\$ 101.03	
– 99215	\$ 135.93	



Medicare Reimbursement

- Clinic uses EMR (2011) after weight factor changes (EMR CREEP)

– 99212 \$ 40.91

– 99213 \$ 68.10 most common

– 99214 \$101.03 most common

– 99215 \$135.93

Does freestanding RHC still work?



Medicare Reimbursement

- Non-RHC Reimbursement (2010 rate – gain from 2010 to 2011)

– 99212	\$ 39.23	-----	\$ 1.68
– 99213	\$ 65.82	-----	\$ 2.28
– 99214	\$ 98.63	-----	\$ 2.40
– 99215	\$133.18	-----	\$ 2.77



Medicare Reimbursement

✓ Freestanding and Provider-Based (over 49 beds) 2011 RHC (2010 was \$77.76)

- 99212 \$ 78.07
- 99213 \$ 78.07 most common
- 99214 \$ 78.07
- 99215 \$ 78.07



Medicare Reimbursement

✓ FQHC Reimbursement (for same service) 2011
(2010 was \$108.81 - \$125.72)

- 99212 \$ 109.24 (Rural) - \$126.22 (Urban)
- 99213 \$ 109.24 - \$126.22 most common
- 99214 \$ 109.24 - \$126.22
- 99215 \$ 109.24 - \$126.22



Medicare Reimbursement

- ✓ Provider-Based-RHC (under 50 beds)
Reimbursement
 - 99212 \$125.00 - \$175.00
 - 99213 \$125.00 - \$175.00 most common
 - 99214 \$125.00 - \$175.00
 - 99215 \$125.00 - \$175.00



Medicare RHC Payments

We have talked about payments based on the cost per visit
but
How are we really paid?

- ✓ If no patient deductible:
 - Medicare pays 80% of the interim rate
 - Patient pays 20% of charges



Medicare RHC Payments

Example if no patient deductible:

Assumptions:	CPT code 99213
	Standard charge \$79
	Medicare interim rate \$100

- ✓ Medicare pays 80% of the \$100 or \$80.00
- ✓ Patient pays 20% of \$79 or \$15.80
- ✓ Total payment \$95.80



Medicare RHC Payments

DOES IT MATTER
HOW WE CODE A VISIT?
YES!

- ✓ Patient payment is affected
- ✓ Medicare considers over coding as a violation of the fraud and abuse regulations because of the additional reimbursement
- ✓ Medicare considers under coding as a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic



Medicare RHC Payments

- ✓ If the patient owes deductible:
 - Patient pays 100% of charges up to the full deductible due
 - Medicare pays 80% of the interim rate less patient deductible
 - Patient pays 20% of charges less patient deductible



Medicare RHC Payments

Example if patient owes deductible:

Assumptions: CPT code 99212
 Standard charge \$58
 Medicare interim rate \$100
 Patient deductible \$25

- ✓ Medicare pays 80% of the \$100 - \$25 or \$60.00
- ✓ Patient pays 20% of \$58 - \$25 or \$6.60 plus \$25.00
- ✓ Total payment \$91.60



Medicare RHC Payments

Example if patient owes deductible: EXTREME EXAMPLE

Assumptions:

CPT code 99213

Standard charge \$79

Medicare interim rate \$68

Patient deductible \$79

- ✓ Medicare pays 80% of the \$68 - \$79 or -\$8.80
- ✓ Patient pays 20% of \$79 - \$79 or \$0.00 plus \$79.00
- ✓ Total payment \$70.20



Medicare Reimbursement

- ✓ Medicare reimbursement is on a reasonable cost basis as determined by the provider's Medicare cost report.
- ✓ However, during the year Medicare payments are based on a interim rate that is based on historical reasonable cost as reflected on filed Medicare cost reports.



Medicaid Reimbursement

Under Medicaid both provider-based and freestanding rural health clinics receive payments in accordance with the minimum amount mandated by federal law. This minimum level should approximate Medicare reimbursement rates.

Once established by the state, the rate can only be adjusted for Medicare inflation which averages from 0.4% to 3.0% annually.



Medicare Revenue Codes

- Effective July 1, 2006
 - 0520 Clinic visit at FQHC
 - 0521 Clinic visit at RHC
 - 0522 Home visit by RHC practitioner
 - 0524 RHC visit SNF patient
 - 0525 RHC visit NF patient
 - 0527 RHC visiting nurse (must have special designation)
 - 0528 RHC visit other locations (accident)
 - 0780 Telehealth
 - 0900 Mental health visits



Medicare Bill Types

- 710 Claim with only non-covered charges
- 711 Original claim
- 715 Late charge – adjustment to prior claim
- 717 Replacement claim – adjustment to prior claim
- 718 Void/cancel previous claim



Medicare and Medicaid Reimbursement

- ✓ A visit is defined as a face-to-face encounter between a clinic patient and one of the following: physician, physicians assistant, nurse practitioner, nurse midwife, clinical psychologist, clinical social worker, or visiting nurse.

Must Be Medically Necessary



Medicare Reimbursement

- ✓ One RHC visit per patient per day with few exceptions
- ✓ Second encounter on same day may be billed if unrelated (sore throat and broken hand)
- ✓ May bill for a Part A visit and a Part B non-RHC visit (hospital visit) on same day



Medicare Reimbursement

Patient seen at one RHC then referred to another related RHC for a medically necessary visit on the same day

✓ Two Billable RHC Visits or One RHC Visit?

ANSWER - Two RHC visits

Each RHC has a separate provider number; therefore, each visit is separately billable provided the second visit is clearly medically necessary.



Medicare Reimbursement

Patient is seen by an RN for a coumadin screening during RHC hours

✓ Billable RHC Visit?

ANSWER – No

A face-to-face encounter with a practitioner did not occur. The charge may only be combined with a previous or subsequent face-to-face encounter. The RHC will only be paid an additional co-insurance of 20% of charges since Medicare does not recognize it as a RHC encounter.



Medicare Reimbursement

Patient seen by a physician for coumadin screening during RHC hours

✓ Billable RHC visit?

ANSWER – Only if the physician involvement is medically necessary

If not medically necessary, handle like RN visit on previous side.



Medicare Reimbursement

Patient is seen by an RN for coumadin screening clinic during non-RHC hours

✓ Billable RHC visit?

ANSWER – No

✓ Billable as non-RHC service?

ANSWER – Yes

All services provided during non-RHC hours are billable to the Part B carrier as non-RHC services.



Medicare Reimbursement

Patient is seen by a physician who performs a scope during RHC hours.

✓ Billable RHC visit?

ANSWER – Yes

✓ Billable as a non-RHC service?

ANSWER – No

Although the physician would be paid more from the Part B carrier, the service was performed in the RHC during RHC hours and is considered by Medicare to be a face-to-face encounter that **must** be billed the Medicare intermediary as a RHC visit.



Medicare Reimbursement

Local home health agency requires a home health certification and the physician performs the certification during RHC hours.

NEW (Refer to MLN Matters SE1038 for more details)

As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying practitioner must document that he or she has had a face-to-face encounter with the patient

- Must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
- Documentation must be present with starts of care on or after 1/01/11
- Certifying physician can “hand off” care
- Face-to-face encounter could be through telehealth in approved site
- **Encounter cannot be billed as an RHC visit**



Medicare Reimbursement

Physician Compensation

Not subject to RCE (reasonable compensation equivalent) limit



Medicare Reimbursement

Physician Owner Compensation

However, CMS is trying to use a reasonable physician cost per visit limit.

In 2006, \$43.61 or \$183,162 for 4,200 visits.

Updated for MEI, this amount in 2011 = \$46.80
or \$196,560



Medicare Reimbursement

Reasonable cost does not include:

Marketing/advertising (except for staff)

Income taxes

Donations/contributions

Dividends paid to owners



Medicare Reimbursement

Reasonable cost is based on accrual accounting.

Cash basis is not permitted.



Medicare Reimbursement

Reasonable cost is based on depreciation computed using straight-line method and AHA useful lives

Tax basis accelerated depreciation methods are not permitted.



Medicare Reimbursement

Reasonable cost does not include related party charges

- ✓ Related party charges must be adjusted to actual cost.
- ✓ Rent must be adjusted to cost as if clinic owned asset.
- ✓ Related individual must be paid at fair market value – no imputed values.



Medicare Productivity Standards

- ✓ 4,200 visits per employed or independent contractor physician FTE (formerly only employed)
- ✓ 2,100 visits per midlevel FTE (midlevel has to be employed)
- ✓ Viewed in aggregate



Medicare Productivity Standard

- Productivity is applied in aggregate.
- Physician and midlevel total actual visits are compared to total productivity visits.
- A midlevel excess productivity can be used to offset any physician shortfall.



Productivity Standard

Independent contractor physicians
are only exempt
from the productivity standard
if they do not work at the clinic
on a regular basis



How Do I Know If A Productivity Problem Exists?

- Actual visits are less than the minimum visits determined using the productivity standard



Medicare Reimbursement

Medicare laws and regulations do permit CMS to use something other than the RCE limit to determine if physician compensation is reasonable.

We have asked for and never received support for the current per visit amount that was based on 2001 data.



What Effect Does A Productivity Problem Have On My Reimbursement?

Perhaps None!

- Cost/Actual Visits = Actual Cost Per Visit
 $\$100,000/1,000 = \100.00
- Cost/Productivity Visits = Productivity Cost Per Visit
 $\$100,000/1,200 = \83.33
- Medicare Cost Per Visit Limit \$78.07
Net Effect = \$0



What Effect Does A Productivity Problem Have On My Reimbursement?

Perhaps A Lot!

- Cost/Actual Visits = Actual Cost Per Visit
 $\$100,000/1,000 = \100.00
- Cost/Productivity Visits = Productivity Cost Per Visit
 $\$100,000/1,200 = \83.33
- Medicare Cost Per Visit Limit – None (provider-based)

Net Effect = \$13.34
(80% OF \$16.67)



What Effect Does A Productivity Problem Have On My Reimbursement?

Perhaps A Lot!

- Cost/Actual Visits = Actual Cost Per Visit
 $\$100,000/1,000 = \100.00
- Cost/Productivity Visits = Productivity Cost Per Visit
 $\$100,000/1,200 = \83.33
- Proposed Medicare Cost Per Visit Limit \$92.00
(if ever passed by Congress)

Net Effect = \$6.94
(80% OF \$8.67)



What Effect Does A Productivity Problem Have On My Reimbursement?

Perhaps None

- Cost/Actual Visits = Actual Cost Per Visit
 $\$100,000/1,000 = \100.00
- Cost/Productivity Visits = Productivity Cost Per Visit
 $\$100,000/1,200 = \83.33
- No Medicaid Cost Per Visit Limit
Potential Net Effect (Medicaid) = \$16.67
Forever



If A Productivity Problem Exists, What Do I Do?

- Check accuracy of FTE count

Use a normal work week and determine how many hours the practitioner is available to provide patient care



If Productivity Problem, What Do I Do?

- Exclude any time that the practitioner is not available for patient care such as administrative and general duties, medical director, non-patient recordkeeping.
- Such time and related costs should be classified as administrative in nature and excluded from the FTE count.



Exclude All Non-RHC Time

- Exclude any time that the practitioner is performing non-RHC services such as services in hospital.
- Such time and related cost should be eliminated from the RHC cost center through cost report adjustment or reclassification.
(new CMS clarification)



Exclude Cost and Time Associated with Emergency Room Call

- If the clinic practitioners are on-call for the emergency room, a portion of the practitioner related cost should be reclassified to the emergency room.



If Nothing Else Works

- Have a talk with the practitioner about productivity
- Change the practitioner's compensation to be productivity based
- Find a new practitioner
- In some instances, a reduction of the practitioner clinic hours will help



Make Sure Actual Visits Are Accurately Stated

- Exclude non-practitioner encounters (RN Visits)
- Exclude non-RHC Visits (Hospital Visits)



Make Sure FTEs, Visits, Costs Are Determined Consistently

- FTEs, visits, and costs associated with non-RHC services should be eliminated
- FTEs, visits, and costs used to determine the RHC cost per visit should only include RHC FTEs, visits, and costs
- Avoid apples and oranges comparisons



Make Sure FTEs, Visits, Costs Are Determined Consistently

- Some intermediaries are requiring RHCs to do practitioner time studies to establish the amount of time the practitioner spends doing RHC and non-RHC services.
- Some intermediaries are allowing two two-week time studies.
- Some intermediaries are requiring year-long time studies.



Medicare non-RHC Billing and Payments

Services provided in the hospital (hospital visits, emergency room visits, operating room procedures)

Option A

- ✓ RHC bill using the physician's Medicare number on Form 1500 to the Part B carrier – payment based on fee scale



Medicare non-RHC Billing and Payments

Services provided in the hospital (hospital visits, emergency room visits, operating room procedures)

Option B
Critical Access Hospital only
Method II Billing Election

- ✓ Hospital must bill **outpatient** physician services with hospital outpatient charges on UB04 – physician portion of payment based on fee scale plus 12% (80% of 15%) and hospital payment unchanged
- ✓ RHC bill for **inpatient** services using the physician's Medicare number on Form 1500 to Part B carrier – payment based on fee scale



Medicare non-RHC Billing and Payments

Other non-RHC services provided (laboratory, radiology, EKG)

Option A

- ✓ Provider-based hospital bill using the hospital's Medicare number on UB04 to intermediary using bill type 14X – payment based on fee scale
- ✓ Freestanding RHC and FQHC bill to Part B carrier



Medicare non-RHC Billing and Payments

Other non-RHC services provided (laboratory, radiology)

Option B

Critical Access Hospital established

Provider-based laboratory and radiology department
in RHC

- ✓ Hospital bill using the hospital's Medicare number on UB04 to intermediary using bill type 85X – payment based on cost



Medicare non-RHC Billing and Payments

Other non-RHC/FQHC services provided (non-encounters, other immunizations, other)

Option A

- ✓ Added to the bill which includes encounter using the clinic's Medicare number on UB04 to the intermediary – additional reimbursement equal to 20% of charges (patient coinsurance). Cost will be included in cost per visit calculation and Medicare will pay 80% of additional cost

Option B

- ✓ Clinic writes off charge and no bill is generated – loss of 20% of charges; however, cost will be included in cost per visit calculation and Medicare will pay 80% of additional cost



Medicare Reimbursement

- ✓ Medicare bad debt reimbursement (Part A deductibles and coinsurance only) at 100% of unpaid amount
 - Not paid by the patients as a reasonable/standard collection effort for 120 days from the date of initial bill to patient has been made. (CMS is now insisting that if turned over to outside collection agency, account cannot be claimed until returned from collection agency.)
 - Denials by Medicaid as secondary payor as long as actually billed and denied – immediate.
 - Documented charity care write-offs – immediate.



Medicare Reimbursement

- ✓ Pneumonia and influenza (including H1N1) immunizations
 - Medicare will pay cost at the end of the year on the cost report
 - Cost-based reimbursement is two to three times standard payment levels
 - Do not bill Medicare. The clinic is only required to maintain a log



Medicare Reimbursement

- ✓ Pneumonia and influenza (including H1N1) log requirements:
 - Must include all patients
 - Separate log for pneumonia and for influenza
 - Information needed:
 - Date of service
 - Patient name
 - Patient Medicare number, if Medicare patient



Medicare Reimbursement

✓ Telehealth Services:

- Two types:

- Originating site

- Distant site



Medicare Reimbursement

- ✓ Telehealth Services (Originating Site):
 - Use revenue code 780
 - Use CPT Code Q3014
 - Reimbursement - \$20 to \$25



Medicare Reimbursement

- ✓ Telehealth Services (Distant Site):
 - Bill the Part B carrier as if the patient was with you face-to-face
 - Payment is made based on current fee schedule



Medicare Reimbursement

✓ Mental Health Visit – Revenue Code 900

- Effective 1/1/2010, Medicare payment is 80% of 68.75% of cost per visit or interim rate (not flat 80% of cost or interim rate).
- Patient deductible is 100% of adjusted charges up to unmet deductible.
- After deductible - Patient coinsurance is 31.25% of billed charges plus 20% of adjusted charges (68.75% of billed charges).



Medicare Reimbursement

✓ Reduction in Mental Health Limitation

- Mental health limitation is phased out effective 1/1/2010 per a Memorandum dated 10/30/2009:
 - 2011 68.75% (Medicare pays 55%, patient pays 45%)
 - 2012 75.00% (Medicare pays 60%, patient pays 40%)
 - 2013 81.25% (Medicare pays 65%, patient pays 35%)
 - 2014 100% (Medicare pays 80%, patient pays 20%)



Medicare Reimbursement

✓ Mental Health Visits Do Not Include

- Initial psychiatric visits
- Psychiatric testing
- Non-psychiatric physician and midlevel visits



Non-RHC Hours How Do They Work?

Establish In Writing Non-RHC Hours
M W F – 7 AM TO 9 AM

Put a notice up in the waiting room

Anything done in the clinic during non-RHC hours must be billed to the Part B carrier.

Non-RHC hours cannot exceed 49% of total clinic hours.



Non-RHC Hours How Do They Work?

- Non-RHC hours work best for freestanding RHCs—
- ✓ Scopes
- ✓ Immunizations (other than flu and pneumonia)
- ✓ B12 injections
- ✓ Allergy injections
- ✓ Nonpractitioner follow-up visits



Non-RHC Hours How Do They Work?

Cannot have a practitioner providing both RHC and non-RHC services within the clinic during the same hours

Generally the clinic is either RHC or non-RHC during specific hours



Non-RHC Hours

How Do They Work?

Since non-RHC FTEs, costs, and visits must be eliminated from the RHC cost center

- ✓ Must keep track of services provided during non-RHC hours
- ✓ Must establish method for identifying related cost



Medicare Reimbursement

Cost Reports

The freestanding RHC intermediary is Cahaba (most common) or the area MAC for new freestanding RHCs after August 2009.

The FQHC intermediary is National Government Services.

Provider-based RHCs use their existing hospital intermediary.



Medicare Reimbursement

Cost Reports (continued)

Cost reports due date - 5 months after

- ✓ Year end
- ✓ Change of ownership
- ✓ Termination of RHC status



Medicare Reimbursement

Non-covered Services

- ✓ Must have signed ABN (advanced beneficiary notice)
- ✓ With ABN, may bill patient
- ✓ Without ABN, must write off



Medicare Reimbursement

Medicare is Secondary

- ✓ Hospitals must ask patient about other coverage every 90 days
- ✓ Must bill Medicare if Medicare is secondary whether primary has paid more than Medicare will pay or not
- ✓ Medicare may recover part of primary payor payment



EHR Incentives for RHCs

● Independent RHCs

- No current provision for supplemental payments from Medicare EHR costs reported on Medicare cost report.
- Eligible professional practicing in RHC may qualify for Medicaid incentive if:

Medicaid + Medicaid Managed Care + Charity Care + Sliding Fee Scale > 30%.

- Average allowable costs are limited to adoption costs of \$25,000 plus \$10,000 of maintenance in years two through five.
- First-year costs no later than 2016; payment after 2021 or five years after first year.



EHR Incentives for RHCs

Critical Access Hospitals with Provider-Based RHCs

- The law states reimbursement for provider-based services is included with main provider's funding

- Medicare reimbursement percentage =

Medicare and Medicare Advantage inpatient acute care days /
[total inpatient acute care days * (1-charity care percentage)]
plus 20% (may not exceed 100%)

- Costs may be expensed in the first year rather than depreciated, if meaningful use is met.
 - Beginning with expenses incurred on or after 2011.
 - Medicare incentives end 2016.



Other Programs: Federally Qualified Health Clinics

- ✓ Rural health clinics must give up RHC status to become a federally qualified health clinic (FQHC).
- ✓ FQHC's are reimbursed the same as rural health clinics except the cost per visit limits are higher. In 2011, the cost per visit for a rural FQHC is \$109.24, whereas the cost per visit for an urban FQHC is \$126.22.
- ✓ FQHCs receive federal grants for indigent care.
- ✓ FQHCs participate in the 340b drug program.
- ✓ FQHCs receive malpractice coverage from the federal government.



Medicare Advantage (Disadvantage)

- A recent report suggests that Medicare is currently spending 12.4% more per person under Medicare Disadvantage than would be spent under traditional Medicare.
- This represents an additional \$8,500,000,000 in fiscal year 2008.



Medicare Advantage (Disadvantage)

Why are RHCs and CAHs
being paid less under
Medicare Disadvantage?



Medicare Advantage (Disadvantage)

- Types of Medicare Advantage contractors
 - PFFS
 - HMO
 - RPPO
 - LPPO
 - SNP



Medicare Advantage (Disadvantage)

- Medicare Advantage contractors are not required to contract with RHCs in their area
- **Old Rule** - Medicare Advantage contractors are required to pay RHCs the same as direct Medicare unless the RHC agrees to take something different.
- **New Rule** – HMO, RPPO, LPPO, and SNP contractors can pay their standard rates even if no contract exists, standard rate available on website, and patient enrollment card identified type of coverage.



Medicare Advantage (Disadvantage)

- RHCs can elect not to contract with the Medicare Advantage contractors – CMS required to ensure proper coverage of an area. However, enforcement may be an issue.
 - If isolated, the RHC may not be affected.
 - If not isolated, Medicare Advantage contractor may refer patients to nearby clinics that are contracting.



Medicare Advantage (Disadvantage)

- RHCs can elect to contract with the Medicare Advantage contractors
 - Usually a one year contract
 - Once you are in the marketing literature, they may not be interested in renewing the contract the second year
 - May change type of Medicare Advantage program which allows fee scale payment with or without contract



Medicare Advantage (Disadvantage)

- RHCs can elect to contract with the Medicare Advantage contractors
 - Does the Medicare Advantage contractor have the ability to pay an RHC at the same rate as direct Medicare?
 - Many of them do not understand Medicare RHC reimbursement. Will they pay for:
 - Medicare related bad debts?
 - Flu and pneumonia at cost?
 - Non-RHC services separately?



Medicare Advantage (Disadvantage)

- FQHCs are eligible for wrap-around payments.
- If the Medicare Advantage program pays less than direct Medicare; Medicare will pay the difference.



What is a Provider-Based Clinic?

The clinic is

- ✓ An outpatient department of the hospital
- ✓ Much like the emergency room



Be Careful - CAH Provider-Based Clinics Have New Restrictions

The clinic must

- ✓ Meet current federal distance requirements
or
- ✓ Must be on main campus that existed at time CAH granted

**VIOLATION MAY BE GROUNDS FOR
DE-CERTIFICATION OF CAH**



How is a Provider-Based Clinic Paid by Medicare?

The bills must be separated into two components

- ✓ A professional component

and

- ✓ A facility component



How is a Provider-Based Clinic Paid by Medicare?

- ✓ Consider the professional component as the portion identified with a – “26” modifier

and

- ✓ The facility component as the portion identified with a – “TC” modifier



How is a Provider-Based Clinic Paid by Medicare?

The professional component is paid based on:

✓ Fee scale PLUS

or

✓ Fee scale plus 12% (80% of 15%) if a department of a critical access hospital electing Method II billing



How is a Provider-Based Clinic Paid by Medicare?

CAHs may not want to elect Method II billing.

For cost report years beginning on or after
October 1, 2009

- Facility component is paid at cost without one percent add-on for all outpatient Medicare claims
- Professional component paid at fee scale plus 12%

Congress said no to CMS – CMS decision reversed – thank you Congress



How is a Provider-Based Clinic Paid by Medicare?

The technical component is paid based on:

- ✓ APC if PPS Hospital

or

- ✓ Cost plus 1% if under a critical access hospital



How is a Provider-Based Clinic Paid by Medicaid?

Critical access hospital

- Same methodology as Medicare CAH
- RCC from Medicare cost multiplied by Medicare charges for technical component
- Medicaid physician fee scale for professional component



How is a Provider-Based Clinic Paid by Medicaid?

PPS Hospital

- Same methodology as Medicare PPS
- APC for technical component
- Medicaid physician fee scale for professional component



What Are the Benefits of Provider-Based Clinic Status?

- ✓ No productivity standard
- ✓ No midlevel requirement
- ✓ No HPSA requirement



What Are the Downsides of Provider-Based Clinic Status?

- ✓ If not a critical access hospital under Method II billing, two bills must be submitted to Medicare.
- ✓ Reimbursement may be less than RHC.



What Are the Downsides of Provider-Based Clinic Status?

Capital improvements may be required because the clinic will be required to be licensed as part of the hospital and meet the outpatient hospital construction code.



Questions

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