



**Provider-Based RHC  
and  
Provider-Based Clinic**

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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.




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**RHC Requirements**

- ✓ Rural
- ✓ HPSA or MUA within four year requirement (formerly three year)
- ✓ Midlevel practitioner 50% of clinic hour
- ✓ Non-profit or For-profit organization




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## 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



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## 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



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## Productivity Standard

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



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## How Do I Know If A Productivity Problem Exists?

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



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## Medicare Reimbursement (continued)

- ✓ 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.



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## Medicare Reimbursement (continued)

Physician Compensation

Not Subject to RCE (reasonable compensation equivalent) limit



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## Medicare Reimbursement (continued)

### Physician Compensation

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

Currently \$43.61 (2006) adjusted for MEI or \$183,162 for 4,200 visits



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## Medicare Reimbursement (continued)

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.



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## 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 \$76.84  
Net Effect = \$0



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## 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 = \$12.67  
(80% OF \$15.84)



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## 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 = \$12.67  
(80% OF \$15.84)



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## 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)  
= \$17.33  
Forever



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## 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



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## 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.



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## 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)



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## 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



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## 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



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## Medicare and Medicaid Reimbursement (continued)

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



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## Make Sure Actual Visits Are Accurately Stated

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



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## 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 Applies and Oranges Comparisons



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## 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 spend doing RHC and non-RHC services
- Some Intermediaries are allowing two two-week time studies
- Some Intermediaries are requiring year-long time studies



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## Medicare Reimbursement

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



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## Medicare Reimbursement (continued)

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



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## Medicare Reimbursement (continued)

- ✓ 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)



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## 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)
- 0900 Mental health visits



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## Medicare Reimbursement (continued)

### ■ Non-RHC Reimbursement (2009)

- 99212 \$ 35.13
- 99213 \$ 58.77 most common
- 99214 \$ 88.51
- 99215 \$ 119.63



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## Medicare Reimbursement (continued)

### ■ Non-RHC Reimbursement (2008 rate - 2009 gain)

- 99212 \$ 34.66 ----- \$ 0.47
- 99213 \$ 56.12 ----- \$ 2.65
- 99214 \$ 84.33 ----- \$ 4.18
- 99215 \$113.87 ----- \$ 5.76



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Medicare Reimbursement (continued)

✓ Freestanding and Provider-Based (over 49 beds) RHC

- 99212 \$ 76.84
  - 99213 \$ 76.84
  - 99214 \$ 76.84
  - 99215 \$ 76.84
- most common



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Medicare Reimbursement (continued)

✓ FQHC reimbursement (for same service)

- 99212 \$ 102.58 - \$119.29
  - 99213 \$ 102.58 - \$119.29
  - 99214 \$ 102.58 - \$119.29
  - 99215 \$ 102.58 - \$119.29
- most common



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Medicare Reimbursement (continued)

✓ Provider-Based-RHC (under 50 beds) reimbursement

- 99212 \$75.00 - \$150.00
  - 99213 \$75.00 - \$150.00
  - 99214 \$75.00 - \$150.00
  - 99215 \$75.00 - \$150.00
- most common



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## Medicare Reimbursement (continued)

- ✓ 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



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## 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



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## Medicare RHC Payments (continued)

Example if no patient deductible:

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

- ✓ Medicare pays 80% of the \$100 or \$80.00
- ✓ Patient pays 20% of \$58 or \$11.60
- ✓ Total payment of \$91.60



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### Medicare RHC Payments (continued)

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



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### Medicare RHC Payments (continued)

✓ 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



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### Medicare RHC Payments (continued)

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



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## Medicare RHC Payments (continued)

Example if patient owes deductible:

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

- ✓ Medicare pays 80% of the \$100 - \$58 or \$33.60
- ✓ Patient pays 20% of \$58 - \$58 or \$0.00 plus \$58.00
- ✓ Total payment \$91.60



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## Medicare RHC Payments (continued)

Example if patient owes deductible: EXTREME EXAMPLE

Assumptions: CPT code 99215  
Standard charge \$125  
Medicare interim rate \$100  
Patient deductible \$79

- ✓ Medicare pays 80% of the \$100 - \$79 or **-\$16.80**
- ✓ Patient pays 20% of \$125 - \$79 or \$9.20 plus \$88.20
- ✓ Total payment \$71.40



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## Medicare RHC Payments

(continued)

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



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## 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



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## Medicare non-RHC Billing and Payments (continued)

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



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## Medicare non-RHC Billing and Payments (continued)

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



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## Medicare non-RHC Billing and Payments (continued)

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



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## Medicare non-RHC Billing and Payments (continued)

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



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## Medicare Reimbursement (continued)

- ✓ 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 can not 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



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## Medicare Reimbursement (continued)

### ✓Pneumonia and Influenza 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



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## Medicare Reimbursement (continued)

### ✓Pneumonia and Influenza 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



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## Medicare Reimbursement (continued)

### Cost Reports

Provider-based RHCs use their existing hospital intermediary



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## Medicare Reimbursement (continued)

### Non-covered services

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



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## Medicare Reimbursement (continued)

### 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



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## What is a Provider-Based Clinic?

The clinic is

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



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## 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**



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## How is a Provider-Based Clinic paid by Medicare?

The bills must be separated into two components

- ✓ A professional component
- and
- ✓ A facility component



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## How is a Provider-Based Clinic paid by Medicare? (continued)

- ✓ Consider the professional component as the portion identified with a - "26" modifier
- and
- ✓ The facility component as the portion identified with a - "TC" modifier



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### How is a Provider-Based Clinic paid by Medicare? (continued)

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



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### How is a Provider-Based clinic paid by Medicare? (continued)

The technical component is paid based on:

- ✓ APC if PPS Hospital  
or
- ✓ Cost plus 1% if under a critical access hospital



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### 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



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## 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



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## What are the benefits of Provider-Based Clinic status?

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



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## 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



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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.



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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



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Medicare Advantage (Disadvantage)

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



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## 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 - Some types of Medicare Advantage contractors can pay their standard rate whether a contract exists or not, if the RHC knows what the standard rate is (including available on website) and knows the patient is covered by that contractor.



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## 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 clinic that are contracting



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## 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.



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## 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?



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## 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**



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## Any Questions?

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