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Riverbend GBA
Rural Health Clinic Presentation

August 21, 2008

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Rural Health Clinic

Local Coverage Determination

LCD L4874

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RHC LCD L4874

- This LCD addresses the medical necessity of the face to face visit in the RHC place of service.
- The companion article addresses statutorily based billing, coding and reimbursement considerations; that article is the definitive reference for RHC coverage interpretations at Riverbend.
- This LCD provides the medical necessity basis for that article.

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RHC LCD L4874

- Rural Health Clinics provide covered services that can be divided into RHC services and non-RHC services;
- RHC services are further subdivided into physician services (evaluation and treatment by a physician *or physician extender*) and;
- Services that are "incident to" a physician service.

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Physician Services

- For a face-to-face encounter to be medically necessary providing evaluation and management services at a skill level that requires the assessment, clinical reasoning, and judgment of a qualified RHC practitioner (i.e. the metaphorical "laying on of hands").

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Physician Services

- The condition of the patient must warrant the specialized skills of the qualified RHC practitioner.
- It is expected that either:

1) The patient will initiate the visit with a new problem or an exacerbation of an existing problem that a prudent layperson would believe requires evaluation and/or diagnosis by a qualified RHC practitioner **OR**

2) The patient has been rescheduled by the practitioner for a follow-up visit under circumstances in which the specified frequency of follow-up is customary, reasonable and necessary.

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Physician Services

- Medical necessity is required for Medicare services to be reimbursable. This includes a necessity for a physician or physician extender level of care in the case of a face-to-face encounter.

- Services that do not medically require active physician/extender involvement during any given trip to the facility lack medical necessity for a face-to-face encounter even though the services themselves may well be medically necessary ancillary or incidental services.

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Physician Services

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Physician Services

- In addition to billing constraints described in the companion article, multiple encounters on the same day are not medically necessary except in the unusual instance in which a patient acutely develops a new condition or complication that medically necessitates a second evaluation on that same day [42 CFR 405.2463(a)(3) and Pub 100-04, Chpt 9, sect 40.4].

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Physician Services

- Medical services that do not follow usually accepted standards of current medical practice are not medically necessary. This includes experimental and investigational treatment, unproven applications of existing technology, and diagnostic/treatment plans outside the mainstream of the practice of medicine.

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Incidental ("Incident to") Services

- Services that are routinely provided by ancillary personnel such as *nurses, therapists, aides, etc*.--i.e. incidental services--do not constitute medically necessary face to face encounters even if provided by a physician/extender, unless specific documented medical necessity exists to require a physician/extender level of expertise to render the service.

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Crucial Element of Medicare Billing

- The correct assignment of charges into these categories is the crucial element of correct Medicare billing, and is discussed in the companion article. This policy focuses on the medical necessity element of that determination, specifically the medical necessity of the face to face encounter with a practitioner.

Mental Health Services

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- Clinical Social Worker services in the RHC are medically necessary as a separate face to face encounter only when they replace the services of another practitioner (e.g. physician), not when they merely provide an incidental service in support of a prior physician visit.
- The revenue code 0900 is used for these services and are subject to the outpatient psychiatric limit.

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Therapy Services

- One on one therapy services with a physician/extender may be billed as face to face visits **IF** it is medically necessary to utilize that level of expertise.

Injections

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- 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.
- Other common injections administrable without a face-to-Face encounter include:
  - *Allergy shots*
  - *Vitamin B12*
  - *Flu and Pneumonia Vaccinations*

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Dressing Changes

- 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.

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Dressing Changes

- 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.

Lab Tests

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- 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.

- All lab services including the venipuncture are billed to your Part b Carrier.

Prescription Services

- Visits for the sole purpose of obtaining or renewing a prescription are not covered RHC services; Reason - No E&M is performed.
- Thus the need for a prescription refill or medication disbursement will not contribute to establishing medical necessity for the face to face encounter.

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Paperwork

- The paperwork involved in maintaining records, documenting encounters for third parties and completing forms for patients is an incidental part of medical practice.
- A period of time spent solely in record keeping cannot be considered as a face to face visit.
- Care Plan Oversight is not a billable service to Medicare Part A or Part B.

Routine Services

- Unless specifically covered by statute, i.e., *Welcome to Medicare Physical Exam*, primary preventive services are not covered and are additionally not considered to be medically necessary for the diagnosis or treatment of disease.

Recurrent Services

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Blood Pressure Measurement:

- Follow-up visits to monitor blood pressure which include physician/extender evaluation and management services are appropriately identified as encounters.
- The documentation should reflect the performance of these services over and above the simple measurement of a blood pressure.
- The frequency of follow-up is medically necessary when consistent with the recommendations of The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure.

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Recurrent Services

- Other Services defined in the RHC LCD as Recurrent Services subject to the frequency follow up limits are:
- *Disease Management Clinics*
- *Lab Follow-up Clinics*
- *Specially Clinics: Diabetes clinics*

Off-site Services

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- A visit to a beneficiary in a skilled SNF bed or a swing bed is medically necessary on a monthly basis to evaluate the patient status as it relates to the skilled service.
- A visit to a beneficiary in a non-skilled bed, intermediate care facility or nursing home is not medically necessary on a routine basis even if the nursing facility requires it as a condition of patient residence.
- A visit to a patient in a non-skilled bed, ICF or nursing home will be considered medically necessary if it has been approximately 60 days (for the purposes of medical review at least six weeks) since the last visit.

Home Visit

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- Medical necessity for the home visit is identical to medical necessity for office visit -- i.e. the fact that the patient is homebound does not confer any additional necessity for a physician/extender level of care.
- A home visit is **not** medically necessary if an office visit would **not** be medically necessary for the same patient condition,

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Revenue Codes

- 0521 - Free-standing clinic-rural health clinic
- 0522 - Free-standing clinic-rural health home
- 0524 - Visit by RHC practitioner to a member in a covered Part A stay at the SNF
- 0525 - Visit by RHC 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 Visiting Nurse Service(s) to a member's home when in a home health shortage area
- 0528 - Visit by RHC practitioner to other non RHC site (scene of accident)
- 0900 - Psychiatric/psychological treatments-general classification

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Documentation Requirements

- The Code of Federal Regulations sets forth minimum requirements for RHC records; the documentation requirements for the RHCs thus have both a medical necessity component and a direct regulatory requirement.

- RHC medical records must include:

  1. Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;

  2. All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress;

  3. Identification and Signatures of the physician or other health care professional. [42 CFR 491.10(a)(3)(iv)]

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Documentation 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.
- This represents Riverbend's interpretation of 42 CFR 491.10(a)(3)(i).
- It may additionally be considered a contractor-specific documentation requirement as well as good medical practice.

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Documentation Requirements

- Each face to face encounter documented in the medical record must include the date on which the encounter occurred.

- 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.

- Documents lacking this signature will not provide evidence of the performance of a specific service or of its medical necessity unless accompanied by a signed affirmation written by the provider who rendered the face to face visit.

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Documentation Requirements

- The provider signature may be appended to the medical record in any of several formats, but in all cases must be sufficiently unique to allow both the provider and Riverbend to determine unequivocally at a later date that the provider personally affixed the signature.

- The RHC LCD is located on the Riverbend Web site at:

  http://www.rgbagov.com/publications/lcd/lcd-files/4874.html

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Questions?