Oregon Office of Rural Health

Rural Health Clinic Practice Management Strategies & Best Practices

October 3, 2018

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HEALTH CARE PRACTICE

AGENDA

- RHC Overview
- RHC Medicare Cost Reporting
- RHC Reimbursement & Billing
- RHC Compliance

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RHC Overview

What Is an RHC?

RHC certification is a designation from the Centers for Medicare & Medicaid Services (CMS) to clinics providing primary care in certain rural, underserved areas, which provides an alternative, cost-based reimbursement system for treating **Medicare and Medicaid** beneficiaries.

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How Are RHCs Paid?

RHCs are paid a flat rate for each *face-to-face encounter* based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs for Medicare services (i.e., cost report) occurring at the end of the fiscal year.

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RHC Overview

Medicare cost-based reimbursement is determined on the average cost per visit.

Medicare - A visit is defined as a medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker and a patient.

In general, if there is no "visit," there is no RHC payment (exceptions for flu/pneumo vaccines).

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RHC Overview

Medicaid cost-based reimbursement is determined on the average budgeted cost per visit.

Are you aware that RNs are considered RHC practitioners by the State of Oregon?

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RHC Overview

General Requirements for RHC Certification

- Located in a rural area
- Current underserved designation
- Primarily primary care services
- Midlevel practitioner at least 50% of time clinic is open
  - At least one midlevel practitioner is employed
- Certain lab services must be able to be performed

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RHC Medicare Cost Reporting

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RHC Medicare Cost Reporting

$$\frac{\textit{Allowable RHC Costs}}{\textit{Rural Health Clinic Visits}} =$$

RHC Cost Per Visit (Rate)

(Not to exceed the maximum reimbursement limits.)

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RHC Medicare Cost Reporting

Medicare Productivity Standards:

- Physician 4,200 visits annually for 1.0 FTE
- Midlevel 2,100 visits annually for 1.0 FTE

Total visits used in calculation of cost per visit is the greater of the actual visits or minimum allowed (FTEs x Productivity Standard).

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Sample Reconciliation of Provider FTE:

Clinical FTE	**0.70**
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	0.05
Total FTE	**1.00**

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Example 1 – Visits Equal Productivity Standards

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1	2	3	4	5
1	Physicians	6.87	25,890	4,200	28,854	
2	Physician Assistants	2.16	7,500	2,100	4,536	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	9.03	33,390		33,390	33,390
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	9.03	33,390			33,390

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RHC Medicare Cost Reporting

Example 2 – Productivity Standards Are Greater Than Visits

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1	2	3	4	5
1	Physicians	6.87	16,221	4,200	28,854	
2	Physician Assistants	2.16	4,773	2,100	4,536	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	9.03	20,994		33,390	33,390
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	9.03	20,994			33,390

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RHC Medicare Cost Reporting

Effect on Cost-Per-Visit

	Greater of Actual Visits or Productivity Standard Visits	Allowable Costs for Cost-Per-Visit Calculation	RHC Cost-Per-Visit
		$ 5,798,460	
Example 1	33,390		$ 173.66
Example 2	20,994		276.20

- Independent RHC – no effect; cost-per-visit limit
- Provider-based RHC to a hospital with less than 50 beds, $102.54 per visit difference
- Could affect Medicaid rate yearly or indefinitely

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RHC Medicare Cost Reporting

Best Practices and Managing Cost Reporting Data

- Who is responsible for gathering FTE/visit data to the Medicare cost report preparer?
  - Do they know the effect of the calculation?
  - Are we simply using payroll reports vs. actual patient time FTEs
  - Time studies
- Track information DURING the year vs. simply at the end of the year
- Medicare cost report quarterly/mid-year estimates
  - Note: Palmetto is making lump sum payment adjustments to RHCs and is increasing the cost-per-visit payments

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RHC Medicare Cost Reporting

Best Practices and Managing Cost Reporting Data

- Record provider FTE for clinic time only (this includes charting time):
  - Time spent in the clinic
  - Time with SNF patients
  - Time with swing bed patients
- Do not include non-clinic time in provider productivity:
  - Hospital time (inpatient or outpatient)
  - Administrative time
  - Committee time
- Provider time for visits by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC are not subject to productivity standards.

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RHC Medicare Cost Reporting

Best Practices and Managing Cost Reporting Data

- Counting of "visits" is easier said than done.
- Computer-generated reports may be misleading:
  - Counting units of service instead of visits
  - Including non-visits (e.g., nurse-only 99211)
  - Including non-RHC visits (e.g., hospital visits)
  - Excluding global visits

Remember: higher visits = lower cost per visit = lower rate!

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RHC Medicare Cost Reporting

Example 1 – Benchmark Report

Category/Indicator	9/30/2016 RHC Values		Mean WI	Mean Midwest	Mean Nation
Number of Facilities	1		65	626	1,993
Clinic Cost per Encounter:					
Total Health Care Staff	167.68	↓	119.39	92.47	84.59
Total Direct Costs of Medical Services	181.87	↓	133.85	111.56	102.19
Allowable GME Overhead	0.00		0.00	0.00	0.00
Clinic Overhead	13.32	↑	25.08	21.72	21.20
Parent Provider Overhead Allocated	87.91	↓	106.18	71.75	67.32
Total Allowable Cost per Actual Encounter	276.20	↓	256.32	198.36	185.59
Total Allowable Cost per Adjusted Encounter	173.66	↓	216.02	186.40	177.16
Total Medicare Encounters	4,234		94,154	1,096,474	5,145,979
Average Medicare Encounters	4,234		1,449	1,752	2,582
Medicare Percent of Visits	20.17%		19.36%	18.62%	24.85%
Injection Cost:					
Cost per Pneumococcal Injection	236.66	↓	218.48	183.93	221.24
Cost per Influenza Injection	35.04	↑	80.62	55.18	73.84

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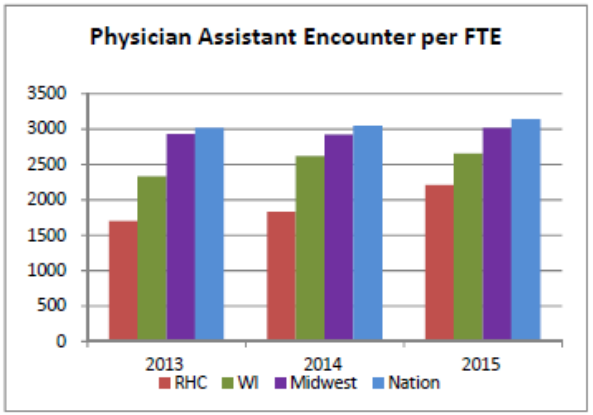
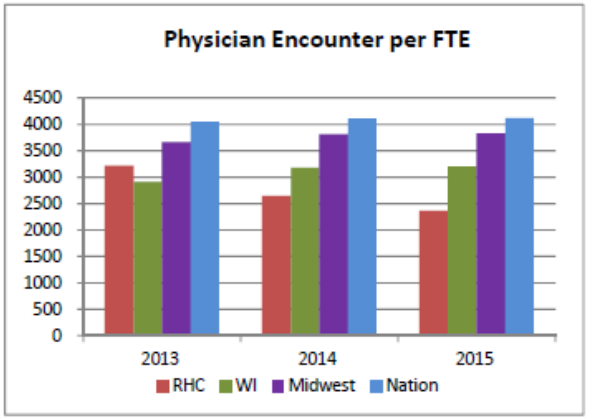
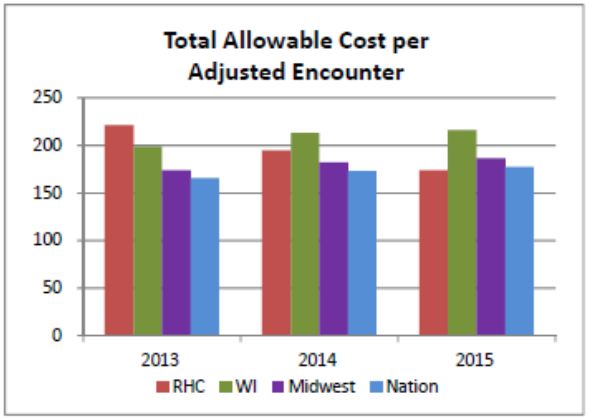
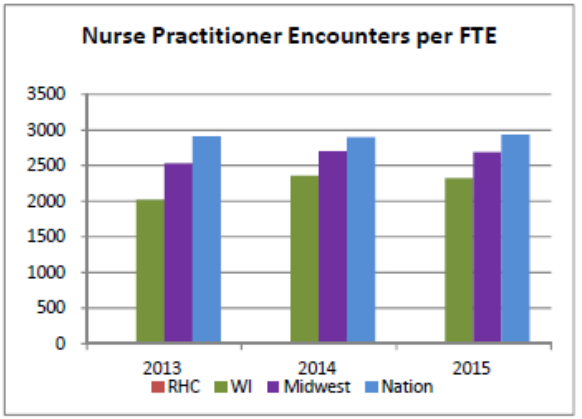
RHC Medicare Cost Reporting

Example 1 – Benchmark Report









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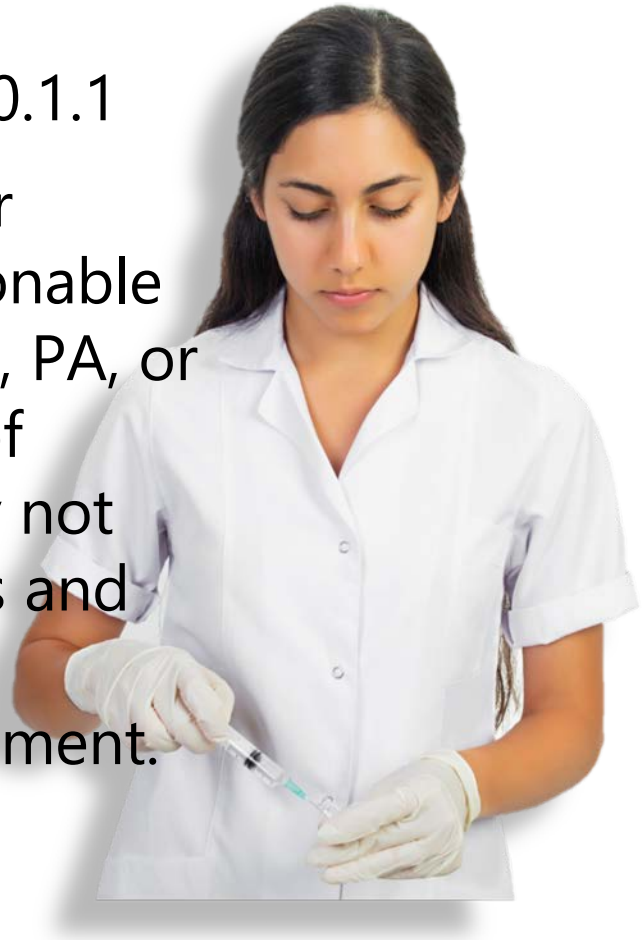
RHC Medicare Cost Reporting

Pneumococcal and Influenza Vaccines

See CMS Publ. 100-02, Chapter 13, Section 210.1.1

Pneumococcal and influenza vaccines and their administration are paid at 100 percent of reasonable cost. When an RHC practitioner (physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the cost of the vaccines and administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should not be reported on an RHC claim when billing for RHC services, and the beneficiary pays no Part B deductible or coinsurance for these services.



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RHC Medicare Cost Reporting

Pneumococcal and Influenza Vaccines – Best Practices & Managing Data

- Track DURING the year
  - Manual vs. Automated Reporting
  - High dose flu
  - Pneumo 13 vs. Pneumo 23

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RHC Medicare Cost Reporting

Worksheet B-1/M-4:

CALCULATION AND TOTAL OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

	Part I - Calculation of Cost	Pneumococcal	Seasonal Influenza
		1	2
1	Health Care Staff Cost	537,821	537,821
2	Ratio of Pneumococcal & Influenza Vaccine Staff Time To Total HC Staff Time	0.000651	0.006340
3	Pneumococcal & Influenza Vaccine Health Care Staff Cost	350	3,410
4	Medical Supplies Cost - Pneumococcal & Influenza Vaccine	2,981	3,648
5	Direct Cost of Pneumococcal & Influenza Vaccine	3,331	7,058
6	Total Direct Cost of the Facility	581,931	581,931
7	Total Facility Overhead	349,902	349,902
8	Ratio of Pneumococcal & Influenza Vaccine Direct Cost to Total Direct Cost	0.005724	0.012129
9	Overhead Cost - Pneumococcal & Influenza Vaccine	2,003	4,244
10	Total Pneumococcal & Influenza Vaccine Cost & Its Administration	5,334	11,302
11	Total Number of Pneumococcal & Influezna Vaccine Injections	35	341
12	Cost Per Pneumococcal & Influenza Vaccine Injection	152	33
13	# of Pneumococcal & Influenza Vaccine Injections Admins To Medicare Beneficiaries	-	169
14	Medicare Cost of Pneumococcal & Influenza & Its Administration	-	5,601
15	Total Cost of Pneumococcal & Influenza Vaccine & Its Administration		16,636
16	Total Medicare Cost of Pneumococcal & Influenza Vaccine and Its Administration		5,601

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RHC Medicare Cost Reporting

Example – Benchmark Report

Category/Indicator	6/30/2015			
	RHC Values	Mean		
		CA	Western	Nation
Injection Cost:				
Cost per Pneumococcal Injection	8,401.75	499.26	267.71	221.24
Cost per Influenza Injection	48.56	94.83	66.03	73.84

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RHC Medicare Cost Reporting

- Medicare bad debt reimbursement is 65% of allowable bad debt claimed.
- Allowable deductible and coinsurance amounts only.
- Debt must be related to covered services.
  - Do not include lab, radiology, or other non-RHC services on the cost report.

1. Provider must be able to establish that reasonable collection efforts were made (120 days from date of first bill).
2. Documented Charity Care Policy
3. Medicare/Medicaid Crossover Patients

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RHC Medicare Cost Reporting

Exhibit 2

Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________________

Prov. Number____________________

FYE ____________________

Prepared By ____________________

Date Prepared ____________________

Inpatient ____________________ Outpatient ____________________

SNF ____________________ RHC____________________

(1) Patient Name	(2) HIC NO.	(3) Dates of Service		(4) Indigency & Wel. Recip (ck if apply)		(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
		From	To	Yes	Medicaid #						
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RHC Billing & Reimbursement

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- The upper payment limit for RHC for 1/1/18 through 12/31/18 is $83.45 per visit (based on the Medicare Economic Index, MEI, 1.4 percent increase over the 2017 rate of $82.30)
  - However, no upper payment limit for RHCs that are provider-based to a hospital with less than 50 beds

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RHC Billing & Reimbursement

RHC Payment Examples

- Customary charge for 99213 is $120
- Assume Medicare fee schedule allowable is $70
- Medicare encounter rate is $160:
  - Limited to $80 for independent RHC
  - No limit for provider-based RHC - Available beds < 50
- Deductibles have been met already

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RHC Billing & Reimbursement

Comparison Between RHCs and Part B Payment Example

Description	RHC Amount (Independent)	RHC Amount (Provider-Based)	Part B Amount
Customary Charge	$120.00	$120.00	$120.00
Patient Copay	24.00	24.00	14.00
Medicare Pays	64.00	128.00	56.00
Total Payment	88.00	152.00	70.00
Contractual Adjustment	32.00	(32.00)	50.00

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RHC Billing & Reimbursement

Freestanding RHC Benchmark Report

Category/Indicator	2015 Mean OR	2016 Mean OR	2017 Mean OR
Number of Facilites	34	30	11
Encounters per FTE:			
Physicians	3,614	3,569	3,343
Physician Assistants	3,091	3,519	3,708
Nurse Practitioners	2,591	2,781	2,483
Clinical Psychologist/Social Worker	708	1,747	523
Midlevel Staffing Ratio	55%	54%	53%
Midlevel Visit Ratio	49%	51%	50%
Cost per Encounter:			
Physician	78.24	88.45	101.20
Physician Assistant	43.55	38.34	51.07
Nurse Practitioner	62.43	61.33	58.88
Clinical Psychologist/Social Worker	107.82	60.78	239.23
Total Health Care Staff Cost	18.82	19.20	23.41
Cost per FTE:			
Physician	281,573	315,043	338,289
Physician Asstistant	134,612	134,900	189,378
Nurse Practitioner	161,728	170,572	146,173
Clinical Psychologist/Social Worker	76,358	106,212	125,192
Total Healthcare Staff Costs per Provider FTE	60,130	64,855	74,550
Clinic Cost per Encounter:			
Payment Rate per Adjusted Encounter	148.65	152.77	165.78
Total Encounters	377,815	396,745	200,857
Total Medicare Encounters	72,483	70,381	35,656
Medicare Percent of Visits	19%	18%	18%

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PB-RHC Benchmark Report

Category/Indicator	2015 Mean OR	2016 Mean OR	2017 Mean OR
Number of Facilities	26	37	19
Encounters per FTE:			
Physicians	3,814	3,570	2,901
Physician Assistants	3,170	3,015	2,758
Nurse Practitioners	2,662	2,675	2,298
Clinical Psychologist/Social Worker	1,504	1,774	2,581
Total Encounters	334,848	408,777	171,203
Midlevel Staffing Ratio	44%	47%	48%
Midlevel Visit Ratio	37%	41%	43%
Cost per Encounter:			
Physician	96.58	105.99	120.88
Physician Assistant	59.64	59.87	50.19
Nurse Practitioner	60.08	59.52	60.71
Clinical Psychologist/Social Worker	85.78	35.83	66.45
Total Health Care Staff Cost	32.03	34.10	38.97
Cost per FTE:			
Physician	357,844	358,465	334,727
Physician Asstistant	189,018	180,500	138,426
Nurse Practitioner	159,966	159,234	139,531
Clinical Psychologist/Social Worker	129,043	63,581	171,513
Total Healthcare Staff Costs per Provider FTE	108,026	108,510	103,339
Clinic Cost per Encounter:			
Rate per Adjusted Encounter	237.58	240.55	215.36
Total Medicare Encounters	80,484	68,887	35,860
Average Medicare Encounters	3,096	1,862	1,887
Medicare Percent of Visits	24%	17%	21%

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RHC Billing & Reimbursement

What Is Different About RHC Billing?

RHC services are billed and reimbursed by Medicare under an all-inclusive payment rate regardless of the type of practitioner (physician vs. midlevel) or the complexity of services performed (99212 vs. 99215, E/M vs. surgical procedure).

RHC services are billed to Medicare on the UB-04 claim form instead of the CMS 1500 form often used for billing physician services.

CPT/HCPCS codes are now reported for Medicare RHC billing purposes effective April 1, 2016.

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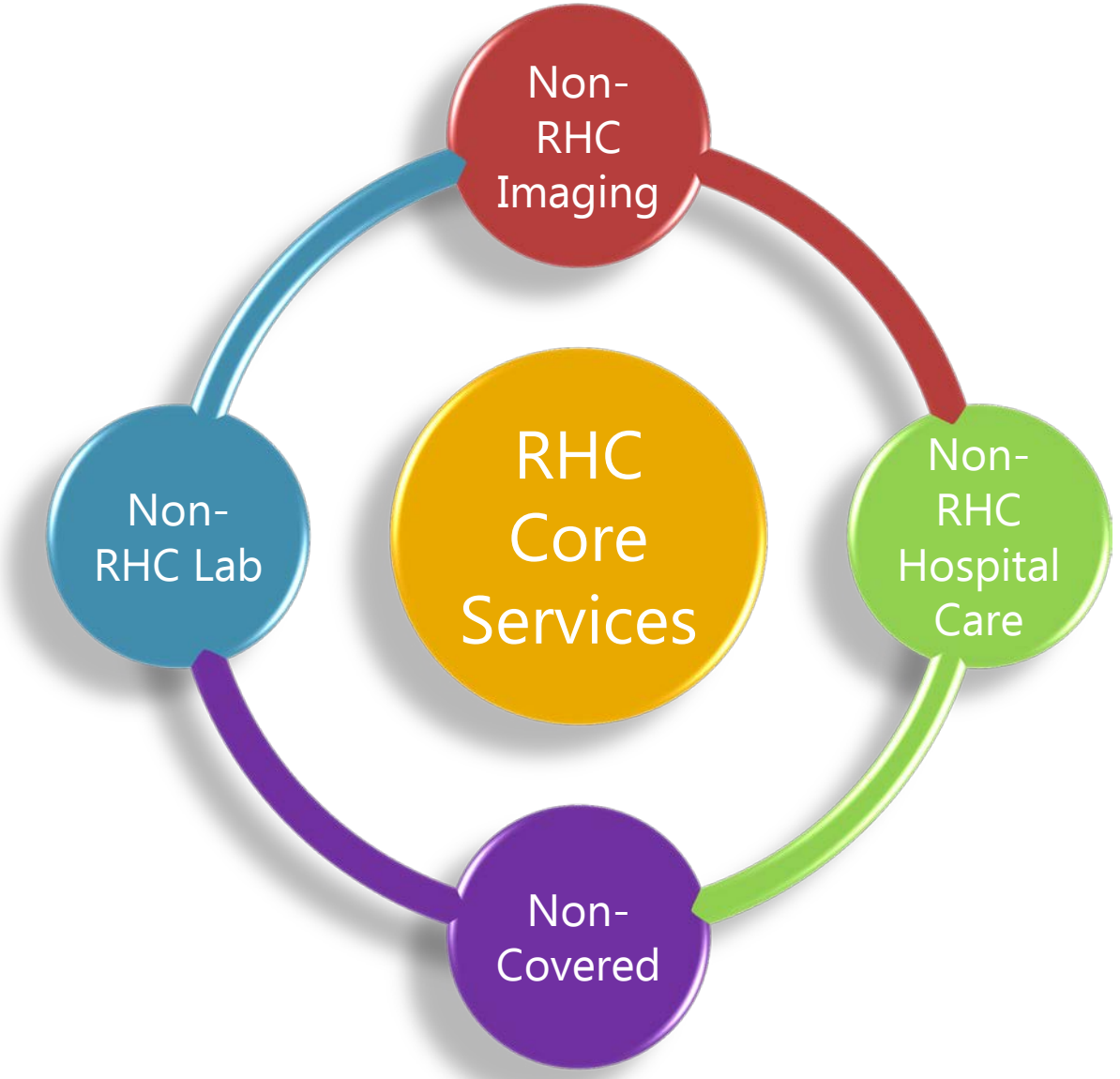
RHC Billing & Reimbursement



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RHC Billing & Reimbursement

RHC Billing Differences (Core Services)

Service	Independent	Provider-Based
RHC services (face-to-face encounter in RHC site of service).	Billed to Independent RHC Regional Fiscal Intermediary - RHC provider number on Form UB-04.	Billed to host Provider Fiscal Intermediary - RHC provider number on Form UB-04.

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RHC Billing & Reimbursement

RHC Billing Differences (Non-RHC Services)

Service	Independent	Provider-Based
Laboratory (excluding the draw procedure, e.g., CPT 36415).	Billed to Part B carrier - Existing group number on Form 1500.	Billed on hospital O/P claim type (14x, 13x, or 85x) on Form UB-04.
Other Diagnostic/Radiology - Professional component.	May be billed with encounter. If read by non-RHC provider, they will bill the carrier.	May be billed with encounter. If read by hospital radiologist, bill the carrier.
Other Diagnostic/Radiology - Technical component.	Billed to Part B carrier - Existing group number on Form 1500.	Billed on hospital O/P claim type (13x or 85x) on Form UB-04.
Non-RHC Professional Services (I/P, ER, other O/P services).	Billed to Part B carrier - Existing group number on Form 1500.	Billed to carrier using existing group number (or if elect Method II as CAH, bill FI for O/P pro fees).

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RHC Billing & Reimbursement

Does it matter how we code the visit if we get paid the same rate?

- Patient payment is affected
  - Medicare considers overcoding a violation of the fraud and abuse regulations because of the additional reimbursement
  - Medicare considers undercoding a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic

Conclusion: Yes, it Matters!

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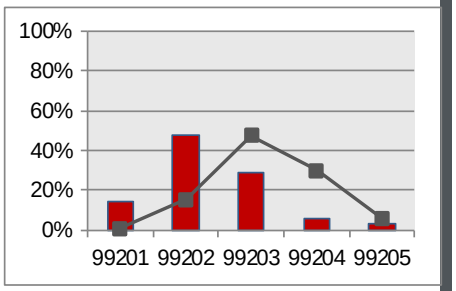
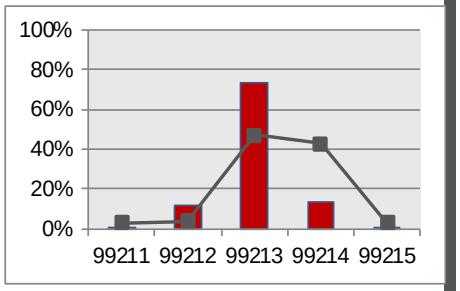
RHC Billing & Reimbursement

External Comparison: CMS Code Experience, Same-Specialty Providers

Grand Total
Change in Revenue: CMS E/M Code Utilization
Date Range: January through September 2015

	ACTUAL UTILIZATION				REDISTRIBUTED UTILIZATION				VARIATION		UTILIZATION CHART
CPT	Units	%	$ Prod	wRVU Prod	Units	CMS %	$ Prod	wRVU Prod	$ Prod	wRVU Prod	
New Patient Office Visits											
99201	254	**14%**	$ 26,088	122	18	**1%**	$ 1,854	9	$ (24,234)	(113)	
99202	860	**48%**	$ 111,938	800	278	**15%**	$ 36,181	259	$ (75,757)	(541)	
99203	525	**29%**	$ 99,246	746	859	**48%**	$ 162,419	1,220	$ 63,173	475	
99204	99	**5%**	$ 28,471	241	542	**30%**	$ 155,730	1,316	$ 127,259	1,075	
99205	67	**4%**	$ 24,210	212	108	**6%**	$ 39,133	343	$ 14,923	131	
Total	1,805	**100%**	$ 289,953	2,120	1,805	**100%**	$ 395,317	3,146	$ 105,364	1,026	
Average LOS											
CMS Average LOS											
Established Patient Office Visits											
99211	98	**1%**	$ 5,096	18	355	**3%**	$ 18,472	64	$ 13,376	46	
99212	1,405	**12%**	$ 115,997	674	474	**4%**	$ 39,104	227	$ (76,893)	(447)	
99213	8,759	**74%**	$ 1,107,488	8,496	5,565	**47%**	$ 703,673	5,398	$ (403,815)	(3,098)	
99214	1,565	**13%**	$ 293,907	2,348	5,092	**43%**	$ 956,208	7,637	$ 662,301	5,290	
99215	14	**0%**	$ 3,549	30	355	**3%**	$ 90,051	750	$ 86,502	720	
Total	11,841	**100%**	$ 1,526,037	11,565	11,841	**100%**	$ 1,807,507	14,077	$ 281,471	2,511	
Average LOS											
CMS Average LOS											





TOTAL	**$ 386,834**	**3,537**
ANNUALIZED TOTAL	**$ 515,779**	**4,717**

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RHC Billing & Reimbursement

Payer Denial Review and Analysis

Top denials (and ensuing write-offs) generally fall under a limited number of categories, frequently issues that are avoidable. They represent the key factors in a clinic's revenue cycle management struggles.

Top 20 Denials/Write-Off Analysis

Code Description	Un-Avoidable	Avoidable	Total Write-off $	Total Write-off %
Write-off timely filing		**$ 97,709**	$ 97,709	37%
Write-off no auth		**$ 36,427**	$ 36,427	14%
Write-off benefit check error		**$ 26,716**	$ 26,716	10%
Deductible write-off	$ 74,712		$ 74,712	28%
Procedure not paid separately	$ 11,285		$ 11,285	4%
Charges exceed contracted fee	$ 7,620		$ 7,620	3%
Mutually exclusive procedures	$ 5,041		$ 5,041	2%
Totals	**$ 101,034**	**$164,172**	**$ 265,206**	
	38%	**62%**		

Denials with <2% impact are hidden

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Except for IPPE, all preventive services furnished on the same day as another medical visit constitute a single billable visit. If an IPPE visit occurs on the same day as another billable visit, two visits may be billed

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Initial Preventive Physical Exam (IPPE)	G0402	Initial preventive physical examination; face-to-face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment.	Yes	Yes	Waived

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Except for DSMT/MNT, all of the preventive services listed below may be billed as a stand-alone visit if no other service is furnished

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	Yes	No	Waived
Annual Wellness Visit	G0439	Annual wellness visit, including PPPS, subsequent visit	Yes	No	Waived

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes	No	Waived
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	Yes	No	Not Waived

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Glaucoma Screening	G0117	Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist	Yes	No	Not Waived
Glaucoma Screening	G0118	Glaucoma screening for high-risk patient furnished under the direct supervision of an optometrist or ophthalmologist	Yes	No	Not Waived

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Screening Pap Test	Q0091	Obtaining screen pap smear	Yes	No	Waived
Alcohol Screening and Behavioral Counseling	G0442	Annual alcohol screen; 15 minutes	Yes	No	Waived

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Alcohol Screening and Behavioral Counseling	G0443	Brief alcohol misuse counsel	Yes	No	Waived
Screening for Depression	G0444	Depression screen annual	Yes	No	Waived

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling	G0445	High intensity behavioral counseling STD; 30 min	Yes	No	Waived

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RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Intensive Behavioral Therapy for Cardiovas-cular Disease	G0446	Intensive behavioral therapy for cardiovascular disease	Yes	No	Waived
Intensive Behavioral Therapy for Obesity	G0447	Behavioral counseling for obesity; 15 min	Yes	No	Waived

RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Smoking and Tobacco Cessation Counseling	99406* (*G0436 discontinued 10/1/2016)	Tobacco-use counseling; 3-10 min	Yes	No	Waived
Smoking and Tobacco Cessation Counseling	99407* (*G0437 discontinued 10/1/2016)	Tobacco-use counseling; >10 min	Yes	No	Waived

RHC Billing & Reimbursement

See http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Service	HCPCS Code	Long Description	Paid at the AIR	Eligible for Same Day Billing	Coinsur./ Deduct.
Lung Cancer Screening with Low Dose Computed Tomography	G0296	Visit to determine LDCT eligibility	Yes	No	Waived

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RHC HCPCS Reporting Requirements

- Compliance with national coding standards and requirements.
- Collect data on RHC services to better inform policies.
- Increase accuracy of RHC claims processing

Centers for Medicare and Medicaid Services

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RHC Billing & Reimbursement

This presentation contains billing and payment examples. The UB-04 sample, HCPCS codes, revenue codes, and the associated charges used in the slides are for illustrative purposes only and should not be used as a guideline for billing or setting rates.

The examples use the following fictional charges for illustrative purposes only:

- 99213 = $140.00
- 90834 = $160.00
- G0101 = $80.00
- 12002 = $200.00
- G0117 = $100.00
- 36415 = $6.00
- 69200 = $150.00

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RHC Billing & Reimbursement

Patient comes to the RHC for a medical visit and venipuncture on

October 1, 2016

Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$146.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$152.00*

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RHC Billing & Reimbursement

Patient comes to the RHC for a medical visit and preventive health services on

October 1, 2016

Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$146.00
0521	Breast/pelvic	G0101	10/01/2016	1	$ 80.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$232.00*

RHC Billing & Reimbursement

Patient comes to the RHC for a medical visit and simple wound repair

October 1, 2016

Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$346.00
0521	Wound repair	12002	10/01/2016	1	$200.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$552.00*

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RHC Billing & Reimbursement

Patient comes to the RHC for a
medical visit and behavioral health visit

October 1, 2016

Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$140.00
0900	BH session	90834 CG	10/01/2016	1	$160.00
001	*TOTAL CHARGE*				*$300.00*

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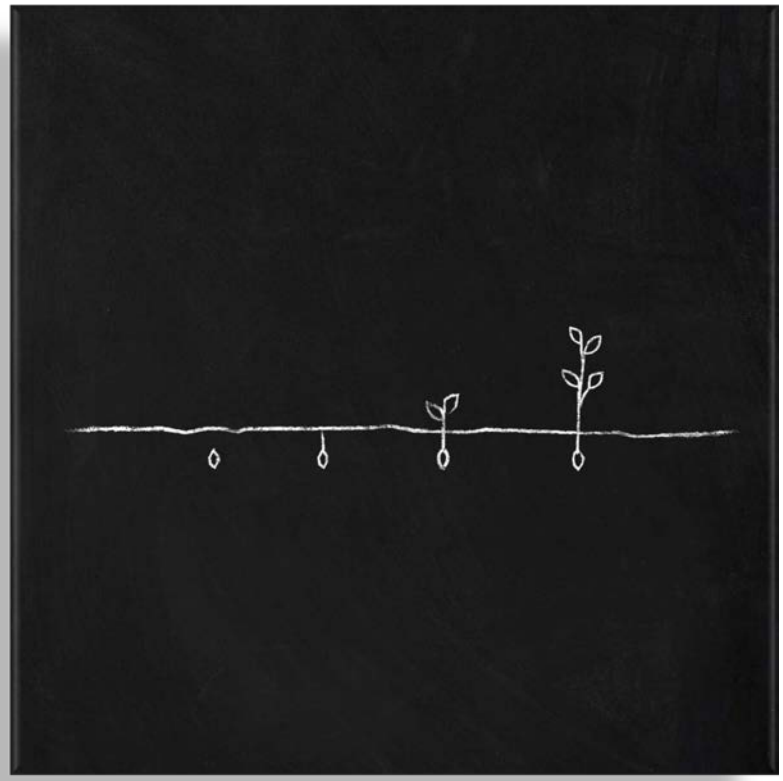

RHC Compliance

RHC Compliance

Rural Health Clinic Conditions of Participation (42 CFR 491)

- Physical Plant and Environment
- Organizational Structure
- Staffing and Staff Responsibilities
- Provision of Services
- Program Evaluation
- Emergency Preparedness (42 CFR 491.12 (a))

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RHC Compliance

Required Lab Services That Must be Furnished as an RHC

- Chemical examinations of urine
- Hemoglobin
- Blood sugar
- Examination of stool specimens
- Pregnancy tests
- Primary culturing for transmittal to a certified laboratory
- Clinic must furnish these basic [CLIA waived] tests; however, they are billed as non-RHC services

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RHC Compliance

- An evaluation of a clinic's total operation including the overall organization, administration, policies and procedures covering personnel, fiscal, and patient care areas must be done at least annually. This evaluation may be done by the clinic, the group of professional personnel required under 42 CFR 491.9(b)(2), or through arrangement with oth

RHC Compliance

The evaluation includes review of:

- The utilization of clinic or center services, including at least the number of patients served and the volume of services.
- A representative sample of both active and closed clinical records.
- The clinic's or center's health care policies.

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RHC Compliance

The purpose of the evaluation is to determine whether:

- The utilization of services was appropriate.
- The established policies were followed.
- Any changes are needed.

The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary.

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RHC Compliance

OREGON OFFICE OF RURAL HEALTH
WIPFLI ASSOCIATES

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RURAL HEALTH CLINIC PRE-CERTIFICATION PRACTICE TOOL

Updated: March 2016

JTAG	REGULATION	THINGS TO LOOK FOR	MEETS SPECIFICATIONS (Y/N)	ACTION NEEDED/COMMENTS
J3	**491.4 Compliance with Federal, State and local laws.** The rural health clinic and its staff are in compliance with applicable Federal, State and local laws and regulations.	This regulation relates to scope of practice and the State's Nurse Practice Act. Oregon Nurse Practice Act can be found here: http://www.oregon.gov/osbn/pages/adminrules.aspx. Compliance with this law maybe be observed through out the survey (ie reviewing patient charts).		
J5	**§ 491.4(b) Licensure, certification or registration of personnel.** Staff of the clinic are licensed, certified or registered in accordance with applicable State and local laws.	❑ All clinical staff must have current BLS certificates on file. ❑ Personnel files must include, employee application, resume (if applicable), current license/certificate, employment forms, performance appraisal.		
J6	**§ 491.5 Location of Clinic**			
J7	**§ 491.5(a) Basic Requirement.** The clinic is located in a rural area that is designated as a shortage area, and may be a permanent or a mobile unit.			
J8	**§ 491.5(a)(1) Permanent unit.** The objects, equipment and supplies necessary for the provision of the services furnished directly by the clinic are housed in a permanent structure. If clinic services are regularly furnished at permanent units in more than one location, each unit will be independently considered for certification as a rural health clinic.	❑ This requirement should be checked by surveyor prior to arriving on site		
J9	**§ 491.5(a)(2) Mobile unit.** The objects, equipment and supplies necessary for the provision of the services furnished directly by the clinic are housed in a mobile structure, which has a fixed, scheduled location(s).	❑ Date, time and place for each mobile unit day must be listed.		
J13	**§ 491.5(c) The facility meets rural area requirements under one of the following criteria.**			
J14	**§ 491.5(c)(1)** Rural areas are areas not delineated as urbanized areas in the last census conducted by the Census Bureau.	Requirement should be checked by surveyor prior to arrival.		
J15	**§ 491.5(c)(2)** Included in the rural area classification are those portions of extended cities that the Census Bureau has determined to be rural.	Requirement should be checked by surveyor prior to arrival.		
J16	**§ 491.5(d) The facility meets the shortage area requirements under one of the following criteria.**			
J17	**§ 491.5(d)(1)** Determination of shortage of personal health services (under section 1302(7) of the Public Health Services Act).	❑ Clinic location is in a current HPSA. Requirement should be checked by surveyor prior to arrival.		
J18	**§ 491.5(d)(2)** Determination of shortage of primary medical care manpower (under section 332(a)(1)(A) of the Public Health Service Act).	❑ Clinic location is in a current MUA. Requirement should be checked by surveyor prior to arrival.		
J19	**§ 491.6 Physical plant and environment**			
	§ 491.6(a) Construction The clinic is constructed, arranged, and maintained to ensure access to and safety of patients, and provides	❑ Hours of operation are posted on the outside of the clinic. ❑ Exit doors are identified. ❑ Clinic does not have any exposed building materials, i.e. insulation,		

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Questions?

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Thank you!

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