OREGON OFFICE of RURAL HEALTH

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OPPORTUNITY Just knock.

OHSU

2026 Oregon Rural Health Conference Presentation Slides

COMMINGLING AND RHCS 2026

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COMMINGLING TOPICS

- ✓ Commingling Definitions
- ✓ Cost Reporting Considerations
- ✓ Duplicate Reimbursement
- ✓ Non-RHC Hours
- ✓ Non-Rural Health Clinic Services
- ✓ Patient Treatment Areas/ Specialty Clinics
- ✓ Co-Location with Provider-Based Entities

COMMINGLING - DEFINITIONS

commingle verb

com·min·gle | \ kə-ˈmiŋ-gəl

1: commingled; commingling; commingles

2 : to combine (funds or properties) into a common fund or stock Proceeds from the sale have been *commingled* with other funds.

SECTION 100: COMMINGLING

Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners.

"RHCs and FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors."

RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.

THE RHC ENCOUNTER RATE

"In general, the all-inclusive rate (AIR) for an RHC or FQHC is calculated by the MAC/FI by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation."

- ✓ (Medicare Benefit Policy Manual. Chapter 13. Section 70.)

RHC RATE AND COST REPORTING

- ✓ The RHC Encounter Rate (AIR) is set via the RHC Cost Report.
- ✓ Provider-based clinics file their CR as part of the hospital cost report.
- ✓ *Costs must be appropriately allocated and tracked for the RHC space and personnel.*
- ✓ Provider FTEs should be measured via formal time study.
- ✓ Medical Director, Physician, PA, NP, Nursing FTEs have a major impact on cost reporting.
- ✓ Laboratory Expenses must be allocated and reclassified appropriately. (RHC vs. Non-RHC)

COST ALLOCATION METHODS!!

The A/B MAC has the authority to determine acceptable accounting methods for allocation of costs between the RHC or FQHC and another entity.

In some situations, the practitioner's employment agreement will provide a useful tool to help determine appropriate accounting.

SECTION 60: NON RHC/FQHC SERVICES

RHCs and FQHCs must be primarily engaged in furnishing primary care services but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit, such as laboratory services or the technical component of an RHC or FQHC service.

If these services are authorized to be furnished by the RHC or FQHC and are covered under a separate Medicare benefit category, the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service.

SECTION 60: NON RHC/FQHC SERVICES - COST ALLOCATION

RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.

NON RHC/FQHC SERVICES

Section 60: Non-RHC/FQHC Services	
Medicare excluded services	Ambulance services
Technical component of an RHC or FQHC service	Prosthetic devices
Laboratory services	Body Braces
Durable medical equipment	Practitioner services at certain other Medicare facility
Telehealth distant-site services	Hospice Services
Group Services	

HOSPITAL SERVICES

- ✓ Physician services at the hospital are billed to the Medicare Administrative Contractor for fee-for-service reimbursement.
- ✓ If the parent-entity is a Critical Access Hospital (CAH) using option II billing – out-patient hospital services are billed to the parent's FI.
- ✓ Physician services at the hospital are reclassified OUT of RHC costs on the Cost Report.
- ✓ This is NOT commingling!

SECTION 100: DUPLICATE MEDICARE/MEDICAID REIMBURSEMENT

- ✓ Duplicate Medicare or Medicaid reimbursement (including situations where the RHC or FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis),
- ✓ Selectively choosing a higher or lower re-imbursement rate for the services.

DUPLICATE MEDICARE REIMBURSEMENT

What would constitute duplicate Medicare reimbursement?

- ✓ Billing Venipuncture to Medicare Part B, Physician Fee Schedule (PFS).
- ✓ Billing injections/procedures on 1500/PFS during RHC hours.
- ✓ Making decisions based on how the service is paid in a particular setting. (Selectively choosing a higher or lower re-imbursement rate for the services.)
- ✓ Unbundling/Billing defined RHC professional services (See Treatment Area discussion)

VENIPUNCTURE

"Although RHCs and FQHCs are required to furnish certain laboratory services…laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit." (MLN Matters® MM8504)

SECTION 100: RHC HOURS

If an RHC or FQHC practitioner furnishes an RHC or FQHC service at the RHC or FQHC during RHC or FQHC hours, the service must be billed as an RHC or FQHC service.

SECTION 100: TREATMENT SPACE

"RHC and FQHC practitioners may not furnish or separately bill for RHC or FQHC- covered professional services as a Part B provider in the RHC or FQHC, or in an area outside of the certified RHC or FQHC space such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation."

SECTION 100: TREATMENT SPACE

- ✓ We cannot have an “island” of non-RHC professional services, within our RHC space.
- ✓ RHC treatment space and patient care areas cannot be shared with non-RHC providers, during RHC hours.
- ✓ …even for NON-RHC providers owned by the same organization. (Think provider-based clinic offering Occupational Therapy in an adjacent non-RHC space.)
- ✓ This is NOT to be confused with sharing treatment space with defined non-RHC ***services*** *(i.e. diagnostic testing, lab, etc.)*

40.2 - HOURS OF OPERATION

Services furnished at times other than the RHC or FQHC posted hours of operation to Medicare beneficiaries who are RHC or FQHC patients may not be billed to Medicare Part B if the practitioner's compensation for these services is included in the RHC/FQHC cost report.

(See MBPM Section 100 on Commingling)

PROFESSIONAL SERVICES

One important source of commingling concern is when we attempt to split “defined RHC services”.

RHC services are:

- ✓ Physician Services/Incident-To
- ✓ NP/PA/CNM Services/Incident-to
- ✓ Medicare Preventive Service Encounters

RHC HOURS VS NON-RHC HOURS

Non-RHC hours may be established to provide professional or other services which will NOT be billed as RHC (UB04/AIR Payment).

- ✓ The entire RHC must be non-Rural Health during these hours.
- ✓ Non-RHC hours must be “carved-out” of the cost report.
- ✓ Non-RHC hours must be posted on the front door, and in the RHC manual.
- ✓ State Agency notification is recommended. Most states will say it is required.

NON-RHC HOURS: QUESTIONS TO ASK BEFORE IMPLEMENTATION

Why? What is your goal? Is it because these are paid better under non-RHC?

- ✓ Is the carve-out being used to bill services that are incident-to RHC encounters?
- ✓ What is the actual volume and reimbursement of the services that you are seeking to carve-out? Are you comparing clinic charge amounts with the AIR or actual payments?
- ✓ Can these be billed under RHC and eliminate the compliance risk?

SECTION 100: PAYER CONTRACTS

Payer arrangements with local employers, specialty payers, or other contracting arrangements are NOT commingling. Examples are:

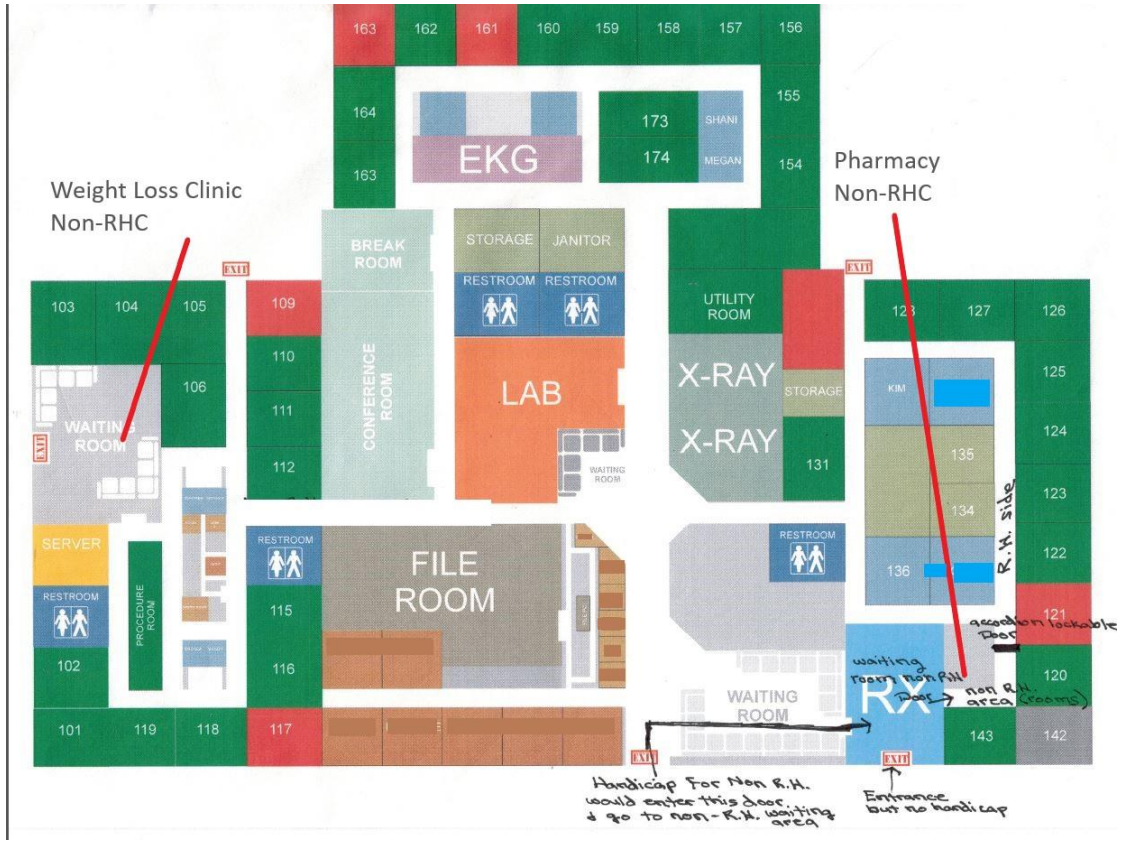
- ✓ A local employer contracts with the RHC to provide care to their employees on a specific fee schedule, during RHC hours. This is not commingling.
- ✓ Drug testing services
- ✓ DOT, FAA, employment physicals
- ✓ Special Payer Contracts

SPACE USAGE EXAMPLE

Commingling Issues

- ✓ Non-RHC Weight Loss Clinic Patients cannot share treatment space with the RHC.
- ✓ Non-RHC patients cannot have access to RHC treatment areas.
- ✓ The pharmacy needs to be sequestered from the RHC.
- ✓ The clinic built interior doors at the ‘file room’ and by the pharmacy to prevent access to the RHC from those areas.

Weight Loss and Pharmacy: Non-RHC



SHARED RESOURCES: WAITING ROOM AND RECEPTION AREAS

RHCs and FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC or FQHC staff, space, or other resources.

Any shared staff, space, or other resources must be allocated appropriately between RHC or FQHC and non-RHC or non-FQHC usage to avoid duplicate reimbursement.

SHARED RESOURCES: WAITING ROOM AND RECEPTION AREAS

If an RHC or FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC or FQHC space must be clearly defined.

If the RHC or FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

VISITING SPECIALISTS IN AN RHC

Any qualified provider (MD, DO, NP, PA) can see patients in an RHC. Specialists in an RHC may, either:

- Bill as RHC providers; no carve-out or service sequestration.
- Rent space; bring staff; performs their own billing; RHC carves out space and overhead from the cost report.
- Signage should indicate that these are NOT RHC providers, but are visiting from an outside practice.

RHC AND SPECIALTY CLINIC: HOW-TO

The RHC shares waiting space and reception areas with specialty providers (from the same organization).

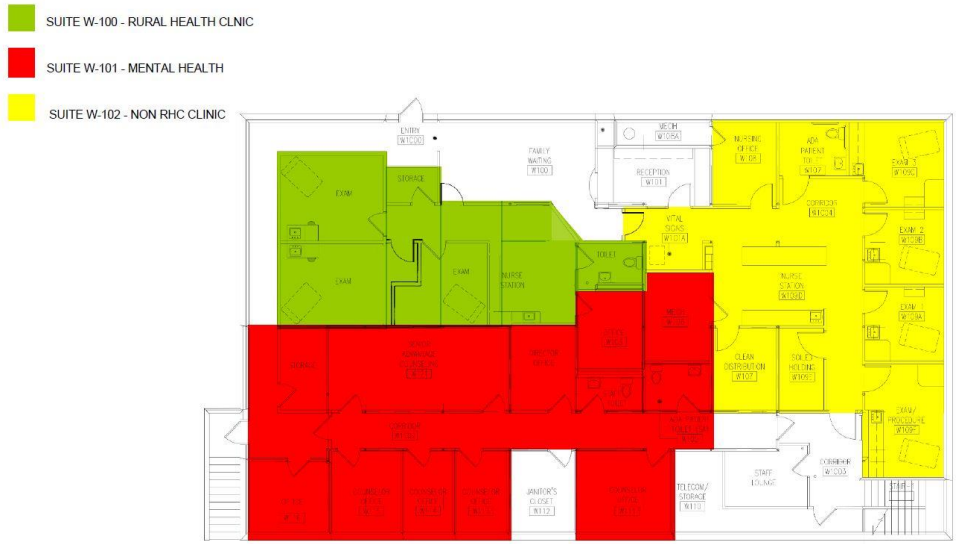
- ✓ The patient treatment areas are totally separate from one another.
- ✓ Each clinic has their own patient registration and check-out personnel, indicated by signage.
- ✓ The clinics function as separate practices, other than sharing waiting and reception space.
- ✓ Costs are accurately tracked, allocated, and allocation method documented.

RHC AND SPECIALTY CLINIC: FLOOR PLAN EXAMPLE

The RHC shares waiting space and reception areas with Behavioral Health and Specialty Clinics. (from the same organization)

- ✓ The patient treatment areas are totally separate from one another.
- ✓ Each clinic has their own patient registration and check-out personnel, indicated by signage.
- ✓ The clinics function operationally as separate practices, other than sharing waiting and reception space.

RHC, Behavioral Health, and Specialty Clinic



CMS GUIDANCE: CO-LOCATED SPACE

May 3, 2019: QSO-19-13-Hospital Revised 11/12/21

Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities (Revised)

“Co-location occurs when two Medicare certified hospitals or a Medicare certified hospital and another healthcare entity are located on the same campus or in the same building and share space, staff, or services.”

CMS DISTINCT AND SHARED SPACE

"Hospitals can be co-located with other hospitals or other healthcare providers. These hospitals may be located on the same campus or in the same building used by another hospital or healthcare facility."

COMMON EXAMPLES OF CO-LOCATION INCLUDE:

- ✓ One hospital entirely located on another hospital's campus or in the same building as another hospital
- ✓ Part of one hospital's inpatient services (e.g., at a remote location or satellite) is in another hospital's building or on another hospital's campus.
- ✓ OR -

SEPARATELY CERTIFIED PROVIDER => RHC

Outpatient department of one hospital *is located on the same campus of or in the same building* as another hospital **OR** a separately Medicare-certified provider/supplier such as an ambulatory surgical center (ASC), **rural health clinic (RHC)**, federally-qualified healthcare center (FQHC), an imaging center, etc.

EACH TO THEIR OWN

“Regardless of the situation, when a hospital is in the same location (campus or building) as another hospital or healthcare entity, each entity is responsible for demonstrating its compliance with all applicable Medicare and Medicaid program participation requirements.”

SPACE

The hospital must consider whether the hospital's spaces that are used by another co-located provider risk their compliance with these requirements. Areas of consideration when sharing space may relate to patient rights, infection prevention and control, governing body, and/or physical environment, among others.

For example, both the hospital and the co-located healthcare provider should demonstrate their compliance to protect and provide a safe environment for their patients, including but not limited to, their right to personal privacy and to receive care in a safe environment under §§482.13(c)(1) and (2), and right to confidentiality of patient records under §482.13(d)

SHARED SPACE – WISCONSIN PHYSICIAN SERVICES

Section 2026A (SOM Chapter 2) states the main hospital must operate as a single provider institution including all components. That is, the provider-based space is to be used only by the main hospital provider-based entity.

State Operations Manual
Chapter 2 - The Certification Process
(Rev. 227; Issued: 12-13-24)

SHARED SPACE

The provider-based space is to be used only by the main hospital provider-based entity. For example, a hospital outpatient department requesting provider-based status is sharing a waiting room with a freestanding physician private practice office.

SHARED SPACE

As another example, a freestanding private physician operates two days of the week in the same space as the main hospital provider-based outpatient department, which operates the other three days of the week. ***This type of arrangement will result in the denial of provider-based attestation and potentially the recoupment of money.***

SHARED SPACE

As part of the provider-based attestation, a provider must submit a floor plan that clearly identifies each room occupied by the hospital provider-based entity. If there is any space in the building occupied by the provider-based entity that is used by an entity not owned or operated by the hospital, that space must be indicated on the floor plan or provide a written explanation of how the space is being used and a copy of the agreement(s) between the hospital and other entity.

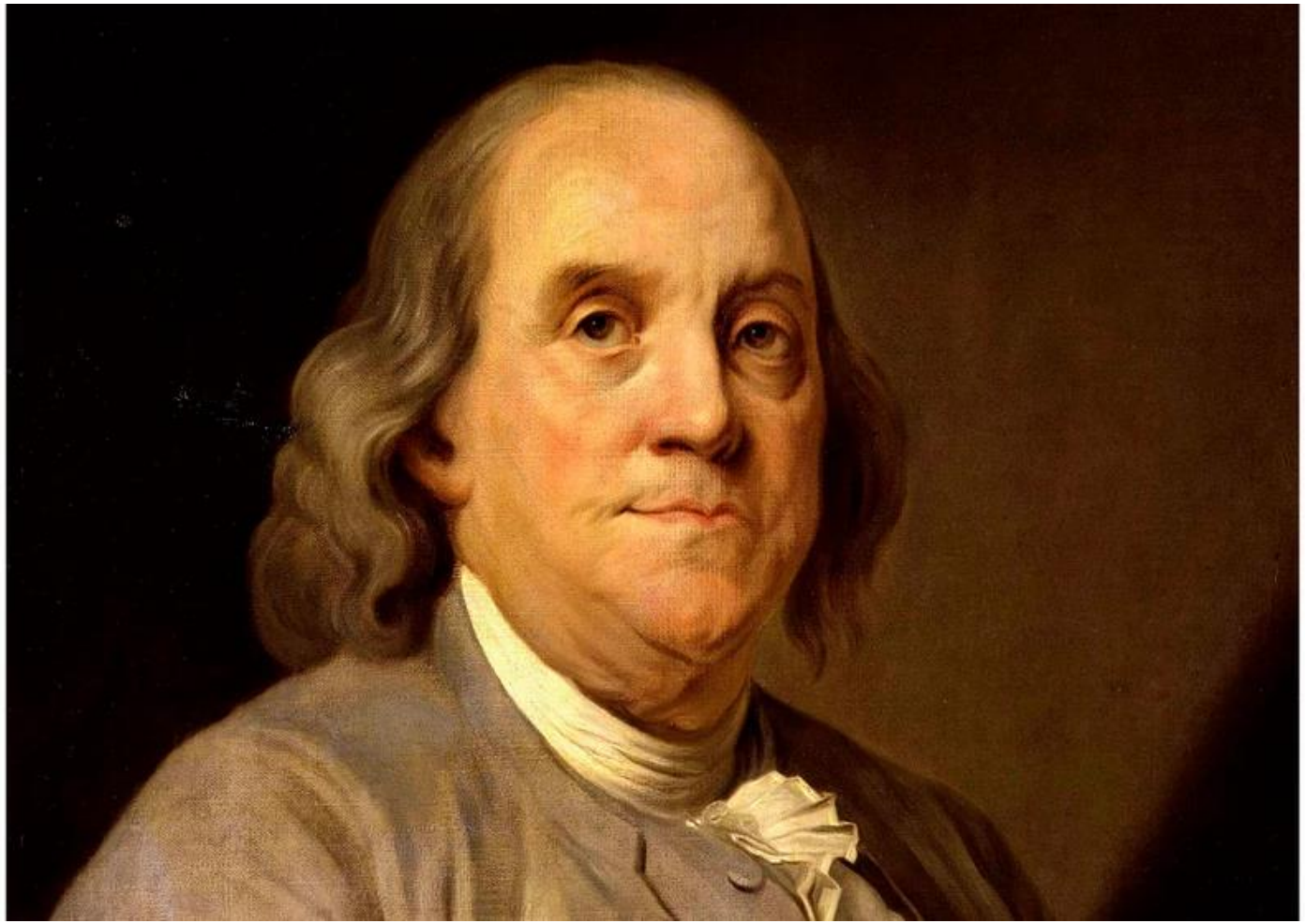
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CONTRACTED SERVICES

A hospital is responsible for providing its services in compliance with the hospital CoPs, which could be provided either directly or under contract or arrangement. Services, such as laboratory, dietary, pharmacy, maintenance, housekeeping, and security services are examples of services that may be contracted or provided under arrangement in a co-located hospital.

“AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE.”

— BENJAMIN FRANKLIN



SUMMARY

- ✓ Commingling becomes a concern with billing PROFESSIONAL services performed in the RHC.
- ✓ All professional services provided in the RHC during RHC hours, must be billed according to RHC rules.
- ✓ Lab and x-ray are always “carved out.”
- ✓ RHC space cannot be shared with another Part B provider billing under a different number.

RHC - CMS RESOURCES

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Benefit Policy Manual- Chapter 15 Other Services

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

PROVIDER BASED CMS RESOURCES

"Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities (Revised)." CMS QSO-19-13-Hospital. May 3, 2019. Revised 11/12/21.

"Provider-based Status On or After October 1, 2002". Centers for Medicare & Medicaid Services (CMS). Transmittal A-03-030. APRIL 18, 2003.

"Requirements for a determination that a facility or an organization has provider-based status". Code of Federal Regulations. 42 CFR 413.65. Aug. 14, 2017.

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