National Organization of State Offices of Rural Health

Understanding RHC Finances – Including Billing, Coding and Cost Reports

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Overview

- Overview of RHC Regulations & changes
- Elements of RHC Billing & Coding
- Overview of RHC Cost Reporting

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RHC CONDITIONS OF PARTICIPATION

- From the NARHC website:
  - http://narhc.org/resources/rhc-rules-and-guidelines/
- Interpretative Guidelines are also given
- Link of General rules redirects to:
  - http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=bd5ea765b228085fc1b9f5a7366f85a0&n=42y2.0.1.2.5.15&r=SUBPART&ty=HTML
  - Current as of 8/1/14

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RHC REGULATIONS

- Medicare Benefit Policy Manual Ch 13 – RHC and FQHC Services Rev 173 issued 11/22/13, effective 1/1/14
- MM8504 issued 11/22/13 updates effective 1/1/14
- Federal Register of 5/2/14 updated RHC regs effective 7/11/14
- CMS clarification of stand-alone preventive services 8/14/14

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RHC UPDATED REGULATIONS

- 40.3 – Multiple Visits Same Day, Payable if
  - Patient has second visit for additional DX
  - A **medical visit** and a **mental health visit** same day (2 visits)
  - **IPPE** and **Medical Visit** and **Mental Health Visit** (3 visits)
  - **AWV** and a **Mental Health Visit** (2 visits)
  - Clinic visit and Hospital admit is per your MAC
    - WPS & Cahaba will allow if medically necessary
    - Patient must have face-to-face contact in hospital

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RHC UPDATED REGULATIONS

- 40.4 – Global Billing
  - All procedures in the RHC are not subject to Globals
  - If RHC sees PT for the surgical DX of another provider, must assure the proc was billed w/54 mod
  - If RHC prov performs hosp proc, bill w/54 mod, and then bill each visit at clinic level as not in global
  - Services never included in global surgical package
    - Initial visit to determine surgery required
    - Visits unrelated to DX for surgical procedure
    - Treatment for underlying condition or an added course of treatment which is not part of normal recovery

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RHC UPDATED REGULATIONS

- 90 – Commingling
  - Sharing space, staff, supplies, equipment and/or other resources with an onsite Medicare Pt B or Medicaid FFS practice operated by the same RHC providers. Commingling is prohibited to prevent:
    - Duplicate reimbursement or selectively choosing a higher or lower reimbursement rate for services
    - May NOT furnish RHC services as a Pt B provider in the RHC or in an area outside the RHC such as a treatment room adjacent to the RHC during RHC hours of operation
    - If RHC is in the building with another entity the RHC space MUST be clearly defined.

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RHC UPDATED REGULATIONS

- 90 – Commingling (con't)
  - If RHC leases/rents space, all costs must be offset by the fees paid
  - Does not prohibit provider going to hosp for emergencies
  - Must follow schedules for hospital and RHC time
  - ***If a RHC practitioner furnishes a RHC service at the RHC during RHC hours, the service must be billed as a RHC service. The service cannot be carved out of the cost report and billed to Part B.***

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HOSPICE SERVICES

- 200 – Hospice Services
  - Can treat Patient for condition not related to hospice DX, must use a condition code of 07 on claim to be paid
  - If treat hospice ailment, cannot bill for visit, even if medically necessary and must look to the hospice company for payment or write off. **Cannot** send to Pt B.
  - Providers should coordinate care with the Hospice Co.

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RHC UPDATED REGULATIONS

- 210 – Preventive Health Services
  - Only the professional services are billed as RHC
  - TCs are billed as nonRHC
  - Must use the appropriate G-codes
  - Flu and Pneumo Vaccines
  - Hepatitis Vaccines
  - Many preventive services have no copay or deductible
  - Diabetes Counseling and Medical Nutrition Services
    - Not separately billable but "incident to" service
    - Costs allowed on the cost report

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2014 Medicare Rates

- Patient Deductible = $147 per year
- IRHC Rate = $79.80/visit
- PBRHC PPS Hospital Rate = $79.80/visit
- PBRHC <50 bed hospitals = No limit

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CPT PROCEDURE CODES

- All Procedure Codes normally performed in a physician's clinic are applicable in the RHC
- Some CPT codes will have to be "split" billed, i.e. EKG, x-ray prof & tech comp

DOES IT MATTER HOW WE CODE A VISIT?

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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What is a Visit?

- Face-to-Face with the Provider
  - Physician, PA, NP, CNM
  - Clinical Social Worker or Clinical Psychologist
- Medically necessary
  - Does it require the skills of a Provider?
- Payer Class
  - All payer classes are counted in the total visit count
- Place of Service
  - Clinic, Home, NH, SNF/SW B, Scene of Accident
- Level of Service
  - All levels apply, to include procedures
  - To include all services "incident to"

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RHC Covered Services

- ✓ Physician services
- ✓ NP, PA & CNM services
- ✓ Services & Supplies incident to provider service
- ✓ Diabetes self-management training services and medical nutrition therapy services for diabetic patients provided by registered dietitians or nutritional professionals
  - ✓ not separately billable for RHCs but indirectly paid
- ✓ Visiting nurse services in non HHA area
- ✓ Clinical psychologist & clinical social worker
- ✓ CP & CSW supplies & services "incident to"

CMS Manual 100-02 Chapter 13 Section 50

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NonCovered as RHC Services (Covered if Billed to Correct Payer)

- Hospital patient services
- Lab tests (except venipuncture is part of Visit)
- Part D Drugs & Self administrable drugs
- DME
- Ambulance services
- Technical components of diagnostic tests
  - i.e. xrays & EKG, Holter Monitoring
- Technical components of screening services
  - i.e. screening paps/pelvic, PSA
- Prosthetic devices
- Braces

CMS Pub. 100-02. Ch 13, Sec 60 & 60.1

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Medicare Covered But Nonbillable Services

- Nurse service w/o face-to-face visit or "incident to" visit
  - I.e. allergy injection, hormone injection, dressing change, venipuncture
  - Provider MUST be in clinic to have "incident to"
  - CMS Manual 100-02 Chapter 13 Section 110.2
- Telephone services
  - CMS Manual 100-02 Chapter 13 Section 100 & 120
- Prescription services
  - CMS Manual 100-02 Chapter 13 Section 100 & 120

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EXAMPLES OF NO MEDICAL NECESSITY

- Routine INR visit for lab
- Simple suture removal
- Dressing change
- Results of normal tests
- Blood pressure monitoring
- B12 injection
- Allergy Injection
- Prescription service only

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Medicare Part A Billing RHC Services

- UB 04 form or 837i electronic format
- Bill Type 711
- Revenue Codes (NO CPT CODES ON CLAIM)
  - Exception when billing preventive services
- Sent to Fiscal Intermediary
- Claims for all RHC visits
  - Office, Skilled Nursing Home, Swing Bed, Nursing Home, Home, Scene of an accident
- Actual charges billed

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Medicare Part A Revenue Codes

- 521 Office visit in clinic
- 522 Home visit
- 524 Visit to a Part A SNF or SW patient
  Only prof service as labs, drugs, x-ray TC, EKG tracing gets billed to the SNF.
- 525 Visit to a Pt in a SNF, NF, ICF MR, AL
  Patient not on a Part A SNF Stay
- 527 Visiting Nurse Service in a HHA shortage
- 528 Visit at other site, I.e. scene of accident
- 780 Telehealth site fee
- 900 Mental Health Services
  - *All drugs & supplies, are bundled with the visit code charges in the Revenue Codes shown above*

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Medicare RHC Provider Number

- RHC office visit services
  - **Excludes** all labs, x-ray TC & EKG Tracing, any TC
  - **Includes** venipuncture effective 1/1/14
- Billed to the FI, UB04 Form or electronic
- Paid on the clinic's "all inclusive rate"
- All Medicare coverage rules apply
  - Reasonable & necessary
  - Allowed preventive is covered, I.e. pap, PSA

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Medicare Part B Provider Number (IRHC)

- All labs, x-ray TC, EKG tracing, any technical components (venipuncture is part of the office visit bundled service)
- All hospital services (IP, OP, ER, OBS)
- Billed to WPS/MAC, HCFA 1500 Form
- Paid on the Medicare Pt B fee schedule

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Medicare Part B Provider Number (PBRHC)

- All hospital services (IP, OP, ER, OBS)*
- Billed to WPS MAC, HCFA 1500 Form
- Paid on the Medicare existing fee schedule

* The only exception is if the CAH is Method II reimbursement; then the OP, ER & OBS professional component is part of the hospital's claim.

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PBRHC - Hospital OP Provider Number

- ALL Laboratory performed in the RHC, including 6 basic tests (venipuncture is part of the office visit bundled service)
  - Billed using 141 bill type for PPS Hospitals
    - MLN SE1412, December 27, 2013
  - CAH 851 bill type
    - For any facility owned by CAH or CAH employee performing test
- Technical Component
  - X-ray, EKG, Holter Monitor
  - All TC's Billed using 131 bill type for PPS Hosp
  - All TC's Billed using 851 bill type for CAH
- Paid on the Medicare Pt B Fee Schedule

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PBRHC - Hospital OP Provider Number

CAH Method II

- Hospital bills for both the professional and technical component when performed in the hospital setting:
  - X-ray
  - EKG
  - Holter Monitor
  - ER
  - OP/OBS/ASC
  - Must have separate line item for the prof service
- Paid on the Medicare Pt B Fee Schedule + 15%

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State Medicaid RHC/nonRHC Billing

- Each State Medicaid is specific as to their State requirements—50 states, 50 plans
- May use either the 1500 or UB04
  - Managed Care Plans have choice as well
- Coverage is specific to each state
- Most States require both RHC and nonRHC Medicaid provider numbers
- Paid on the RHC rate or a PPS rate

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Private Pay or Private Insurance

- Billed as in fee-for-service clinic
- No changes in reimbursement
- Must not discount charges
  - no cash discounts at time of service payment
  - no professional discounts given
- All discounts given should be based on finances of patients
  - i.e. sliding fee scales can be developed to as high as 400% of poverty guidelines per Federal Regulations

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Medicare Advantage (MA)

Two types of plans

PFFS – Private Fee for Service
Send Claims on UB04 with Medicare Rate letter

Regional/PPO Plans
Must provide service to the entire region per CMS
Send Claims on UB04; you negotiate payment

When patients switch to MA, they are on your "Private" section of your visit counts

You may want to keep them separate as they will count as Medicare patients if you need to figure the % of Medicare utilization.

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MEDICARE INJECTIONS

- Injections with an Office Visit
  - Charge All CPT codes in system
  - Bundle all charges and submit claim to RHC MCR
  - If it is a Pt D drug, it must be sent to Pt D plan or Patient
- Injections only—nurse service
  - Charge in system
  - Either DO NOT bill (write off) as there is no f-t-f visit
  - OR can be bundled with a visit within 30 days pre or post nursing service and submitted with that f-t-f visit
  - If injectable is a Part D drug it MUST not be a part of the RHC claim as it is only billable to the patient or to Part D

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PART D - INJECTIONS

- Injectable/Vaccine as a Part D drug – 1/1/08
  - The injectable/vaccine is payable only through Pt D
  - If injectable/vaccine is obtained at the clinic level, then the patient is to pay for the injectable/vaccine and the administration privately and then they have to submit that claim to their Part D company to be reimbursed for the services.

Clinics can link to: www.mytrnsactrx.com and bill the Pt D drug and get payment to include administration of the drug and let you know the copay amount.

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Preventive Services

- Allowed Medicare Preventive Services are billed through the Rural Health Clinic on the UB04
- Technical Components, labs, EKG tracing are billed on the nonRHC side, either through the Hospital OP provider number (PBRHC) or to MCR Pt B (IRHC) use correct G-codes
- Each preventive service MUST be on a separate line on the UB with the G-code

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Service	HCPCS Code	Long Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance/Deductible	CMS Pub 100-04
Initial Preventive Physical Examination (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	Ch 9 §150 Ch 18 §80
Diabetes Self-Management Training (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	No	No	Not Waived	Ch 9 §181 Ch 18 §120
Medical Nutrition Therapy (MNT)	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	No	No	Waived	Ch 9 §182
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	No	No	Waived	
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	No	No	Waived	
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	Yes	No	Waived	Ch 18 §140
	G0439	Annual wellness visit, including PPPS, subsequent visit	Yes	No	Waived	
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes	No	Waived	Ch 18 §40
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	Yes	No	Not Waived	Ch 18 §50
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	Yes	No	Not Waived	Ch 18 §70
	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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Preventive Services

Preventive Services Quick Reference Guide:

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf

IPPE Quick Reference Guide:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

Annual Wellness Visit Quick Reference Guide:

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

More Preventive Service info:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

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

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Services Rendered on non-visit days— "Incident To" Services

- Can be combined on claim with a visit within 30-days pre or post
- "incident to" service for plan of treatment
- NEVER considered a separate visit
- List only the date of the visit as date of service
- Charges should reflect all services bundled
- When added, the added reimb is the 20% copay
- Adjustments OK—717 Type of Bill; CC=D1; remarks "changes in charges"
- Otherwise, the costs are shown on your cost report and claimed indirectly

CMS 100-02, Ch 13, Sec 110; Sec 130; Sec 150

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Behavioral Health Services

- Clinical Psychologist (PhD)
  - Doctoral level of education
- Clinical Social Worker (CSW)
  - Masters level with at least 2 years experience
- Use 900 revenue code to bill therapeutic behavioral health
- The first visit to determine services by a physician/PA/NP is an RHC visit, then behavioral health services apply
- Reimbursement in 2014 is 80/20

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Flu & Pneumonia Injections

- Keep a log of injections, or have your computer track
- Medicare paid on your Medicare Cost Report
- Flu payable once per season; pneumo once lifetime
- Medicaid is paid only if in your State benefits at time of service
- Keep track of vaccine and supply costs
- Determine average nursing hours per week
- Determine average provider hours per week
- Generally allow 10 minutes per injection on Cost Report, but do a time study
- NO Medicare Advantage on log
- **LOGS MUST BE LEGIBLE**

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Telehealth Site Fee Services

- Bill to RHC FI
- Revenue Code 780
- Does not require a Face-to-Face visit same day
- Q3014 code is paid separately from all-inclusive rate at the Medicare Phys Fee Schedule
- Bill for transmission fee
- **REQUIRED** to put the Q code on the claim
- RHCs **are not** allowed to be the provider

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BILLING NONCOVERED CHARGES

How do you bill noncovered charges?

If all charges are noncovered, send 710 TOB with all charges as noncovered and condition code 21.

If only some of the charges are noncovered, per CMS Internet-Only Manual, Publication 100-04, Chapter 1,Adobe Portable Document Format Section 60.1.1.1. This section of the manual states, "... all of a bundled service must be billed as noncovered, or none of it. Therefore, as long as part of a bundled service is certain to be covered or medically necessary, billing the entire bundled service as covered is appropriate."

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RHC CHART REVIEW

- ✓ Documentation !!!
  - ✓ Must use either 1995 or 1997 documentation guidelines
- ✓ Develop policies as to which guidelines used
- ✓ Develop billing policies and assure claims are sent correctly
- ✓ Develop Collection policies and assure RHC is following policy when determine RHC bad debt
- ✓ Support Billing?
- ✓ Are lab tests warranted by diagnoses?
- ✓ If not, do we have an ABN signed?
- ✓ Does the Chart, Claim and Encounter form match for services and level of care?
- ✓ Have we asked the MSP questions?
  - ✓ Required at time of each visit

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RHC Cost Reporting

Provider based – owned, operated by Hospital, SNF, HHA (Schedule M)

Independent – (Freestanding) – may be MD/DO owned, privately owned or owned by other health professionals (CMS 222)

- ⊡ Cost reports must be submitted in electronic format (ECR File) on CMS approved software
- ⊡ Vendor list on the CMS website
  - ▪ Many use HFS software

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RHC Cost Report

- Method to reconcile and verify payments to allowable costs
- Allowable RHC Costs/RHC Visits = RHC Cost Per Visit = RHC rate; *not to exceed the maximum allowable reimbursement rate for current period. ($79.80 2014)*
- Determines future reimbursement rates
- Cost reports are due five months after FYE
- Must obtain (PS&R) Provider Summary Report 90 days after FYE through the IACS internet system

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Productivity Standards

- Physician
  - FTE (Full Time Equivalent = 40 hrs/wk, 52 wks/yr or 2080 hrs year)
  - 4,200 visits per each FTE
- PA, NP, CNM
  - 2,100 visits per each FTE

VISITS OF ALL PAYER CLASSES ARE COUNTED TO DETERMINE PRODUCTIVITY STANDARD

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Statistics needed within the RHC

- Number of RHC encounters by each Physician, NP or PA by payer class
- Number of nonRHC (hospital services) encounters by Physician, NP or PA
- Log of all Flu and Pneumonia injections to include: date, patient name, Medicare #
- Staffing schedules & Time studies
  - Determines FTE (full time equivalency) of providers
- TIME STUDIES!

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Financial Statements

- Balance Sheet
- Profit and Loss Statement
- Trial Balance
- Depreciation Schedule
- All accounting in the accrual method of accounting

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Information Needed to Complete the RHC Cost Report

- Medicare Bad Debt (Exhibit 5 of CMS 339)
- Laboratory Costs (From time study & financials)
- Non-RHC X-ray Costs (From time study & financials)

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Vaccine Information

- Influenza and Pneumovax
  - Total vaccines given of each to all payer types
  - Total Medicare vaccines given of each (log must accompany cost report – sample log attached)
  - Cost per dose of each from invoices
    - Must submit copies of invoices with cost report

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Medicare Bad Debts—CMS 339 Exhibit 5

- Medicare bad debt form must accompany cost report of total bad debt being claimed.
- Medicare bad debt is claimed on the cost report based on which fiscal year the bad debt was written off in, not date of service.
- All Bad Debts must have been written off "after" at least 120 days of statements sent (4)
- Accounts cannot be sent to collection and claimed as bad debt

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PS&R

- RHC must request the PS&R at approx. 90 days after FYE using the IACS internet system
- Compare PS&R total to your Medicare visit count. Is this accurate? If not, determine why and if this is a common issue that occurred when pulling all insurance visit type information

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Medicare Corporate Compliance

- All practices that accept Medicare & Medicaid dollars are required to have a Clinic Corporate Compliance Policy
- HIPAA Policies in place
- Do we have consents signed?
- Are we getting ABNs (Advanced Beneficiary Notices) when appropriate (CMS-R-131 03/11)
- Are we asking the MSP (Medicare Secondary Payer) questions? Must keep 10 years
- Are time studies performed
- Are visits counted correctly

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INTERNET WEBSITES OF INTEREST

www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MPS_QRI_IPPE001a.pdf

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ /AWV_Chart_ICN905706.pdf

www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf

Make sure you are a part of your MAC listserve for updated info!

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Internet Websites of Interest

www.ruralhealthweb.org (NRHA)

www.nebraskaruralhealth.org (NeRHA)

www.cms.gov

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf *(new RHC/FQHC Regulations 11/13)*

www.cms.gov/Regulations-and-Guidance/Guidance /Manuals/Downloads/clm104c09.pdf *(RHC CMS Claims Manual)*

www.wpsmedicare.com

www.cahabagba.com

www.narhc.org

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Questions ?

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