
	Michigan Rural Health Conference
	<p>Billing and Cost Reporting for Rural Health Clinics</p> <p>March 25, 2009 1:45 p.m. – 2:45 p.m.</p> <p>Jeff Bramschreiber, CPA, Partner Wipfli Health Care Practice</p>
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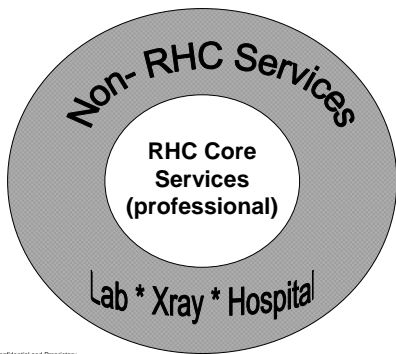
	Overview of Today's Session
Agenda	
Billing <ul style="list-style-type: none"> • Rural Health Clinic Services • Non-RHC Services • Non-Covered Services • Payment • Filing a Claim 	
Cost Report <ul style="list-style-type: none"> • Allowable/non-allowable costs • Visits • Provider FTEs • Medicare Bad Debt 	
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How Are Rural Health Clinics Paid?

Rural health clinics 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 (i.e., cost report) occurring at the end of the fiscal year.

There are 2 types of RHCs; billing and payment are slightly different:

1. Independent RHCs bill RHC services to one of five regional fiscal intermediaries (transitioning to MAC).
2. Provider-based RHCs bill RHC services to the FI/MAC of the host provider (usually a hospital).



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RHC Services		
RHC Billing Differences		
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 UB-04 form	Billed to Host Provider Fiscal Intermediary – RHC provider number on UB-04 form

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RHC Services		
RHC Billing Differences		
Service	Independent	Provider-Based
Laboratory (including the draw procedure, e.g., CPT code 36415)	Billed to Part B carrier – existing group number on 1500 form	Billed on hospital O/P claim type (14x, 13x, or 85x) on UB04
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 1500 form	Billed on hospital O/P claim type (13x or 85x) on UB04
Non-RHC Professional Services (I/P, ER, other O/P services)	Billed to Part B carrier – existing group number on 1500 form	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 Services		
<ul style="list-style-type: none"> • Physician's services • Services and supplies incident to physician's services • Services of NP, PA <ul style="list-style-type: none"> – Including certified nurse midwives • Services and supplies incident to NP/PA • Visiting nurse services to the homebound • Clinical psychologist and clinical social worker services • Services and supplies incident to clinical psychologist and clinical social workers • Physician services for beneficiaries in Part A stay in SNF (including hospital swing bed) separately billable effective 1/1/05 		

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Non-RHC Services

- DME
- Ambulance services
- Diagnostic tests such as X-ray and EKGs
- Lab test – *although must be able to perform 6 required tests in RHC*
- Screening mammography services
- Prosthetic devices
- Services provided to hospital patients (except those in a swing bed)

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Payment Calculations

RHC Payment Example #1:

- The customary charge for 99213 is \$90.00.
- The Medicare encounter rate is \$128.00. Limited to \$76 for independent RHC. No limit for provider-based RHC – available beds < 50.
- Deductibles have been met already.

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Payment Calculations

RHC Payment Example (Independent RHC):

Description	Amount	Comment
Customary Charge	\$ 90.00	UB-04, Revenue Code 521
Patient Co-Pay	18.00	Based on 20% of customary charge.
Medicare Pays	60.80	Based on 80% of \$76.00 encounter rate.
Total Payment	\$ 78.80	Received more than encounter rate due to co-insurance.
Contractual Adjustment	\$11.20	Contractual adjustment booked resulted due to charge being > payment.

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Payment Calculations		
RHC Payment Example (Provider-based RHC):		
Description	Amount	Comment
Customary Charge	\$ 90.00	UB-04, Revenue Code 521
Patient Co-Pay	18.00	Based on 20% of customary charge.
Medicare Pays	102.40	Based on 80% of \$128.00 encounter rate.
Total Payment	\$120.40	The full \$128 rate was not received because charge < \$128 encounter rate.
Contractual Adjustment	- \$ 30.40	Total payment exceeds charges; creates negative adjustment.

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Payment Calculations		
Standard Part B Payment Example (not RHC):		
Description	Amount	Comment
Customary Charge	\$ 90.00	CMS 1500 form to Part B carrier.
Patient Co-Pay	11.80	Based on 20% of Medicare approved amount of \$59.00.
Medicare Pays	47.20	Based on 80% of \$59.00 approved amount.
Total Payment	\$ 59.00	Total payment is the Medicare approved amount.
Contractual Adjustment	\$ 31.00	Total payment is less than charges.

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Payment Calculations			
Comparison Between RHCs and Part B Payment Example:			
Description	RHC Amount (independent)	RHC Amount (Provider-based)	Part B Amount
Customary Charge	\$ 90.00	\$ 90.00	\$ 90.00
Patient Co-Pay	18.00	18.00	11.80
Medicare Pays	60.80	102.40	47.20
Total Payment	\$ 78.80	\$ 120.40	\$ 59.00
Contractual Adjustment	\$ 11.20	-\$ 30.40	\$ 31.00

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Filing a Claim

- UB-04 (CMS Form 1450)
- Bill type 71x
- Revenue centers allowable 52x and 900
(maximum unit of 1 per day)
- No HCPCS required
- Bill all non-RHC ancillary services SEPARATELY!
 - Independent – To Part B carrier using existing group number
 - Provider-based – Through the hospital provider number on 13x, 85x, or 14x type of bill (A-00-36 7/28/00)
- Separate RHC billing number (for each RHC)
- Only RHC services on RHC billing number
- Non-RHC professional services billed to Part B carrier utilizing existing group number

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Billing for Lab Services

Required lab services that must be available as an RHC:

- Chemical examinations of urine (CPT 81002)
- Hemoglobin (CPT 83026)
- Blood sugar (CPT 82962)
- Examination of stool specimens (82270)
- Pregnancy tests (81025)
- Primary culturing for transmittal to a certified laboratory

Clinic must have the ability to perform these basic [CLIA waived] tests; however, they are billed as non-RHC services.

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Billing for Lab Services

Lab performed in the RHC setting (RHC is part of a Critical Access Hospital (CAH)) . . .

CAH designation allows cost reimbursement for outpatient laboratory services that are performed on-site at the CAH. Non-patient (reference) laboratory services would remain under the existing "fee schedule" reimbursement methodology.

As noted in the August 1, 2003, *Federal Register*, the criteria for payment on a reasonableness cost basis for clinical diagnostic laboratory services performed by a CAH is as follows:

- Payment on a reasonable cost basis will be made only if the individuals for whom the tests are performed are outpatients of the CAH at the time specimens are collected and are *physically present in the CAH* at the time the specimens are collected.
- Clinical diagnostic lab tests for individuals who do not meet these criteria will be made only on a fee schedule basis.
- *Effective with dates of service October 1, 2003 – June 30, 2009.*

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Lab performed by a Critical Access Hospital (CAH) . . .

Medicare Improvements for Patients and Providers Act of 2008 allows cost-based reimbursement for all laboratory services provided by any provider-type (i.e., SNF, RHC or other physician clinic) that is operated by the CAH regardless of where the lab specimen is collected – i.e., *the patient does not have to be physically present in the CAH at the time the specimens are collected.*

Goes into effect for services dates on or after, July 1, 2009.

Billing Lab Services performed in an RHC

- Independent RHC
 - Bill all laboratory services (including the 6 basic required tests) to Part B carrier on CMS 1500
 - Including the lab draw procedure (CPT code 36415)
- Provider-based RHC operated by a CAH or PPS hospital
 - Bill all laboratory services (including the 6 basic required tests for RHC COP) performed in RHC as reference lab to Fiscal Intermediary on UB-04 claim form using hospital billing number
 - Again, bill under hospital main provider number (not RHC number!)
 - Bill type 14X
 - Revenue code 030X
 - CPT code required field
 - Fee schedule reimbursement
 - For CAH, lab services with dates of service beginning July 1, 2009, use 85X bill type to receive cost reimbursement for lab services.

**Rural Health Clinic
Cost Report**

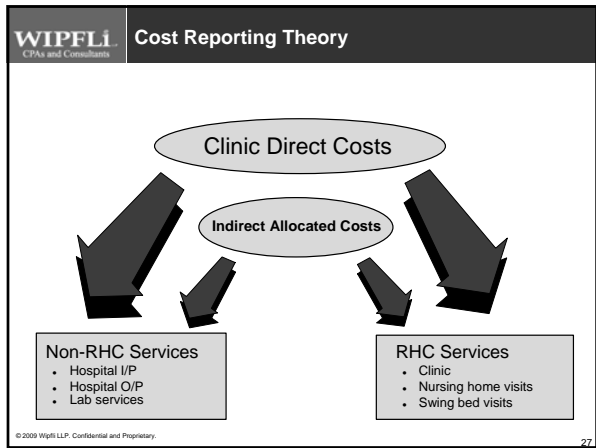
Completing the Rural Health Clinic cost report is the method for reconciling payments made by Medicare with the allowable costs for providing those services.

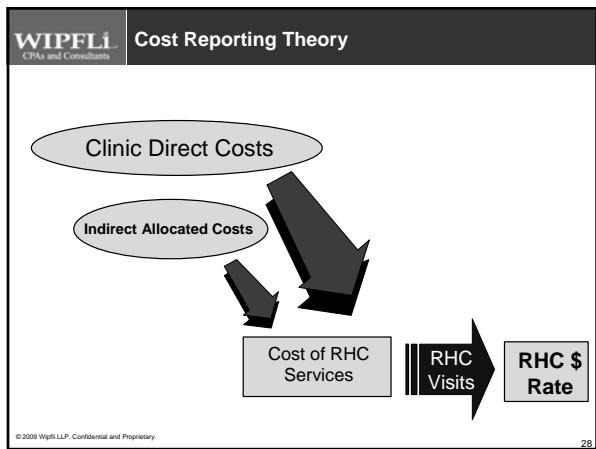
If total Medicare payments exceed the allowable costs, the provider must pay back the difference.

If total Medicare payments are less than the allowable costs, Medicare will make an additional payment to the provider.

- Cost report is due 5 months after the close of the period covered.
- Terminating cost reports are due 150 days after the termination of provider agreement.
- Extension to file the cost report may be granted by intermediary only for extraordinary circumstances such as a natural disaster or fire or flood.

- Intermediary furnishes the Provider Summary Report (PS&R) no later than the last day of the fourth month or 120 days following the end of the provider's fiscal year. This will be sent to the provider by certified mail.
- For cost reporting periods ending on or after March 31, 2005, providers must submit an electronic file of the cost report (ECR) prepared on CMS-approved vendor software and a print image file of the cost report.





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Payment Rate Calculation

$$\text{RHC Cost Per Visit (Rate)} = \frac{\text{Allowable RHC Costs}}{\text{Rural Health Clinic Visits}}$$

(Not to exceed the maximum reimbursement limits.)

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WIPFLI CPAs and Consultants **Payment Rate Calculation**

RHC Reimbursement Limits *

	2004	2005	2006	2007	2008	2009
Maximum	\$ 68.65	\$ 70.78	\$ 72.76	\$ 74.29	\$ 75.63	\$ 76.84
Increase	2.9%	3.1%	2.8%	2.8%	1.8%	1.6%

*Limits do not apply to RHCs in hospitals < 50 beds.

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WIPFLI CPAs and Consultants **Allowable Costs**

Allowable RHC Costs:

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WIPFLI CPAs and Consultants **Allowable Costs - Flu/Pneumococcal Vaccines**

Computation of Flu/PPV Costs

- May be the only settlement on the cost report.
- Reimburse on cost per injection basis.
- Do not bill to FI during year. Keep a log with the following information:
 - Patient Name
 - HIC Number
 - Date of Injection
- Compute ratio of injection staff time to total health care staff time.

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Computation of Flu/PPV Costs

Data Required:

- Estimated time to give injection (usually 8-12 minutes)
- Total injections
- Medicare injections
- Direct supply costs
- Total health care staff hours
- Compute ratio of injection time to total health care time

Common Non-RHC Services

- Laboratory services
- Diagnostic radiology
- Hospital patients (inpatient/ER/ASC)
- Medical directorships
- Mammography
- DME

Laboratory Services

Most common direct costs associated with lab:

- Lab tech salaries/benefits
- Nursing salaries/benefits (for venipunctures)
- Reagent costs
- Other lab supplies
- Lab equipment depreciation
- CLIA licensure/reference lab fees

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Non-RHC Costs

Commingling

CMS goal is to:

- Remove opportunities for duplicate billing.
- Eliminate opportunities for RHCs to shift between functioning as RHC and other entities to achieve higher reimbursement.

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Non-RHC Costs

Commingling (continued)

New Rules (status pending):

- Under the new rule, CMS prohibits the use of RHC space, professional staff, equipment, and other resources by another health care professional (during RHC hours of operations).
- New rules allow for operation of multi-purpose facilities but preclude any RHC provider from furnishing non-RHC services during RHC hours of operation.

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Non-RHC Costs

Avoid Commingling by:

- Maintaining cost records for each facility/department—if operating specialty clinic next to RHC, need to maintain time studies for staff sharing between departments.
- Do not use same staff simultaneously.
- Separate certification may be necessary (e.g., CLIA).
- Establish separate hours of operation (post it!).

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**Rural Health Clinic
Visits**

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Total RHC Visits on the Cost Report:

- Greater of actual visits or productivity standards.
- Higher visit count lowers cost per visit.
- Penalty for low productivity.
- Standard applies in aggregate:
 - 4,200 per physician FTE
 - 2,100 per midlevel FTE

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Example of Total RHC Visits on the Cost Report:

	Number of FTEs	Total Visits	Standard	Minimum Visits	Greater of
Physicians	0.8	3,000	4,200	3,360	
Physician Asst.	0.75	1,500	2,100	1,575	
Nurse Practitioners	0.5	1,200	2,100	1,050	
Subtotal	2.05	5,700		5,985	<u>5,985</u>

If actual RHC costs are \$300,000

Actual Cost per Visit	\$ 52.63
Adjusted Cost per Visit	\$ 50.13

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**Physician/Provider
Full-Time Equivalents (FTEs)**

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Sample Reconciliation of FTEs reported on
Worksheet B, Part I:

Clinical FTE (w/s B, Part I)	0.70
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	<u>0.05</u>
Total FTE	1.00

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Medicare Bad Debts

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Medicare will reimburse the rural health clinic for all uncollectible Medicare deductibles and coinsurance, if considered to be "allowable" bad debts.

The amount of allowable Medicare bad debts is added to the RHC cost report settlement.

CMS Pub. 15-I Section 308 states the criteria for allowable Medicare bad debts:

- Debt must be related to covered services and derived from deductible and coinsurance.
- Provider must be able to establish that reasonable collection efforts were made.
- Debt must be actually uncollectible when claimed as worthless.
- Sound business judgment must have been established that there was no likelihood of recovery at any time in the future.

CMS Pub. 15-I Section 310 defines reasonable collection effort:

- Similar to effort for non-Medicare patients.
- Issuance of bill to responsible party.
- May include subsequent statements, collection letters, and telephone calls.
- Referral to collection agency if used for non-Medicare patients of "like amounts."

Presumption of Non-collectibility, CMS Pub. 15-I Section 310.2:

If after reasonable and customary attempts to collect a bill, the dept remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

Indigent Patients, CMS Pub. 15-I Section 312:

- Clinics can claim bad debt without waiting the 120-day collection period.
- Determination of indigence must be documented in the patient's file.
- Beneficiary considered indigent if eligible for Medicaid.
- Provider must determine that no other source is legally responsible for payment.

Documentation Required With Cost Report:

- Beneficiary name and HIC number.
- Date(s) of service.
- Date of first bill sent to patient.
- Medicare paid date (R/A).
- Write-off date.
- Separation of deductible and coinsurance amounts.
- Medicaid payment and paid date (if any).

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Resources

CMS Online Manuals

- Pub 100-4, Chapter 3, Section 30
Inpatient Part A Hospital Manual
- Pub 100-4, Chapter 4, Section 250
Part B Hospital (including Inpatient Hospital Part B and OPPTS)
- Pub 100-4, Chapter 6, Section 20
SNF Inpatient Part A Billing
- Pub 100-4, Chapter 9 – RHC/FQHC Manual
- Pub 100-4, Chapter 16, Sections 30.3 & 40.3.1
Laboratory Services from Independent Labs, Physicians & Providers

Other

- Medicare Prescription Drug Improvement & Modernization Act of 2003
- Medicare Improvements for Patients and Providers Act of 2008
- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, January 2005 (a PDF file at www.cms.hhs.gov/medlearn/psguid.pdf)
- United Government Services CAH Training Manual (available in PDF at www.ugsmedicare.com/Training.htm)
- Noridian Administrative Services LLC www.noridianmedicare.com

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Questions

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