

Medicare Rural Health Clinic Information 2013

Info applies only to Medicare unless otherwise indicated

HHS resource links

ORHP & related

RHC Technical Assistance Series Archive - <http://www.hrsa.gov/ruralhealth/policy/confcall/>

Starting a Rural Health Clinic - A How-To Manual - <http://www.hrsa.gov/ruralhealth/pdf/rhcmanual1.pdf>

Comparison of the RHC and FQHC Programs - <http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf>

Rural Assistance Center RHC page - <http://www.raconline.org/topics/clinics/rhc.php>

CMS

RHC Center - <http://www.cms.gov/center/rural.asp>

RHC Fact Sheet - <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinctshst.pdf>

RHC Certification and Compliance - http://www.cms.gov/CertificationandCompliance/18_RHCs.asp

RHC Claim Processing Manual - <http://www.cms.gov/manuals/downloads/clm104c09.pdf>

RHC Benefit Policy Manual - <http://www.cms.gov/manuals/Downloads/bp102c13.pdf>

FI/MAC Info - <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>

Medicare Advantage guide - <https://www.cms.gov/MedicareAdvgtgSpecRateStats/downloads/oon-payments.pdf>

State Survey Agency contacts - http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/State_Agency_Contacts.pdf

History

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare beneficiaries in rural areas and to increase the utilization of non-physician practitioners such as NPs and PAs in rural areas. There are approximately 4,000 RHCs nationwide (January 2013).

Location Requirements

To be certified as an RHC, at the time of survey a clinic must be located in a Census-designated, non-urbanized area and in a shortage area (geographic or population HPSA, MUA [not MUP], or governor-designated). The shortage area must have been designated or renewed within the previous four years (through the end of the calendar year in which it expires).^{*} The Balanced Budget Act of 1997 amended the RHC statute to authorize CMS to decertify RHCs that no longer meet the location requirements, but only after adopting regulations that create an exemption for RHCs determined to be “essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic.” CMS hasn't finalized such regulations, so all RHCs are, in effect, grandfathered into the program. However, if an RHC relocates, the new address must meet all location and compliance requirements to maintain certification.

If an RHC is certified as the result of a MUA or governor-designated shortage area, it may seek a facility HPSA designation from HRSA, which facilitates participation in the National Health Service Corps (NHSC). For more information, visit:

<http://bhpr.hrsa.gov/shortage/hpsas/ruralhealthhpsa.html>

Rural/Non-urbanized Area: To determine whether a clinic location is non-urbanized, use one of these web-based tools:

⇒ RAC – Am I Rural? (Census non-urbanized status) - <http://ims2.missouri.edu/rac/amirural/default.asp>

⇒ 2010 Census ‘rural’ search - <http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=addr&refresh=t>

Note: If no “urbanized area” result is included in the Geographies search result list, the address is rural for RHC certification purposes. It will not actually include a “rural” entry on the list. Rural includes urban clusters.

For more information about Census rural and urban classifications, visit the 2010 Census Urban and Rural Classification page at:

<http://www.census.gov/geo/www/ua/2010urbanruralclass.html>

Shortage Area: To determine whether a clinic location is in a qualifying shortage area, use the *HRSA Find A Shortage Area* tool located at: <http://bhpr.hrsa.gov/shortage/shortageareas/index.html>

*The regulations state three years. The requirement was amended in statute, but CMS has not updated the regulations.

Part A vs. Part B

RHCs submit claims to a Part A FI/MAC, so they are often referred to as Part A providers; however, they are paid from the Part B trust fund. Beneficiaries must have Part B coverage at the time of service in order to be reimbursed.

Enrollment

In order to bill Medicare for services provided to a beneficiary, a facility or clinician must:

- 1) obtain a National Provider Identifier (NPI) via the National Plan & Provider Enumeration System (NPPES), then
- 2) enroll using the appropriate CMS-855 form via the Provider, Enrollment, Chain and Ownership System (PECOS).

There are two types of NPI: Type 1 (individual) and Type 2 (organization). RHCs bill Medicare under a clinic Type 2 NPI. Clinicians and facilities submit CMS-855 enrollment forms through PECOS according to their situation:

- 855A is for facilities such as RHCs
- 855I is for individual clinicians for Part B services
- 855B is a group practice form
- 855R is used to reassign billing privileges
- 855O is an individual form for clinicians who do not bill Medicare Part B, but need to order and refer.*

An RHC typically enrolls twice:

- an 855A to receive a CMS Certification Number (CCN; formerly the Medicare/Medicaid Provider Number or OSCAR Provider Number), which facilitates RHC claims; and
- an 855B to receive a Provider Transaction Access Number (PTAN; frequently called the "legacy provider ID number" or "Medicare PIN"), which facilitates claims for non-RHC services (e.g., labs and diagnostic tests).

An RHC clinician also typically completes two forms:

- an 855I to receive a PTAN; and
- an 855R to reassign billing privileges established via the 855I enrollment to the RHC 855B group entity to facilitate non-RHC claims.

RHC clinicians do not need to reassign benefits to the RHC (855A).

NOTE: Medicare is working to revise and simplify all of the 855 enrollment forms by the end of 2013.

*Section 6405 of the Affordable Care Act requires that all clinicians who refer beneficiaries to other providers or order services (lab, home health, DME, etc.) be enrolled. Medicare will not compensate providers for referrals or services ordered by a non-enrolled clinician. Because RHC clinicians generally require billing privileges for non-RHC services, the 855O is typically not an option.

CMS Certification Numbers (CCNs)

The CCN is a six-digit number used to verify Medicare/Medicaid certification for survey and certification, assessment-related activities, and communications. The first two digits indicate the state in which the provider is located. The last 4 digits identify the type of facility.

- | | |
|-------------------------|---------------------------------------|
| 3800-3974 and 8900-8999 | Rural Health Clinics (Free-Standing) |
| 3975-3999 and 8500-8899 | Rural Health Clinics (Provider-Based) |

Clinic Types

RHCs are either independent (aka free-standing) or provider-based (mostly hospital-owned, but also nursing homes or home health agencies). Hospitals can own and operate provider-based and/or independent RHCs. Provider-based RHCs

must be financially and operationally integrated units of the parent entity. There are proximity restrictions (35 miles) for provider-based RHCs, except for those of CAHs and rural (non-MSA) hospitals with fewer than 50 beds.

RHCs can be gender and age specific (e.g., pediatric-only, adult-only, or OB-Gyn) as long as the majority of care provided is primary care.

RHCs can be public, nonprofit, or for-profit.

Practitioners

Recognized RHC practitioners include a physician (MD, DO, some DC and DPM, etc.), PA, NP, CNM, CP, and CSW. Practitioners may only provide services covered by Medicare (some specialists are limited in the services they may provide). CPs and CSWs must have specific education, licensing, and experience.

An RHC must employ at least one NP or PA. An NP, PA, and/or CNM must work at least 50% of the scheduled operating hours.* If a clinic has been unable to meet either of these staffing requirements for 90 days, it can seek a waiver for up to one year. The RHC must have actively sought to fill the vacancy, and must continue to do so if a waiver is issued. To seek a waiver, an RHC must contact the [state survey and certification agency](#).

All personnel included on the cost report – except physicians – must be employed by the RHC, not under contract.

RHCs are permitted to host non-RHC practitioners, such as specialists. The RHC must “carve out” (deduct) the value of facility and staff expenses provided the outside practitioner on its cost report.

*RHC regulations state 60%. The requirement was amended in statute, but CMS has not updated the regulations.

Productivity Standards

RHC practitioners are required to achieve a minimum level of productivity each year, which is implemented via annual cost report reconciliation. At reconciliation, total reasonable costs are divided by the greater of the number of actual RHC visits or the minimum productivity standards, resulting in the clinic’s effective all-inclusive reimbursement rate.

Physician: 4,200 visits per year, per FTE

PA/NP/CNM: 2,100 visits per year, per FTE

RHC Hours

RHCs are permitted to have non-RHC hours, during which practitioners bill Part B for services provided to Medicare beneficiaries. However, clinics must be “primarily engaged” in delivering RHC services (which CMS has interpreted to mean at least 51% of total hours of operation). In addition, it is against Medicare regulations to “cherry pick” – i.e., to schedule beneficiary appointments during non-RHC hours for procedures with high fee schedule reimbursement (e.g., AWV, colonoscopy). It is also a violation of commingling principles to bill Part B physician services during RHC hours, because all clinic costs are included in the all-inclusive rate.

Patient Visit/Encounter

In order for a service to be billable, it must be a face-to-face encounter for a medically necessary service that is covered by Medicare and that requires the level of clinical knowledge and expertise of the RHC professional to perform. (Blood draws, blood pressure, prescription renewal, injection, suture removal, dressing change, reporting normal test results, etc., don’t qualify. Exam and/or medical decision making is required. Patient chart documentation must support the claim.)

An RHC is limited to one billable encounter per patient per day, regardless of the number of providers seen or conditions addressed, except when a patient:

- suffers an unrelated illness or injury after the first visit;
- has a medical visit and a separate mental health visit with a CP or CSW;
- has an IPPE visit (Welcome to Medicare) and a separate medical and/or mental health visit

A Medicare Annual Wellness Visit can be billed as an encounter if it is the only medical service provided; however, if it furnished on the same day as a medical visit, it is not separately billable. It can be billed separately from a mental health visit.

Effective January 1, 2013, CMS implemented two fee schedule transitional care management CPT codes related to post-discharge (acute, LTC, CMHC, etc.) care coordination services for beneficiaries. RHCs do not bill CPT codes; however, because the codes include a face-to-face visit and clinical decision making, CMS has determined that RHCs may bill an encounter for these services (as long as it is not covered under a global billing code).

All-Inclusive Rate and Payment Cap

Payment for covered RHC services furnished to Medicare patients is made by means of an all-inclusive rate for each visit. Other services such as labs and the technical components of diagnostic tests are the same as for similar services provided under Part A or Part B.

The RHC payment rate is calculated, in general, by dividing total allowable costs by the number of total visits for RHC services. At the end of its reporting period, an RHC submits a cost report to its designated Medicare Administrative Contractor (MAC), which reconciles total allowable costs with payments made to the RHC, subject to productivity standards, screening guidelines, and – if applicable – an upper payment limit. A lump sum payment is made to, or repayment is made by, the RHC.

Provider-based RHCs of hospitals with <50 beds* are not subject to a per visit payment limit. In addition, a provider-based RHC of a sole community hospital is exempt from the payment limit if the hospital has an average daily census <=40 and it is located in an Urban Influence Code 8-level or 9-level nonmetropolitan county.

From 1977 to 1986, Congress set the payment cap. The OBRA of 1987 amended SSA Sec. 1833(f)(2) and established a cap that is adjusted annually to reflect changes in the Medicare Economic Index. The 2013 payment limit is \$79.17. Unlike Part B fee schedule claims, the RHC is paid the same amount regardless of which provider sees the patient.

*The definition in 42 CFR 412.105(b) is used to determine the number of beds for the current cost reporting period.

(Medicare Claims Processing Manual, Chapter 9 -- 20.6.3 - Exceptions to Maximum Payment Limit (Cap) in Encounter Payment Rate for Provider-Based RHCs)

RHC vs. FQHC Reimbursement

FQHCs are required under PHS Act Sec. 330 to provide certain services, but Medicare-covered FQHC services are similar to RHC services. (The primary difference is FQHC preventive services benefits.) The 2013 rural FQHC limit is \$110.78 and the urban limit is \$128.00 (FQHCs in CBSAs qualify for urban status). In 1992, the FQHC payment cap was established using a RBRVS payment methodology that placed a greater value on primary care services than the old system and resulted in a higher cap for rural FQHCs than for RHCs (~28%). The original FQHC rate was based partially on RHC data that was adjusted significantly based on available data from Federally Funded Health Centers (FFHCs). The RHC costs for those core services was then adjusted upwards for the higher percentage of visits conducted by physicians at FFHCs, the 15% payment increase for family practice physicians as a result of transition to the Physician Fee Schedule, an urban increase of 16.3% based on FFHC experience, and the aforementioned preventive services based on FFHC costs. CMS estimated that the additional cost of providing FQHC services per visit was \$2.60 in rural areas and \$3.02 in urban areas.

More recently, the Affordable Care Act directed CMS to establish a Medicare PPS for FQHCs beginning in 2014.

For additional information comparing RHCs and FQHCs:

⇒ Comparison of the RHC and FQHC Programs - <http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf>

⇒ Comparison of RHC and FQHC Program Provisions (2009 CMS presentation) - http://www.trha.org/Conference_2009/Presentations/10%20Access%20to%20Care%20Models%20-%20A%20Comparison%20of%20RHCs%20and%20FQHCs%20-.pdf

Beneficiary Deductible and Coinsurance/Co-pay

A beneficiary is responsible for the Part B deductible (\$147 in 2013) and coinsurance. CMS pays 80% of the all-inclusive rate. Coinsurance is 20% of reasonable and customary charges, not of the all-inclusive rate. (For comparison, an established patient visit of moderate to high complexity – CPT Codes 99213-15 – results in total payment above the cap.)

When a beneficiary hasn't met the deductible, if the amount of charges exceeds the all-inclusive rate, Medicare expects the RHC to collect the full charges up to the deductible amount and any applicable coinsurance from the patient. Medicare then requires the RHC to remit the excess charges above the all-inclusive rate.

Certain preventive services (Welcome to Medicare, AWV) are not subject to a deductible or coinsurance and Medicare pays the full RHC rate. However, RHCs must separately track and report the charges related to these services. A practice management system should be able to track and report Medicare preventive services CPT codes to complete the cost report. [Note: AWV is NOT a physical. The only physical covered by Medicare is the Welcome to Medicare visit.]

Claims Detail

RHCs submit claims on a UB-04 (CMS 1450) form. Non-RHC, Part B claims (e.g., labs and diagnostic tests) are submitted on a CMS 1500 form. (CMS was previously called HCFA, so the forms are also known as a HCFA 1500 and 1450.) The clinic NPI (type 2) is required on each claim, as is the NPI of the practitioner (type 1) who actually provided the care (the "rendering provider"). The PTAN is not included on either claim (though the MAC/FI crosswalks the NPI to the PTAN).

RHCs are only required to submit detailed HCPCS codes for preventive services with a U.S. Preventive Services Task Force grade of A or B in order to waive coinsurance and deductible. (See CMS Change Request 7208, transmittal 2122). This includes the Welcome to Medicare and Annual Wellness Visit exams.

RHC Bill Types (UB-04 claim form, 71X)

- 710 – Claim with only non-covered charges
- 711 – *Original claim* [typical]
- 715 – Late charge – adjustment to prior claim
- 717 – Replacement claim – adjustment to prior claim
- 718 – Void/cancel previous claim

Revenue codes

- 0521 – Clinic visit by member to RHC
- 0522 – Home visit by RHC practitioner
- 0524 – Visit by RHC practitioner to member in covered Part A stay at SNF
- 0525 – Visit by RHC practitioner to member in SNF (no Part A stay) or NF or ICF or other residential facility
- 0527 – RHC Visiting Nurse Service(s) to member's home when in home health shortage area
- 0528 – Visit by RHC practitioner to other non-RHC site (e.g., scene of accident)
- 0780 – Telehealth originating site (include appropriate HCPCS code and Q3014 modifier)
- 0900 – Psychological services

NP/PA/CNM Billing

Some RHCs use the physician medical director NPI as the rendering provider on all RHC claims (UB-04), which facilitates payment on Medicare secondary payer claims when dealing with a commercial insurer that may not recognize PAs or NPs. However, clinics that do not accurately report which practitioner provided the service are non-compliant. In addition, there could be a productivity issue as claims data would underreport PA or NP visits and overstate those of the physician. It creates a conflict between the cost report and what can be verified on claims data.

Not all commercial insurers recognize PAs or NPs, or they have specific supervision/collaboration requirements that must be met as a condition for payment, despite the fact that the service was provided in accordance with state law/regulation.

Some commercial insurers only want the physician identified on the claim form, while others require the identity of the providing PA or NP. This complicates claims when the patient has two types of insurance coverage.

Lab/Diagnostic Services

RHCs are required to “directly furnish routine diagnostic and laboratory services” and to “furnish onsite all of the following six laboratory tests”: urine (by stick and/or tablet); hemoglobin or hematocrit; blood sugar; stool specimen (for occult blood); pregnancy; and primary culturing for transmittal to a lab. CMS interprets this to mean that RHCs must be able to perform all of these tests, but may have the labs drawn elsewhere (e.g., provider-based RHC may use hospital lab).

RHCs bill Part B separately for the technical components of diagnostic tests, labs, and venipunctures, as well as DME products (to the DME MAC). They are not bundled with the all-inclusive rate (since January 1, 2001), including the six required tests. There is no Medicare co-pay for labs.

- For independent RHCs, the technical component of any diagnostic service is billed using the clinic’s NPI, as well as that of the rendering provider.
- For provider-based RHCs, the technical component is billed under the hospital outpatient provider number on the 851 Type of Bill to the hospital’s MAC. A CAH can have only one 851 TOB submitted for each date of service, so the RHC services must be billed at the same time if the CAH has services on the same day. Many PB-RHCs have the CAH do the billing so all are on the claim at the same time.
- For all RHCs, the professional components are bundled with the face-to-face encounter.

RHCs must have the appropriate CLIA certification for tests being performed. While many tests are waived, some kits are marked for moderate complexity laboratories. For example, if practitioners are doing microscopy, the RHC should have at least a Provider-Performed Microscopy certificate. Most simple chemistry tests are available as waived, but some are not. Having a moderate complexity lab requires participation in a proficiency program.

ICD-10/5010 Issues

Small provider ICD-10 info: <http://www.cms.gov/Medicare/Coding/ICD10/ICD-10ImplementationTimelines.html>

5010 requirements for RHC billing: *(per Janet Lytton, 01/24/12)*

- FL 14 Type = 1 Emergency; 2 Urgent; 3 Elective; 4 newborn; 5 trauma center; 9 unavailable. *RHC typically uses 2 or 3.*
- FL 15 Source = 1 non-healthcare point of origin; 5 transfer from ICF, SNF or ALF; 9 info not available. *RHC usually uses 1.*
- FL 17 Status = 01 discharged to home or self-care (routine discharge); 02 discharged to hospital; 03 discharged to a SNF; 04 discharged to a facility with custodial care. *RHC typically uses 01.*
- No admission date is required, only the statement covers dates.
- Each claim must have FL 52 REL. INFO (release of information) and FL 53 ASG.BEN (assignment of benefits) marked. *RHC typically responds Y (yes) and Y (yes).*
- Claims are paid based on the NPI # (FL 56).
- FL 70 Patient reason for visit – diagnosis code
- The taxonomy code for the RHC listed in FL 81CC is code B3 (in first small box) 261QR1300X (matches 855A).
- The Name of the Facility with the correct 9 digit zip code, the Tax ID, the NPI and the taxonomy code MUST match exactly or it will error out and not pass edits.
- The claim does not require a HCPCS Code unless it is a preventive service with no co-pay or deductible. If there is a visit and a preventive service, there must be two line items on the claim, each with 521 revenue code, so Medicare does not apply the co-pay or deductible to the preventive service. The clinic will receive the normal RHC rate; however, when the cost report is completed, the preventive charges are shown and the co-pays will be added to the clinic settlement.

RHC Charges

Guidance for setting a schedule of RHC charges: Fee schedules can be obtained from various carriers' (Medicare part B, Medicaid, commercial) websites. Create a table showing the CPT and description down the left side and the various carriers along the top. Enter the fees from the carriers into the table and set the recommended fee based on the highest payer (round up). It isn't advisable to set charges solely based on the Medicare schedule.

		Current Fee	Medicare	Medicaid	Insurance 1	Insurance 2	Recommended Fee
CPT Code	Description						

All patients must be charged the same amount for services, though what the RHC collects can vary based on policies such as cash and same day payment discounts, sliding fee schedule, etc.

Medicare Bad Debt

Any co-insurance or deductible amount not paid by the beneficiary, supplemental insurance, or Medicaid is considered Medicare bad debt and can be claimed on the cost report for reimbursement, assuming the required collection efforts are performed. Bad debt is reimbursed in addition to the AIR and is not subject to the payment cap, if relevant. However, all patients must be treated the same, regardless of payer. Collections must include genuine efforts, including multiple letters, and bad debt generally cannot be written off less than 120 days following a visit or payment on account. If the beneficiary is a dual-eligible, the debt can be written off immediately. As a result of the Middle Class Tax Relief and Job Creation Act of 2012, the allowable bad debt claimed by RHCs will decrease over three years to 65%.

Physician Supervision of PAs/NPs

Every RHC must be "under the medical direction of a physician," [42 CFR 491.7(a)(1)] but the physician's level of direct patient care may be very limited. CMS has not established a minimum amount of time for physician on-site availability. The arrangement must comply with state law (scope of practice) and provide for at least one onsite visit by the physician every two weeks* (except in extraordinary circumstances). The physician must be an MD or DO.

**CMS issued a NPRM on 02/04/13 proposing to eliminate the two week requirement.*

RHC Interpretive Guidelines

Physician Responsibilities.--Ascertain through written documentation, such as dates and signatures, that the physician staff member satisfactorily meets the requirement of periodically reviewing the clinic's patient records, provides medical orders, and provides medical care services to the patients.

A physician is required to be present in the clinic for sufficient periods of time to perform the duties and responsibilities described in 42 CFR 491.8(b)(i), (ii), and (iii). The term "sufficient periods of time" requires relative evaluations. There are a number of elements to consider in weighing what would constitute a reasonable time sufficient to discharge the physician's responsibilities. These elements include: patient case load and mix (type), number of patient care records which must be reviewed in order to establish a good overview for adherence to policies and principles of quality patient care, number of patient care records which require review and discussion of specific health problems and regimens of therapy; need for consultative time with other members of the clinic's staff; need for revision to the clinic's patient care guidelines; and need for time to provide medical care to patients.

Time required to accomplish these activities will fluctuate. Thus, the "sufficient time" the physician must spend in the clinic will vary. The survey should verify the time spent in the clinic by the physician for consulting records, etc. Extraordinary circumstances which constitute exceptions to the requirement that the physician be present in the clinic at least once every two weeks for "sufficient time" to discharge the physician's responsibilities are primarily nonrecurring circumstances beyond the control of the physician and which postpone (not cancel) the visit. These circumstances include illness, extreme weather or driving conditions of short duration, or those emergencies which occur in the physician's practice and require his presence elsewhere. When nonrecurring circumstances cause postponement of the physician's visit, they should be documented in the clinic's records.

PQRS and eRx Incentives

RHC claims are not fee schedule claims, so they are ineligible for PQRS and e-prescribing (e-Rx) incentives and are not subject to payment adjustments (penalties). However, if RHC clinicians submit Part B claims for non-RHC services that include certain CPT codes, they could be subject to the penalties. The codes are primarily ambulatory E&M codes; hospital service codes are not included. RHC clinicians may be eligible to apply for an [eRx significant hardship exemption](#).

Note: When PQRS (then PQRI) was established, the incentive payment was adopted in lieu of an inflationary adjustment for Part B services. RHCs, by comparison, received an inflationary increase that year that was higher than the amount of the incentive payment.

EHR Meaningful Use Incentives

Because RHC physicians do not submit Part B fee schedule claims, they are generally ineligible for [Medicare EHR incentive program](#) payments and not subject to payment adjustments (penalties). However, physicians working in RHCs may qualify, if they have sufficient fee schedule billing outside the RHC setting.

Eligible professionals (EPs) working in an RHC are eligible for [Medicaid EHR incentive program](#) payments up to \$63,750 over 6 years if they meet the needy patient threshold requirement. RHC EPs include physicians, NPs, and CNMs; PAs are also eligible if their RHC is PA-led (i.e., if the PA is an owner, the clinical or medical director, or the primary provider -- e.g., part-time physician and full-time PA). During the first year, EPs can get payments for "adoption, implementation or upgrading" of a certified EHR. For years 2-6, they must meet the applicable meaningful use criteria.

To meet the needy patient threshold, during any continuous 90-day period within the calendar year prior to reporting, either 30% of the aggregate RHC visits (encounters) or 30% of the EP's visits must be with needy patients. A needy patient is one who is covered by Medicaid (incl. dual eligibles) or CHIP, or is furnished uncompensated care or care at reduced or no cost based on a sliding fee scale. [RHCs may need to demonstrate the appropriateness of using the aggregate clinic visits method. If an EP never sees needy patients, CMS could deny the EHR incentive payment for him/her.]

HIPAA

In January 2013, the HHS issued revised HIPAA privacy standards. Several changes were made to ensure privacy of Protected Health Information (PHI). The final rule: <http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>

RHC Visits at Nursing Homes/SNFs/Swing Beds

Nursing home, skilled nursing facility, and swing bed visits are all RHC visits. If the patient is on a Medicare Part A stay in the SNF or swing bed, the revenue code is 524; if the patient is a resident of a nursing home and/or not on a Medicare Part A stay, the code is 525. The nursing home CPT codes (99304-99309) can be used, but they do not show on a claim, only the revenue code and the unit of 1 and the total charges. [In addition to the CPT codes, place of service code 31 is used. The name and NPI of the nursing home must also be included.]

Hospital Visits

Hospital admits, ER, OBs, and any hospital OP professional services are billed to Medicare Part B on the 1500. The only service in the hospital setting that is billed as an RHC visit is a swing bed visit.

Home Health Eligibility Certification

The Affordable Care Act mandates that, before a physician (MD, DO, or DPM) certifies a patient's eligibility for the home health benefit, an eligible practitioner (physician, NP, PA, CNM, CNS) must have a face-to-face encounter with the patient. (See [MLM SE1038](#), 12/16/10) Home health certifications are RHC services; however, certification alone may not meet the medical necessity requirement for an RHC encounter. Specific documentation of medical necessity is required.

RHC Visiting Nurse Services

RHCs may request approval to provide visiting nurse services to patients in areas where a home health agency shortage has been determined to exist. The determination process (as of early 2012) is not clearly defined or uniform across CMS regions. The following is excerpted from the State Operations Manual:

2246 - Clinic's Request to Provide Visiting Nurse Services (Rev. 1, 05-21-04) An approved RHC may also seek approval to provide covered visiting nurse services. An RN, LPN, or licensed vocational nurse must furnish these services.

When a request is received, the SA determines if a shortage of HHAs exists in the area. Refer to 42 CFR Part 405.2417 and consults with the RO, as appropriate. If there is an existing HHA furnishing services in the RHC area, the SA contacts the HHA for a statement of its ability or inability to adequately furnish nursing services in the area. In addition, the SA obtains information from the local or State health planning organization.

If there is not a shortage of home health services for the area, the SA notifies the RO. In such cases, approval to furnish visiting nursing services to homebound patients will not be granted, and the RHC must refer its homebound patients to the HHA serving the area.

If there is a shortage of home health services, the SA notifies the RO and evaluates the qualifications of RHC personnel who are responsible for the delivery of nursing services. This evaluation must include compliance with applicable State licensure/certification requirements for RNs, LPNs, or licensed vocational nurses who provide services for the clinic.

Hospice Visits

If services rendered to a beneficiary who has elected the hospice benefit are not related to the terminal illness, the RHC may bill using condition code 07. An RHC practitioner cannot provide services related to the terminal illness while on duty at the RHC, even if s/he is the beneficiary's designated attending physician. S/he can provide and bill for Part B services during non-RHC hours or when not on duty at the RHC.

Telehealth/Telemedicine

An RHC is a recognized "originating" (patient) site and can bill Medicare for a telehealth site origination fee (Rev Code 0780 and CPT code Q3014), which is \$24.43 in 2013. The telehealth visit does not qualify as an RHC encounter, although the beneficiary can have an RHC-billable encounter on the same day for another purpose.

An RHC cannot bill Medicare as a "distant" (specialist) site during RHC hours. This is because an RHC is not an authorized physician or practitioner under the telehealth statute, and an RHC is not permitted to bill Part B fee-for-service during RHC hours (except diagnostic tests).

Medicaid policy on telehealth varies from state-to-state. Contact the state Medicaid agency to see whether telemedicine is covered and certain health professionals are recognized telehealth providers. *Medicare staff has indicated that the distance site prohibition extends to Medicaid, though Medicaid staff disagrees.*

Injections/Vaccines

Administration of influenza and pneumonia vaccinations does not constitute a billable RHC encounter; however, Medicare fully reimburses RHCs for their administration as part of year-end cost report reconciliation. RHCs report the cost of the vaccine, personnel (incl. nursing), and other administrative and ancillary costs on supplemental worksheet B, entitled, "Computation of Pneumococcal and Influenza Vaccine Cost". These costs are not subject to the RHC payment cap.

If any other injection is given to a Medicare patient, but it is not performed during a medically-necessary face-to-face encounter, it is not billable. Charge the patient's account, then write it off as a non-billable service. If performed during an encounter, charge for injection administration and the serum and bundle those charges in with the other charges for the encounter. Medicare reimbursement will not increase, but patient co-pay will, since it is based on 20% of the total charges for the encounter. Never bill Part B for injections given in the RHC during RHC hours of operation.

Alternately, using the "30-30" process, attach the non-billable charge to an encounter that occurred within 30 days (before or after, thus 30-30) of the non-billable injection. This can be cumbersome and delay claims processing, and may result in timely filing issues (if forgotten). The only impact is the additional 20% of charges, so the process of holding claims or going back to attach charges may not be worthwhile.

Part D vaccine administration is bundled into that D benefit and is not chargeable to the RHC cost report. For Part D billing, visit www.mytrnsactrx.com.

Mental Health Services

Only a PhD level Clinical Psychologist, Masters Level Clinical Social Worker, or an MD, DO, NP, or PA within his/her scope of practice may provide RHC mental health encounters. Counselors may not, even though they may be recognized and licensed by the state.

The mental health payment differential is being [phased out over a five year period](#). Medicare payment to a clinic is reduced by a percentage of the usual charge, which is then billed to the beneficiary as additional coinsurance. The limitation will change as follows: 2013=81.25%; and 2014 and onward=100%.

Interim Payment Rate for New RHCs

Chapter 9, Section 20.2 of the CMS Claims Processing Manual states: "If the RHC/FQHC is in the initial reporting period, the all-inclusive rate is determined on the basis of a budget the RHC/FQHC submits. The budget estimates the allowable cost to be incurred by the RHC/FQHC during the reporting period and the number of visits for RHC/FQHC services expected during the reporting period. RHCs/FQHCs supply this information using Form CMS-222-92. In determining the payment rate for new RHCs/FQHCs and for those who have submitted cost reports, the FI applies screening guidelines and the maximum payment per visit limitation as described in §20.4." The payment limit is not used to set the initial rate.

Non-RHC Services/Comingling Prohibition

Offering non-RHC services inside the four walls of an RHC is permissible, but comingling must not occur (i.e., operating a Part B practice and RHC simultaneously, which can lead to billing according to highest reimbursement and/or receiving duplicate payment by including expenses on the cost report that are also factored into fee schedule payments).

RHCs may host other providers (e.g., specialists) who deliver non-RHC services and bill independently for their services. In such cases, issues that must be addressed include whether the provider's services are supported by RHC staff (admin, clinical) and the value of the space utilized (market rent or overhead costs). Because the RHC is paid on a cost basis, the value of support staff, office space, etc., utilized by the outside provider must be carved out on the cost report to avoid duplicate payment.

Sliding Fee Schedule/National Health Service Corps

RHCs are not required to have a sliding fee schedule as a condition for certification under Medicare.

RHCs located in HPSAs are eligible to become a [National Health Service Corps site](#). Approved sites are required to have a sliding fee scale (based on documented income); accept Medicare, Medicaid, and CHIP patients; and see all patients regardless of ability to pay, among other requirements. (Note: Refusal to pay is not the same as unable to pay.) In return, RHCs may recruit clinicians who are eligible for NHSC loan repayment or scholarships.

Medicare Advantage Participation

When a beneficiary enrolls in a Medicare Advantage (MA) plan, they are no longer classified as a Medicare patient for cost reporting purposes. These individuals are effectively treated as privately insured individuals.

MA plans must show that they have an "adequate" provider network in each market they serve. In an underserved area, it may be difficult for the MA plan to meet the market adequacy requirement if an existing RHC is not part of the network.

If an RHC is a contracted provider within a MA network, the RHC is obligated to follow whatever is established in the contract. Payment could be cost-based, fee-for-service, or even capitation.

Non-network providers are able to see patients enrolled in MA plans, but the terms and conditions for payment vary by type of plan (fee schedule, capitation, enhanced fee-for-service, etc.). The most common MA plan in rural communities is private fee-for-service (PFFS). Under this type of arrangement, the MA plan is required to pay the RHC its all-inclusive rate. However, the billing format is up to the plan.

Flu and pneumonia vaccines administered to MA patients are not captured on the RHC cost report. Reimbursement should come through the MA plan.

Affiliated RHCs

Each RHC must be individually certified by CMS and must submit claims using its own clinic NPI. However, commonly owned RHCs may submit a unified cost report.

Change of Ownership (CHOW)

When an RHC is sold, the seller is required to submit a Form CMS-855A or CMS-855B citing the termination of current ownership. *A CMS-29 is not required.* Two options are available to the new owner:

1) Accept assignment of the Medicare provider agreement, wherein the agreement, financial obligation, CCN, etc., transfer to the new owner. If the RHC no longer meets the location requirements, the grandfather status transfers to the new owner. However, if the RHC relocates as part of the CHOW, the grandfather status is forfeited and the new owner must complete a CMS-29 to help determine whether the location and staffing requirements are met at the new location. A survey is not automatically required; however, based on the information received, the CMS Regional Office may determine a resurvey is warranted.

If the RHC also changes between independent and provider-based, the existing provider number (CCN) will be retired and a new one issued (which doesn't affect grandfathering). A change in CCN will disrupt claims, and the encounter rate may change. The new owner may also continue the existing cost reporting cycle or initiate a new one.

2) Reject assignment of the agreement, wherein the provider agreement, financial obligation, CCN, etc., are terminated, the location grandfather status is forfeited, and the facility must submit a new RHC certification application.

A CHOW must also be reported to the state Medicaid office, which may have its own procedures.

Further, all patients will be considered new patients for the purpose of consent, release, HIPAA, etc., forms, but not for the purpose of charging as a new patient, assuming the same providers are seeing the patients.

Translation/Interpreter Services

As part of the certification process, RHCs must complete [OMB Form 0990-0243](#), *Civil Rights Information Request*, and receive a civil rights clearance from the HHS Office for Civil Rights. The form includes certification of a nondiscrimination policy and requires provision for services to LEP and hearing impaired individuals (Section II, items 2, 7 & 8).

Medicaid RHC Information

Reimbursement

State Medicaid programs must recognize RHC services and may reimburse RHCs through one of two methods. The first method is a prospective payment system (PPS), which was created by the Benefits Improvement and Protection Act of 2000 (BIPA) to replace the cost-based reimbursement method. Under PPS, the state determines a per visit rate based on 100 percent of the reasonable costs from the first two fiscal years of operation. Once this is determined, the baseline is increased for each year by the Medicare Economic Index factor. A second reimbursement method option is Alternative Payment. This system varies by state, but requires that the clinic agree to the methodology and that the payment be at least equal to the payment under PPS. States may also choose to cover additional ambulatory services and dental care.

Managed Care

States are required to make wrap-around payments to RHCs when the Medicaid managed care rates are less than what the RHCs would have received under regular Medicaid. The managed care plan cannot offer RHCs payment rates less than what they offer other clinics (some might do so knowing the state must make the clinic "whole" due to wrap-around).

In general, the Medicaid wrap-around payments are based upon the total amount received from the managed care plan during each quarter. If the RHC got less from the plan than they would have under traditional Medicaid, the state makes a wrap-around payment to cover the difference. If the plan paid the same as or more than what the RHC would have received, no wrap-around payment is necessary.