Rural Health Clinic: Topics in Billing, Cost Reporting & Reimbursement



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Some Things Old . . . Some Things New

- RHC Billing – CMS Charts
- Billing for Pneumococcal, and Influenza (including H1N1) Vaccines
- 2010 RHC Maximum Rates
- Requesting Medicare Provider Statistical & Reimbursement Reports
- Provider Visits and Productivity Standards
- Medicare Bad Debts
- Wisconsin Medicaid Overhead Limitation

Medicare Billing Information Chart for Rural Providers

Download at on CMS website at:

http://www.cms.hhs.gov/OpenDoorForums/24_ODF_RuralHealth.asp

QUICK REFERENCE RURAL BILLING CHARTS

	Ambulance Services	Office Visits**	Hospital Services	Radiology & Diagnostics	Clinical Lab Tests	Supplies & Drugs	PREVENTIVE SERVICES: Screening Mammography Services & Pelvic Screening Exams	PREVENTIVE SERVICES: Cardiovascular Screening, Diabetes Screening, & Screening Pap Tests	PREVENTIVE SERVICES: IPPEs	PREVENTIVE SERVICES: Influenza & PPVs	PREVENTIVE SERVICES: HBVs	PREVENTIVE SERVICES: Colorectal & Prostate Cancer Screenings & BMMs***	PREVENTIVE SERVICES: Glaucoma Screenings
RURAL HEALTH CLINIC	N/A	Bill FI or A/B MAC	N/A	**Provider based** Professional component Bill FI or A/B MAC Technical component Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Professional component Bill Carrier or A/B MAC Technical component Bill Carrier or A/B MAC using practitioner's ID number*	**Provider based** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Bill Carrier or A/B MAC using practitioner's ID number*	RHCs receive no additional payment; costs included in encounter rate	**Provider based** Professional component Bill FI or A/B MAC Technical component Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Professional component Bill FI or A/B MAC Technical component Bill Carrier or A/B MAC using practitioner's ID number*	**Provider based** Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Bill Carrier or A/B MAC using practitioner's ID number*	**Provider based** Professional component Bill FI or A/B MAC Technical component of EKGs Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Professional component Bill FI or A/B MAC Technical component of EKGs Bill Carrier using practitioner's ID number	Costs for vaccines included in cost report; no line items for vaccines are billed to FI or A/B MAC in addition to encounter	RHCs receive no additional payment; costs included in encounter rate	**Provider based** Professional component Bill FI or A/B MAC Technical component Bill FI or A/B MAC using base provider's ID number* **Non-provider based** Professional component Bill FI or A/B MAC Technical component Bill Carrier or A/B MAC using practitioner's ID number*	If & only if beneficiary has an otherwise covered encounter Bill FI or A/B MAC **All provider types** No separable technical component

*Generally, RHCs cannot bill for non-RHC services. Base provider or individual practitioner bills for such services using base provider or practitioner's ID number.

**RHC physicians and mid-level professionals may visit beneficiaries in a SNF and bill for the encounter.

***Screening colonoscopies are not covered when furnished in a RHC.

DETAILED RURAL BILLING CHARTS

RURAL HEALTH CLINIC		
TYPE OF SERVICE	**BILLING INFORMATION**	**CMS MANUAL REFERENCE**
Physician, PA, NP, CP, CSW, and CNM services Services and supplies (including drugs) incident to the services of a physician, PA, NP, CP, CSW, or CNM Visiting nurse services to the homebound in home health shortage areas	Generally, RHCs cannot bill for non-RHC services. Bill FI or A/B MAC servicing the RHC.	Medicare Claims Processing Manual Chapter 9 Medicare Benefit Policy Manual Chapter 13
PREVENTIVE SERVICES		
DSMT	Not separately billable by RHCs.	Medicare Claims Processing Manual Chapters 9 and 18 Medicare Benefit Policy Manual Chapters 13 and 15
MNT	Not separately billable by RHCs.	Medicare Claims Processing Manual Chapters 4 and 9
Screening mammography services Pelvic screening exams	Generally, RHCs cannot bill for non-RHC services. **PROVIDER BASED** – **Professional component** – Bill FI or A/B MAC servicing the RHC. **Technical component** – Base provider bills FI or A/B MAC servicing the base provider using base provider's ID number. **NON-PROVIDER BASED** – **Professional component** – Bill FI or A/B MAC servicing the RHC. **Technical component** – Individual practitioner bills their Carrier or A/B MAC using practitioner's ID number.	Medicare Claims Processing Manual Chapters 9 and 18 Medicare Benefit Policy Manual Chapter 13

DETAILED RURAL BILLING CHARTS

RURAL HEALTH CLINIC		
TYPE OF SERVICE	**BILLING INFORMATION**	**CMS MANUAL REFERENCE**
PREVENTIVE SERVICES		
Cardiovascular screening tests Diabetes screening tests Screening Pap tests	Generally, RHCs cannot bill for non-RHC services. **PROVIDER BASED** – Base provider bills FI or A/B MAC servicing the base provider using base provider's ID number for lab tests. **NON-PROVIDER BASED** – Individual practitioner bills their Carrier or A/B MAC using practitioner's ID number.	Medicare Claims Processing Manual Chapters 9 and 18
IPPEs – Effective January 1, 2007, AAA screenings for at risk beneficiaries are not included but may be furnished at same encounter	Generally, RHCs cannot bill for non-RHC services. **PROVIDER BASED** – **Professional component** – Bill FI or A/B MAC servicing the RHC. **Technical component of EKGs** – Base provider bills FI or A/B MAC servicing the base provider using base provider's ID number. **NON-PROVIDER BASED** – **Professional component** – Bill FI or A/B MAC servicing the RHC. **Technical component of EKGs** – Individual practitioner bills their Carrier or A/B MAC using practitioner's ID number.	Medicare Claims Processing Manual Chapters 9 and 18
Influenza and PPVs	Costs are included in the cost report. No line items are billed to FI or A/B MAC for either vaccination. Payment is made at cost settlement.	Medicare Claims Processing Manual Chapters 9 and 18
HBVs	RHCs receive no additional payment. Costs are included in the encounter rate.	Medicare Claims Processing Manual Chapters 9 and 18

DETAILED RURAL BILLING CHARTS

RURAL HEALTH CLINIC		
TYPE OF SERVICE	**BILLING INFORMATION**	**CMS MANUAL REFERENCE**
PREVENTIVE SERVICES		
Colorectal cancer screenings – Screening colonoscopies are not covered when furnished in a RHC Prostate cancer screenings BMMs	Generally, RHCs cannot bill for non-RHC services. **PROVIDER BASED** – **Professional component** – Bill FI or A/B MAC servicing the RHC. **Technical component** – Base provider bills FI or A/B MAC servicing the base provider using base provider's ID number. **NON-PROVIDER BASED** – **Professional component** – Bill FI or A/B MAC servicing the RHC. **Technical component** – Individual practitioner bills their Carrier or A/B MAC using their practitioner ID number.	Medicare Claims Processing Manual Chapters 9 and 18 Medicare Benefit Policy Manual Chapters 13 and 15
Glaucoma screenings	**If and only if the beneficiary has an otherwise covered encounter** – Bill FI or A/B MAC. **ALL PROVIDER TYPES** – No separable technical component.	Medicare Claims Processing Manual Chapters 9 and 18 Medicare Benefit Policy Manual Chapters 13 and 15
Smoking and tobacco-use cessation counseling services	Bill FI or A/B MAC servicing the RHC. Services furnished by a CNS are considered incident to and do not constitute a billable visit although they may be combined with a billable encounter.	Medicare Claims Processing Manual Chapter 32

Billing for Pneumococcal, and Influenza (including H1N1) Vaccines

Pneumococcal and flu (including H1N1) vaccines have "special" treatment for cost-based reimbursement.

Do not file claims for flu/PPV.

Requires maintaining a log with the patient's name, HIC number, and date of service. *Hint: Automate!*

Reported and paid separately on the RHC cost report.

Billing for Pneumococcal, and Influenza (including H1N1) Vaccines

Computation of Flu/PPV Costs

Data Required:

- Estimated time to give injection (usually 8-12 minutes)
- Total injections
- Medicare injections
- Direct supply costs (may be -0- for H1N1)
- Total health care staff hours
- Compute ratio of injection time to total health care time

2010 Medicare RHC Maximum Payment Rates

RHC Reimbursement Limits *

	2004	2005	2006	2007	2008	2009	2010
Maximum	$68.65	$70.78	$72.76	$74.29	$75.63	$76.84	$77.76
Increase	2.9%	3.1%	2.8%	2.8%	1.8%	1.6%	1.2%

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

Medicare Provider Statistical & Reimbursement

Provider Statistical & Reimbursement (PS&R) report is an essential component of cost report reconciliation. This report summarizes all paid claims. It was previously mailed to providers.

The PS&R Redesign System:

- Allows/requires users to download summary PS&R reports via the internet.
- All users must first establish an Individuals Authorized Access to CMS Computer Systems (IACS) account.
- Refer to *MLN Matters MM6519* on the CMS website.

Provider Visits and Productivity Standards

RHC visits are defined as medically necessary, face-to-face encounters with RHC practitioner.

VISITS AND PRODUCTIVITY						
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	Positions	1	2	3	4	5
1	Physicians	3.80	12,000	4,200	15,960	
2	Physician Assistants	0.90	5,200	2,100	1,890	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	4.70	17,200		17,850	17,850
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	4.70	17,200			17,850
9	Physician Services Under Agreements					

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Provider Visits and Productivity Standards

Productivity screens limit the actual visits to 17,850 "adjusted" visits.

If allowable costs were $1,290,000 then actual cost per visit = $1,290,000/17,200 = $75.00.

However, Medicare reimbursement would based on $1,290,000/17,850 = $72.27.

If Medicare is 40% of the visits, the actual loss per Medicare visit would be $75.00 - $72.27 = $2.73 x 40% x 17,200 = $18,782.

Provider Visits and Productivity Standards

Helpful Hints:

- Determine if your RHC is impacted by the productivity screens.

- If so, verify the provider FTE count and the visit statistics.

Medicare Bad Debts

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.

Medicare Bad Debts

Medicare bad debts are being disallowed if they are still being worked by a collection agency. Intermediaries are requesting a copy of the correspondence from the collection agency as to which claims have been returned to the provider as being noncollectible before they are allowing the bad debt to be claimed on the cost report.

Medicare Bad Debts

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.

Medicare Bad Debts

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.”

Medicare Bad Debts

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.

Medicare Bad Debts

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.

Medicare Bad Debts

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).

Wisconsin Medicaid Overhead Limit

- Wisconsin Medicaid Overhead Limit only applies to provider-based RHC with hospitals < 50 beds.
- Reported on Form F-11080 CP (04/09).
- Purpose is to limit indirect overhead expenses to 30% of direct costs.
- Direct costs include health care staff, medical supplies, medical equipment, malpractice insurance, medical records, and other.
- Overhead expenses include occupancy, administration, office, legal/professional, hospital allocated overhead, etc.

Wisconsin Medicaid Overhead Limit

Sample calculation of Overhead Limit:

SECTION II — DETERMINATION OF RURAL HEALTH CLINIC ENCOUNTER RATE	
1. Total Cost of RHC Services (Reclassification and Adjustment Form; Section III, Column 7, Line 16)	$1,200,000
2. Non-RHC Costs (Reclassification and Adjustment Form; Section V, Column 7, Line 45)	$200,000
3. Sum of Lines 1 and 2	$1,400,000
4. Percentage of Non-RHC Costs to Sum of Costs (Line 2 Divided by Line 3)	14%
5. Total Facility Overhead (Reclassification and Adjustment form; Section V, Column 7, Line 37)	$700,000
6. Overhead Applicable to Services Other than RHC Services (Line 5 Multiplied by Line 4)	$100,000
7. 30% Overhead Applicable to RHC Services (30% of Line 1)	$360,000
8. Total Cost with Overhead for RHC Services (Sum of Line 1 and Line 7)	$1,560,000
9. Total RHC Encounters (Medicare Cost Report, CMS Form 2552-96, Worksheet M-2, Line 8)	17,200
10. Rural Health Clinic Encounter Rate (Line 8 Divided by Line 9)	$90.70

In this example, about $240,000 (or $14 per visit) of overhead was disallowed. If Medicaid volume was 10%, then $24,000 in Medicaid costs were not reimbursed.

Wisconsin Medicaid Overhead Limit

Helpful Hints:

- Check Medicaid cost report to determine how much, if any, overhead has been disallowed.
- Verify direct and overhead costs are properly assigned.
- Assign hospital allocated costs to direct cost center, if appropriate (e.g., benefits, CPE, malpractice, etc.)

Rural Health Clinics and EHR Incentives

Independent RHCs:

- No current provision for supplemental payments from Medicare. EHR costs reported on Medicare cost report.
- Eligible professional practicing in RHC/FQHC with at least 30% of patient volume of "needy" individuals may qualify for Medicaid incentive.
  - Average allowable costs are limited to adoption costs of $25,000 plus $10,000 of maintenance in each of 5 years.
  - First year costs no later than 2016; no payments after 2021 or 5 years after first year.

Rural Health Clinics and EHR Incentives

Critical Access Hospitals:

- Medicare incentive based on EHR system cost and Medicare's share + 20% add-on.
- Costs may be expensed in first year rather than depreciated, if meaningful use is met.
- Beginning with expenses incurred on or after 2011. (may cause some to postpone investment until meaningful use can be met.)
- Medicare incentives end 2016.

For More Information

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