# Local Medical Review Policies

**This document was the Local Medical Review Policies of Riverbend GBA. It was the best single source for billing information on rural health clinics as produced by a Medicare Intermediary. We are reprinting it and have changed the obvious things that we know are different now; but, since no MAC has produced a document of near the value; we are reprinting it for your use in training and reference. Please review your MACs coverage decisions and billing guidance before using this guidance; but, since you are likely to have very guidance at this point; this document could really help you to bill appropriately. Date:2/23/2010.**

## Summary of Changes or Clarifications

| Description |
|---|
| A physician/Extender must be onsite before the clinic can provide any incident to services. |
| It clarifies that Extender's are not subject to the "incident to" regulations related to the physician being physically present. |
| Coumadin patients will not generate a visit every time the patient is seen due to medical necessity. |
| Riverbend's documentation requirements are spelled out clearly in this document |
| ICF Nursing Home patients can now only be seen routinely every 60 days versus 30 days in the past. (The Medical Review Department is using at least six weeks from the previous visit) |
| A visit can not be charged for obtaining blood for lab tests. Even a low level 99211 visit. |
| Only one on one visits for therapy will be paid as a visit. Groups are includable in the cost report. |
| Preventive Health services will not generate a visit unless it is medically necessary for a Physician/NP/PA to see the patient. (i.e. Mammography, Bone Density) |
| Diabetes self-management and Medical Nutritional Therapy should never be billed. It is includable as an allowable cost. |
| Tele Health can not be charged the Q3014 code as an originating site and have a medically necessary visit at the same time. You could only bill the visit if they occur on the same day. |

# Local Medical Review Polices (LMRP)

## Introduction

In June of 2002, Riverbend Government Benefits Administrator (RGBA) (the intermediary for most of the independent RHCs) released their first Local Medical Review Policy (LMRP) for rural health clinics. It immediately created a storm in the RHC community and created a flood of activity to stop its implementation. Complaints regarding cardiac rehab, Coumadin patients, chronic pain[1], nursing home patients, and the determination of an encounter sparked controversy. Riverbend published a final rule in December, 2002 with an effective date of March 11, 2003.[2]

The LMRP has been in place since that time and is something that has already greatly lowered the number of patients seen by their practice. Every provider (physician and advanced practitioner) should know this document from front to cover and fully understand the concepts and billing mechanisms. **We have included the LMRP in its entirety due to its importance to your clinic. We have modified it some without taking any of the content. Someone in your organization must understand this document in order for you to bill correctly**

## Medical Review Policies

Many of our clients are concerned that in the Local Medical Review Policies issued by Riverbend effective March 11, 2003 that their clinics could become subject to audit paybacks based upon the LMRP guidance. For example; clinics have been told for years that one routine visit per month for a Level 1 Nursing Home visit was well within the guidelines of good medical practice. The LMRP indicates that only 1 routine visit should be allowed every 60 days and only by the physician. The LMRP also states that this is simply a clarification of the policy which has always existed.

This raised the question: "If it has always been this way; can Riverbend go back and audit my nursing home visits for the last five years and take back money for routine visits that occurred more often than once every 60 days or where not performed by the physician?" Riverbend in their July, 2003 RHC meeting in Nashville, Tennessee and again on March 24, 2004 indicated that they would not subject RHCs to these guidelines prior to March 11, 2003. However, clinics should make every effort to comply with the LMRP when appropriate and should evaluate and document medical necessity of every visit.

[1] Per Riverbend in the March 24, 2004 meeting the most common issue is pain management and is something that Riverbend and other intermediaries are looking at closely.


www.ruralhealthclinic.com
Telephone: (423) 899-0945 Fax: (800) 268-5055 Email: la_vita_nouva@hotmail.com

# Final LMRP Published by Riverbend Government Benefits Administrator in December, 2002 Effective: March 11, 2003

## The Least You Need to Know

Rural Health Clinics provide covered services that can be divided into RHC services and non-RHC services; RHC services are further subdivided into physician services (evaluation and treatment by a physician or physician extender) and services that are "incident to" a physician service.

When a patient presents with a problem or an exacerbation of an existing problem requiring an evaluation and diagnosis by a qualified RHC practitioner, this constitutes a visit. The documentation must support that physician services (as defined above) were performed by that qualified practitioner. Patients that present to the clinic for services that do not require the expertise of a qualified RHC practitioner are receiving services "incident to" a prior physician/extender service (face-to-face visit). This does not require a new face to face encounter. If the physician/extender does not personally perform the service, the episode does not constitute a face to face encounter. However, even if the provider of the service is a qualified RHC practitioner, the episode still does not constitute a "visit" unless physician/extender services are provided in addition to the "incidental" services. Further, the face to face encounter is not medically necessary because the service does not require a practitioner level of expertise.

Thus there are situations in which the provider of the service (e.g. the person giving an injection) may be a qualified practitioner and the service (e.g. the injection) may be medically necessary but it is not medically necessary to have the practitioner re-examine the patient to deliver the service. In these cases it is the physician/extender services that are medically unnecessary; using physician/extenders for services routinely performed by ancillary staff does not create additional face-to-face encounters as Medicare is specifically prohibited from reimbursing medically unnecessary services [Section 1862(a)(1) of the Act].

Riverbend is further charged with ensuring that RHC utilization patterns do not diverge from hospital outpatient and physician office patterns [Program Integrity Manual 83-2-2.4.3.1], as would be the case here. Note that the services that do not require physician/extender expertise (and are "incidental" services) are medically necessary incidental services and are reimbursable through the cost report.

Many specialty services, such as PT, cardiac rehab, and coumadin clinics, provide primarily non-physician services and therefore generate a high level of costs per face to face visit. These services are not prohibited in the RHC environment, but the RHC may find that excluding them into a non-RHC provider type creates a more appropriate reimbursement model. [Refer to 27-501ff]

This is neither a new limitation on medically necessary services nor a new interpretation of policy; rather it represents a compendium and explication of Riverbend's longstanding interpretation of the various CMS regulations that govern RHC services. Specific billing instructions and documentation requirements are included.

**Note: This document is derived from the Local Medical Review Policies as promulgated by Riverbend Government Benefits Administrator. The order of the document has been changed to place relevant information in one location (ie. All laboratory information is in one place). The content of the original document was not changed.**

| | | |
|---|---|---|
| Type of Bill Code | 71x | Clinic-rural health |
| Revenue Codes | 052X | Free-standing clinic general classification |
| | 090X | Psychiatric/psychological services general classification |


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# Office Visits

Rural health centers (RHCs) provide primary care services to beneficiaries in rural physician shortage areas. To assist them in that mission, Congress created a special reimbursement mechanism. Independent RHCs are paid a flat rate for each face-to-face encounter based on the anticipated average cost for direct and supporting services, with reconciliation of costs occurring at the end of the fiscal year. This policy applies specifically to independent (free-standing) RHCs but also applies to facility-based institutions except where certain filing instructions are obviously inapplicable due to the different mechanism of reimbursement.

The services provided at a rural health center can be divided into four categories:

1. Face-to-face encounters (or "visits")[27-500.A].

2. RHC services incident to a face-to-face encounter. These services are not directly billed but are reimbursed through the cost report. [27-502] Incidental services are typically provided by non practitioners under general physician/extender supervision, although practitioners (particularly therapists who are directly employed by the RHC) frequently also provide incidental services.

3. Non RHC services. RHCs can provide part B covered services that do not fall within their congressional mandate. Examples include physician services to hospital inpatients and physical therapy by contracted therapists. Non RHC services are not reimbursed under the all inclusive rate; rather, they must be billed separately to the appropriate carrier. [27-501.1]

4. Noncovered services. Noncovered services may be provided and billed directly to RHC patients. However, in no instance can Medicare beneficiaries be billed for services that would be covered under Medicare. [27-321]

The correct assignment of charges into these categories is the crucial element of correct Medicare billing.


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# Definition of a Visit or Encounter

RHC "visits" are defined by Medicare as a face to face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. [27-504] (Hereinafter the term physician/extender will be used to refer to the list of physician, PA, NP/NM, CP and CSW.) RHC services are limited to physician/extender services, services incident to those physician/extender services and (under limited circumstances) visiting nurse services [MIM 3191.1]. Physician/extender services are further defined as those professional services performed by a physician for a patient including diagnosis, therapy, surgery, and consultation [27-405.1], thereby codifying the distinction between a visit and a non-visit incidental service.

Incidental services are those services that are commonly rendered in a physician's office without charge. Ancillary services are those which are customarily provided with an additional charge. [42 USC 1395f(d)(3), later applied to outpatient services] Due to the wide variation of billing practices the distinction is not absolute. However, the significance of the distinction is that RHC services include only a) face-to-face encounters that deliver physician services and b) services that are incident to those encounters; all non-incidental ancillary services, such as encounters with a contracted physical therapist, are c) non-RHC services. Any service provided by an RHC will fall into one of these three categories.

# Physician Services

A face to face visit is an encounter between a clinic patient and a physician, PA, NP, nurse midwife or (for visiting nurse services) a visiting nurse.[42 CFR 405.2463(a)] Clinical psychologist and social worker encounters are visits in both an FQHC environment and an RHC setting. [42 CFR 405.2463(a)(2) and (a)(4) as modified by OBRA 1987 Section 6113] Podiatrists, optometrists, dentists and chiropractors are physicians for certain procedures; however they are not licensed to provide general medical care. An encounter with a


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podiatrist, optometrist, dentist or chiropractor MAY constitute a valid face to face visit if the provider is acting within the limits of his specialty and no other coverage and medical necessity restrictions apply [42 CFR 405.2401]. However they are not able to supervise physician extenders in the provision of RHC services, nor do they qualify as physicians for the purpose of determining physician coverage (i.e. an MD or DO must be present to consider the hours "physician covered").[27-123]

A face-to-face encounter requires direct interaction between the practitioner and the patient for the purpose of providing evaluation and management services at a skill level that requires the assessment, clinical reasoning, and judgment of a qualified RHC practitioner (i.e. the metaphorical "laying on of hands"). The condition of the patient must warrant the specialized skills of the qualified RHC practitioner. It is expected that either:

1) The patient will initiate the visit with a new problem or an exacerbation of an existing problem that a prudent layperson would believe requires evaluation and/or diagnosis by a qualified RHC practitioner OR

2) The patient has been rescheduled by the practitioner for a follow-up visit under circumstances in which the specified frequency of follow-up is customary, reasonable and necessary.

Medical necessity is required for Medicare services to be reimbursable. This includes a necessity for a physician or physician extender level of care in the case of a face-to-face encounter. Services that do not medically require active physician/extender involvement during any given trip to the facility lack medical necessity for a face-to-face encounter even though the services themselves may well be medically necessary ancillary or incidental services.

As a corollary, a visit solely to obtain an ancillary or incidental service does not constitute a medically necessary face-to-face encounter.

Since the RHC benefit is a primary care benefit, encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except in the unusual instance in which a patient develops a new

condition or complication that medically necessitates a second evaluation on that same day [42 CFR 405.2463(a)(3) and 27-504].

RHC face to face visits are covered when furnished to a patient at the clinic, a skilled nursing facility or other non-hospital medical facility, the patient's place of residence, or elsewhere (e.g., at the scene of an accident), subject to MIM 3642.B [27-401]. Note that visits performed outside of the RHC physical plant have specific limitations as discussed below.

Although a service may be considered to be a covered physician service as long as the physician/extender is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment [27-405.1], all physician services do not equate to face to face encounters. Such non face-to-face services (e.g. review of an X-ray, EKG or tissue sample) may be non-RHC Part B services billed to the carrier (such as the review of a tissue sample) or they may be integral to a prior face to face encounter. Covered services that do not qualify as face to face encounters and that cannot be billed to the carrier are still reimbursable through the cost report.

Medical services that do not follow usually accepted standards of current medical practice are not medically necessary. This includes experimental and investigational treatment, unproven applications of existing technology, and diagnostic/treatment plans outside the mainstream of the practice of medicine. In these instances the service is not medically necessary, as is any visit whose primary purpose is to order, render or evaluate the non-covered service.

## Documentation Requirements for RHC Services

The Code of Federal Regulations sets forth minimum requirements for RHC records. These records must include:

1. Reports of physical examinations, diagnostic and laboratory test results and consultative findings;
2. All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress;


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3. Identification and Signatures of the physician or other health care professional. [42 CFR 491.10(a)(3)(iv)]

Each page of the medical record must be assignable to a specific patient by some form of identification, either a complete patient name or a unique medical record number. This represents Riverbend's interpretation of 42 CFR 491.10(a)(3)(i). It may additionally be considered a contractor-specific documentation requirement as well as good medical practice. Documents lacking this identification will not provide evidence of the performance of a specific service or of its medical necessity unless accompanied by a signed affirmation from the provider of that service. The affirmation must state that the provider personally remembers providing that service to the specific beneficiary in question on that date documented. The medical records must contain enough sufficiently unique information to support the ability to affirm that relationship after whatever time has transpired between the service and the affirmation.

Each face to face encounter documented in the medical record must include the date on which the encounter occurred or, in the case of multiple visits on a single day, the date and time of the visits. This represents Riverbend's interpretation of the Social Security Act Section 1833(e), which charges the FI with obtaining the necessary records to ensure that services are billed and reimbursed as provided. It may additionally be considered a contractor-specific documentation requirement as well as good medical practice.

Documents lacking a date will not provide evidence of the performance of a specific service or of its medical necessity unless accompanied by a signed affirmation from the provider who rendered the face to face. That affirmation must state that the provider personally remembers providing the service to the beneficiary on the specified date. The medical records must contain sufficient information to plausibly support an ability to remember that relationship between the service and the date after whatever time has transpired between the service and the affirmation. An affirmation signed more than sixty days after the service was rendered will not usually validate a memory of a specific date.

Each face to face encounter documented in the medical record must end with the signature of the provider who personally performed the face to face visit. This represents Riverbend's interpretation of 42 CFR 491.10(a)(3)(iv). It may additionally be considered a contractor-specific documentation requirement as well as good medical practice. Documents lacking this signature will not provide evidence of the performance of a specific service or of its medical necessity unless accompanied by a signed affirmation written by the provider who rendered the face to face visit. The affirmation must state that the provider personally remembers performing the face to face with the specified beneficiary on the date in question. The medical records must contain sufficiently unique information to support the ability to affirm that provider relationship after whatever time has transpired between the service and the affirmation. An affirmation signed more than sixty days after the service was rendered will not usually validate a memory of a specific service, unless the documentation clearly shows a level of expertise that only the actual provider (out of all the personnel at that facility) would possess.

In the above instances, the term affirmation refers to a simple signed and dated notation by the provider attesting that he can vouch for the validity of the record despite its documentary deficiency. No particular legal forms or securities are required or expected.

The provider signature may be appended to the medical record in any of several formats, but in all cases must be sufficiently unique to allow both the provider and Riverbend to determine unequivocally at a later date that the provider personally affixed the signature. The signature should ideally be legible but must at the minimum be ideographic (a consistently reproducible and unique autograph). A full name (e.g. John Smith) or a last name and credentials (e.g. Smith MD) are necessary for the signature to stand alone. If the signature serves to authenticate a typed, stamped, dictated, computer-generated signature or third-party signature, it must still be sufficiently unique to unequivocally identify the author. Printed initials are inadequate for that purpose; a last name or script initials is usually the minimum appropriate validation. If credentials are not appended to the signature, the credentials associated with the signature must be apparent elsewhere in the documentation.



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1. Handwritten entry by the provider with provider signature. Since the entry itself is ideographic, the signature need only include enough legible information to identify the provider. A last name is generally sufficient. If the facility wishes to keep a "signature registry" of its providers (a page with signatures and typed or printed entries identifying the owners of the autographs), it can provide a copy of the appropriate entry with any requested records in order to allow the decoding of illegible ideographs.

2. Handwritten entry by staff with provider signature. The signature must conclusively identify the provider, and the entry itself must make it clear that the provider (rather than the staff member) performed the face to face.

3. Dictated entry. A dictated (typed) signature must be countersigned (an ideographic validation as detailed above) by the provider who performed the face to face, confirming that the provider has reviewed the dictation and verified that it was correct.

4. Stamped signature. A stamped signature is acceptable as long as the facility has implemented procedures which clearly establish ownership and control over access to the stamp. The physicians/extenders must be able to affirm that the stamp is available to them alone and that sufficient controls exist such that the stamped signature can be identified as being personally affixed by the provider and therefore equivalent to an inked autograph. A single affirmation for each physician/extender, which may be combined with a signature registry, should be kept on file at the facility. A copy should be provided if medical records with stamped signatures are requested; it is not necessary to create a new document for each record request. No specific format is required, however a template is provided for convenience at the end of this policy.

5. Computer generated typed signature. Computer generated paper records are analogous to dictations. The typed signature must be countersigned by the provider who performed the face to face, confirming that provider has reviewed the computer generated record and verified that it was correct.


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6. Electronic signature on electronic records. Purely electronic records are those that are stored electronically and printed only when documentation is needed by a third party such as Riverbend. These records must be accompanied by a copy of an affirmation from the provider that entries are password protected and ONLY the provider has access to the password. A single affirmation by each physician/extender may be kept by the office and copied for submission with any record requests; it is unnecessary and unduly burdensome for providers to create a unique affirmation for each record request.

The intention of these regulations is to make sure that the physician/extender's documentation is clearly attributable to that individual and to ensure that services are clearly documented in such a way that it is obvious who was providing the service and to what extent. For example, some offices allow nurses to administer injections and also initial documents with the provider's initials. If these situations occurred together, it could create a misrepresentation of a face to face encounter that had never occurred.

If medical records are requested for review, the provider should furnish:

1. The record for the requested date of service and, to define the therapeutic milieu in which the service is being rendered, the notes for the two preceding visits. If more than two visits occurred in the 30-day period immediately preceding the date of service, all additional notes for that period should be included.

2. Visits for recurring services and follow-ups should include a copy of the notes for the visit that established the need for the follow-up service.

3. The inclusion of a provider phone number may facilitate an accurate review and provider feedback.

4. Identification of signatory by title if titles were not included in signatures.

5. Copy of affirmation of password protection for electronic records, affirmation of control of signature stamp, or signature registry, if applicable.


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Appendices Verification of Signature

FACILITY NAME: ___________________________________________________________

Electronic Signatures: If this facility uses electronic signatures, system controls exist such that ONLY the provider has access to the password that allows the system to affix the "signature" that identifies that provider as the author of the record. This facility [ ] DOES [ ] DOES NOT use electronic signatures.

Stamped Signatures: If any providers at this facility use signatures stamps, sufficient controls exist at all times such that ONLY the provider has access to the stamp. The use of the stamp will therefore clearly identify the provider as the author of the record. This facility [ ] DOES [ ] DOES NOT allow use of stamped signatures.

Signed: _____________ Facility Administrator
Date:________________

The following signatures identify the providers indicated and additionally signify their affirmation of the above statements.

Use Signature Stamp TYPED(PRINTED)NAME SIGNATURE DATE

# Utilization Guidelines

The Fiscal Intermediary is required to compare RHC and outpatient hospital utilization for the same services to identify any significant differences in utilization patterns, and also to compare RHC claims with carrier claims for similar services in physician offices. Riverbend also looks at norms for type and frequency of service by beneficiary for specific diagnoses in RHC and non-RHC (outpatient) places of service. [PIM Chpt 2 Section 2.4.3.1]

Claims will not be globally denied based on utilization patterns. However, individual services will be reviewed and face to face encounters will be denied as not medically necessary if the frequency of visits is not consistent with norms in other outpatient venues, unless the documentation in the medical



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records clearly supports the need for the excessive utilization. Similarly, the intensity of service during face to face encounters will also be reviewed and visits will be denied as not medically necessary if an abnormal number of brief low-intensity visits are performed relative to other outpatient norms. Services that are split across several visits will have all except the initial visit denied if they are usually performed at a single visit in other outpatient environments.

Potentially excessive utilization patterns will be evaluated along two lines, based on the distinction between scheduled (provider initiated return) and unscheduled (patient initiated return) visits

a. Scheduled return visits are not medically necessary when the RHC practitioner schedules routine monitoring or follow-up at a frequency that significantly exceeds usual standards of practice and for which the medical record does not show clinical necessity.

b. Unscheduled return visits are not medically necessary when the patient exhibits a pattern of presenting without a problem or an exacerbation of an existing problem that would cause a prudent layperson to seek medical evaluation and treatment. This pattern of behavior constitutes an excessive utilization problem for the RHC primarily when the facility a) does not attempt to educate the patient about the appropriate use of medical resources, b) enables multiple patients to overuse resources or c) maintains a fee structure that inappropriately encourages casual utilization.

# Reasons for Denials

**1. Documentation does not support the performance of a medically necessary face to face with an authorized provider as billed:**

No documentation to support that the visits or services were rendered

Illegible handwriting

Illegible documentation, copy too light or cannot be read.

Insufficient documentation to support the performance of an encounter

Insufficient documentation to support the medical necessity of the encounter

Reason for visit not documented or listed only as f/u or checkup (does not support medical necessity)

Progress note undated or incorrectly dated

Billing for one date yet documentation reflects care delivered on a different date

Changing dates of service in a manner other than strike-through, correction and initialing

Lack of qualified provider signature or inability to identify the signatory by provider

Dictated note not signed (and dated) by provider

Stamped signature not validated (see "Documentation Requirements")

## 2. Improper Billing:

Billing non-physician/extender services as a physician/extender visit (face to face encounter)

Billing services under visit that should be filed on cost report

Billing visits separately that should be bundled as "incident to" a face to face visit

Billing for completion of handicapped, disability paper work, etc.

Billing for excluded services (physicals, routine services, etc.)

## 3. Services not provided by an eligible provider:

Sanctioned, unlicensed or otherwise ineligible provider

Provider not eligible to furnish services provided (e.g. podiatrist treating a URI)

Student without countersignature and appropriate supervision

Staff member performing service is not a licensed physician/extender

### 4. Lack of Medical Necessity for the Encounter:

A. An encounter for care that is not covered (e.g. acupuncture).


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B. Patient seen only for a service that does not require the skills of a physician/extender

1. Prescription refill or filling a pill box
2. BP check
3. Lab test sample collection (blood draw) or reporting of uncomplicated results
4. Injections (flu shots, b12, epogen, allergy shots, etc.)
5. Dressing changes

## C. Inappropriate Utilization

Follow-up visits for conditions (or at a frequency) not warranted by current standards of care

Repetitive visits lacking a need for a medical evaluation for new problem or exacerbation of a current condition, as perceived by a "prudent layperson"

Frequent narcotic injections or narcotic prescription refills in the absence of an active and documented pain management strategy

Failure to provide patient/caretaker education that would decrease patient reliance on the provider for services that can normally be taught to be self-administered

Non-covered ICD-9 Codes

Non-covered Diagnoses

# Incidental ("Incident to") Services

Services and supplies incident to a physician's professional services consist of those services that are commonly furnished by employees in an office setting under general physician supervision as an incidental, although integral, part of a physician's professional services. This includes all routine services performed by the clinic staff, e.g., nurses, therapists, technicians, and other aides. [27-406] Incidental services are not limited to the same day as a face to face visit; rather they must merely be tied to an actual physician/extender


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service (either a face to face or a non face-to-face covered service such as a telephone consultation). For example, non-physician services are incidental when performed during a course of treatment in which the physician/extender performs an initial evaluation and remains actively involved (directs) that course of treatment. [27-406.1] ***The physician supervision requirement is satisfied as long as the physician/extender is on the premises and immediately available during the services. [27-406.3]***

Services that fit this description of incidental services do not establish medical necessity for a face to face encounter. Services that are routinely provided by ancillary personnel such as nurses, therapists, aides, etc.--i.e. incidental services--should not be billed as face to face encounters even if provided by a physician/extender, unless specific documented medical necessity exists to require a physician/extender level of expertise to render the service. However, medical necessity does exist for periodic physician/extender evaluations to manage the incidental services; only those intermittent evaluation and management encounters should be billed as face to face visits. For the purposes of determining whether a service is customarily a physician service or an incidental/ancillary service, the FI will look at the usual practices of the RHC for non-Medicare patients, the usual practice of other RHCs, and the usual practice of outpatient clinics and traditional physician offices. [PIM Chapter 2 Section 2.4.3.1.A]

## Incident to services are reimbursed through the Cost Report

Services incident to an RHC physician service (incident to a face-to-face encounter) are reimbursed through the cost report, but they may be included on the claim for accounting purposes (such as the establishment of the co-payment). Services provided on a date where a face-to-face encounter did not occur may not be submitted by themselves. They may, however, be included on the claim with the prior or subsequent encounter they were incident to. In that case the date span of the claim should reflect only the date span of the face to face visits.


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# Cost Report Reimbursement

Reference is made in this policy to costs, such as the costs of services incident to the physician visit that are not directly billed but are included in the cost report. It is important to remember that these costs are reimbursed by Medicare but not directly; instead they are included in the computations used to set the per visit rate for the facility. Typical allowable costs include, to the extent reasonable:

- Compensation for the services of physicians, physician assistants, nurse practitioners, nurse midwives, specialized nurse practitioners, clinical psychologist, and clinical social workers you employed;
- Compensation for duties that a supervising physician is required to perform
- Costs of services and supplies incident to the services of a physician/extender. [27-502]

These charges and costs must not be confused with those items and services which are covered under Part B but which are not included in the definition of RHC services. These costs are excluded from the RHC's allowable costs, and are directly billed to the Part B Carrier on a CMS Form 1500. The only excluded services paid for by the Fiscal Intermediary are the administration of influenza and pneumococcal vaccines, but even these are reimbursed through an addition to the cost report; there are no non-visit charges paid by the FI. All other excluded costs (e.g., independent laboratory services, durable medical equipment, ambulance services, etc.) must be billed to the Carrier. [27-501.1]

# Routine &Preventive Services

Routine physician/extender examination, vision exams and examinations for hearing aids are not Medicare covered services. The routine physical checkup exclusion applies to all examinations performed without a relationship to the treatment or diagnosis of a specific illness, symptom, complaint, or injury; it also applies to examinations required by third parties (such as employment or insurance evaluations). Eye examinations are not covered for the purpose of prescribing, fitting or changing eyeglasses (e.g. refractions). Eye examinations

are only covered in conjunction with a medically necessary evaluation to diagnose or treat an eye disease, and hearing exams must be directed to uncovering a specific pathology. [27-437] Routine foot care is not covered except in the setting of a systemic disease that requires care to be performed by a skilled practitioner in order to avoid the risk of injury to the patient. [27-438.C]

Most primary preventive services are not covered under the RHC benefit even when provided by RHCs. These include medical social services, nutritional assessments, preventive health education, prenatal and postpartum care, routine physicals (including well child care), immunizations, eye and ear screening, family planning, routine screening procedures (urine dipstick, stool guaiac, serum cholesterol, weight and BP), risk assessment (including undirected history taking and physical exam to ascertain risks), and thyroid screening. Group presentations, educational activities and dental services are never covered. [27-404.1]

Certain screening and/or preventive services such as mammography have a special benefit delineated by Congress. The professional portion of theses services are considered covered RHC services in accordance with PM A-00-30. If a face-to-face visit is medically necessary, it is covered and may be billed on that basis; if not, the services are still covered as "incident to" costs but the charges must be billed in such a way that a 'visit" is neither reported nor paid. Thus, the professional component of a sigmoidoscopy would be covered and would support a face to face encounter, while the technical component can be billed to the Part B Carrier. The professional components of bone mass measurement and mammography are always covered as RHC services, but should only generate a face to face visit if the physician personally performed the service; the preparation of the report is not a face to face visit by itself although charges could still be included on a claim as a covered physician service but only in association with another visit. Stool guaiac for cancer screening would similarly not support a face to face (unless the digital rectal exam benefit was being provided) and thus would create only a Carrier (lab) claim. Conversely, a pelvic exam would only generate a face to face visit; lacking a technical component, there would be no Carrier claim (unless the RHC interpreted its own Pap smears).

Two services never should be billed as face to face visits. Medical nutritional therapy, in accordance with BIPA 105, must be provided by a registered dietician or nutrition professional; it is therefore an "incident to" service for which costs are reported but no visit. Diabetes self management (DSM) represents a similar situation. PM-A-00-30 identifies DSM as an RHC service, but MIM 3619 specifies that G0108/9 codes are not payable for beneficiaries receiving services in an RHC. Although DSM (as defined in Section 4105 of the BBA of 1997) must be certified as medically necessary by a physician/extender, the actual educational intervention is usually provided by other professionals, typically nurses. A face-to-face service beyond that which occurred when the intervention was ordered (certified) is not medically necessary. Therefore it too is an "incident to" service for which costs may be reported but no visit reported. Lacking technical components, neither of these services would generate Carrier claims either.

# Prescription Services

Visits for the sole purpose of obtaining or renewing a prescription, the need for which was previously determined (so that no examination of the patient is medically indicated), are not covered face to face services but are incident to the visit at which the physician/extender determined the need for the prescription. [27-405.3] Incidental services such as intermittently dispensing medications (oral or injectable) to psychiatric patients or drug abusers and counting/filling pill dispensers for disabled or demented beneficiaries may be performed, but these services do not require a face to face evaluation. Thus the need for a prescription refill or medication disbursement will not contribute to establishing medical necessity for the face to face encounter.

## Pain Management

Pain management is a covered RHC service but the enabling of a drug addiction (either within or outside of a drug rehabilitation program) is not. Frequent medication refills for narcotics do not represent medically necessary face to face encounters, but they nonetheless indicate a potential quality of care issue and the overall pain management strategy should be well

documented in the chart. Frequent visits for the injection of narcotics usually require an evaluation and thus a face to face visit, but they should also be part of a well documented pain management strategy that includes diagnostic investigations and/or pain specialty consultations that attempt to minimize addiction and maximize patient well being. A pattern of over-utilization of the RHC for multiple patients in the absence of pain management strategies is not medically necessary and may be an indicator of more serious problems.

# Dressing Changes

There may be instances when a caretaker is unable to adequately perform dressing changes or where the level of complexity of the care requires the skills of a nurse. These dressing changes do not constitute medically necessary face to face visits solely because the service was provided by a physician/extender if similar services could be provided by nurses or other designated office staff. Except in the special case of visiting nurse services, medical necessity for a face to face encounter is based on:

1) The need for a physician/extender to monitor the underlying wound at a frequency that does not differ from the usual patterns of utilization in an office or outpatient clinic OR
2) An exacerbation or complication that would trigger an examination in those environments OR
3) Sharp debridement requiring the skills of a physician/extender.

## Tele Health or Tele-Medicine

An RHC may serve as a Tele-Health originating site. If the patient is attending the site solely to participate in the Tele-Health consultation, the originating site facility fee should be billed to the intermediary using HCPCS code Q3014 and the facility's provider ID. This is paid outside the RHC rates using a unique reimbursement mechanism and no face-to-face encounter is billed [PM AB-01-69]. If the Tele Health consultation occurs as part of a face-to-face encounter that is medically necessary outside of the need for the consultation, only the face-to-face encounter should be billed as the Tele health consultation is incidental to the primary physician service. The originating site fee and the face-to-face encounter may only both be billed on the same day if


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there are two separate patient trips to the facility and the need for the physician/extender encounter is unrelated to the need for the consultation.

A Tele health consultation for a patient at a distance site does not constitute a face-to-face encounter nor does it qualify as an RHC service. In the unlikely event that RHC provider serves as the distant consultant, he must bill the part B Carrier using the appropriate HCPCS code and modifier. The Intermediary cannot be billed for a face-to-face encounter.

# Mental Health Services

A clinical social worker may provide services that are typically physician services as well as services that are typically provided incident to physician services. [27-419.2 and 27-500 .A] An encounter with a clinical social worker may be billed as a face-to-face visit by the RHC [42 CFR 405.2463 as modified by OBRA 1987, Section 6113] only when the CSW is providing a medically necessary physician service. Services that are entirely incident to a contemporary or prior physician visit may not be billed as face-to-face visits although they are covered services and are reimbursed on the cost report. This includes all CSW services in the RHC.

Encounters with a clinical psychologist should be billed as face-to-face visits by the RHC. [27-419.1 and 27-500.a] Medical necessity will be assessed, and the visit must show evidence that the psychologist's expertise was required and that the visit was providing more than an incidental service in support of a prior physician visit. (The latter case constitutes an "incident to" service that is cost report reimbursed; this applies to all clinical psychologist services in the RHC.)

All RHC non-diagnostic psychiatric services (psychiatrist, clinical psychologist and LCSW professional services) should be totaled and billed to revenue code 90X (Psychiatric visit). When a physician (or a physician extender) functioning as a generalist provides services where only a minimum level of psychiatric intervention is involved, such as prescribing an antidepressant in the course of treatment for fatigue, that service should be considered to be a medical service. True psychiatric services involving psychotherapy and the active treatment of psychiatric disease, however, should be billed under revenue

code 90X even when provided by a non-psychiatrist. Similarly, a psychiatrist functioning as a specialist (i.e. in a consultation for another RHC provider) is always providing psychiatric care, so this should be billed as 90X except for visits to define a diagnosis (typically the initial visit.) Non-diagnostic consultations (e.g. for medication adjustment) are always considered 90X. Charges for services incident to psychiatric visits may be included in the total for the 90X line or may be assigned to multiple revenue codes. Again, the total units in revenue Code 90X must equal the total number of medically necessary face-to-face encounters, and the dates of service for the claim should only reflect the dates of the face to face encounters.

### Clinical Psychologists and Clinical Social Workers

Clinical psychologists' and clinical social workers' services are covered RHC services but the outpatient mental health treatment limitation applies. Therapeutic services must consequently be identified separately from other clinic visits: RHCs bill these services under revenue code 90X, as applicable. [13-3-3642.D and 27-419.1.F] Diagnostic services (typically the first visit where the expertise of the mental health worker is required to define a diagnosis OR a visit for psychiatric testing) do not have this limitation applied and should be billed under 52X.

## Recurrent Services

1. Blood Pressure Measurement: Follow-up visits to monitor blood pressure can take two forms. Some visits include physician/extender evaluation and management services and are therefore appropriately identified as encounters. The documentation should reflect the performance of these services over and above the simple measurement of a blood pressure. The frequency of follow-up is medically necessary when consistent with the recommendations of The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure.

2. [http://www.nhlbi.nih.gov/guidelines/hypertension/jncintro.htm]

**Specific medical necessity must be clearly documented to support frequencies greater than:**

New diagnosis (first 6 months); lifestyle modification: monthly (q 30 days)
New diagnosis (first 6 months); pharmacological management: monthly (q 30 days)
Established diagnosis; lifestyle modification; controlled: quarterly (q 90 days)

Established diagnosis; pharmacological management; uncontrolled: monthly as long as at least every other visit supports active intervention (change in therapy)

Established diagnosis; pharmacological management; controlled: quarterly (q 90 days)

Accelerated or unstable hypertension with a need for rapid control of pressure: medically necessary as long as each visit supports ongoing direct and active intervention (change in therapy) during the period of frequent follow-up.

Other visits may be solely to obtain a BP measurement as a data point for the diagnosis or tracking of the hypertension. Visits solely to obtain BP measurements are incidental to the primary E&M visit, and any follow-up at a frequency that is not supported by current standards of care is not medically necessary.

2. Disease Management Clinics: Disease Management clinics do not represent a special Medicare benefit category. Visits to clinics of this type are subject to the same requirements for medical necessity as all other face-to-face encounters: namely, there must be a requirement for a physician/extender level evaluation, re-evaluation or therapeutic intervention at each visit. Routine visits, i.e. visits at a frequency greater than that which is supported by current standards of care in physician offices and outpatient departments, are not medically necessary and are not covered.

3. Lab Follow-up Clinics: Visits to lipid clinics, prothrombin (Coumadin) clinics and other lab-based follow-up clinics generally do not demonstrate a need for physician/extender face-to-face discussion of results other than in the two or three visits following diagnosis. Exceptions are expected to demonstrate a well-documented and unique need for the face to face interaction. The routine use of a visit to discuss lab results is clearly not medically necessary; medical necessity for this is discussed above.

4. Specially Clinics: Diabetes clinic visits are medically necessary when medical complications of the disease are addressed, or when monitored at a frequency consistent with recommended standards of care. Routine Foot Care clinics are always not medically necessary and non-covered [RHC Manual 438.C] except in the setting of diabetes with loss of protective sensation [CIM 50-8.1]. Pain Management clinic visits demonstrate medical necessity for a given frequency of visits when supported by the immediate pain management needs at the time of each visit and by the documentation of progress with respect to the overall pain management strategy.

5. Chiropractic clinics: Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation of the spine for the purpose of correcting a subluxation that has been demonstrated by x-ray or physical examination. The patient must have a significant health problem (neuromusculoskeletal condition) necessitating treatment, and the manual manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered. Continued or repetitive treatment without an achievable and clearly defined goal is also considered maintenance therapy and is not covered. No other diagnostic or therapeutic services furnished by a chiropractor or under his/her order are covered by Medicare. Any additional conditions of coverage imposed by the local Carrier for office based chiropractic care will be applicable, and chiropractic care must augment (not replace) the primary care nature of the RHC.


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## Coding Guidelines for Office Visits

Charges for RHC medical services may be totaled under revenue code 52X (RHC visit) or they may be assigned to multiple revenue codes. However, the total units on the line for revenue code 52X must equal the total number of medically necessary face-to-face encounters billed. [RHC 27-640] The dates of service for the claim should only reflect the dates of the face to face encounters, not the dates of all incidental or ancillary services.

# Off-site Services

## Skilled Nursing Beds

A physician/extender visit to a beneficiary in a skilled SNF bed or a swing bed is medically necessary on a monthly basis to evaluate the patient status as it relates to the skilled service. A physician/extender visit may constitute a medically necessary face-to-face more often than monthly only if the medical record supports the necessity of more frequent evaluation. (For the purposes of medical review, monthly shall mean no less than 21 days between visits.) Visits to patients who are covered under Part A may not be billed by the RHC as they are bundled into the SNF Consolidated Billing. The RHC can bill visits only for patients whose stay is not covered under Part A. [PM a-00-30] (The physician/extender may directly bill the Carrier for these services if not compensated by the RHC under agreement.)

A physician/extender visit to a beneficiary in a non-skilled bed, intermediate care facility or nursing home is not medically necessary on a routine basis even if the nursing facility requires it as a condition of patient residence. However, Medicare does "presume" visits to be medically necessary if they are used to satisfy Federal Regulations. Based on these requirements, detailed in the Code of Federal Regulations [42 CFR 483.40], a visit to a patient in a non-skilled bed, ICF or nursing home will be considered medically necessary if it has been approximately 60 days (for the purposes of medical review at least six weeks) since the last visit. At frequencies greater than this the encounter is only medically necessary if it occurs in response to a patient complaint or in follow-up to an established medical condition; in both

instances the visit is medically necessary only if an office visit would be medically necessary under the same circumstances.

Note that a physician/extender may provide RHC services in one professional capacity and may provide SNF or nursing home medical services in a different professional capacity. In that case a patient visit that is provided under the auspices of the RHC should be billed as an RHC visit if separate billing is allowed. A visit provided by the physician/extender in his private (non-RHC) capacity has nothing to do with the RHC and should therefore neither generate an RHC claim nor impact the cost report; this visit would be billed by the physician/extender to the Carrier. The determination that a physician/extender is acting under the auspices of the RHC as opposed to acting independently is based on such factors as the physician/extender's contract with the RHC, his malpractice coverage, and the consistency of clinical responsibilities for other RHC and non-RHC patients. For example, it would not be appropriate if patients covered under Part A were seen in an independent capacity while patients covered under Part B were seen as RHC visits. More importantly, in no instances should services be reflected in RHC claims or cost reports and be billed to the Carrier as independent services. Code as either Revenue Code 0524 or 0525 depending on if the patient was in a Part A stay or not. (524 for a Part A  stay and 0525 for not).

## Home Visit

The RHC home visit is an RHC physician service that is qualified in the same manner as an office visit. It must have the same face-to-face component with history, physical exam, assessment and disposition. There are no special requirements (e.g. homebound status) on a home visit, nor are there any unique exemptions. Medical necessity for the home visit is identical to medical necessity for office visit -- i.e. the fact that the patient is homebound does not confer any additional necessity for a physician/extender level of care. A home visit is not medically necessary if an office visit would not be medically necessary for the same patient condition. Revenue Code 0522.


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# Telephone Services

Services by means of a telephone call between a physician/extender and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are Medicare covered services that are included in the payment made to the RHC. However, such services do not constitute face to face encounters and may not be billed as visits. Reimbursement for these services is made through the cost report. [27-405.2]

# Paperwork

The paperwork involved in maintaining records, documenting encounters for third parties and completing forms for patients is an incidental part of medical practice. These services (when provided in support of an activity not otherwise excluded from coverage, such as disability examinations) are reimbursed by Medicare through the cost report as services incidental to the covered encounter. A period of time spent solely in record keeping cannot be considered as a face to face visit. An actual face to face encounter solely for the purpose of creating paperwork is not a medically necessary visit; the visit must be justified by a medically necessary evaluation or treatment.

# Family Consultation

A consultation with the beneficiary's family would generally be incidental to an accompanying office visit. The consultation may only be billed as a separate face-to-face encounter if it represents a complex and protracted interview involving the beneficiary's care which could not be reasonably expected to be incorporated with the preceding face-to-face encounter with the patient. Counseling sessions with the beneficiary's family may only be billed under similar limited circumstances [CIM 35-14]

# Ancillary Services

## Laboratory Tests

***An encounter expressly for the purpose of obtaining blood for lab tests does not constitute a medically necessary face-to-face visit even if a face-to-face contact with the provider is made.*** To be considered as a face-to-face visit, there must be some additional medically necessary evaluation or management component. All laboratory services, including venipunctures that are not integral to a face-to-face visit, are non-RHC services that must be billed to the part B Carrier (or the FI for provider-based RHCs only). [PM A-00-30 as amended]

The process of reporting a lab result to the patient, even if a medication is changed as a result, is also usually incidental to the initial visit. A visit for the purpose of reporting the lab result is only medically necessary (in the absence of a separately indicated evaluation) when the information being reported to the patient is of sufficient complexity or gravity to demand an additional extended physician/extender discussion with the patient. Examples of this would include (but are not limited to) a complex metabolic profile with multiple abnormalities, an evaluation for cancer, and a finding of a new disease (e.g. diabetes). The periodic monitoring of a given test (e.g. INR, CBC, etc.) should not be associated with routine follow-up visits to report the results as this does not reflect the practice in physician offices and outpatient clinics. The routine use of a visit to discuss lab results is not medically necessary.

All laboratory services provided in the RHC's laboratory (the six basic laboratory tests required for certification [42 CFR 491.9 (c)(2)] as well as any other tests performed in the RHC lab) are excluded from the all-inclusive rate payment to the RHC. Charges for face to face visits associated with these services should be included on the claim form (revenue code 52X), but costs associated with the provision of laboratory services are excluded. This includes sample collection charges. All laboratory services performed in the RHC should be billed to the Part B Carrier (FI for provider-based RHCs), including the six basic tests and any other tests the laboratory is certified to perform.


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Any tests sent to an outside laboratory are billed to the Part B carrier by that outside lab. [PM A-00-30]

# Therapy Services

Therapy (PT, OT and ST) can be incidental, ancillary (non-RHC) or physician/extender (face to face) services. [42 CFR 410.60(e) (2) (iv)] When performed by a therapist, therapy sessions are incidental (cost report reimbursed) if the therapist is an employee of the clinic and ancillary (separately billed under Part B as a non-RHC service) when the clinic arranges sessions with an independent therapist. [27-406.6 and 13-3-3191.3]

When personally performed by a physician/extender, therapy services are valid physician services [42 USC 1395l (g) (1)]. One on one therapy services with a physician/extender may be billed as face to face visits. However, for the purposes of determining whether a given service is a physician service or an incidental/ancillary service, the FI will look at the usual practices of the RHC for non-Medicare patients and the usual practice of other RHCs. Further, utilization patterns will be compared with outpatient clinics and traditional physician offices. Face to face therapy encounters that are uncharacteristically shorter or less intensive than their traditional ancillary service counterparts (i.e. typically less than 30 minutes) will be denied as not medically necessary. [PIM 2.4.3.1] Group therapy sessions are not consistent with a traditional physician-patient visit, are appropriately treated as incidental (cost report reimbursable) services, and are not medically necessary for the physician/extender level of expertise. ***Only one-on-one therapy sessions may be treated as face to face visits; group sessions are covered RHC services and are reimbursed through the cost report.***

Cardiac and Pulmonary rehabilitation (CR/PR) are NOT therapies [CIM 35-25 and c.f. RGBA LMRP-079-01].In accordance with the Medicare benefit structure, these services must be provided incident to physician services in the outpatient environment, making them cost report reimbursable for the RHC. Based on utilization patterns in other outpatient environments [PIM 2.4.3.1], up to three physician contacts ("face-to-face visits") will be considered medically appropriate to monitor the course of cardiac or pulmonary rehab.


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Typically the first CR/PR visit will consist of the new patient comprehensive examination and associated stress test, while the remaining two visits consist of examinations needed to monitor patient progress (and effect routine medication and treatment changes) and/or a post-service evaluation and stress-test. Additional face to face visits only demonstrate medical necessity when precipitated by a sudden deterioration or acute event that necessitates a physician evaluation. A rhythm strip interpretation would be covered (charges bundled) along with the face to face in the setting of a physician evaluation following an acute event, but the routine review of strips generated during CR/PR is typically done after the fact, so additional face to face encounters are not medically necessary.

Similarly, routine changes in treatment regimens are usually done based on reported progress, not face to face exams, so again medically necessary face to face encounters do not occur.

Monitoring and medically supervising rehabilitation is not within the scope of practice of physician extenders. Physician extenders can and do provide the individual services, but the individual services themselves do not require a physician/physician extender level of expertise. Therefore the individual rehabilitation sessions are "incident to" and do not represent medically necessary face to face encounters even when rendered by a physician/extender.

## Injections

***A visit solely to receive an injection does not constitute a medically necessary face-to-face visit if the need for the injection was previously determined. This is true even if a face-to-face contact is made.*** [MIM 11-3660.7, MCM 14-3-15050.C, RHC 27-406, MCM 14-5202, PIM 83-2.4.3.1]

Allergy shots. A visit solely to receive an allergy shot does not constitute a medically necessary face-to-face visit even if a face-to-face contact is made. The allergy shot is generally administered by ancillary personnel and represents a service that is incident to a prior physician visit. However, if the patient has an adverse reaction that necessitates a physician/extender evaluation (and that

examination, assessment and plan is appropriately documented), the encounter may then be appropriately billed as a face-to-face visit.

Methotrexate. Methotrexate in immunomodulating doses does not require a physician visit beyond the frequency necessitated by the underlying disease.

Vitamin B12. The IM administration of B12 may be transiently necessary in any B12 deficiency state but is only medically necessary chronically following a definitive diagnosis of pernicious anemia (Schilling test, radiolabeled B12 uptake and/or other standard diagnostic criteria). However, even when appropriately administered, a face to face encounter is not medically necessary with each injection. In the setting of newly diagnosed B12 deficiency with symptoms, patient evaluations may be required weekly times four and then monthly times twelve. In the absence of symptoms attributable to B12 deficiency, two or three visits within the first six months may be necessary for patient education and re-evaluation. Following this initial period, annual visits may be necessary (whether or not the patient is continuing injections) if the patient is not being otherwise seen for chronic problems. More frequent physician/extender encounters are not medically necessary due to the slow rate of relapse following B12 repletion.

## Flu Shots and Vaccinations

Flu shots and vaccinations (influenza, hepatitis B and pneumonia vaccines) do not necessitate a face to face visit. They are administered incidental to a contemporary or prior physician service. Note that whereas the administration of influenza and pneumococcal vaccine is a non-RHC service reimbursed outside the all-inclusive rate while hepatitis-B is an incidental RHC service covered under the rate, neither are specifically reimbursed on a claim by claim basis; both are cost report reimbursable. [27-614 and MIM 3660.7.G]

Other injections (such as epogen) also usually represent incidental services when the need for the injection is previously established, even if the physician/extender specifies a change in dosage. This is because the physician/extender is merely responding to a lab test; a re-evaluation of the patient is not indicated with each adjustment. Conversely, a face to face



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encounter is medically necessary when it is the accepted standard of practice in physician offices and outpatient clinics, generally because a clinical re-evaluation of the patient is also indicated (e.g. 24 hours after an initial dose of IM antibiotics but not routinely after each subsequent dose).

## Visiting Nurse Services

Under certain conditions visiting nurse services are covered as RHC services and are billed as face to face encounters. There must be documentation that the RHC is located in an area where CMS has determined that there is a shortage of home health agencies, and the patient must be homebound. The care must be performed by a registered nurse, licensed practical nurse or licensed vocational nurse operating under a written plan of treatment. [27-412.1] A physician/extender home visit to perform services typically rendered by home health or visiting nurses is only covered when the criteria for VNS are met. When VNS criteria are not met, the home visit is subject to the same medical necessity requirements as an office-based face to face encounter, and a physician/extender home visit solely to perform home health services will be denied as not medically necessary for a physician level of expertise.

## Non-RHC Services Provided by the RHC

There are items and services covered and payable under Part B which does not fall under the definition of RHC services but which RHCs may furnish. The RHC bills the carrier for these services on the Form HCFA-1500. MIM 3191.2 [27-402]. It includes:

Services furnished in a hospital;

Durable medical equipment (whether rented or sold);
Ambulance services;

Prosthetic devices for internal organs, and supplies and replacements related to the prosthetic (includes colostomy supplies but excludes dental prostheses);


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External prosthetics and braces, including supplies and replacements required due to a change in the patient's physical condition (includes neck braces, artificial legs, eyes, etc.)

Technical component of diagnostic tests such as x-rays and EKGs (see §405.1);

Technical component of screening mammography services;

The arranging of physical, speech, or occupational therapy with suppliers not employed by the RHC.

Radiological services.

## Services to Hospital Patients

Services provided to hospital patients by RHC practitioners (including emergency room services) are not RHC covered services. Such services are billed to the Part B Medicare Carrier. [27-401]

## Non-RHC Professional Services

All RHC physician/extenders who furnish non-RHC services bill the Carrier on Form HCFA-1500 for payment. For Medicare purposes, non-RHC services include services furnished to beneficiaries who are not patients of the RHC, off-site services furnished to RHC patients that are not
Compensated for by the clinic, and services furnished to hospital patients. [MIM 3642.C]

# Visit for Non-covered Service

Face to face encounters primarily to receive services that are not covered by Medicare (such as acupuncture) are themselves not covered.

Services that are non-covered by Medicare, including non-RHC services, may be billed uncovered under Condition Code 21 if a statement of non-coverage is being requested. Other non-RHC services should not be included on the UB-92 as they are billed to the Carrier.

# Reimbursable Through the Cost Report" Example

When Medicare tells you "It's reimbursable through the cost report"; it usually can be translated as "You're not going to get paid for this" if you're cost per visit is above the cap[3]. To illustrate this point; we have prepared the following table which assumes we have added two Certified Dietitians and paid them $100,000 during the course of the year. They saw 1,000 patients during the year and all of the patients were Medicare. Under our LMRP, we simply include their cost in the cost report and do not report any visits for the Dietitians. Our example illustrates that our Medicare reimbursement would not be affected by including the cost in the cost report; because we were above the Medicare Cap for 2002.

| Cost Report Description | As Filed Cost Report | Diabetes Management | Variance |
|---|---|---|---|
| Total RHC Costs | 500,000 | 500,000 | 0 |
| Diabetes Costs | 0 | 100,000 | 100,000 |
| Total Reimbursable Costs | 500,000 | 600,000 | 100,000 |
| Total Visits | 7,500 | 7,500 | 0 |
| Cost per Visit | $66.66 | $80.00 | 13.34 |
| Reimbursement Cap | $64.78 | 64.78 | 0 |
| Medicare Visits | 1,000 | 1,000 | 0 |
| Total Medicare Payments | 64,780 | 64,780 | 0 |

[3] And you are not a provider-based RHC with a less than 50 bed hospital which are not subject to caps. Most RHCs are at or above the cap.


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