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Rural Health Clinic Billing 101

1. What is a rural health clinic?
 - a. Is a certification from CMS that allows physician practices to qualify for cost-based reimbursement from Medicare and Medicaid.
 - b. May be either independent or provider-based.
 - i. Independent is owned by physicians, non-profits, or even hospitals.
 1. Reimbursement is capped at \$77.76 in 2010
 2. Uses the Form 222 Cost Report Form
 3. Bills use the UB-04 Form for billing Medicare services.
 - ii. Provider-Based is owned by hospitals and meets the 8 provider-based criteria (location, common governance, common medical direction, financially integrated, etc.)
 1. Reimbursement is not limited to \$77.76 per visit if the hospital has less than 50 beds (not licensed, but beds that could be operational within a 24 period of time); otherwise, the Medicare rate is limited to \$77.76.
 2. Is a Department (63.50 in most cases) of the hospital cost report (Form 2552).
 3. Uses the UB-04 for billing Medicare services.
 - c. Must meet 8 conditions of participation including location in a non-urban area and in a medical shortage area.
 - i. http://www.cahabagba.com/part_a/forms/enroll_attest.pdf



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2. **Why is rural health clinic billing beneficial?**
 - a. **Enhanced Medicaid reimbursement is the biggest advantage to rural health clinic billing. Many states pay all-inclusive cost-based rates that are much higher than fee-for-service rates and Medicaid cost-based rates well in excess of the Medicare rate. We have recently seen Medicaid rates in the \$140 to \$150 range.**
 - i. **Because Medicaid is the best payer in the RHC setting pediatricians typically receive the highest percentage increase in reimbursement once they become a rural health clinic.**
 - ii. **Additionally, the best performing clinics have lots of visits. Even though the program is a cost-based program, the lower cap on Medicare means that physicians that have lower level visits (99212 and 99213) perform better financially.**
 1. **In summary, you need Medicaid patients.**
 2. **And a good volume of patients.**
 - a. **If provider-based you can survive on a lower volume of patients; however, you would be dependent on a high payer mix of Medicare/Medicaid patients.**
 - i. **For example, I recently went to a clinic with low volume and a Medicare rate of \$250 and a Medicaid rate of \$150, yet they lost \$300,000 per year due to having only 20% Medicare and 10% Medicaid patients.**
 - iii. **Typically, internal medicine fares the worst under RHC reimbursement due to low**



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- volume/high intensity of the patients and the high number of procedures that internal medicine physicians perform.
- b. Rural health clinics do receive a cost-based reimbursement rate that increases each year and is not frozen by the SGR computations. Currently, the reimbursement from Medicare is in excess of 99213 of the typical Medicare fee schedule, however, is less than the 99214.
 - c. Rural Health Clinics are not subject to limiting charges. If the clinic charges \$100 for a 99213, the clinic is allowed to collect 20% of the charge from the patient/secondary insurance. This can be as much a \$7 per visit increase in reimbursement depending on your fee schedule.
 - d. Medicare co-payments and deductibles are reimbursable if uncollectible on the Medicare cost report included unpaid Medicare/Medicaid dual legible or crossover bad debt.
 - e. Influenza and pneumococcal shot are reimbursed at cost in addition to the reimbursement rate on the cost report. Typical reimbursement under cost-based reimbursement is \$75 for pneumococcal shots and \$35 for influenza shots.
 - f. RHC Billing can be simpler in some aspects:
 - i. CPT/HCPCS Codes are not required on the UB-04
 - 1. unless the service is a preventive health service with a frequency limitation.
 - ii. Revenue Codes are used to bundle all services:
 - 1. Office Visit – Revenue Code 0521
 - 2. Home Visit – Revenue Code 0522
 - 3. SNF Visit (Part A) Revenue Code 0524



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4. SNF/NF Visit (not Part A) R. Code 0525

- 3. What are disadvantages of being a rural health clinic as far as billing is concerned.**
- a. First, you must have a nurse practitioner or Physician Assistant seeing patients at least 50% of the time the clinic is open and have a provider(physician, NP, PA) on site to perform services on a patient.**
 - b. The definition of a visit for Medicare purposes does not include nurse only visits (99211). Those services are absorbed into the cost report or paid “incident too” (which means, “you ain’t getting paid”)**
 - c. You must use the UB-04 Form for Medicare Billing and by so doing you are disqualified from participating in several incentive programs:**
 - i. HPSA 10% Geographic Bonus**
 - ii. Electronic Prescribing 2% Bonus**
 - iii. PQRI 2% Bonus**
 - iv. EHR Stimulus payments from Medicare based upon charges on the 1500. (although, RHCs do have some advantages in the Medicaid program)**
 - d. Procedures are paid as an office visit and reimbursed relatively poorly compared to traditional Medicare reimbursement.**
 - e. RHC Cost reporting and annual evaluations are costly and an administrative burden.**
 - f. RHC billing can be relatively complex as it does not cover all the services that Medicare covers including:**
 - i. Laboratory including the 6 required RHC tests**
 - 1. pregnancy test**
 - 2. Hemoglobin or Hematcrit**
 - 3. primary culturing for transmittal**



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4. blood sugar
5. xxx
6. xxx
 - a. Why: Lab services are not subject to deductibles and copays and if they were billed on the UB-04 the beneficiary would pay more to use the RHC.
- ii. Technical components are not covered under the RHC benefit and are paid fee-for-service.
 1. Provider-based clinics and CAHs should review billing for these components carefully because they may qualify for cost-based reimbursement. (use the Hospital Provider number to bill and use the Type of Bill used by the hospital)
- iii. Hospital services are not covered under the RHC benefit and are billed fee-for service.
- g. Negative reimbursement tends to have a greater impact in rural health clinics than in traditional Medicare.
 - i. If services are subject to the annual deductible (\$155 in 2010); then Medicare would actually not pay you for providing service to the patient; but withhold money from your check. For example:
 1. Your cost per visit is \$75 and you charge \$155 for a service that is subject to the deductible, Medicare would withhold \$80 from your check. (Ouch!!!)
4. Are there other cost-based programs beside rural health clinics?
 - a. Provider-based clinics are owned by the hospital and receive cost based reimbursement for the overhead



of the clinic and fee for service (minus a discount) for physician services. Medicaid typically does not recognize this form of reimbursement and most of the clinics with heavy Medicare utilization are better off becoming a provider-based clinic if they qualify.

- b. FQHCs- Non-profit entities that receive Section 330 grants or are look-alikes. Growing rapidly and have received around \$46 billion in funding over the next 5 years.
 - c. Indian Health – Must be on a Indian reservation; however, does receive very high reimbursement per visit.
5. **Conclusion: Are you in the right place? Do you want to learn more about rural health clinic billing or do you want to run away as fast as you can? Questions? Thank you!!!!**



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Rural Health Clinic Billing 102

- I. How does becoming a rural health clinic affect billing in my clinic?
 - a. RHC certification does not have any affect on other payer types besides Medicare and Medicaid.
 - b. We will discuss the Medicare rules in some detail as they are generally the same throughout the country.
 - c. Medicaid rules are specific to each state and Medicaid in your state should be notified regarding their payment rules.
 - d. Remember the “Golden Rule”
 - i. “He who has the gold makes the rules”
- II. Who makes the rules?
 - a. CMS in Baltimore and D.C. makes the rules that RHCs must abide by and Medicare payment is delegated (contracted) to 12 different Medicare Administrative Contractors (MACs) in 15 different regions throughout the USA. Some examples are:
 - i. Noridian
 - ii. Highmark Medicare Services
 - iii. National Government Services
 - iv. Cahaba Government Benefits Administrator
 - v. Trailblazer
 - b. CMS makes rules for States to receive matching Federal funds (usually 57%) and in most cases the states are required to fund RHC using a prospective payment rate based upon cost from cost reports. (See BIPA 2000)
 - i. Each State implements this differently. Some use Managed Care Organizations (MCOs) and some states pay quarterly wrap-around payments.



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III. How can we find the Medicare Payment Rules? The internet, of course. Here are some good starting places:

- a. <https://www.cms.gov/MLNProducts/downloads/QuickReferenceAllMedicareProviders.pdf>
- b. <http://www.cms.gov/MLNEdWebGuide>
- c. <http://www.cms.gov/center/rural.asp>
- d. <http://www.cms.gov/manuals/downloads/clm104c09.pdf>
- e. <http://www.cms.gov/manuals/Downloads/bp102c13.pdf>

i. The MACs will have teleconferences and training that will be beneficial to you. Check their websites regularly.

IV. What are the Medicare rules?

a. First, a provider (physician, NP, PA) must be physically onsite to provide medical services to a patient in a rural health clinic. This is a certification issue more so than a billing issue, however, it is relevant.

b. What is the definition of a rural health clinic visit and how is it different from a traditional Medicare visit?

i. Must be between a physician, nurse practitioner, Physician Assistant, Nurse Midwives and a patient. Must be a face-to-face encounter. (Note: there are exceptions to this rule as there are for most Medicare rules)

ii. The service must be medically necessary,

iii. The services must be provided by someone with the appropriate level of training and not by someone outside the scope of practice of their training. (for example, a physician can not give an allergy shot and charge a visit as it does not require the expertise of a physician to provide an allergy shot)



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1. How to determine if you are abusing the Medicare program?
 - a. Do you treat Medicare patients differently from other patients for reimbursement purposes?
 - b. Do you treat your patients differently than other physicians do in your area for reimbursement purposes?
 - c. Do you treat your patients differently than other RHCs do in your area for reimbursement purposes?
- c. What about “incident to” regulations. Do they apply to rural health clinics?
 - i. RHC status elevates NPs and PAs to the status of a physician as far as incident to regulations are concerned. All services must be provided with at least a physician, NP, or PA physically onsite. The traditional Medicare rules of:
 1. The physician must see the patient first.
 2. The physician must be in the clinic.
 3. The physician must continue to see the patient (one in three visits, or one in four)
 4. and the physician must have an employment relationship with the patient.
 - a. If all of these rules are met the physician can bill the NP/PA services incident to and receive 100% of the Medicare fee schedule.
 - b. These rules do not apply to rural health clinics and RHCs receive 100% of the RHC clinic rate regardless if the physician is on site or not.



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- V. How are Medicare Services paid in a rural health clinic?
- a. Medicare pays 80% of the cost reimbursement rate, typically \$77.76 in independent rural health clinics.
 - b. The patient pays 20% of the charge without being subject to limiting charges in a rural health clinic.
 - c. The patient is subject to the Medicare annual outpatient deductible which is currently \$155 (2010).
 - d. Rural Health Clinic reimbursement covers:
 - i. Office visits (Revenue Code 0521)
 - ii. Home visits (Revenue Code 0522)
 - iii. Skilled Nursing Home visits paid for by Medicare Part A (Revenue Code 0524)
 - iv. Skilled Nursing Home and Nursing Home visits not paid by Medicare Part A (Revenue Code 0525)
 - v. Telemedicine (Revenue Code 0780)
 - vi. Psychiatric services (Revenue Code 0900) (Currently paid a reduced rate)
 1. 2011 68.75%
 2. 2012 75.00%
 3. 2013 81.25
 4. 2014 100%
 - e. RHC services can be provided in three places:
 - i. The certified rural health clinic
 - ii. The patient's home
 1. includes skilled and NF nursing homes
 2. assisted living facility
 3. swing bed
 - a. Does not include:
 - i. Hospital
 - ii. Jail
 - iii. Scene of an accident (Revenue Code 0528)



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- f. There are 4 types of RHC services
 - i. Face to Face Encounters (meets the three criteria for a visit)
 - 1. Counted as visits and billed on the UB-04
 - ii. “Incident too” services (do not meet the criteria for a visit)
 - a. Can be bundled with an office visit that occurs within 30 days before or after and will increase charges. I.e.
 - i. Allergy shots
 - ii. B-12 shots
 - iii. Blood pressure checks
 - iv. Dressing changes
 - v. Diabetic counseling
 - vi. Nutritional counseling
 - iii. Non-RHC Services (services that are covered by Medicare; however, are not covered by the RHC benefit).
 - 1. Can be billed fee for service in independent rural health clinics or Provider-based clinics and CAHs should review billing for these components carefully because they may qualify for cost-based reimbursement. (Use the Hospital Provider number to bill and use the Type of Bill used by the hospital).
Examples are:
 - a. Laboratory services
 - b. Hospital services
 - c. Technical components
 - d. Procedures or visits performed outside of rural health clinic hours



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time and exclude the cost from the cost report and bill it to Medicare Part B as long as it occurs and is documented as occurring during non-RHC hours.

- iii. How do I bill for surgeries in the hospital?
 - 1. Bill it as procedure only and count the visits that occur in the RHC and bill those to Medicare.
 - 2. If you bill a global charge for the procedure, you would need to track the visits that occur during the global period and not bill them as a RHC visit.
- iv. How do I bill for surgeries in the clinic?
 - 1. Code an E and M code with the procedure and roll the fee up into the Revenue Code 0521 and bill this on the UB-04. Do not bill this to Medicare Part B and get paid fee for service for it.
- v. Can I set up some time or a treatment room and bill procedures that occur in the treatment room to Part B? Ask your MAC before you do this. Some consultants indicate that you can do this and some (me) say that you do this based on time only. The cost report is set up to handle time and not other methods; however, consultants indicate that this is being done with MAC approval.
- vi. How do I bill for Hospice patients?
 - 1. You must get paid from the Hospice unless the ICD-9 code is different than the terminal diagnosis. Indicate in Form Locator 83 Remarks that the visit was unrelated to the terminal diagnosis.



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- vii. How are Medicare Advantage patients paid for by rural health?
 - 1. They are not. They are not covered as a rural health clinic service and you must negotiate with the Medicare Advantage Plan for payment. If you do not have a contract with the plan, you are supposed to get your RHC reimbursement rate; however, in reality that is difficult.
- viii. How are claims paid when Medicare is secondary to other insurance?
 - 1. Medicare is listed second in Form Locator 50 of the UB-04 Form.
 - 2. A condition code is included in Form Locator 11 through 18 indicating why Medicare is secondary.
 - 3. Value Code 44 is placed in Form Locator 39 and the amount the insurance company paid is listed.
- ix. How are claims paid when Medicare is primary and insurance is secondary?
 - 1. Medicare is listed as the first payer in Form Locator 50 of the UB-04 and the secondary payer is listed in the line below.
 - 2. The claim will automatically crossover and the secondary will pay the co-pay and deductible.
 - a. What happens when the secondary denies payment for using a UB-04 or receiving a “facility” payment?
 - i. Drop a 1500 and copy the remittance advice and send it to



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the insurance company for payment.

- x. What are value codes, condition codes, occurrence codes, and modifiers.
 - 1. Condition Codes –
 - 2. Occurrence codes cover a span of time and must have a date when they are used. Examples are:
 - 3. Value Codes describe an amount and always include an amount. Examples are primary insurance payments
 - 4. Modifiers are typically used with the 1500 form; but, can be used on UB-04s to describe a CPT code.
- xi. How are preventive services handled in rural health clinics?
 - 1. The professional service or face to face encounter is charged to Medicare if the frequency requirement is met and the technical component is billed to Part B and paid fee for service. (if provider-based see note above on billing technical components). You are required to use the CPT/HCPCS Code on the UB-04 in this situation.