



HBS

Update

May 1, 2011

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CMS PROPOSES TO EXPAND ACCESS TO SEASONAL INFLUENZA IMMUNIZATION

On April 29th, CMS issued proposed rules requiring that rural health clinics offer all patients an annual influenza vaccination during flu season, unless medically contraindicated. This will most likely have minimal effect on rural health clinics as well over 90% of the RHCs we prepare cost reports for do provide seasonal influenza shots. There will be a need to prepare new policies and procedures documenting the procedures and you may need to develop a patient registry to ensure that all patients have been provided the opportunity to be immunized.

I highly encourage our clinics to provide flu shots as last year our cost report benchmarks showed that our clinics averaged a payment of \$75 for pneumococcal shots and paid \$32 for them in direct supply cost and the average influenza payment was \$30 versus an average direct supply cost of \$9. Thus, it was profitable for the clinic, albeit, a long wait for the cash.



One thing that would help the cash flow is if all the MACs would calculate the interim payments based upon total payments due to the provider which includes the interim rate, the flu and pneu. shots, and the bad debts. For example, I am working on a cost report for a West Virginia provider and their interim rate is established at \$85.00 per visit. Highmark Medicare Services is the only MAC (at least that I am aware) that does this as the others limit the independent interim rate to the Medicare cap of \$78.07. If we could get all the MACs to use such a formula as Highmark uses it would certainly help



cash flow to fund the flu and pneumococcal shots. The announcement from CMS is as follows:

Proposed Requirement Would Make Flu Shots Available to Patients at Most Commonly Visited Medicare-certified Health Care Facilities

The Centers for Medicare & Medicaid Services (CMS) today proposed new requirements for Medicare-certified providers that are designed to expand access to seasonal influenza vaccination. The notice of proposed rulemaking would update the conditions of participation and conditions for coverage for a number of provider types, in an effort to increase access to the vaccine, increase the number of patients receiving annual vaccination against seasonal influenza, and to decrease flu-linked morbidity and mortality.

“Today’s proposed rule will expand Medicare beneficiaries’ options for where to receive a flu shot during flu season,” said CMS Administrator, Donald M. Berwick, M.D. “The new requirements would make flu shots available in more of the health care facilities that Medicare beneficiaries are most likely to visit, including hospitals and rural health clinics.”

This proposed rule would require many Medicare providers and suppliers to offer all patients an annual influenza vaccination during flu season, unless medically contraindicated. As always, any patient would retain the right to decline any vaccination. This proposed requirement would extend to Medicare-certified:

- ▯ Hospitals, including Short-term Acute Care, Psychiatric, Rehabilitation, Long-Term Care, Children’s, and Cancer; Critical Access Hospitals (CAHs);
- ▯ Rural Health Clinics (RHCs); Federally Qualified Health Centers (FQHCs)
- ▯ End-Stage Renal Disease (ESRD) Facilities that offer dialysis services.

Today’s proposed rule would update the conditions of participation and conditions for coverage for all of the provider types above. These rules apply



to health care organizations that seek to begin and continue participating in the Medicare and Medicaid programs. The conditions are health and safety standards that are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS implements these standards through state departments of health and accrediting organizations recognized by CMS (through a process called "deeming"), which review provider practices to assure they meet or exceed the Medicare's condition standards.

In order to meet these proposed provisions, the providers and suppliers would need to develop and implement policies and procedures for offering and administering seasonal influenza vaccine. The proposed rule does allow for situations in which vaccine supplies may be unavailable or in short supply, and recognizes that providers and suppliers could not be held accountable for providing vaccine for all patients in such circumstances.



Additionally, the proposed rule would require the included providers and suppliers to develop policies and procedures that would allow them to offer vaccinations for pandemic influenza, in case of a future pandemic influenza event for which a vaccine is developed.

“This proposal will remove barriers for Medicare beneficiaries who want to receive annual flu shots as part of their preventive health routine,” said Dr. Berwick. “While CMS believes that flu vaccination is the best way to keep beneficiaries and their families safe and healthy during flu season, our proposal respects the rights of beneficiaries and their families to choose whether the flu shot is best for them. However, we hope that by expanding the breadth of places where flu shots are offered, beneficiaries will make the



choice about whether to vaccinate based on health needs rather than convenience or availability.”

CMS will accept public comments on the CMS proposed rule until July 5, 2011, and will respond to comments in a final rule to be published in the coming months. To submit comments, please visit <http://www.regulations.gov> and search for rule “CMS-3213-P.”

The proposed rule is available online from the *Federal Register* at http://www.ofr.gov/OFRUpload/OFRData/2011-10646_PL.pdf

To view the announcement from Medicare follows this link:

<http://www.modernhealthcare.com/assets/pdf/CH73780429.PDF>

Seasonal Flu

Flu caused by viruses that are already among people. The best way to prevent it is by getting an annual flu shot.

Click here for more information on **Seasonal Flu.**



Office of Rural Health Policy Announces Application Release for the Rural Health Information Technology (HIT) Grant Program

On April 27, 2011, the Office of Rural Health Policy (ORHP) announced the release of the Rural Health Information Technology (HIT) Grant Program to support rural organizations in their ability to effectively achieve "meaningful use" requirements. HIT is critically important for rural communities and while a lot of the early innovation in the use of electronic records and HIT networks was done in rural communities, many challenges still remain. This pilot program was developed as a result of the President's Rural Health Initiative which identifies HIT as a priority area and the Secretary's Rural HIT Taskforce. To address these and other HIT issues, Secretary Sebelius established an HHS Rural HIT task force co-led by HRSA Administrator Dr. Mary Wakefield and the Office of the National Coordinator. The purpose of the taskforce is to discuss the challenges rural communities face in adopting HIT, ways to address these challenges, and how to coordinate resources from the federal level. One of the major challenges that the taskforce has identified is access to capital and ORHP anticipates that this program will assist rural communities in addressing this challenge.

Due to the unique broadness and flexibility of the 330a authorization, ORHP had a great opportunity to develop this grant program in response to these initiatives. The rural HIT program was developed out of the Network Development Program legislation, keeping the focus on rural networks.

To download the funding opportunity, please visit the links below:

Link for Funding Opportunity Synopsis:

<http://www.grants.gov/search/search.do;jsessionid=kqm8N4cF3Z3STSzYZ8Vk0B2zsG8hWt9Zy8Cwn7QyzcHJIK2z6V2K!-210279180?oppId=90039&mode=VIEW>



Link to apply for Funding Opportunity:

<http://www.grants.gov/search/search.do;jsessionid=kqm8N4cF3Z3STSzYZ8Vk0B2zsG8hWt9Zy8Cwn7QyzcHJIK2z6V2K!-210279180?oppId=90039&mode=VIEW>

The deadline to submit an application in grants.gov is **May 27th, 2011**. ORHP **strongly recommends** that applicants submit their applications prior to the due date to avoid any technological problems. All applications have to be submitted electronically in www.grants.gov

There will be a technical assistance call for this funding announcement which will be held May 10th at 2pm eastern. The toll-free number to call in is **1-888-577-8992**. The Passcode is **HIT**. For your reference, the Technical Assistance call will be recorded and available for playback within one hour of the end of the call and will be available until June 10, 2011 11:59 PM (ET). The phone number to hear the recorded call is: 1-866-420-5718. For further questions on this funding opportunity, please contact the program coordinator, Marcia Green at 301-443-3261 or mgreen@hrsa.gov.

Source: http://www.raconline.org/news/news_details.php?news_id=15722

More on Health Information Technology

The South Carolina Office of Rural Health had their annual meeting in April and this presentation by Susan Hartnett is excellent in taking you through the registration process for the Electronic Health Records stimulus payments.

<http://www.scorh.net/Susan%20Hartnett.pdf>

Additionally, Todd Thornburg, PhD attended our Columbia Update meeting and provided his business card for our South Carolina rural health clinics that need assistance in obtaining the electronic health records stimulus payments.



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How should new Rural Health Clinics bill Medicare after they have been certified but do not have provider numbers or a rate?

One of the ongoing questions regarding Medicare billing is how new RHCs should bill Medicare during the time after they have been certified as a rural health clinic; however, they do not have providers or rates. You get answers ranging from one consultant's admonishment that if you bill Medicare B during this year it is illegal and the implication that you will go to jail. My advice has been since August, 2009 (when Riverbend lost the contract) to just bill Medicare Part B and when they get your rate set and provider number established, then start billing with 2 months the claims to . The problem is CMS and the MACs refuse to communicate to the provider community their expectations; which make it rather difficult to comply with uncommunicated expectations.

Riverbend had a process called retroactive recognition where the clinics would bill Medicare Part B during the start up period of time and could get a settlement on the first cost report using the retroactive recognition form which was basically a detail listing of claims billed to Part B and the amount paid. To my knowledge, Cahaba has not had such a process until April 21, 2011 when CMS communicated to them that they could recognize the Part B payments and pay a settlement based upon these payments. (Here is a little warning on this; you may find that as a rural health clinic you are receiving less from Medicare Part A than you would from Medicare Part B). Here is the form that Cahaba would like for providers to complete

[2011 Retroactive Recognition Worksheet from Cahaba called Worksheet 14 for Part B claims during the new startup phase.xlsx](#)



Here is what Cahaba has communicated to me and is a direct quote from the Cahaba personnel. I will not reveal the name as they for some reason did not want the provider community to be aware of the process.

“We will not have any communication going out on this issue at this time. CMS may publish something at a later time. For agencies that processing tie in notices timely, the preferred method is to wait until you have your rate established to start billing for the Medicare services and bill Part A at that time. Some states are further behind than others in processing a tie in and certification of a rural health, in this situation they may have billed Part B in order to keep their operations moving smoothly. If they have billed Part B they are excepted to keep the log of Part B patients and billing information and support for those services. They must file this on their cost report with an explanation as to why this was necessary and include the supporting log with the cost report. As soon as possible after the providers rate is established they should start billing part A, but no later than 60 days after their rate is set.”

To summarize the billing process for new clinics:

1. Continue billing Medicare B for all services.
2. Obtain Provider Number and reimbursement rate from Medicare.
3. Start billing Medicare Part A within 60 days of obtaining a reimbursement rate from Medicare.
4. Prepare Worksheet 14 which is a detail of billing to Part B during this startup period with an explanation that it was necessary to continue operations and attach it to the first filed cost report.

[2011 Retroactive Recognition Worksheet from Cahaba called Worksheet 14 for Part B claims during the new startup phase.xlsx](#)

You have most likely not seen anything in writing on the above process as little has been communicated about it. I welcome the advice and consultation of others who are knowledgeable of the processes of the various MACs. Additionally, I did not discuss Medicaid as each Medicaid program has different processes and requirements. Anyone wishing to communicate those to me, I will prepare a table and distribute that information on our website and newsletter.



CPT Coding Presentation for Rural Health Clinics by Carolyn Duncan, CPC, CPC-H on May 6, 2011

The following is the CPT Coding presentation for Rural Health Clinics provided by Carolyn Duncan, CPC, CPC-H. This presentation will be presented from 8:00 AM to 9:30 AM on Friday, May 6th at our RHC Update Seminar in St. Louis.

[2011 CPT Coding Presentation by Carolyn Duncan in St Louis MO on May 6 2011.ppt](#)

There is still limited space for the seminar if you are interested in attending. Here is the information that will help you register for the seminar.

http://www.ruralhealthclinic.com/st_louis,mo.htm

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At our seminar in Columbia, Katie Noyes discussed converting from a RHC status to FQHC. This process is very interesting to some rural health clinics and if you are interested in becoming a FQHC, you may want to consider giving Katie a call. She indicated that she would be happy to discuss this process with anyone.

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HBS

Healthcare Business Specialists

Thanks for reading this newsletter. I am working on cost reports this month and most likely will not be producing any newsletters the rest of the month. Please limit your phone calls if possible during this month to just necessary communications as I will be working diligently to get all the cost reports completed. Thank you very much for entrusting us to perform this important work and best regards to all.

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