RuralHealthClinic.com
Experienced Knowledge

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RHC Update Seminars for Spring, 2011 announced

Healthcare Business Specialists is pleased to announce that the RHC Spring Update seminars have been scheduled for 2011. The dates and locations are Nashville, Tennessee on April 7, 2011, Knoxville, Tennessee on April 8, 2011, Indianapolis on April 22, 2011, Columbia, SC on April 29, 2011, and St. Louis, MO on May 6, 2011. We will start at 9:30 and run till noon. We will have 1 hour break for lunch which will be provided from 12:00 to 1:00 pm. The seminar will then run from 1:00 to 3:30 pm in the afternoon. Orange Juice, Coffee, and soft drinks will be served at the seminars.

Each seminar will have special guests invited to talk about relevant topics for the State that we are in. For example, Greg Hawkins, Julie Rogers, and Marsha Holman from the State of Tennessee are confirmed as speakers for our meeting in Nashville on the preparation of the Quarterly Tenncare Settlement Reports. Glen H. Beussink, Director of Clinic Development & Research from Midwest Health Care, Inc. will be presenting on Tenncare Settlement Reports with the State as well. We will update you on any additional speakers that we may have at the meetings.

If you would like to speak or sponsor a meeting, please let me know as we can arrange for you to sponsor the meeting and will provide some time to discuss your product with the seminar attendees.

The price of the seminar will be $250.00 per person for the full day The printed materials including full color slides is not a part of the fee and if you want to obtain the Workbook the cost is $125 per notebook and the notebook will include a DVD with all the presentations and additional information related to RHCs. Again, the Workbook is an additional fee from the seminar fee.

Payment can be made to la_vita_nouva@hotmail.com using PayPal or by sending a check to Mark Lynn, Healthcare Business Specialists at Suite 214, 502 Shadow Parkway, Chattanooga, TN 37421. You can sign up online and pay with Visa, Mastercard, and Discover credit cards. We do not accept American Express.

What you missed last year. Here are some of the presentations that we presented at the 2010 RHC Update Seminars. Much of the information is still applicable so you may find it helpful. This year's seminar will be completely updated with new information. We do expect new regulations for RHCs be finalized by the time the seminars are conducted this year so much of the seminar will be dedicated to quality improvement, potential loss of RHC status and potential safeguards, and all the provisions that may change due to the new final conditions of participation. Here are the presentations:

2010 RHC Update Presentation on Healthcare Reform, ACOs, and PCMHs

2010 Electronic Health Records Stimulus Payments for RHCs Presentation as of December 10 2010.pdf

2010 RHC Billing 101 Presentation in Boise Idaho on November 3 2010.pdf

2010 RHC Billing 102 Presentation for Boise Idaho presentation on November 3 2010.pdf

RHC Update Seminars – Table of Dates, Locations, and Times

Date	*Location*	*Time*
Thursday, April 7	Nashville, TN	9:30 to 3:30
Friday, April 8	Knoxville, TN	9:30 to 3:30
Friday, April 22	Indianapolis	9:30 to 3:30
Friday, April 29	Columbia, SC	9:30 to 3:30
Friday, May 6	St. Louis	9:30 to 3:30

If you want sign up for the seminars, here are the hyperlinks

RHC Update Seminar in Nashville, TN on April 7, 2011

RHC Update Seminar in Knoxville, TN on April 8, 2011

RHC Update Seminar in Indianapolis, Indiana on April 22, 2011

RHC Update Seminar in Columbia, SC on April 29, 2011

RHC Update Seminar in St. Louis, MO on May 6, 2011

"We're not in Kansas anymore"

Rural Health Clinics have had it pretty good over the years. With Riverbend and Trailblazer being the intermediary for the majority of the rural health clinics (RHC) for the vast majority of the existence of the RHC program, things have been relatively stable. However, with Section 911 (how appropriate) of the Medicare Modernization Act of 2003 and the establishment of 15 different jurisdictions (now its 10) with different Medicare Administrative Contractors (MACs) processing rural health clinic Medicare claims and cost reports, things have changed. As Dorothy, said to Toto in the Wizard of Oz. "…we're not in Kansas anymore".

Medicare Cost Report audits are being conducted by MACs that were not processing RHC claims for the time period of the audit. States are going back and recouping payments as far back as 2001 for Medicaid "prospective" payments, and some states are changing the way Quarterly Wrap-around payments are paid and are recouping as much as One million dollars from rural health clinics. It's not enough that RHCs must worry about healthcare reform, electronic health records implementation, EHS stimulus payments, and ICD-10 coding changes; but, now we are being told that the past is not the past. Now, more than ever, it's time to have a larger organization on your side such as the National Association of Rural Health Clinics (NARHC) that can help rural health clinics battle these inequities.

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Physician compensation is one of the problem areas that I have noticed in the Medicare audits. One MAC was using the Reasonable Compensation Equivalent of $144,000 as the maximum allowable compensation for any physician whether that physician is an owner or not. After many hours of negotiating and pages and pages of documentation, we did get the allowable compensation amount up to $283,000 which I felt was reasonable. Our benchmarking database of cost reports indicates that the average physician compensation was $257,296 in 2009. Not only does Medicare have issues with allowable compensation; but, Medicaid is known to audit and disallow physician compensation as well.

Another audit issue was of course Medicare Bad Debt. The bad debt process is detailed and cumbersome. Every column on the Bad Debt spreadsheet must be addressed or Medicare will disallow the bad debt and typically will use a sample of claims to disallow an amount from the entire population of debts. In other words, if Medicare audits 10 claims and one of them is missing needed documentation, the MAC will reduce your Bad Debt claim by 10%. The best thing you can do to protect yourself from this is to keep up your bad debt spreadsheets on a monthly basis and not get behind on the paperwork, otherwise, it will be difficult to go back and find the necessary information Medicare requires to claim a bad debt.

State budgets are in the worst shape in years and they are looking for every dollar they can wrangle out of providers. California is going back to 2001 and recouping money paid out under the "prospective" payment system. Tennessee is recouping money paid out on the quarterly settlements and auditing just about every rural health clinic in the state. Some of the requested repayments will

bankrupt rural health clinics, if they are determined to be accurate. Don't just take the State's word for it when you get one of these requests. Make sure you review the accuracy of the computations and ask for assistance from your CPA, consultant, or legal council before you pay any monies back to the State. Also, ask for help on the NARHC List-Serve as the members will be more than willing to assist you and provide their experience in similar situations. I know I asked for help in dealing with an audit issue and found the advice instrumental in getting a more favorable result for our client.

In closing, just a reminder that the environment has changed that rural health clinics operate and it is more important than ever to stay up to date with changes that are coming to the RHC program. Proposed changes to Conditions of Participation as mandated by the Balanced Budget Act of 1997 are due any day now and now is a great time to plan on going to the National Association of RHCs Spring Institute meeting in San Antonio in March, 2011. If the regulations have been finalized by then, they are sure to be a hot topic of the meeting. See you on the River Walk. Here is the information on the meeting.

Mark Your Calendars for the 2011 Spring Institute!

The 2011 Spring Institute dates have been set for March 23-25th at the beautiful Hyatt Regency in San Antonio, Texas. Click here to register for the event.

Click here for a draft agenda.

Click here to make hotel reservations online or call 800.233.1234. Be sure to mention you are with NARHC to receive the discounted room rate of $169.00/night.

Click here for vendor/sponsorship information.

"Medicare Preventive Services for 2011"

I have received a number of emails and calls related to the new Medicare Preventive Services for 2011 and the waiving of copayments and deductibles related to these services. CMS has tried to clarify this information by releasing a Medlearn Matters article addressing the issue. Unfortunately, it may have caused more confusion than clarification. RHCs and FQHCS are treated differently and this could have caused some of the confusion. First, here is the link to the Medlearn Matters article.

http://www.cms.gov/MLNMattersArticles/downloads/SE1039.pdf

Let's take a look at the summary of the document which is located on the last page of the article.

Element	RHCs	FQHCs
Revenue Codes	052X series	All except: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x
HCPCS code	Required for Preventive Services only excluding Flu and PPV	Required for **all** services rendered during encounter/visit
Modifier 59	Not applicable at this time	Should be used to report two distinct unrelated visits on the same day
DSMT and MNT	Not separately payable	All inclusive payment rate

So what is different for rural health clinics? Previously, all charges were bundled into one line with a revenue code of 0521 (for an office visit). RHCs are now specifically instructed to separate preventive health from sick care (implying that you can have both a sick and well visit on the same day). Now, you can have two lines on the UB-04 with a revenue code for a sick office visit and a revenue code for a preventive service accompanied with a HCPCS.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are waived for the IPPE, the annual wellness visit, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. Lab and technical components should continue to be billed as non RHC services.

Some confusion from the MACs has already been noticed as Palmetto is requiring all RHCs to have HCPCS codes on claims, even though the article makes it clear that this provision only applies to FQHCs.

To make matters worse and more confusing, the Centers for Medicare & Medicaid Services (CMS) has identified an issue when Healthcare Common Procedure Coding System (HCPCS) codes are reported for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B on

Rural Health Clinic claims (71X) for dates of service on or after January 1, 2011. Since the additional revenue line(s) are not separately payable, the contractors have been instructed to move the charges associated with these revenue lines to the non covered field and to override reason code 31577. This will allow the claim to continue processing and not delay payments. After the changes for CR 7208, transmittal 2122, are implemented on April 4, 2011, contractors will mass adjust these claims to ensure the charges are reflected as covered. Providers should not attempt to resubmit affected claims as their FI or MAC will be initiating adjustments for the sole purpose of correcting the charges. Providers should anticipate the initiation of these adjustments within 30 calendar days after the implementation of CR 7208.

Since these payments will be mass adjusted and you most likely would only be creating negative reimbursement due to the $162.00 deductible, it may not be a bad idea to hold off on billing Medicare claims with preventive services until Medicare figures out how to get the additional lines to pay appropriately. Here is some more from Trailblazer from January 1, 2011 which is a summary of the Medlearn article.

SE1039 is based on Change Requests (CRs) 7038 and 7208 and provides a billing guide for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). It describes the information FQHCs are required to submit for CMS to develop and implement a Prospective Payment System (PPS) for Medicare FQHCs. It also explains how RHCs should bill for certain preventive services under the Affordable Care Act (ACA).

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Historically, RHCs' and FQHCs' billing instructions have been the same. However, effective January 1, 2011, the billing requirements will be different for each of these facility types.

RHC (Type of Bill (TOB) 71X)

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the Initial Preventive Physical Examination (IPPE) provided by RHCs. However, to ensure coinsurance and deductible are not applied, detailed HCPCS coding must be provided for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. The ACA also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

To ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052X series with the approved preventive service HCPCS code and the associated charges as follows:

Line	Revenue Code	HCPCS code	Date of Service	Charges
1	052X		01/01/2011	100.00
2	052X	Preventive Service Code	01/01/2011	50.00

The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate; coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable to the service line with the preventive service.

Revenue Code	Definition
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC/FQHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)

http://www.cms.gov/transmittals/downloads/R2122CP.pdf

Rural Health Open Door has Preventive Services Coding for RHCs on the Agenda

If you are as confused as I am about the new Preventive Services Coding the proposed agenda for the next Rural Health Open Door Forum includes preventive services and you may want to listen in. Here is the announcement from CMS.

The proposed agenda for The next Rural Health Open Door Forum is scheduled for Wednesday, January 26, 2011 from 11:30am-12:30pmET is as follows: EMTALA Advanced Notice of Proposed Rulemaking (ANPR); RHC & FQHC Preventive Services Coding; Home Health & Hospice Fact-to-Face Requirement; Clinical Lab Signatures; EHR Incentive Payment Enrollment Update. This agenda is subject to Change. This call is Conference Call Only. If you wish to participate, dial 1-800-837-1935 Conference ID 29119737. Please see the full participation announcement in the Downloads section below.

The Rural Health ODF addresses Rural Health Clinic (RHC), Critical Access Hospital (CAH) and Federally Qualified Health Center (FQHC) issues, as well as some inclusion of other questions and concerns that occur in clinical practice pertaining to other CMS payment systems that also extend into these settings. Topics that frequently arise on this forum often deal with payment & billing for services subject to Health Professional Shortage Area (HPSA) and/or Physician Shortage Area (PSA) status, cost report clarifications, classifications for & qualifications of rural provider types, and the many special provisions being implemented for improving rural health in the Medicare Modernization Act of 2003. Timely announcements and clarifications regarding important rulemaking, quality program initiatives, and other related areas are also included in the Forums.

Helpful Information from Trailblazer

Trailblazer published a table with the Medicare coinsurance and deductible amounts for 2011. The Medicare outpatient deductible increased from $155 in 2010 to $162 in 2011. Remember this amount will affect negative reimbursement in January and February when the deductible is due. Here is the link and a sample of the information.

http://www.trailblazerhealth.com/Publications/Job%20Aid/MedDedCoIns.pdf?DomainID=1

Medicare Deductibles and Coinsurance Amounts

Calendar Year	Inpatient Deductible	Inpatient Coinsurance	Lifetime Reserve (LTR)	Skilled Nursing Facility (SNF) Coinsurance	Part B Annual Deductible
2011	$1,132	$283	$566	$141.50	$162
2010	$1,100	$275	$550	$137.50	$155
2009	$1,068	$267	$534	$133.50	$135

On December 14, 2010, Trailblazer had an ask-the-contractor teleconference and here is the 6 page document of questions and answers. Not all of the information is specific to rural health clinics; but, there are a couple of answers on PECOS that may be helpful.

http://www.trailblazerhealth.com/Publications/Questions%20and%20Answers/ACTQAPartBJ412-15-10.pdf

RHC Reimbursement Rate Cap Increase for 2011

The maximum cost reimbursement rate cap for independent (freestanding) RHCs and provider-based RHCs with hospitals with 50 or more beds received a .4% increase from $77.76 per visit in 2010 to $78.07 in 2011. Provider-based rural health clinics with hospitals with less than 50 beds continue to be uncapped.

CMS recently updated the RHC Fact Sheet. Here is a link to the most recent copy.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Rural Health Clinic

RURAL HEALTH FACT SHEET SERIES

This publication provides the following information about Rural Health Clinics (RCH):

- RHC services;
- Medicare certification as a RHC;
- RHC visits;
- RHC payments;
- Cost reports;
- Annual reconciliation; and
- Resources.

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas. There are approximately 3,800 RHCs nationwide that provide access to primary care services in rural areas.

Rural Health Clinic Services

RHCs furnish:

- Physician services;
- Services and supplies incident to the services of a physician;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies incident to the services of a NP, PA, CNM, CP, and CSW;
- Medicare Part B covered drugs that are furnished by and incident to services of a RHC provider; and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there is a shortage of Home Health Agencies.

Medicare Certification as a Rural Health Clinic

To qualify as a RHC, a clinic must be located in:

- An non-urbanized area, as defined by the U.S. Census Bureau; and
- An area currently designated by the Health Resources and Services Administration as one of the following types of Federally designated or certified shortage areas:
  - Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act;
  - Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act;
  - Medically Underserved Area under Section 330(b)(3) of the PHS Act; or
  - Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act of 1989.

ICN: 006398/September 2010

http://www.cms.gov/MLNProducts/downloads/RuralHlthClinfctsht.pdf

Application Fee for Provider Enrollment and Revalidation

The Affordable Care Act requires that CMS impose a fee on each application of an institutional provider of medical or other items or services or supplies, and on required revalidation applications. The fee will be used to cover the cost of screening providers and to carry out the screening and program integrity efforts under the Affordable Care Act.

While the Affordable Care Act excludes eligible professionals, such as physicians and nurse practitioners, from paying an enrollment application fee, CMS takes a comprehensive view of what is an "institutional provider of medical or other items or services or supplier," with the exception of Part B medical groups or clinics and physician and non-physician practitioners who submit the CMS 855I form to enroll in Medicare. CMS includes, for example, hospitals, ASCs, HHAs, hospices, DMEPOS suppliers and ESRD facilities as "institutional providers." CMS will begin collecting the enrollment application fee beginning on March 23, 2011, for new enrollments, and from revalidating entities for all revalidation activity beginning after March 23, 2011.

The Affordable Care Act establishes a $500 application fee for providers in 2010 as a starting base, and for 2011 and each subsequent year, the amount for the preceding year will be adjusted by the percentage change in the Consumer Price Index. CMS can, on a case-by-case basis, exempt a provider from the application fee if its application would result in a hardship. CMS may waive the fee for Medicaid providers where a state demonstrates that the fee would impede Medicaid beneficiaries' access to care.

New MAC Jurisdictions

On July 21, 2010 CMS announced the cancellation of the bid for the Part A and Part B Medicare Administrative Contractor (A/B MAC) for Jurisdiction 2 comprised of the states of Washington, Oregon, Idaho and Alaska.

CMS also notified Noridian Administrative Services (NAS) that they would consolidate the Jurisdiction 2 and Jurisdiction 3 workloads and MAC contracts and issue a new request for proposal (RFP). The notice to NAS also stated that the consolidation of the J2 & J3 MACs was the result of CMS' reevaluation of the initial approach to the A/B MAC jurisdictions.

NAS is the legacy contractor for Alaska, Idaho (Part A), Oregon and Washington and the J3 A/B MAC which includes Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming. According to CMS the combined J2 & J3 MAC represent one of the smallest MAC contractors with just less than 6% of the total MAC workload nationwide.

On July 22, 2010 CMS posted a Request for Information (RFI) in which they list the following A/B MAC Program Strategy Elements:

- CMS will consolidate the present 15 A/B MAC jurisdictions into 10 A/B MAC jurisdictions, in a phased process that will take several years to complete.

- CMS will implement an award limit for the A/B MAC contracts, to be included in all A/B MAC solicitations beginning with the consolidated A/B MAC Jurisdiction 2/Jurisdiction 3 competition that CMS intends to issue later this summer.
- CMS will implement changes in the A/B MAC statement of work to augment and enhance the role of the contractor medical directors, including a requirement that each A/B MAC contract be supported by at least one full-time, fully dedicated medical director.

In the RFI CMS outlines their plan, over the next serveral years, to reduce the current 15 A/B MAC Jurisdictions to 10 A/B MAC Jurisdictions. The following 10 A/B MACs will be paired to form 5 consolidated A/B MACs:

- A/B MAC J2 & J3 - Alaska, Washington, Oregon, Idaho, North Dakota, South Dakota, Montana, Wyoming, Utah and Arizona
- A/B MAC J4 & J7 - Louisiana, Arkansas, Mississippi, Texas, Oklahoma, Colorado and New Mexico
- A/B MAC J5 & J6 - Minnesota, Wisconsin, Illinois, Kansas, Nebraska, Iowa and Missouri
- A/B MAC J8 & J15 - Kentucky, Ohio, Michigan and Indiana
- A/B MAC J13 & J14 - New York, Connecticut, Massachusetts, Rhode Island, Vermont, Maine and New Hampshire

The planned consolidation will start with the scheduled re-competition of implemented A/B MAC contracts and is to be completed over the next five years.

According to CMS the following A/B MAC jurisdictions will **not** be further consolidated:

- A/B MAC J1 - California, Hawaii, Nevada, Pacific Islands
- A/B MAC J9 - Florida, Puerto Rico, US Virgin Islands
- A/B MAC J10 - Alabama, Georgia, Mississippi, Tennessee
- A/B MAC J11 - North Carolina, South Carolina, Virginia, West Virginia
- A/B MAC J 12 - Delaware, Maryland, Pennsylvania, New Jersey, Washington DC

CMS is also proposing to change the name of the A/B MACs from the current Jurisdiction 1 - Jurisdiction 15 to Jurisdiction E - Jurisdiction N.

Website Changes

If you go to www.ruralhealthclinic.com you will notice big changes to our website. We have filed all the information that was previously on the home page and resulted in one long scroll of unrelated information. All the information has been categorized by subject and can be located on its corresponding page. I have included a blog page that is where I will continue to provide updates. The home page will also include the most recent posts; however, the information will be quickly filed to their appropriate page.

I hope this makes the site more useful to you and easier to find content that is of interest to you. If you have problems with tool bars on the side that help you navigate to the proper content, here are the hyperlinks to get you there.

Additionally, we have started a new website that will be used for Ecommerce and it is called www.healthcarebusinessspecialists.com. We have a new email address which is marklynn@healthcarebusinessspecialists.com and we will use that for business communications. (I will still use la_vita_nouva@hotmail.com for personal purposes so you may continue to use it if you prefer.)

Links to Information on Rural Health Clinic.com

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H B S

Healthcare Business Specialists

Thanks for reading this newsletter. I am working on the cost report Notebooks for 2011, so look for those to go out within the next week or so. If you would like for us to prepare your 2010 cost report, we still have some availably, (but, not much), so let us know soon. Thanks for all your help during 2010 and we look forward to another very productive year in 2011.

Please sign up for the seminars as soon as possible as well as all have very limited space. Thanks and look forward to seeing everyone at one of the seminars.

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