CPAs & BUSINESS ADVISORS

MONTANA FINANCIAL & OPERATIONAL INDICATORS IN RURAL HEALTH CLINICS

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WEBINAR PROGRAM INTRODUCTION

- Hosted by the Montana Health Research and Education Foundation with funds from the Medicare Rural Hospital Flexibility (Flex) Grant Program
  - August 5, 2019

- Focused specifically on Rural Health Clinics (RHC)

OBJECTIVES OF THE PROJECT

- Development of State specific RHC financial indicators
  - Definitions
  - Averages
  - Benchmarks

- Discussion on RHC best practice strategies
  - Operational
  - Cost Report
  - Billing

THE SOURCE FOR DATA

- Different than the CAH Financial & Operational Indicators Improvement Project
  - The Flex Monitoring Team does not gather and report this information
- Data source
  - Medicare Cost Reports
  - Financial information from Montana providers
  - Possibly the first state specific data base of its kind for RHCs

THE SOURCE FOR DATA

- Information requested for two fiscal years
  - Fiscal years ending in 2017 and 2018
  - 17 providers participated

- An option for transparency
  - Voluntary
  - Majority of providers agreed to transparent reporting

TRANSPARENT FACILITIES

- Roosevelt Medical Center – RMC
- St. Luke Community Healthcare – SLCH
- Dahl Memorial Healthcare – DMHC
- Marcus Daly Memorial Hospital – MDMH
- North Valley Hospital – NVH
- Sidney Health Center – SHC
- Frances Mahon Deaconess Hospital – FMDH
- Sheridan Memorial Hospital – SMH
- Clark Fork Valley Hospital – CFVH
- Northern Rockies Medical Center – NRMC

HOW WERE THE INDICATORS SELECTED?

- Small Rural Hospital and Clinic Finance 101
  - Released July 2018
  - https://www.ruralcenter.org/resource-library/finance-101-manual

DAYS IN ACCOUNTS RECEIVABLE (GROSS AND NET)

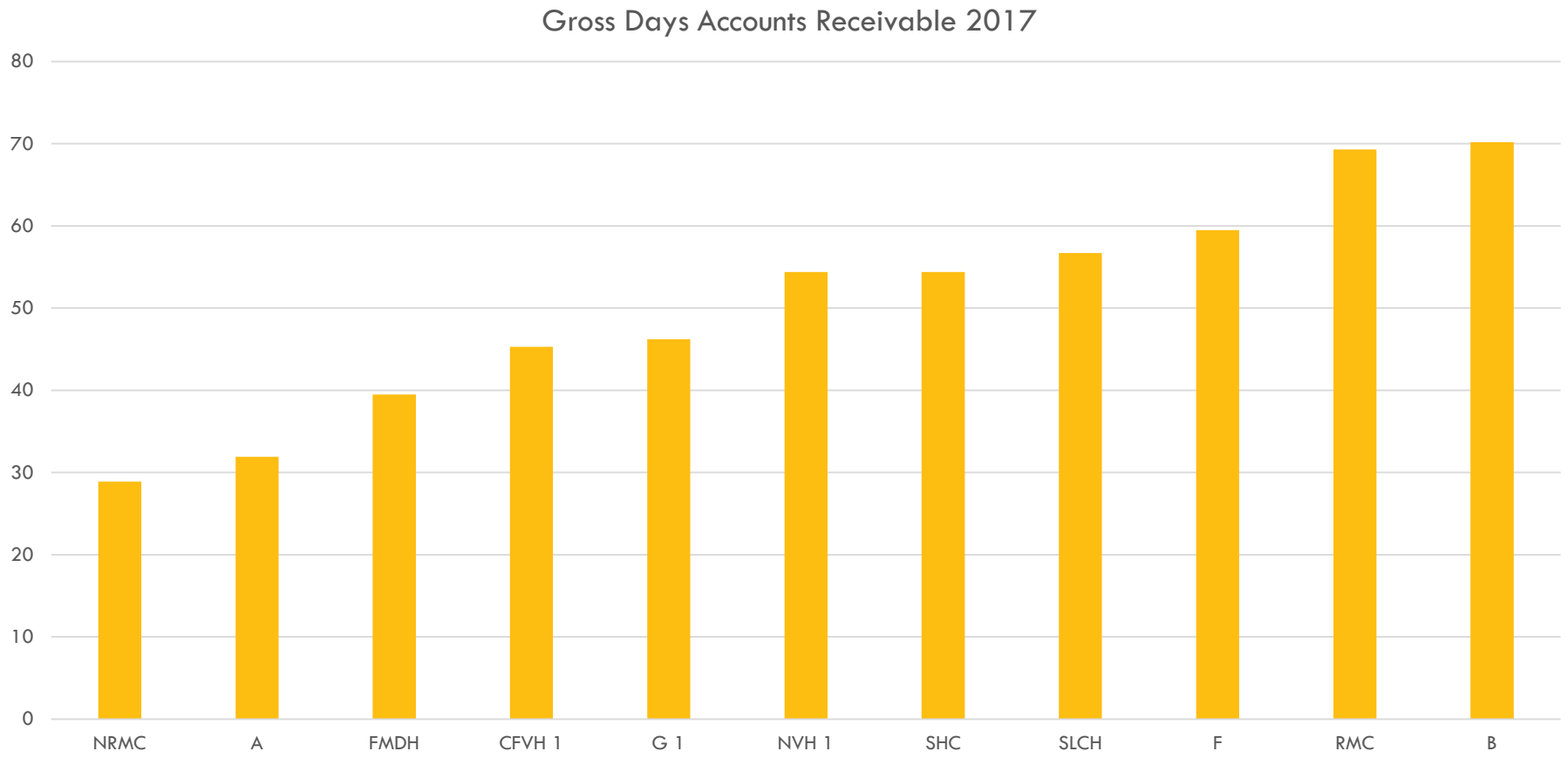
- One of the few common indicators that can be calculated separately for the RHC versus the rest of the hospital

- Requires separate reporting of gross and net revenues for the RHC as well as accounts receivable for the RHC. Measures the time in days that it takes for an organization to collect its accounts receivable for services rendered.
  - 11 of the 17 providers were able to separately report
  - Opportunity for more providers to report in the future.

- Higher days in accounts receivable can be an indication of issues in
  - Chargemaster
  - Coding
  - Charge capture
  - Communications
  - Processes

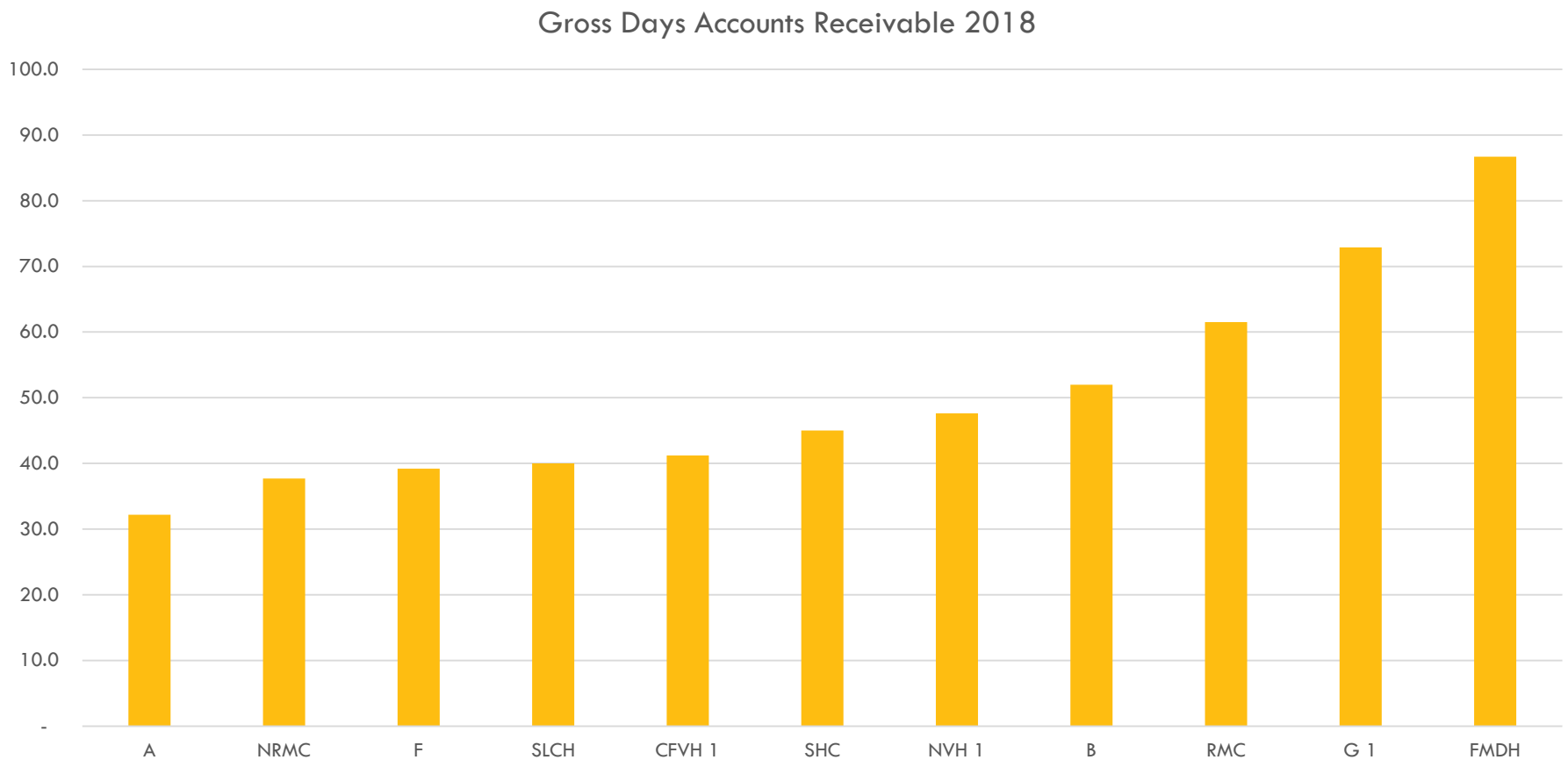
- Lower values are favorable

GROSS DAYS IN ACCOUNTS RECEIVABLE



High = 70.2
Low = 28.9
Average = 50.0
75th Percentile = 39.5

GROSS DAYS IN ACCOUNTS RECEIVABLE

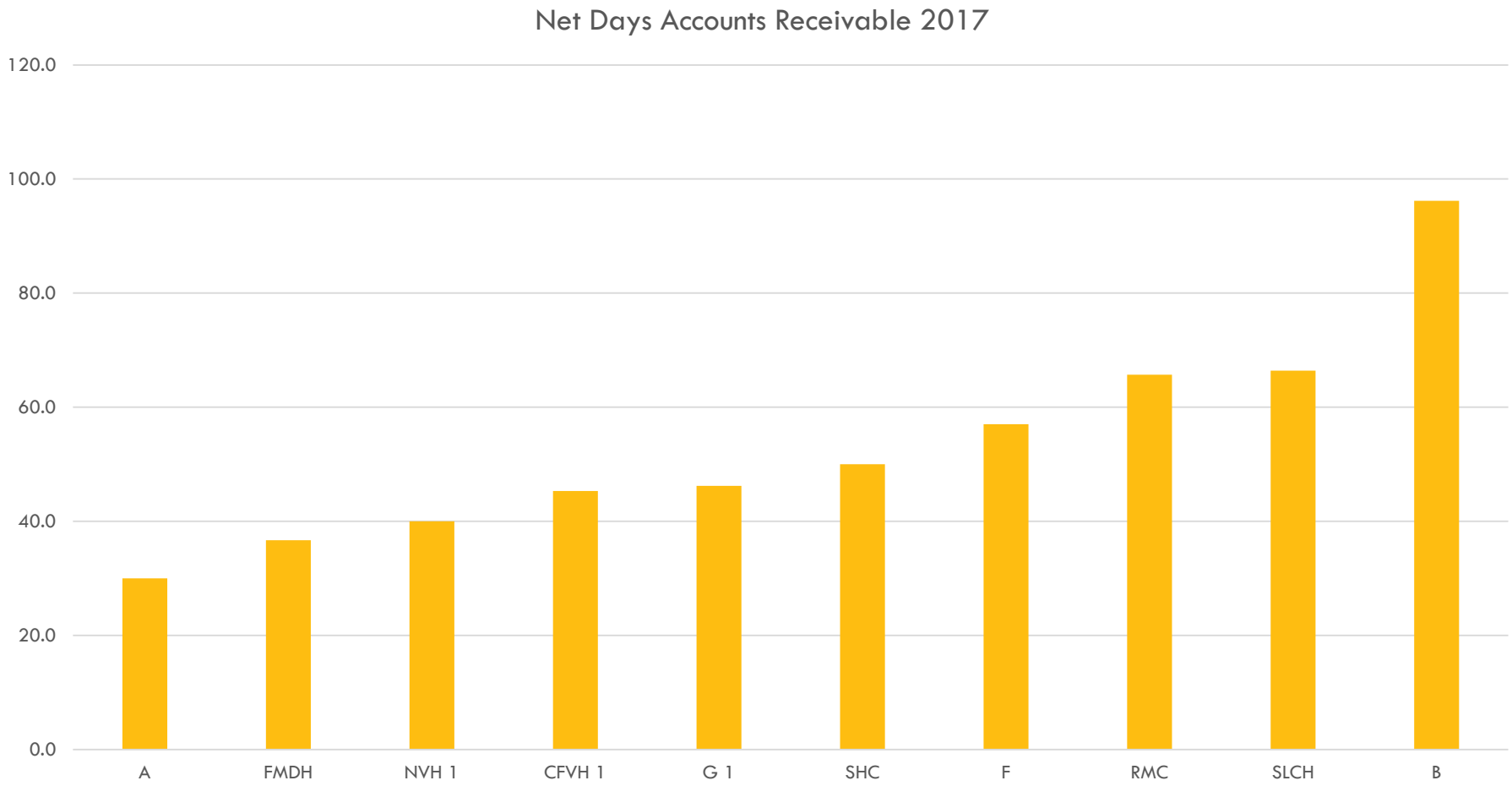


High = 86.7
Low = 32.2
Average = 51.6
75th Percentile = 39.2

GROSS DAYS IN ACCOUNTS RECEIVABLE

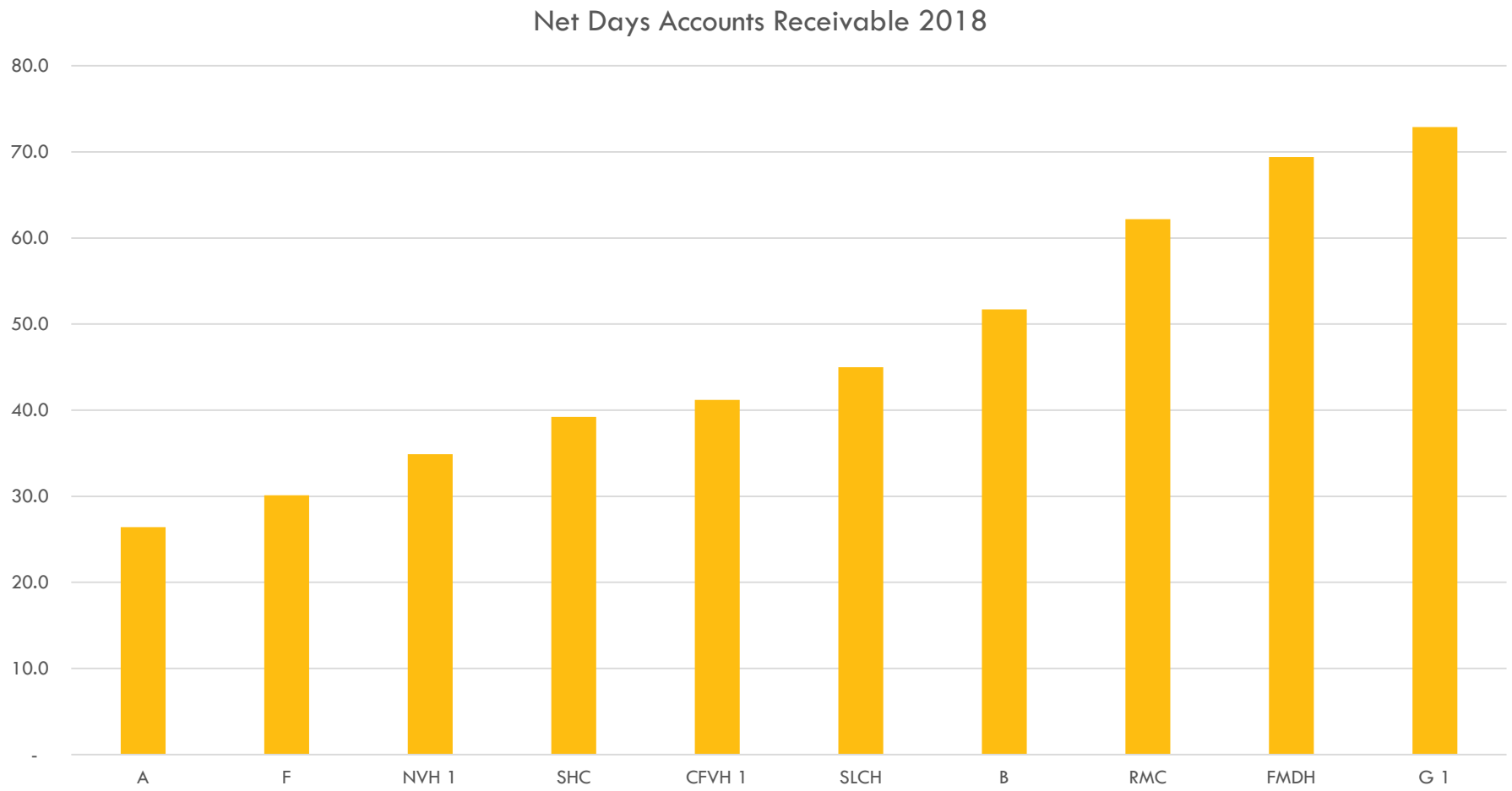
	2017	2018
HIGH	70.2	86.7
LOW	28.9	32.2
AVERAGE	50.0	51.6
75th PERCENTILE	39.5	39.2

NET DAYS IN ACCOUNTS RECEIVABLE



High = 96.2
Low = 30.0
Average = 51.9
75th Percentile = 39.2

NET DAYS IN ACCOUNTS RECEIVABLE



High = 72.9
Low = 26.4
Average = 47.6
75th Percentile = 33.7

NET DAYS IN ACCOUNTS RECEIVABLE

	2017	2018
HIGH	96.2	72.9
LOW	30.0	26.4
AVERAGE	51.9	47.6
75th PERCENTILE	39.2	33.7

DAYS IN ACCOUNT RECEIVABLE

- To manage Days in Accounts Receivable, the RHC must either decrease the accounts receivable balance and/or increase revenues

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Review of the revenue cycle processes
  - Rework
  - Denials
  - Coding
  - Demographics
- Ongoing communication
- Regular meetings
  - Trending of AR reports
  - Denial issues
  - Dig into details and monitor trends

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Utilization of EHR processes
  - Work queues
  - Claim edit builds
  - Error identification
  - Timely resolution
  - Working with EHR vendor on automated solutions

- Self pay management
  - Early detection (60-90 days)
  - Establishment of payment plans
  - Identification of need for other financial services
  - Watch for frequent flyers

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Regular CDM reviews
  - Confirm accuracy of CPT/HCPCS
  - Monitor appropriateness of pricing

- Understand the capabilities of the billing system
  - Manual versus automated processes
  - Functionality varies by system
    - Understand the system – invest in training
    - Hold vendor accountable to address and fix issues
  - Have seen success and failure on all systems

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

- Understand and manage your payor contracts
  - Payment methodology
  - Coverage issues
  - Timely filing limitations
  - Collection of copays

- Turnover of Staff
  - Strategies to reduce level of turnover
  - Cross training for absences and eventual turnover
  - Exercise care in outsourcing

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

Collections

- Strong consistent policy
  - Avoid exceptions
- Use pre-collection letters
- Outsource self pay collections
  - 120 day review and movement to bad debt
  - Internal versus external efficiency
- Monitor and compare collection agencies
- Factoring of receivables can be used – temporary solution

DAYS IN ACCOUNTS RECEIVABLE STRATEGIES

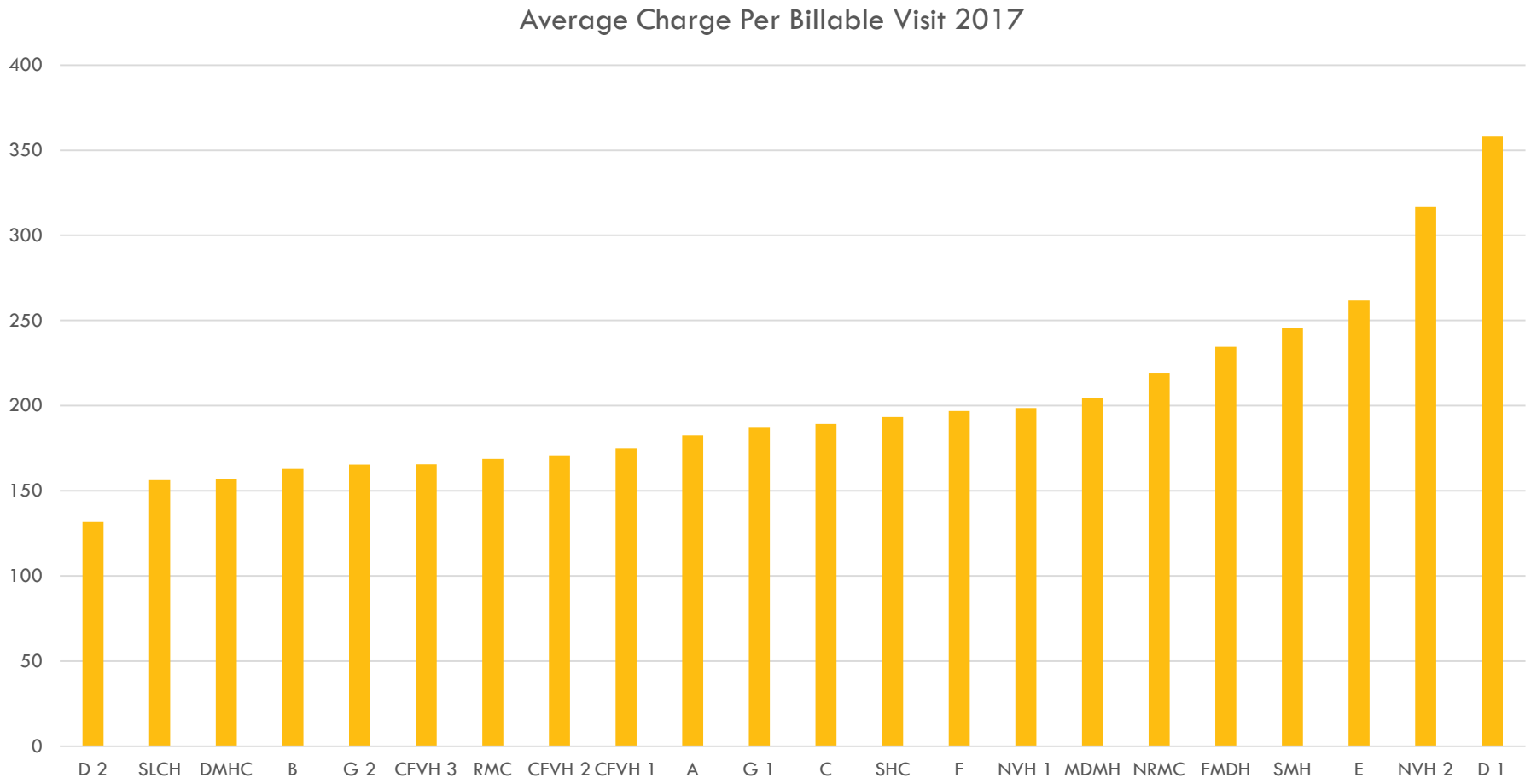
Identify opportunities and needs for education

- HFMA – Healthcare Financial Management Association
- MGMA – Medical Group Management Association
- NARHC – National Association of Rural Health Clinics

AVERAGE CHARGE PER BILLABLE VISIT

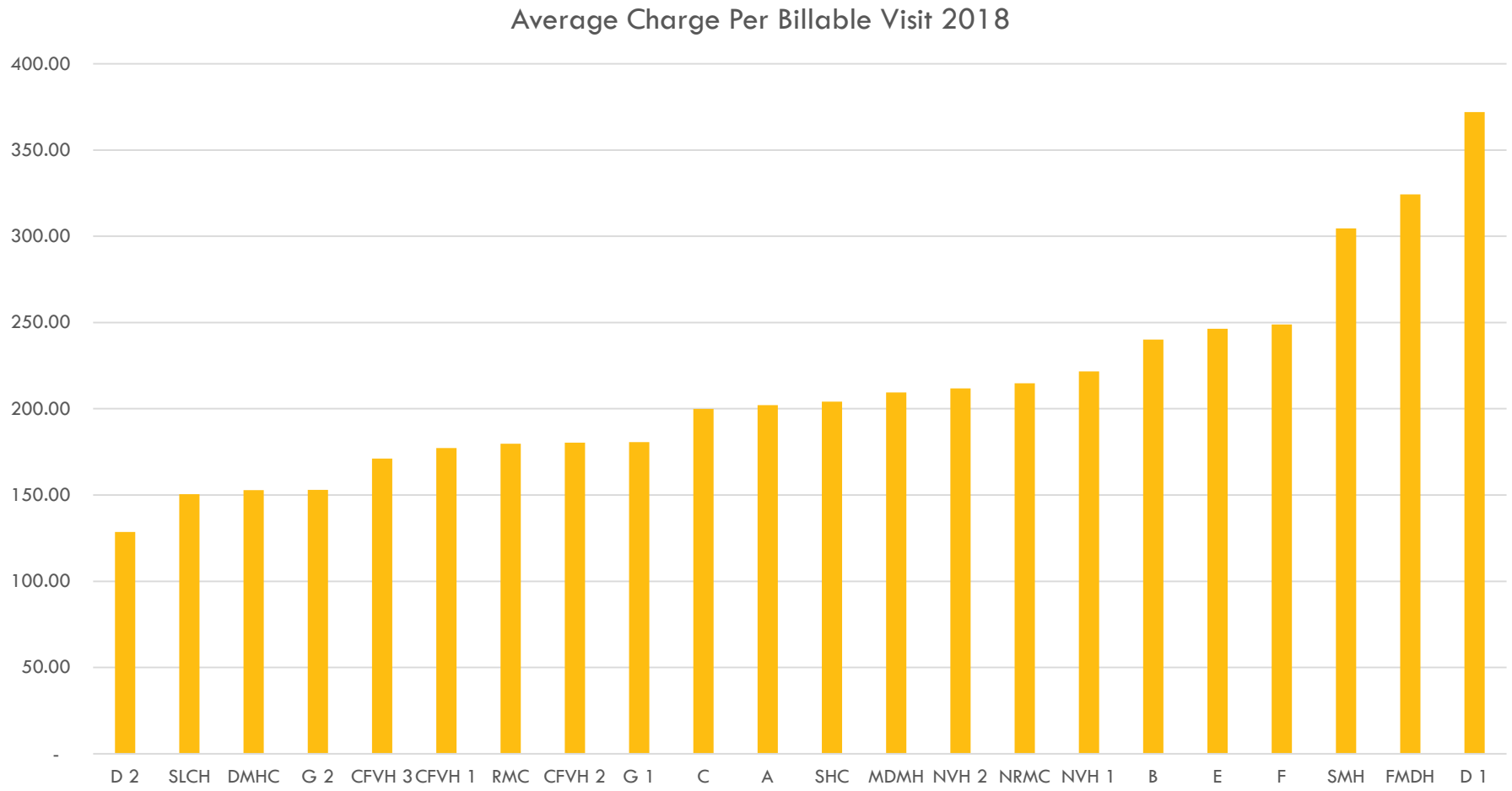
- Charges matter!
  - Medicare reimbursement is based on 80% cost and 20% charge
  - Other payors frequently reimburse on lower of charge or fee schedule
  - Higher values tend to be favorable
- Higher values may indicate:
  - Provider has appropriately priced services
  - There is adequate documentation, coding and charge capture
- Lower values may indicate:
  - Pricing is below average
  - Opportunities to improve documentation, coding and charge capture
  - Less complex patients

AVERAGE CHARGE PER BILLABLE VISIT



High = 357.86
Low = 131.72
Average = 201.86
75th Percentile = 223.02

AVERAGE CHARGE PER BILLABLE VISIT



High = 372.03

Low = 128.63

Average = 212.46

75th Percentile = 241.74

AVERAGE CHARGE PER BILLABLE VISIT

	2017	2018
HIGH	357.86	372.03
LOW	131.72	128.63
AVERAGE	201.86	212.46
75th PERCENTILE	223.02	241.74

AVERAGE CHARGE PER BILLABLE VISIT STRATEGIES

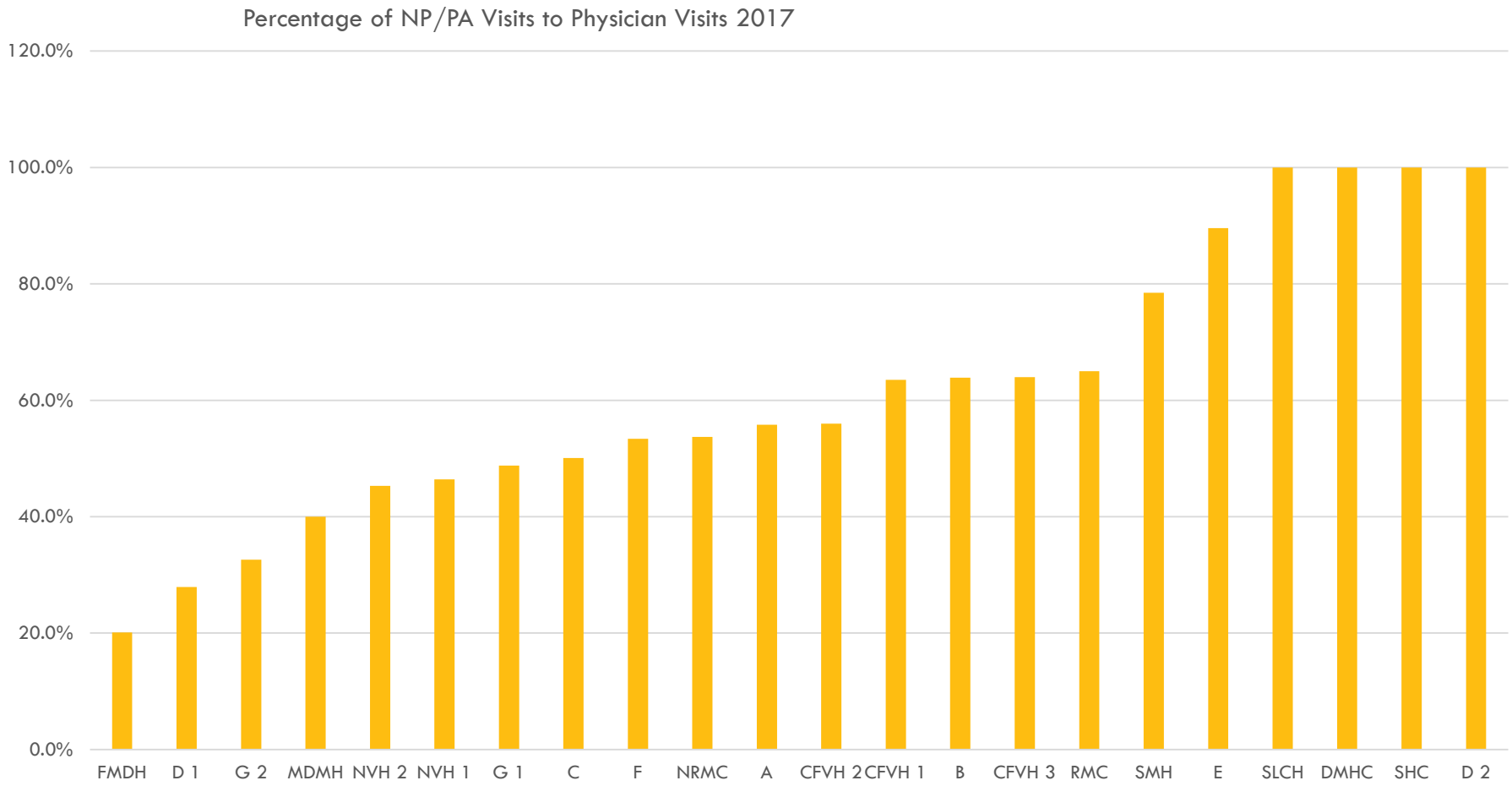
- Review and verify all services are being documented charges captured

- Complete review of pricing against survey data
  - National
  - State

PERCENTAGE OF NP/PA FTES TO TOTAL PROVIDER FTES

- Requirement for minimum coverage by NP/PAs
- Percentage of total FTEs that are NP/PA varies significantly
  - Nationally
  - Statewide
- Potential benefits of higher percentage of NP/PA FTEs
  - Lower cost per FTE
  - Lower productivity standards for NP/PA
  - Control of cost to improve profitability of clinic services to other payors

PERCENTAGE OF NP/PA VISITS TO PHYSICIAN VISITS



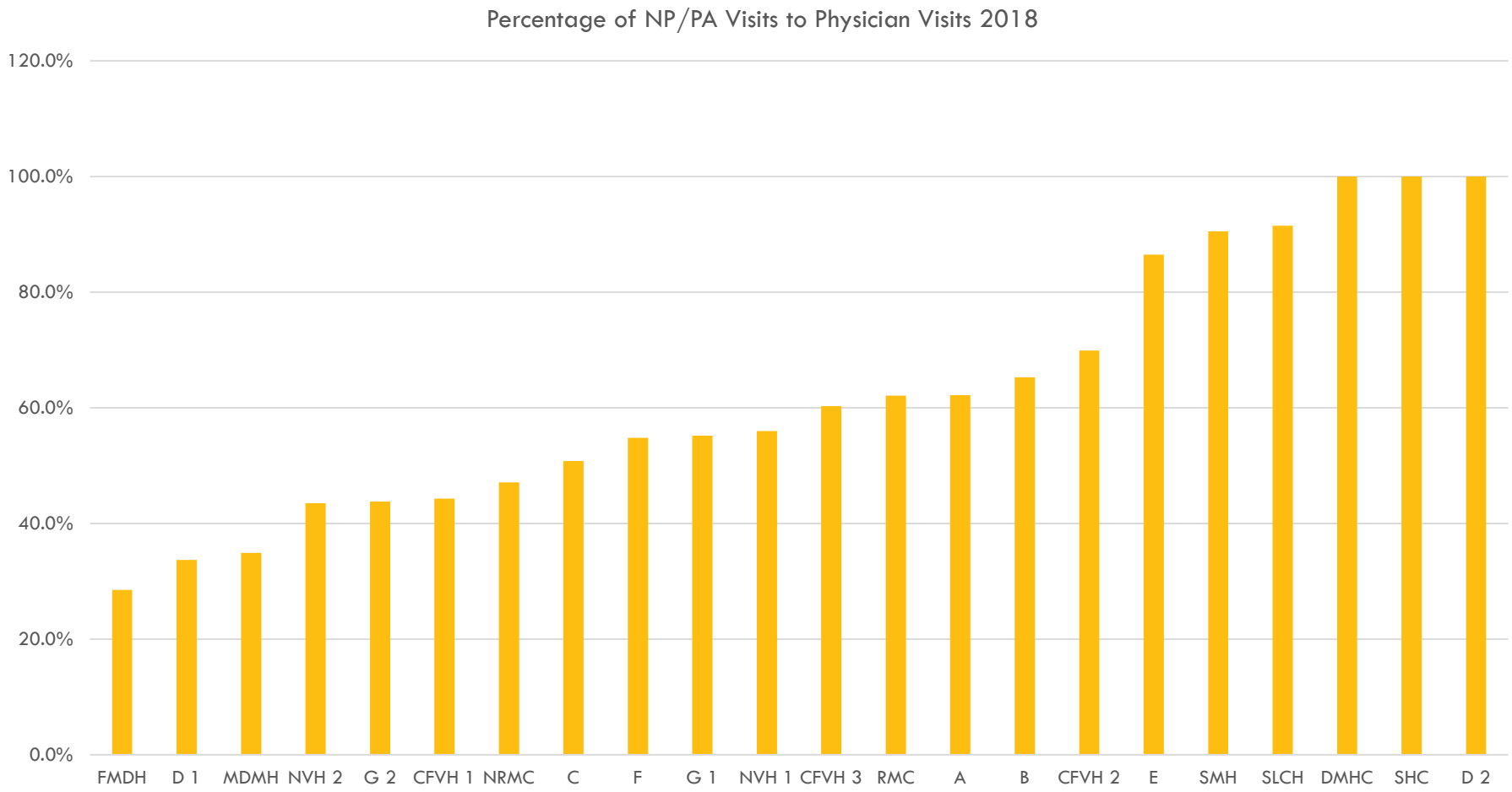
High = 100.0

Low = 20.1

Average = 61.6

75th Percentile = 81.3

PERCENTAGE OF NP/PA VISITS TO PHYSICIAN VISITS



High = 100.0

Low = 28.5

Average = 62.8

75^{th} Percentile = 87.5

PERCENTAGE OF NP/PA VISITS TO PHYSICIAN VISITS

	2017	2018
HIGH	100.0	100.0
LOW	20.1	28.5
AVERAGE	61.6	62.8
75th PERCENTILE	81.3	87.5

PERCENTAGE OF NP/PA FTES TO TOTAL PROVIDER FTES

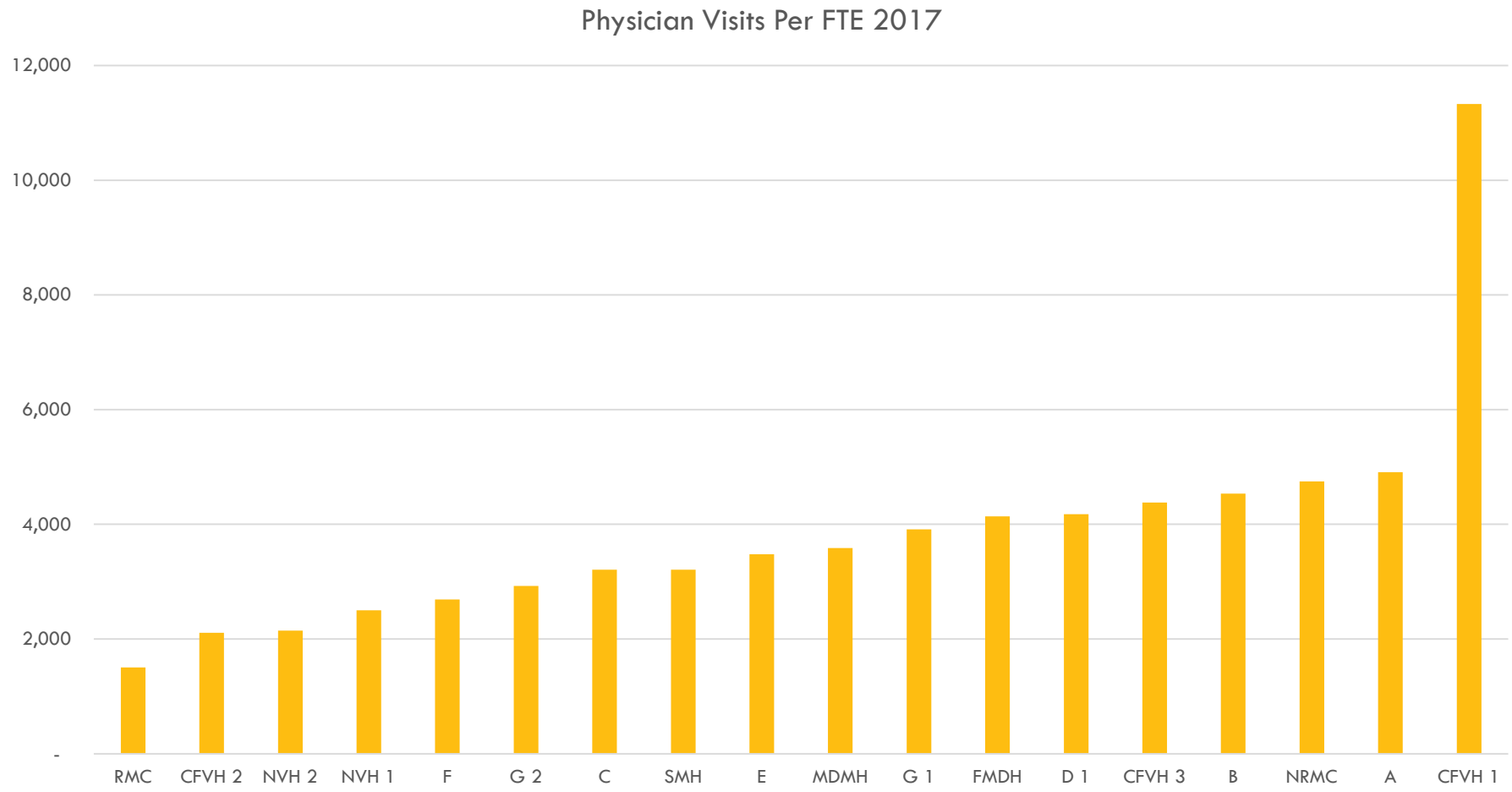
- Changes in percentages may take a significant amount of time

- May require a change in mindset
  - Board
  - Physicians
  - ER Coverage
  - Community

VISITS PER PHYSICIAN/NP/PA

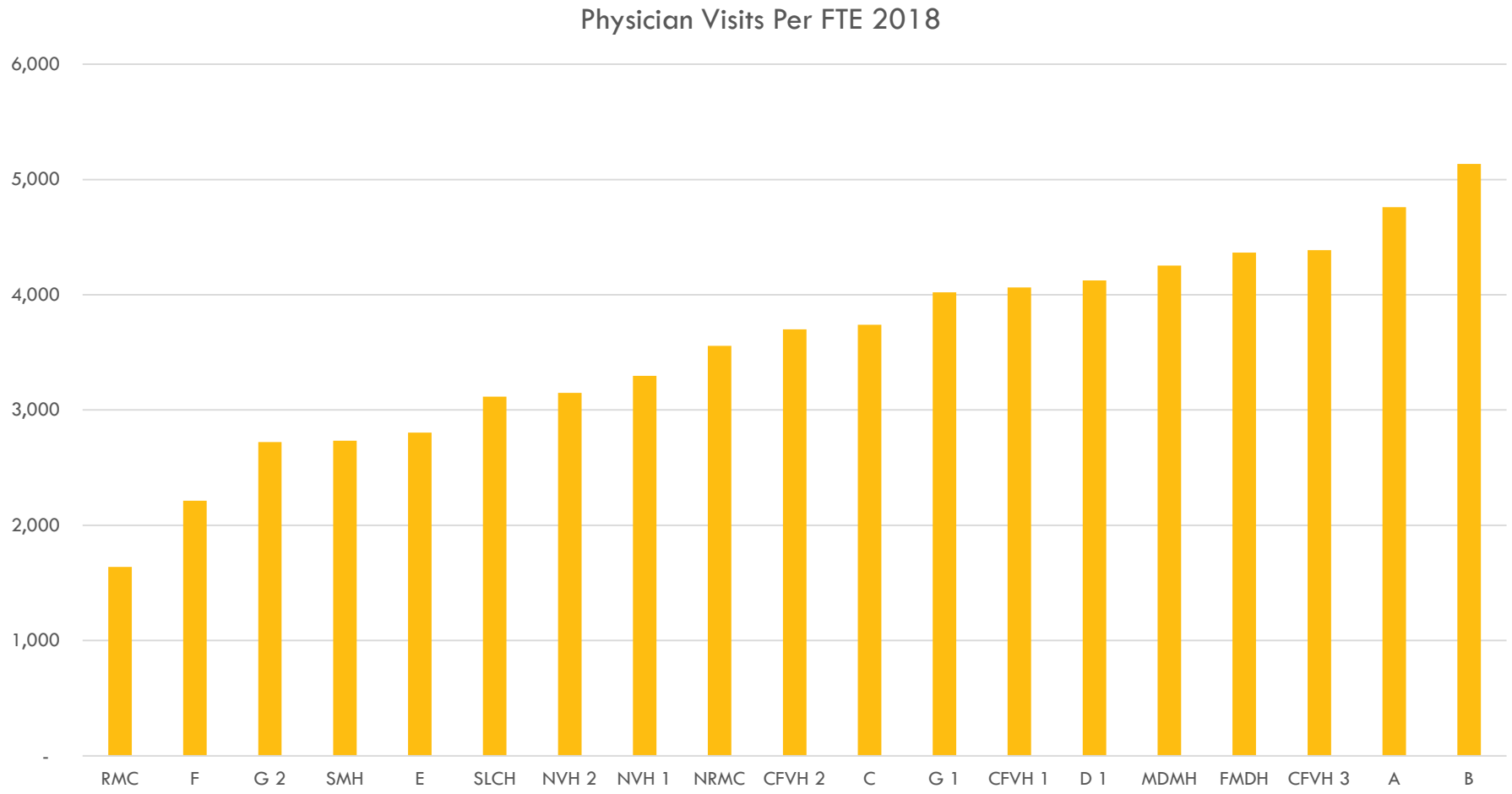
- Number of visits used to calculate productivity standard as applied by Medicare
  - 4,200 visits per Physician FTE
  - 2,100 visits per NP/PA
  - Applied in the aggregate
- Higher visit numbers are an indicator of greater productivity
  - Can lower cost per visit
  - Can improve profitability of services provided to other payors
- Higher numbers are favorable

PHYSICIAN VISITS PER FTE



High = 11,330
Low = 1,504
Average = 3,860
75th Percentile = 4,420

PHYSICIAN VISITS PER FTE

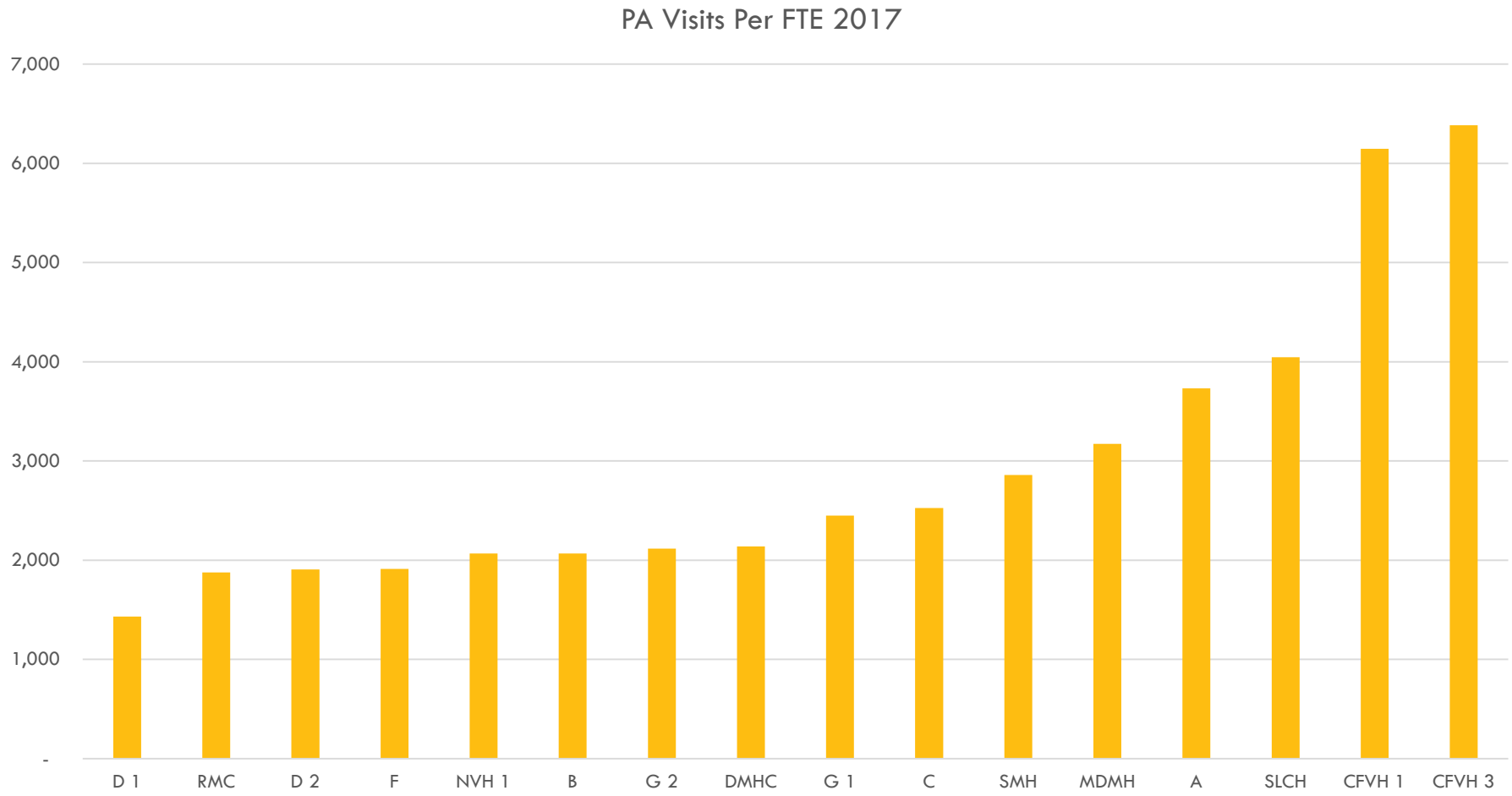


High = 5,134
Low = 1,639
Average = 3,568
75th Percentile = 4,254

PHYSICIAN VISITS PER FTE

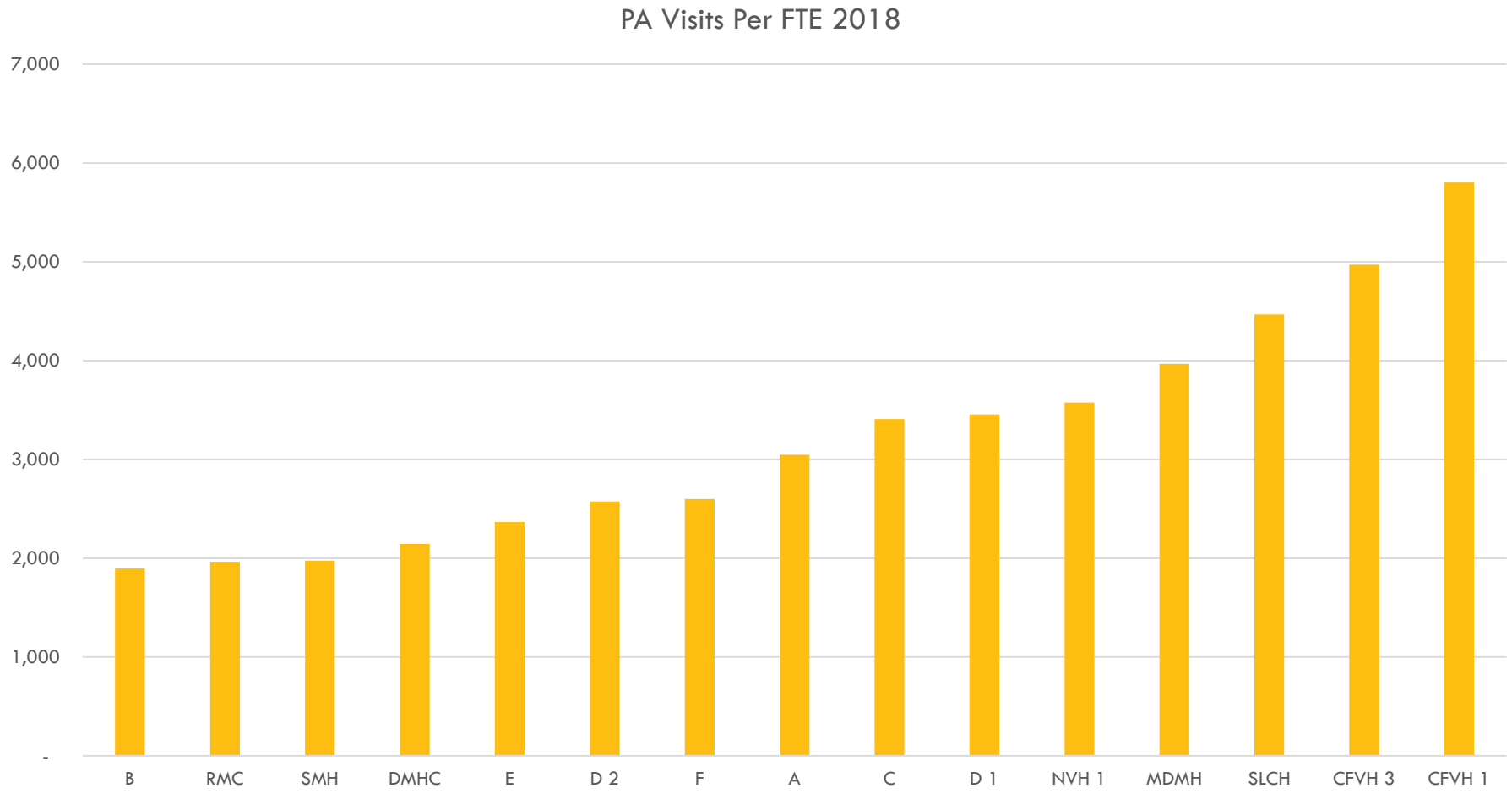
	2017	2018
HIGH	11,330	5,134
LOW	1,504	1,639
AVERAGE	3,860	3,568
75th PERCENTILE	4,420	4,254

PA VISITS PER FTE



High = 6,384
Low = 1,136
Average = 2,927
75th Percentile = 3,592

PA VISITS PER FTE

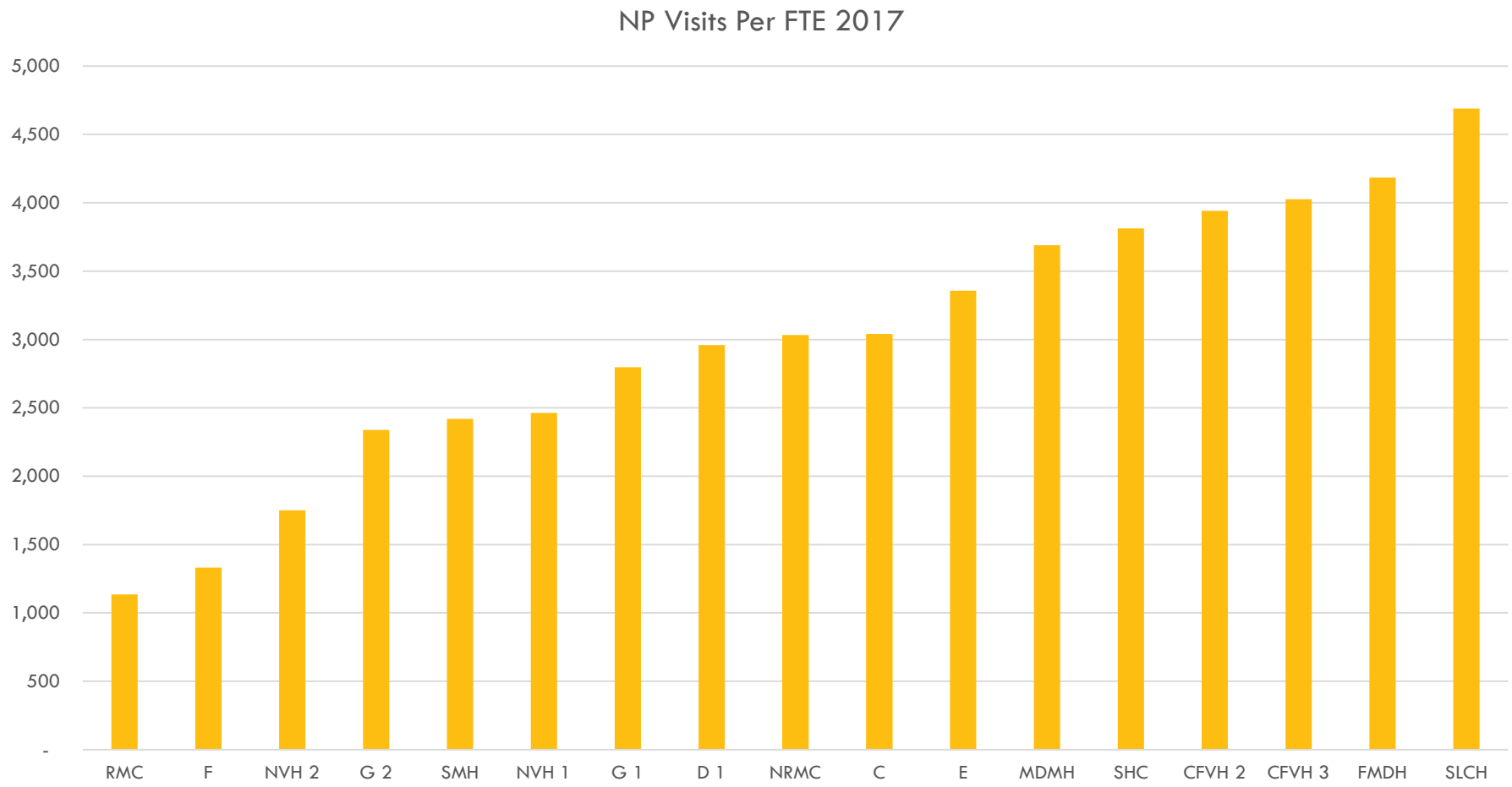


High = 5,802
Low = 1,895
Average = 3,214
75th Percentile = 3,967

PA VISITS PER FTE

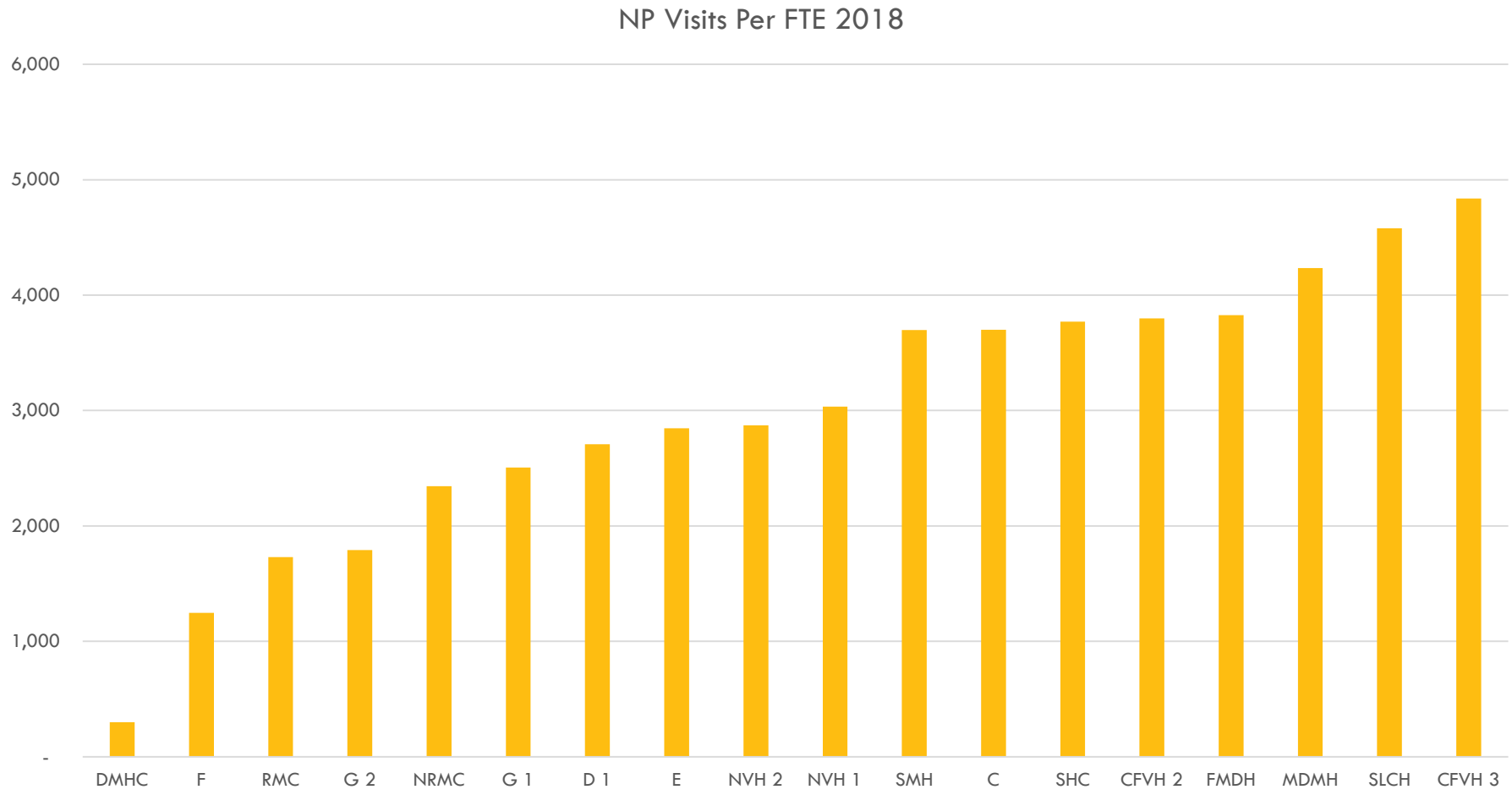
	2017	2018
HIGH	6,384	5,802
LOW	1,431	1,895
AVERAGE	2,927	3,214
75th PERCENTILE	3,592	3,967

NP VISITS PER FTE



High = 4,184
Low = 1,136
Average = 2,939
75th Percentile = 3,751

NP VISITS PER FTE



High = 4,838
Low = 300
Average = 2,990
75th Percentile = 3,805

NP VISITS PER FTE

	2017	2018
HIGH	4,184	4,838
LOW	1,136	300
AVERAGE	2,939	2,990
75th PERCENTILE	3,751	3,805

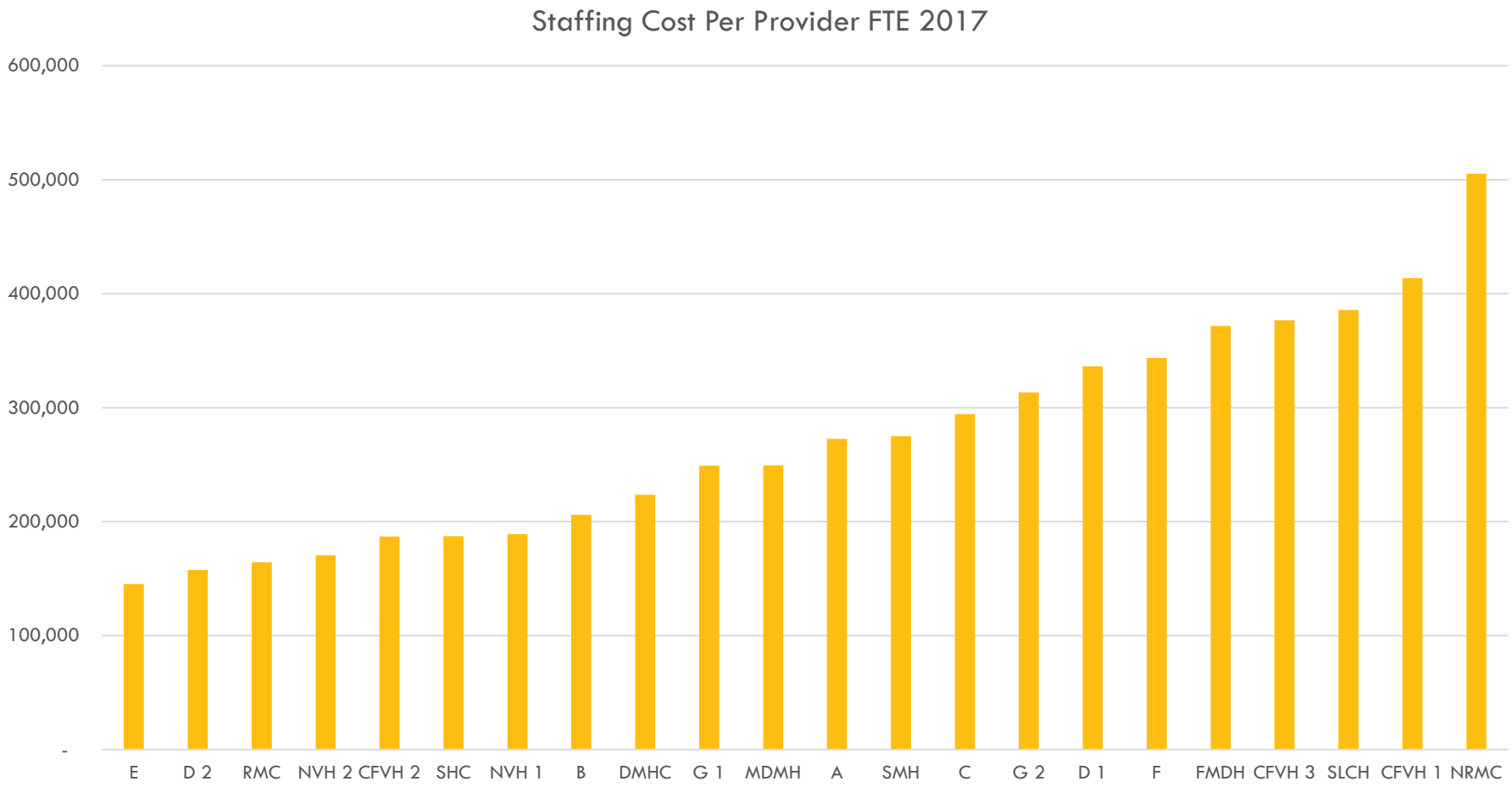
VISIT PER FTE STRATEGIES

- Review scheduling strategies to ensure maximum number of visits available
  - Protocols vary significantly
    - Between practices
    - Between providers in same practices
- Determine appropriateness of support personnel
  - Adequacy of hours
  - Appropriate skillsets
- Review times blocked off an “unavailable” for visits
  - Late starts
  - Early departures
  - Excessive time for documentation
- Understand the FTE calculation and determine strategies
  - Supervision time
  - PTO/CME
  - ER call
  - Medical directorships

STAFFING COST PER PROVIDER FTE

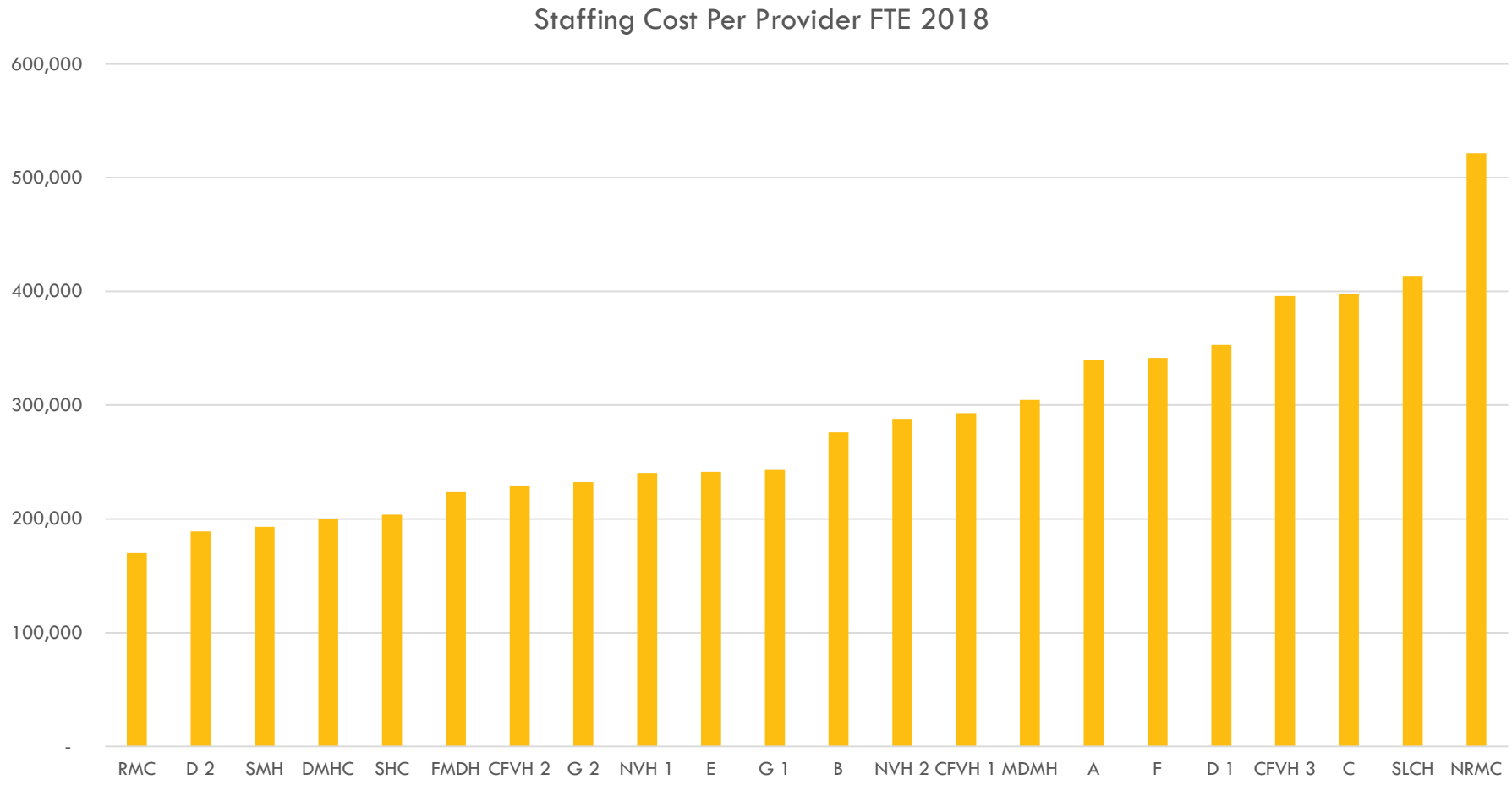
- Compensation levels vary significantly between RHCs
  - Physician vs NP vs PA
    - Can be calculated separately - would require some additional statewide effort
  - Market driven
  - Unknown……
- Average impact by above
  - Provider mix can also have significant impact
- Lower calculations may:
  - Demonstrate ability to control costs
  - Improve profitability of services to other payors

STAFFING COST PER PROVIDER FTE



High = 505,254
Low = 145,184
Average = 273,449
75th Percentile = 187,043

STAFFING COST PER PROVIDER FTE



High = 521,398
Low = 169,932
Average = 285,863
75th Percentile = 218,529

STAFFING COST PER PROVIDER FTE

	2017	2018
HIGH	505,254	521,398
LOW	145,184	169,932
AVERAGE	273,449	285,863
75th PERCENTILE	187,043	218,529

STAFFING COST PER PROVIDER FTE STRATEGIES

- Alter mix of providers to improve blended calculation
  - May require a change in mind set
    - Board
    - Physicians
    - ER Coverage
    - Community
- Review compensation methodologies
  - Survey data
  - Contract split for non-RHC services

COST PER VISIT

- Higher cost per visits lead to lower profitability for other payors
  - May also impact Medicaid
  - Remember Medicare 80/20 calculation limitation
- Lower cost is favorable over time
  - Initial impact on Medicaid

COST PER VISIT

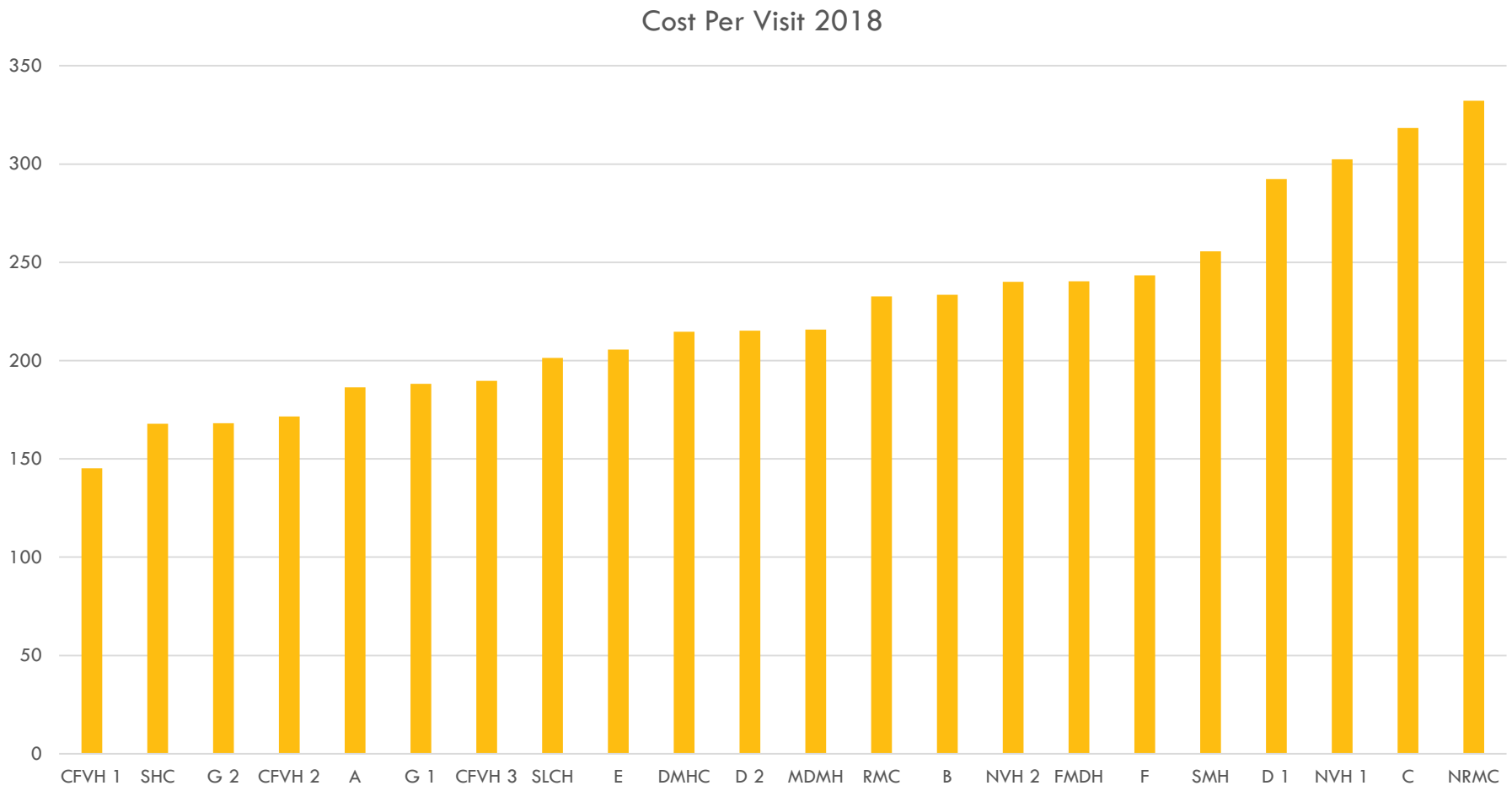
High = 317.69

Low = 154.26

Average = 217.06

75th Percentile = 181.66

COST PER VISIT



High = 332.25

Low = 145.17

Average = 225.49

75^{th} Percentile = 187.79

COST PER VISIT

	2017	2018
HIGH	317.69	332.25
LOW	154.26	145.17
AVERAGE	217.06	225.49
75th PERCENTILE	181.66	187.79

COST PER VISIT STRATEGIES

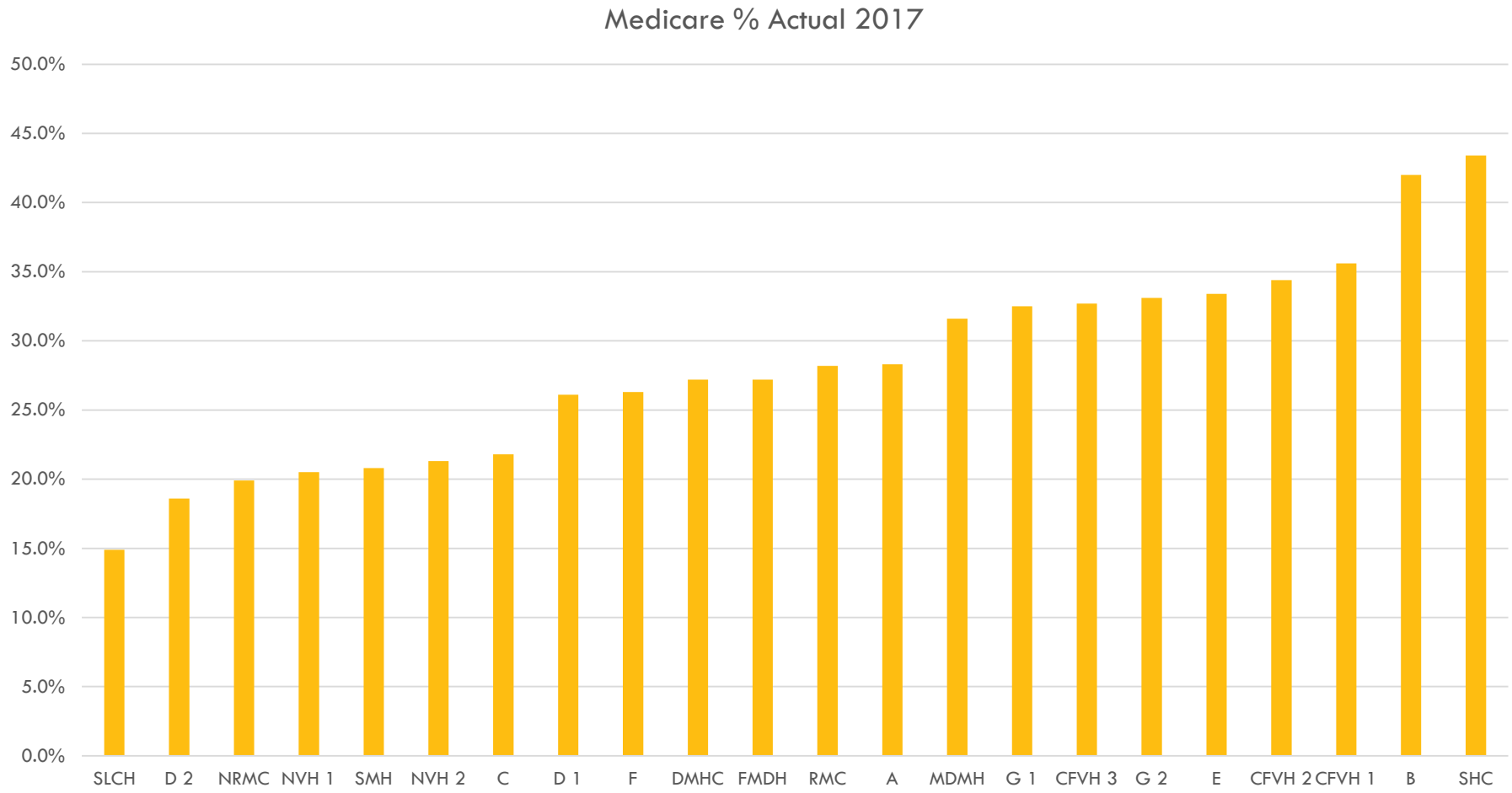
- Employ strategies identified in
  - NP/PA FTEs to Total FTEs
  - Provider visits per FTE
  - Cost per FTE Provider
- Review other staffing levels for appropriateness
- Review overhead costs
  - Department specific
    - Staff
    - Supplies
    - Pharmacy
    - Etc.
  - Facility specific
    - Building cost
    - Utilities
    - Administrative and General

MEDICARE PAYER MIX

- May be an indication of profitability

- Lower Medicare payor mix may assist in improving financial performance
  - Impact will vary based on cost per visit versus commercial payment
  - Calculation can be impacted by high Medicare Advantage penetration
  - Higher Medicaid payor utilization may have bigger impact than higher Medicare

MEDICARE PERCENTAGE ACTUAL



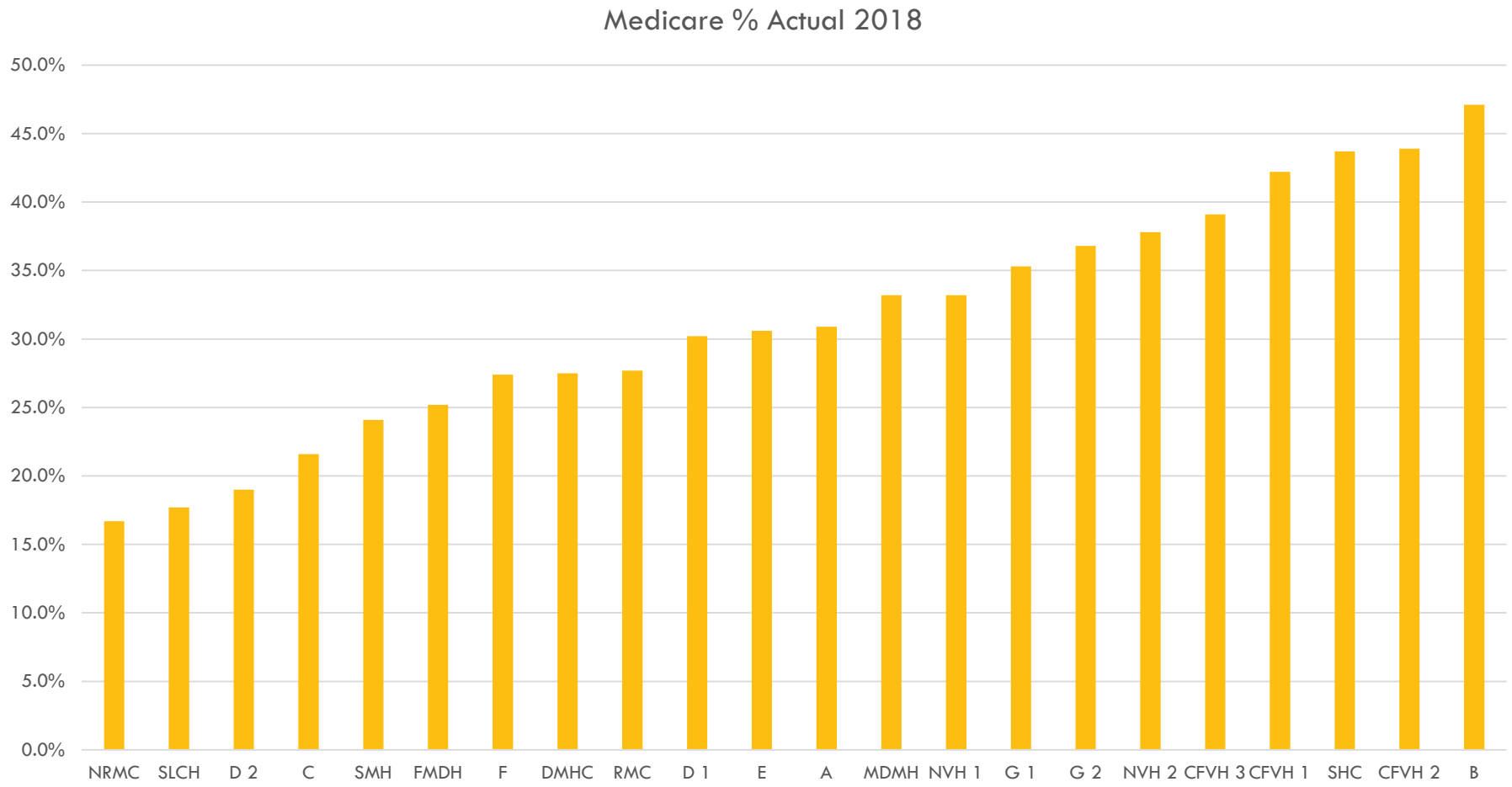
High = 43.4

Low = 14.9

Average = 28.2

75th Percentile = 21.2

MEDICARE PERCENTAGE ACTUAL



High = 47.1

Low = 16.7

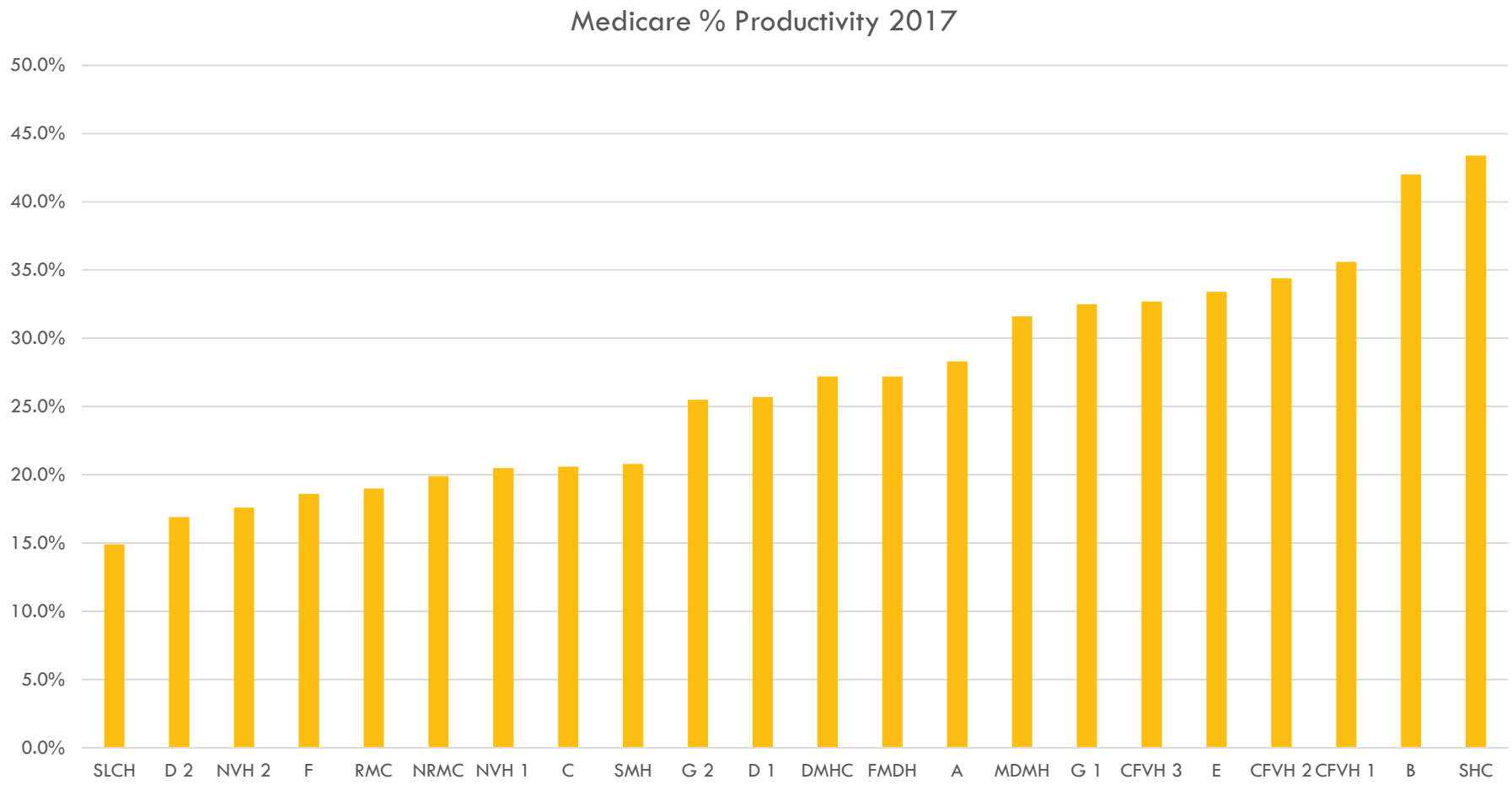
Average = 31.4

75th Percentile = 24.9

MEDICARE PERCENTAGE ACTUAL

	2017	2018
HIGH	43.4	47.1
LOW	14.9	16.7
AVERAGE	28.2	31.4
75th PERCENTILE	21.2	24.9

MEDICARE PERCENTAGE PRODUCTIVITY



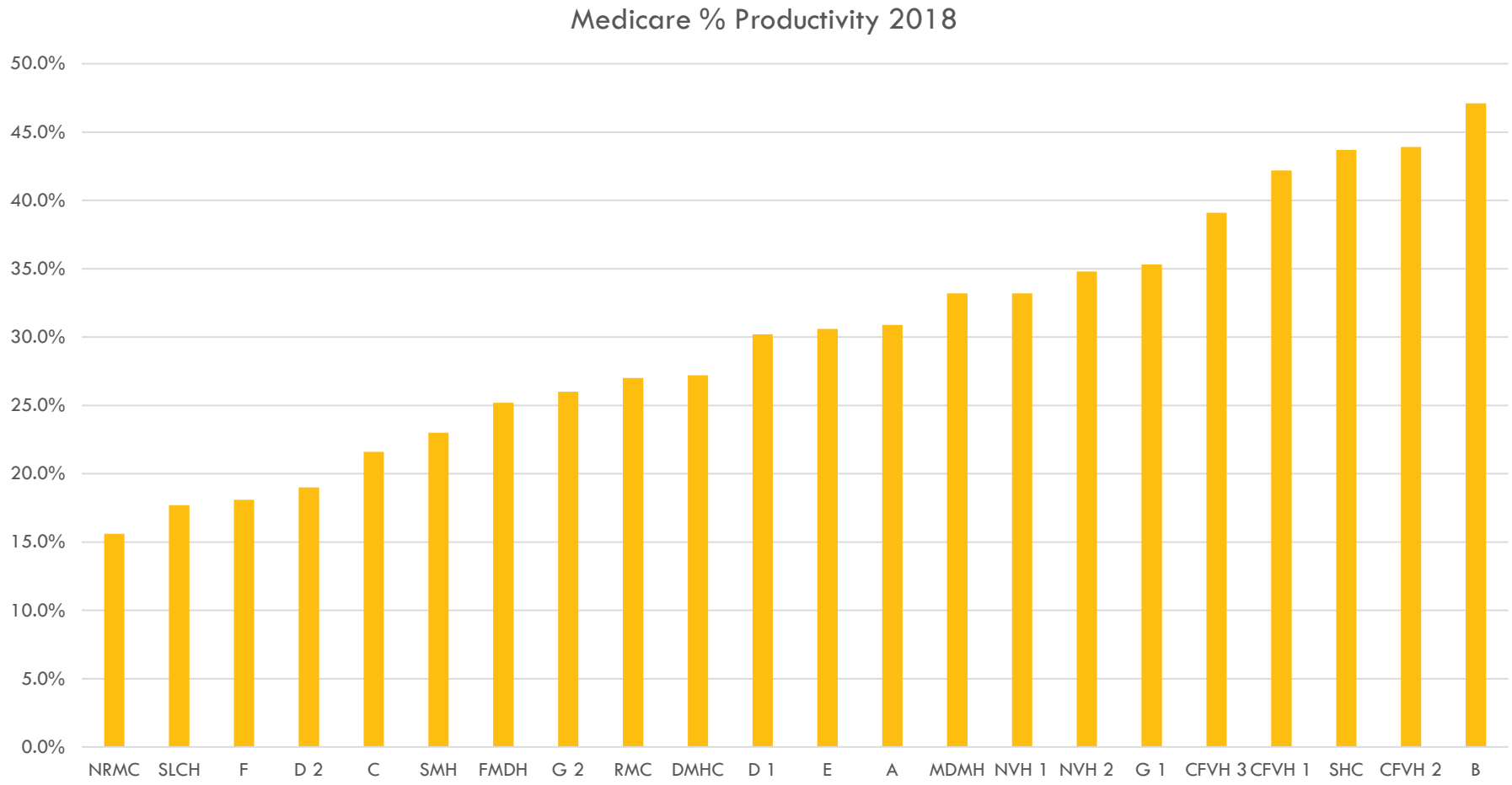
High = 43.4

Low = 14.9

Average = 26.7

75th Percentile = 19.7

MEDICARE PERCENTAGE PRODUCTIVITY



High = 47.1

Low = 15.6

Average = 30.2

75th Percentile = 22.7

MEDICARE PERCENTAGE PRODUCTIVITY

	2017	2018
HIGH	43.4	47.1
LOW	14.9	15.6
AVERAGE	26.7	30.2
75th PERCENTILE	19.7	22.7

MEDICARE PERCENTAGE STRATEGIES

- Maximize non-Medicare volumes
  - Do not focus on minimizing Medicare volumes
  - Consider marketing efforts
  - Explore alternative clinic hours
  - Think access

- Important notes
  - Higher Medicare percentage may appear to be beneficial is there is a high cost per visit
  - Need to think long term versus short term strategy

COST REPORT STRATEGIES

- Incorrect cost report completion can have a significant negative impact
  - Know your cost report
  - Ask questions

- Areas of specific concern/opportunity
  - Calculation of FTEs – Make sure to carve out hours for time not to be included
    - Non-RHC
    - PTO/CME
    - Supervision
    - Medical Directors
  - Counting of visits
    - Remember the definition of a billable visit
    - Don't include non-RHC visits
  - Watch for classification of costs in the cost report
    - Pharmacy costs

COST REPORT STRATEGIES

- Areas of specific concern/opportunity
  - Understand Non-RHC services
    - Telehealth
    - Chronic Care Management

RHC BILLING

RHC CLAIM DATA

Type of Bill = 071X

Revenue Codes are used to determine the location of services when billed on the RHC UB-04.

- 0521 - Clinic visit at RHC
- 0522 - Home Visit
- 0524 - SNF (Swing bed) visit during a Part A covered stay
- 0525 - SNF/NF visit not associated with Part A covered stay
- 0527 - Visiting Nurse services (Home Health shortage designation)
- 0528 - Visit at scene of an accident
- 0780 - Telehealth
- 0900 - Mental Health Visit

CG modifier required effective April 1, 2016

RHC CPT CODE REPORTING

RHC professional services payable visit codes:

- E/M (Office) Visit = 99201-99205 & 99212-99215
- Nursing Facility = 99304-99310 & 99315-99318
- Domiciliary/Rest Home = 99324-99328 & 99334-99337
- Home Visit = 99341-99345 & 99347-99350

Procedures with CPT codes in the 10,000 to 69,999 range

- Issues with Rural Health Clinic Qualifying Visit List (QVL) from 2016.
- Not an "all-inclusive list" of allowed codes billable without office visit.
- Noridian website also states "not an all-inclusive list".

HCPCS codes listed under CMS Preventive Services

Advanced Care Planning (ACP) is a stand-alone billable RHC Visit.

- 99497 (first 30 minutes) & 99498 (second 30 minutes)
  - Deductible/coinsurance apply (when billed alone or with non-AWV visit)
- Add modifier 33 if performed on same date as AWV by same provider
  - Deductible /coinsurance will be waived

EXCEPTIONS TO 1 AIR PAYMENT PER DATE OF SERVICE

Medical and Mental visit on the same date of service

- Two AIR paid
- Coinsurance of 20% of each total charge for 0521 and 900 revenue codes.

Separate encounter on same day for unrelated visit

- Two AIR paid
- Append 25 or 59 modifier
- Beneficiary sees provider, leaves clinic and returns due to accident or injury later in the day
  - Completely unrelated diagnosis

Medical/Mental visit and IPPE (Welcome to Medicare) on same day

- Two AIR paid

MODIFIER 25 OR 59

Does not follow coding rules for all other payers that require the 25 modifier in order to reimbursement for a procedure and E/M on same date of service.

- Results in coding burden to organization

There is only one situation where a 25/59 modifier is reported on the RHC Medicare UB-04 claim.

- When the patient presents for a second visit on the same date of service for a completely separately identifiable visit.

Establish Billing/Clearinghouse edit to catch coding errors.

MODIFIER CG

Attached to a professional service CPT code (RC 052X and 0900)

- If both medical and mental health services are provided on the same date of service apply CG modifier to both.

Sum of all charges must be reported on the RHC qualifying visit line of service.

- When multiple lines are billed for professional services, doesn't matter which one the CG modifier is appended to.
- Exception for preventive services provided on same date of service
  - Do not include the preventive service charge into CG line.

The CG modifier line indicates to the Medicare claims processing system:

- Line with total charge of all non-preventive services.
- Line that pays the AIR.
- These are the total charges on which deductible/coinsurance is applied.
  - Deductible/coinsurance is waived for preventive services so don't include.
- If only preventive services are provided append CG to preventive code

Do not append CG modifier to IPPE, CCM or Virtual Communication Services

COMMON PREVENTIVE SERVICES

Beneficiary Coinsurance and Deductible Waived

- One AIR is paid for all services provided on same date of service
- Exception is IPPE which would result in a payment when other professional services provided on the same date of service

HCPCS/CPT	Short Descriptor
G0402	IPPE - Initial preventive exam
G0438	AWV - Initial visit
G0439	AWV - Subsequent visit
G0101	Ca screen; pelvic/breast exam
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear
99406	Tobacco-use counsel 3-10 min
99407	Tobacco-use counsel >10

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

RHC BILLING EXAMPLE #1

Patient presents for a visit which includes an injection and blood draw.

Charges

$125 = Level II Established Patient Office Visit
$ 25 = Venipuncture
$ 25 = Injection
$ 50 = Drug
$225 = TOTAL

	Rev Code	Description	HCPCS/CPT	Service Date	Service units	Total Charge (Billing Option)	0.01 Charge (Billing Option)
1	0300	Venipuncture	36415	010119	1	25.00	0.01
2	0521	Injection administration	96372	010119	1	25.00	0.01
3	0521	Level III Established Visit	99213-CG	010119	1	225.00	225.00
4	0636	Rocephin 1 gm	J0696	010119	4	50.00	0.01
					TOTALS	325.00	225.03

One AIR is paid & patient coinsurance $45 ($225 x .20).

RHC BILLING EXAMPLE #2

Example of a separately billable service.

- Patient presents for initial visit as previous slide and later returns the same date of service for medically necessary, separately identifiable visit.

Second visit billed for Level IV Established Patient

	Rev Code	Description	HCPCS/CPT	Service Date	Service units	Total Charge (Billing Option)	0.01 Charge (Billing Option)
1	0300	Venipuncture	36415	010119	1	25.00	0.01
2	0521	Injection administration	96372	010119	1	25.00	0.01
3	0521	Level III Established Visit	99213-CG	010119	1	225.00	225.00
4	0521	Level IV Established Visit	99214-25 or 59	010119	1	175.00	175.00
5	0636	Rocephin 1 gm	J0696	010119	4	50.00	0.01
					TOTALS	500.00	400.03

Two AIR are paid.

- CG is appended first visit only (total of initial visit)
- Second visit with 25 or 59 modifier (total of 2nd visit)
- Patient coinsurance 20% = $80 ($400 x .20)

RHC BILLING EXAMPLE #3

Medical services provided on same date of service as the Annual Wellness Visit (G0438 or G0439).

	Rev Code	Description	HCPCS/CPT	Service Date	Service units	Total Charge (Billing Option)	0.01 Charge (Billing Option)
1	0300	Venipuncture	36415	010119	1	25.00	0.01
2	0521	Injection administration	96372	010119	1	25.00	0.01
3	0521	Level III Established Visit	99213-CG	010119	1	225.00	225.00
4	0521	Subsequent AWV	G0439	010119	1	125.00	125.00
5	0636	Rocephin 1 gm	J0696	010119	4	50.00	0.01
					TOTALS	450.00	350.03

One AIR is paid.

- Don't include AWV charge on CG line
  - Remember preventive services have deductible/coinsurance waived
- Patient coinsurance $45 ($225 x .20) – Medicare pays 80%

RHC BILLING EXAMPLE #4

Services provided on same date of service

- Medical visit
- IPPE

	Rev Code	Description	HCPCS/CPT	Service Date	Service units	Total Charge (Billing Option)	0.01 Charge (Billing Option)
1	0300	Venipuncture	36415	010119	1	25.00	0.01
2	0521	Injection administration	96372	010119	1	25.00	0.01
3	0521	Level III Established Visit	99213-CG	010119	1	225.00	225.00
4	0521	IPPE	G0402	010119	1	175.00	175.00
5	0636	Rocephin 1 gm	J0696	010119	4	50.00	0.01
					TOTALS	500.00	400.03

Two AIR are paid

- G0402 – Medicare pays 100% AIR (no patient coinsurance)
- CG line – Medicare pays 80% - coinsurance $45 ($225 x .20)

LABORATORY/RADIOLOGY/EKG – PB RHC

Lab/Radiology services are billed under the CAH NPI when the RHC is designated as provider-based.

- Billed as TOB 85X.
- Venipuncture remains on RHC UB-04 if drawn in clinic.
- Charges are included on the same UB-04 as other outpatient services the patient may have received at the hospital on the same date of service.
- Paid the Medicare CAH OP rate.

EKG can be billed global (93000) for non-Medicare payors, but for Medicare must be split into:

- Professional component (93010) billed along with RHC encounter if eligible provider reads and prepares report.
- Technical component (93005) billed by CAH.

LABORATORY/RADIOLOGY/EKG – FS RHC

Lab/Radiology services are billed under the RHC NPI when designated as free-standing.

- Billed on CMS-1500 to Medicare Part B.
- Fee Schedule reimbursement.
- Venipuncture remains on RHC UB-04 if drawn in clinic.

EKG can be billed global (93000) for non-Medicare payors, but for Medicare must be split into:

- Professional component (93010) billed along with RHC encounter if eligible provider reads and prepares report.
- Technical component (93005) billed on CMS-1500 under RHC NPI.

SERVICES PAID ON FEE SCHEDULE (NOT AIR)

Chronic Care Management (CCM)

- G0511 is billed in the RHC
  - 99490, 99487, 99491 & 99484
  - G0506 for Initiating CCM code not billable in RHC
- Revenue Code 0521
- Paid at the National Average blended rate of $67.03
- Beneficiary responsible for deductible/coinsurance 20% of allowed
- Minimum charge amount higher than G0511 allowed amount
- Date of service billed is the date time requirements are met or any date after that within the calendar month.

Telehealth Originating Site – Distant site provider billing not allowed in RHC setting.

- Q3014 is billed with Revenue Code 0780
- Paid at the National Average rate of $26.15
- Beneficiary responsible for deductible / coinsurance 20% of charges

VIRTUAL COMMUNICATION SERVICES

Service which is new to RHCs (January 1, 2019) where the face-to-face requirement is waived.

Billing Criteria:

- Furnish at least 5 minutes of communications-based technology or remote evaluation.
- Beneficiary must have had a billable RHC visit within the last year.
- Medical discussion or remote evaluated condition requirements:
  - Not related to another RHC service provided within the previous 7 days.
  - Doesn't lead to an RHC visit within next 24 hours (or next available appt).

Claim data:

- Code G0071 paid $13.69 which is National Average blended rate
  - For code G2012 (communication technology-based services) $14.78
  - And code G2010 (remote evaluation services) $12.61
- Deductible/coinsurance amounts apply

INFLUENZA AND PNEUMOCOCCAL INJECTIONS

Covered under the RHC Program but with unique billing rules.

Traditional Medicare services are NOT included on RHC claim:

- Submit log for vaccine & administration expense on Cost Report
- Beneficiary name, date of service and MBI

Medicare Advantage plans are billed separately on a CMS-1500

- Vaccine CPT Code
- Administration Code
  - G0008 = Flu Vaccination
  - G0009 = Pneumococcal Vaccination
- Diagnosis Code Z23

PATIENT RESPONSIBILITY DEDUCTIBLE/COINSURANCE

If no patient deductible:

- Medicare pays 80% of the AIR
- Patient pays 20% of charges reported on CG line

Deductible owed will be calculated up to 100% of charges:

- Example 1: Patient owes partial deductible:
  - Charge is $70, AIR is $100 and patient deductible due is $25
  - Medicare pays 80% of $100 less $25 deductible ($75) = $60
  - Patient coinsurance 20% of $70 less $25 deductible ($45) = $9
    - Deductible $25 + Coinsurance $9 = Total patient amount due $34
  - Medicare payment + Patient Payment = $94 (contractual gain $24)
- Example 2: Patient owes deductible:
  - Charge is $115, AIR is $95 and patient owes deductible
  - Medicare applied total charge $115 to deductible
  - Patient is responsible for $115 deductible (charge amount)
  - Medicare reimbursement -$20 + Patient Payment $115 = $95 AIR amount

NONBILLABLE MEDICARE SERVICES

Nurse only visits (no face-to-face encounter with eligible provider)

- Injection
- Dressing change
- Blood pressure monitoring
- Blood draw

Dietary Consultations only billable incident to face-to-face visit

- DSMT (Diabetic Self Management Training)
- MNT (Medical Nutrition Therapy

These services continue to be billable to NON-MEDICARE payers.

COUNTING RHC VISITS

Includes all RHC billable visits (face-to-face encounters) by eligible provider in the following locations:

- RHC Office
- Nursing Home (including swing bed)
- Assisted Living
- Patient Home
- Scene of an accident

Develop process for capturing data on daily/weekly/monthly basis:

- Scheduling system may or may not be viable tool to use.
- Revenue and usage reports won't work.
- Exclude nurse-only visits.
- Assign to a staff member that is educated on definition of RHC visit.
- Track for each provider separately.

VISITS

Example

Provider Visits						
	NON-RHC VISITS			RHC VISITS		
Discipline	**Inpatient/Outpatient**	**ER Visits During RHC Hours**	**ER Visit After RHC Hours**	**Nursing Home and Swing bed Billed as RHC**	**Rural Health Clinic**	**Total Visits**
Physician #1						
Physician #2						
Physician Assistant #1						
Nurse Practitioner #1						
Nurse Practitioner #2						
Contracted Physicians (*)						
Locum Tenens (*)						
Clinical Social Worker						

** Contracted physicians include regularly scheduled physician staff the facility contracts with for services. Locum Tenens include only those physicians contracted or employed for the coverage of vacations, short term coverage due to lost physicians, etc.*

AUDITING RHC CLAIMS

Perform internal claims audit

- Services are documented in patient record for which no charges exist.
- Charges are not supported in the patient record.
- Did claims generate for all scheduled patients.
  - Medicare/Medicaid require face-to-face visit.
  - Non-Medicare/Medicaid nurse only visits are billed to payer.

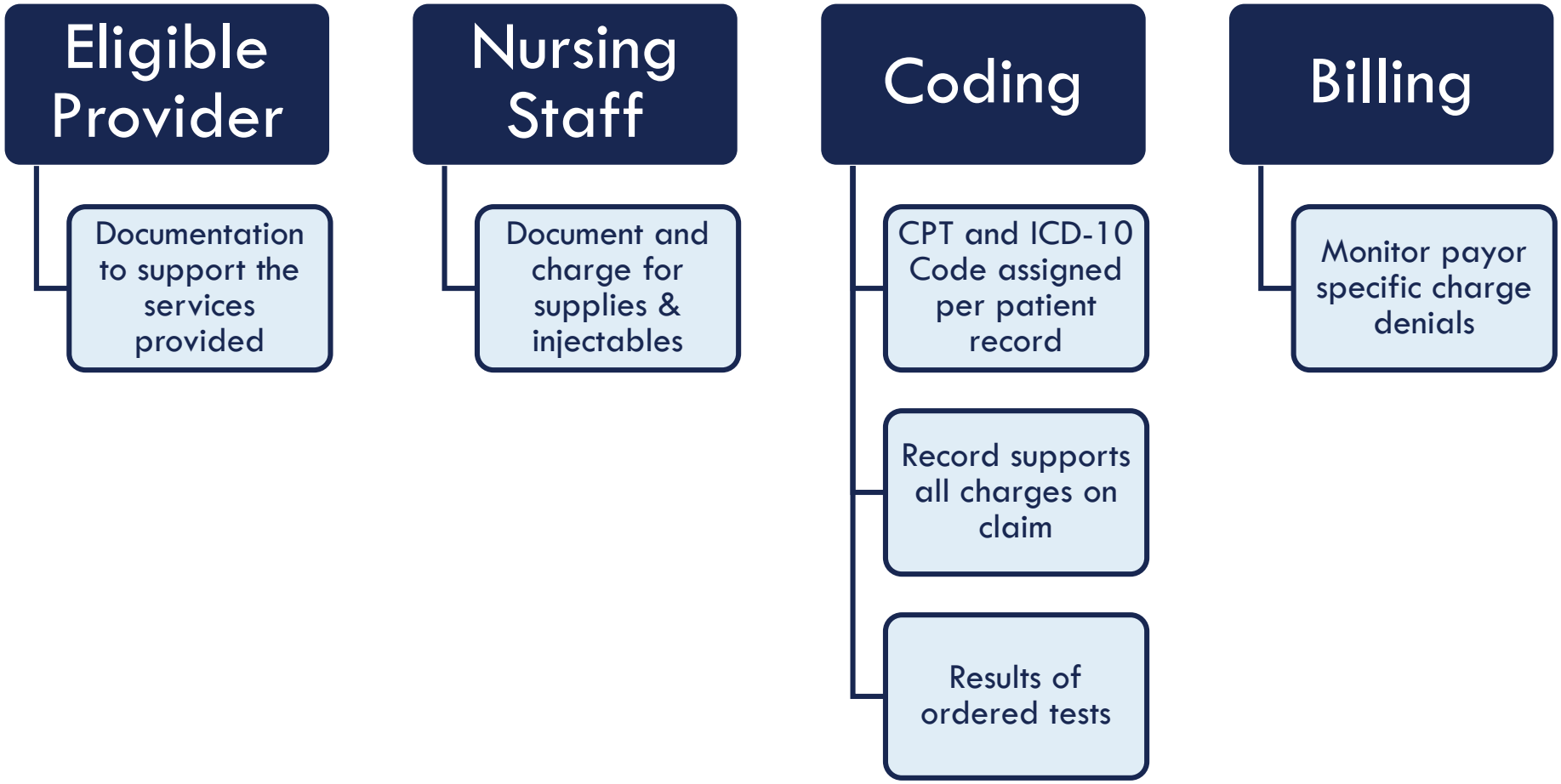
Compare system generated claim to Medicare billing system

- Track manual changes by billing/clearinghouse vendor edits.
- Billable services vs. Non-billable services.

Conduct monthly review remittance advice

- Medicare AIR payments correct (verify documentation supports more than one).
- Patient deductible/coinsurance properly applied.
- Non-Medicare payments are per payer contracts.

CHARGE CAPTURE RESPONSIBILITY



MEDICARE BAD DEBT – COST REPORTING

Beneficiary deductible and coinsurance designated as uncollectible at this time and there is no likelihood of collecting in the future.

Collection efforts for all payers and uninsured must be handled the same.

Do not include balances which meet small balance write-off criteria.

Calculate balance for dually enrolled beneficiaries (Medicare/Medicaid).

Reported in the Cost Reporting year when deemed uncollectible.

SUMMARY

RHC billing has many exceptions to the rules.

- Subscribe to CMS and Intermediary mailing lists to stay current with billing regulations.
- Share this information with all staff.

CMS continues to focus on prevention of chronic conditions by looking at value of services vs. volume.

- Dedicate staff to focus on prevention services.

QUESTIONS?

This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general information purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.

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THANK YOU!

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