

CAPITOL ASSOCIATES

Moderator: Bill Finerfrock
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1:00 pm CT

Operator: Good day, ladies and gentlemen, and welcome to the Rural Health Clinics Billing 5010 Requirements conference. As a reminder today's program is being recorded.

At this time, I would like to hand things over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, Operator and thank you everyone for taking the time out today to join us for this important teleconference for Rural Health Clinics Technical Assistance call. Rural Health Clinics - some of the challenges of transitioning from 4010 to 5010 in RHC billing.

I want to welcome everyone to today's call and as you said, my name is Bill Finerfrock and I'm the executive director of the National Association of Rural Health Clinics and I'll be the moderator for today's call. Our speaker today is Janet Lytton.

She's the Director of Reimbursement with Rural Health Development Healthcare Consulting and Management out of Cambridge, Nebraska. Janet's lived in rural America all her life and she's worked with Rural Health Clinics and Rural Healthcare for the last 27 years.

She's been director of reimbursement for her company for 20 years and has worked with both provider based and independent RHCs all across the United States.

She consults on RHC feasibility, certification, billing, coding and does many RHC cost reports annually as well as gives numerous workshops and presentations on RHC and topics across the country.

Many of you may know Janet having seen her at various National Association of Rural Health Clinics meetings. Today we've asked her to talk about RHC billing specifically addressing some of the challenges that you're facing making the transition from 4010 to 5010.

As you know this officially began on January 1 although CMS did announce that they would not enforce or impose penalties on providers who fail to comply for the first 90 days.

The format of today's program will be approximately 45 minutes for the presentation followed by questions and answers.

This series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy and is presented in conjunction with the National Association of Rural Health Clinics.

The purpose of the series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call is the 45th in the series which began in late 2004. During that time over 12,000 individuals have participated on the bi-monthly RHC national teleconferences.

As you all know, there's no charge to participate in the Rural Health Clinical Technical Assistance series and we encourage you to refer others who might benefit from this information to sign up and receive announcements regarding dates, topics and speaker presentations.

To do that you can go to the Office of Rural Health Policies Web site which is www.HRSA.gov/RuralHealth/Policy/confcall/INDEX.html. During the question and answer period we will ask that you identify yourself by name as well as the city and state you're calling from.

If you have suggestions for future topics please send them to Info@NARHC.org and put RHC TA Topic in the subject line. Similarly, if you have questions, you can send them to that email address as well.

Janet, we really appreciate you taking the time to talk with us today. The rest of the time is yours.

Janet Lytton: Thank you, Bill and good afternoon to everybody. Today, we are going to discuss some Rural Health Clinic claims issues and our 5010 requirements that began on January 1st of this year. We're going to know the requirements of our 5010 Rural Health Clinic claims.

We want to make sure that we are submitting the required format to comply with the 5010. We want to make sure also that we are submitting our preventive services correctly and then I'm going to give you some information where you can find references to use for the billing of Rural Health Clinic claims as well as the 5010 requirement.

Within our Rural Health Clinic the - one of the main issues with the 5010 is that we have all the Rural Health Clinic demographics that are on the CMS 855 form to be the exact name of the Rural Health Clinic, the exact address of the Rural Health Clinic and no post office box numbers are allowed.

And the nine digit zip code of which I know several have probably had to call the post office to find out what our last four digits were. At least I did on some of my facilities.

Our federal tax ID that's associated with the Rural Health Clinic, the NPI of the Rural Health Clinic and the taxonomy code for a Rural Health Clinic. The taxonomy for Rural Health Clinic is 261QR1300X.

It's important that that taxonomy code be used for the Rural Health Clinic. Slide number 4 - all of our Rural Health Clinic billing is on the UB04 form.

Yes we do use the 1500 form or the hospital does the billing for certain services within our Rural Health Clinic which are our non RHC services which are our X-ray technical component, our EKG tracing and our lab services done within our Rural Health Clinic.

Those are either billed on the 1500 form again or the provider based bill using the hospital outpatient provider number. These are requirements by CMS for the individual Rural Health Clinics. There are specific field locators required for the Rural Health Clinic billing.

Don't make it any harder than it is. Keep it simple. Only have the field locators that are required be submitted to your clearinghouse. And they submit those to the Medicare biller. It's important that we bill as they want us to bill.

All requirements for the claim submission are located in the CMS manual. There's 100-4, it's chapter 25. That's the information on the UB04. Then there's also the CMS manual 100-4 chapter 9 which is the Rural Health Clinic claims. They do not get into the specifics as I will get into.

However, the main information is on the Web site. Many times I will refer clinics to look at the PC Ace Pro 32 software that Medicare has for your usage and it's free of charge. And many times I will ask them to look at it for a reference.

Any claims that are submitted through the PC Ace Pro 32 software are considered Medicare compliant and have - will pass all the edits going into your Medicare fiscal intermediary or (MAC).

And this is - this can be used for institutional claims which is our UB04 or the professional claims which is the 1500 format. Both forms are capable through the PC Ace Pro 32.

Many practice management systems and clearinghouses are actually requiring more submitted to them that is actually required on our UB04.

This is probably one of our main concerns and one of the main reasons why claims are not giving to Medicare as they should. For instance, many of the clearinghouses will ask for a place of service. There is not a place of service within a Rural Health Clinic for the service providers provided.

We use the revenue codes to distinguish the difference between our places of service. So it's important that they understand that as well.

Not to take anything away from a clearinghouse but many clearinghouses are geared for regular fee for service clinics of which when we throw a Rural Health Clinic in the mix then they have to think of institutional claims. So be sure if you are contracting with a clearinghouse, that they truly understand the institutional UB04 formatting for your Rural Health Clinic.

Next slide - field locator one is required. That is your name of your facility - the name, street, city, zip code, phone and fax. All those are a part of that field locator. Field locator two is not required. Field locator three which is a patient control number is required.

Many people will use a medical record number or an account number. It's fine. It's whatever your numbering system may be. That field locator 3B it is medical record number. It is a situational situation - field locator.

It is not required but many clinics or institutions will use the medical record number again or their account number. It's entirely up to you what you use or if you use that field. Next slide, field locator four - the bill type, this is required.

The Rural Health Clinic bill type is always going to be a 711 in 99% of your claims that you submit. You may want to submit a 0710. And this would be if you want a denial for the services that you are providing to that patient on that day.

If you do a 710 type of bill you will also be required to have a 21 condition code present. And all charges that are on the claim would be listed as non-covered.

That 21 code means that you want a denial notice issued to you and perhaps that patient has a secondary insurance that would pay for that particular service. Another instance would be a Rural Health Clinic adjustment claim. That bill type is a 0717 or a cancel claim is a 0718.

The 0717 and the 0718 require that a document control number be put on the claim. That document control number is on your remittance advice that you receive from Medicare and it's the claim number that they associate those charges and that submission for that date of service on your remittance advice.

That is required on the adjustment or the canceled claim in order to complete the cancel or adjustment. Field locator five is your federal tax ID number. This is a required field and it will be your Rural Health Clinic tax ID number.

What number was on the 855 form when you submitted the information to CMS? Field locator six - the statement from and through date - I encourage the from and through date to be the date of service only, for instance, 1/27/12 through 1/27/12.

This means one service, one day and you're sending the claim individually each time they're seen by the provider.

If you put a from and through date you have a chance of your claim not going through because they're seeing either not enough services or too many services with your 521 revenue code. So each date of service, each claim is an submitted.

Slide number 7 - field locator seven is not used. Field locator eight - the patient name is required. Make sure that the name that you put on your claim is exactly the way it is on the Medicare card. That's very important.

Many of us use slang names or nicknames or our middle name instead of the first name. It must be exactly as on the Medicare card. The patient address is required. The birth date is required. The patient's sex is required. The admission date you do not use on an outpatient claim.

We used to have to do that with a 4010 claim. We do not use that on the 5010 claim. The admission hour is not used on an outpatient claim. So those are two that we do not have to use that we did prior to January 1st have to use. Field locator 14 is the admission type. This is required.

This is something that is new to the Rural Health Clinics. The Rural Health Clinic will most likely use a 2 is urgent, a 3 is elective and elective would mean that the patient made the appointment and they elected to come to your clinic or a 9 as information not available.

Probably typically you're going to be using the 3 probably 95% of the time. A field locator 15 is source. This is also required. The Rural Health Clinic will most likely use a 1 for non-healthcare point of origin which would be coming from their home.

They could use a 5 if they've come from an ICF, a skilled nursing facility or an assisted living facility or you've got 9, information not available. Typically we're going to be using the 1. On the next slide, field locator 16, discharge hour is not required so you do not use that on outpatient claims.

Field locator 17 is status. Where is the patient going when he leaves your clinic? It's required by the Rural Health Clinic claim formatting. A 01 means that they're discharged to home or to self-care, 03 they're discharged to a (SNF).

That could happen if you're seeing a nursing home resident and they can go back to the skilled nursing facility. A 04 is if they're discharged to a custodial care facility.

For instance, an assisted living or an ICF there has been a question on the listserv that Trailblazer did not require this but their claims were going through. However, if you look at the Trailblazer Website, they've got UB04 examples for Rural Health Clinics.

And that particular field locator 17 is a required field on their example. It could be at this point in time, they're not editing for that as yet. But come the end of 90 days they could be editing for that. So I would suggest that you format your claims to be filled in for that field locator 17.

Field locator 18 to 28 are condition codes. These are very rarely used within the Rural Health Clinic.

However if you have a hospice patient that you are seeing within your clinic and they are being seen for a reason or a diagnosis other than the hospice diagnosis you must put a 07 condition code in that field locator or the claim will not get paid.

Also if you're wanting a denial that's where you put that condition code I talked about earlier, that 21 that you're sending the claims for denial purposes so that you can use that denial to send to the supplemental insurance of that particular patient.

Some other additional condition codes are used when you're doing Medicare secondary payer billing. There is an excellent handout on the Cahaba Website for Medicare secondary payer billing.

And it's an algorithm that is used and it gives you all the different circumstances on what you put in which fields. And it would be very good for your billers to have as a reference in their office. Field locator 29, accident date - that is not required in the Rural Health Clinic.

Field locator 30 is not used. Field locator 31 through 34 which are occurrence codes and dates - these are situational but normally not used. It may be used within a Medicare secondary payer situation but with probably 99% of the time in the Rural Health Clinic or 99.9% you will not be using an occurrence code and date.

Slide 11 - the occurrence span codes which are field locators 35 and 36 - they are not used within a Rural Health Clinic. Field locator 37 is not used. Field locator 38 is responsible party, not required. Usually the patient name and address does default to this particular field locator and that is okay.

Even on the PC Ace program when submitting a claim the patient's name and address defaults to that field locator which is fine. Field locator 39 to 41, our value codes and amount - and these are only used within Medicare secondary payer situations.

Other settings, other institutions do use the value codes and amounts quite frequently but not within the Rural Health Clinic. Field locator 42, the revenue code - this is required. And in order to have a revenue code we must have our face to face visit.

These all are part of our Rural Health Clinic billing. And if we don't have a face to face visit we don't have a billable claim to Medicare. Our 0521 is our in office visit, 0522 is a home visit, a 0524 is a skilled nursing facility or swing bed patient or resident on a Part A stay.

A 0525 is a nursing home visit, 0527 is a visiting nurse visit within a non-home health agency area as this does require a special designation by CMS. And there are actually very few clinics that have this capability or designation.

The 0528 is any other site, for instance, at the scene of an accident that the provider may go to. The 0900 is a behavioral health visit. The 0780 is a tele-health site fee and 0001 are the total charges that are shown at the very bottom of the claim form when all charges are submitted and is a required field.

Most systems will automatically put that 0001 with the total charge, at the bottom. Slide 13 - our field locator 43 is the description. This is not a required field for the Rural Health Clinic claim.

Many systems and the PCAce system will default to say "clinic visit". That is fine.

Or you could have it hard coded in to say "clinic visit". The field locator 44 is the HCPCS, the rate or the HIPPS code. It is not required in the Rural Health Clinic on a Rural Health Clinic claim unless it is a preventive service that has been performed.

Then the CPT code must be part of that claim. This is very, very important guys. Even though you have a visit you could have one line item that is your visit. You could have the second line item with the 521 revenue code, your CPT code of your preventive service, the charge for that service.

And what Medicare does is they apply copay and deductible to the first line and they apply no copay or deductible to the second line which is your preventive service. I was just at a clinic this week that stated "Well it just doesn't matter because that's all we get is our rate".

I understand that you will still get your rate but it is important that the CMS system know that we have had this particular preventive service performed for this patient because again the patient does not have to pay a 20% copay and if we bill incorrectly and we know that, that's on our fraud and abuse hotline.

And it's a compliance issue. So by all means make sure that you're billing your preventive services correctly. Field locator 45 - the service date is required. This date will be the same date as the from and through date.

The field locator 46, our service units - with a revenue code of a 521 it's always going to be a one service unit. Even if you've had more procedures in that one day it still must be a one because it is a bundled unit at that point in time.

When you add a preventive service that preventive service will be a 521 with a one unit as well. The Medicare payers were having a problem with the payment of these preventive services.

I think they have had a resolution of that issue but this is how it has to be billed even until they get the whole payment process figured out. If you have two visits in one day you will put in the remarks section why. You will then have a 521 with two visits.

They are very difficult to get paid however you will also have to send in documentation to make sure that it's not the same ailment for both visits. The next slide, field locator 47 is our total charges. It is a required field. This will be the total charges for the day of your bundled services.

Field locator 48 is not - is very rarely used. But if you're billing for a denial that is where all of your charges will fall, into that non covered column. Field locator 49 is not used. The next two slides, both slide 15 and slide 16 is actually a claim for a Rural Health Clinic service.

And the first one is a regular Rural Health Clinic claim. And you will see these are the actual field locators that we've just went through that is required by Medicare. And these actually came from the PC Ace Pro 32 software. The next slide is 16. It shows you how to bill your preventive service.

Now depending on the preventive CPT code, that's what would change instead of the G0402 you may have a different preventive service perhaps. Slide number 17 shows a clinic visit that you have both the clinic visit and you have the preventive service both on the same day.

And they're billed on the same claim form but they do not apply copay and deductible to the second line item but they do apply copay and deductible for the first line item. Slide 18, the payer field locator 50 - the payer name is required. For us it will be Medicare or could be Cahaba or it could be WPS.

Whatever your Medicare payer requires right there that would be what would be there. The field locator 51 is their health plan ID. For instance, WPS - Wisconsin Physician Services may use 05401 or 52280 depending on if you were with Blue Cross or if you were with Mutual.

So it just depends on which one it is. So your Medicare payer will have their own five digit health ID number. Field Locator 52 is release of information. This is required and usually it's a yes, a Y because we have obtained the release of information data from the patient when they came in.

The field locator 53, assignment of benefits - most of our consents also have an assignment of benefits that they have signed off on and that would be a Y. If they have said "no" then it is an N. And that's required in that field. Slide 19, field locator 54, prior payments.

This is left blank for the regular Rural Health Clinic claim. It may be completed in a Medicare secondary payer situation. Field locator 55 is estimated amount due. This is the amount due from the patient. It's not required so you don't put anything in that field.

Field locator 56, the NPI - this is required and it's the NPI number of the billing provider, the Rural Health Clinic NPI number that goes in that field. Field locator 57, provider ID of the second and third payers is required.

For instance, if they have a coinsurance you're going to want to put that coinsurance company and they may also have the state Medicaid program. So that would be in field - the number two and the number three and then the information associated with those particular insurance companies.

If you do not have those on your claim there is no chance for that claim to crossover which is much easier if the claims crossover from Medicare to the secondary payers than if it has to submit paper claims or go again and do the electronic claims to the next payer.

Field locator 58 through field locator 62 is required. This is the patient insurance information from the insured's name, the patient relation and typically it's an 18 meaning self, the patient's

Medicare number or their insurance number and any applicable group name or group number as those would be on your coinsurance as the secondary or the tertiary insurance.

The next slide - field locator 63, treatment authorization code is not required on a Rural Health Clinic claim. However if it's an HMO or a PPO claim this could be required if there is a preauthorization that is required for you to see that patient at that time.

But typically you will not use this particular field locator. Field locator 64 - the document control number, this is usually not used.

However, if you've done an adjustment or a cancel claim then you would put that document control number that is assigned on the remittance advice in this particular field.

When you do the adjustment or the cancel you must also have a condition code of a D0 through a D9 whichever most applies to the particular reason that you're doing the adjustment or the cancel.

Typically it's going to be a D1, a change to the charges if we are doing an adjustment claim and we're adding charges.

Maybe they were in several times after the face to face visit for injections that we don't want to lose the coinsurance amount on so we've put them with that face to face visit within that 30 day period.

And we can add the charges to that and the coinsurance applicable to those additional dollars that we've added we will receive and they will process that claim over. It'll look like they take the money back and then they will pay us again and that's exactly what they do.

However, the coinsurance company gets the information that now they owe X amount instead of the Y amount that they previously did owe. So it's important to know which condition code to use. A D5 would be if we wanted to cancel the claim to correct a Medicare number.

And that happens. I've had to do that myself before. A D9 is for any other change. If you have a D9 that's a catch-all, any other change there must be a remark in the remarks section to go along with what that other change is on our claim.

The next slide, 21 is field locator 65 is the employer name and that is of the insured. And it is not used on a Rural Health Clinic claim. Field locator 66, the diagnosis of the patient for the visit - that is a required one.

Some V codes are appropriate as primary codes and you list as many as the provider has addressed or were considered during the patient's visit and his treatment plan so and just below that field locator 66 if the claim is printed you will see a 9.

That 9 signifies that we have been using the ICD-9 codes. You do not input that. It automatically goes in that particular field. And I don't think it shows on the electronic file but I can't say that for 100% sure. Field locator 68 is not used.

Field locator 69, the admission diagnosis, is not required on outpatient claims. Field locator 70, patient reason diagnosis is not required in the Rural Health Clinic. Field locators 71, 72 and 73 are not used. Field locator 74, the principal procedure codes and dates are not used on outpatient claims.

This is only an area that is used for inpatient claims. Our procedures within our Rural Health Clinic are part of our 521 bundled revenue code. So field locator 75 is not used. Slide 23, our field locator 76 - the attending provider NPI number, last name and first name is required.

You may have other numbers in your system that could also be a part of the claim. But the NPI number is required. You may have a state license number which is a 0B. You may have the UPIN number which is a 1G. Or you may have a provider commercial number which is a G2.

However, those are not required on the Rural Health Clinic claim. It will not error out if those numbers are in there but what they are looking at is the particular provider NPI number. Field locators 77, 78 and 79, other providers, are not used on the Rural Health Clinic claim.

Field locator 80 - that's the remarks section. This is only used if needed and you must have a remark in there if you have done an adjustment claim, a canceled claim or if you've had two allowed visits on the same day.

Those are the only reasons that I could think of that you would have a remark in that field locator 80. Slide number 24 is field locator 81CCa.

This will show if you have a - the demographics of your patients in your system and if you have a marital status the marital status will show in this field with a B2 that automatically goes in there for the marital status and an S would be single.

Now in your system - it does not require that we put in a marital status but if you have it in your system it will print on the UB04. If there is no marital status in your system then what we have is our taxonomy code will be in that field.

So if you have a marital status and then you have the taxonomy code, that taxonomy code will be in field locator 81CCb. And again it will be noted with a B3 noting taxonomy code. And our taxonomy code is the 261QR1300X.

The next slide is slide 25. Some of the other taxonomy codes that you may see and we don't want on our Rural Health Clinic claim but you may have within your system would be like a critical access hospital clinic which is not a Rural Health Clinic.

It would be considered a provider based clinic through the critical access hospital, not Rural Health Clinic. I have listed that number there. There's a fee for service clinic number there as well as a critical access hospital and an acute care hospital.

Those are some of the other taxonomy codes that are used within our settings that we deal with every day. So on slide 26 this is the bottom portion of the claim for any Rural Health Clinic claim that we may have.

Yes, the diagnoses will change but typically other than that everything is going to be exactly like it is right here with the exception, you're going to be billing a different provider - a Medicare payer. I have Medicare A for Nebraska but other than that it's going to be pretty much like that.

Not really much required on the claim. Some of the other issues that I see happening within our Rural Health Clinic - come the beginning of the year we've got those negative reimbursements that we all see on our remittance advice.

And part of us understand how they work and part of us do not understand how they work. What Medicare is typically doing is they are limiting our payment to the Rural Health Clinic to be our - 80% of our all-inclusive rate.

Now we know that after the deductible and the coinsurance or after the deductibles are met they pay us 80% of our rate just like clockwork.

However, until the deductibles are met they will be taking money away from your clinic with the knowledge that you are going to be collecting that copay and deductible amount which is \$140.00 this year, from the Medicare patient or their supplemental insurance.

So it is very important that you understand that and also that the patients understand that and the insurance companies understand that.

I just had a call this morning from a clinic that actually had a Blue Cross payer say that we don't owe you any of that money because Medicare's taking money away so why shouldn't we be taking money away. That is not correct.

Make sure that you get the copays and the deductibles from the Medicare patients themselves or their supplemental insurance. Trailblazers has a very good explanation on their Website which on slide 28 is exactly what they've got on their Website.

It also gives you an example - total amount billed was \$186.00. The provider reimbursement rate happened to be \$64.78. The beneficiary's deductible that was remaining was \$100.00. The beneficiary applicable copay was \$17.20.

They get that number by taking \$100.00 from the \$186.00 and the \$86.00 times 20%. That's where the \$17.20 comes from. The beneficiary's responsibility will be \$117.20 and Medicare's responsibility will show a \$35.22 taken away from the clinic.

That's because you're required to collect that money and come out whole is what it basically is, from your copays, your deductibles and the amount taken away. So you might want to refer to the Website that I have on there at Trailblazers. It's a very good tool.

Another issue on slide 29 is our Rural Health Clinic cost report. Since the first of the year they've changed it just a little bit because of our preventive services.

These services we disclose on a line on our cost report now the total dollar amount of the preventive service charges that we have had within our clinics since January 1, 2011.

Because through the Medicare cost report they will determine if we are due an additional payment which most likely we will be for that 20% of the charge that we did not get to get paid from the beneficiary or their coinsurance company.

So it's important that you track those or have a way of tracking those whether it's from the CPT codes on the preventive service, I love the quick reference tools that CMS has out there, and believe me, every time I go to a clinic I take them with me and make copies for them and tell them where to get them.

So it's important that you know which code, which diagnose to use, which frequency is allowed within the Rural Health Clinic and make sure that they're billed correctly.

On slide 30 some of the references that I have used today, the CMS manual, the www.CMS.gov/Manual of which the chapter 9 that I referred to earlier and chapter 25 on the Medicare Manual 100-04 and then the manual - there's a UB04 manual that is created.

Medicare used to have the entire UB04 manual on their claim form or on their Web site but they do not now. And you can obtain one of those from the www.NUBC.org. Now the new one is not available until July of this year and you can't get an old one. I've already tried so it doesn't work.

There's also another reference that I did not put on here but I need to tell you about. And that's the billing guide for preventive services of which I put it on the listserv. I originally put the incorrect one on there but I changed it this morning. And it's under the Medicare CMS Web site.

And it is under the Med Learn Matters and it's SE as in Evan, 1039. And that's the billing guide for preventive services for Rural Health Clinics and federally qualified health clinics.

Bill Finerfrock: Janet, your voice faded out. Can you give that address again or that title again?

Janet Lytton: Yes. It is SE1039 and it can be obtained on the CMS Web site, the Med Learn Matters section.

Bill Finerfrock: Thank you.

Janet Lytton: Another reference that is used and I use all the time, is the Medicare preventive services quick reference guide, also the Medicare annual wellness visit quick reference and they've also got an IPPE quick reference guide.

Also there's a Medicare secondary payer quick reference. This is the one I was referring to on the Cahaba Website which is a very good tool also for a Medicare secondary payer. If any of you can't get any of these to work email me and I would be happy to email them to you.

Other than that I would be happy to answer any questions. If I do not have the answer to the question I will find out and give it to Bill and put it on the listserv. Thank you.

Operator: And ladies...

Bill Finerfrock: Thank you. Go ahead Operator.

Operator: Ladies and gentlemen, if you would like to ask a question, please press star 1 on your touch-tone telephone. A voice prompt on your phone line will indicate when your line is open. We ask that you state your name and location before posing your question. Once again ladies and gentlemen star 1 for questions.

And we'll go to our first caller.

Bill Finerfrock: Can you...

Operator: Your line is...

Bill Finerfrock: ...hold on just a second Operator? Let me do a couple of things real quick. One, I want to thank Janet for an excellent presentation. I think there was some really very useful and timely information there.

I know I learned some things and I really appreciate you taking the time out to help educate your Rural Health Clinic colleagues. I do want to mention and I probably should have said at the outset, CMS yesterday published a revised transmittal with regard to the Rural Health Clinic cap.

They believe that they made a mistake in the calculation of the adjustment that was - went into effect on January 1. And so they published basically an errata yesterday indicating that the cap for 2012 is \$78.54 for those who are subject to the cap.

Now I believe and NARHC believes that this is not correct and we are going to go back and try and fight this. But until such time as it were to be changed you're going to have to operate at - the cap for 2012 will be \$78.54.

There's a dispute over what the proper inflationary adjustment should be on that so please be aware of that. In addition I just want to put in a shameless plug but I hope you'll all consider attending the National Association of Rural Health Clinic Spring Institute in San Antonio, Texas this March.

Janet and others will be our speakers. We have a wonderful program dealing with billing and cost reporting and survey and certification issues that I think you'll come away with. It's very educational. If you want to get more information about the conference visit our Web site, www.NARHC.org.

Click on the events banner at the top of the page and you can get links to all of the information you need for that conference. It's March 19th to the 21st in San Antonio, Texas and we'd love to see you all there. Operator at this time if you can open it up for questions we'll take as much as we can.

Operator: And caller, your line is now open.

Bill Finerfrock: Go ahead caller.

(Tricia Block): Hi yes. We had a question. We...

Bill Finerfrock: State your name and where you're calling from.

(Tricia Block): (Tricia Block) from Washington State. We submit our claims to Cahaba.

Bill Finerfrock: Okay.

(Tricia Block): And the last error message that we receive now on all our claims states patient reason for visit is required on all outpatient claims. And I'm unsure where that information is supposed to come from.

Janet Lytton: It's supposed to - it's field locator 70. However, it's - actually it doesn't say that it is required for the Rural Health Clinic claim. However if they're wanting it I would definitely put it in.

(Tricia Block): Would that be just the primary diagnosis on the visit?

Janet Lytton: It would be. That would be what you would put in that one it would be the reason for the visit. Yes.

(Tricia Block): Thank you.

Janet Lytton: If it's - it could be hypertension, it could be diabetes, it could be anything. Yes.

Bill Finerfrock: Okay.

(Tricia Block): Okay, thank you. Thank you.

Operator: And once again, ladies and gentlemen, please state your name and location before posing your question. We'll go to our next caller.

Bill Finerfrock: Go ahead caller. Is your line on mute?

(Tawny): Can you hear me?

Bill Finerfrock: We can hear you now.

(Tawny): Okay. My name is (Tawny) and I'm with the (Hannibal) Regional Medical Group. I'd like to ask a question in something from the beginning in locator 5. You stated...

Bill Finerfrock: Where is (Hannibal) (Tawny)?

(Tawny): I beg your pardon?

Bill Finerfrock: Where is (Hannibal)?

(Tawny): In Missouri.

Bill Finerfrock: Great. That's what I thought. Just checking.

(Tawny): Okay. I'm sorry.

Bill Finerfrock: That's okay.

(Tawny): On locator 5 she indicated to use our tax ID number but we own more than one Rural Health Clinic and we are using the NPI attached to the Rural Health Clinic.

Janet Lytton: And field locator 5 must be a federal tax ID number.

(Tawny): Okay. Is that new because we have not done that in the past?

Janet Lytton: That's been a requirement for a long time. Are your claims going through without it?

(Tawny): Yes. We're getting them paid. We're hospital owned. I don't know if that makes a difference or not but...

Janet Lytton: I - and right now it could be that it's just not editing out for us.

(Tawny): That may be. Okay, that's...

Janet Lytton: That is a requirement. Because if you look on the claim that's the only place on the claim that it has the federal tax ID number associated with it. And they have to put dollars associated with the federal tax ID number.

So I think it would be in your best interest to make sure that your Rural Health Clinic NPI that you have in box 56, whatever the tax ID number is associated with that NPI number, goes in field locator 5.

(Tawny): Okay. That answers my question. Thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: Thank you.

Operator: Next question your line is open.

Bill Finerfrock: Go ahead caller.

(Debbie): Yes. (Debbie) from Forest City Family Practice in St. James, Missouri. Would you repeat that number on that guide please? It was a little hard to understand the initials - the letters.

Janet Lytton: S as in Sam, E as in Every, 1039 I believe.

(Debbie): Thank you.

Janet Lytton: Yes.

Operator: And we'll go to the next question. Your line is open.

Bill Finerfrock: Go ahead.

(Debra): Hi. My name is (Debra) and I'm calling from Mt. San Rafael Hospital.

Bill Finerfrock: And where is that located?

(Debra): In Trinidad, Colorado.

Bill Finerfrock: Okay, great. Go ahead (Debra).

(Debra): I'm not exactly sure how to phrase my question but I was hoping for a little bit more explanation on the billing of preventive services.

Janet Lytton: Okay. The preventive services that are allowed by Medicare are all on that preventive quick reference guide. It gives you CPT codes, it gives you diagnosis codes and it also gives you the frequency of each one of those that apply to the Medicare payment for those codes.

It also tells you if copay and/or deductible are either waived or not waived. Ninety five percent of them are all waived for copay and deductible.

Those services must have a CPT code in box 44 on your claim form with the revenue code of a 521 with the dollar amount for that service either on the first line of your Rural Health Clinic claim or if you've had another service it would be on the second line of your Rural Health Clinic services that day just like the example shows.

(Debra): If...

Janet Lytton: And then Medicare will not apply copays and deductibles to that particular line item.

(Debra): If we're billing for like a welcome to Medicare or a...

Janet Lytton: Yep.

(Debra): ...annual...

Janet Lytton: Yep.

(Debra): ...would we bill the evaluation in management without the CPT code or just the...

Janet Lytton: If you - if they've had another reason let's say they've also got diabetes or hypertension...

(Debra): Okay.

Janet Lytton: You would have a 521 with an E & M code that does not show on your claim form with the service date with the unit of one with the total charge of your - those services. You would have a second line item for the IPPE physical which is a G0 whatever it was, 0401 or something like that.

Then that code would be on there with the service date of the same date as your visit with one unit and the charge for that particular line item. You've got two services on that one day just like the examples. That's exactly what the examples show. That's how...

(Debra): Is there a...

Janet Lytton: ...you must code those and get them paid correctly within the Rural Health Clinic.

(Debra): Is there a reference somewhere that shows exactly I guess what criteria I've covered under like the welcome to Medicare or the annual exam?

Janet Lytton: Yes, there is. And that's the quick reference guide that I was referring to on those last slides that give you that Website to get them off of. Absolutely.

(Debra): Okay. Thanks.

Bill Finerfrock: Okay?

Janet Lytton: And that's on the CMS Website.

(Debra): Okay. Thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: Thank you (Debra). Next question?

Operator: Caller, your line is open.

(Maria): Hi. My name is (Maria) and I'm with (Yukawa) Valley Rural Health Center in California. And I'm not sure if you've already given your email address Janet, but I wasn't in at the very beginning of the call so I'm hoping that you could repeat it.

Janet Lytton: I will repeat it. It's actually on the first slide as well.

(Maria): Well I don't have access to the slides. I'm sorry.

Janet Lytton: Oh, okay. Sure. That's fine. No problem. R as in Robert, H as in Harry, D as in David, Consult J as in Janet, L as in Lytton at Hotmail dot com.

(Maria): Thank you.

Janet Lytton: You're welcome.

Operator: And next caller...

Janet Lytton: I will also say that I do answer all the emails that I get. However, if you have not heard from me within a week or so it could have went into a junk box that I don't have access to so email me again.

Operator: And we'll go to our next question.

Bill Finerfrock: Caller. Go ahead caller. Who's next?

(Chris): This is (Chris). I'm calling from the (Mild) West Clinic in (Muston), Wisconsin and we'd like to know what the recommendation is for field locator 15 and field locator 17 if our provider is going

into a skilled nursing facility to do nursing home rounds and we're billing out a 524 or 525 revenue code.

Janet Lytton: Let me look. Just a second. For the source I would say on the field locator 15 I would do a 5 because that's a skilled nursing facility ICF or an assisted living.

And on the status for 17 I would use if they're on a skilled space I would do a 03 and if they were on a - just in as a custodial patient, excuse me, I would use a 04.

Bill Finerfrock: Did that answer your question (Chris)?

(Chris): Yes. Thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: Tell (Mary Peterson) we said hello.

(Mary Peterson): Hi Bill. I'm right here.

Bill Finerfrock: I was shocked. I didn't - I thought you were the only one who worked at the Miles Bluff Clinic.

(Mary Peterson): These people would be offended.

Bill Finerfrock: I'm just teasing. You guys have a great...

(Mary Peterson): I know.

Bill Finerfrock: ...operation out there. Thank you for your question. Do you want to open the next caller?

Operator: And caller, your line is open. Caller, please check your mute function. Your line is open.

(Leanne Castle): Hello? Can you hear us?

Janet Lytton: Yes.

Bill Finerfrock: We can hear you now.

(Leanne Castle): Hi. This is (Leanne Castle) from St. Mary's in Michigan Standish Hospital in Michigan.

Bill Finerfrock: Okay. Go ahead (Leanne).

(Leanne Castle): My question in regard to the preventive service for the RHC, when it's just the one liner
and it's just the annual wellness what is the proper diagnosis to submit on that claim?

Janet Lytton: That quick reference tells you but I don't have that quick reference in front of me.

(Leanne Castle): Well we kind of had this issue in our facility last week and I am looking at the quick
reference information and it...

Janet Lytton: Does it...

(Leanne Castle): ...states on there no specific diagnosis code...

Janet Lytton: Okay. Then there isn't one.

(Leanne Castle): ...required. To contact the local Medicare contractor for guidance which we did and we still were not given an answer. And there is no actual preventive diagnosis.

Janet Lytton: I would be that you would use a V code for - I don't remember what - it was going to be a V70 something.

(Leanne Castle): That is a - that states that that is a routine service and that - we did submit a claim with that and that was rejected.

Janet Lytton: It was? Well the...

(Leanne Castle): Yes. Yes, we can't get a straight answer out of anyone.

Janet Lytton: Who's your...

Bill Finerfrock: Who's your...

Janet Lytton: ...(FI)?

Bill Finerfrock: ...Medicare contractor?

(Leanne Castle): UGS, National Government Services, United Government Services. And it states right on the reference guide no specific diagnosis code. Contact the local Medicare contractor for guidance.

Janet Lytton: Yep.

(Leanne Castle): So we really need some guidance on this.

Bill Finerfrock: Are they not responding to your inquiry or in other words they're not even answering the phone or...

(Leanne Castle): Didn't answer the question.

Bill Finerfrock: ...are they not answering your questions?

(Leanne Castle): She understood our dilemma and she kept repeating, according to this document it states no specific diagnosis code is required.

Bill Finerfrock: So if you leave that field blank your claim is still getting rejected?

(Leanne Castle): I did not submit that without a diagnosis. We do have...

Janet Lytton: Are you getting...

(Leanne Castle): ...a vendor and, you know, you do need...

Janet Lytton: Yes, you can't do that.

(Leanne Castle): ...to do...

Janet Lytton: You have to have a diagnosis....

(Leanne Castle): You have to...

Janet Lytton: ...for a claim...

(Leanne Castle): ...in order for that to be a valid claim. Yes, so we...

Janet Lytton: Right.

(Leanne Castle): ...are in a great dilemma with that and I just wondered if anyone else out there was in the same issue.

Janet Lytton: If I were you I would call back and ask for the next higher person.

Bill Finerfrock: Ask to speak to that person's supervisor.

Janet Lytton: Yes.

(Leanne Castle): Okay.

Bill Finerfrock: All right?

(Leanne Castle): Thank you.

Bill Finerfrock: Okay. Sorry (Leanne). All right. Next question?

Operator: And caller your line is open.

Bill Finerfrock: Go ahead caller. Is your line on mute or did you give up?

(Peggy): I'm sorry. This is (Peggy) calling from Mount Shasta, California. And we were wondering if you had some reference tools for Medicaid or MediCal?

Janet Lytton: I don't. Every state is different on the Medicaid side. However, I do know that California does have a lot of references on their Web site. And you might want to look there.

Female: Okay, thank you.

Janet Lytton: You're welcome.

Bill Finerfrock: Any caller?

Operator: Caller, your line is open.

Bill Finerfrock: Go ahead.

(Kathleen): Yes. This is (Kathleen) at Audubon Medical Clinic in Audubon, Iowa.

Janet Lytton: Hi (Kathleen).

(Kathleen): Hey, how are you, Janet?

Janet Lytton: ((inaudible)) good.

(Kathleen): I've got a question on why our UB-524 and UB-525 claims have had no interruption in processing our payments. But the UB-521s haven't been paid since December 2 until we had a recent tweak with our - with not Cahaba but our ((inaudible)) clearinghouse on the 25th of January. Now, those seem to be going through.

But for some reason, there must be a difference in how those claims are processed at Medicare.

We haven't had an interruption for skilled care or nursing home. But for office services, we have.

Janet Lytton: I wouldn't think there should have been any difference in the Medicare system. I would suspect more of a clearinghouse system issue instead of the Medicare. But I don't know that for a fact.

(Kathleen): So they're not asking for any different information necessarily...

Janet Lytton: No.

(Kathleen): ...on the 25s and 24s than on the 21s, okay.

Janet Lytton: No, nothing.

(Kathleen): Okay.

Janet Lytton: Nothing, because the revenue code just designates where that service was provided at.

(Kathleen): Okay. Well, I think we've got a handle on it now. But boy, it's been a struggle. And it's been really frustrating for the last about 60 days here.

Janet Lytton: Right. Right. You know, and many times, I don't know if it's our clinics that are having the problems more than our clearinghouses are having the problems.

(Kathleen): Well, and, yes, I was thinking maybe what Medicare was asking from the clearinghouses as well, so that communication both ways.

Bill Finerfrock: Yes. I mean, Janet and I were talking about this before we went live. And I think that there are some great clearinghouses out there.

But I think that there are also some clearinghouses where the bulk of their business is the Medicare Part B business. And consequently, a lot of their resources in doing the conversion from 4010 to 5010 were primarily directed to doing the Part B side of Medicare. And perhaps a little bit less attention was paid to the UB-04 side. And consequently, some of the things that have gone on have been some problems at a clearinghouse level.

Some of them have been, I think, clearly at an RHC level. And I think that was why we wanted to here is let's make sure everybody knows what fields need to be filled in, what needs to go into what fields, and at least eliminate that as much as we can as a source of the problems that people are having.

I'll also say that I do a lot of work with providers who submit claims on traditional Part B. And there are a lot of problems occurring with claims on the Part B side of Medicare as a result of the transition from 4010 to 5010.

So if you ever feel as though you're sitting there and you're being put upon as a rural health clinic, life isn't a whole lot better for traditional physicians offices either.

(Kathleen): Well, that's good to know.

Bill Finerfrock: Operator, how many more questions do we have in the queue?

Operator: We have about ten still.

Bill Finerfrock: I don't know that we're going to be able to get to them all. Why don't we take one or two more? And then if we don't get to your question, if you - Janet gave her email if you'd like to submit it to her directly. Or if you want to submit it to me at Info -- I-N-F-O -- @NARHC.org, we'll try and get back to you with an answer. But we'll take - why don't we take two more questions off of the phone lines.

Operator: Absolutely. And next caller, your line is open.

Bill Finerfrock: Go ahead...

(Mary Beth): Yes.

Bill Finerfrock: ...caller.

(Mary Beth): My name is (Mary Beth). And I'm calling from Florida Hospital Adventist Health System. And now, we didn't have access to the PowerPoint. So I was wanting to find out if there'd be a way we could get a copy of it.

Bill Finerfrock: It's up on the Office of Rural Health Policy's Web site. I know there were some problems earlier with the government's Website, that it was giving a message of page not found. My understanding is that that's been corrected. And so if you go to the Office of Rural Health Policy, it's www.HRSA.gov/ruralhealth. And then you go to the icon that says, "Rural Health Clinic," or the words - you can click on it. And it should be there.

If that still doesn't work, or you can't find it, send an email to me at info@NARHC.org, and I will email it to you.

(Mary Beth): Okay, Info@NARHC...

Bill Finerfrock: Info@NARHC.org. I'm sorry, (Mary Beth).

(Mary Beth):org.

Bill Finerfrock: Yes. Where are you calling from?

(Mary Beth): I'm from Florida Hospital.

Bill Finerfrock: Florida, okay.

(Mary Beth): Yes. Okay, thank you very much.

Bill Finerfrock: Thank you.

Operator: And we'll go to the next question.

Bill Finerfrock: All right. Go ahead, caller.

(Mary): Hi Bill. (Mary) from ((inaudible)) Clinic. Just a theoretical question, are we still working from a rural health perspective from your perspective on trying to get us better reimbursement for doing double the work for all of these preventive services that CMS is, you know, granting coverage for?

You know, we do our - a sick visit. We do an annual wellness visit, or Welcome to Medicare exam, we get one encounter rate. So I mean, I really think that it's becoming imperative that, you know, we try to say something about this reimbursement problem.

Bill Finerfrock: Well we - legislation...

Female: I mean, we do try to tell our patients, you know, or try to tell our physicians, "Try to schedule these on different days." But, you know, when the patient's there and they've traveled many miles to get to you, you don't want to have them to have to come back.

Bill Finerfrock: Sure. We have been working on trying to get the rural health clinics rate increases - the cap rates for those that are subject to the cap. And legislation was - has - was introduced a couple of months ago in the Senate to raise the rural health clinic cap to \$101 a visit.

And a comparable bill was introduced in the House on Tuesday to raise that to \$101 a visit. And we are continuing to push to get that raised to a much higher level, which would help a lot.

I think, you know, it's a larger issue. Some of these issues, you know, we're asking the Congress to really look at what's going on there and make sure that, you know, we're adequately compensating for some of these services that where the payment is higher but we're expecting them to be done in an RHC.

Yes. As I'm sure everybody who watches the news knows, there's a large budget issue going on here in Washington. Raising the rural health clinics cap obviously would cost money. They're trying to fix the (FTR) problem on the physician side. To do that, would cost \$300 billion.

There's a lot of pressure to try and increase a whole range of provider payments. And we're all competing with one another for either limited or non-existent dollars. But we'll continue to push and make the case.

(Mary): But obviously, as you know, on the B side, they're encouraging providers, you know, to massively do annual wellness visit as a revenue producer because of the high amount of reimbursement.

Bill Finerfrock: Right.

(Mary): In addition to the fact, you know, that they can get reimbursed for the - in addition for the fact that a nurse can do that visit, where we have to have a provider be involved in that visit. So there's a whole lot of unfairness there in that whole equation. And I understand what you're saying about Washington. But it's just sometimes nice to gripe a little bit.

Bill Finerfrock: No, that's fine. Glad to give you the opportunity to vent.

(Lisa): Hey, Bill, this is (Lisa). I work with (Mary). I do our Medicare billing. I sent an email to you or to the Info@NARHC.org beforehand about how our preventive and annuums are supposed to be appropriately paid.

We have been paid in about four or five different scenarios. And we don't seem to be seeing anything consistent on them. Do you know what is the appropriate way to - for them to be paying these?

Janet Lytton: You're supposed to be getting your...

Bill Finerfrock: There you go, Janet.

Janet Lytton: You're supposed to be getting your all-inclusive rate - 80% of your all-inclusive rate. And then through the cost reports, they're going to making - supposed to be making up the difference for the 20% part of the preventive service that the patient does not have to pay. Only Medicare will make up that difference. That's what you're supposed to be getting.

(Lisa): Okay. So if we bill an annum and a preventive where we have to have those two line items split out because of the co-insurance...

Janet Lytton: Correct.

(Lisa): ...are we - we get just one encounter rate for both line items?

Janet Lytton: That's correct.

(Lisa): Okay. So what if we're getting an encounter rate, our 80% on our (E&M), plus we're getting our full encounter rate on the preventive service?

Janet Lytton: I'd say you're one of the lucky ones.

(Lisa): Well, we're one of the ones - I have give or take 70-plus claims that they've paid incorrectly on. They were paying double the encounter rate on some services. I don't know if they're going to reprocess those to repay them correctly or what. And I can't - we can't seem to get any answer from Cahaba.

Janet Lytton: I would say that they will be reprocessing those. Actually, when you know that you received a wrong payment, that would be considered a - the - we have to do that quarterly report for Medicare overpayments. You know that report I'm talking about?

(Lisa): I'm not familiar with it, but (Mary) is.

Female: But one thing - Janet, I'm just going to interrupt. On October the 3rd, they recognized that there was an issue with paying preventive - overpayments to preventives. But they never said on the

issues log as to what we were - you know, were they going to correct the claims? Were we having to do adjustments? You know, they never said.

Female: But now it's archived.

Female: And now it's archived. And you get no update on it.

Janet Lytton: I don't know for sure if they're going to do a mass adjustment. I would think that they would. But, however, I don't know how they would know that they have done with all the claims that they've received by paying the rate twice. I don't know. I don't have an answer for that.

Female: Okay.

Female: Okay.

Janet Lytton: Maybe through Cahaba we can find out an answers at our - at least at our...

Bill Finerfrock: Cahaba, I believe will have a representative at the San Antonio meeting.

Janet Lytton: Right.

Bill Finerfrock: I don't know if you're planning to send anyone there, but...

Female: No.

Bill Finerfrock: ...((inaudible)) they want to have someone attend the NARHC meeting in San Antonio. We'd love to see you there.

Female: Bill, we've been there once. And I don't think we'll ever get there - we just put an (EHR) in. So we're kind of strapped, but anyway...

Bill Finerfrock: ((inaudible)) all right. So I want to thank everyone. I'm sorry that we're not going to be able to get to all the questions. As I said, if you'd like to submit your question to me at Info -- I-N-F-O -- @NARHC.org, we will try and get you an answer. Or you can submit it to Janet.

Janet, do you want to give your email address one more time?

Janet Lytton: Again, it's RHDConsultJL@Hotmail.com.

Bill Finerfrock: Okay.

Janet Lytton: And just FYI, the slides are working on the Web site as well.

Bill Finerfrock: Okay. Again, thank you everyone for participating. And we will be getting information out on our next rural health clinic technical assistance call. Hopefully it'll be scheduled in the month of March. And we'll have more information on that as we get a little bit closer.

Hope everyone has a great day. And thanks for your participation.

Janet Lytton: Thanks everybody.

Operator: And once again, ladies and gentlemen, that does conclude today's conference. We would like to thank you all for your participation.

END