

Moderator: Bill Finerfrock  
January 13, 2009  
1:00 pm CT

Operator: Good day everyone and welcome to today's RHC Technical Assistance Conference Call. Today's call is being recorded.

At this time, I'd like to turn the conference over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, operator, and I want to welcome all of our callers to today's Rural Health Clinic Technical Assistance call on Rural Health Clinic billing.

Our speaker today is Charles James who is President and CEO of North American Healthcare Management Services, they do a fair amount of Rural Health Clinic consulting and we're pleased to have Charles with us today.

I am the Executive Director of the National Association of Rural Health Clinics and I'll be the moderator for today's call.

Charles is from St. Louis, Missouri, which is where his company is based. He has considerable amount of expertise in the area of claims reimbursement, office management and information systems.

Today's program is scheduled for one hour, the first 45 minutes will be devoted to our speaker's presentation and the final 15 minutes will be reserved for questions and answers from you.

This call series is sponsored by the Health Resources and Services Administration, Federal Office of Rural Health Policy, 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 28 in the series and it began in late 2004. As you all know, there is no charge to participate in the series. We encourage you to refer others who might benefit from the series to sign up to receive announcements regarding the call dates, topics, and speaker presentations and you can get that information off of the Internet at [www.ruralhealth](http://www.ruralhealth) – that's one word – [hrsa.gov/rhc](http://hrsa.gov/rhc).

During the Q&A period of today's call, we ask that you identify yourself by name and location, what state you're calling from before asking your question. And in the future, if you have questions that you'd like to ask or topics that you think you'd like to suggest, you can feel free to contact us at info, that's [info@NARHC.org](mailto:info@NARHC.org) and put RHC teleconference question or topic in the subject line.

I also want to remind you that you should have received slides for today's call, which were sent out by e-mail prior to today. I want to thank you all for being with us, and I will turn control of the meeting over to our speaker, Charles James. Charles, it's all yours.

Charles James: Great. Hello, great. Thanks a lot, Bill. I appreciate the introduction.

My name is Charles James. Bill covered all the bases in the – in his introduction of me, with North American Healthcare Management Services in St. Louis. We've been in business since 1992 and done a significant amount of rural health clinic billing, cost reporting and consulting.

Bill gave me a call a few weeks ago and after a flurry of things out on the listserv said you know maybe we should revisit some rural health clinic billing basic components and revisit some of the subjects that recur on the listserv. So that's why we're here today.

So, first – or secondly, at this point, Bill, thank you very much for having me. I appreciate the national association inviting me to do this and for all of you, I know travel is a burden, but the National Association of Rural Health Clinics, NARHC.org, obviously you're on the listserv is you are attending the call, its an excellent resource for everything rural health, get to their spring conference in San Antonito, there will be this and much more information and those are excellent networking opportunities so you can get a chance to speak to people from your state and so I highly encourage everyone to get to those conferences if they can because they're definitely worth the travel.

So, you should have a PDF with the slides and if you go on the first slide, obviously has the title, if you would go to slide 2, just a brief overview of some of the areas that we're going to cover today, again, we're going to talk about the basic components of rural health clinic billing and I want to talk and define the rural health clinic encounter and medical necessity, like to talk about rural health services, versus non rural health clinic services, brief not on preventive services, some basic claim submission requirements and then some resources to – if you need to dig more deeply.

So, on the next slide, slide 3. First, I would like to start with defining some basic terms that we're going to talk about. In rural health clinic speak, anyway, the FI of fiscal intermediary is a term you'll frequently hear, this is your rural health clinic administrator or payer, and your FI is going to be all things rural health to you. They administer the program for rural health clinics, they process and settle cost reports, they set the encounter rate, they pay or deny, or otherwise adjudicate rural health clinic claims and they will determine rural health clinic billing and coverage issues.

So, we will talk about independent versus provider-based. So, for provider-based rural health clinics, the FI has the same purpose, except that it's your parent entities fiscal intermediary as well.

So, if you're a provider-based clinic, your parent entity, normal a hospital, their payer will be your rural health clinic payer. So, when we talk about fiscal intermediary, we're generally talking about rural health clinic claims.

On the next slide, Medicare Part B, FFS or fee for service, when we use that term Medicare fee for service carrier, any of those terms, we're generally talking about fee for service claims for non-rural health services, and of course, we're going to define those shortly, but the term Medicare Part B carrier, fee for service, we're generally talking about non-rural health services.

Now, as many of us know and love, many of our carriers are FIs as well and many provider-based cases are consolidating to the MACs or Medicare Administrative Contractors.

If we go to the next slide, the MAC transition, it's just stated, we know many of those are changing, there's some uncertainty about when we independent rural health clinics will transition, particularly those of us with Riverbend should be the last to transition. I think there's some activity going on out there, of course with new CMS leadership that could change, but right now, independent rural health clinic will be the last to transition. So new rural health clinics may be assigned to the new MACs. That transition is in full swing.

So, next slide, never assume and that's a serious rule of thumb for us in life as well as in rural health clinic billing. That we should never assume you know rural health clinic billing rules are similar across payers, it goes by Medicare law in general, but for those of us with different FIs, different MACs, they can have different interpretations of the same rules. So they may implement the program a little differently. So, particularly when you're on the listserv, or when you're speaking with people, always make sure that what you're hearing is relevant to your own FI, because it can be different from FI to FI.

The next slide, same with state law and Medicaid. Again, on the listserv, I see a lot of question about what particular providers can do and what kind of collaboration there has to be, what various Medicaid requirements there are and those are – there are 50 different ways to do it. Probably more than that. So medical practice laws, collaborative requirements, different state Medicaid programs, they vary widely. So always check with state agencies, Medicaid offices before you make any assumptions. Particularly on collaboration and medical practice. We see a lot of questions. I see a lot of questions on the listserv about that.

So, if we go to the next slide, again provider-based versus independent. Independent rural health clinics basically are those that don't qualify for a provider-based status. These claims are going to be billed to a regional FI or MAC. A lot of us have Riverbend, maybe Trailblazers, there's certainly some others out there. But rural health clinics are – those listed aren't provider-based. And generally say they're physician owned independent organizations, but of course, they can be owned by other entities as well.

Provider-based rural health clinics are outpatient departments of the parent entity. Normally this parent entity is a hospital and so the claims are going – for that provider-based rural health clinic are going to be billed to the parent entities fiscal intermediary. So that's the big distinction. Its for technical considerations, it's an outpatient department of that entity. Sometimes you may not feel like it, but indeed that's how it's classified and then the cost report for that clinic is integrated with that parent entities cost report as just another department.

So that is the distinction between the two and there are some nuances between the billing and we'll get into those shortly.

So, if we could go to the next slide, rural health clinic billing 101. It is all about the encounter. Rural health clinic billing starts – the thing to always consider is whether or not an encounter occurred. And I reference two excellent resources for a definition of an encounter. And again, these are particular intermediaries so some of your FIs may be different than this, but these will give a great guide.

On the next slide, the rural health clinic encounter, I define, and this comes directly from Riverbend's LCD, but translates to all, is that it's the provision of a valuation management services, the skill level that requires the assessment, clinical reasoning, et cetera of a qualified RAC provider.

So the metaphorical laying on of hands, I always say, hands or eyes on the patient by a physician, nurse practitioner, PA, certified nurse midwife, clinical psychologist or social worker, we'll get into the providers briefly. But basically, hands or eyes by a qualified provider on the patient.

So, medical necessity is required, by has to be a medically necessary visit by one of the qualified providers to constitute an encounter.

If there is no encounter, then there is nothing to bill, to a rural health clinic payer. So we'll talk about how to handle some of these different situations. But that is the definition of encounter. So I always get a lot of telephone calls, or I see discussion on the listserv, but mostly somebody calls me up and they say, hey I've got this situation and X, Y or Z and it always starts with whether or not a physician or nurse practitioner PA saw that patient.

So, for example, counseling with a family member, when the patient is not there, that is not an encounter. The patient has to be present and there has to be medical necessity.

So, on the next slide, I give some examples of what is not medically necessary and would not constitute an encounter. We'll talk about how to handle some of these, but for example, patient comes in solely for administration of an injection, that is not an encounter. Patient comes in for dressing changes, not an encounter. Lab results, refilling prescriptions, none of those are encounters. It may be stating the obvious, but it's also explicit that those are not medically necessary.

So the next slide, qualified RHC providers are...

Bill Finerfrock: Charles?

Charles James: Yes?

Bill Finerfrock: ((inaudible)) how that is not therefore considered a medically necessary service, even through the physician ordered that or ((inaudible)).

Charles James: Bill, I'm sorry, you're breaking up very badly.

Bill Finerfrock: ((inaudible)) is any better. Could you just go into ...

Charles James: There we go.

Bill Finerfrock: ... but could you just go into a little bit more why certain services why they are ((inaudible)) by the office even though the physician has said that ((inaudible)) medically necessary.

Charles James: Right, and what I understand the question is – and you were – like I said, you were cutting in and out there, but even – the question arises to Bill frequently, if the physician orders the service, why is it not medically necessary. Did I recap that correctly? And the answer is basically, from my understanding is that even if a physician orders it, it may be incident to the physician services, A, but B, it may not necessarily require the skills of the physician or the midlevel – pardon me, the nurse practitioner or PA. So that those incident-to services that the physician orders would be considered part of the encounter, but they're not necessarily an encounter in and of themselves.

Does that get at what you were after, Bill?

Bill Finerfrock: ((inaudible)).

Charles James: OK. So, and I'm going to talk in more detail about some of those incident-to services very shortly, in the next couple of slides. And so first is to establish that qualified providers or physicians, nurse practitioners, PAs, certified nurse midwives, clinical psychologists and clinical social workers for mental health services. So, those are qualified providers in an RHC setting and next slide shows rural health services.

Now, when we're going through these rural health services, these are not necessarily encounters in and of themselves. So they're either an encounter or they are included in the encounter. So, rural health services are the physician services, the services and supplies that are incident to the physician service, nurse practitioner, PA, certified nurse mid wife services and services and supplies incident to those same providers.

On the next slide, rural health services continued, it talks about visiting nurse services to the homebound, now that's specific to visiting nurse services, if they're in a home health shortage area, and I think that's relatively rare, but it is in the benefit policy manual. Clinical psychologists, clinical social worker services.

And the last two are very important, so services of registered dietitians and otherwise covered drugs that are furnished by. Now, those are prime examples, those are incident-to services and I think that the reason they get defined, they're ordered by the physician, they're – the physician considers them medically necessary, but they don't constitute separately payable services so they're incident to and they get bundled with the encounter. So they're part of the encounter, even if they may happen on a separate date, they are part of that rural health clinic encounter and considered to be all part of the same service. And again, I'm going to get into more detail about that.

So, on the next slide, we talk about the locations. So, rural health clinic service locations encounters can be rendered at the clinic or center, at a nursing home, (Smith) beds, part A beds are included. So if rural health clinic providers go out to a nursing home and that nursing home is a part A covered (Smith), that's a rural health clinic encounter. If it's just a typical custodial care nursing facility, that's a rural health clinic encounter.

If the provider goes to the patient's home, or place of residence, that's a rural health clinic encounter. Now, that place of residence can be kind of a tricky one, fairly you know obviously with the patient's home, but sometimes in juvenile facilities or detention centers, that that's where the patient lives, some of those can be questionable, but the patient's home, its go to be a patient's place of residence, the patient's home is a rural health clinic visit and the regulations also seriously say elsewhere this i.e. scene of an accident. I've never seen a scene of an accident rural health clinic encounter, but it's in there.

So typically, rural health clinic encounters and services incident to the rural health encounter are payable from the clinic, nursing home, or patient's home. That's what we're saying.

So, the next slide, the incident-to services. So, first we've talked about the encounter, we've talked about where they can be rendered, and now we're talking about what's included with those. So, all those incident-to services that I referenced earlier, when we do a lot of talking about bundling charges with rural health clinic encounters. And at first blush, for those of us that may be new to rural health clinics and certainly when I first got into it, we talked about bundling encounters and everybody got very uncomfortable, because basically where we're you know charges are fluctuating for the same ENM codes, it seems. But what we're really talking about is billing incident-to services with the encounter and bundling those together. I'm going to give an example on the next slide of how to do that.

So, any drugs that are administered, services and supplies you know dressings, anything that's again, incident-to gets bundled with that, and they don't necessarily have to occur

on the same date as the encounter, so they can be bundled together and traditionally a 30 day rule has been applied so that an incident-to service, 30 days before or after the encounter, you can bundle it together with that account.

Oftentimes, people will say, well, those injections, I don't get paid for them, so why should I bill them? Well, Medicare wants the services rendered to be reported. Obviously the services are going to be in the medical note, in the medical record and those services that are incident to are considered covered, they just may not be separately payable and we're going to report actual charges. So when we report the actual charges, there will be an effect on the co-insurance, and the co-insurance will fluctuate on the fact that incident-to services are included with the encounter.

So, when you hear somebody say the cost of services are included in the cost report, that's what we're talking about. These incident-to services by their nature, the expenses of those are included in the financial statement on the expense side and they go on the cost report, but you may not have a separately payable claim.

So if we go to the next slide, obviously, examples of incident-to, we're talking about injections, dressing changes, prescription services, blood pressure monitoring, we could add to the list, but I think we all know the types of things that we're talking about.

So, if we go to the next slide and how to bundle those and just a very basic example. The patient comes in for an office visit, say it's a 99213 for \$70 and there's also an injection for \$20 and the services provided, the office visit is by the physician and maybe a nurse gives the injection, but we have a \$90 total charges, an encounter that was provided by the physician and PA or certified nurse midwife.

What we're going to do is, on the UB04, we're going to talk about UB04 billing, there will be one line item that we will combine both of those services for a total charge of \$90 that gets submitted to Medicare. So the patient is going to have an \$18 copay, which is 20% of the charge amount and all we're going to do is add those together and the UB04 goes out with a \$90 – one \$90 line item on it for one date.

Now, how you handle that on your practice management system often becomes a different question. A lot of you may be using electronic medical records and it can be a little tricky there, but on a practice management system, what we always advise folks to do is that you post – we used a 99213, and the typical charge is \$70, so we post a 99213, override the \$70 price to the sum of the services, to \$90, then post a zero charge so that you on your practice management system have record of what actually occurred, and then the zero charge would obviously get suppressed then we just – then the practice management when it produces the UB04 should produce one line with the appropriate charge.

Now, none of what I just said about positioning that is any kind of Medicare requirement. It's a suggestion on how to bundle services so that your claims are generated appropriately and the correct dollar amount goes out on the claim form.

So, let's go to the next slide. I'm sure we'll get some question about bundling those charges, but if we go to the next slide, influenza, pneumococcal injections, these are the one instance where injections are paid. So these are covered Medicare services, we're not going to submit claims for flu and pneumococcal shots. We're actually going to generate a log, the log will be submitted with the cost report and all of those claims will be paid with annual costs for reconciliation. Pardon me, I said all those claims will be paid, all of those injections will be paid with the cost report reconciliation. So the cost report actually has a worksheet on it that has number of injections given, staff time per injection, cost per the medication, and then there's a calculation of what you'll get per injection. Now, the downside is that you don't get the money until your cost report reconciliation comes through which it – most of us do flu shots in October and November, at least the majority of them, and you may not get your money until 2, 3, 4 months after your cost report is submitted. But those do get paid.

Let's go to the next slide, non-rural health services. So we've talked about what's included in the encounter and what are rural health services and how to handle the incident-to things that may not qualify alone as encounters, and now we want to talk about non-rural health services and things that are not going to be billed using rural health clinic procedures, using rural health clinic billing guidelines.

So, non-rural health services can be billed to your fee for service, Medicare part B carrier, or to the hospital's FI, and these services include the technical components of diagnostic testing, X-ray, EKG, ultrasound, holter monitors, et cetera. The technical components for those. That includes all laboratory services, and it includes the services rendered in the hospital by rural health care providers. So technical components of diagnostic tests, laboratory services, hospital professional services can all be billed, fee for service.

We go to the next slide, under diagnostic testing and lab, this is where some of the difference between provider-based and independent can get a little tricky. So diagnostic testing for independent and lab for independent, the professional component of the X-ray or EKG is going to be bundled with the RHC encounter. So the visualization of a particular diagnostic test is part of the encounter. But the charge for actually taking the picture, the technical component of that, is going to be billed to Medicare part B carrier, using the fee for service provider number, and this is independent.

So, let's talk about that again, professional components for diagnostic tests bundled with the encounter. The technical components get billed fee for service and all labs get billed fee for service to the part B carrier independent clinics.

Let's go to the next slide and talk about provider-based and I see recurring questions about this on the listserv where you know one answer may come back for independent and it can be very confusing. So for provider-based clinics, the professional component of the X-ray or EKG is handled the same way we just talked about, the professional component gets bundled with the RHC encounter. The difference for provider-based is

that the technical components for X-rays, EKGs, ultrasounds, et cetera are billed to the FI, using the parent entities provider number.

That's the major difference. It gets billed under the parent entities provider number, now this is for Medicare. The lab services get billed the same way. So the lab services provider-based get billed to the FI using the parent entities provider number. So that is a major distinction between provider-based and independent.

So if we go to the next slide – pardon me, the next slide for lab services for provider-based, and there are a couple different ways to handle this. So, the lab tests performed in the clinic, patients in the clinic, the draws taken in the clinic, the lab is processed using clinic equipment, the type of bill 141 is submitted using the parent's provider number, the parent endings provider number.

Example two is if the lab is drawn in the clinic, but then the sample or the specimen get sent to the hospital for processing, you still have a type of bill 141. The type of bill 141s I believe are paid on a fee schedule.

If the patient is seen in the clinic, but then they're sent to the parent hospital to have the lab specimen drawn, as well as processed at the hospital, then the type of bill 851 is submitted using the parent's provider number. And the type of bill 851 is cost based reimbursement to the hospital.

I am no expert on hospital billing whatsoever, that's about as much as I know about it. But that's the different ways that the tests are handled on for provider-based lab tests.

I'm sure we'll have some questions about that.

If we could go to the next slide, CMS, not too long ago, issued a quick reference guide for those various billing procedures for different provider-based and independent rural health clinics. If you just cut and paste that link into your Web browser, that should get you there, I'm going to post this on my Web site as well, but there are all types of entities in there, not just RHCs, but there is an RHC page that gives a real nice, quick and dirty reference for all the different diagnostic testing billing, lab billing et cetera. The wasa just released that, I think in December, maybe November, but it lays it out pretty clearly there.

If we go to the next slide, I'm going to jump to 99211 office visits. This is another question that routinely comes up. As we all know, and I certainly don't want to get into evaluation and management coding session here, but 99211s, I believe in the CPT code book are referenced as the nursing visits. Administration of an injection, blood pressure check, it's a nursing visit. Frequently physicians may bill a 99211, but regardless, for RHC purposes, these are not RHC encounters.

So, if we go to the next slide, first if a 99211 is performed by a nurse, it doesn't qualify as an encounter. That nursing service is incident to. So if that nurse gives an injection, its

going to be bundled with the office visit like we talked about. If a patient comes in and only the nurse sees them and they give an injection, there's nothing billable. Its incident to something, its incident to physician services, but in and of itself, there's nothing that you can bill for rural health right there. It does not qualify as an encounter.

If a 99211 was performed by a physician, A, its probably under-coded – pardon me, if it was performed by a physician, nurse practitioner, PA or other qualified provider, its probably under coded and if they did do it, it does not require the expertise of a physician or nurse practitioner or mid level – the medically necessary encounter has to require the skill level of that provider. So, for example, if somebody comes in and needs a suture removal, and the physician does it should be documented in the patient's chart why the physician needed to do that particular removal. If there's a reason, my bet is that there's at least a 99212. So a lot of times, the physicians are doing – so maybe it's a particularly complicated removal or there's an infection or something of that sort, and again, I'm not a coding expert, but typically that's going to be something that's going to be under coded if it's a physician performing a 99211.

So, that would be something to look at, but in general, 99211's are not rural health encounters.

Let's move on to the next slide, if we could, hospital services. Hospital services, we saw back at the initial side, hospital services are non-rural health services. They can be billed to the Medicare carrier for fee for service reimbursement. In patient or outpatient, if it's a non-rural health services billed to these – billed fee for service, part B.

Of course, with all the things rural health there are always the exceptions and the exception in this case is if the parent entity is a critical access hospital and have chosen option two billing, out-patient hospital services are to go to the parent FI using their provider number. But that's going to be a fairly unique set of circumstances, but that's the only case where that's the situation. So, hospital services Medicare Part B.

So, we go on to the next slide, preventive services, Medicare preventive services are partially payable as encounters, and these are the preventive services that fall within the scope of Medicare covered preventive – Medicare covered preventive services and those are the welcome to Medicare physical, the screening PAP or pelvic exam cardiovascular screening.

Let's go to the next slide.

Bill Finerfrock: Charles, we have about 5 minutes ...

Charles James: OK.

Bill Finerfrock: ... for your presentation.

Charles James: OK, great. Thank you.

Professional component – I'll breeze through these, professional component, let's just say for Medicare physician, professional component gets billed as an RHC encounter, diagnostic portion is going to go to part B, the welcome to medical physical is once per lifetime, deductible and co-insurances apply.

The other preventive services, on the next slide, professional component gets billed, gain same drill. Professional component, part of the RHC encounter, the technical component, diagnostic tests get billed to the carrier FI and the big thing with preventive services is that any encounters with routine diagnoses are typically going to be rejected. So if it's a preventive service that's outside of the scope of the covered Medicare schedule, its going to get bounced and that's where and ABN would apply and the patient would either pay for that or you submit a claim for a non-covered service.

Let's go to the next slide, diabetic and nutrition counseling. These services are incident-to. These are covered under the RHC encounter, its not separately billable and you could not submit a Medicare part B claim for that, if it's rendered during rural health clinic hours. The services are part of the cost report.

So, next slide, mental health services. Mental health service performed by a clinical psychologist or clinical social worker, billed using revenue code 900, that – you know mental health service claims are rather tricky, the diagnostic services are paid 100% of the rate, but therapeutic services are subject to a 62-1/2% payment limitation and the calculation on those gets a little hairy. But both types are payable and actually a mental health service and rural health clinic encounter are payable on the same day.

We go to the next page, claim submissions, most of them, we all know they go on a UB04. The most important thing here is that actual charges have to be submitted, not your encounter rate. So, just like on the bundling example given, we want to submit an actual charge, the payment is going to come back based on the rural health clinic rate and co-insurance deductible amounts are going to be applied based on the charge. A medically necessary diagnosis has got to be on a claim to get it paid. Only one encounter per day is billable.

If we go to the next slide, visits with – somebody comes in to the physician and the nurse practitioner, they have more than one visit, same day, is one encounter. Some payers, and this is where it's very important to check with your intermediary, for example, Riverbend, will allow an RHC encounter and a hospital admission on the same day, others don't. I believe that Trailblazers does not. So some allow it, some don't. Theoretically, two encounters on the same day for different diagnoses are payable, so somebody comes in in the morning for hypertension, they break a finger in the afternoon and come back, they're theoretically payable, of course it will be tricky to get that paid. And again, rural health clinic encounters and mental health visits on the same day are payable.

Next page, next slide revenue codes, a list of revenue codes, the one I want to make the distinction of is the 524, which is a visit to a part A bed, and the 525, which is a non-part A visit. The 522 is a home visit, and 521 is what's going to be on most of your claims.

On the UB04, typically you'll have the revenue code stated here, you'll have the date of service, and you'll have the charge amount. CPTs can be included but they go through more rigorous edit testing, so you're not required to submit the actual CPT codes for independents anyway, and that facilitates the bundling as well.

MSP questionnaire, next slide, I think one place where I see a lot of clinics that probably are not in compliance with Medicare is with MSP. And even RHCs, you must – and some of these interpretations vary per payer, but RHCs have to have a mechanism for documenting the long version of the MSP questionnaire at every visit. So, for example, if you have an MSP questionnaire on file per patient that you do at the beginning of the year, then follow up visits for the rest of the year, you have to at least document that you asked them the questions in that questionnaire. But something I think a lot of rural health clinics probably need to think about are whether or not they're in compliance with Medicare as a secondary payer. There's a link also on there to the whole MSP section.

Finally, DDE, direct data entry. Next slide. DDE, Florida shared, direct data entry, there are many names for it, is an excellent online tool. Its an old bulletin board system is what it is, that gets you into Medicare's – into the Medicare system and its available to part A providers of – for rural health clinic's, that's what we are. And it's a great way to get in, do eligibility online, check patient eligibility. You can correct your 201 reports online, and it really becomes a critical claim management tool for rural health clinics and especially those of us that may be new to it and may be our system isn't all worked out and we're having a bunch of claim rejection. It's a great way to get on and correct the claim real time and get your claims adjudicated.

There is a cost, I think it's typically \$200 to get in, but it's well worth the money because it really is a great revenue cycle management tool.

So, next slide, just to summarize what we just talked about DDE tools with B claim status, correct claims online, if we go to the next few slides, there are some additional resources there.

On the National Association listserv, just remember when you're posting comments out there, its extremely public, it goes across the country you know CMS and FIs monitor the listserv, and of course, you cant discuss setting fees on it. So just remember you know it's a very public forum, sometimes we don't feel that way behind our computers, but it goes out to everybody.

If we go to the next – actually the resources continued, go to the next one, the CMS resources. Those are really important resources for being able to do your own research on these issues. Get out to the Medicare site, the CMSHSS.gov and get to that rural center because it really is chock full of information that you'll find very useful.

More CMS resources, get to the UB04 completion, the claims processing manual and that gives you very specific field by field instruction for the UB04 and then the claims processing manual for RHC coverage issues, and don't forget about the Med Learn Catalog. There is some very specific information for rural health clinics out there.

So, final part of that was kind of quick, but I think its time to open it up for questions. So, Bill?

Bill Finerfrock: Operator, do you want to give the instructions?

Operator: Thank you, sir. Today's question and answer session will be conducted electronically. If you'd like to signal to ask a question, please press star 1 on your touch tone phone. If you're using a speaker phone, please make sure you're mute function is turned off to allow your signal to reach our equipment. A voice prompt will let you know when your line is open. We ask that you please state your name, and location before posing your question. Once again, that's star 1 if you'd like to ask a question and we'll go to our first.

Bill Finerfrock: Go ahead, caller.

Operator: Please, go ahead. Your line is open. Please, check your mute button. We're unable to hear you. OK, hearing no response. We'll move on to our next question.

Bill Finerfrock: Go ahead, caller.

Mary Peterson: Mary Peterson, Mile Bluff Clinic Mauston, Wisconsin.

Charles James: Hello.

Mary Peterson: Bill, this regard to the question we called you about the other day, the IPPE exam or the welcome to Medicare physical.

Bill Finerfrock: I figured I'd hear from you.

Mary Peterson: I'm just you know trying to put this out as a possible alert to other rural health clinics, until we get some clarification that you know I'm wondering how Riverbend is going to be able to distinguish or other rural health clinic contractors are going to be able to distinguish that we are billing and IPPE exam and it is not to be applied to the deductible and in the past, last year, when there was only a 6 month window, patients pretty much so – had to meet – were meeting their deductible with it.

But now that there is no deductible requirement, as I understand it at least, that this covers all Medicare, including rural health, how will the contractors be able to recognize this – to me they would have to key on the diagnosis code. But again, if we have a sick

visit and the IPPE exam and it's commingled on a 521, multiple diagnosis codes on a UB04, how is this going to get accomplished.

Bill Finerfrock: And we're looking into that and as soon as we get clarification, we will post that up on the listserv.

Mary Peterson: OK, and I – just so other clinics – you know if you start to bill this, we haven't gone that route yet, but you know it could be a possible problem for our beneficiaries.

Bill Finerfrock: Thanks, Mary.

Mary Peterson: Yes.

Operator: And we'll take our next question.

Bill Finerfrock: Go ahead, caller.

Female: This is Pioneer Memorial in South Dakota. Question on the MSP, does it have to be completed by the Medicare patient that a physician goes to the nursing home or a home visit, or if it's just in the clinic proper?

Charles James: I believe that it would have to be completed for any and I guess in the nursing home that their agent or the – I think it's technically called their agent, would have to fill that out. We should probably get clarification of that from Riverbend or from the payer, but I believe it's for any Medicare beneficiary.

Female: Thank you.

Operator: And we'll take our next question.

Bill Finerfrock: Go ahead, caller.

(Terra Geiger): (Terra Geiger), Sioux City, Iowa Mercy Medical Clinics. On the incident-to services, where we can bill and bundle within 30 days?

Charles James: Right.

(Terra Geiger): Like a patient came in with pneumonia and then they have to come in within the next few days and get (reseven) shots.

Charles James: Right.

(Terra Geiger): Are we supposed to be putting like a range of dates on that claim, or just the first date that the doctor saw them and bundled the fee?

Charles James: You know the – I think the guidance by payors is going to vary a little bit, but the standard advice has been to give the encounter date for those.

(Terra Geiger): OK, thank you.

Female: The original encounter date?

Charles James: Correct. Or whatever date that they saw the provider.

Operator: And we'll take our next question. Please go ahead.

Bill Finerfrock: Go ahead, caller. Don't be shy.

(Beth): Hi, this is (Beth) with Magnolia Regional Health Center.

Bill Finerfrock: Where's that, (Beth)?

(Beth): Yes.

Bill Finerfrock: Where?

(Beth): In Corinth, Mississippi.

Bill Finerfrock: Mississippi, great. Thank you.

(Beth): Back to the – I have a question on the preventive services, what exactly are you referring to as partially payable?

Charles James: Well, just the fact that the professional component is billed as part of the encounter.

(Beth): OK, OK.

Charles James: Yes, and then the technical components gets billed to the carrier.

(Beth): We were just unclear on what you were referring to as partially payable.

Charles James: Yes, yes.

(Beth): Thank you very much.

Bill Finerfrock: Next caller.

Operator: And – yes, we'll take our next question, sir.

(Connie): Yes, this is (Connie) with the Hannibal Regional Hospital and I have a question in regards to the flu shots. I currently – I am a hospital owned provider, and we currently bill out flu shots as a fill type 131, under the hospital provider number and you did not indicate that that could be done.

Charles James: OK, and you're correct. And for provider-based, some FIs want you to bill them directly to them, others require the log with the hospital's cost report.

(Connie): OK, and I have one more question for you. Does the same date of service on a hospital based clinic still apply? Ruling still apply. In other words, if I have a hospital lab test for the same date that a patient had an encounter at the rural health clinic, on some of the ancillary services, those have to be combined and billed.

Charles James: Right, that's correct, and I believe for critical access, that – you're talking about the 72 hours rule?

(Connie): I – well, its not just the 72 hour rule, it's the same date of service rule too.

Charles James: Right.

(Connie): Used to be separate rulings basically.

Charles James: Right. So, but I believe for critical access hospitals, that that is waived.

(Connie): OK, I'm not a critical access hospital.

Charles James: Yes. So you would be subject to that.

(Connie): Yes, it would not be – yes, I am subject to that.

Charles James: Yes.

(Connie): OK, thank you.

Operator: And we'll take our next question.

Bill Finerfrock: Go ahead, caller.

(Heather): This is (Heather) from North Coast Family Health Center in California, and my question is on psychiatrist services. Is a psychiatrist a qualified provider for the mental health visits?

Charles James: Yes, because they're an M.D.

(Heather): Thank you.

Operator: And we'll take our next.

Bill Finerfrock: Go ahead, caller.

(Diane): Hello, this is (Diane) from a provider-based clinic in Missouri, and I'm calling to verify the property way to bill office procedures, like a joint injection or a skin tag removal. Particularly on the same day when the patient has an ENM code as well.

Charles James: Right. Right. Those are going to be incident to or part of one whole encounter.

(Diane): OK.

Charles James: So, if you have an ENM code and a surgical procedure, you're going to have one encounter.

(Diane): OK, and bundle the charges?

Charles James: Correct.

(Diane): OK. Thank you.

Charles James: Sure.

Operator: And we'll move to our next.

Bill Finerfrock: Go ahead. Go ahead, caller.

Roz Leon: Hello, this is Roz Leon from Family Practice in Newport, Vermont. And my question was we are a provider-based clinic, there are several of us that are under this one hospital, and we recently had like a group flu clinic that was open, how should those flue clinic services get billed? Can they still go on our individual cost reports?

Charles James: They should, but who was all included in the group? Was it your group of clinics or were there other...

Roz Leon: It was open to the public, but we individually billed our own services.

Bill Finerfrock: How would you determine who was responsible for doing the billing for their own services?

Roz Leon: Because they patients were registered as they came in and we have an electronic.

Bill Finerfrock: So they were – you were able to identify them as being linked to a specific RHC?

Roz Leon: Correct.

Bill Finerfrock: Go ahead, Charles.

Charles James: Yes, then I would say that they're – they get billed with that specific RHC's cost report.

Bill Finerfrock: OK, thank you.

Operator: And we'll take our next question.

Bill Finerfrock: Go ahead, caller. ((Inaudible)).

(Alice Reary): Can you hear me? It's (Alice Reary) in Juneau, Alaska?

Charles James: We can hear you from Juneau, Alaska.

(Alice Reary): Great.

Bill Finerfrock: Thanks.

(Alice Reary): Thank you. I just wondered about telehealth encounters. It sounds as though they are not going to be billable as an account.

Charles James: No, they are. Tele health is and actually I did not put those in because we're doing basic billing but tele health is payable and there is also a site origination fee. If you will e-mail me, I can e-mail you some of the specifics on that.

(Alice Reary): OK, thanks.

Charles James: But tele health is, and then the provider at the opposite end gets their little piece too.

Bill Finerfrock: RHC is a recognized tele health site and you get, as Charles said, the transmission fee and the other provider on the other end of the connection, those four, his or her services.

Charles James: Yes.

(Alice Reary): OK, thank you.

Bill Finerfrock: You would not get an RHC encounter rate for that, though, you're just getting the tele health billable rate.

Charles James: Right.

Bill Finerfrock: OK?

Operator: Yes, we'll take our next caller.

Bill Finerfrock: Caller? Go ahead, caller.

(Shirley Mingus): (Shirley Mingus), (Copper Coin) Hospital, Bixby, Arizona.

Bill Finerfrock: Arizona?

(Shirley Mingus): Yes.

Bill Finerfrock: OK, great.

(Shirley Mingus): My question is, on a critical access provider-based clinic, the visits to our swing bed patients, are those considered hospital services or clinical health, or rural health services?

Charles James: The provider services, you can bill as an encounter.

Bill Finerfrock: It's a rural health clinic encounter.

Charles James: Yes, and then, of course, the critical access hospital would bill their part A – you know the part A bed as well. But the provider visit to that bed is a rural health clinic encounter.

(Shirley Mingus): OK, thank you.

Bill Finerfrock: See, at the time that they went there it was – you said it was a swing bed?

(Shirley Mingus): Yes.

Bill Finerfrock: OK, the patient was a (Smith) patient as opposed to an acute patient?

(Shirley Mingus): Correct.

Bill Finerfrock: OK, yes, then it's an RHC.

(Shirley Mingus): OK.

Bill Finerfrock: Just want to make sure which way it was swinging.

Operator: And we'll take our next question.

Bill Finerfrock: Go ahead, caller.

(Denise): (Denise) of Family Hospital in Marion, Kansas. We have a question about commercial payers, do the same rules apply to all commercial payers, or is it only just to Medicare and Medicaid?

Charles James: To commercial payers, none of these rules apply. So this is just – this is really just for your Medicare patients. Medicaid, the same parameters generally apply, but every state's Medicaid is going to be a little different, so definitely check with them, but typically it does not affect commercial patients.

(Denise): So all the injections and things, even though we're an RHC, we can still go to commercial payers?

Charles James: Correct.

(Denise): Thank you.

Operator: And we'll take our next question.

Female: Yes, our question has already been answered to the questions and answers that have been going on.

Charles James: Perfect.

Operator: Thank you. And if you have – if you do find that your question has been answered, please press star Q, and we'll move to our next question.

(Tammy Michula): Hi, this is (Tammy Michula) with Custer County Medical Center, West Cook, Colorado. We are a free standing rural health clinic, and you didn't touch anything as far as carve outs for like Medicare B, is that something that we discussed or ...

Charles James: You're right, and I specifically did not because those can get pretty touchy but yes, you can do carve outs.

(Tammy Michula): OK.

Charles James: And just for everyone listening, a carve-out is basically taking a portion of the rural health clinic and eliminating allowable costs from the cost report. But the caution is that first of all, for carving out physician services is dramatically different than carving out other items. So, for example, lab services are automatically carved out and you can bill those, but if you're talking about carving out physician services say for example, you want to do minor surgical procedures.

(Tammy Michula): ((inaudible)).

Charles James: And you would have to set aside non-rural health clinic hours to carve out physician services. And during non rural health clinic hours, everything you do is non-rural health clinic and has to be billed to Medicare part B.

(Tammy Michula): Now, does that have to be like scheduled separately?

Charles James: Yes.

(Tammy Michula): Like if we have someone come in after hours because we're pretty rural, we're 60 miles from nowhere. And the provider does an EKG, everything – well, basically everything that's done during that time is carved out.

Charles James: That's correct.

(Tammy Michula): OK.

Bill Finerfrock: Yes, and you did it during non-RHC hours.

(Tammy Michula): Right.

Bill Finerfrock: So technically, to me, you're not even carving it out...

Charles James: Right.

Bill Finerfrock: Because it's during non-RHC time.

Charles James: Right.

(Tammy Michula): So, any time they come in for a physical and do an EKG, that can't be considered a non-RHC?

Charles James: That is absolutely correct. So it would have to be during non-rural health clinic hours.

(Tammy Michula): OK.

Charles James: And yes.

(Tammy Michula): OK.

Charles James: You're correct.

So, for example, what you can't do is have one corner of your building for non-rural health services and the rest of it for rural health and say, oh, well here you go over to the – go over across the rural health clinic line and we'll do that for you. You know that's commingling and that's where discussion of carve outs can be very dangerous.

(Tammy Michula): OK, so it's not just a separation of time – the time carved out, or anything like that. If a nurse does an X-ray, there are a – I mean they are an X-ray tech with limited scope. If the nurse goes in off of an order form the doctor and goes and does that X-ray, that can be billed as a carve out?

Charles James: Correct. The technical components and lab services are really – they're really not carve outs because they're non-rural health clinic services and that's how you're billing them.

(Tammy Michula): OK.

Charles James: So, carve out is really if you're trying to carve out physician services.

Female: That mean it's new?

Female: Hello?

Charles James: Yes.

Female: I didn't know how that worked, how we knew it was out turn. Oh, and by the way, you can't hear us in the background can you?

Charles James: Not till now.

Female: Not till now. OK. All right. We had...

Bill Finerfrock: Could you identify yourself please?

(Eva Sorenson): I'm sorry. My name is (Eva Sorenson).

Bill Finerfrock: And where are you from?

(Eva Sorenson): I'm calling from Eastern Oregon Medical Associates, we're an independent RHC.

Bill Finerfrock: Great.

(Eva Sorenson): In Baker, Oregon. And somebody earlier mentioned something about the welcome to Medicare physician not being subject to deductible. When did that change?

Bill Finerfrock: This is an issue that has just been brought to our attention recently. Mary Peterson, who was our initial questioner, shared with me some information yesterday that we're looking into and we don't have any clear answer on that yet. Sorry.

(Eva Sorenson): I hadn't heard anything about it.

Bill Finerfrock: We just heard about it yesterday. So...

Charles James: You're not alone.

Bill Finerfrock: You're only getting it 24 hours later than I did.

(Eva Sorenson): I see. OK. All right. OK, thank you. Now, so do I just put you back on speaker now?

Bill Finerfrock: Do whatever you want to do, the operator will take care of disconnecting you from the voice part of this.

(Eva Sorenson): Oh, I see. OK, thank you.

Charles James: Thank you.

Operator: And we'll take our next question.

Bill Finerfrock: Go ahead, caller.

(Sharon): Hello, this is (Sharon) from Mid Columbia Medical Center in The Dells, Oregon. I, too, have a question regarding the preventative services discussions, in their it talks about welcome to Medicare physicals and screening the PAP and pelvic, but it does not refer to a man's physician, and we know that the digital rectal exam has its own code, but it does not refer to a V70.30, a routine medical exam.

Charles James: Right, and I was just trying to keep it relatively simple.

(Sharon): OK.

Charles James: For this discussion.

(Sharon): OK.

Charles James: So, those preventive services, if they're rendered according to Medicare coverage schedule, the professional component will be part of the encounter and the technicals will be billable to part B. So no, I did not include everyone in there that's billable.

(Sharon): OK, I just wanted to make sure it was not excluded from.

Charles James: No.

Bill Finerfrock: We're only going to have time for one question here, we're already running a little bit over, so this next question will have to be our last question.

Operator: Thank you, sir. And we will take our final question for the day.

Bill Finerfrock: Go ahead, caller. You get to close it out.

Operator: Please, go ahead your line is open. Please check your mute button.

(Angie Libel): Hi, my name is (Angie Libel).

Bill Finerfrock: Where are you from, (Angie)?

(Angie Libel): I'm calling from Atkinson, Nebraska, Greater Sandhill's Family Healthcare.

Bill Finerfrock: Great. Welcome, what's your question.

(Angie Libel): I got a question on the injections or the infinite two services given after an encounter.

Charles James: OK.

(Angie Libel): But say the encounter has already been billed out, how do you capture those extra charges if you didn't know that patent was coming back in?

Charles James: One way you could do that – in effect you're best option, you're going to eat that.

(Angie Libel): OK.

Charles James: I mean you could bill a corrected claim, so I don't have the type of – so you'd send in a – I think its 718, but don't quote me on that. So you'd send in a type of bill with a corrected claim to correct the amount of the charge on there.

(Angie Libel): OK.

Charles James: Is the only way to do that. You know ...

(Angie Libel): So, basically we just really need to have our physicians make sure and document if that patient is coming back in?

Charles James: Right, it really becomes an internal control issue that you're able to track that. And that's why that incident-to billing is kind of problematic, because some of the measurement of it is more expensive than what you're going to get back from it.

(Angie Libel): OK, thank you.

Bill Finerfrock: Great. Thank you, Charles, and thank you to all of our questioners and participants. I'm sorry we weren't able to get to everybody's questions, but I want to thank everyone for participating and I want to thank the Office of Rural Health Policy for sponsoring this series with the National Association of Rural Health Clinics. As was mentioned at the outset, we do make a recording of the call available, in addition, there will be a transcript available as well, and those are posted on the Office of Rural Health Policy Web site. I gave you that Web address earlier, but let me give it to you once more and if I can find it in my notes here I will give it to you. It is [www.ruralhealth – one word, ruralhealth.HRSA.gov/rhc](http://www.ruralhealth-oneword.ruralhealth.HRSA.gov/rhc).

You also see transcripts of all of our previous calls as well as the recordings that we started to do this past year of our previous calls. That typically is available in about a week or so after the call.

Our next rural technical assistance call will be the second Tuesday in March at 2:00 Eastern. We have not identified the topic as yet, but we will get information on that as well as the speaker and additional information when it is available.

Again, I want to thank everyone for participating in today's call and have a great day. Thank you very much.

Operator: Thank you, sir. And that does conclude today's conference call. Thank you for your participation. You may disconnect at this time.

END