Provider-Based Rural Health Clinic Enrollment Issues

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Presentation Topics

- ✓ Provider-Based Requirements
- ✓ Provider-based Enrollment Issues
- ✓ PBRHC – Department of the Hospital?
- ✓ Provider Numbers
- ✓ Provider and nursing staff employment
- ✓ RHC Providers, RHC Services, and Incident-To Services
- ✓ Non-RHC Services Billing/Enrollment
- ✓ Locum Tenens

Provider-Based RHC Compliance Components

- ✓ Licensure
- ✓ Clinical Services
- ✓ Financial Integration
- ✓ Public Awareness
- ✓ Obligations of hospital outpatient departments
- ✓ Joint Ventures

Operation, Supervision, and Control

- ✓ 100% ownership by parent entity.
- ✓ Same governance as parent entity.
- ✓ Same by-laws/organizing documents.
- ✓ Parent entity has full responsibility and final authority.
- ✓ Organizational structure and reporting requirements are the same as other departments of parent entity.

Provider-Based RHCs – NOT a ***Department***

42 eCFR 413.65 (a)(2):

For purposes of this part, the term “department of a provider” does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC.

Outpatient PPS 2017

A key interpretation in 2017 implemented Section 603 of the Bipartisan Budget Act of 2015, which affected how Medicare pays for certain items and services furnished by certain ***off-campus outpatient departments of a provider*** (hereinafter referenced as off-campus "provider-based departments" (PBDs)).

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-06.html

Places of Service Codes – Danger!!

Rural Health Clinics are NOT Hospital Outpatient Departments (PBD). Place of Service Codes 72 or 11 are only ones relevant for RHC claims.

Outpatient Hospital Places of Service are hereby “those which shall not be named”!

Place of Service Codes	
72 – Rural Health Clinic (Yay – Money!)	19 – Satellite Outpatient Department (Boo! Shall Not Be Named)
11 - Office (Better than those which shall not be named)	22 – Outpatient Hospital (Hiss! Shall Not Be Named)

Distance Requirement

An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in §412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds, as determined under §412.105(b) of chapter IV of Title 42, is not subject to the [location requirements]…of this PM.

Payment Window Provisions

(f) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at §412.2(c)(5) of this chapter and at §413.40(c)(2), respectively.

NOTE: The payment window provisions do not apply to critical access hospitals (CAHs).

Provider-Based RHC Enrollment

- ✓ All RHC Enrollment begins with the Medicare 855A.
- ✓ All Provider-Based RHCs must be enrolled under their parent hospital EIN number.
- ✓ Advise getting RHC NPI (261QR1300X Taxonomy).
- ✓ Enroll RHC as additional service site under the Hospital PTAN.

Provider Numbers

Provider Number	Description
RHC PTAN	Six Digit (XX-XXXX) P-Tan – RHC Site/Address Enrolled using Medicare 855A Application
Hospital PTAN	Hospital Provider Number (Hospital NPI/EIN)
Medicare Part B Group	Fee-For-Service (1500) Medicare Group
Medicare Part B Individual	Fee-for-Service (1500) Individual Medicare 855I and reassigned to Medicare Group via (855R)
NPI Number	National Provider Identifier “Universal” Number for individual providers and facilities One or more “taxonomy codes” is attached to NPI numbers indicating specialty or facility type.

RHC Claims - Medicare Part A

- ✓ RHC Services are submitted on a CMS-UB04 claim form.
- ✓ The formal electronic format is ANSI837-Institutional.
- ✓ Rural Health Clinic claims are administered by Medicare Part A.
- ✓ It is a Part B (Physician Service) benefit, using the structure of Medicare Part A.
- ✓ This is why we deal with UB04, Cost Reports, Revenue Codes, etc.

Providers and support staff

Main providers are not required to employ other support staff, such as maintenance or security personnel, who are not directly involved in providing patient care, nor are licensed professional caregivers such as physicians, physician assistants, or certified registered nurse anesthetists required to become provider employees.

Commercial Payers

- ✓ Only ONE EIN can be billed out of a Provider-based RHC during RHC hours.
- ✓ All commercial claims during RHC hours must be billed under the hospital EIN…NOT under a separate medical group EIN.
- ✓ All commercial payers should be approached to add "outpatient professional services" to provider contracts to enable compliant billing.

Qualified RHC Providers

An RHC encounter can be billed for the following providers:

- ✓ Physicians (MD, or DO)
- ✓ Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives
- ✓ Clinical Psychologists (PhD)
- ✓ Clinical Social Workers (CSW or LCSW)

Leased Employees

The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at part 414 of chapter IV of Title 42.

(CMS A03-030 Transmittal)

No “Leased” Patient Care Staff

Other than staff that may be paid under such a Medicare fee schedule, the main provider may not utilize the services of “leased” employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

RHC Services include:

- ✓ Physicians' services, as described in section 100;
- ✓ Services and supplies incident to a physician's services, as described in section 110;
- ✓ Services of NPs, PAs, and CNMs, as described in section 120;
- ✓ Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 130;
- ✓ CP and CSW services, as described in section 140;
- ✓ Services and supplies incident to the services of CPs and CSWs, as described in section 150; and
- ✓ Visiting nurse services to the homebound as described in section 180.

The RHC Encounter is:

"A RHC or FQHC visit is defined as a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered. A Transitional Care Management (TCM) service can also be a RHC or FQHC visit."

(Medicare Benefit Policy Manual. Chapter 13. Section 40.)

Incident-to Services Defined

- ✓ Incident-to services are considered covered ***and paid*** under the RHC.
- ✓ They must be bundled with the RHC encounter. They are not separately billable or payable.
- ✓ Services that do not occur on the same date as the encounter can be bundled if they occur 30 days before or after.
- ✓ The effect on payment is an increase in the charge, and therefore in the co-insurance.
- ✓ The cost for these services are included in the cost report, but are not separately payable on claims.

Provision of Incident-to Services

- ✓ Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service.
- ✓ Direct supervision does not mean that the physician must be present in the same room…the physician must be in the RHC or FQHC and immediately available.

(Medicare Benefit Policy Manual. Chapter 13. Section 110.1)

Locums, RHCs, Provider Enrollment

- ✓ There is no such thing as a Locum Tenen Nurse Practitioner or Physician Assistant.
- ✓ Reciprocal billing is for physicians and physical therapists (effective June 13, 2017)
- ✓ Nurse practitioners receive 100% reimbursement for RHC encounters.
- ✓ There is no 15% discount for billing under the NP/PA.
- ✓ MOST commercial payers enroll Nurse Practitioners.

Locum Tenens and RHCs

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

30.2.10 Payment Under Reciprocal Billing Arrangements - Claims Submitted to A/B MACS Part B(Rev.3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

The patient's regular ***physician*** or physical therapist may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services which the regular ***physician*** or physical therapist arranges to be provided by a ***substitute physician*** or physical therapist on an occasional reciprocal basis, if:

- ✓ The regular ***physician*** or physical therapist is unavailable to provide the services;
- ✓ The Medicare patient has arranged or seeks to receive the services from the regular ***physician*** or physical therapist;
- ✓ The substitute ***physician*** or physical therapist does not provide the services to Medicare patients over a continuous period of longer than 60 days…

Locum Tenens and NPs

- ✓ There is NO additional Medicare enrollment process, for approved providers (MD/DO/NP/PA) in an RHC.
- ✓ NPs and PAs are paid at 100% of the RHC Encounter Rate.
- ✓ NPs and PAs individual NPIs normally have to be ‘attached’ to an RHC Medicaid Provider number.
- ✓ There is a separate enrollment process and set of requirements for each commercial plan.

Non-Rural Health Services

Non-Rural Health Services can be billed to the fee-for-service carrier (or hospital FI).

These services include:

- ✓ Diagnostic testing - X-Ray, EKG, etc.
- ✓ Laboratory services – except Venipuncture!
- ✓ Professional services rendered in the hospital

Diagnostic Testing and Lab: Provider-Based

The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.

The technical components for X-Ray, EKG, ultrasounds, etc. are billed to the FI using the parent entity's billing number.

Lab services are also billed to the MAC using the parent entity's CCN.

Provider-based Diagnostic Claims

PBRHC **owned by CAH**:

- ✓ Billed using parent's CCN.
- ✓ LAB: TOB 851/Rev Code 300/UB04
- ✓ RAD-TC: TOB 851/Rev Code 320/UB04
- ✓ EKG-TC: TOB 851/Rev Code 730/UB04
- ✓ Payment is cost-based.

PBRHC owned **by PPS**

Billed using parent's CCN.

- ✓ Lab: TOB 141/Rev Code 300/UB04
- ✓ Rad-TC: TOB 131/Rev Code 320/UB04
- ✓ EKG-TC: TOB 131/Rev Code 730/UB04
- ✓ Payment is on Medicare Fee Schedule.

Provider-Based RHC Enrollment: Conclusion

- ✓ Two Tax IDs cannot be billed out of the Provider-based entity at once.
- ✓ Physicians and NPs may be contracted or directly employed.
- ✓ If the providers remain employed by an outside medical group, a service agreement back to the Provider-based parent is acceptable.
- ✓ No patient care staff may be directly employed by a third-party.
- ✓ Commercial contracts must be changed so that claims can be submitted using the parent entity's EIN.
- ✓ Contracting under the parent EIN, should begin long before the RHC survey/approval date.

CMS Resources

Medicare Claims Processing Manual – UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

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