



Rural Health Clinic 101

LOCATION

Rural Health Clinics must be located in an area that is designated as rural and it must be in a Healthcare Professional Shortage Area/Medically Underserved Area.

A Primary Care HPSA is an area where there is less than 1 primary care provider per 3,500 population. The HPSA designations are updated every three years. The last global update occurred in October, 2017. States may validate a HPSA by submitting data to HRSA for consideration/reconsideration.

A RHC is grandfathered into its HPSA if the designation is withdrawn subsequent to the original status. A grandfathered RHC may not relocate, change address, or have a change in ownership or it will lose its HPSA status.

CERTIFICATION

Rural Health Clinics are certified by CMS as facilities and are enrolled as institutional providers. Each RHC is certified at a specific geographic location and as a defined surveyed clinic footprint. A RHC cannot have satellite locations. Each location must be certified and operate under a distinct CCN provider number.

The RHC must be held out by the legal name and dba name under which it was first certified. Any changes in ownership or operational changes must be reported to and approved by CMS.

Provider-based RHCs must be held out as an extension of the parent entity through ownership disclosure, signage, and public awareness.

RHCs are subject to initial and periodic certification surveys.

STAFFING

RHCs must have a physician who is responsible for the medical direction of the clinic. The medical director may be contracted or an employed physician. The clinic must also employ at least one nurse practitioner. Moreover, the clinic must be staffed with a nurse practitioner, physician assistant, or certified nurse midwife at least 50% of the time that the clinic is open to see patients.

Qualified RHC providers include: physicians (MD or DO), NPs, PAs, Certified Nurse Midwife, or a Master's level or above LCSW or PC within the state scope of practice.

A RHC provider must be in the four walls of the clinics during any posted patient care hours. No patients can be roomed or triaged without a provider in the building. No services can be provided if a provider is absent.

Provision of Services

The RHC is located in a primary care shortage area. Therefore, 51% of the services must be primary care services. Primary care includes: Family Medicine, Internal Medicine, Pediatrics, Women's Health, and Gerontology.

RHCs must provide services which would normally be provided in a medical office related to diagnosis and treatment of both acute and chronic conditions. No services can be provided without a provider in the building—no lab draws, injections, blood pressure checks.

The RHC must be able to coordinate care, refer patients for specialty care and follow patients.

Specialty care

Specialty care can be provided in a RHC. However, primary care must be 51% of the services provided on a visit by visit basis.

Visiting specialists can be billed as RHC providers by NPI number for Medicare purposes. The RHC would receive the AIR for specialty services.

If visiting specialists provide services with commingled resources, the resources must be able to be allocated correctly for cost reporting purposes.

If visiting specialists rent or lease space, the arrangements must be at fair market value and there can be no shared resources.

COMMINGLING

Rural Health Clinics are certified to operate within a uniquely-identified clinic footprint. RHCs are also reimbursed based on the cost to provide care as defined per RHC encounter.

Therefore, care must be taken not to commingle resources of RHC and non-RHC activities. No other provider can occupy or provide services within the certified RHC space. No other provider can be held out as a RHC provider if they are not providing services under the RHC program regulations.

Shared space or resources must be able to be clearly identified and carved out of the RHC costs as reported on the annual cost report.

The RHC cannot "cherry-pick" or mix reimbursement. Services provided in the RHC during RHC hours by RHC providers cannot be billed to Part B.

Laboratory services

RHCs must be able to perform, at a minimum, the six required, point of care CLIA-waived tests:

- ▶ Urinalysis
- ▶ Blood Glucose
- ▶ Urine Pregnancy
- ▶ Hgb or Hct
- ▶ Fecal Occult Blood
- ▶ Collection and Preparation for Specimen Sent-out

The tests must be performed at a frequency which ensures the proper operation of clinical equipment and staff competency. Other CLIA-waived tests may be performed in the RHC as desired.

Environment of care

RHCs must maintain an environment of care that is clean, safe and orderly. The interpretation of this standard is wide-spread and accounts for a majority of the certification survey. Patient safety, infection control, proper drug storage and handling, maintenance of equipment, medical management and plant operations are all encompassed under the environment of care regulations.

EMERGENCY CARE

RHCs must be able to act as first responders and be able to provide emergency care that would normally be available in a medical office or by a physician/health care professional. RHCs must also have an emergency preparedness plan and conduct emergency training.

EMERGENCY KIT

STAFF TRAINING

TRANSFER AGREEMENTS

INPATIENT ADMISSION ARRANGEMENTS

EMERGENCY PREPAREDNESS PLAN

Written policies & Procedures

RHCs must have written policies and procedures. This is mandated by 42 CFR §491.

The policies must be developed in a collaborative effort which includes the medical director and the mid-level providers. The policies must be formally reviewed at least annually as part of the annual program evaluation. The review must be documented.

The CFR requires certain policies on non-discrimination, medical management/patient care; infection control, utilization review and annual program evaluation to name a few.

Medical records/chart review

Medical records must be complete and contain all the elements as described in 42 CFR §491.10. Periodic chart review are done for two reasons:

1. To ensure the completeness of medical records; and
2. To ensure appropriateness of care. The medical director or a RHC physician must periodically review NP and PA charts even if the state licensing/scope of practice does not require it. These chart reviews are for internal quality/utilization review.

Proof of chart review is required for survey and resurvey.

Staff training & Evaluation

RHCs must train all employees and staff upon hire and periodically thereafter. Areas of training:

- ▶ HIPAA: Privacy and Security
- ▶ Compliance: Standard of Conduct; Non-retaliation; Fraud, Waste and Abuse
- ▶ OCR: Civil Rights and Non-discrimination; Grievance Policy
- ▶ Employee Handbook
- ▶ RHC Policies and Procedures
- ▶ Clinical Competencies
- ▶ Performance Evaluation
- ▶ Emergency Preparedness Plan/ Training & Drills

HR and credentialing files

RHCs must maintain complete HR and/or Credentialing files on all staff and employees. The files must include all elements to support compliance with federal and state laws.

- ▶ Proof of compliance, OCR and HIPAA training
- ▶ Current licensure, certification and malpractice.
- ▶ Signed job descriptions
- ▶ TB and HEP B employee health
- ▶ Immigration or citizenship status
- ▶ Clinical competencies
- ▶ Background checks: OIG, criminal or sex offender as required by your state.

Annual RHC evaluation

RHCs are required to undergo an annual program evaluation. The evaluation must be performed at least every 12 months and the findings are presented to the appropriate stakeholders. The evaluation may be conducted internally or it may be conducted by a consultant or other 3rd party.

Elements of the evaluation include:

- ▶ Review of Policies and Procedures and current evidence documents
- ▶ A mock survey (physical plant; documents; conditions of certification)
- ▶ A review of open and closed medical records
- ▶ A review of utilization and financial data.

RHC Federal Regulations

42 CFR § 491

<https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part491.pdf>

CMS Policy Benefit Manual, Chapter 13

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf>

CMS Claims Processing Manual, Chapter 9

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf>

State Operations Manual, Appendix G

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

Medicare Reimbursement

- * RHCs can be Independent or Provider-Based.
- * RHCs are paid an all-inclusive rate by Medicare (CMS) through claims filed with the MAC/Novitas.
- * Independent RHCs are capped for 2017 at \$82.30. (1.2%↑ over the 2016 capped rate of \$81.32)
- * Provider-based RHCs with parent entity < 50 beds are not capped. Bed count is not licensed beds, but is determined by available beds as defined by CMS.
- * The AIR is adjusted annually based on the cost report data calculation.
- * Not all cost report preparation is equal.
 - * Productivity Calculation
 - * Allowable Costs (non-allowable versus reclassified)
 - * Flu/Pneumococcal Immunization
 - * Bad Debt
 - * Allocation of A & G from parent entity

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Reimbursement

- RHCs can be Independent or Provider-Based.
- RHCs are paid an all-inclusive rate by Medicare (CMS) through claims filed with the MAC.
- Independent RHCs are capped for 2018 at \$83.45. (1.4% over the 2017 capped rate of \$82.30).
- Provider-based RHCs with parent entity < 50 beds are not capped. Bed count is not licensed beds, but is determined by available beds as defined by CMS.
- The AIR is adjusted annually based on the cost report data calculation.
- Not all cost report preparation is equal.

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It is all about the ENCOUNTER!



- RHC visits are medially necessary face-to-face medical or mental health visits or qualified preventative visits between the patient and a physician, NP, PA, CNM, CP (PhD) or CSW (Master's level) during which a qualified RHC service is furnished. A Transitional Care Management (TCM) service can also be a RHC visit. Evaluation & Management services as well as other professional services are included in the AIR.
- No services can be provided without a RHC provider being in the clinic.
- Patients should not be roomed in advance of a provider's arrival.
- Visits must be medically necessary to be billable encounters:
 - No medication refill only visits
 - No lab result visits only
 - No injection only visits
 - Suture removal or bandage change without additional face to face
 - Services can be bundled into another RHC encounter

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FACE-TO-FACE,
ONE ON ONE
(PHYSICIAN OR
MIDLEVEL)



**MEDICALLY
NECESSARY**



LEVEL 2 OR
HIGHER
Requires a
Provider*

RHC ENCOUNTER (Billable)

* Or a procedure on the qualified visit list.

As a Standalone Visit
Really!

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Revenue Codes: Place of Service

Revenue Code	Description
0521	Clinic Visit by a member to RHC
0522	Home visit by RHC practitioner
0524	Visit by RHC practitioner to a member in a covered Part A stay at SNF
0525	Visit by a RHC practitioner to a member in a Part B SNF or Nursing Facility or other residential facility
0528	Visit by a RHC practitioner to other non RHC site (e.g., scene of accident)

For Medicare claims only.

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Patient Deductible/Co-Ins

- * The Part B Deductible amount for the current calendar year is applied to RHC Visits.
* \$183.00 for 2017
- * Co-insurance = 20% of total visit charges –not the Medicare Fee-for-service Allowable.
- * Medicare remit will be 80% of the RHC AIR. The cost share will be 20% of charges.
- * At the first of each calendar year, the first RHC claim for the patient may reflect a negative payment if the encounter rate is less than the deductible, because Medicare assumes that the patient will be paying for the full visit as their deductible portion. Medicare expects you to recover the full encounter rate and co-insurance from the patient if the deductible has not been met.

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Common UB-04 RHC Bill Types

Bill Type	Type of Service	Comment
711	RHC Covered Services: or mixed covered/non-covered	For example: covered services with a B-12 injection
710	All charges are non-covered; claim is sent to trigger denial	Condition Code 21
717	Adjusted Claims	Comment on reason

HOSPICE PATIENTS

Services to a Hospice Patient for an acute condition or injury not related to the hospice diagnosis:

- Condition Code 07
- Use the diagnosis code which relates to the visit. Do not use the terminal illness as the diagnosis.

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Revenue Codes for CPT® Billing

Revenue codes are used in institutional billing to reflect the place of service and to validate the service performed in that place of service.

All Revenue codes EXCEPT the following are allowed for RHC billing:

002X-024X, 029X, 045X, 054X, 056X, 060X, 065X, 067X-072X, 080X-088X, 093X, 096X-310X

Some common allowed Revenue codes might include:

0250: Pharmacy (no J code)

0636: Drugs with J code

0300: Venipuncture

0420, 0430, 0440: PT/OT/ST

0780: Telemedicine site

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RHC Billing By Type Matrix

Type of RHC	Encounter Prof. Services RHC Service	CLIA Lab Performed in RHC	Other Technical Components (non-RHC)	Professional Services Outside RHC Hours
Independent or Freestanding	Part A UB-04	Part B Form 1500	Part B Form 1500	Part B Form 1500
Provider - Based	Part A UB-04	Billed by Parent hospital TOB 141/131 for PPS hospital; CAH: 851.	Billed by Parent hospital/entity as outpatient service TOB 131 for PPS hospital; CAH:851	Billed either Part B to MAC or as hospital charge if appropriate.

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RHC Billing Type Example

Mary presents to ABC Rural Health Clinic, with symptoms of a lower respiratory infection. The provider orders an in-house chest x-ray to confirm the diagnosis. During the ROS and exam, the provider also suspects that Mary may have a UTI. An in-house UA (one of the required RHC tests) is also performed. Mary also receives one unit of Rocephin IM.

*Red is provider-based RHC.

Service	Billed On	Provider #	Reimbursed
E & M Service for office visit (99214)	UB-04	RHC Number	Encounter Rate AIR
Rocephin (J0696)	UB-04	RHC Number	Encounter Rate AIR
Urinalysis	1500/ UB-04	Part B Group # if independent: Hospital # if provider-based	PFS, Lab Fee Schedule or Addendum B
X-ray (Technical Component Only)	1500/UB-04	Part B Group #: Hospital # if provider-based	PFS or Addendum B

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Modifier -59

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59. **Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.**

This is an unconventional use of -59 and is only used in this way, unique to RHC billing of multiple visits on the same date of service.

Use of modifiers (-59, -25) other than the -CG modifier on Medicare claims may trigger an incorrect overpayment.

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Medicare RHC Billing After October 1, 2016

Beginning on October 1, 2016, the MACs will accept **modifier CG** on RHC claims and claim adjustments. This applies to all claims submitted after 10/01/2016 regardless of DOS. The -CG modifier is appended to the qualifying visit code for the E & M service or the service for which the visit is most primarily correlated. **RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line per day, which includes all charges subject to coinsurance and deductible for the visit.**

For RHCs, the coinsurance is 20 percent of the charges. Therefore, coinsurance and deductible will be based on the charges reported on the revenue code 052x and/or 0900 service

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf>

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RHC Billing After 10/1/2016

- * CPT/HCPCS® Level Codes are reported for ALL services that are provided.
- * Revenue Codes are reported for each CPT/HCPCS® Code.
- * ALL Charges are totaled and reported on the line with the **qualifying visit code** for that encounter. This is the "pay" line.
- * The qualifying visit code/pay line is designated by the **CG modifier**. All charges are rolled up to this line item. This line is either the E & M code or the code which is most closely related to the chief complaint.
- * All other line items must include a charge amount of $\geq \$0.01$. The amount may be your actual charge or the penny amount.
- * The total line (0001) will NOT equal the total for all charges. It will appear overstated. Coinsurance is calculated from the total charges line and not the total line.
- * After 10/1/2016 (processing date), all qualifying visit codes should be billable as standalone codes. The CG modifier will trigger the AIR.

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Incident-to Billing

Incident-to billing is billing for services which are subsequent to an initial service for which are for the continuing care of the initial treatment plan. Incident-to billing for these services (bandage change, blood pressure check, suture removal) are not separately billable unless the visit requires an additional professional service. There are no 99211 billable nurse visits for RHCs.

"Incident-to" is also used to describe services of a NP or PA which are billed under the supervising physician. For RHCs, this provides no additional reimbursement since all providers receive the AIR rate. If you do bill a NP or PA service as if it were a physician service, then all of the payer's criteria must be met. The most compliant action is to bill all providers under their own number.

Co-signing the progress note does not substantiate "incident-to" billing.

Novitas has an **INCIDENT-TO** Tool and good educational information on this topic.

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ICD-10-CM Diagnosis Codes

- Code to the highest level of specificity reflected in the clinical documentation.
- Unspecified codes: Only appropriate when the clinical documentation does not give sufficient detail to assign a more specific code.
 - NOS
 - May end in 9 or have 9 in one of the last characters
 - Grace period ended October 1, 2016.
- NEC: Not Elsewhere Classified means there is not a code in the code set which describes the condition in the clinical documentation.

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New Patient?

A new patient is any patient who has not been seen within the last 3 years by a provider of the same specialty under the same EIN.

- * A RHC patient is not new to the provider just because the provider is new to the RHC.
- * A RHC patient is not new if he/she has been seen or a professional service billed by the RHC in another setting if reported under the same EIN.
- * A RHC patient is not new to the provider if the provider was at another location/clinic and provided another professional service.
- * For CAHS and small hospitals who use providers in the RHC, Emergency Department, and Hospitalist programs, this can be very difficult to determine.

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Preventative Services Guide

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf>

This CMS reference give examples of preventative services and indicates when the AIR is received and how the deductible and coinsurance amounts are applied.

The -CG modifier is appended if the only service provided is the preventative service. The -CG modifier is not needed for the IPPE but may be added. Preventative services provided on the same day as a qualifying medical visit are reported but are not bundled into the -CG line.

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Chronic Care Management

For 2017, the direct supervision requirement has been removed for RHCs. RHCs are not allowed to have general supervision of CCM which opens the door for contracted services to be used. However, most of the other requirements are still in place.

An NARHC analysis of the changes to CCM in RHCs can be found [here](#).

<http://narhc.org/discussions-2/legislate-updates/>

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Advanced Care Planning

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Sample-Billing.pdf>

- As a standalone service, the AIR is paid.
- When provided on same dos as AWV, the service is included in the one AIR payment.

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Medicare Flu and Pneumococcal Shots

- * RHCs do NOT bill Medicare for Flu or Pneumococcal Immunizations on claims.
- * CPT codes for administration and for the vaccine are never included in the claim detail. Can be set up as zero charge/no bill for tracking.
- * Prevnar 13 immunizations are included.
- * Charges for Flu and Pneumococcal Injections are not included in the total encounter charge.
- * RHCs must keep a log with Patient's name, HIC, date of immunization, etc. Some EMR and PM systems will generate log; if not, must be manual.
- * The immunizations are directly reimbursed on the Medicare Cost Report at the end of the year. RHC must report cost of administration, vaccine and number of immunizations.
- * Medicare Advantage Plans/Medicare HMOs are billed for these immunizations. However, make sure your contracts have provisions for additional reimbursement. The costs of these immunizations are not included on the regular Medicare cost report.
- * Medical necessity restrictions

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Home Health Certifications and Care Plan Oversight

CMS Claims Processing Manual, Chapter 13

110.2 - Treatment Plans or Home Care Plans (Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16) Except for comprehensive care plans that are a component of CCM services, treatment plans and home care oversight provided by RHC or FQHC physicians to RHC or FQHC patients are considered part of the RHC or FQHC visit and are not a separately billable service.

These services **cannot** be billed as Part B services as G0179, G0180, G0181 for example.

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RHC Do's and Don'ts

- DO disclose the RHC ownership to the public.
- DO post Non-discrimination/OCR Notice with language taglines.
- DO make patients aware of financial policies, patient rights & responsibilities, and privacy practices.
- DO train employees upon hire and at least annually on policies & procedures, HIPAA, emergency drills, and Standards of Conduct.
- DO create a positive culture that focuses on team-building and customer service.

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RHC Do's and Don'ts

- Don't have patients in treatment areas or rooms without a provider in the four walls of the RHC. This means no lab draws, injections, blood pressure checks, or bandage changes.
- Don't leave patients in treatment areas or rooms if the physician or provider has gone over to the hospital.
- Don't perform Part B services while the provider is wearing his/her RHC hat. No treatment rooms are allowed for the purpose of alternative billing.
- DO provide the same services for all financial classes of patients.
- Don't pick and choose which services you will perform in which setting based on the reimbursement or financial class of the patient. No financial triaging.

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RHC Do's and Don'ts

- DO perform the six required test on site. If you are a provider-based clinic, you must be able to demonstrate competency and have unexpired supplies.
- DON'T bill nursing facility visits as RHC encounters unless the clinical documentation is in your system.
- DON'T bill INR/Comaudin clinic visits or other specialty services as RHC encounters unless all criteria is met.
- DO have nursing notes or documentation for incident-to services even if they are not standalone visits.
- DO conduct your RHC annual evaluation at least every 12 months.

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Questions?

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Patty Harper is CEO of InQuiseek, LLC, a business and healthcare consulting company based in Louisiana. She has over 18 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and physician practice management. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a Registered Health Information Administrator (RHA) and is also recognized as an AHIMA-Approved ICD-10-CM/PCS Trainer. Patty has holds AHIMA Certified Healthcare Technology Specialist (CHTS) credentials as a CHTS-IM (EHR Implementation Specialist) and CHTS-PW (Practice Workflow and Information Management Redesign Specialist). She is also a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other related-reimbursement topics. She holds active memberships in a number of regional, state and national organizations including NARHC, NRHA, AAPC, AHIMA, MGMA and HFMA.

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