

RHC Technical Assistance Series Call

“Updates to the RHC Manual”

February 20, 2013, 2:00 pm ET

Coordinator: Welcome, and thanks for standing by. At this time all participants will be able to listen only until the question and answer session of the conference. At that time if you would like to ask a question you may do so by pressing star one. I would also like to remind participants that today’s conference is being recorded. If anyone has any objections, you may disconnect at this time. And now I will turn the meeting over to Mr. (Bill Finerfrock). Sir, you may begin.

(Bill Finerfrock): Thank you, (Gwen), and I appreciate everyone joining us today for the rural health clinic technical assistance conference call on updates to the rural health clinic manual. Our speaker today is (Captain Corinne Axelrod) from the Centers for Medicare and Medicaid Services. (Corinne) is a health insurance specialist focusing a significant amount of her time on the rural health clinic program. She’s in the Hospital and Ambulatory Policy Group within CMS.

(Corinne)’s been working with rural health clinics now for several years and we’re really lucky and fortunate to have her with us today. Today’s topic as I mentioned is updates to the rural health clinic manual. By way of background, on February 1st, CMS released a revised version of the RHC manual. This latest version updates and clarifies a number of policy areas, and during today’s call (Corinne) will go through the manual section by section.

We hope you have a copy of it in front of you. It was shared - the link was shared with the announcement so that you can go through it with her as she will not be using slides. I’m going to point out that this series is sponsored by the health resources and services administration’s federal Office of Rural Health Policy, and is in conjunction with the National Organization of State Offices of Rural Health and the National Association of Rural Health Clinics.

The purpose of this series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call is the 52nd in the series which began in late 2004. During that time over 13,000 combined participants on these calls have been part of our project. As you know, there is no charge to participate in this series, and we encourage you to refer others who might benefit. If you'd like to have others sign up or get more information, you can go to:

www.hrsa.gov/ruralhealth/policy/confcall/index.html

Now before turning the call over to (Corinne), I also wanted to mention that shortly after the rural health clinic manual was released, there was a proposed rule change released by the Centers for Medicare and Medicaid Services that would impact on rural health clinics. We won't be talking about those proposed rule changes today, but I did want to make you aware of it. Those of you who were on the rural health clinic technical assistance call series got a link to that document, and I want to encourage everyone to take a look at it.

In particular I want to encourage you to look at those areas where CMS is soliciting comment and feedback on some possible changes they might want to consider in the future. There's a particularly open-ended question where issues that they may not have thought of or people have brought before them are their areas where there's a regulatory burden that you're experiencing as a rural health clinic that they might go back and relook at to see if there's a way to relieve that regulatory burden.

We will probably send this out again. Any RHC as an organization will be commenting, but I did want to bring this to your attention, encourage you all to review that document, take a look at it, and where possible submit comments, and the instructions for submitting comments are part of that announcement. If you have questions about this series or in the future topics, you can submit those topics to info@narhc.org, and put RHC topic or RHC question in the subject line.

During today's question and answer period we ask that you please provide the name, your city and state location before asking your question. I want to again thank (Corinne) for being here and we look forward to your comments today about updates to the rural health clinic manual. (Corinne), it's - the time is now yours as they say.

(Corinne Axelrod): Great. Thank you so much, (Bill), and thank you, everybody, for taking the time out of your schedules to be on this call. I'm going to as (Bill) said go through each section and address the questions that we've received in the last three weeks since this manual was distributed, and also in some cases highlight some things that I want to bring especially to your attention, but before I start on that I just want to provide a little bit of background.

Usually when a manual is updated and released, the changes appear redlined or italicized in red so that you can see the difference between the old manual and the new manual. We didn't do that for this manual because since it's completely reorganized, basically everything in the manual would have been redlined or crossed off or whatever and it would have pretty much been a mess to read. I just want to let you know that as we do updates in the future you will be able to clearly see any changes that are made or any new information that is added.

The new manual does not have any policy changes from the old manual, but there may be some information in here that you're not aware of, so it may seem new. The major changes from the old manual are first that it's reorganized and some of the language is revised, so hopefully you'll find the information you need more easily and it will be more clear and understandable. Where we've had legislative changes that affected the RHC program such as the Health Care Safety Net Act of 2008, the Medicare Improvement for Patients and Providers Act of 2008, and the Patient Protection and Affordable Care Act of 2010, we've updated the relevant information.

We've also added updated links to Web sites and other resources, but mostly we've added information in response to questions that either I or the regional Rural Health Coordinators have received over the last several years, so please continue to contact your regional Rural Health Coordinator if you have questions, and if we start

getting a lot of the same questions, then we'll know that it's something that may need to be added to the manual.

We really want to keep the manual current and if there's anything that's not clear, let us know. We'll do our best to clarify the information and make the revisions where needed. As I said, I'm going to go through each section, so let's begin with the first section, which is section 10. Section 10, "Rural Health Clinics and Federally Qualified Health Centers, General Information". This first section is an overview of the requirements. It's not meant to be comprehensive. It's just meant to provide a description and a summary of the major provisions which are discussed in more detail in the rest of the document.

The next section, section 20, is "RHC and FQHC Location Requirements". This includes the types of designations acceptable for RHC certification, the timeframe for the designation, and the census bureau requirements. I want to draw your attention to the very first sentence under 20.1 which says "to be eligible for certification for an RHC". These location requirements do not currently apply to existing RHCs. Even though the law states that existing RHCs must meet the location requirements, we cannot implement that provision without regulations, and we have not published regulations.

So if your clinic has already been certified as an RHC, you are not required to continue to meet the location requirements. If at some point new proposed regulations are published, you will know about it and have the opportunity to comment, but for now I just want everybody to be very clear that no existing RHCs will be terminated for not meeting the location requirements and the location requirements only apply to clinics that are seeking RHC certification.

A little bit further on in the same section under 20.1.2, after the four bullets that describe the type of designations that are acceptable, the paragraph begins "No other type of shortage area designation (except for the ones above) are accepted for the purposes of RHC certification. The designation cannot be more than four years old." This is a new

provision that used to be three years, but this was changed by the Health Care Safety Net Act of 2008.

So at that time it was changed from three years to four years, and again this is only for new clinics that are applying to the RHC program. Okay, the next section is section 30, “RHC and FQHC Staffing Requirements” that includes information on staffing and waiver requirements. I want to make a few comments on this section. Under 30.1.1, it says “In addition to the location requirements, an RHC must:” and there’s two bullets. The first bullet is “Employ an NP or PA” (nurse practitioner or physician assistant), and then “Have an NP, PA, or CNM, (certified nurse midwife), working at the clinic at least 50% of the time the clinic is operating as an RHC”.

I just want to note that these are two separate requirements. They are in different parts of the RHC provisions of the Social Security Act, and both of them have to be met. The next sentence, “The employment may be full or part-time. The following situations would not satisfy this requirement”, and then there’s three bullets there about situations which would not satisfy the requirements. It’s not an exhaustive list. These are just situations that we’ve been asked about over the years, so there may be others that are not acceptable but these are the ones that have been brought to our attention.

A few more paragraphs down, there’s a paragraph that begins with, “A clinic located on island that otherwise meets the requirements for RHC certification is not required to employ an NP or PA, although it is still required to have an NP or PA at least 50% of the time that the RHC is in operation.” Our attorneys have reviewed the statutory language, and they concluded that the island waiver applies to the employment requirement, but does not apply to the 50% requirement. This waiver enables island RHCs to contract with NPs or PAs.

This is the only situation in which an RHC can contract with an NP or PA. Otherwise they must be employed. We’ve gotten some comments on this from some people who believe that our interpretation of the island exception is not correct. If I receive any information to support another interpretation of this provision, I will have

our attorneys review it, but until that happens and they would determine otherwise, this provision will stand. So I just wanted to bring that to your attention.

(Bill Finerfrock): The - (Corinne), this is (Bill). Just - and for the folks who are listening in, obviously this affects only a relatively handful of RHCs. I think there may be eight RHCs in the country that are located on islands, but it is our belief that this is an incorrect interpretation of the statute, and we have pulled the Congressional report language that accompanied this statutory change that was adopted in 1989 to show what the intent of Congress was when they passed it, changing the RHC statute, so we will be pursuing this with CMS.

We believe that the intent of the statute was that there was no requirement at all for a PA or an NP to be in an RHC located on an island and it could exist with just physician staffing, and it was not focused on whether it had to be an independent contractor versus an employee/employer, but rather a waiver of the requirement that they utilize a PA at all, but we will pursue that through the appropriate channel.

(Corinne Axelrod): Okay, thanks, (Bill). Okay, so the next section is section 40, "RHC and FQHC visits". This includes information on requirements for available visits, locations where visits can take place, hours of operations, when multiple visits on the same day can occur, and visits occurring during a global period or a three-day painted window period, so lots of good stuff in this section. I do want to talk about a few things here. Under 40.1, "Location", it says "An RHC or FQHC visit may take place in the RHC or FQHC, the patient's residence, an assisted living facility, in a Medicare- covered Part A SNP, the scene of an accident, or any other location except" - and then there's two exceptions.

We recognize that in rural areas there may be situations where the RHC visit takes place in another location such as a SNF, the scene of an accident, etcetera, and we've tried to provide as much flexibility as possible within the legislative and regulatory requirements. This does not mean that an RHC can pay physicians in non-certified locations to see patients and bill them as RHC visits. RHCs must still meet all

certification and reimbursement requirements consistent with Medicare cost reporting principles.

We've always allowed RHC visits to take place outside of the RHC under certain conditions, and there is even a revenue code 528 for billing a visit to other non-RHC sites. The intention of this section of the manual was to make clear that these may be billable visits, not that a physician can set up a practice in a non-RHC location and run their billing through the RHC. All the manual is saying is that in situations where a physician works part time at the RHC and part-time elsewhere, services provided in accordance with the physicians employment agreement will help to determine if the services provided are RHC services and that it should be accurately reflected on the cost report.

I wanted to clarify that because I think the language here may have confused some people, so we're just trying to make it clear that nothing has changed, but there's always been questions about when things are billed when they're provided in other locations, so I'm hoping that this is more clear to people, and if not, please let me know, because we don't want people to think that this is just open season for setting up an RHC anywhere without certification.

Okay, let's go on to another part of this section, 40.4, which is Global Billing. We have been asked if an RHC can bill for a visit when a patient comes in for a skin lesion removal on day 8 of a 10-day global period. The RHC could bill a visit only if the skin lesion removal is not included in the global, and the RHC requirements are met - that it's medically necessary with an RHC provider, etcetera, so this is a good question because it comes up a lot. So again, the way that you'll know whether it could be billed or not is two things: one, if it's included in a global, then obviously we can't have double billing so it could not be billed by the RHC; and in order for it to be billed in the RHC it has to of course meet the regular RHC requirements of being medically necessary with an RHC provider.

We have also been asked how an RHC would know what is included in a global visit, so we did provide the citation here, which will give you the link for information

on what's included in global billing. And in some cases I would assume that the RHC provider might be able to check with the physician who did the surgery, but in any case the manual on global billing outlines what's included and what is not. Okay, that's it for that section, and (Bill), if I'm going too fast or anything, please let me know.

(Bill Finerfrock): No, I just - I'm kind of trying to think through what you - maybe go over this global billing issue again, at least what you were saying is how would the RHC know that the surgeon billed it globally so that - let's say the patient goes to a more urbanized area, has surgery, comes back, comes in to see the RHC provider. How would the RHC know how the surgeon billed that procedure, whether they did it just procedure only or globally billed?

(Corinne Axelrod): I think that's a good question. The manual on global billing is pretty specific, and I believe that if it's in there under global billing that it's not as optional as it used to be, but I will have to check on that and whether it's required that it's billed globally. I believe that there's certain things that have to be globally billed, and of course there's exceptions, so we'll have to check into that, but I think for starters this link will be very helpful for people to see what is generally included under global billing.

We've looked into whether an RHC can access a common system to see how something is billed, and so far we haven't come up with any way that they can do that, so...

(Bill Finerfrock): Yes, that - it's really at an operational level. It's not that - you know, they obviously aren't intentionally seeking to global bill. It's just they don't know that those post-surgical visits were globally billed by the surgeon, and so when the RHC patient comes in, wants to have the suture bandages checked, everything checked, that they don't know that the surgeon was paid for that, so they're submitting a claim for what they believe is a legitimate RHC encounter only to find out that you know, it was already paid to the surgeon and then they're kind of in the bind.

(Corinne Axelrod): Right, right. So I'm not sure that there's a real easy way, but I think looking at the manual on global billing would be very helpful, and that would cover a lot of the situations, not 100% but certainly a lot, and we'll keep looking to see if there's any operational way that they can easily find out if it was globally billed.

(Bill Finerfrock): Thank you.

(Corinne Axelrod): Okay, the next section is section 50, "RHC and FQHC Services" and this includes information on what services are considered RHC or FQHC services, requirements for emergency services, and the application of EMTALA. Actually there was nothing in this - we didn't get any questions on this section. The next section, section 60, on non-RHC FQHC services, where we are clarifying which services are not part of the RHC or FQHC benefits, I wanted to mention under laboratory services, we've been asked if lab draws are bundled with the encounter or separately billable under the fee schedule.

I'm aware that some contractors have allowed lab draws to be billed separately and some have not, so we are reviewing this issue right now and we will clarify the policy as soon as possible, but in terms of the lab draws, I don't have a policy that I can state right now, but I just want you all to know that we're looking at that because we've gotten a few questions on it. The lab service itself is clear - it must be billed to Part B, but the draw, we're looking at that. So as soon as we resolve that and work with you, (Bill), on that, we'll let everybody know.

Okay, the next section is 70, "RHC and FQHC Payment Rate and Exceptions". This includes information on payment rate calculations, the payment limits and exceptions, cost reports and productivity standards. I didn't get any questions on that section. The next section, 80, "RHC and FQHC Patient Charges." which includes information on charges, waivers, and sliding fee scale, no questions there. I realize that you've had the manual only a few weeks and you may have questions later as things come up but certainly if you do we're happy to address them later as well.

(Bill Finerfrock): You said, (Corinne) folks may not have had questions. If there are issues or things that you want to particularly just point out to folks, what you may have done or clarified if there are specific points that you wanted to make even if no one has asked a question, please feel free to fill that in or make those observations.

(Corinne Axelrod): Yes, and I have been doing that, but again, maybe I'm not hitting on everything people are thinking.

(Bill Finerfrock): Fine, I just - that's fine. Okay.

(Corinne Axelrod): Okay, the next section is, "Commingling". This includes information on when resources can be shared and when the sharing of resources is prohibited, so a couple of things here. The paragraph that says: "RHC and FQHC practitioners may not furnish RHC or FQHC covered professional services as a part B provider in the RHC or FQHC or in an area outside of the certified RHC or FQHC space, such as a treatment room adjacent to the RHC or FQHC during RHC or FQHC hours of operation."

I know it's a long sentence, but we have been asked if an RHC practitioner can perform minor surgical procedures such as lesion removal in non-RHC space during RHC hours if the practitioner is employed by both the RHC and another medical practice that has leased space to the RHC. The answer to that is no. An RHC practitioner may work for another entity during the time he or she is not an RHC practitioner, but while working as an RHC practitioner, the practitioner cannot go to non-RHC space and bill Part B.

I want to make sure that everybody understands this, because we've had a lot of questions over the years on this. The RHC space and the hours of operation must be clearly defined, and an RHC practitioner cannot go into non-RHC space and provide part B services such as skin lesion removal or supplies such as drugs or biological that are part of the RHC benefit. This would be considered commingling and is prohibited.

You can't carve out services, RHC services, during RHC hours, so whether or not the practitioner also works for another entity is not really relevant. What's relevant is that during RHC hours, the practitioner who is working for the RHC cannot bill Part B for RHC services.

(Bill Finerfrock): Okay, and I think the point on this one, and I think it deserves a little bit more discussion, is this notion of simultaneously and trying to create clear, bright lines that distinguish when you're an RHC provider working in the RHC, when you're not an RHC provider and not working in the RHC as opposed to sometimes the question seems like folks want to just you know, move back and forth and it just creates all kinds of problems and issues, and to the extent you can, just create very clear, bright lines.

Monday, Wednesday, Friday, from noon to four, you're an RHC provider and you're in - you know, providing RHC services in the RHC. Other bright line times, you're in a non-RHC space providing non-RHC services as opposed to oh, I'm going to go over here, I'm still on the clock, I'm not on the clock, it's - it can get very confusing and I think you really - folks want to try and make sure they're not double billing.

I think that's really one of the key things here is think about you know, who's paying for the time that provider is providing those services, and you're on the RHC clock and your provider is also providing services that are going to turn around and bill part B, then your practice is double billing. You're getting paid for that time on your cost report, and then you're turning around and billing Part B for that same service provided during that time.

(Corinne Axelrod): Okay, thanks, (Bill). There's another paragraph here that starts out, "This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency or prohibit an RHC physician from providing on-call services for an emergency room as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate

appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the physician with the hospital emergency department would not be a common occurrence."

So it's the last sentence that some people made some comments on. We got some questions about this, and we've been told that RHCs that are - some RHCs that are attached to or adjacent to a critical access hospital, that it's fairly common for the RHC physician or other RHC practitioner to cover the emergency department.

So I do want to address this, because we recognize that in many rural areas there may be limited health care practitioners, which is why we have tried to provide as much flexibility as possible within the statutory and regulatory requirements. However, anytime that an RHC practitioner is providing emergency care at a CAH, all costs associated with that practitioner must be carved out of the RHC cost report, so obviously if the practitioner is frequently in the emergency department and not in the RHC, the RHC will have difficulty meeting their conditions for coverage, and the allocation of costs becomes far more complex.

This is why we expect that the sharing of the RHC physician with an emergency department would not be a common occurrence. The specifics of how much time is appropriate would be determined by the MAC, so we're not putting any exact time limits on it, but if it's so excessive that the conditions for coverage in the RHC cannot be met or that the allocation of costs starts getting really fuzzy, then that's when it really becomes a problem.

So it really should not be a common occurrence, but we want to retain the flexibility, because we know that a lot of areas don't have an abundance of practitioners, so I hope that that clarifies that.

(Bill Finerfrock): (Corinne)?

(Corinne Axelrod): Yes.

(Bill Finerfrock): In this previous section you make reference at the opening to health care practitioners, and then it gets specific and talks about physicians. Is it - does the policy cover PAs and NPs as well, or is it - which would be suggested by the use of the term health care practitioner, but then it does - uses physician specific, so is it everybody or just the physician?

(Corinne Axelrod): It's everybody. It's the RHC practitioner, so if there's some cases where - I guess we used physician because normally in most cases it would more likely be a physician, but you're right that it would be any RHC provider.

(Bill Finerfrock): Yes, and in a CAH it wouldn't be unusual to have a PA or nurse practitioner with the CAH, so in that specific situation, I think it would have PA or NP, so that's why I was - I just wanted to clarify that it does include them, even though the specific reference there only said physician.

(Corinne Axelrod): So it perhaps in our next update we'll change that to practitioner. That would be helpful, thanks.

(Bill Finerfrock): Thank you.

(Corinne Axelrod): Okay, the next section, 100, "Physician Services", includes information on what physician services are billable, the types of providers that can bill for physician services, billing for telehealth, hospice, and GME. We did get a question, if you go to 100.2, "Treatment Plans or Home Care Plans", we were asked if this is now a billable visit since home care plan oversight now requires a face to face visit, but the answer is no. It is not a billable visit in an RHC. If at some point that changes, we'll let you know.

110, Section 110, "Services and Supplies Furnished Incident to Physician's Services" includes information on what services and supplies are considered incident to physician services, who can finish, who can furnish incident to services, and where they can be provided and how they are paid. Just a note on the exception that is listed below. If a physician, and in this case it must be a physician, prepares a specific

formulation of an antigen and the RHC administers the antigen, the physician preparing the antigen can bill for the cost of the antigen and the RHC can bill for the cost of the administration of the antigen.

This is the only exception for drugs that are administered in an RHC. Other drugs, whether they cost a dollar, \$100, or \$1000, are not separately billable, but are included in the RHC's all-inclusive rate. This exception is just for physicians, and it's just for antigens. That's something that was not in any other document, so I wanted to bring that to your attention.

(Bill Finerfrock): (Corinne), can we go back a second to that 100.2, the treatment of the home care plans?

(Corinne Axelrod): Yes, yes.

(Bill Finerfrock): And I want to - because I was a little bit surprised by your answer, and I want to make sure if I'm making the proper distinction, or you are. There's the new transitional care management benefit, which incorporates a face to face encounter for a medically necessary service which could be billable under the RHC as an RHC service, because the definition is the same. Now are you making a distinction between that and what is here as treatment plans or home care plans?

(Corinne Axelrod): Yes, I am. You are correct that the RHCs can bill for care coordination visits. That is new and that's not in here because that happened just as we were finalizing this manual, so we'll certainly put that in the next update, but the home care plans are different, and perhaps we need to clarify a little bit better what the difference is between those two.

(Bill Finerfrock): Yes, I think, because when I heard the question, I was thinking of the care coordination, and then when I heard your answer, I think you're right as far as home care and some of the more traditional, but the new benefit, so I do think that's an area where perhaps some clarification would be warranted.

(Corinne Axelrod): Yes, so we'll definitely include in the next revision to this information that RHCs can bill for face to face care coordination visits.

(Bill Finerfrock): Thank you.

(Corinne Axelrod): Okay, section 120 is, "Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services". It includes the requirements and information on payments for these services, and the payment exceptions for PAs. If we look at section 120.2, it says "Physician Supervision" and (Bill) mentioned at the beginning of this call about the proposed rule that was issued on February 7th. That proposed rule proposes to eliminate the requirement that a physician be onsite at least once in every two-week period.

If that proposal is finalized we will remove this requirement from the manual, but until that proposal is finalized, this requirement will still be in effect. On 120.3, "Payment to Physician Assistants..."

(Bill Finerfrock): (Corinne), that would also I believe you were also proposing to have the definition of a physician be more consistent with the Medicare definition, so in this section it says the physician must be a doctor of medicine or osteopathy. Would that change as well?

(Corinne Axelrod): Yes. Yes, so whatever it's finalized in the rule, we will update the manual to be consistent with that.

(Bill Finerfrock): Okay, thank you.

(Corinne Axelrod): On 120.3, "Payment to Physician Assistants", please note there is one very limited exception in here in regards to payment for physician assistants. If you are a physician assistant, an RHC owner who's a PA, or a group of PAs, you cannot bill Part B for non-RHC services unless you've provided services continuously from beginning before 1997 and ending before 2003, so I don't think that there's probably anybody on this call that this would apply to, but that's the only exceptions for PA directly billing for Part B.

Okay, section 130, “Services and Supplies Incident to NP, PA, and CNM Services”, section 140, “Clinical Psychologists and Clinical Social worker services. This includes requirements and information on payment for these services. Section 150, “Services and Supplies Incident to CP and CSW (clinical psychologist and clinical social worker) Services, and then section 160, “Outpatient Mental Health Treatment”, includes information on the outpatient mental health treatment limitations.

Starting on January 1st, 2013, Medicare coverage is now up to 65%. Last year it was 60%. Next year it will be the full 80%, and that’s the result of the Medicare Improvements for Patients and Providers Act of 2008. Okay, section 170 is “Physical and Occupational Therapy”. It includes information on when RHCs can bill for PT or OT. This was not in the previous manual, but it’s something that we get a lot of questions on, so I hope that this clarifies how and when these services can be paid.

Okay, the next section, section 180, this is “Visiting Nursing Services”, includes information on requirements for visiting nursing services and where these visits can take place. Just a little note here, under 180.3, “Home Health Agency Shortage”, says “A shortage of home health agencies exists if an RHC or FQHC is located in a county, parish, or similar geographic area in which the secretary has determined that..” and then there’s two bullets.

We’re sometimes asked about home health shortage designations. These are not the same as the health professional shortage area designations, and there is no listing of areas that qualify as home health shortage areas like there is for the primary care or mental health shortage areas, so this is handled through survey and certification, and you have to work with your state department of health for a determination on this.

Okay, the next section is section 190, “Telehealth Services”. This clarifies that RHCs and FQHCs can be originating sites for telehealth, but not distances site providers for telehealth services. Section 200, “Hospice Services”, clarifies when RHCs and FQHCs can provide services to hospice beneficiaries. We were asked if an

RHC provider who is the attending physician for a hospice patient can bill to Part B if the patient is seen for their hospice diagnosis during non-RHC hours.

So the question is asking whether someone who is an RHC provider can bill part B during non-RHC hours. We do not dictate what an RHC practitioner does during non-RHC hours, so whether this person could be a hospice attending physician during the time that he or she is not an RHC physician or practitioner would depend on the hospice rules, but RHCs cannot bill for hospice services because the hospice is already paid for providing hospice services. The RHC can only be reimbursed for non-hospice related services provided that all other requirements are met.

Okay, and then the last section is 210, "Preventive Health Services. This includes information on required preventive health services for RHCs and FQHCs including vaccines, DSMT, and MNT, information on co-payment and deductibles for preventive services.

So that's the new RHC/FQHC manual and I hope it'll be helpful to all of you as you navigate through Medicare payment policy, and I think there's some time that we can take questions if anybody has any questions.

(Bill Finerfrock): First, before we open it up to questions, I want to thank (Corinne) for taking the time to be here with us today, but also for the countless number of hours she's spent working on this document. As you can imagine, it was not an easy task, I'm sure, to go through this document, to try and rewrite it, to update it, to try and clarify the language so that it read a little bit better, it was more understandable, and I want to thank (Corinne) and her colleagues at CMS, whoever else may have been involved in this initiative for the hard work that they did.

I do think personally speaking on behalf of myself I think there are some areas where there've been some significant improvements in the language and will help to avoid a lot of questions in the future that have perplexed people in the past. There are some areas as I've already noted where we think that perhaps some additional change

may be necessary and we'll pursue those through the appropriate channels, but I think that CMS is to be commended for putting the effort into this initiative.

I think as I mentioned earlier also, there are a number of proposed rule questions, some of them directly related to issues that (Corinne) touched on, telemedicine and hospice in particular. There are issues that CMS has raised there for possible consideration in the future, so I want to thank (Corinne). I hope everyone will thank her at the appropriate time if the opportunity arises for the work that she's put in to try and make things a little bit easier for the RHC community. So thank you.

(Corinne Axelrod): Thanks, (Bill). I really appreciate that, and I also want to just acknowledge that I did have a lot of help. We had a little team from some of the regional rural health coordinators who put a lot of hours in this with me as well, and I'd just like to acknowledge them. Some of them have moved onto other jobs now. I guess maybe this did them in, I don't know, but (Christine Davidson) from Region 5, (Becky Peal-Scone) from Region 6, and (Lyla Nichols) from Region 8, were really part of the core group, and also here in central office, (Tracey Mackey) was also enormously helpful in doing this.

So thank you for your comments, and I also just want to acknowledge other people that worked on this and then also reviewed it, and you know, we tried - we had a lot of people read it and review it, but you know, no matter how many times you do that, there's always going to be some things that you miss, so we're happy to get comments and keep improving this as we go along.

(Bill Finerfrock): Well, and as a reward for all of your efforts, on March 1 we're going to see an across-the-board budget cut that's going to cut every federal employee's salary, so...

(Corinne Axelrod): Yes, thank you.

(Bill Finerfrock): Anyway, at this point, Operator, what we'd like to do is open it up for questions. (Corinne) has graciously agreed to spend some time with us answering your questions, so it's really your time now, so if you would, Operator, give the

instructions for how people are to ask questions and we'll take as many as time will allow.

Coordinator: Thank you. At this time if you would like to ask a question, please press star one. Please record your first and last name. To withdraw your request, press star two. Once again, to ask a question, please press star one. If you have muted your own line, please un-mute your line before recording your name. Please state your name slowly and clearly. Before asking your question if you could also state your city and state. Again, please record your first and last name and before asking your question if you could also state your city and state, one moment please for your first question.

(Bill Finerfrock): And that is star one?

Coordinator: Yes.

(Bill Finerfrock): Yes, okay, thank you.

Coordinator: Your first question comes from (Charlotte Boone).

(Bill Finerfrock): Go ahead, (Charlotte).

(Charlotte Boone): Hi, (Charlotte) - this is (Charlotte Boone) in Wynnesboro, Louisiana.

(Bill Finerfrock): How you doing? Good.

(Charlotte Boone): I have a quick question, comment, concern, problem, I don't know how you want to address that, but we are currently operating a new RHC that opened in October. The initial application for its Medicare number was sent in, in June. We opened October 1st, and we are yet to have been issued a number. When we called and questioned that or asked you know, how long, we've been told, well, I was on vacation for three weeks. You're probably 25th in line. I've called back and now, well, you can call back in two more weeks. We just haven't had the problem

addressed in a timely manner and we have heard that this has been an issue with other facilities.

(Bill Finerfrock): (Corinne), I don't know if you want to take a stab at that. I don't suspect that you do.

(Corinne Axelrod): Well just, I'm very sorry. I know it's very frustrating, but it's not in the area that I work in or really know what to say to you, so (Bill), if you have any advice, please go ahead.

(Bill Finerfrock): First, what - who's the contractor that you're working with? Who's the Medicare contractor?

(Charlotte Boone): When it was originally done, it was done on Pinnacle, which we were issued by DHH a letter saying it's being sent to Pinnacle early August, and it changed to Novitas mid-August, so in lies our first problem. We readdressed that, got it straightened out to where it was - it did not fall into a queue as they put it, for Novitas, and I had to send it in hard copy. They - okay, now we have it, but it has pretty much been in limbo since.

(Bill Finerfrock): Okay, rather than - I think what we're going to need to do is get some more information and pursue this with CMS with the folks who handle provider enrollment and we deal with them so what I would ask that you do is send me an email to info@narhc.org. Put your contact information in there and a brief description of the problem, and then we can pursue it offline with the appropriate folks at CMS.

(Charlotte Boone): Okay, thank you.

(Bill Finerfrock): All right, sure. And what you're experiencing is not right. I mean, it should not have taken this long, so there's no excuse for what you've experienced.

(Charlotte Boone): Thank you.

(Bill Finerfrock): Go ahead, Operator. Next question.

Coordinator: Your next question comes from (Tara Jo Carson).

(Bill Finerfrock): Go ahead, (Tara Jo).

(Tara Jo Carson): Hello. I'm calling from Pinckneyville, Illinois, and I know (Corinne) stated that the location requirements portion of the new manual didn't pertain to existing RHCs, but it - if we would be in the process of moving our RHC less than two miles within the same ZIP code as part of a hospital replacement facility, would that trigger those requirements, and then would there be any other requirements that we would have to do for - to maintain our RHC certification in relation to such a move?

(Corinne Axelrod): Thank you for your question. The initial certification is handled by our survey and certification folks, and here in central office, the contact person would be (Shonte Carter). You may want to talk though with your regional Rural Health coordinator. That's usually the first person to go to, to find out what the requirements are, so I would suggest that you contact your - you're in Region 5 – your Region 5 Rural Health Coordinator. If you don't have the person's information please email me and I can send it to you.

(Bill Finerfrock): Did you want to give out your email, (Corinne)?

(Corinne Axelrod): Oh, yes. My email is Corinne.axelrod@cms.hhs.gov , so you do have to spell my name right, otherwise I won't get it, so again it's C-O-R-I-N-N-E dot A-X-E-L-R-O-D at cms.hhs.gov.

(Tara Jo Carson): Okay. Thank you, (Corinne).

(Bill Finerfrock): (Tara), I will say that in previous instances there is no hard and fast rule as far as there's a bright line test. In general what they will look at is, is the facility serving essentially the same population, the same community, the same patients, the same service area, but it is at the discretion of the region as to whether or not they choose to treat this as a brand new rural health clinic and put you through a full blown survey

and certification and eligibility test or that this is simply a move that is not consequential and therefore would inspect the facility to ensure that it meets safety and other requirements but not put you through an eligibility process. So it's subjective in that sense, but the general rule is if you're serving the same service area, same patients, same community, they in general would treat you as the same facility.

(Tara Jo Carson): All right, thank you.

(Bill Finerfrock): Next question, Operator?

Coordinator: Your next question comes from (Allison Page).

(Bill Finerfrock): Go ahead, (Allison).

(Allison Page): Hi. Thanks for taking the call. Say, we're - we are a real health clinic - a provider based real health clinic co-located with a critical access hospital.

(Bill Finerfrock): And where are you located?

(Allison Page): I'm sorry, in Baldwin, Wisconsin, western Wisconsin.

(Bill Finerfrock): Okay.

(Allison Page): And we've added a group of counselors, behavioral therapy people, including you know, PhD psychologists, etcetera, and we are looking at launching a telehealth psychiatry program from our rural health clinic, and I just want to make sure I'm understanding correctly, under 190, is it that we can have the telehealth equipment in the rural health clinic? We would coordinate it with the psychiatrist who might be in New Jersey and we can bill a facility fee and the doctor, whoever the doctor is, would bill accordingly from their end. Is that the smartest way to do that, I'm wondering?

(Corinne Axelrod): Well, whether it's the smartest way or not, I don't know, but that's the way that you can - the only thing you can do as an RHC is bill for the facility fee. The patient

will be at the RHC and you can bill for the facility fee, the provider at the other end would bill however the provider at the other end normally would bill.

(Allison Page): Okay, and that's all perfectly legitimate or another option, which I could discuss probably with someone else would be to put the telehealth equipment in the hospital side and lease time from the psychiatrist and bill out on the critical access hospital side?

(Corinne Axelrod): So you know, we get a lot of questions on telehealth that sometimes are very creative, and I think you know, if you want to email me the situation, we can look at it, but I do want to be really clear that the statute does not allow RHCs or FQHCs to be distant site providers, so you can only be the originating site, not the distant site providers.

(Allison Page): Meaning where the patient is.

(Bill Finerfrock): Where the patient is, that's correct.

(Allison Page): Okay, so that was a little confusing to me too, but anyway, that helps a lot. Thanks so much.

(Bill Finerfrock): Okay, thanks, (Allison). Next question? Operator?

Coordinator: Your next question comes from (Debra Williamson).

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

(Debra Williamson): Hi. I'm in Plainsford, Georgia. We saw a patient, long time patient, who had been diagnosed with cancer, saw her early in the morning one day, made a referral to our local hospice who admitted her at 7 o'clock that evening. We went ahead and billed to her Medicare Advantage plan, which denied the claim, stating that she was under hospice care and we would have to bill Medicare ourselves.

Of course our claim was denied, and I'm wondering what is the process that we need to follow. It's not something that happens very often. We actually went through the hospice and they paid our claim, but we need to have some clearer understanding I think of how to handle a situation like this.

(Corinne Axelrod): (Bill), do you want to address the Medicare Advantage plans?

(Bill Finerfrock): Thanks. I'm not sure if I can. There are a couple of different factors, but the Medicare Advantage plan is supposed to deal with the situations in the same way that regular Medicare would, if I'm remembering that benefit. It's been a while, but the other complicating factor is what type of Medicare Advantage plan the individual is enrolled in. There are a couple of different models, and how you might be dealt with could be impacted by the type of model of Medicare Advantage plan they're enrolled in.

As with the first question, if you want to - I know we had some stuff. I got some emails, and I don't know if it was yours or not, about this a little while ago, and I had written and done some research. If you would send me an email, then I can try and pull that up and take a look at it and see if we can figure out what the appropriate approach is here.

(Debra Williamson): Okay. I appreciate it.

(Bill Finerfrock): Sure. Anything else?

(Debra Williamson): No, that's all I needed today.

(Bill Finerfrock): Okay. Next question? Next caller, Operator?

Coordinator: Your next question comes from (Mary Peterson).

(Bill Finerfrock): (Mary Peterson).

(Mary Peterson): Hello, (Bill).

(Bill Finerfrock): From Mothton, Wisconsin, the Mile Bluff Clinic.

(Mary Peterson): No, the Mile Bluff Medical Center.

(Bill Finerfrock): Oh, Mile Bluff Medical Center now, aren't we getting fancy.

(Mary Peterson): My question concerns 40.3, and this is new, because we are talking about annual wellness visits and the IPPE exam, so I refer to that third bullet on that page, the patient has his or her IPPE, and on that same day you could be billing for a sick visit encounter, but yet it's distinguished that for an annual wellness visit, that that would have to be bundled into a sick visit on the same day, and my question is why?

These are both risk assessments, one of them being the first time that you come in after you turn 65, and the other one being the annual visit thereafter. What is the difference?

(Corinne Axelrod): Well, thank you for your question. It certainly sounds logical, and I'm sure there's an answer for it, but I don't know the answer why the wellness visit is bundled and the IPPE is not. We didn't make that up. It came from somewhere, so I'd have to kind of dig back and see just what the origin of that is, but that wasn't something that we actually sat around here and said well, let's pay for this one and not that one.

(Mary Peterson): Right, because they're both risk assessments.

(Corinne Axelrod): Yes.

(Bill Finerfrock): Yes, and it would - that's a good point, (Mary), because it also goes on to say that if you have a mental health visit on the same day as the annual wellness visit, that is billable separately as an RHC visit, so why if you came in - let's say you had your annual wellness visit at 9 in the morning and at 3 in the afternoon the individual fell

and broke his or her arm and they came in and had to have it set and casted and so forth, that wouldn't be a separately billable service for a completely different reason.

(Mary Peterson): Correct.

(Corinne Axelrod): Yes, and it could be that the IPPE is a one-time thing and that's why it's allowed to be billed separately, whereas the AWB is an annual visit so you know, again, I'm just speculating here what the reasoning might have been behind this, but I certainly can see if I can find anything out.

(Bill Finerfrock): Okay. All right, and (Mary), you may want to just communicate directly with (Corinne). She gave her email out, so if you want to deal with her correctly, or (Corinne), you want to provide it to us if it is different, however you want to handle it.

(Corinne Axelrod): Yes, and you know, I assume that the question's not just why, but can we change it, and so we'll certainly look at that.

(Bill Finerfrock): I would - (Mary), I'm going to embarrass you, because you know, (Mary) has been a long time participant in our rural health clinics call. She's also very active on the CMS rural provider calls, and (Mary) is going to be retiring here in the next couple of weeks she recently informed me, and I just want to thank (Mary) for all of her work on behalf of her community first of all. The community that she's in, in Mile Bluff Medical Center is losing a wonderful individual and someone who's very dedicated and passionate about what she does.

And the rural health clinic community, (Mary)'s always been very good about participating and she asks a lot of great questions and has been just a real wonderful person to get to know and I just want to wish her all the best of luck as she goes on to spend some time with her grandchildren who live on the East Coast and she and her husband get to enjoy some quiet time for all the hard work that she's done, so thanks, (Mary), for everything you've done.

(Mary Peterson): You're welcome, (Bill), and yes, you did embarrass me.

(Bill Finerfrock): All right. Let's move on, next question, next caller.

Coordinator: Your next question comes from (Denise), Strawberry Clinic, John Day, Oregon.

(Denise): Hi. We're - this is in relation to a hospice billing.

(Bill Finerfrock): And I - (Denise), I don't know you, so I won't embarrass you.

(Denise): Okay, thank you very much. This is in relation to a hospice billing. We have a hospice patient that gets admitted to the inpatient for the hospice, and it's for a hospice related condition, and I guess I'm trying to figure out in that sense would we bill the hospice for that or would we not bill it at all, and my second question is, is we are a group rural health clinic I guess per se, so if the attending physician doesn't see that patient and someone sees on rounds for that patient, another physician in our group, would that still be considered - do we take that into consideration too and would we try to bill hospice or who would we bill, or not at all? That's my question.

(Bill Finerfrock): All right, (Corinne)?

(Corinne Axelrod): Thank you. So the RHC as you know, cannot bill for the patient or Medicare for anything related to the condition for the hospice, the terminal illness. Whether or not the RHC can bill hospice is kind of the new question for me, so I don't really know if there's anything that prohibits an RHC from billing another entity for a service. You know, it's something I'd have to look into. I don't think I've ever been asked that, but it does sound a little weird to me. So I would say be careful and let's look into that, if that's actually allowed.

(Denise): Okay. Thanks.

(Bill Finerfrock): I do think it's allowed, and I think the earlier caller, (Debra), indicated that in her situation the hospice did compensate them for the care that they provided to the

patient, and I think part of that question was, was the Medicare Advantage plan essentially shifting financial responsibility to the hospice when in fact in that instance perhaps the Medicare Advantage plan should have been responsible.

But my understanding is that the hospice can - has the flexibility to contract or provide those services through whatever arrangements they choose, and so they could choose to make that available and use the RHC as part of their contracted provider network to deliver those services, and that's just something that would be separate and distinct. It would probably contract with you for physician service or something, but however that arrangement, there's nothing that I'm aware of that would preclude you from having that kind of an independent contractor relationship with the hospice.

(Corinne Axelrod): So if you wouldn't mind just sort of sending me that scenario, and you know, and we can look into it and see if there's any issues with it because I'm a little curious myself just in terms of that arrangement, so if you wouldn't mind doing that, that would be helpful, and then we can clarify it for everybody else.

(Bill Finerfrock): Okay.

(Denise): Sure. I can do that. Thank you.

(Bill Finerfrock): Thanks, (Denise).

(Denise): Yes, thank you.

(Bill Finerfrock): And we're going to be going over. If there are questions, if folks want to stay on the line, (Corinne) has graciously agreed to take some additional time, so we - even though the hour that we originally - we've gone over, we can continue to take questions for a little while longer, so if you have questions, feel free to stay on the line and we'll try and get to as many as we can. So next question, operator?

Coordinator: The next question, the only thing that recorded was (O'Reilly). Your line is open.

(Jennifer O'Reilly): My name is (Jennifer O'Reilly) and I'm calling from the Port Levaca Clinic in Port Levaca, Texas. My question is I know in the past we've been told regarding patient visits on the same day as a hospital admission we were told that it was up to the FI whether or not we could bill for the office visit, so we recently transitioned to Novitas last fall, so Trailblazer didn't let us do it, so when we contacted Novitas, they referred us to CMS.

When we went through the handbook, we weren't able to find it, so that's my question. Are we able to bill an office visit and a hospital admission on the same day for the same diagnosis?

(Corinne Axelrod): Okay, thanks, (Jennifer), and that's one of the situations where I think that the MAC tends to look at each case individually, so I don't think that there's a yes or no answer on this. I think it's one of these it depends, and that that's something that the MAC would - the MAC or the FI would look at, so - and I think it's really would vary depending on the circumstances.

(Jennifer O'Reilly): Okay, so then you're referring me back to the FI?

(Corinne Axelrod): Well, only because it's hard to come up with a policy that can apply clear across the board on - and we always try to sort of find a balance between allowing flexibility and clarifying the policies, so there's some situations where I think that the FI would allow it, and there's some situations where I think they would not allow it, and so I think it's something they look at on an individual basis.

(Jennifer O'Reilly): Okay, so then I guess I can call them back and tell them they referred me to CMS but CMS is telling me that I need to get the answer from them. Would that be correct?

(Corinne Axelrod): Yes, that would be correct.

(Jennifer O'Reilly): Okay, well thank you very much.

(Bill Finerfrock): When - and how does that response, (Corinne) - under 40.5, the three day payment rule, where typically the RHC services are not subject to the three-day payment rule or the one-day rule for a non-subsection D hospital, so why would it be any different?

(Corinne Axelrod): You know, it may not be, but there's so many possible scenarios under this that we've talked about it internally and have really been unable to come up with any kind of guidance that really could be applied across the board, so I think that's the only reason that there's just so many variables on this one. We're certainly open to further discussion if we can clarify, because I know, people don't want to just be at the whim of you know, somebody's having a bad day and says yes or no, but I think just in the scenarios that we've had, there's just been so much variation. It's been really - we haven't been able to come up with something that we've felt would be fair to apply across the board.

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

Coordinator: Your next question comes from (Kathy Diorio).

(Kathy Diorio): This is (Kathy Diorio) at the (unintelligible) in Florence, Colorado. This is just kind of a definition question. Under 30.1.1 under requirements, there are two bullets. The first one is employing an NP or PA. By employ, do you define that as a W2, W4, type employee, or can it be an owner?

(Corinne Axelrod): I'm looking - I'm turning my pages here, so "employee" has been defined here as someone that has a W2 type of relationship and we have sort of tried to loosen that up a bit, but it's I think still is a W2 type of relationship, so I don't think we've - in previous proposed rules, we've addressed that, but since those rules were not finalized, I think we're still in the traditional definition of employee.

(Bill Finerfrock): The question also asked about ownership, which would be also - be permissible, so for example if a PA or an NP owned the RHC, that would satisfy the employment requirement and since PAs or NPs are permitted to own, they would - there might not necessarily be a W2 situation there if they're the owner of the clinic, correct?

(Corinne Axelrod): So the NP or PA certainly can be the owner of the clinic, but in order to meet the staffing requirements, the NP or PA must - who is working in the clinic - must be employed, and must be employed at least 50% of the total, the PA, NP or CNM must be at least 50% of the time, so it's not an automatic thing that if somebody's the owner, then that employment requirement is satisfied.

(Bill Finerfrock): Well, but if they're - (Kathy), did you want to follow up?

(Kathy Diorio): Well, just that if they have to work that part - the second bullet has to be fulfilled, but the first one is what concerns me. It's if the NP or PA works the second - fulfills the second bullet but isn't a W2, W4 type employee, because they are the owner, is that meeting the first bullet?

(Bill Finerfrock): That's - and that's what I thought you were getting at, and I think that's what was missed in your answer, (Corinne). So if the PA or the NP owns the clinic, and they work there full time, but because they're the owner they don't get a W2 or W4...

(Corinne Axelrod): Right

(Bill Finerfrock): ...they still are fulfilling and meeting the requirements, because they're allowed to own and I - because I believe the statute says unless they are an owner of the clinic or the regulations stipulate unless they are the owner of the clinic.

(Corinne Axelrod): Yes, I would assume so. I mean, I imagine that somebody could be the owner of a clinic and then contract themselves to the clinic and that would not be permissible, so - you know, so I think in general, yes, but as long as the person's not contracted then it should be fine.

(Bill Finerfrock): But we're getting into the nuances of perhaps tax law, but what you're suggesting here is not the way that this has always worked. If a PA or an NP is the owner of the RHC and they are working there, they are deemed to have met that requirement, and whether or not - you know, I don't know when what they - maybe they - you know,

the clinic doesn't make enough money that they take a salary, so there is no employment relationship. I - you know, whatever it may be, but you're saying - you're implying that if the RHC is owned by a PA or an NP and they have something - and they work there full-time, but have something other than a W2 relationship with themselves, that would not be permissible?

(Corinne Axelrod): No, that's not - I don't think that's what I said, but I just don't want to make any blanket statements just because somebody is the owner of the clinic. They still could have some other arrangements, other than what we're talking about here, so I think in general, I mean, you know, the rule is that the NP or PA cannot be contracted unless the clinic is on an island. That's the only exception, so as long as they're not working under a contract, that's fine, and that the employment is generally evidenced by W2, but certainly there you know, may be some other acceptable arrangements. So again, it is getting into sort of an area of employment law that I'm not familiar with, so sorry.

(Bill Finerfrock): On that same, I have a question on that same issue. It says employee and NP or PA. And so the issue has come up that if I have a rural health clinic that has multiple nurse practitioners and physician assistants working in the RHC, this says employee and NP or PA, so does that mean that only one of them has to be an employee as evidenced by the issuance of a W2, and the other PAs and NPs that work in the RHC can be independent contractors, because it was a very specific word and presumably word choice. You could have said employ all NPs or PAs, but it says employee and NP or PA, which implies it in the singular.

(Corinne Axelrod): Right, and so the statute uses the word employ, but in the current regulations, there's a regulation that specifies that RHCs cannot contract, so if that regulation was revised, then there would be a lot more flexibility, but it's not the statute. The statute only says employ, but it's the regulation that is specific that RHCs cannot contract for providers other than physicians.

(Bill Finerfrock): It just - it struck me that as you - all right, we don't need to debate it here. Okay.

(Corinne Axelrod): But I do want people to be clear that under the current regulations, RHCs can only contract with physicians. They cannot contract with NPs, PAs, or CNMs, unless they're on an island.

(Bill Finerfrock): Okay, okay. Next question, Operator?

Coordinator: Your next question comes from (Cynthia Yan). Your line is open.

(Cynthia Yan): Yes, this is (Cynthia Yan) from the Wagner Medical Clinic in Shiner, Texas, and - can you hear me?

(Bill Finerfrock): Yes.

(Cynthia Yan): Okay. And we have a question about that transitional care. When our doctors do - they just started doing that, so when they do it during non-RHC hours we've been billing Part B, but they do it during RHC hours we bill with the revenue code and just take the encounter rate. Is that correct?

(Corinne Axelrod): Yes, that's correct.

(Cynthia Yan): So basically it's really more efficient to do it after hours, basically, because it pays better basically that way. Is that correct?

(Corinne Axelrod): Well, I...

(Cynthia Yan): Or is there some ruling that you have to do it during?

(Corinne Axelrod): Well, I think you know, you do what's medically appropriate. RHCs are allowed now to bill a face to face visit for transitional care, and whether it's done during the RHC hours by the provider or some other arrangement, you know, I really can't comment on which one would pay more.

(Cynthia Yan): Okay, okay. And the other question I had on number 70, number .4, the productivity standard.

(Corinne Axelrod): Okay, yes.

(Cynthia Yan): Is that like, a requirement, that number of visits, or like per physician? And if you don't have that many you don't qualify for RHC anymore? Could you clarify that statement?

(Corinne Axelrod): So I'm sorry, can you repeat what's - what you're looking at?

(Cynthia Yan): On the productivity standard.

(Bill Finerfrock): 70.4, 7-0.4.

(Corinne Axelrod): 70.4.

(Cynthia Yan): I didn't hear you go over that during the...

(Corinne Axelrod): Okay, so on 70.4, your question is whether...

(Cynthia Yan): The 4,200 per physician, is that a requirement to stay an RHC? Or do you...?

(Corinne Axelrod): No, it is not a requirement, but if you do not meet it, if you're below that, then that would be used as the number.

(Cynthia Yan): Okay, so if you get lower than that, they still say that's the number of visits you had, correct?

(Corinne Axelrod): Yes, you're not going to be terminated as an RHC if you don't meet the productivity standards.

(Cynthia Yan): Right, but they'll calculate it on that standard.

(Corinne Axelrod): Correct, yes.

(Cynthia Yan): Okay.

(Bill Finerfrock): Can I - just to clarify on that point, however, that your visits are calculated in the aggregate so that if you have - let's say you have a physician who sees 4000 patients, and the productivity standard is 4200. You have a nurse practitioner who sees 3000 patients, and the productivity standard is 2100. Combined they've seen 7000 patients. The minimum productivity standard would have been 6,300, so the NP's extra visits can be substituted for the lower number on the physician side.

(Cynthia Yan): Okay. Like, if we have three physicians and three of them - and two of them see more than the other, that's okay. They don't have to each see...

(Bill Finerfrock): It's calculated - it's not calculated individually. It's calculated collectively.

(Corinne Axelrod): As a group.

(Bill Finerfrock): As a group.

(Cynthia Yan): As the individuals in the group, okay.

(Bill Finerfrock): If you have an underperforming individual, they can be offset by an over-performing individual, and I use those terms only in the context of the standard, not that one who's doing better or doing better or whatever, but - okay?

(Cynthia Yan): Okay, and the other question was back on the issue where you discussed like lesion removals or something on patients that are seen, like we see ours in the treatment room after RHC hours. Do - if a doctor sees them during RHC hours, then those aren't carved out, or you can carve them out?

(Corinne Axelrod): The RHC practitioner who provides an RHC service during RHC hours cannot carve that out and bill Part B.

(Cynthia Yan): Okay, that's what I'm asking. So that would be the same thing as preventive care, too. If he sees a preventive care visit in the treatment room basically during RHC hours, you can't carve that out.

(Corinne Axelrod): Correct.

(Cynthia Yan): Okay. That's the only questions I had. And then when is this going to re-air or when is it going to be on again, this session?

(Bill Finerfrock): The program is being recorded, and it will be posted up on the office of rural health policy's Web site hopefully in a week to 10 days. The only thing that will delay that is the transcript of it needs to be reviewed to make sure that the transcript accurately reflects what is on the recording in order to meet the government requirements, so depending upon how quickly it takes to edit the transcript, it should be up hopefully within a week to ten days.

(Cynthia Yan): Okay, thank you very much.

(Corinne Axelrod): Did you want to listen to this again ...?

(Bill Finerfrock): It's a long plane ride, so...

(Corinne Axelrod): Yes.

(Bill Finerfrock): Operator, how many more questions do we have? How many people?

Coordinator: 14.

(Bill Finerfrock): I don't know that we're going to get to all those. I think we're going to have to end this, but let's try and get to as many as we can here in the next couple minutes.

Coordinator: Your next question comes from (Barb Townsend).

(Bill Finerfrock): Go ahead, (Barb).

(Barb Townsend): Hi. I'm from Hancock, Michigan. I have a question regarding 40.4 on the global billing. You went into a great bit of detail regarding surgical procedures done other than done not in the RHC, but the first paragraph I was looking for clarification so surgical procedures done in an RHC are not subject to the Medicare global billing requirements. My staff freaked out at that. So you're saying that a lesion removal, and if they're seen again in 8 days, it's a medically necessary visit, but it's still related to the lesion removal. We are not subject to the global billing?

(Corinne Axelrod): Correct.

(Barb Townsend): Oh, okay.

(Bill Finerfrock): Well, now, let's make this be clear. The initial lesion removal is going to be billed as an RHC encounter. It's not going to be billed under a global code.

(Barb Townsend): Well it's billed as an RHC encounter, correct?

(Bill Finerfrock): And so then they come back. You're going to get another RHC encounter, so yes. They're just going to make sure you're not billing it as a - under a global code initially. It's billed as an RHC encounter.

(Barb Townsend): That is correct. Okay, and I had a second question regarding 40.3 multiple visits on same day. It's looking - I - the last sentence of that first paragraph indicates that you cannot bill a second visit if they are seen by another RHC for a different condition. Is that a typo?

(Corinne Axelrod): No, that's correct. RHCs can bill for one visit per day except for the exceptions that are listed, so even if it's for a different condition, it's just all part of the one - the visit on the same day.

(Barb Townsend): But on the first bullet it says you can bill for a second visit if it requires additional diagnoses, so that's where I got...

(Corinne Axelrod): Yes, okay, I see what you're saying. So on that bullet if the patient comes in and has a couple things - a couple of you know, medical things to be dealt with, then whether that person sees one or two practitioners in the RHC, that would be one visit, but if that patient has their RHC visit and goes home and then something happens that wasn't present when they came into the RHC earlier in the day, then that could be a second visit.

(Barb Townsend): Right, so that last sentence in that first bullet are - conflict.

(Bill Finerfrock): No, it doesn't. I think the difference is that in the - in that sentence you're reading, it is a concurrent situation. So a patient comes into the RHC, is seen by Doctor A for a condition, and then immediately goes over and is seen by Doctor B or PA C, or NP, and is seen for something different. Because those are occurring concurrently, those would still be considered one RHC visit. Under the bullet, what they're talking about there is two separate visits that are not simultaneous for two separate conditions.

So a patient comes in and the one I used earlier, patient comes in in the morning for their welcome to Medicare physical, goes home, 2 o'clock they're at home, they slip and fall and they think they've broken their wrist. They come back at 2:30 and they're seen for a completely different reason. That is also billable as an RHC visit because they were not concurrent and they were for completely different reasons. In the first paragraph, those are concurrent visits that are occurring during the same visit to the RHC.

(Barb Townsend): Thank you for the clarification. That's all my questions.

(Bill Finerfrock): Okay, next question, Operator.

Coordinator: Your next question comes from (Greg Nanami), Wallawalla, Washington.

(Bill Finerfrock): Boy, that's a mouthful. Go ahead, (Greg).

(Greg Nanami): Hello. I had a question that we've touched on a couple times, but there's one item that I wanted to clarify, and this regards using - having an RHC practitioner use non-RHC space for something such as a lesion. One principle that we were provided is that we need to look at whether we have bright line times, and one of the reasons provided for that is that if the provider is being paid for his RHC time and then he goes over to a non-RHC space and does work, effectively the RHC is paying for that non-RHC work.

What I'm wondering is would it be appropriate to have a provider, assuming that the provider is paid purely on productivity, he's not paid for his time, and that he does use non-RHC space during the day, would that be an appropriate I guess carve-out? Again, he is not being paid for his time, only for what he does.

(Corinne Axelrod): In the RHC, the provider - the way that the provider is paid is really the employment agreement between the RHC and the provider, and we don't get involved in those employment agreements and whether they're paid per patient, per hour, per this, per that, whatever, but the principle of this is that the RHC is paid a per visit rate, and for some services that rate is going to be higher than if it would have been under the fee schedule. In other cases, it'll be lower, but in the aggregate, that it's generally better for the RHC.

And so the issue with commingling is there's two here. One is that we - again duplicate payment, that we don't want to pay for the same service twice, and the other one is steering patients in order to selectively get a higher reimbursement, and so we would really look at that and kind of say, well what's going on here? This is an RHC service. It's an RHC provider, and so are you - you know, you can't just say you're

going to pay for 46 minutes of this service and 13 minutes here, that it's really an all-inclusive payment.

And so the RHC provider, regardless of how he or she is paid by the clinic, cannot provide an RHC service and bill part B. You know, I think just to keep it simple, the RHC provider is being paid by the RHC. It's an all-inclusive rate, and you can't just carve that out, go to another room, and bill Part B. So if I've misunderstood the question I apologize, but I just think this is really important for everybody to be very clear about.

(Greg Nanami): Okay, thank you and you didn't misunderstand the question. However, you know, where we have - we're a medical center, have a hospital-based RHC, and so some of our providers have either blocked time or call time where they will get pulled from the RHC into the hospital for some issues, so there are going to be times - I guess what I'm trying to figure it out is that it is not categorically inappropriate. Under what circumstances is it appropriate? That's what I'm trying to get a handle on.

(Corinne Axelrod): So it sounds like it's similar to what we discussed earlier in terms of the emergency department, when a physician in the RHC has to go over to the emergency department, that it's permissible, but it should not be a common occurrence, so I think you know, it's kind of in the same category as that.

(Greg Nanami): Okay, thank you.

(Corinne Axelrod): Thank you.

(Bill Finerfrock): We're trying - how about - I apologize to everybody who didn't - isn't going to be able to get your questions asked. You did get (Corinne)'s email and I would ask that perhaps (unintelligible) up here she'd give it again, but how about we take - try and take one or two more questions, depending on how long the first one is? So go ahead, Operator.

Coordinator: Your next question comes from (Terri Crumb). Your line is open.

(Terri Crumb): Okay, my name is (Terri Crumb). I'm from Craig, Oklahoma, and my question is about the commingling teams. I have a provider based rural health clinic, and I'm going to give a scenario. We have a patient that comes in. They have an abscess. The doctor sees them in a room but then sends them over to our emergency room and gets them on one of their beds where they have access to the medication can numb this area to where they can open it up and get out the infection.

But we bill it through the RHC. We don't bill it through the emergency room. It bills through the clinic as a clinic visit. Are you saying that's okay to do that, or not okay to do that?

(Corinne Axelrod): So I guess I'm confused - the emergency room is not part of the RHC, right? Or is it?

(Terri Crumb): No, it's not part of the RHC. We're in the same building, but it is not part of the RHC.

(Corinne Axelrod): Great. So generally you can bill an RHC visit in RHC space. I mean, obviously there is exceptions, which we talked about, but RHC visits cannot take place in a hospital, and so assuming the emergency room is in the hospital, then the RHC could not bill for that.

(Terri Crumb): Okay.

(Bill Finerfrock): But if they went out into the parking lot they could?

(Corinne Axelrod): Well, if you want to have your abscess drained in a parking lot, (Bill), you go right ahead?

(Bill Finerfrock): No, I'm just - I mean, I - I don't know. I mean, I think you guys have tried to be flexible on some things and I understand and I - we appreciate that. It just seems like in this instance - (Terri), are you still on the line?

(Terri Crumb): Yes, I'm still here.

(Bill Finerfrock): Going over it's because of the anesthetizing drug that's available in the ER?

(Terri Crumb): Yes.

(Bill Finerfrock): Any reason they couldn't bring the drug to the RHC instead of taking the patient to the drug?

(Terri Crumb): Part of it was where the abscess was. For the physician it was just going to be easier to do it in the ER with - they had better supplies. It was more adequate to take care of the situation.

(Bill Finerfrock): Like this is (Bill Finerfrock). How often does this happen?

(Terri Crumb): Not very. I mean, not - in the 11 years I've been here I think this has happened one time, maybe twice.

(Bill Finerfrock): My general sense is, now cover your ears, but who's going to find out how you did that?

(Terri Crumb): No one.

(Bill Finerfrock): So I mean, you know, there are situations that occur. I always tell people then again my friends in the government don't like it, but tonight when you go home, check and see how often you stay within the speed limit on the highway and whether or not you're going over the speed limit, and sometimes things happen and you just - you know, it's just the way you have to do it. That's (Bill Finerfrock).

(Corinne Axelrod): Okay, so this is (Corinne), and I didn't hear any of the preceding conversation.

(Bill Finerfrock): Exactly.

(Corinne Axelrod): But I do want to just point to 40.1, that RHC visits cannot take place in an inpatient or outpatient hospital, including CAHs, so I believe that that's statutory, so I just want you all to be aware of that.

(Bill Finerfrock): Okay, next question. This'll have to be the last question.

Coordinator: Next we have (Deana Murphy). Your line is open.

(Bill Finerfrock): Go ahead, (Deana).

(Gina Murphy): It's actually (Gina).

(Bill Finerfrock): Sorry, (Gina).

(Gina Murphy): That's all right, from El Dorado Springs, Missouri, CCNH Medical Mall Clinic, and my question is for 140. We recently employed a licensed clinical - a licensed social worker - clinical social worker, and when I called Medicare we used WPS and I asked if there was a limit because of course Medicaid, you know, has a limit. You have to get prior auth, and Medicare told me no, there was no limit, but I need some clarification.

(Bill Finerfrock): You mean the limit on the number of visits?

(Gina Murphy): For yes, licensed clinical social worker seeing patients in the RHC, because back around 10.1 the RHC general information, like the second page, like under in addition to requirements an RHC must - that one bulletin shows not be a rehabilitation agency or a facility that is primarily for mental health treatment.

(Bill Finerfrock): Right.

(Gina Murphy): So I'd like a little clarification. I mean, if there's no limits, then that 10.1 is kind of confusing, because I mean, if they're coming to see a licensed clinical social worker,

you know, that's basically for mental health so that doesn't make sense. It kind of conflicts with each other, unless I'm misunderstanding.

(Corinne Axelrod): So I would look at that as not in terms of the actual provider but in terms of the clinic, so the clinic cannot have more than 50% of the clinic visits as mental health, and that's in the statute, but the individual provider, obviously if they're a mental health provider, then I would assume 100% of their services would be for mental health. It's the RHC that cannot be a facility that provides more than 50% of the services as outpatient mental health. But the individual provider that is different. Does that help?

(Gina Murphy): Yes, I believe so, because we would bill on a HCFA 1500, correct? And so therefore that would be under the provider?

(Bill Finerfrock): No, why are you billing on the...?

(Gina Murphy): Oh, that's right. I'm sorry. Yes, we would bill them under UBO4. Oh, sorry, I haven't billed Medicare yet for one of these. We do have a patient that's been seen. It's just been Medicaid that has been billing that right, so yes. We're billing under our group, then, so that would fall under cannot bill 50% more than, right?

(Bill Finerfrock): What is your staffing? Do you have a doc, a PA, a mental health?

(Gina Murphy): Yes, we have two doctors, one nurse practitioner, and then the like this clinical social worker that just started in January, January 1st.

(Bill Finerfrock): Okay, and all those are full time?

(Gina Murphy): Yes.

(Bill Finerfrock): So you have two full time physicians, one full time nurse practitioner, and one full time clinical - licensed clinical social worker. So to (Corinne)'s part, let's say that they all say 1000 patients during the next 12 months, the doc, the - the two docs saw -

each saw 1000. The NP saw 1000, and the licensed clinical social worker. That would mean 25% of the visits that were incurred in that RHC were for mental health. The other three, presuming they were doing primary care, so you would not even begin to approach that 50% threshold because you're looking at them all in the aggregate.

(Gina Murphy): Okay.

(Corinne Axelrod): And I would just add that the other practitioners such as the physician could be a psychiatrist, so that could be all mental health, and NPs and PAs, if it's in their scope of practice, can do mental health, but...

(Gina Murphy): Yes, we do have a lot of patients that have been seeing our physicians and nurse practitioners before a clinical worker came for, you know, for multiple you know, diagnoses, like bipolar, depression, ADHD, you know, all those types of diagnoses, and so one of our physicians sees a lot of nursing home patients also, so I mean, he's one that you know, has - and he's also an admitting doctor, so he's trying to refer, you know, remember that you know, our licensed clinical worker can also see patients for those type of diagnoses too, because sometimes you know, when I have medical mixed in with mental, you know, on the same visit, I mean, they may just you know, need to separate them, you know like...

(Corinne Axelrod): Getting back to your original question, though, just keep in mind that it's in the aggregate. It's not per provider.

(Gina Murphy): Okay.

(Corinne Axelrod): Okay.

(Bill Finerfrock): Well, we've probably greatly overstayed our welcome with (Corinne), but we really appreciate all the time you've taken out of your schedule to help folks work through some of these issues and answer their questions, and we greatly appreciate it. Do you want to give your email address again, and so folks have questions, they can submit

them to you, and then if necessary if you think appropriate you can send it back to us with your response and we can get it posted up onto the list serve?

(Corinne Axelrod): Yes, I'll be happy to. My email address is Corinne.axelrod@cms.hhs.gov . In some cases, I may refer you to your regional Rural Health Coordinator, just depending on the nature of your questions, but I also just want to thank everybody and encourage you that if there are areas that we could just make more clear or if there's additional information, let us know because we can make revisions to the manual and we just want to make it as useful to people as possible. So any suggestions you have are welcome, no promises, but we welcome your comments and suggestions. And thank you, (Bill), for hosting this call.

(Bill Finerfrock): Sure. Glad to, and thanks, everybody, for participating. Our next RHC technical assistance call will hopefully be in April. We've got some ideas on the topic, but we have to finalize things there. We'll get you information on that as soon as it's available. Hopefully you've gotten some of your questions answered today, and we look forward to your participation in future series. And we also want to take one final opportunity to thank the office of rural health policy for their generous support for this project and this initiative and making this available to the RHC community. So thanks, everyone. Talk to you next time.

Coordinator: Thank you for your participation on today's call. You may disconnect at this time.

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