

## **Ask the Experts**

Rural Health Clinic Technical Assistance Series Call

September 8, 2015

2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen only mode until the question and answer session of today's conference. At that time, to ask a question, press star 1 on your phone and record your name at the prompt.

This call is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the call over to Bill Finerfrock. Sir, you may begin.

Bill Finerfrock: Thanks, operator. As the operator said, my name is Bill Finerfrock. I'm the executive director of the National Association of Rural Health Clinics and I'll be the moderator for today's call.

Today's topic is Ask the Experts. We've compiled a group of RHC experts who are going to be available to you today to talk about issues that - and questions that you want to know the answers to.

The series today that we are participating in is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy and is done in conjunction with the National Association of Rural Health Clinics.

We're supported by a cooperative agreement, as you can see in your screen, through the Federal Office of Rural Policy and that allows us to bring you these calls free of charge.

The purpose of this series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call is the 67th in the series which began in late 2004.

During that time, there have been over 17,000 combined participants on these bimonthly RHC monthly teleconference calls now being done also as Webinars.

As you know, there is no charge to participate and we encourage you to refer others might benefit from this information to sign up and receive announcements.

Later on your screen, you'll see a link to where people can go to get that - to sign up or to give suggestions for topics and also to see past calls and transcripts and recordings of past calls.

This is fully going to be a Q&A session. You can either type your question, if you're online, into the chat room. Now, someone has written in that there's music on top of my - of the speaker. Operator, is there music in the background?

Coordinator: I'm not hearing any music at this time.

Bill Finerfrock: Okay, I'm not sure what you're hearing, (Becky), but it doesn't appear to be from our end of it. In the future, if you have topics or suggestions you can email those to [Info@NARHC.org](mailto:Info@NARHC.org) and put RHC TA questions in the subject line.

Up on your screen you will see, again, here's the information if you want to share it with others to join this listserv. You can go and sign up, if you know

of people who want to sign up, and also the link to where you can go listen to past Webinars and calls.

We'll go back to that at the end. Here is a list of today's participants in our Ask the Experts program. And here's their contact information so if you hear somebody that has a question and you want to follow up, we can do that and you'll know how to contact them all.

So with that, operator, why don't we go ahead and open up the phone lines and allow individuals to start getting in the queue for their Ask the Experts questions? And while we're waiting for people, I'll go ahead and pose one to (Mark Lynn) that we got ahead of time.

(Mark), we've noticed that some of them MACs have limited their pneumococcal and influenza reimbursement to \$66 and \$20 per shot respectively. Why is that happening and how can clinics avoid not getting paid their full cost for pneumonia and influenza injections?

(Mark Lynn): Okay, Bill, thank you. Thank you for the opportunity to speak today and I appreciate everybody signing in on this Webinar.

The answer to that is we have been getting a lot of those, especially from Cahaba. In their tentative settlements you can see in the work papers, they are limiting the tentative reimbursement for pneumococcal shots to \$66 per shots and influenza shots to \$28 per shot.

That's not going to be your final settlement on the cost reports. That's just their tentative settlement. Once they will review all the invoices that you have and reviewed the cost report to make sure the allocations of time is correct, then you should get your full cost.

I mean, when you - one good thing to do is look at the National Association of Rural Health Clinic's and Wipfli have a benchmarking survey and it shows the national averages for pneumococcal shots - for influenza and for pneumococcal for both provider based and independent clinics.

In the last couple of surveys have showed where pneumococcal costs are coming in around \$135 - anywhere between \$140 to, like, \$120, depending on whether your provider base (is independent) I pneumococcal and the influenza shots are coming in at around \$28 to \$40 per shot depending on whether you're provider-based or pneumococcal.

So I wouldn't worry about that so much as you will be getting your money. They're just going to hold onto it a little bit more. And we do get a lot of questions about whether Prevar 13 and 23 are covered in the RHC environment and (it is) interviewing the guidelines for receiving the pneumococcal shots, the patient has to wait for over one year to get a second pneumococcal shots.

So keep that in mind that you - if they are going to get a second shot, they must wait for over one year. And do keep in mind, those shots are very expensive and that could run up your cost per injection pretty high.

So that covers your pneumococcal and influenza. Do remember this is flu season. Remember you need your logs done for the cost report. We basically need the patient name, the HIC number, which is the Medicare number and the date that you gave them the shot.

We need that just for your Medicare pneumococcal and influenza. We need it in a log format or if your computer system can get that information for you easily, that's fine, too. So okay, Bill, that's all I've got.

Bill Finerfrock: Great. Does anybody else want to add anything to that? If not, operator, do we have questions on the phone lines?

Coordinator: Actually, there are no questions through the phones at this time. But again, if you would like to ask a question, please press star 1 on your touchtone phone and record your name at the prompt. If you need to withdraw your question at any time, you may press star 2. Again, that's star 1 and record your name if you'd like to ask a question.

Nathan Baugh: Okay, so the next question is from Peter Garcia who asks will medical patients be able to qualify for CCMR?

Bill Finerfrock I'm assuming by CCMR you're talking about the new chronic care management benefit. And do any of the consultants want to take that one on? If not, I'll go ahead and weigh in.

Then - if, by CCMR, you do mean the chronic care management benefit, this was issued as the proposed rule a few months ago. CMS proposed extending the - okay, it's not apparently about the CCM chronic care management.

It's a Medi-Cal. Can you - (Peter), you're going to need to be more specific. What is CCMR in Medi-Cal? While we're waiting for that, we have a question from (Christie Knudsen).

Nathan Baugh Christie asks, the state of Iowa has recently bid out the majority of their Medicaid business to for - I'm assuming for-profit private payers. The payers are proposing not paying me entire rate previously set by the state but paying a percentage of the Medicare cost - Medicare rate. Also they're proposing to not do a cost settlement on that at the end of the year. Is this allowed?

Bill Finerfrock: Again, if any one of the consultants wants to respond, otherwise they can try and take that one. All right...

(Julie Quinn): Bill, this is Julie Quinn. Is this - did they say Iowa Medicaid? I'm sorry.

Bill Finerfrock: Yes, it's a Medicaid question on Iowa.

(Julie Quinn): In Iowa has its own settlement process at the end of the year. So to fully answer that question, we would want to go to Iowa Medicaid and see what the end process is going to be.

In many of the states, when the MCOs are used, there is a wraparound process to make the RHCs whole to their RHC rate. We see this in a lot of states that go to the MCO model. And what happens is the state then creates a new billing system or another reconciliation system to make the RHC whole.

Bill Finerfrock: Yes, that's the - that really is the, (Christie) and others, if your state goes to a Medicaid managed care option and get away from traditional Medicaid, the law allows them to do that.

It stipulates that they (MCOs) have to pay the RHC's rates that are equivalent to what they're paying other providers for those same services. So they are not required to pay you your RHC rate.

However, the state is required to come in and provide a wraparound payment, as Julie said, to make you hold to whatever your RHC rate would have been. And so what they're going to have to do is look at it on a - typically they would want to do it on a quarterly basis or some basis to see what you are paid by the Medicaid managed care organization for the care you provided to the Medicaid patients.

Let's say the page on a capitated per member, per month basis. Then you look at the actual visits that you provided to those patients, which you would have gotten from Medicaid had you been paid your Medicaid rate as a rural health clinic, and to the extent that what you were paid by the Medicaid managed care organization was not up to what you would have received as a rural health clinic, the state is obligated to make a wraparound payment to make you whole to that number.

(Mark Lynn): Bill, this is (Mark Lynn).

Bill Finerfrock: Yes.

(Mark Lynn): On that same issue, you have to keep in mind, too, that unless the state has what's called a 1116 - I think an 1116 waiver, they have to pay RHC their full cost reimbursement rate.

And there are a lot of states that have implemented these wraparound programs with the MCOs. The problem is, if you get into a state like Kentucky that did not really think about it, and they have a complete mess up there.

So what you want to do is get with the state and let them know that you are owed this money and it's better to start thinking about it ahead of time instead of two or three years later and trying to go back and re-create something that, you know, the cat is already out of the bag.

I'm, right now, working on \$86,000 problem for this little old man and lady up in Kentucky and, you know, they're going to lose their clinic because the MCO, you know, is asking them for \$86,000 back. And they're going to have to go back in look through storage units from 2009 trying to count up MCO wraparound payments, so just keep that in mind.

Bill Finerfrock: Great. Great. Okay, operator, any calls on the phone lines, or any questions?

Coordinator: I'm showing no questions in the queue at this time, but again, its star 1 and record your name if you'd like to ask a question.

Bill Finerfrock: Yes, and they're coming in through the chat room here. So next up is a question from (Charlotte Walker) who asks

Nathan Baugh: Can you speak to how mental health services are reimbursed in the RHC environments?

Bill Finerfrock: Do any of you want to take that one on? Come on. Well, the mental health services are covered in RHC to the extent that they would be covered by Medicare under a traditional Medicare in the sense that those visits that are mental health, behavioral health, that are medically necessary and that would otherwise be covered by Medicare are covered, if provided in a rural health clinic with recognized providers in the RHC setting are a psychiatrist - mental health providers, psychiatrist, psychologist, PhD level psychologists or a master trained clinical social worker.

So if you have a mental health visit - mental health service that is covered by Medicare that is provided by a psychiatrist, a psychologist - this would also include a nurse practitioner has special training in psychology either as a nurse practitioner or a PA or a physician who may not necessarily be in psychiatry but who feels comfortable providing a mental health service.

Those would all be visits that are billable under the Medicare program. It has to be face-to-face. It has to meet all of the other requirements and due to the mental health parity, it's paid at the same rate as would a physical health visit that meets all of the rural health clinic Medicare coverage criteria.

(Mark Lynn): Bill, this is (Mark Lynn) again. As a rural health clinic, too, as a - if they would use revenue code 0900 for therapeutic services for mental health services and 0521 for diagnosing the patient, you know, if they're diagnosing whatever is wrong with them, it's going to be a revenue code 0521.

But once they start treating them in therapeutic treatment for that patient, it's going to be 0900. It will not matter, and like you said, the Mental Health Parity Act is now fully in place and so there is no reduction as there used to be.

There's also a new mental health fact sheet that came out, probably either in June or July on mental health services, about 16 or 17 pages that Medicare published. So if you just Google, you know, Medicare mental health fact sheet, there's about 16 or 17 pages a very good information there that will help you with mental health service.

Bill Finerfrock: Thanks Mark.

Nathan Baugh: Okay. All right, so the next question is a question that was submitted prior to the call and that's a question for (Sara) who asks, under the ACA, adult children up to the age of 26 are able to remain on their parents health insurance. What are my obligations to the adult patient under their parent's policy in regards to that HIPAA privacy rule? (Sara), do want to tackle that?

Sara Badahman: Sure. So under the Affordable Care Act, children - adult children are allowed to remain on their parent's insurance until they are 26 years old. So this is - my statement is for children ages 18 to 26, so adult patients.

Even though their parents are footing the bill for the insurance premium and possibly even paying for their co-pays, these adult children do have a right to

privacy. So their parents are not allowed to know which medical services their adult children are seeking.

And so this can be very tricky whatever we're talking about how, like, the bills are being mailed out, even the explanations of benefits. Those will come from the payer. And so the adult child actually has to ask the clinic or the hospital to not submit that information to the parent where it typically goes to.

So really the clinic only has an obligation to send out what the child says is okay to send out to the parent. So if the child doesn't ask - is the adult child is not asked to restricted, then you can do what you normally do for all of your other clinics - all your other patients, rather. Make sense?

Bill Finerfrock: Sounds good to me.

Nathan Baugh: Thank you, (Sara).

Nathan Baugh: All right, so the next question is from Jan who asks, as a provider based RHC, the required to have the ability to perform certain lab tests and EKGs. And she says that they are concurrently performing the services in their RHC.

She wants to know, are they required to perform these services in the RHC or can we elect to have the patient received the services at the hospital instead? Can she...

Marty Bennet: Oh, sorry.

Nathan Baugh: Yes, this question is asked because the physical mechanics of capturing the services as hospital charges for billing purposes would be difficult as the two billing systems are not integrated. We also have concerns related to the

documentation of lab results in the EMR. So does someone want to jump in and handle - take that?

(Marty Bennet): (This is) (Marty). Yes, I'd be happy to jump in. So the (rates do) say that you have to have the capability to do them. Whether or not you choose to perform them as a send out, really, or have them done in a hospital based environment, is up to the provider.

As far as, if you have an integrated system and the hospital is close by and they're doing this for you, it may well benefit you to have those labs back imported but I know of no mandate that says you have to perform them. You have to be able to perform them should you need to.

Nathan: Does anybody else want to jump in on that?

Mark Lynn: Yes, this is (Mark Lynn). They've changed that, (Marty), where, if you read chapter 13 of the manual and, you know, at the meeting, you know, (Aaron) would always jump up with anybody would give you the answer which - you gave the answer which I've always given, you know, for 20 years.

And (Aaron) would say, "No, you have to - they have to physically be able to do those." And when they changed the chapter 13 of the manual, and when you look at the CFR, when I was reading it for this session here, it specifically says that they have to be able to provide those (six tests) physically in the rural health clinic.

Now, there's no requirement to be providing EKGs in a rural health clinic but the six mandated lab tests, it says very specifically, that they have to be done in the RHC. In like I said, that language just changed in the - I think it was effective either January 1, 2014 or January 1, 2015, but the language is in there now.

Marty: I guess I see it somewhat as semantics. If it benefits the patient, many of the lab tests that are required are duplicative. Of course, the UAs are done in the clinical all the time.

But, you know, if it's cost effective and more practical to have labs be - some of the labs combined, certainly we have the capacity to do them. But where the provider has been done, you know - and I think functionally most practices do but I still think you basically have a choice.

(Marty): I wouldn't change it necessarily online billing...

Bill Finerfrock: Yes, I think, (Mark), you're - you know, there still is some dispute. I mean, I think - I tend to fall more in the (Marty) camp. I know what language you're referring to.

I'm not sure how you whatever know that, if every patient came in - the patient is, like (Marty) said, for economical patient access reasons it was more practical to have them have a certain test performed off-site, that that could be done.

You're not going to be billing for it and you're still going to have the ability to do it. I think there's - I think that there is an ability to exercise some practical judgment but in the survey or comes in, they're going to want documentation that you've actually performed those lab services on patients when necessary.

So you would need to be able to pull patient records to document that you actually performed them. Not just simply that you have the equipment and that the equipment is in operating shape, but that you actually did perform those.

So I think it would behoove a clinic to perform those tests during the course of the year, but I don't think it's a requirement that every patient that the need of those tests, it absolutely has to be done at the RHC.

Mark Lynn: I think you have to have the ability to physically do those within the clinic. Now, I mean, that's the number one key. You don't have to do them all there, but you definitely have to have the ability to do that. You have to have the equipment, the (agents).

Bill Finerfrock: ...need to show that you've actually done it, I think.

Julie Quinn: And this is (Julie Quinn). I just want to jump in for second and folks that are more well-versed than billing may be able to answer this better. But it is my understanding that regardless of the location, where the lab, where the EKG happens, for a provider-based RHC, it still has to be billed to the hospital under the hospital's provider number.

Bill Finerfrock: Correct.

Bill Finerfrock: Yes, lab is not (an RHC) service. Even though it's a - the six are required tests - they are not billable under the RHC all-inclusive rate.

Nathan: Okay, excellent. Operator, do we have any calls on the phone?

Coordinator: Yes, we did have one question in and it is from (Christina). Your line is open.

Christina: Hi, I just - we're an independent rural health clinic and I just had a quick question about billing for telehealth, specifically the originating site fee as an

originating site for telehealth services. Can you speak a little bit about the billing...

Bill Finerfrock: Where you calling from, (Christina)?

(Christina): Kentucky. We're an independent rural health clinic, family and internal medicine.

Man: Okay, okay. What is he wanted to know about telehealth and the originating fee?

(Christina): As a rural - independent rural health clinic, can we bill telehealth as an originating site fee and how do we go about doing that because I think there're some questions on that?

Bill Finerfrock: Any of the consultants? Okay, rural health clinic is an approved originating site for telehealth visits. And the payment for that is roughly \$20- I think it's about \$25 for that service.

You would bill it using a 1500 - I believe you would bill it using a 1500 claim form, but a rural health clinic is an approved sites for - or the originating fee for a telehealth encounter.

Bill Finerfrock: The provider on the other end would (bill) for the service if they would have had they seen the patient in their office.

(Christina): So it would go a professional claim form as opposed to (a UB)?

Man: I believe it goes on the professional. I don't believe it goes on UB. I don't know if there's anybody on the call can verify that are correct me if I'm wrong but I believe it goes on the...

Mark Lynn: This is Mark. It does go on a UB04. It does go on a separate line item. You have - you know, say you had an office visit of 0521. That will go on the first line. You would not include the HCPCS in there but you would drop down and you would put it on the second line of the UB04.

It would go under remedy code 0780. And then there's a Q- I can't remember the code off the top of my head. It's like a Q231- something and they pay about \$25, \$26 for and you would get that \$25 or \$26 in addition to whatever your Medicare reimbursement rate is for that.

So that's how they pay. It's not a lot of money. That's why there aren't a lot of folks who do it unless you've got some grant funding to help you pay for the equipment. It's really hard to make it worthwhile with the reimbursement that we've been seeing for it.

(Christina): Well, I have a quick question. Those guidelines should follow the same as for a Medicare Advantage insurance, right?

Mark Lynn: Are you - the question - is the Medicare Advantage...

(Christina): How to build and getting paid for the services.

Mark Lynn: I'm going to leave that for (Bill). I don't think it is.

Bill Finerfrock: Are you a contracted provider under the Medicare Advantage plan?

(Christina): They pay us our rural health rate for our Medicare Advantage claims.

Bill Finerfrock: Right, but are you contracted with them? You're under the same contract with the Medicare Advantage plan?

(Christina): Yes. Yes.

Bill Finerfrock: Then you would have the - whatever the terms and conditions are of that contract is what you would be obligated to adhere to.

(Christina): Okay, so for Medicare patient we do build on a UB form with 0780 revenue code with a (unintelligible).

Bill: If that's what the Medicare Advantage plans as they want you to do, and that's what you would do.

(Christina): Okay. All right, thank you.

Bill Finerfrock: I want to go back to a question that we had originally. There was some confusion with regard to Medi-Cal and Medicare from (Peter). It was whether or not - he wanted to know whether or not you can fill the chronic care management for Medi-Cal patients or is it only for Medicare patients?

That really is - I don't know that there's anyone who can answer that. Perhaps (Steve), I know you work in California. Maybe you know. But each Medicaid program establishes coverage services that they wish to cover, so whether or not Medi-Cal covered that, would be a determination by the Medi-Cal program.

And I wouldn't have - we wouldn't have information on that. Currently, Medicare is looking to cover chronic care management beginning January 1. (Steve), do you by any chance have any familiarity with the Medi-Cal program as it relates to chronic care management?

Steve Rousso: Well if it was - it depends on who the provider was. If it was a physician or mid-level, whereas, you mentioned the mental health professionals. And if it's Medi-Cal managed care, which every County here in California is, but the Medi-Cal managed care paid it basically at it was a medically necessary visit, and the state would pay the wraparound because it's a (rural health clinic visit. So it would be...

((Crosstalk))

Bill Finerfrock: But what about chronic care management which would be services - you know, Medicare is not going to pay for chronic care management which are services not provided by the physician, the PA or the NP. Does Medi-Cal have a provision, anything similar for chronic care management under the Medi-Cal program, do you know?

Steve Rousso: No, not that I know of and I don't think it would be - the Medi-Cal managed care me. But the rest of the payment would be denied.

Bill Finerfrock: Okay. All right. I would - yes, I would - (Peter), I would check with California. You might want to contact the California Association of Rural Health Clinics (unintelligible) (Gail Nickerson) who's the president to see if she can give you better insight into what the Medi-Cal program may do.

Nathan: Okay, so (Jan) - this is (Jan)'s second part to her question and she asks are charges for flu and pneumococcal vaccines and administration captured by the (encounter rate) and subsequently written off for the services tracked through the use of a log only?

Bill: (Julie), or one of the (unintelligible) folks want to...

Julie Quinn: Yes, I can speak to that. And pneumococcal and influenza, it is captured through the log and also through the calculation of the vaccine ratio that your cost report preparers will calculate for you.

It's a - probably more advanced than what we want to go through today but it is not a charge base. It is a cost-based reimbursement system and the documentation would be your log) and then also invoices to support the actual - the cost of the actual vaccine itself.

Bill: Okay. Anybody else?

Robin Veltkamp: (Bill), this is Robin. Also when they speak of this, they are talking, on a regular basis, the regular Medicare. What entities need to do, if they are talking of a Medicare managed program, they have to find it if they're going to put that as part of any kind of a cost report factor or if they are going to continue to build those out as a fee-for-service, but that would only be for some of the Medicare HMOs.

Nathan: Okay, excellent.

Julie: So for - yes, so for Medicare HMOs, it's different than regular Medicare. The only thing on the cost report is regular Medicare. Thanks, (Robin).

Nathan: Thank you guys. Operator, do we have any calls over the phone?

Coordinator: I show no questions in the queue at this time.

Nathan: Okay, so the next question we're going to talk about is (Theresa Kennedy) who asks, we have out the orders that came in for a draw (venipuncture) 36415. And they're not seeing a physician in the facility. Is there anyway, as an RHC that we can bill for those?

Also, patients come in for a CPT, venipuncture which is done a week or show after visit. Can it be billed as an individual charge? Any of the consultants want to jump in on that?

Marty Bennett: And be happy to step in on that. This is (Marty). So the - and the administrator in a small rural health clinic that's independent and frequently we have patients that come in and request a venipuncture just to have labs to send to an outlying provider that is some distance away.

And what we choose to do is to that - for commercial carriers, they're often - you can build a nurse visit or a low level, like, 99211, which doesn't qualify as a rural health clinic visit.

But for Medicare, you can - I mean, essentially what we do is we do it as a public service. We don't - we do the documentation and because it doesn't meet the encounter rate.

If they have a visit, the venipuncture can be added to a visit, I believe it's within 30 days. But - so sometimes we just do that sort of as a PR thing and no it's not available RHC encounter.

Bill: Anybody else want to add to that?

Mark: Yes, (Bill), I mean, the 36415 is a big problem. But there is a - you know, that changed January 1, 2014 to where Medicare considered a lab draw, the 36415, not to be a lab service and it's actually part of our RHC rate. See you cannot bill that to Medicare Part B or as a part of the - under the hospital provider number if you're a provider base anymore.

It is the part of the RHC benefit which, again, is not logical to me. And so that creates all sorts of problems for us because if the doctor asks us to come back, you know, the patient come back for a, you know, a fasting glucose or a fasting - whatever type of test it is, the patient comes back and you've got what's called an incident to service which means you can combine any of those services that occur within 30 days before or after an office visit with that bill.

And you'll use that date of the office visit as the date of all the services. Don't (span bill) but just use that one date. And in this case, we would have to be - we have to roll that 36415 into that office visit. It just creates an accounting nightmare for you guys to either hold for bills or you can do a claim edit for you send a bill type 717 where you change the amount of charges later on.

But it becomes an extreme hassle for you guys to be dealing with a, you know, a \$15 venipuncture, when before, you could bill at to Medicare Part B, get your \$3 and everybody would be happy. So that's what's happening on the 36415.

Bill: Okay. Okay, there's - we've gotten some - just as a general rule, we've gotten some Medicaid questions. And those tend to be state specific. And so there's some - we'll try and see if we can't help out a little bit but mostly for Medicaid, you're going to need to look to folks in your state to be able to hand those - to respond to those because it just could be so variable from state to state.

But we did have one from (Carrie) about school physicals.

Nathan Carrie asks, if had many calls from parents asking for appointments for kid's physicals for school and for sports physicals. In California, are these covered

or are they payable visits for Medi-Cal and management (of) Medi-Cal in California?

Bill: Any - I'm not sure that we have anybody. This is a Medicaid question, but anybody know the California Medi-Cal program, whether or not they're covered?

Steve Rousso: I'm here out in California. Yes. Anyway, so I basically the Medi-Cal managed care is a primary insurance so if they don't approve it you can't go any further. So once they proved, basically, and you do have an eligible RHC visit with a mid-level position, then you would be able to bill the state for the remaining wraparound portion.

So again, it's just basically - it's an RHC visit but you have to have Medi-Cal managed care approved the initial visit because without them, you couldn't bill the wraparound payment.

Bill: So whether it's for a school physical or a sports physical, it could be covered but you'd have to get prior authorization from the managed-care plan?

Steve: Yes. It's going to be - the primary - yes, they're the primary payer. They are first in line basically.

Bill: Okay.

Steve: Because they're primary. Medi-Cal is secondary, the way it works.

Bill: Okay.

Marty Bennett: Sometimes what we have done in the state of Louisiana that may transition is, the physical is within their early prevention screening diagnostic window, sometimes we will - and it actually gives us an opportunity to catch gets up.

So if the parent presents looking for a school or sports physical and we're able to extrapolate the fact that they're out of date for their annual physicals that are definitely covered by the Medicaid program, sometimes we just perform both at once and just step up our services.

It gets them the sports physical documentation. It's just filled out in the same visit. And we hit two birds with one stone. So sometimes it pays to think creatively.

Bill: Yes, good point.

Robin Veltkamp: (Marty), this is (Robin). And that is becoming pretty universal from what I see across the nation. The biggest thing is make sure that the documentation of the note supports a rural health visit.

Marty: Absolutely.

Marty: Well, what we're doing is, we're way overkilling the sports physical. We're doing a full comprehensive physical and, oh, by the way, we signed off their sports note at the same time.

(Robin): Correct. And then the sports card physical that they've completed, it's just an extra piece of documentation.

((Crosstalk))

Marty: A bonus. Yes, exactly. Well, as the providers are becoming to be more and more incentivized I meeting these preventative care benchmarks across the age continuum with the Medicaid programs beginning to be more aware about preventative medicine for children and actually applying some mandates or some incentive payments availability to all the folks out there, I would encourage you to really, really look, both at your commercial carriers and your governmental payers.

Because they're looking a lot alike these days - and find out what they're incentivizing because during slow periods or if you set up a process to seek out some of those preventative services, it's a great improvement in the health of your community as well as it can supplement revenue and things lag.

Bill Finerfrock: Okay, we had another question that was submitted ahead of time. I'm going to throw this one to (Steve). It has to do with eligibility of RHCs. Can you talk a little bit about the eligibility to the RHCs for - in terms of the Census Bureau, what tools CMS uses in the current HPSA requirement?

And also, what if an RHC wants to move or goes through a change of ownership? We've seen a lot of independent RHCs that have been purchased by hospitals or we've had some situations recently where RHCs have outgrown their physical plant and are looking to possibly move. Could you address that?

Steve Rousso: Sure. I will try, Bill. Sure. So basically the feds use basically American Fact Finder which is basically part of the Census Bureau Web site, in order to be a rural health clinic, you have to meet two eligibility guidelines. It's not either/or. It's both

The first one being, you have to be in a non-urbanized area as defined by the Census Bureau. You have to have an underserved designation which could

either be a health professional shortage area which is the HPSA or a medically underserved area which is the MUA.

But it should be a current designation and the HPSA program which actually is going under a lot of changes right now by HRSA, have to be current within four years. And the MUA is never a current designation because there's no mechanism right now to review the MUA designation.

So, again, it's the American Fact Finder for determining whether you're non-urbanized. But the only problem with American Fact Finder is about a 98% success rate, meaning that in about 2%, 3% of the time, the addresses don't come up, and even when they do come up, it basically says things like place or urban cluster which basically means you qualify.

But it may not basically be definitive. So CMS actually defaults back to a Web site called Am I Rural - or at least they do and CMS Region 9 on the West Coast. So the American Fact Finder is not always 100% accurate.

As far as a move, it's CMS's basic opinion that if you move you have to go through the same eligibility guidelines, meaning that you have to (meet the) non-urbanized definition and also it being a current underserved designation.

As far as a change of ownership, basically there is no eligibility test used for changes of ownership because it's - you're already taking over an existing certified rural health clinic.

So if some of the agencies in your state are using that, there shouldn't be any eligibility for change of ownership. So hopefully that answered us of your questions, Bill, and the ones you (asked) me.

Bill Finerfrock: Yes. No, that's great. Thank you, (Steve).

Nathan: Thank you, (Steve). The next question is from (Holly) who asks, can CPT code G0108 for diabetic self-management training be reimbursed if performed by a collaborating pharmacist under the RHC? Does it have to be on the same day as a provider visit? Experts?

Marty: I would say that's a no because the collaborating pharmacist is not considered an RHC provider and diabetes self-management isn't a covered service in an RHC.

Bill: Right. It's something we're trying to get changed. We submitted a proposal to congress to change the statutes to allow that. But as (Marty) said, diabetes self-management training does not currently recognize when provided in an RHC as an RHC encounter.

(Marty): Now, I want to clarify that RHC - I mean, diabetes self-management training happens functionally all the time in rural health clinics. It's just not separately billable from the E&M code and wouldn't be billable at all if there were no RHC provider encounters provided. Did that make sense?

Nathan: Yes.

Nathan: Yes. Excellent. Thank you. Operator, do we have any questions over the phone?

Coordinator: I'm showing no questions in the queue at this time, but again, that's star 1 if you would like to ask a question.

Nathan: Okay, so the next question online is from (Janice) who asked, is medical nutrition therapy provided by a registered dietitian covered?

Bill Finerfrock: I'll just take that one real quickly. No, same as diabetes self-management, medical nutrition therapy is not recognized as an RHC service. And again, that's, as with diabetes self-management, something we've requested from congress to change the statute make that permissible. But it is currently not a recognized service provided in an RHC as a billable visit.

Steve Rousso: I wanted to add to that. So basically, again, if the Medi-Cal managed care organization pays for it, that would be fine, and some of them do. But then you can bill what's called the wraparound rate which is the remaining portion of the RHC rate. So some of the Medi-Cal managed care organizations will pay for those services, but then just putting basically bill the remaining of the rate.

Bill: Right, if it's Medi-Cal eligible?

Steve: If it's Medi-Cal eligible, some of the managed - Medi-Cal managed care (unintelligible) may pay for service. They treat you like a fee for service provider basically so then you can fill the remaining portion to the state for the RHC portion of it.

Nathan: Okay.

Nathan: Okay, the next question is from (Tammy) who says that she submitted a question online last week regarding how RHCs are supposed to bill for appliances such as wrist braces, knee braces, et cetera.

Bill Finerfrock: So for D- this is basically a DME question. Any of you folks want to take a crack at it?

Marty: DME is not covered in a rural health clinic encounter and, therefore, typically we would write a script and send them to a DME provider. It - to my

knowledge, clinics - I mean, I'm not sure why there would be the provision of DME through an RHC, but they're not covered under Part A.

Robin: This is (Robin). Marty is very correct on the fact that it's not part of the RHC and many do just write a script. Some do make collaborating agreements with the DME company that will house the supplies on the premises and still manage the distribution through a script format. And then they'll collect separate demographics for the DME company to do their own billing.

(Marty): That's a great point, (Robin). Often I see - we actually do that here in-house - nebulizers, because often it's a patient that comes in an asthmatic crisis that receives the neb, and then especially if it's a pediatric, it's imperative that they get sent home with that.

So top two DME suppliers, we keep theirs on our shelves. We do nothing with the billing. We just - it just takes up space until we write a script, send it to them and then dispense it to the family. But there's no monetary gain at the RHC level for those services.

And on the alternate side, there are times that we keep certain DME supplies, but again, it's more of a public relations community involvement thing. I mean, they may splint - provide someone with a splint but it's not billable.

(Robin): And then from a compliance perspective, if you have, for instance, as (Marty) mentioned, nebulizers, et cetera, if you have those electronic devices that you are sampling out, per se, you need to make sure that you have those properly put into a sample area or through a script area.

If you put any of those into implementation for use within the clinic, they have to go through the compliance of being inspected. And sometimes clinics - their nebulizer will kind of fall short and so they're, like, "Oh, we've got

some in the DME supply. We're just going to pull one and implemented for us - or, to use on a regular basis."

If you do that, then the one you put into implementation must go through the annual maintenance inspection. That's where I see some of the biggest deficiencies take place.

Nathan: Great. So hopefully that answers your question, (Tammy). The next - I think we're going to jump to the next question because we have a lot left. (Angel) asks, does a cost report settlement come from Medicare Part A or B or both? Anyone want to tackle that?

Julie Quinn: Part A. Only Part A.

Nathan: Only Part A. all right, the next question is from (guest 8) who asks, billing Medicare for an LCSW - does this roll up into the 92213 or something different? Does anyone want to take that one? Do we need clarification on that? Do we...

Bill Finerfrock: Yes, I mean I - well, I'm not sure when you - why you're rolling it up. You know, as an RHC you're using revenue codes, on the next year you'll start using CPT codes.

So a visit for an LCSW, something that's a Master's trained clinical social worker, would be billed as an RHC encounter with - (Mark), you gave out the revenue codes earlier, I think, for the two types of visits. I forget what the revenue codes are for the mental health. Do you want to restate what that would be? We lost (Mark).

The - or, (Mark), if you're on mute, we can't hear you. So, yes, an LCSW billing to Medicare would be the same as billing any other recognized

provider. The proper - just using the proper revenue code for that. Beginning in January, you'll use CPT codes but right now we're still using revenue codes.

Marty: So, Bill, this was an area of question. I think what our question is, is if they have primary care and mental health in the same clinic, E&M codes, the 99213, there's some - there is a separate set of codes that the mental health providers use themselves the therapy that they provide.

So she's saying, are we using - doesn't have to be a medically necessary visit or can it fall within the category of some mental health CPT codes that are paid by Medicare?

Nathan: Great.

Bill: And next up we had a Medicaid question on a Medicaid cost report, basically, even when it's not Medicaid managed care. And this question is, I heard that Alabama does not increase their rate once it is set. Is that legal?

Under the Medicaid rural health clinic's benefit, the state has the authority to establish an alternative payment methodology using the average, and then trend forward.

The state is supposed to adjust each year to reflect medical inflation and the RHC has the option to go back and petition the state to adjust their rate based on changes in services once the original rate is set.

If you send me an email directly at Info - I-N-F-O, at NARHC, I'll send you a copy of the Q&A that CMS released two years ago that talks about what the state's obligations are under the Medicaid program for updating for rural health clinics.

(Julie Quinn): And this is (Julie). As a side note, Alabama does increase their rate each year.

Bill Finerfrock: They do? Okay.

(Julie Quinn): They do.

Bill: Okay.

(Julie Quinn): I have seen recent rate increase letters.

Nathan: Okay. Okay, so this is a follow-up to something we were talking about earlier. (Amy) asks, for those lab test/EKG completed at the RHC and builds through the critical access hospital, is this for all payer types? She says they are currently only billing through the critical access hospital if it was a Medicare patient. Anybody want to take that one?

Marty: It's my understanding you can bill through where we want as long as the pricing is consistent.

Bill: And, (Mark), I think we're getting your - we're hearing you type.

(Mark): Oh, okay. I didn't think you all could hear me at all. That's why I started typing. So - okay, that's good. Okay, great.

Nathan: Okay. Okay, so does anyone want to handle - I guess, the answer was that for commercial insurers, you do whatever you do. What we've been talking about here is the Medicare policy for RHC.

All right, the next question is from (Dawn) who asks how do I bill for Medicare patient to receive a vaccination as a result of an accident for a patient that, because of an illness, is medically necessary to be vaccinated?

She's talking about a vaccine other than pneumo or flu. And she also wants to know if the patient receives a vaccine without a face-to-face encounter. She says that she has Medicare patients who request the vaccination and then want me to bill Medicare.

I understand - or she understands these vaccinations should be billed to the patient's Medicare Part D. a couple of questions in there. You guys want to handle that one?

Marty: The way we handle those is we send them - we typically send them to the pharmacy and they get a script. It's sort of that same thing. If you have a Medicare patient that comes in with a laceration and you're repairing a laceration in the office, we administer a TDAP.

The - yes, it's one of those that doesn't come up very often. But typically, if it's scheduled and not an urgent thing, we send them to have a script in the either get it administered at the pharmacy or bring it back to the clinic. I'm not sure that - well, maybe - I take that back. I don't think they release vaccines. Maybe I haven't run into that.

Man: Yes, I think - this was from (Dawn Quinn). (Dawn), if you want to send me a separate email with that question, we could try and get it to some folks who perhaps have a little bit more experience with the Part D billing.

(Mark Lynn): Yes, Bill, this is (Mark Lynn). This is (Mark). On Part D - and most of us have very little experience with it, but they cover very few drugs. I mean, it's mainly, like, (Zostavax) and the shingles vaccine and you know, there're only about four or five drugs that they will actually cover and pay for. They are very expensive.

And then the other immunizations that a Medicare patient would receive, those would be actually settled through the cost report. So you would not receive any additional money for those. If the patient came in and it wasn't an office visit, and that's going to be just like an incident to service.

So, you know, they're going to be settled just like any other service that you provide in addition to an office visit. You just bundle it into the revenue code 0521 at this point.

Nathan: Okay, so we're coming up on the 3:00 end the call, but I think we'll go a little bit extra. (Bill), do...

Bill Finerfrock: Yes, that's fine. But we're probably going to have to cover - we're not going to be able to take any questions beyond those that have already been submitted. So please don't ask any more but we'll try and get through here what we can in the last ten minutes.

Nathan: All right, so the next question is a follow-up from (Becky) who says that she's been told that the RHC would have to carve out any costs or revenues from their cost study for the originating site fee, and then she also says that the (Cahaba) system can't bill the originating site facility fee of \$25. It sounds like...

Bill Finerfrock: This is the mental health question on the originating fee. (Mark), I knew you had a lot of experience with (Tohaba) or (Julie), you have, in terms of - have you ever heard that (Tohaba) is asking you to carve out for that originating fee? I don't believe that's correct. You shouldn't have to. But what - if you had any experience with that?

(Julie Quinn): Well, in theory, if they're paying for it outside of the RHC rate, then yes, it should be carved out because it is - in calculating the rate, it is cost divided by

visit and the cost is the cost of providing RHC services which goes into calculating that rate.

So anything that's paid outside of that rate - lab, EKG, anything over and above, we have to drop into a non-reversible cost center or somehow carve out - capture costs to make sure that the cost of providing those services is not double dipped, if you will, so you don't get it over here from Part B and then also get it as part of your rate. So in theory, I would say yes. I've not seen it in practice, anyone ask for that, but it does make sense to me that they would.

Bill Finerfrock: (Mark), have you had any...

(Mark Lynn): Yes, this is (Mark). I have not - you know, we have - the problem is, like I said, it's just not cost-effective to be doing (tele-medicine) the way it's being paid and, you know, we have - I've never had it on the cost report ever.

I know we - at one time, and Augusta, there were a few rural health clinics that did it, and they called me up and ask questions about it. But they are - it's been ten years ago.

I mean, it's just hard to - it's hard to make it work on \$25 for equipment that costs, you know, \$30,000, \$40,000 because it has to be HIPAA compliant and you have to have, you know, very, very sophisticated equipment to do something that, in theory, sounds so easy.

Man: I think that that whole telehealth benefit is under review at the federal level and folks are looking at ways to try and improve and make it more feasible for people to provide.

So a lot of the shortcomings that you folks have addressed, the deficiencies, I think there's at least an interest in looking at those at the federal level. And so I - hopefully we may see some changes in the not-too-distant future.

Nathan: Okay, so we're going to go to (Jan)'s question who asks, as in Idaho provider-based RHC, are we required to accept a non-contracted Medicare Advantage payer's contractual adjustment? Can we bill the patient the balance due?

Bill Finerfrock: So if I can, so the situation is that Medicare Advantage patient has come to the rural health clinic. You're not - the RHC is not a contracted provider. So they're coming to you as an out of network provider. Do any of you want to take a crack at that?

What I can tell you is if it's a - there're a number of different products that are available under the Medicare Advantage, so it's difficult to speak universally in the context of what would just be Medicare Advantage.

You have private fee-for-service products. You have Medicare HMO products. You have Medicare PPO products. The ramifications for you as a rural health clinic, really depend on the type of product that the patient is presenting with.

If it's a Medicare fee-for-service, the Medicare Advantage private fee-for-service product, and your non-contracted, then the plan is obligated to pay you your rural health clinic rates.

That also a technical include cost settlement for that service. If there are PPOs, they are required to base it on your RHC rate but only pay you the percentage for an out of network provider. If it's an HMO, you're exclusively out of network and there's no RHC requirement that I'm aware of.

So you're going to have to investigate what particular type of Medicare Advantage product it is that the patient is presenting with to know what your rights are.

Having said all that, if the patient is in a Medicare Advantage and you're not in network, I'm also not aware of anything that would preclude you from seeking to collect from that patient what you feel you're owed in terms of (balance) billing.

That may discourage a patient from ever coming back to you which is perhaps what the plan once. But because you're not contracted, I'm not aware of anything that would prevent you from seeking to collect that from the patient because essentially you have no contractual obligation to that plan.

Nathan: Okay, so the next question is on telehealth. It's pretty straightforward, so Bill, you could probably answer this. She wants to know what defines - (Donna) wants to know what defines where the patient is located and where the provider is located?

Bill Finerfrock: Well, you're - where the patient is located is going to be referred to as the originating site. And so that is typically - there are certain sites that are deemed eligible by Medicare as originating sites and rural health clinics is a statutorily recognized originating sites. The site where the provider is located is what's referred to as the delivery sites. And that...

Bill Finerfrock: Or the distant site. And they can literally be wherever that provider is at the time that he or she is providing that service. So if you're in Idaho and you're in rural Idaho and the distant site is in Boise, the Boise - the provider in Boise will bill Medicare as though that patient had visited his or her practice in Boise and the RHC in rural Idaho would bill is the originating site.

I mean, that would be the case for Medicare wherever you may be. Now, you're going to run into - you're going to typically want the distance site to be in the same state where you're located as the originating provider because it gets into the state laws and other issues.

But the originating site is the RHC where the patient is physically located. The distant site is where the provider is located. And you, as an RHC, bill for an originating fee which is, as we said, \$25 or \$26. I'm going to jump down to some folks who haven't asked some questions. (Byron Bershard).

Nathan: (Byron) asked we had one of our clinics accredited in order to speed the RHC certification with the Florida Medicaid agency. However, we are required to produce a tie-in letter from CMS.

It's been very difficult obtaining the required tie-in letter and the representative at CMS in Atlanta has been very slow in her response and has - and the response has been very slow. Does anyone have any suggestions for (Bryon)?

(Mark Lynn): Yes, this is (Mark Lynn). I've got a lot of experience in the Atlanta market and working with the Atlanta folks. And it's been amazing how fast those guys have been lately. I've been getting tie-in notices within seven days to ten days of the inspections here lately.

So I'm not sure what's going on, if the accreditation organization has not sent over everything they need to. If he wants to email me, I know typically if you email (Alana Dennis), who's the original director over there, you know, she makes sure that those folks take care of their business pretty quickly.

So we've not been having any issues in Atlanta whatsoever. So, you know, Atlanta will usually take care of it for you. If you want to email me, email me and I'll get some contacts working on it. I'd be glad to help you.

Bill Finerfrock: And that's (Mark Lynn). His email is up on the screen. You can pull it down from there.

Man: Okay, the next question is from (Theresa Kennedy) who asks, can you bill the patient directly for a DME if they choose to pay for it instead of having to drive very, very far from a DME vendor? I think this is a follow-up from earlier.

Bill Finerfrock: (Marty)?

(Marty): I don't know what the tracking of that would be and can you sell it? I'm - I would recommend that you not just because I'm not sure what your regulatory obligations are for carrying inventory and some of those kinds of things.

Like I've said, we keep a few things and dispense them but they're not billed for it. So I would certainly look to maybe your state agency or - for further guidance on carrying DME within your facility or, as we mentioned earlier, talk to a DME facility and see if you couldn't find - makes some kind of partnership where they would provide stock and you could just have access quicker.

Bill: Yes, in general, I think Medicare takes a dim view if you bill the patient for something that Medicare would have covered.

(Marty): Exactly.

(Robin): And this is (Robin). In order to bill for DME to Medicare, you have to have a specific approval as a DME supplier. So you have to be credentialed to be able to bill for the DME.

Bill: Yes.

Nathan: We're going to jump to (Connie)'s question you asked, for diabetes and medical nutrition therapy, can diabetes educators employed by the (CAH) provide services in the RHC and bill for the services through the CAH and not the clinic?

Bill: I mean, it sounds like you're getting into a carve out situation where you're bringing the diabetes - or the diabetes medical nutrition therapy individual into the RHC space but you want to bill it as a (CAH) outpatient service which you're going to run into - earlier you heard some references made to double billing.

Essentially you, in all likelihood, captured that space on your RHC cost report, then to turn around and bill Medicare for that service, even though that's not an RHC provider, part of the payment for that service through the other means, assumes that there was an office and overhead included.

So you, in essence would be getting double billing. So you're really going to run into a carve out situation which could create a lot of administrative and costs reporting challenges. So I'm not sure that you necessarily want to do that.

Nathan: All right, unfortunately, that has to be our last question. We're running over time and the Webinar will abruptly end, so I think we should jump to the wrap up. Bill, you have anything to close it out?

Bill Finerfrock: Just, last one, I want to thank, again, all of our consultants who participated today - (Mark), (Steve), (Robin), (Julie), (Sara) and (Marty), and I think (Glen) had some technical difficulties but he is willing to help out.

You have their contact information on your screen if you want to reach out to them, if there was a question you wanted to follow up with or answer that you didn't necessarily get clear that you wanted to take care of.

So thank you everyone for your time today. Please, for those of you who are participating, encourage others who may be interested, to register for their RHC technical assistance series.

We welcome you to email your thoughts and suggestions on future topics to Info - that's I-N-F-O, at, N-A-R-H-C.org and put RHC TA topic in the subject line. We'll be having another call in about a month or so.

We'll announce that and the topic as soon as we decide - we finalize that. Again, thanks everyone for participating. Thanks to the Federal Office of Rural Health Policy for supporting this project. And thanks to all of our consultants who took time out of their busy schedules to answer your questions. Thanks everyone and we'll talk to you soon. Have a great day.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

END