

CAPITOL ASSOCIATES

Moderator: Bill Finerfrock
September 9, 2010
1:00 pm CT

Operator: Good day and welcome to today's Rural Health Clinic's technical assistance national teleconference, ask the experts, our HC consultants answer your questions. As a reminder this call is being recorded.

If you do have a question at any time, please press star 1 on your touchtone telephone. If you are using a speakerphone, please make sure that you're mute function is turned off to allow your signal to reach our equipment. A voice prompt on your phone line will indicate when your line is open to ask a question and please state your name and your city and state location when you ask your question. Once again, that is star 1 if you'd like to ask a question.

And at this time, I would like to turn the conference over to your host, Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, Operator and I appreciate everyone joining us today for this different kind of Rural Health Clinic technical assistance call.

For those of you who participated in the past, you know our usual format is to have a speaker and then take questions on that topic at the end. This based on a lot of the traffic on the Rural Health

Clinic list serve and others, we thought maybe this would be an opportunity to give an open mic night or open mic day if you will.

As I said, I'm Bill Finerfrock, and I'm the Executive Director of the National Association of Rural Health Clinic's and I'll be the moderator for today's call. Joining us today on the call as our experts are some RHC billing, coding, cost reporting and survey and certification folks who've been involved in this field for a long time.

We have (Jeff Johnson) who is with (Wipfli) CPAs and Consultants, Ron Nelson with Health Service Associates, (Barry Martin) with MRT Consulting, Charles James with North American Health Care Management, Glen Beussink with Midwest Health Care and Jim Estes with Health Care Horizons.

As I said, this will be an open line opportunity. We do have some questions that were submitted ahead of time. And we'll alternate back and forth between those that you have when you get in the queue and those that were submitted ahead of time. This series is sponsored by the Health Resources and Services Administrations, Federal Office of Rural Health Policy and in conjunction with 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 36th call in the series which began in late 2004. During that time, over 9,000 individuals have participated on this national teleconference series. As you know, there is no charge to participate. We encourage you to refer others who might benefit from this series to sign up to receive announcements regarding call dates, topics and presentations.

If you want information you can go to www.ruralhealth.hrsa.gov/rhc. We do ask that when your line is open and you ask your question that you identify yourself with your name, your city and state that you're calling from before asking your question. So without further ado, we'd like to

begin this process and I'll start off so that you can now get folks have an opportunity to get in the queue to ask your questions.

One of the questions was submitted ahead of time. This comes from (Shannon Stickford). (Shannon) asks "Are provider based RHCs a facility for purposes of secondary billing?" How would you guys like to answer that?

Male: An RHC for the purpose of provider based you know I don't think for the secondary claims that they're most likely going to recognize it as a facility and I had seen the question before the session and it went on to ask about billing these claims on an UB versus the 1500 and they're getting rejections, et cetera.

Unfortunately I think it's going to come down to each individual payer. I don't think there's – you know for example some payers are not going to take the secondary claim on an UB. Some payers will indeed say it's a non covered service as a facility; they're not going to pay the client.

Bill Finerfrock: In this case they went on – they described a situation they said daily we deal with problems of rejected claims. Our contract with the – when we bill a physician claim, because our Medicare EOB is a facility format, our contract with the other payers is as a physician so we bill as a physician. Doesn't the outpatient prospective payment guidelines classify as a part B physician service? These claims are only processed by a part A intermediary.

Charles James: I have to pass on the (PPS).

Bill Finerfrock: OK, anybody else want to take and also if you guys would identify yourselves, that was Charles James with North American. Any of you other folks want to take a crack at it? They go on to say, "We've heard of a few providers that bill the secondary claims in an UB institutional format with the HIPPA RHC code and then the patient has high out of pocket costs for non

covered services. (Others bill as a position) and deal with the very problems of the secondary confused with a physician claim with an institutional EOB. Is there a right and a wrong way legally?"

Charles James: This is still Charles. I just go on to amend my statement, I think the problem with the way the question is phrased and the issue that creates a lot of confusion is that even though we're Rural Health Clinic's, the mechanism is all part A facility it's really to the patients it's still a part B ...

Bill Finerfrock: Right.

Charles James: ... claim. So you know that's going to go to their part B deductible or coinsurance. So you know while I can't answer the legality of the outpatient perspective payment system you know I think the confusion that where part A with a part B label slapped on it and it does create a lot of confusion. So where we've had to deal with this we'd call up the payer and say hey you may not like the remit like it is, but at the end of the day Medicare says this is the amount of the deductible or this amount of the coinsurance and here it is on the remit. What are your requirements for the claim?

Bill Finerfrock: OK, anybody else want to ...

(Jeff Johnson): Yes, this is (Jeff Johnson) from (Wipfli). And I think the question was intended to be all encompassing. And essentially my presumption here is that we have a Rural Health Clinic that is provider based to a (PTS) hospital, in other words, not a critical access hospital, but a hospital that gets paid on APC services for outpatient claims and so forth.

But that doesn't really apply in this situation because the Rural Health Clinic itself is a different type of entity or provider based entity to the hospital. And that in my opinion how I would treat

that is – is that those secondary, just like Charles said, I agree with Charles, that the secondary claims are case-by-case basis depending on the payer.

But certainly you want to either if the – if the secondary claim accepts the UB great, if not what I've seen other Rural Health Clinic's do or what other clinics do is they'll just provide that service as a place of service code 11 if you will on a 1500 form and run it through part B to get the cross over or whatever the case may be.

Bill Finerfrock: OK, all right. Operator? Anybody else what to contribute or add in on that? If not, we'll move onto our first question from the callers. OK operator, you want to take our first question?

Operator: As a reminder that is star 1 if you have a question. And we'll take our first question, caller please go ahead.

(Janie Elliot): I think that's me, this is (Janie Elliot) and I was just responding to that – to the issue of the Secondaries. What has happened is WPS which happens to be my intermediary forwards those in the EB format. What I'm hearing from my insurance companies is that they won't accept it that way, so I just automatically drop my claim as a 1500 and attach my EOB, my Medicare EOB and send it to the individual companies and it gets paid.

Bill Finerfrock: And (Janie), where are you located?

(Janie Elliot): In Harrisville, Missouri.

Male: That's precisely what we see happen the most commonly.

(Janie Elliot): And a lot of these problems started when I think it was in October of last year when Medicare started forwarding all of our secondary claims just automatically, which they've stopped

now, but that's beside the point. And then you know my Coventry and my Blue Cross and Blue Shield started rejecting them, saying no this is a facility because it came in on an UB format.

Male: Right.

(Janie Elliot): So I just drop it to a 1500 and mail it.

Male: That's a good approach.

Bill Finerfrock: (Janie), did you have a question or you just wanted to add to the conversation?

(Janie Elliot): No actually I do have a question and my question is involving labs that are done in a provider based clinic. We did a quick view influenza, a quick wave test in the clinic; the patient was then referred to the hospital for a state CBC. So my claim went in on one form for my quick view influenza, then the hospital billed us a CBC and chem panel on a separate claim form.

Now they're editing out. Is there a condition code or something that I can add to my lab so that it will – it will tell them that it was done in two separate places? Because it's provider based, they're both being billed under the same provider number.

(Jeff Johnson): So if I can understand the question correctly, this is (Jeff) again. The lab service was not billed on the RHC bill type but billed on the ...

(Janie Elliot): Hospital provider number, yes.

(Jeff Johnson): OK, critical access or?

(Janie Elliot): Yes.

(Jeff Johnson): CPS?

(Janie Elliot): Critical access.

(Jeff Johnson): OK, so that lab service along with the other lab service should be all billed on the same claim form an 851 bill type and you should get cost reimbursement for that.

(Janie Elliot): But there's no way to get them on the same claim form because we bill our Rural Health Clinic Services through a separate billing service.

(Jeff Johnson): Right ...

(Janie Elliot): Through a separate billing ...

(Jeff Johnson): What needs to happen is those lab services need to be – I don't – if you have a separate practice management system that you're billing...

(Janie Elliot): Right.

(Jeff Johnson): ... the Rural Health Clinic Services from, what needs to happen is those labs need to basically somehow be taken off your practice management system and added to the hospital practice.

(Janie Elliot): And added to the hospital, OK.

(Jeff Johnson): Yes.

(Janie Elliot): OK, so otherwise if I can't get that done then it is appropriate that I just write the lab off in the Rural Health Clinic right?

(Jeff Johnson): Well I wouldn't write the lab off, I would make sure you can get the service billed on the hospital ...

(Janie Elliot): Well I'm going – I'm going to do my best to figure out a process, but I'm talking about a 30 mile – I mean a 30 mile difference from my critical access hospital and so sometimes the communication piece is hard.

(Jeff Johnson): Right.

(Janie Elliot): So OK then that's what I needed to know.

(Jeff Johnson): No problem.

(Janie Elliot): Thank you.

Bill Finerfrock: Thanks (Janie). Our next question comes from and I apologize if I don't produce the name correctly, (Joy Awer). (Joy) writes, "Please clarify. Other than the IPPE visit, if a patient is being seen in a RHC for preventative care only and having a routine pap and a breast exam, where it has been 2 years since her previous exam, is the visit considered a billable RHC encounter? We've been advised that preventative care is considered a billable RHC encounter, is this correct?"

Charles James: Yes, if it's within the – this is Charles – within the, you know, (buy any old) pap then basically the professional piece is going to go as a RHC encounter and any of the technical

components are going to go fee for service. But if it's according to Medicare's preventative services schedule, then yes that should be an encounter.

Bill Finerfrock: So those would be qualified as a face-to-face encounter presuming they use what they cover a recognized provider and a medically necessary service.

Charles James: Correct.

Bill Finerfrock: OK, anybody else want to add to that or – anymore? OK.

Male: I might add that there's a really resource that CMS has put out the last few years, it's called the – I might get the name wrong, but it's on CMS's Web site, the Medicare Guide to Preventative Services. And it has a lot of great information on there for those preventative covered Medicare services. It even tells you how to bill it if you're a PPS hospital a physicians you know just a regular clinic, an independent Rural Health Clinic or a provider based Rural Health Clinic.

Bill Finerfrock: OK, all right, we'll see if we can't get a link to that and if we can we'll put it out on the list serve. Operator, we'll take our next question from the callers.

Operator: Caller, please go ahead.

(Betsy): Yes, our question is that we ...

Bill Finerfrock: Give a name and where you're calling from.

(Betsy): (Betsy) from Florida and ...

Bill Finerfrock: OK, go ahead.

(Betsy): And we're at the Rural Health Clinic and we have nursing home patients in an adjacent county.

Are we allowed to bill those through our Rural Health Clinic which is in an adjacent county?

Jim Estes: This is Jim Estes with Healthcare Horizons. I have a lot of clients that do that and I'm not aware of any issue with the clinic, as long as you're billing them through a clinic, which is in a shortage area and is a Rural Health Clinic. The patient's location could be in another county, in fact I know of some that are in a larger city that they are able to provide those services.

But this was several years ago I got clarification from what was then (Riverbend) and the patient's address is not really an issue. It's the location of the clinic through which the services are being provided.

Bill Finerfrock: But the individual's in that nursing home have to be Rural Health Clinic's patients? In other words ...

Jim Estes: That doesn't ((inaudible)) ...

Bill Finerfrock: I mean how do they – how do they document that that's an RHC patient as opposed to somebody that they've gone and said hey we'd really like to get a higher reimbursement rate we want you to come in and see our patients get them covered as Rural Health Clinic patients?

Jim Estes: Well the Rural Health Clinic patient establishment is basically opening a chart on that patient, so you would have a medical chart with documentation to support the services provided to that patient in the nursing home that were billed as a Rural Health encounter.

So any time a billing goes out from that clinic, you better have documentation to show that it was medically necessary and that it was a patient of the clinic and that services were provided by a

medical provider who is on the staff of the Rural Health Clinic. In other words, they're in the cost report. They're cost is there in the Rural Health Clinic cost report.

Bill Finerfrock: All right.

Glen Beussink: Bill?

(Betsy): Thank you very much.

Bill Finerfrock: Yes, go ahead ...

Male: Can I add something to that? It's Glen.

Bill Finerfrock: Go ahead Glen.

Glen Beussink: I think a key thing about nursing homes that we need to remember is exactly what Jim said. A lot of doctors go to the nursing home, see a patient and the chart remains at the nursing home. That will not work in a Rural Health Clinic. They'll have to have a chart in the Rural Health Clinic to establish that patient as a nursing home patient. So they actually have to have a duplicate chart.

The other thing is remember that that nursing home must be located in a health professional shortage area because in Florida for instance you may have a Rural Health Clinic attached to an urban area that's not a (HIPSA) and it is my understanding that the nursing home must be located in health professional shortage area no different than the person's place of residency would have to be in a health professional shortage area. There's something in the regs somewhere but I have ...

Male: I believe that, Jim, you would take issue that.

Ron Nelson: This is Ron Nelson responding.

Bill Finerfrock: OK Ron, go ahead.

Ron Nelson: I disagree. There's nothing in the regs that show that's there a requirement of the resident's of the nursing home patient has to be in a (HIPSA), it doesn't exist in the regs. The test is still what Jim pointed out which is, is there evidence of a record in Rural Health Clinic? Is it performed by a Rural Health Clinic provider? And is it medically necessary?

And the fact that the nursing home may be in another county as long as that's a patient of the Rural Health Clinic that exists and is in a HIPSA, there's no requirement for a residency relative to nursing home patients.

Bill Finerfrock: OK, I want to point out here that you know much of this for things there's not always a clear black and white piece of paper that says what is or is not correct. And one of the reasons we wanted to have a number of different consultants is that there are differences of opinion at times on how one may choose to interpret or what a policy may say.

And the answer is that folks here are offering are based on their experience with the program. I realize that as an audience that sometimes may create some ambiguity, but unfortunately that's the nature of the world that we all have to operate in, is that we don't always have a clear black and white answer.

So, where there are disagreements between how one consultant may view an issue versus another doesn't mean one's right or one's wrong necessarily. It may be their interpretation. You

as an audience you know listen to what they say and what seems to make sense. But you know hopefully there is not a whole lot of disagreement at the time.

But it's not unusual or uncommon for there to be disagreements. We'll take the next call or the next question that was submitted. My question is regarding an MSP, Medicare secondary. As a provider based RHC, are we to file our MSP claims through our part A intermediary or to part B? Should we be filing these electronically or by paper?

I think this is an add-on to the discussion we had on the first question. But who'd like to jump in on this one? Anybody? I'll start picking people.

(Jeff Johnson): Well this is (Jeff), (Jeff Johnson). And I would agree that this is kind of the initial question. But essentially that if you know if they cross it over, great. If they don't then you have to draw up a claim on a 1500 type form.

Bill Finerfrock: OK. All right, why don't we take another one from the pre-submitted? When a nursing home resident has – well this is actually similar to the discussion we just had. But would a nursing home resident have to have been a patient of the RHC prior to being admitted to the nursing home to be considered and RHC visit?

And I don't know that we specifically got into that aspect of it. I think it was discussed and they have to be an RHC patient but that relationship, can that be established post nursing home admission or is that something that would have to have been established prior to the individual being in the nursing home?

Jim Estes: This is Jim Estes again. I'll come back to my answer that I gave previously. I don't see anywhere in the rules where it says they have to be physically present in the Rural Health Clinic to be established as a patient. And one of the rationales behind that that I use is many, many

times, and in your own case it may be relatives that face this. They are in the hospital then they go to a skilled bed for a certain number of days.

If they don't progress as well as they thought they would so they end up going to a long term care and then they're there until they pass on. They're never physically able to even leave a care setting to come to the clinic. So it's ludicrous to say they're required to actually be wheeled into the clinic so they're physically present.

One of the three locations you can provide services are the patients place of residence, a nursing facility, or in the Rural Health Clinic. So having services provided in any of those locations as long as you have the documentation in the charts that's retained in the clinic would establish you as a patient in the Rural Health Clinic.

Bill Finerfrock: OK.

(Jeff Johnson): I would agree. This is (Jeff). I would agree with that and also I just want to make sure that everyone's very clear that a swing bed is considered a skilled nursing facility care. And it is also a Rural Health Clinic visit. So for your critical access hospitals out there, make sure that you're billing that as such.

Bill Finerfrock: Just to clarify now, when you refer to a swing bed I suspect most people, but a swing bed can either be a hospital in patient bed or a nursing home bed. What you're referring to is when that bed is classified as a nursing home bed, not an acute in patient bed.

(Jeff Johnson): Correct. That would be a transitional care bed or a skilled nursing bed in a – that may be the physically same you know really actually the physical same bed as the hospital bed. But it's actually from an admission standpoint they're actually discharged as an inpatient and then admitted as a swing bed patient.

Bill Finerfrock: Right, OK, just to further clarify that. Operator we'll take our next call, call in.

Operator: As a reminder, that is star 1 if you have a question and please state your name and city and state location before posing your question. We'll take our next caller. Please go ahead.

(Mary Peterson): Hi my name is (Mary Peterson) calling from (Mile Bluff Clinic) in Mauston, Wisconsin. And I have a question regarding the Medicaid stimulus. We have been talking with our state of Wisconsin and our medical society, and they cautioned us that the Medicaid stimulus is only for Medicaid Title 19 patients.

And in questioning further they said it would not be for Title 21 patients, which in the state of Wisconsin we believe is the Well Women's program. So, I guess in reading I have not ever seen anything differentiated that it would not be all of our Medicaid patients no matter what title they may be under.

Bill Finerfrock: I'm not aware of anything from the federal government that suggests that there would be a differentiation between the type of Medicaid patient. If an individual is classified as a Medicaid patient whether it be the differentiation you've made, but they're classified as a Medicaid patient, that they would be counted for purposes of meeting your 30% threshold.

(Mary Peterson): Well this just came up today.

Bill Finerfrock: I'm sorry?

(Mary Peterson): This just came up today. And you know when we look up eligibility you don't even see what title they may be under. You just see eligible, yes or no.

Bill Finerfrock: Yes. Stay for some documentation on that.

(Jeff Johnson): Hey (Mary), this is (Jeff). Just a quick thing. That's not uncommon for several states to have some kind of a state program that sometimes gets confused as a Medicaid patient when it truly isn't. So that's just something specific that you're going to have to address with the state of Wisconsin.

Bill Finerfrock: (Jeff) are you saying that these patients that (Mary) identified are not Medicaid patients?

(Jeff Johnson): They may not be construed as Medicaid patients for purposes of counting you know to meet the 30% I think it is threshold or whatever.

Bill Finerfrock: Why are they not a Medicaid – well they're either a Medicaid patient or they're not.

(Mary Peterson): Like they have Medicaid limited benefits.

Ron Nelson: Well this is Ron. Part of the problem and having had experience particularly in that state is that the state does have some latitude in interpretation of those programs and unless the statute is specific, what we see is the states will say OK, it's only Title 19 because the statute doesn't say specifically you know.

And so the question will be whether CMS says no, it is all Medicaid, Title 19 and 21 or CMS says well it's not clear in the legislation so it's up to the state. And their state plan is what governs how they apply this. At least that's generally been the response that we get from a state level.

Bill Finerfrock: Well we'll look into that (Mary) and we'll try and get an answer and when we get an answer we'll post it on the list serve.

(Mary Peterson): OK, thanks a lot.

Bill Finerfrock: OK. We'll take another question from the phone lines. Operator?

Operator: Caller, your line is open. Please go ahead. Caller your line is open to ask a question. Please un-mute your phone.

(Linda Whit): There you go. Hi, this is (Linda Whit) in Sioux City Iowa. And I'm not sure if anybody else has had a problem, but we've had a problem with patients' Medicare secondary payer records getting updated on the common working file.

And I was just wondering if anybody has a solution as far as getting updates made. When we've called they've not been able to take our information and they indicate that the patient or a person who is responsible for the patient has to call with the information. And sometimes that's just not possible. Does anybody have any ideas on how to resolve that?

Charles James: From our experience – this is Charles again. It is indeed the patient or the patient's representative that's got to do that, unless anyone has any differing guidance?

(Linda Whit): OK. I've even had to contact, had the patient contact their state representative because they've called and called and not been able to get it updates. And finally when the state representative calls things happen. But I'm just wondering if there is an easier work around? It is confusing and hard to get in for the patient to speak to someone who can explain things to them.

Bill Finerfrock: I feel your pain.

Charles James: Ditto.

(Linda Whit): All right, well thank you.

Bill Finerfrock: OK, all right. Thank you (Linda). All right this was a pre-submitted question. "If a patient is a Medicare or a Medicaid patient, the patient has a 90 day global surgery and then is seen back in the Rural Health Clinic for post op which the surgeon is in the RHC clinic who performed the surgery but is having post op seroma or infection or just a suture removal, can the visit be billed as an encounter rate or is it billed as a 99024 post op or should a modifier always be put on the procedure code?"

I've had people say to put the modifier on than all HRC encounters are billed out. But if you don't use the modifier then you have to follow global rules. What's the correct way to bill this? This comes from (Coretta Corrigan) and she says, "I always thought that any face to face visit in RHC by the physician is always billed out as an encounter rate. Please help me with this issue."

This issue of the global billing and surgery and RHC's is one that comes up fairly frequently. Who wants to jump in?

Ron Nelson: This is Ron. I'd like to comment because we have a CMS official who did comment on the list serve about this very specific issue about 2 months ago. And she clarified that the surgeon has to correctly code for what they are doing.

If the surgeon knows and is employed in the Rural Health Clinic that they will be doing the follow up visits in the Rural Health Clinic, they should be coding for the surgery only. And then the visits are ad fact coded based on the RHC face to face encounter.

And I think that has been clarified. It still doesn't take away the confusion people have between CPT and RHC policy. But you know regardless of whether the patient has a seroma which is a complication of surgery or its routine follow up, those visits in the RHC should be billed as RHC

visits but that surgery should have been billed with the modifier code for surgery only. Now that doesn't take into account if the surgeon did provide the care, the surgical care in the hospital and then subsequently a patient has a complication and goes to an RHC that's unrelated then those are visits that are also billed as RHC visits and not affected by the global CPT rules.

Charles James: Can I just this is Charles again can I ...

Male: Charles just let me before you go and then I'll let you. So there are two questions if I heard it correctly. One is how did the original surgeon bill for the surgery? Was it billed surgery only or global, because when they bill global the expectation is there's a certain amount of post-operative care that has been paid to that surgeon through that global fee and to pay for the RHC if that physician is affiliated with the RHC would essentially constitute double payment.

Male: Exactly.

Male: And the other issue is whether or not that surgeon is affiliated with the RHC or not. If they're not affiliated with the RHC then the RHC doing post-operative care would not be held to, would receive payment regardless of whether or not the surgeon billed globally or not because they are not affiliated with that surgeon. Whereas if the RHC is affiliated with the surgeon and they billed global there would be no post-operative visits allowed at RHC counters because they have all ready been paid for that.

Male: That's my interpretation and what we received from CMS.

Male: Charles you wanted to add on that?

Charles James: The only thing I was going to add is that I think what I found problematic in the question was the blanket statement that qualified provider sees that patient and the RHC it's an RHC visit.

It's certainly in general terms correct but it has to be medically necessary as we have all ready talked about a lot and it has to warrant that skills of that provider. So, so you know a suture removal, if there's no other exasperating problems, does not really warrant the skills of the provider previously.

Male: So even when it's done by a physician it's not classified as a face to face encounter because it's not medically necessary for the physician to remove those sutures and therefore does not meet the test of an encounter.

Male: You know in the days of Riverbend they would say, they specifically excluded in there LCD suture removal as not medically necessary. And their response always seemed to be if there's a particular reason that that patient needed the skills of the doc, maybe it was a particularly bad wound it got infected, etc cetera, etc cetera. Then make sure it's documented.

Male: OK. All right well great thanks. We'll take a question from the callers.

Operator: Caller, please go ahead. Your line is open.

(Janie Elliot): Yes, this is (Janie Elliot) again. And I think we need to re-visit the question about MSP's because that it's two different issues. The first issue that we talked about was Medicare secondary payment due – Medicare paid primary, then we had to get our secondary payment our patients co-pay or co-insurance or deductible. MSP's are when Medicare is primary, I mean Medicare is secondary. So we've built commercial insurance as primary now we have to get our co-insurance, co-pay to Medicare that is a totally different issue.

And I think that question is asking about MSP's and I specifically have talked to WPS and they say that they do not pay a Medicare secondary pay or claim as a real ((inaudible)) clinic encounter.

Male: They are going to pick up whatever the co-insurance is.

(Janie Elliot): That's correct and that's it. And they will not accept it any way but electronically. You have to get it to them electronically first.

Male: Which also excludes DDE you can't do it on DDE anymore.

(Janie Elliot): Exactly yes. But I think we just needed to make that clear because I am pretty sure that's where the question came from.

Male: Which takes it back to your practice management system and making sure I'm going making an assumption that people are submitting antsy claims in a 50/10 format to, for their UB's and the institutional. And that whatever your practice managements systems is needs to be able to populate the correct fields for the condition code etc cetera to pass that MSP claim and obviously the clearing house takes it to. So there are a number of places that claim can easily fall off starting with the practice management system.

(Janie Elliot): Right.

Male: OK. Thank you (Janie) for pointing out that distinction and getting that clarification. We'll take another call from the callers, operator.

Operator: Caller, please go ahead. Caller your line is open please go ahead.

(Michelle): Can you hear me?

Male: Yes speak up just a little bit but we can hear you.

(Michelle): OK this is (Michelle) from Lake City I have two or three questions so do you want me just to ask one and then go back into queue?

Male: No you can go ahead if they are not too long. Where is Lake City?

(Michelle): In Florida. OK first question is we are an RHC clinic and if we see the child here and then we admit them on the same day. We can't bill and get paid for it, is there some way around or is that just the way it is? Second question is concerning the wrap around payments because we're still not receiving any of those and I'm wondering if there is something we need – OK.

Third, on the third question is the stimulus package for going to EMR has anyone actually received any money from that program yet? Because we are wanting to do that but we are wanting to see that they are actually paying out also.

Male: Who wants to take, well I wanted to try and break them down because I think we are going to forget. What the first question – go back ask your first question again.

(Michelle): OK if we see the child here at the RHC clinic and we admit them to the hospital when we bill for that, if they are admitted the same day we do not get paid for it. Is there something that we can do so that we actually get billed or we can get paid for seeing them in here at the clinic?

Male: And I'm going to assume that as a child it's probably Medicaid we're not dealing with a disabled child that is covered by Medicare?

(Michelle): It is Medicaid yes.

Male: OK. Anybody want to take a crack at a Florida Medicaid?

Male: Only that Florida Medicaid does whatever Florida Medicaid wants to. They tend to be non-compliant in terms of the RHC program. And I think there is adequate argument been made previously by the largest previous FI of the Rural Health Clinics program. And there's adequate argument is some appeals documents that I've recently reviewed. That if there's documentation of service being provided in a Rural Health Clinic and service being provided in a Part B facility like in the hospital, that even as Medicaid they are required to pay two payments.

However CMS tends to defer to whatever the state put in their plan. And if they say in their plan that they were only going to pay for one visit, until we get some interpretation on this issue which we have asked from CMS I think you're probably at the mercy of the Florida Medicaid program with this and will only get paid one visit.

Male: OK. (Michelle), your next question? Did we lose (Michelle)?

(Michelle): Can you hear me?

Male: Yes.

Male: Up around ...

Male: Yes we can hear you now.

(Michelle): The wrap around payment, we're still not receiving those and they keep saying they broke it down into a project for 2009 and then 2010, anybody heard anything, receiving any of these payments, know what's going on?

Male: Are you talking about wrap-arounds from you're Medicaid managed care to your rate?

(Michelle): Yes.

Male: What wrap around payment do you mean?

(Crosstalk)

Male: So you have a Medicaid managed contract and the amount that you're being paid under that contract is less than what you would have gotten under your RHC all inclusive rate or PPS rate.

(Michelle): Right.

Male: The state has not paid you your quarterly wrap around payments to make you whole.

(Michelle): Correct.

Male: And is that unique to you or is that all providers in Florida and have other – I don't know if any of you or our consultants work with clinics in Florida or is that a universal problem in Florida or is that something that maybe unique to their clinic?

Male: Getting correct payments on (Ferrill House) in Florida is problematic across the spectrum.

Male: OK and this is from ((inaudible)) I agree with them, we – and his problem is that Florida pays on a fixed rate to most clinics. And so then when the managed care Medicaid started to come back into Florida it raised huge issues for reconciling as Charles pointed out.

It's just problematic and Florida tends to pretty much ignore and do what Florida wants to do.

Male: OK

Male: But they should ...

Male: So if you would send me – just a second (Glen) – if you would send me an e-mail at info@narhc.org we can make some inquiries to CMS see if they're aware that Florida may not be complying. Clearly they're required to make those payments if they're not and see if we can't – I'm not – don't want to be overly optimistic but we can at least see if we can get CMS to try and force the state to be compliant.

(Michelle): OK and your (Jeff) ...

Male: (Glen) if you – (Glen) you wanted to add something?

Glen Beussink: No I ((inaudible))

Male: ((Inaudible)).

(Jeff Johnson): This is (Jeff Johnson), I'm sorry. Just that from a matter of perspective, that's not uncommon in several other states and in fact in the state of Minnesota which is where I reside. One of the avenues they took is they – the Rural Health Clinics partnered with the FQHC's which tend to have for one reason or another a large lobbying or at least have a little more – somewhere along the way at least in the state of Minnesota a little weight, because of the urban presence. And they have the same issue so it might be just the lawsuit type of thing, where you just need to kind of address it from that perspective.

Male: And then (Michelle) your last question had to do, I believe with incentive payments?

(Michelle): The question – what's your name?

Bill Finerfrock: This is Bill.

(Michelle): And you're the – sent me the e-mail address for info@nhrc.org right?

(Bill): Info@narhc.org correct.

(Michelle): RHC, OK just wanted to make sure. OK yes the last was about the EMR and has anyone actually received payments from those as an incentive?

Male: No they – well there were two – there's two components, states are authorized to begin making payments in 2010 for the adoption implementation, or upgrading of an EHR.

Those on a voluntary basis, the actual meaningful use incentive payments don't begin until 2011, and cash from that won't begin to flow until later in the year. Providers will have to demonstrate they're meaningful use of the electronic health record that they already – that they have and they will have to meet those objectives and measures within those objectives.

And it will take – they're going to have to take 90 to 120 days to be able to demonstrate that they can meet those meaningful – to provide the data to justify meaningful use. So we won't see any incentive money for EHR flowing until later of the second half or fourth quarter of 2011.

(Michelle): OK.

Male: Keep in mind that, that is you know for us as Rural Health Clinics the federal incentive is based on Medicare fee for service payments. So we're all going to be firmly in the state Medicaid incentive plan to get anything out of it.

Male: Right.

(Michelle): OK so we'll be state level not federal?

Male: Right but the states will administer the program but just the money for the Medicaid incentives is a direct pass through from the federal government. So it is not something that should be – that the state should be able to either siphon off or prohibit clinics who meet the criteria from receiving those. It's not a state budgetary issue, since that money is a direct pass through from the federal government.

(Michelle): OK now are there any exceptions relating to pediatric clinics or is just clinics in as a whole?

Male: The only exception with the pediatrics is some of the threshold levels; you can get a reduced payment, lower threshold on a 20% threshold as opposed to 30% threshold. And then you only get 2/3 of the financial incentive that's available for pediatricians but other than that they're health is the same standard as everybody else.

Male: All right, we'll take – I'll take another pre-submitted question – "I have OBGYN physician in one of my clinics and she'll do procedures in the office, (colposcopies), or removal of IUD's and this is also a Florida Medicaid. Some things that are 'billable' but what about Medicare? How do we get paid for some things with them or is some of this in the cost reporting?" Anyone?

Ron Nelson: This is Ron you know OBGYN physicians practice's can be established as for health clinics because they're considered also part of primary care. The problem is that they tend to do some procedures in their offices pointed out in the question that can be more expensive and in fact tend to be difficult to billing get paid for.

And some of the states they allow for a separate billing fee for service for those larger procedures that might include things like family planning with double ((inaudible)) injections, colposcopy, IUD insertions, and they cover them separately under also.

In some cases under a women's health program such as – referred to as I think is Title 21 in Wisconsin, the problem is if it's an independent Rural Health Clinic, you have to waive the rate, the cap rate that you have for your Medicaid services against the cost of doing these services that are going to be in your costs.

If your costs far exceed the cap you may want to reevaluate doing those services on Medicaid patients in your office, if there's a proximity to an out-patient hospital facility. One might try and do some of those within the hospital facility to help reduce you know some of the costs and the potential loss on the Medicaid side.

Male: OK.

Male: We'll take another caller operator.

Operator: Caller, your line is open please go ahead. Caller, we are unable to hear you if you're on mute please ...

Female: Hello?

Male: Go ahead, caller.

(Shannon): Hi this is (Shannon) again from Wayne Medical Center, Piedmont, Missouri. I want to open back up the MSP because I heard a question arise and I need clarification on. One the response was that Medicare and Medicaid secondary claims should be billed to WPS in the state of

Missouri anyway on the Medicare side not to Cahaba. Am I understanding that response correctly? Because I was under the impression if it was in the Rural Health Clinic even though it was secondary Medicare it's still part of the (RXC) contract.

Charles James: I think that this – this Charles again, I think the confusion is that – and (Janie) can correct me if I'm wrong. I think (Janie) is provider based and they as a provider base RWPS is their intermediary.

(Shannon): OK.

Charles James: So they are provider based through a health clinic and they use WPS for their fee for service as well as their Rural Health Clinic claims. You being Cahaba if it's a Medicare as secondary payer that MSP after the commercial is paid is going to go to Cahaba.

(Shannon): Thank you for that clarification.

Charles James: Yes.

Bill Finerfrock: All right, we'll take another caller operator.

Operator: Caller, please go ahead.

(Betsy): Yes, this is (Betsy) from Bushnell, Florida and my question is, is there a possibility with a physician that does minor surgery in a rural area to carve out part of the Rural Health Clinic when there's no other patient there to do minor surgery.

Bill Finerfrock: That would occur within the building that is identified as a Rural Health Clinic.

(Betsy): The building is a Rural Health Clinic correct.

Bill Finerfrock: OK and you want to know if you can take a room and carve it out of the RHC cost report and provide procedures or surgery and bill those to Part B.

(Betsy): Correct and just only because there's nobody in the area that does these minor you know lesion removals those kinds of things.

Charles James: This is Charles I'm sorry if I'm talking too much and somebody tell me to shut up. I just gave a – when you put it on those terms that because there are no other providers in the area you – I think you have a solid basis to establish some non Rural Health Clinic hours and do that.

I just gave a presentation down in Texas and there was a guy from Trailblazers there who is – you know he keeps an ear to the ground. And he used the words to me this financial triage that when you're doing things because you get paid better under one scenario that CMS is going to start looking at that stuff so when your reasoning is that you know if there's nobody else in the area I think you're on firm footing. So maybe I'll let somebody else speak to taking just a room and carving that out.

(Jeff Johnson): Yes, this is (Jeff Johnson) from (Wipfli). I guess there is no prohibition of establishing a specialty clinic within a Rural Health Clinic as long as you can identify separately those costs.

And in your case set up an hours of operation; say if you're open 8:00 to 5:00 strictly and you want to establish this 2 or 3 days a week from 1:00 to 5:00 or something like that. As long as that is not fluctuating and as Charles put it triaging those patients for financial reward you will have no problem with an intermediary a cost report reviewer auditor in establishing that.

In fact what we have typically done is once we've established kind of what we want to do with this type of service line if you will we often identify exactly in a letter to the intermediary here's what we're going to do, here's the cost and there's not cost you know shifting one from a Rural Health Clinic to surgery or whatever just because of the reimbursement differences and so forth. And this is typically for independence more than provider based Rural Health Clinics. That has not been a problem at all and typically, they will sign off on that.

(Betsy): And your name is.

(Jeff Johnson): (Jeff Johnson) from (Wipfli).

Charles James: But it has to be the whole clinic right (Jeff)?

(Jeff Johnson): No, it does not have to be the whole clinic ...

Charles James: OK.

(Jeff Johnson): ... it can be as Bill kind of precluded or you know kind of prefaced it can be an area of the clinic that we identify as a – you may identify as a specialty clinic OK. And in fact, I would go that route more so Charles than just banking on the fact that you're the only caregiver in the area that does that service.

Bill Finerfrock: The other thing though that is important is you need to post that and it needs to be part of your posted hours ...

(Jeff Johnson): Correct.

Bill Finerfrock: ... saying that you have a specialty. For example, in my practice that's exactly what we do 8:00 to 10:00 every Thursday morning is for procedures. And that's non-RHC time and it's posted and that's important to also post those hours. But I agree also with (Jeff) and Charles it's certainly a methodology that can be done it's just that you need to make sure you have a good methodology that you can defend and demonstrate to your auditors.

(Jeff Johnson): And well documented.

Bill Finerfrock: And it also is not just the space but the staff how much of your staff time you know what is your administrative support staff obligation or work with regard to that specialty space or the specialty clinic? If you captured 100% of your staff time on your RHC cost report but yet those staff are responsible for doing administrative work for what's going under that specialty clinic then you would run into a problem there.

Because you're essentially going to be, double paid or you're double booking that administration. So it's not enough to just look at the physical space but look at all the other costs that may also have to be carved in association with what's going on in that space is that correct.

(Jeff Johnson): That is correct Bill that is correct.

Jim Estes: OK this is Jim I'm a little bit confused so I'm going to pose a question to the other guys. I thought on the cost report when it asked for non-RHC hours of operation on page 2 you define when you're an RHC and when you're not.

It is talking about the entire facility not just one room because then that effects the overall cost you're reducing all of your overhead in administrative cost middle section by whatever percentage of overall time you're not a Rural Health Clinic.

Otherwise, you're talking about a doctor walking out of one room where he's doing specialty work and then walking across the hall to his is regular Rural Health Clinic during hours of operation. I mean we don't have a distinction between Rural Health hours and non Rural Health hours for the whole building just a room that's what I heard is that you could have just one room that was non Rural Health during certain hours.

Ron Nelson: Jim this is Ron I believe that it has to do with the methodology and I do believe you have to post the hours that you in fact are operating as (Jeff) has referred to as specialty clinic or you're doing surgical procedures that that's non-RHC time. The issue of total facility and saying it's the total facility really is the methodology you need to determine to say OK it's for example in my office there's a surgical procedure room.

And we have developed a methodology to say what the cost are associated with the operation of that surgical procedure room from the hours of 8:00 to 10:00 on Thursday, which makes it non-RHC during that time and those costs are appropriately all carved out of RHC cost center. And it gets down to having an appropriate methodology unfortunately many clinics don't have the ability to have that kind of process in place to keep track of carving those out and there's a tendency for people to do what you say.

Well I'll do a procedure but geez now another patient walked in I'll go see them and that is not allowed. I absolutely agree that is not allowed but I think you know in my case for example in my clinic 8:00 to 10:00 all I do is procedures so I'm not walking in and seeing other RHC patients. It's a procedure day it's non-RHC day and that all of those costs are accounted for relative to the room and the staff and what I do relative to 8:00 to 10:00 on Thursdays. And I think ...

Jim Estes: There's no (mainly) issues covered by that methodology I think the ((inaudible)) ...

Male: Absolutely.

Jim Estes: ... also, the clinic needs to look and compare their reimbursements. We're talking lumps and bumps and minor things are you really going to get that much more by having it Part B when you compare how much your cost may be reduced by having to take that off of your cost report.

You know if you're just barely at the (cusp) as a pre standing clinic you might not want to do that because they may drop you below that maximum reimbursement level once you make those carve offs. Are you going to recover the difference from the more that you get from billing those to Part B? Look how much of your business is Medicare because you can't just say Medicare patients have to come in Tuesdays from 8:00 to 10:00 it's got to be everybody.

Ron Nelson: And I think that's – I think that's the point you need to do the analysis to see if it's truly advantageous.

Jim Estes: There you go.

Male: And set it up very gingerly I think just the level of detail we just covered right here showed you know it's something to be careful with.

Male: It's something that you can do but you have to do it correctly and if you don't do it correctly you can get cross wise with the auditors and so make sure you get good advice and you do it correctly I think is what the take away message is it's permissible but it's only permissible if done correctly.

Male: You don't want to be answering for that when you're sitting across the desk from the wrong person.

Bill Finerfrock: Right we'll take another caller operator and how many calls do we have in the queue?

Operator: We have three currently in the queue.

Bill Finerfrock: OK why don't we we'll just go to all the callers and if we still, have some time we'll try and get to some of the written questions. So go to the callers.

Operator: Caller your line is open please go ahead.

(Wendy): Hi, this is (Wendy) with (Monessen Medical) in (Monessen), Pennsylvania, we're an RHC. And I have a curiosity to see if any of the other RHCs received any notification of CMS rate changes in a timely manner ever.

An example is that we find that we are being reimbursed above the (capitated) rates that is allowable by CMS for our cost report so it went from year to year we either have a credit of a significant amount of money or we have unexpected payment of significant money. So I'm just trying to find out if there's a way to be notified of those changes prior end of fiscal year and a final cost report.

(Jeff Johnson): You must be – this is (Jeff) I'll take that one. You must be a provider based to a probably a PPS or critical access hospital.

(Wendy): In fact, we're an outpatient Rural Health Clinic and we bill an entity.

(Jeff Johnson): Right so you're a provider based Rural Health Clinic and the fact that you are is why you have those fluctuations. Because a lot of the independent Rural Health Clinics are capped at the you know for this year I think it's 77.76 – \$77.76 but as a provider based Rural Health Clinic attached to a hospital with less than 50 beds there is no limit OK.

So you are unlimited in your cost per encounter and so but obviously, that cost per encounter will fluctuate based on productivity and cost one year to the next. In order to avoid that is for you to

talk with your CFO of the hospital and make sure that they are doing interim cost reports at least on a quarterly basis.

And you can submit those to the intermediary to get that rate changed proactively versus waiting until the end. Because obviously you want to if you're being under paid your cost per encounter have gone up and you're being under paid you want to get that cash now.

(Wendy): That's the issue it's very difficult to project the outcome and when you're looking at a nonprofit and having a slim budget to begin with you know I mean it can make or break you honestly. And you're not affiliated with the hospital we are independent so I am the administrator and even my accounts come to me and they don't know what we should do. But you are suggesting a quarterly interim cost report is that correct.

(Jeff Johnson): Correct with the intermediary yes.

Male: Yes, if you were operating under the assumption that she was a provider based RHC with the hospital with fewer than 50 beds what I think I just heard her say is no she's an independent RHC does that change anything.

(Jeff Johnson): Well the only thing that would change is if you – if your cost is so low that you're less than the limit. That would be the only thing that would make that change if you're independent now. I thought you said you were provider based to a hospital.

(Wendy): No, we are an outpatient Rural Health Clinic and we bill as an entity with one physician and two mid levels. We are independent we are community owned and operated.

(Jeff Johnson): OK.

Male: So the issue is more that what you're actually experience is, is significantly different from one year to the next, and so you're projected cost report is substantially different than your actual cost report resulting in a significant either over payment or under payment when you get to the end of the year.

(Wendy): Absolutely and we've tried everything to try to get some direction from every you know governing agency we can think of and we just get the same answer because our protocol this is how we do it. And it ...

Male: Who is your intermediary?

(Wendy): (Highmark).

Male: Yes, it should be (Highmark).

(Jeff Johnson): OK.

Male: You know I would think that – and you guys know this stuff better than I do. But one is having an internal mechanism where they can better monitor and track their costs and their productivity to determine whether or not they're having you know – seeing far fewer patients, seeing far more patients, which is going to cause an adjustment to their average cost per visit, or if there's some significant fluctuation in their cost their cost that they incurred in one year and not previous years or in previous years and not this year. But ...

(Wendy): Let me just interject by saying that honestly from year-to-year our encounters are relatively similar so our business component as far as I – we're not changing like our bottom line does not fluctuate that much.

The number of patients that we see does not fluctuate that much it's just we're getting – here's the perfect example last year we got a \$9800 credit this year I owe \$22,000 due within like 2 weeks.

Male: Well if – guys you want to address that?

Male: Go ahead.

Male: If your encounters aren't changing from year-to-year and your cost is not changing from year-to-year I just – there's something weird going on there. I just don't – unless there's a bonus that maybe is – that you know if there's some kind of compensation adjustment at the yearend that's not being picked up because the cost report has to be made on the accrual basis or prepared on accrual basis and maybe you're filing as cash basis. So one year it's ...

(Wendy): We are a cash basis operation.

Male: Yes, so that would be the only that could potentially be doing that is if you know – and I can't imagine anything else.

Male: I don't know you just may Male: Well just make sure that you have someone preparing across your ports also that understands you know the RHC program because as (Jeff) points out something doesn't make sense. If you're stable in terms of current dollar volume and visits then there shouldn't be any major fluctuations and it doesn't make sense unless somehow that in your cost report preparation something is happening.

Male: I would suggest getting the last 3 years cost report and contact one of the people on this call and have them take a look at them.

Male: Absolutely.

(Wendy): Would there be any one in particular?

Male: Anyone on this call would be able to help you.

Bill Finerfrock: If you can send that to me electronically what I can do is forward it on to all the folks on the call and others and anyone who wants to take a look at it and get back to you we'll do it that way, OK.

(Wendy): Are you – is that – are you Bill?

Bill Finerfrock: Yes at info@narat.org if you can, whatever you can send me electronically, I will forward on and folks can take a look at it.

(Wendy): I have a disk would I be able to send that regular mail to you? Would that ...

Bill Finerfrock: I don't know. I'm not an electronic guru. Send me an e-mail with your phone number I will call you we will try to figure something out.

(Wendy): That would be awesome. The other issue I wanted to raise real quickly is we just received notification from about 5 years ago from our clinic that we are entitled to clearly about \$30,000 that we had not ever received.

Male: Walk – run don't walk.

(Wendy): Yes it makes no sense. I don't understand. None. It's a Medicaid.

Male: So Medicaid?

(Wendy): Yes.

Male: Oh Medicaid I wouldn't spend it anytime soon you can put it in the bank and let it sit there. Next year they may send you a bill.

(Wendy): Exactly.

Male: Well it's kind of related, it's kind of related to the Florida question and some of the other examples I have or that have been brought up. The states are often way behind on settling the difference between your Medicaid fee schedule if you get paid that way, which every state is different, or the managed care and the actual PPS rate that they established back in 2001.

(Wendy): Seven years is quite some time to ...

Male: Sounds like everybody is invited to Mt. Union for a Bar-B Q.

(Wendy): OK bring the food.

Male: All right thank you. We'll go on to our next caller. Next question from a caller.

Operator: Caller, please go ahead.

(Michelle): Hi this is (Michelle) from Lake City again. I have a question concerning we have a satellite clinic and we would like to change the location, move it from one building to another. But we've got some conflicting comments on that. Does it change the rate that we will be able to collect and

do we have to re-apply for everything as a Rural Health Clinic again just simply moving from like down the road like 2 or 3 miles.

Male: First of all ...

Male: You just have to do it.

Male: Go ahead.

Male: No pardon me go ahead Jim.

Jim Estes: This is Jim Estes, when you said satellite clinic that always raises a little hair on the back of my neck. You mean another facility that's affiliated with your organization it's under your umbrella but has its own provider number but is a Rural Health Clinic?

(Michelle): Yes. It's a second office that we have absorbs our – it has its own Rural Health Clinic designation.

Jim Estes: OK all right good satellite clinics don't ...

Male: But you want to move – but you want to move that physical facility from its current location to a location that is 2 to 3 miles away is that what you're asking?

(Michelle): Yes that's what I'm asking.

Male: In my experience that requires a change of information with Medicare and Medicaid. It can trigger a new inspection depends on your state, it doesn't always, but I don't think you're talking about closing the clinic and re-opening as far as re-filing a ((inaudible)) application and going through all

that nightmare process again. But you do definitely have to file the change of information, make sure your new address is still in a health professional shortage area and it's still rural so that it still qualifies. If the zip code is changing that could make a difference.

(Michelle): OK. OK but as long as the zip code is not changing we shouldn't have to re-apply for everything and it shouldn't change everything, correct?

Male: That's my understanding, what do you guys think?

Male: ((Inaudible)) surveyors, it's a judgment call on their part as to how they want to handle it.

Female: That's what I'm afraid of in Florida.

Male: Well as far as ((inaudible)) your chair is concerned ...

Male: If you're moving 2 or 3 miles away as opposed to across the street you're entering into an area, a grey area where the state may come back and say no this is very significant change in location, we want re-evaluate it, make sure that the area qualifies, we want to inspect the physical plant and conduct a new inspection because it's a significant change in location. Others may take a less stringent view of things.

(Michelle): Well actually it's less than a mile down the road so, do you think that would trigger?

Male: It's hard to say with the state. The Medicare – all you are needing to look is filing the change of information with your address changes and so forth with that provider number. As far as what the state's going to do for an inspection I'd check with your state inspector and tell them this is what we are doing.

(Michelle): OK.

Male: Make sure you're accurate. I mean you went from moving down the road to, 2 or 3 mile, to back to less than a mile. And I don't know what it is but you know whatever you describe it, if you come back subsequently and change and say well it's actually this I think you create the impression that you are trying to get away with something. So you know if it's a mile it's a mile, if it's 2 blocks it's 2 blocks, if it's 3 miles it's 3 miles.

However you describe the move make sure you describe it accurately and completely the first time.

(Michelle): OK sounds good.

Male: OK. Next caller, do we have any more callers?

(Carol): Hi. Hi this is (Carol) from the Miles Bluff Clinic in Mauston, Wisconsin.

Male: Hey (Carol).

(Carol): Hi just following up on some questions regarding the stimulus criteria. As I understand it, am I correct in saying that RHC providers do not qualify for the Medicare stimulus because we don't bill through the intermediary Part B, we bill to Part A? So that when we do it in reporting – is that correct?

Male: It's not that you don't ...

Male: Yes, there's a couple of words there. It's not that you don't qualify. Every physician who could potentially qualifies. The amount of the incentive payment that a physician can get from Medicare

is a percentage of what they submit based on the fee schedule. There are physicians working in RHC's who submit Rural Health Clinic claims but who also submit claims on based on the fee schedule.

(Carol): Right that I understand.

Male: OK well but you said qualified and ...

(Carol): Yes and I apologize for that. Then the second thing then is the Part B when they submit their hospital bills, that does not qualify or excuse me that is not eligible for stimulus dollars because it's – (the site of service) is the hospital?

Male: I don't believe that is correct.

(Carol): Well if they ...

Male: Why would that not qualify as a claim from that physician or be disqualified or discounted as a claim for purposes of calculating the amount of money you'd receive under a stimulus?

(Carol): OK that's good so then they can. OK then my last question is for meeting the Medicaid stimulus 30% threshold can you qualify – can they qualify for an entire clinic so you could include the PA's that are not eligible professionals in that or do you have to meet the threshold per individual?

Male: You can do it either way. You can do it as an individual or as a facility so that if 30% of the facility's patients visits were with Medicaid patients but let's say that you're not a PA led clinic and so you're only qualifying for a physician. You can still qualify based on the aggregate or you can qualify based on the individual numbers.

(Carol): Including the PA?

Male: It would be calculated in the aggregate for the entire – for whoever is billing under that aggregate number the NPI for the organization. So all those PA claims would be calculable for meeting the aggregate number even though individual you may not be a PA led clinic. Now I would say that there is some flexibility in there in terms of being a PA led clinic if you recall one of it is if the PA is a clinical director – designated as a clinical director for the facility then the clinic – then it would be classified as a PA led clinic.

And you would be your PA's would be eligible. I don't see any reason why as your RAC why you could not designate your PA's as clinic directors.

(Carol): Is there a physician there that is?

Male: The physician is a medical director. If you recall in the rule there were two different classifications. One is a medical director, and the other is a clinical director. And it says if the PA is the medical director or the clinical director the facility can classify – can qualify as a PA led clinic. So your physician is your medical director, classify your PA as a clinical director and therefore can qualify as a PA led clinic.

(Carol): If you do that then can all of your PA's be eligible for Medicaid dollars or is it just the one?

Male: I don't have the language in front of me. But I don't think it made a distinction in terms of the numbers I think it said if you have a PA clinical director the facility is classified as a PA led clinic and therefore the, what it says is in the statute physician assistance are eligible to the extent that they are working in a PA led clinic.

(Carol): OK make sense, OK thank you.

Operator: We had two more queue up.

Male: OK we will take those.

Operator: Caller, please go ahead. Caller your line is open.

Female: ((Inaudible)) Pennsylvania.

Male: OK.

Female: Other than grants that are independently being offered is the (NEHRC) able or looking at collaboration from multiple RHC sites or in numbers in volume of numbers for applying or utilizing independent RHC, I don't know how I want to word this. But for grant money toward purchasing an EMR, is there any affiliation out there for collaboration in an attempt to seek funding for the purchase of an EMR?

Male: I guess the immediate answer is no because we have not engaged any of the vendors or anything of that nature. Is what you're asking however is there some opportunity for some type of group purchasing arrangement that might allow for a lower cost product to be available because it would be made available at a bulk price rather than individual RHC purchasing them at a unit level?

Female: Yes. For instance I'm not sure how many but we use a centrality scheduling system and billing system through virtual office. And I have quotes out there you know from different vendors but it's at this point still even as the cost has come down so much it still almost cost prohibitive just for us independently to purchase that to get in guideline you know for the regulations that are coming forth.

And I didn't other than ...

Male: Well to answer your question no we've not and that's something maybe we can take a look at to see if there is some way to try and get lower cost products available or you know see what might be available. But at this time no there is nothing in the works.

Female: OK, thank you.

Bill Finerfrock: Next caller?

Operator: Caller your line is open please go ahead.

(Lisa Odom): Hi this is (Lisa Odom) with the Sisters of Mercy Health System in Missouri and just wanted to clarify when we were talking about the specialty clinic if you were saying that the specialty services has to be during non-RHC time that they could not be during the RHC time. Were you making that distinct separation?

Male: I didn't quite understand the question.

Male: I think it – well it was on the carving out of space for providing specialty care services that you would bill as non-RHC. Did that have to during non-RHC hours or could it occur during RHC hours. I think that's what your question was.

(Lisa Odom): Right, that's exactly right.

Charles James: I think that two of us were saying it could occur during RHC hours and two of us were saying that the whole – that it had been our understanding that the whole clinic needed to be. So I think where the discussion ended was to say at least and I don't want to put words in Ron and

(Jeff's) mouths but so I understand what they said you can establish a space in the clinic that is non-RHC but has distinctly identifiable costs.

You've got a methodology for identifying those costs and that you've posted the house that that space is non-RHC. So a lot of it came down to how well you documented and identified the costs and posted the hours associated with that non-RHC space.

Male: That's more or less correct, Charles.

Jim Estes: Yes, this is Jim again and I'm just you know that whole concept makes me very uncomfortable ...

Male: Likewise.

Jim Estes: ... just the whole co-mingling thing and the fact that if you mark that you've got non-RHC hours which you would have to do on the second page of the cost report I've been told by numerous auditors that that's automatically a cause for them to look a little closer to make sure that you're doing it right and that you are making the correct adjustments and re-classifications.

So it's just one of those things where you really better be able to make more significantly or that it increases access to care or broadens your scope of practice enough to where you're really meeting community needs in order to really justify doing that.

Also keep in mind that if you're talking about having the room and like Ron was saying that's all he does on those days is procedures. You better have enough of those to keep your provider busy during the time that you've set those up because technically they're not supposed to go across the hall and provide other services.

They're on the clock of the non-RHC area during those times. So the same is true if you set hours of operation for the whole clinic. What happens to your walk-in patients when you come in? I know of a lot of clinics that don't even have a regular Medicaid provider number anymore. When they become a Rural Health Clinic that entity loses its Medicaid number in that particular state. How would you bill for those services that you did with walk-ins? Would you turn them away?

A lot of issues that before anyone goes down that path they really need to do as Ron was saying the analysis from a cost and a practicality and an increase of access to care, change of scope of practice, all these things needs to be considered. It's not something you just go off half cocked and do.

(Lisa Odom): Thank you.

Bill Finerfrock: OK, are there any other calls in the queue operator?

Operator: None at this time.

Bill Finerfrock: OK, what – because we have actually gone over and have prevailed there was some questions that were submitted in writing that we didn't get to. What I'd like to do is I'm going to send those to the consultants and ask them if they'd like to weigh in on any of the answers on the written questions we didn't get to and then we will distribute those responses to the list serve.

If that's not too great of an imposition, if we have – rather than taking up more of people's time today. I know everybody is very busy. So with that I'd like to end and thank everyone for their participation and particularly thank the office of Rural Health Policy within the Health Resources and Services Administration for their support of this initiative.

A transcript of today's call will be made available and a recording of the call also will be posted on the Office of Rural Health Policy's Web site. I gave that information out earlier. I want to encourage you if you know others who would value – get value from participating in this service please make them aware of it. Get them to sign up, there is no charge, there is no registration to participate.

We just ask for their e-mail address so we can send information about the series, the questions and the topics that we're talking about. We are planning another technical assistance call for later this month. We're having some difficulties scheduling with the speakers so we have not been able to set that date yet but we hope to have another call dealing with some possible changes in the Rural Health Clinic rules and regulations that may be announced later this year.

But we will get information out on that through the RHC list serve. I want to thank everyone for participating. I particularly want to thank all of our experts, (Jeff Johnson) with (Wipfli's) CPA and Consultants, Ron Nelson with HSA; Health Services Associates. I don't know that (Barry Martin) was able to make it with (MRT Consulting), Charles James with North American Healthcare Management, Glen Beussink with Midwest Healthcare and Jim Estes with Healthcare Horizons.

I think it was a very good call. I think it was clear that we have a lot of questions and appreciate everybody's time and efforts in helping to educate and answer questions for the RHC community. Thank you and we'll talk with you next time. Thanks, operator.

Operator: This does conclude today's presentation. Thank you for your participation.

END