

Ask the Experts

Rural Health Clinic Technical Assistance Series Call

September 30, 2014, 2:00 pm ET

Coordinator: Welcome everyone and thank you for standing by. All participants have been placed on a listen-only mode until the question-and-answer session. To ask a question, you may press star, 1, on your touchtone phone, and please record your first and last name when prompted. Today's call is being recorded. If you have any objections, please disconnect at this time. I would now like to turn the conference over to Bill Finerfrock. You may begin.

Bill Finerfrock: Thank you, operator. As she said, my name is Bill Finerfrock, and I am the Executive Director of the National Association of Rural Health Clinics, and I'm the moderator for today's call.

Today's topic is Ask the Experts. There are no presentations today. Our speakers are a group of rural health clinic consultants who have agreed to make themselves available to take your calls or questions either as calls, and we had a number that were emailed in ahead of time.

Let me quickly go through and let you know who's on the call. First, in no particular order, we have Steve Rousso, who's the principal and co-founder of HFS Consultants, which is an employment management consulting and reimbursement firm based out of California, and they do a lot of work for Hospitals and rural health clinics.

Next we have David James, who's a CPA and a financial officer. His specialty - he's with North American Rural - I'm sorry, North American Healthcare Management Services, and he specializes in independent rural health clinic cost reports.

Next, who I don't think has gotten on the call, but we'll have Glen Beussink, who's Director of Clinic Development and he works particularly on enrollment and compliance issues. He's with Midwest Healthcare.

Next would be Jim Estes, who's the President of Healthcare Horizons. He specializes in RHC feasibility studies, annual evaluations, startups, and purchases.

Next we'll have, and I don't know that he's on yet, but Mark Lynn, who's a rural clinic consultant with Healthcare Business Specialists out of Chattanooga,

Tennessee. He does RHC cost reporting, certification, annual evaluations, and billing.

Janet Lytton, who's Director of Reimbursement for Rural Health Development, and she specializes in RHC billing and coding.

Then we have Robin VeltKamp, who's Vice President, Medical Compliance and Consulting Services with Health Services Associates. She's also a certified ICD-10 Trainer.

Then we have Julie Quinn, who's VP of Cost Reporting and Provider Education with Health Service Associates. She does Medicare and Medicaid cost reporting, rate setting, and financial analysis.

And then finally Jeff Johnson, who's a partner with Wipfli CPA and Consultants, and he does RHC and hospital cost reporting.

So operator, if you would give the instructions for people to - who want to ask a question to do that, and then while we're waiting for those to get in the queue, we'll take some of the questions that were emailed in ahead of time for folks.

Coordinator: Thank you.

To ask a question over the phone line, please press star, 1, on your touchtone phone. Please ensure your line is unmuted and record your first and last name when prompted so you may be announced before your question.

To withdraw your question, you may press star, 2.

Once again that is star, 1, for any questions or comments please.

Bill Finerfrock: Okay. And what I'm going to do is I'll take a couple of the emailed in questions and then perhaps we can open it up to the phone lines. We'll go back and forth.

So the first one, and to our consultants, if you'd just kind of give your name and whoever wants to jump in, and then we'll give anybody who wants to add, and we'll try and keep track to make sure we have a relatively even distribution of folks have an opportunity to chime in.

First up, "Can you clarify billing for vena puncture? If I understand it correctly, this code was no longer to be billed to our Part B carrier, but billed with our RHC claims. Can you clarify or expand on that, or what should be done with regard to vena puncture?"

Janet Lytton: This is Janet, Bill.

Bill Finerfrock: Anybody want to - okay. Go ahead, Janet.

Janet Lytton: The Medicare benefit policy manual states that venipunctures are now a part of our encounter rate being paid, so a clinic would bill out their office visit services, also bill out their venipuncture services and bundle that on the one line item.

Bill Finerfrock: Okay. Anybody else want to add anything?

Okay, take another one from the emailed in.

“Need clarification on billing for Medicare Advantage patients. Note, no cost settlement agreement in place. Please review what should be the billing when there is no eligible face-to-face encounter, presumably an EKG performed on-site, therapeutic injection, or vena puncture service, or X-ray only.”

Anybody want to tackle a Medicare Advantage question?

Okay, first...

Janet Lytton: Bill, I will attempt it.

Bill Finerfrock: Okay.

Janet Lytton: When a Medicare beneficiary switches to a Medicare Advantage plan, those plans now become a private commercial insurance company and you go by the regulations that that Medicare Advantage plans have in place.

Now those plans are supposed to pay you your rate if they're a private fee-for-service plan, or if they're a PPO or an HMO, you have to negotiate rates with those companies.

There are companies out there that will pay you for nursing services only, or injections only, but it's all across-the-board on how they will pay you, and you need to make communication with those companies to verify if you're billing them correctly or not correctly.

Bill Finerfrock: Okay.

Operator, do we have some calls - questions from the callers?

Coordinator: I have one question in queue from (John Trimble). Your line is open.

Bill Finerfrock: Go ahead, (John).

(John Trimble): My question is on maintaining employed mid-level providers. Does that - half of the time that you're open have to be every month, or is it an average for the year? We happen to have a couple of maternity leaves at the same time.

Bill Finerfrock: Folks - survey and certification. I think this is - those of you?

Jim Estes: This is Jim Estes. This - that's kind of up for grabs as far as what the inspector that's there doing your recertification survey determines when he gets there - or she gets there. I've never seen them go with any more than a one month period, because that's typically a pay period (unintelligible).

So you can't look at the whole year, though, and say, "Well, for the full 12 months we had a mid-level provider and nurse practitioner PA, or certified nurse midwife there half the time for a 12-month period. I've never seen them accept that because that means you went - you know, you could've gone three or four months without one of those providers in the clinic, and that would be in violation of the regulations.

Any of the other consultants that have had experience with other inspectors, (unintelligible) involved in, they just - they wouldn't go about much more than a month. If they were looking at the most recent month prior to them being there, it's usually right when they're there. "Do you have one now? You don't? Well, how long have you not had one here covering that half-time requirement?" And if it's more than you know three weeks or so, they're going to give you a problem.

If you think you're going to be without a PA into your (CNN) for more than a month, you need to apply for a waiver from the state certification folks - for a six month waiver to let them know.

David James: Yes, Jim, this is David James. We actually had an experience in Indiana where they - any absence of a mid-level provider was considered to be non-compliant, and so they - any - if they were actually gone for their vacation week or any kind of - even a short leave, they considered that to be non-compliant.

Now we disagree with that, but this particular provider actually had to go out and get coverage for the mid-levels when they were actually even on vacation.

Steve Rousso: Hey Bill, this is Steve Rousso. On the RHC interpretive guidelines, they refer to the month's schedule, so if they do a recertification survey, they'll (see the)

schedule for the month and they'll either be in compliance or not. So they use the monthly period like Jim said.

Bill Finerfrock: Yes, that's what I was going to say. If you go to the NARHC Web site and you look under there under resources, you'll see a link that says RHC Rules and Guidelines, and if you scan down through there, it does talk about staffing and staff availability and the scheduling, and it does, as both have said, refers to looking at a monthly schedule.

So you know, they don't look at it on an annual basis, but more typically they're going to look at it on a month-to-month basis. Okay?

(John Trimble): Okay.

Bill Finerfrock: This one is, "We have several new directors that have never worked in an RHC before. Could you run through the cost report process and what dates they are due?" And they don't indicate whether they're independent or provider-based. And if there's a difference, perhaps we could you know approach it once for if you're an independent or a provider-based, or if it's the same? What are the responses?

Jeff Johnson: Well this is Jeff Johnson. I can at least start us off.

The - first of all, the due date for whether you're independent or provider-based is five months after the close of your fiscal year, or calendar year for - most the independents are calendar year, but hospital-based rural health clinics can have a variety of different year-ends. But either way, it's five months after the end of your fiscal year.

And the cost report that - for independents, they file a separate cost report. It's a cost report just specific for rural health clinic - independent RHCs and federally qualified health centers. It's the same cost reporting form CMS form 222 - 92.

For the hospitals, it's based - for the provider-based rural health clinic, it's part of the hospital's overall cost report, and so in a sense the rural health clinic is a - kind of a subprovider, if you will, of the hospital - of the main parent.

And on that note, it's a separate entity - it's a separate provider-based entity of the hospital, and it's the M-series of the hospital cost report.

Mark Lynn: This is Mark Lynn. One thing to remember is that if you are - have a change of ownership or you know you're terminating from the program, you have 150 days from the date of that termination, so keep in mind that is one of your deadlines.

Also, you're going to need to pull your PS&R in the (IACS) system, and that thing is a bear, so you need to start early on that. You can't be waiting until you know, May the 15th if your cost report is due on May 31st to start trying to get your credentials for that. That's going to be a sure fail. And the (MACs) are much tougher than they used to be. At one time when (Henry Vick) worked at Cahaba, you could just shoot him an email, and five minutes later you had a PS&R. Those days are gone, so keep that in mind you have to start early to try to get that PS&R.

David James: Yes, and this is David James. Just to expand on that a little bit, Mark, is - I know that a lot of the approvals for the change of ownerships and terminations are lasting longer than that 150 days. You can't really file the cost report until you have that approval, if it's not on your fiscal period.

It - a lot - normally, they will allow 30 days after that change if it's past the 150 days, but I've actually seen some of the intermediaries require those cost reports to be filed immediately. So, you got to watch out for those change of ownerships and terminations.

Bill Finerfrock: Okay, anybody else want to contribute?

Steve Rousso: Yes, so this is Steve Rousso. The one thing I was going to add was even though there's a hard and fast deadline and Medicare will put you on a withhold if they don't receive it within like a week or ten days, there is no penalty with interest accrued. So if a provider gets the cost reported late in Medicare, it's more of a withhold thing than a penalty with interest issue.

Bill Finerfrock: All right, any questions on the phones there, operator?

Coordinator: Yes, I do have a few. The first one is from (Jackie Hennen). Your line is open.

Bill Finerfrock: Go ahead, (Jackie). And could you tell us where you're from? I apologize. I should've been asking that of others. Go ahead, (Jackie).

Coordinator: Please check your mute.

(Vickie Hiennen): I think it was supposed to be for (Vickie Hiennen).

Bill Finerfrock: Okay. Well your line's open, so you have the opportunity to ask your question. And where are you from?

(Vickie Hiennen): I'm from Sioux Falls, South Dakota.

Bill Finerfrock: Great.

(Vickie Hiennen): Okay. I am calling on CPTs 99307 through 99310. We've been having them drop to a (unintelligible) instead of staying on a UV, and I was wondering if there's supposed to be a Part B? When I went into read stuff on Medicare, it sounds like they're all Part B. The places they're...

Janet Lytton: What's those codes for?

(Vickie Hiennen): Um...

Janet Lytton: What's the verbal part of it?

(Vickie Hiennen): (Unintelligible). I know the diagnosis on most of them are (unintelligible). They're like subsequent nursing for nursing homes.

Bill Finerfrock: Yes. 99307 is subsequent nursing home visit. For subsequent nursing home facility care per day. So it's all for nursing facility care.

(Vickie Hiennen): And some of the diagnosis is like mental health, so I'm just wondering if they should be a Part B?

Janet Lytton: Well it depends. If you pay your providers while they're in that nursing home as part of your RHC expenses, then these visits are RHC visits, but if the providers are not working for the RHC at that time the visits would be billed to Part B. Most generally they are billed as RHC visits with the 524 revenue code. (oh dear—shrill screech on those was heard)

Bill Finerfrock: Oh, who's that coming from?

Janet Lytton: I don't know - to seeing residents, then its part of your rural health clinic. If you pay your providers separately for those visits, then it's part of your non-rural health clinic. So it depends on how your providers are paid.

So if you've got those costs in your cost report, they're part of your rural health clinic visits, and you know if you don't, it isn't.

Bill Finerfrock: But aren't these the - these are the mandatory monthly visits to skilled nursing facility patients, so wouldn't they just be billed as rural health clinic visits?

Janet Lytton: They should be.

Bill Finerfrock: As an (unintelligible)...

((Crosstalk))

Janet Lytton: Yes.

Bill Finerfrock: With the appropriate site of service being the (snip)...

Janet Lytton: Which is a 525.

Bill Finerfrock: 525. Yes. Are you doing it with the correct revenue code?

(Vickie Hiennen): Well, it didn't land on a UB, so we had like a place of service of 14 and...

Janet Lytton: Oh, no. It's got to be on a UB.

(Vickie Hiennen): Okay.

Janet Lytton: And, it's got to be a 525 revenue code with your charge and it goes just like you would any other claims in your clinic.

(Vickie Hiennen): Any other...

Bill Finerfrock: Just like a rural health clinic encounter. I suspect what may be happening is because you're billing it with that place of service, it's rejecting it. If you bill it with the right revenue code, you may find more success.

But, those should all be rural health clinic visits.

(Vickie Hiennen): Okay. Okay, that's what I needed to know.

All right, thank you.

Bill Finerfrock: Okay.

Go ahead, operator. Next call from the phone line.

Coordinator: The next question is from (Debbie Lee).

Bill Finerfrock: Go ahead, (Debbie). Where are you calling...?

(Debbie Lee): Hello. (Debbie) here in Eureka, California. Hi.

I sent you a - several text - or emails last week and I was just trying to find out because we're a rural health clinic, and I know all of you there can help me here, does my (FNP)s or PAs have to be enrolled into the Medicare program if we're only seeing patient visits in the office?

I have been...

Bill Finerfrock: So they're only doing RHC - they're only seeing RHC patients. You're not billing anything out on a 1500 for those RHCs? Everything they do is submitted as part of a UB RHC claim?

(Debbie Lee): Yes, because they have deactivated a lot of the - anybody who hasn't used their NPI number, they get deactivated. I was told to use the 855O to bill...

Bill Finerfrock: (Unintelligible) - it's the letter O, it's not a zero.

(Debbie Lee): Yes, it's the letter. I'm sorry. The letter O. I was told to use that form and send it in and then I talked to someone from Medicare and they stated no, it doesn't work that way. You have to enroll your mid-levels into the Medicare program.

I've been checking around with a lot of different clinics, and as far as I can tell, the mid-levels are not enrolled into the Medicare program.

Bill Finerfrock: Okay...

(Debbie Lee): They work under the NPI number of the practice because we are an RHC billing to (KOHAVA).

Bill Finerfrock: Well - okay. I think we've got it. I can give an answer, but you guys go ahead and then if I have anything to add, I'll add it. But go ahead. One of the consultants want to take that, or do you want me to?

Jeff Johnson: Well, I would just say the first thing is that each individual provider needs to have an NPI number.

(Debbie Lee): They all have an NPI number.

Jeff Johnson: Okay, so they're being on the claim. So the only thing that - from a reimbursement - I mean from a billing standpoint, if they're only providing services out of the rural health clinic, as long as they have a valid NPI number and if we're only talking Medicare, there wouldn't necessarily need to - they wouldn't necessarily need to have a Part B billing - or an NPI number to bill Part B.

I mean it'd be the same number. They wouldn't have to have a Part B number I guess.

Bill Finerfrock: No. But - okay, here's the reason. The 855 is an enrollment form, just as the 855I, 855R.

(Debbie Lee): Correct.

Bill Finerfrock: The 855O, and the O stands for ordering and referring, last year Medicare mandated that in order for a claim to be paid to a provider to whom a Medicare patient had been ordered or referred - an order for a service or referred, the referring provider or the ordering provider had to be enrolled in Medicare.

Because you have rural health clinics where the provider may not be submitting claims, therefore they're enrollment would be deactivated, CMS created the special 855O which is for providers solely for the purpose of ordering and referring.

So if your provider is going to refer patients let's say to a radiologist or order a (DME), or order a lab, they would need to be enrolled - okay. Then they need to be enrolled in Medicare in order for that lab or that imaging professional, or whoever it is, the one who is fulfilling that order or taking that referral - the referring provider/ordering provider has to be enrolled and you use the 855O.

If they're not doing ordering and referring, if they're not going to submit any claims, then they don't need to be enrolled, but those would be the two reasons. Either they're going to submit a claim on a 1500, or they're going to order a service or refer a patient. They have to be enrolled solely for that purpose. And that's true whether it's the doc, the PA, or the NP.

Jeff Johnson: All right, yes.

(Debbie Lee): Okay. So I can use the 855O.

Bill Finerfrock: Correct.

(Debbie Lee): I did send in one for one of my nurse practitioners and it was rejected, as usual, stating that I needed to enroll them into the Medicare program. But I think Medicare - you know, trying to tell them that we're a rural health clinic also, and you're talking directly to Medicare, they get - they're confused as to you know...

Bill Finerfrock: Okay. Then...

(Debbie Lee): ...a rural health clinic versus you know a private office.

Bill Finerfrock: ...let's - what I've stated to you is a policy. If they're not following it, then contact me offline - off of this call, give me the details and I'll contact the CMS enrollment staff in Baltimore and ask them to look into why this is being rejected because it shouldn't be rejected. So, somebody's confused somewhere, and - but let's deal with that as a casework problem.

(Debbie Lee): Okay.

Bill Finerfrock: But the policy as I've articulated it is what the policy should be.

(Debbie Lee): Okay, I appreciate it. Thank you, Bill.

Bill Finerfrock: Okay.

Operator, next question on line?

Coordinator: The next question is from (Jackie VanShuttle). Your line is open.

Bill Finerfrock: Okay.

(Jackie VanShuttle): Hi. Can I ask two questions?

Bill Finerfrock: Okay, fine.

(Jackie VanShuttle): Okay.

My first question is we are billing on the same data service. One service is a 521 revenue code for an office visit and the second visit is on a separate claim with a 900 revenue code for behavioral health. And our - the 900 is always getting rejected. We - as a duplicate service, or a duplicate claim, duplicate service. And when we called NGS they indicated we had to put a Modifier 59 on there, but the problem is is that CPTs aren't usually sent with those because it's a revenue line rolled up.

Janet Lytton: It needs to be on one claim form to begin with.

(Jackie VanShuttle): Even though they see two providers for two separate issues?

Janet Lytton: Even though - yes.

(Jackie VanShuttle): Okay. So it should be on one...

Janet Lytton: One claim...

(Jackie VanShuttle): ...one claim form.

Janet Lytton: With one being the 521 revenue code, or whatever revenue code, and then the other one being the 900 revenue code, and that's when you'll get paid two per diems because one's an ailment visit and one's a mental health visit on the same day.

(Jackie VanShuttle): Okay. So one claim, two lines, two revenue codes.

Janet Lytton: Correct.

(Jackie VanShuttle): Okay. Well we'll give that a try and see if that works.

Bill Finerfrock: Can I have your name again and where you were calling from?

(Jackie VanShuttle): Oh, I'm sorry. (Jackie VanShuttle) from Cadillac, Michigan.

Bill Finerfrock: Great. Thank you, (Jackie).

(Jackie VanShuttle): And then my second question is on Medicare credit balance report. When we're filling in the method of payment, I normally put an X in there. We don't normally send a check with our credit balance report. What we would like to do is have them recoup from our checks that they send us. Is that the best way to go about that?

Janet Lytton: That's the way you're supposed to go about that.

(Jackie VanShuttle): Okay. Because it does take them a long time to recoup, and I just wondered if we were going - if we were doing this correctly.

Janet Lytton: You are correct. They will take it back on a future remittance advice, but sometimes it's not very soon.

(Jackie VanShuttle): Okay. And that's what's happening. I just wanted to make sure that we were doing that correctly.

Janet Lytton: Yes.

(Jackie VanShuttle): All right, thank you very much.

Bill Finerfrock: Thanks, (Jackie).

I'll take a couple that were emailed in. This is from (Joe Cotrell) from Portsmouth, Ohio. "I recall somewhere a Web site mentioned where we could view the number of encounters Medicare has on file. Am I remembering this correctly? And if so, what is the site?"

Would that be their PS&R report?

Janet Lytton: I think that's the only place it is.

Bill Finerfrock: So how would they go ahead and get their PS&R report?

Janet Lytton: They would have to be signed up with the IACS system. That's - I don't remember what it stands for, but that's PS&R Web-based system that you apply for the - or request the PS&R in summary form, and then it gives you how many claims have been processed through whatever date that you put in on the request form.

Bill Finerfrock: Mark, did you (unintelligible)...

((Crosstalk))

Mark Lynn: (Unintelligible).

Bill Finerfrock: Okay.

Mark Lynn: Yes. I don't have the exact Web site in front of me, but I know in April of this year - it was either March or April, Medicare did release all of the Medicare Part D data for you know all of the physicians in the country. Obviously, it didn't affect rural health clinic physicians as much because we bill the majority of our claims to Part A, and they didn't release that.

But you could go on there and it actually lists - it had a bunch of our RHC physician's Part B data listed. And in fact, we have one office manager get fired over it because you could go in there, you could see exactly what was billed to Medicare Part B. You could see the units. You could see the number of charges, and I could - well I would say real quickly and figure it up a couple of these guys were billing you know a bunch of stuff to Part B that was covered under the RHC benefit.

So - and it was - and so that is a very useful tool. If you probably Google The Wall Street Journal article about Medicare - release of Medicare Part B data, it'll

be around March, there's a link to that and they - it's a very easy way to populate - in fact, they put - they sort all the data by zip code, so you could just type in a zip code and bring up every doctor in that area. Note: Here is the website: <http://projects.wsj.com/medicarebilling/?mod=medicarein>. **(This website address was not included in the oral remarks.)**

And, we do our annual evaluations, we will look at that data to see if there's anything being billed to Medicare Part B that shouldn't be, and we'll do some education of those folks.

And I mean I was in a clinic last week and we had to educate them, "No. No. No. This stuff does not go to Part B. You can't be doing that." So, it's a very useful too.

Bill Finerfrock: Okay. But that's just the Part B part.

Mark Lynn: Yes. That's not...

Bill Finerfrock: Right. The B...

((Crosstalk))

Mark Lynn: (Unintelligible)...

Bill Finerfrock: Right. The IACS - you go to - if you contact - whoever your contactor is, they should be able to tell you how to sign up for IACS, and out of that you can then get your clinic's PS&R - what's called the PS&R report, and that will tell you the actual number of visits and whether they have in their system. NOTE: The IACS system can be found here: <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/IACS/index.html?redirect=/iacs>. **(Note: This website address was not included in the oral remarks.)**

David James: Well, the IACS is under the CMS.gov Web site as well.

Bill Finerfrock: Right. I just figured it'd be easier to go (unintelligible)...

((Crosstalk))

Janet Lytton: Do a search for "IACS" on the CMS website.

Bill Finerfrock: Go ahead. Go ahead. IACS I think.

Janet Lytton: Yes.

Jeff Johnson: It stands for individual or authorization - individual's authorized access to the CMS computer system.

Bill Finerfrock: Right.

And then you'll have to - each clinic has to identify who the authorized individual is and then create that account.

Jeff Johnson: Kind of to Mark's point before, that - you got to stay on top of that because the password changes after - once you get set up, and whoever the person is, and sometimes that person leaves, you know goes to a different facility or whatever, but the password changes - I think, Mark, it's every 90 days or something like that.

Mark Lynn: Yes. I think - they link - they used to be every 45 or every 60 days. They've linked them to time somewhat, but it's - you are absolutely right. A lot of our clients lose their credentials and they lose it and it's too late to get them recredentialed by the time it's time to file the cost reports, so that happens all the time.

Jeff Johnson: Exactly.

We've done - just as a tip, what we've done here at Wipfli, is we - our clients provide us that information and we kind of maintain it for them because we're usually the ones doing their cost reports anyway.

Bill Finerfrock: Okay, great. Operator, we have calls on the line?

Coordinator: The next question is from (Ashley).

Bill Finerfrock: (Ashley), where you calling from?

(Ashley): Hey, we're in Lake Providence, Louisiana.

Bill Finerfrock: Great. What's your question?

(Ashley): Our question is for our Medicare and Medicaid patients, we're a provider-based facility owned by a hospital, so we were wondering if for patients for Medicare/Medicaid come in for a visit in the office that day, but are sent over to the hospital to be admitted into the hospital, are we allowed to count that visit for our clinic? Are we allowed to bill it, or how does that work?

Bill Finerfrock: (Unintelligible)...

((Crosstalk))

Mark Lynn: This is Mark Lynn. The...

Bill Finerfrock: Go ahead.

Mark Lynn: Yes, Bill, this is Mark Lynn. I just listened to the technical assistance conference call this morning with (Captain Axelrod), and the guidance from CMS is that it depends. It's - and basically, what (Captain Axelrod) said was that you probably - you ought to bill it to your (MAC) and see if they'll pay because it's on an individual basis and in some situations they will pay, and some situations they will not.

I know a lot of times if that patient is admitted to the hospital and they go into observation instead to the hospital admission, that claim will typically reject if the patient is admitted to observation.

Well if they're admitted into the hospital, then both claims will tend to be paid. And all the (MACs) are not consistent - they're all over the board on this issue. Some will only pay one of the visits. Some will pay both. Basically I think what (Captain Axelrod) said was shoot them the bill and see if they'll pay it.

So that's the comment we've had so far.

Jeff Johnson: Yes, I would agree with that, Mark.

Bill Finerfrock: Yes. We - each contractor seems to handle it differently.

Steve Rousso: Hey Bill, this is Steve Rousso. I think Medicare has this thing called the 72-hour rule with your - it's the provider that has its own outpatient clinic - they do outpatient diagnostics and then you're admitted to the hospital. Those payments are included in the - on those payments at an in-patient stay under Medicare. It's an issue with Medicare that's...

Bill Finerfrock: Some of the - but some of the contractors are still allowing that to be billed because the way that they are interpreting it is it's a separate and distinct service, and therefore is still billable even though there is the 72-hour rule.

Jeff Johnson: Yes. And the 72-hour rule really wouldn't apply to professional services, and so typically whether it's an outpatient - you know, and obviously as a rural health clinic, even though it's considered an outpatient - or it could be a - you know, it's

provider-based to a hospital, we - one must keep in mind that it isn't technically an outpatient department. It's an outpatient entity - or provider-based entity of the hospital. And there is a distinction there.

Janet Lytton: Right.

Man: Right.

Bill Finerfrock: Did that help, (Ashley)?

(Ashley): Yes, it did. Thank you.

Bill Finerfrock: Okay.

I'll take one of the emailed in questions. This is from (Rhonda Cochran) with the Marquette General Health System. "On the Medicare cost report, we report the charges for preventive care. Can you tell me if that includes the following codes; G0402, 0438, 0439, as well as CBT codes 99381399386, and 99391399396?" Anybody want to take a crack at that?

Janet Lytton: It does not...

Mark Lynn: This is Mark Lynn - oh, go ahead, Janet.

Janet Lytton: Go ahead, Mark. That's fine.

Bill Finerfrock: Go ahead, Mark.

Mark Lynn: The first - the G-codes it would include because those are covered RHC benefits. Typically, the easiest way is - to get that information is in that (IACS) - or I can't pronounce it right. I just call it the pain in the ass system.

The (IACS) system is - they have two different reports you should pull if you're doing a cost report. There's a 710 and a 71S, and the 71S will list your preventive charges that have processed. So that's the form I would use, and that would include those G-codes.

But the last series of codes that she listed out there, those were actually physicals, and Medicare this day still does not cover physicals, so those would not be covered in that benefit, so those would be excluded. Those 99 - I forget the exact code, but they - I think those were physical codes, and those would not be covered.

Bill Finerfrock: 99381399386 and 99391399396.

Mark Lynn: Yes. Those I don't believe would be covered. Janet, you can correct me if I'm wrong.

Janet Lytton: You're right, Mark. You're absolutely right.

And that line on the cost report is for the Medicare preventive services only, and so those are not codes that Medicare even covers.

Bill Finerfrock: Right. Okay. All right, hopefully that answered her question.

Operator, how about somebody from the phone lines?

Coordinator: The next question is from (Crystal Arnold).

Bill Finerfrock: (Crystal), where are you calling from?

(Crystal Arnold): (Unintelligible), Florida.

Bill Finerfrock: Great. What's your question?

(Crystal Arnold): Okay, one of my - I have two questions, and I'll ask them quick. The first one was is there any way you can give me a brief run down for flu vaccines for Medicare? How the different billing with the G-codes and the Q-codes, because I'm not - I'm new to this and I'm not sure what the difference is when you're doing Medicare.

Bill Finerfrock: Okay.

Janet Lytton: Medicare doesn't pay for flu shots on an individualized basis. It pays for flu shots through your cost report.

(Crystal Arnold): Correct. But do we need to bill those under the G-codes?

Janet Lytton: No. No, you don't do no billing for them. It's all disclosed by the number of total flu shots given on your cost report, and then the total of your Medicare-only flu shots given on your cost report, along with the cost of your vaccines and supplies and the ratio of your administration for that piece of it. So you don't send any claim in with a flu or pneumonia shot on it to Medicare.

(Crystal Arnold): Okay.

Bill Finerfrock: Anybody want to talk about how to put together the roster and the need to maintain a roster for that?

Woman: This is...

((Crosstalk))

Mark Lynn: This is Mark.

Woman: Go ahead.

Mark Lynn: All you have to do is put the patient name, the HIC number, or the Medicare number, on there and the date that you gave them the shot and you need to list your Medicare patients for your influenza and your pneumococcal That is the log you need to prepare and give that to whoever prepares your cost reports because that will need to be submitted with the cost report in order for you to get paid.

David James: Well - and this is David. A lot of times what you'll do is you can enter those as a zero charge through your systems so your billing system can actually spit out a - the log through a query.

(Crystal Arnold): Right. Yes, that's kind of how we - I was just making sure that that's how we needed to be doing it.

David James: Yes.

Bill Finerfrock: Okay.

Robin VeltKamp: Yes, this is Robin VeltKamp.

Bill Finerfrock: Okay, go ahead Robin.

Robin VeltKamp: I just wanted to just emphasize again that there are two separate logs. One is through - one is (unintelligible), but also this is only for straight Medicare. When you are dealing with your Advantage Plan Medicares, your HMO Medicares, those are billable using the full billable code, and those are paid through the Medicare Advantage plans either through their individual costing report that they have them, or as a deeper service.

Bill Finerfrock: Okay, great. Thank you for the clarification. You had a second question, (Crystal)?

(Crystal Arnold): Yes. I'm sorry. And I'm not really sure how to ask this one, but is there anything - because we're provider-based, any of the Part B services that we're supposed to be billing under the hospital's Part B, or does it all go through our clinic?

Robin VeltKamp: This is Robin again. As a provider-base, all of your technical components of the support services, non-professional, that would be the (unintelligible)...

(Crystal Arnold): I'm sorry. You're breaking up.

Robin VeltKamp: I'm sorry. That would be the taking of an X-ray, the taking of an EKG, any of the technical components, those are billed under the main entity.

(Crystal Arnold): Okay. Well then how do you keep that separate? Does it come through as it being paid?

Janet Lytton: It gets paid to your hospital.

(Crystal Arnold): Okay.

Janet Lytton: Because the hospital's provider number is on those claims, so all the payments will go to that provider number.

(Crystal Arnold): Okay.

Jeff Johnson: Yes. Essentially, you're submitting two claims, for example lab or an X-ray, that was done in conjunction with the rural health clinic. If you're a critical access hospital, that lab and X-ray would go on an 851 bill type under the hospital's provider number, not the rural health clinic's provider number.

Janet Lytton: Correct.

Robin VeltKamp: And again, this is Robin. The most challenging thing for provider-based entities that I have worked with is finding a mechanism of the services rendered within the rural health clinic and taking those labs that were performed in the clinic and making sure that they are getting billed under the main entity without lumping any of the labs that they have been done within the entity.

An example, let's say I'm a patient in your RHC 20, and you do the draw along with a urinalysis, you have to find a mechanism within your system to include that urinalysis that was done in the clinic along with maybe that comprehensive metabolic panel that was sent to the hospital on the same day because they all have to go into one claim. Medicare will only pay one bill type per day.

And so that tends to be one of the largest challenges of provider-based clinics.

Janet Lytton: Yes.

(Crystal Arnold): Okay.

Is there any way I can get a list - where would I find a list of exactly what needs to be - are the technical codes or billing services?

Jeff Johnson: Well one way to look at that is, you know, one kind of fail-safe way to do it is look at the Medicare fee schedule, and wherever - like you know for the lab or even the - probably the X-ray is more prevalent where they have a professional component and a technical component. And so the technical component, it'll list - if there's a technical component or a - what's called a - using a TC-modifier for radiology for instance, or even other diagnostic type services, those would all be billed under the hospital.

(Crystal Arnold): So like...

Jeff Johnson: And...

(Crystal Arnold): ...EKGs also?

Jeff Johnson: Yes. The technical component only.

For EKG's, I don't remember the codes, but there's - you know, there's the global one and then there's the two separate ones, the professional read-only and the actual technical piece. So you would bundle for instance the professional with the rural health clinic encounter and bill that as one line item with the 521 revenue code with the 711 bill type for the rural health clinic.

And then for the actual technical component of the EKG, that would be billed under the hospital's provider number.

And if you are a critical access hospital, that would be under the 851 bill type.

(Crystal Arnold): Yes, we are. Okay.

Robin VeltKamp: And again, this is Robin, and another thing that you need to make sure you're doing is that when you set this system up, you're doing it for your Medicare services rendered within the clinic.

Jeff Johnson: Right.

Robin VeltKamp: You can still bill the globals. You can still do all of that to your commercial.

(Crystal Arnold): Right.

Robin VeltKamp: But you're only extracting for your Medicare services when you're billing in this format.

Bill Finerfrock: Okay?

(Crystal Arnold): All right.

Bill Finerfrock: Next up I'll take a question that was emailed in. This is from (Char Fowler). It doesn't indicate where she's from. She says, "We are a new RHC. We have Medicare patients who come for allergy injections at least once a week or twice monthly. What is the correct way to bill for these multiple dates of service?"

Robin VeltKamp: Again, this is Robin. The allergy injections would typically fall under the injectable guidelines where you can attach it to a visit 30 days prior or 30 days post. Many clinics choose to not (unintelligible) at tracking, but you can bill it, but it would have to be attached to a visit. Again, 30 days prior or 30 days post.

Bill Finerfrock: Right.

And a visit solely for the purpose of the allergy injection would not qualify as a rural health clinic billable visit.

Robin VeltKamp: Correct.

Bill Finerfrock: What Robin is suggesting is that you can attach it or bill it out and you would be able to collect the beneficiary co-pay for that, but it would not in and of itself constitute a rural health clinic visit because it does not meet the test of a billable RHC visit.

Robin VeltKamp: Correct.

Bill Finerfrock: Okay?

Mark Lynn: Bill, that's what is called Incident to in the RHC guidelines, and so the way I describe Incident to, especially to an independent RHC, is you ain't getting paid because that - you know, that visit - or that occurrence does not create a visit, like you said, and so you're not going to get paid a visit for that. But you can bundle it.

And what you're going to do is use the date of service where there's an office visit. Just use that one date of service. Don't span bill, but use - if the office visit occurred on September 30, then use that date of service and bundle everything under that revenue code 0521 and change your charge from - you know say it's a 99213 for \$100, and you've added \$150 of allergy shots, change that revenue code 0521 from \$100 to \$250. And like they said, that's going to increase your co-pays from 20% of \$100 to 20% of \$250, and that's how you're going to generate revenue for your clinic.

So it's hard to do, but those - owning your claims is difficult. Filing adjusted claims is difficult. I mean, it's not a great situation for RHCs.

Bill Finerfrock: I would also note - add - let me - because I think this is an important point. The fact that a service may not generate a billable visit does not necessarily mean you're not getting paid for that service. The cost of the drug, the cost of the personnel, the space in which the service was provided is all included in your cost report.

So it's built into your all-inclusive rate. So even though it's not a billable visit doesn't mean that you're not getting paid for it. It means that the costs for that have already been built into your all-inclusive rate.

Mark Lynn: Bill, I'm assuming that everybody's over the cap. I guess as an independent - and that's why I say the independents.

Bill Finerfrock: I think you're right.

Yes, I think the cap is an issue, but I - you know, something has to have to have cost to get you to the cap.

Mark Lynn: Yes. You're right.

Bill Finerfrock: And those costs are - you know, which cost it was that maybe put you over, we don't know. But you know, all those costs are captured on your cost report.

Okay, we have a caller - a question from a caller, operator?

Coordinator: Yes, I have a question from (Lori Mashinski). Your line is open.

Bill Finerfrock: (Lori), where you calling from?

(Lori Mashinski): I'm calling from Columbus, Texas.

Bill Finerfrock: Great. What's your question?

(Lori Mashinski): We're a rural health-based rural health clinic, and I don't know if this is something new to (Previnar 13) being given to our Medicare 65 and older patients. I'm just wondering how do we bill for those.

David James: This is David. This is something that we've had some difficulty with, with some of the intermediaries. I know specifically Cahaba had said that they – do – normally, you will include those on your log as a pneumococcal injection, and they will pay those through the cost report. We have finally gotten some clarification Cahaba is not allowing those because they considered those to be an injection for a child injection, but they have expanded those, you know, sometimes, and now they are – do have a geriatric version of that.

And so yes, they are now covering those. We do have guidance from CMS on that, and yes you will include those on your pneumococcal log for reimbursement through the cost report.

(Lori Mashinski): Okay. So no filing them. Just they need to be shown on the cost report?

Bill Finerfrock: There's a separate form that is an - a part of the cost report specifically for capturing flu and pneumo and you get 100% of your costs. So that's why you need the log and that's why you need to be able to track and report the cost of your drug, the personnel, et cetera, and then you get 100% of that when you reconcile your cost report.

(Lori Mashinski): Okay, thank you.

Bill Finerfrock: Okay?

Let me take an emailed in question. "Can you please cover the topic of global billing in an RHC? Also, the billing for OB services for Medicaid?" If you don't want to - Medicaid is state-specific, but anybody want to just specifically address global billing, when I presume this means you have a patient who perhaps has gone to the hospital, had a surgical procedure and there is a follow-up visit, whether or not you can bill that as a rural health clinic visit.

Janet Lytton: Bill it's going to - this is Janet. This is going to depend on how it was billed by the provider that performed the surgery at the hospital. If that provider has billed with a 54 modifier of the procedure only, then each and every visit at the clinic can be a visit that's billable as a rural clinic visit.

If they did not put that 54 modifier on there, if they come in the clinic for follow-up, the clinic is not allowed to bill a visit for that particular follow-up.

Now the clinic can always bill for visits of the patient's ailments, but not the follow-up.

Bill Finerfrock: Okay.

Janet Lytton: And any service that's started in the clinic doesn't have globals attached to it. So each time they come in the clinic after the initial procedure is a visit within the clinic if it's a medically necessary visit.

Bill Finerfrock: Okay, operator, a question from a caller?

Coordinator: The next question is from (Stephanie Kilgore).

Bill Finerfrock: Go ahead, (Stephanie). Where you calling from?

(Stephanie Kilgore): Hi. How are you all? I'm calling from Franklin, Tennessee.

Bill Finerfrock: Great. What's your question?

(Stephanie Kilgore): I have a billing question. It is in regards to preventive services. We are still receiving denials for the G0101 code as a standalone procedure. We are billing it with a 521 rev code, but we are not billing it with any other procedures on the same day. So we are still getting denials for that. Can I get some clarification on the latest - on how those should be billed so that we do get the all-inclusive rate payment?

Janet Lytton: Well from what you've said...

((Crosstalk))

Janet Lytton: You've billed it correctly if the G-code is on the claim and it is on that single line item; however, since CMS has made the clarification that there are those specific standalone codes, I don't think that the (Mac) systems have been brought up to date and may still be erroring it out in their system, not that it shouldn't have been paid. It probably should have.

But from what I have read lately, that it's going to take awhile, and I don't know what awhile means, for them to get their systems up to date so that they won't error out.

(Stephanie Kilgore): Okay.

So another question on that, and you probably are very well versed in the rural health clinic center on the CMS Web site, but when it gives the sample billing for screening pelvic and clinical breast examination, it does list it with two line items. I was interpreting that as perhaps it needed to be billed with an (ENN) code, but you're saying that it should be paid without any other codes and as a standalone. The (Mac)s just haven't been brought up to speed yet.

Am I understanding that correctly?

Okay.

Janet Lytton: Is that what you understand, Bill?

Bill Finerfrock: Yes. I think you're absolutely right, that that's - those are clarified and those are billable as standalone visits. That was clarified and corrected by Medicare, so if they're denying it, something's wrong internally in the system. But, those should process through and you should get paid on them.

Mark Lynn: Bill, this is Mark. You would need the HCPCS code on there because there is a frequency guideline on those particular services, and those - you know, there's a couple exceptions when you have to use HCPCS codes on the (UB-O4), and those preventive services are one of those. So you - I think the other one is telemedicine. So those are the two exceptions. So you would have to have that HCPCS code on there for them to pay for that. And may be the issue if you're not putting that HCPCS code on there with the G-code on there.

Also, they - you know, of course they - you know, that just came out at I guess the end of August, maybe the first of August, they expanded that list. Initially, they only had two standalone services that they would pay. There was an IPPE and the annual wellness, and then Bill Finerfrock and the NARHC lobbied CMS and got expanded to five different services.

The pelvic exam, glaucoma screening, and then there's -- I don't have it in front of me -- there's one other one as well that...

Bill Finerfrock: Prostate and breast.

Mark Lynn: Prostate? Okay.

So there's five now that are standalone services. The rest of those - that big huge listing of preventive services, those are Incident to services that you will have to have an office visit to attach with that in order for you to bill for that service.

Bill Finerfrock: Yes.

Janet Lytton: And make sure that even though you have put your G-code on the claim, make sure that it's not getting scrubbed off clearinghouse.

(Stephanie Kilgore): Okay.

Janet Lytton: Because I have had that happen within the last week too.

(Stephanie Kilgore): Okay.

So if it's going over electronically to CMS as an encounter and not the G0101 code, as an example, they would deny it because they are seeing it as an encounter, not the G-code?

Bill Finerfrock: Your G-code is basically telling them what you did that allows it to be classified as a rural health clinic visit, and then what Mark is saying, because many of these have a frequency that Medicare will pay for once a year, once every two years, you need that so that Medicare can verify that they're not paying it more frequently than what is permissible under the Medicare policy.

(Stephanie Kilgore): Okay.

All right, thank you.

Bill Finerfrock: Okay? All right. Operator, we have a question from the phone line?

Coordinator: Yes, I have a question from (Sarah). Your line is open.

Bill Finerfrock: (Sarah), where you calling from?

(Sarah): So I also sent the same question in to the email. It pertains to the State of California MediCal Code 18 (unintelligible) reconciliation.

Bill Finerfrock: Okay.

(Sarah): The question we have is if there is a patient that has Blue Shield say for primary and Managed MediCal secondary, I guess the first question is are we supposed to bill the (unintelligible) for that?

And if we are, do we count the primary payer, say Blue Shield, payment in our reconciliation?

Bill Finerfrock: First, and to all of our listeners, Medicaid questions - I don't know if we have somebody who can answer that because they are so state-specific. Steve, I know you are in California. I don't know whether you have much experience with California Medicaid or if any of our other folks have worked with California Medicaid. Has anybody had any experience with California Medicaid?

Steve Rousso: Yes, Bill, this is Steve. Yes, I do. So if the only question you had was on the Blue Shield, was that a MediCal managed care program or was that commercial?

(Sarah): It's - the primary would be commercial and then they have Managed MediCal as secondary.

Steve Rousso: Right. So basically, you're either going to bill a Code 02 or an 18. So - and that one's probably a Code 18. You bill the (unintelligible) to the MediCal program.

(Sarah): Correct. We would bill like Blue Shield primary. The secondary would go to our Managed MediCal payer partnership, and then we'd bill a Code 18 to the State of California.

Steve Rousso: Yes.

(Sarah): So on those ones when we do the reconciliation to the State of California, are we to include the Blue Shield payments as part of the visit to the State?

Steve Rousso: On the reconciliation, they want you to include payments only from MediCal managed care providers, not from commercial plans. So I have to think about the form. It's really for MediCal managed care, not the commercial, so I don't think it would go on the reconciliation, but I'd have to double-check the form.

(Sarah): Okay.

Steve Rousso: Because if it's commercial, it's not - that's only the secondary billing for MediCal, so I don't believe the commercial payments go on the reconciliation for (GPS) reconciliation for MediCal.

Bill Finerfrock: Okay?

(Sarah): I'm sorry. Can you say that again?

Steve Rousso: You don't put payments from commercial plans on the reconciliation, so I don't believe the payments from Blue Shield would be on the reconciliation.

(Sarah): Okay.

And we don't include that visit in the reconciliation either, because we are billing a Code 18 for it.

Steve Rousso: Right. You would count the Code 18. Again, I'm not - I don't have the form in front of me, so I just don't want to tell you wrong. I'd have to look at the form. I could let you know. I'm not positive if it's commercial.

Bill Finerfrock: Can you - (Sarah) or Steve, whichever, do you want - Steve, if you don't mind, do you want to give her your email address and then you can communicate directly?

Steve Rousso: Sure.

(Sarah): If you can give me it, that'd be great.

Bill Finerfrock: Go ahead, Steve.

Steve Rousso: So it's SRousso -- R-O-U-S-S-O -- @hfsconsultants.com.

(Sarah): Okay, thank you.

Bill Finerfrock: Okay, I have a question online. It says, "We're an independent RHC and operate two clinics. My question is regarding RHC visits. Do we include all payers, Medicare, Medicaid, private, and third party, or just Medicare-only visits on Worksheet B of the cost report?"

Mark Lynn: This is Mark. All visits.

Bill Finerfrock: Okay. Operator, how many questions do we have online?

Coordinator: I have four more in queue.

Bill Finerfrock: Okay. To the folks here, I know we're up on the hour, and if you need to drop off, I certainly - we certainly understand. If you can stay on, we'll be happy to do that.

One of the things that I will do for all of the folks is we will send out -- if you guys don't mind -- we'll send out everybody who's participated today your names on the ListServ with your email address if folks wish to contact you directly after the call for a follow-up, or if they have other questions.

So operator, why don't we finish out with the calls that we have online.

Coordinator: The next question is from (Toni Johns).

Bill Finerfrock: (Toni), what's your question and where are you calling from?

(Toni Johns): Hello. I'm calling from Cadillac, Michigan.

Bill Finerfrock: Great.

(Toni Johns): I have a question relating to a previous question and one small additional one.

Bill Finerfrock: Okay.

(Toni Johns): When you spoke to (Jackie VanShuttle) regarding the two revenue codes on one claim for a social worker and a physician...

Bill Finerfrock: Okay?

(Toni Johns): How do you show the second provider on the UB, and do you need a modifier?

Janet Lytton: You don't show the second provider on the UB. It's all billed through the rural health clinic and the provider of service is - basically, it's going to be one or the other. It's just however many clinics don't understand they will be receiving two per diems because they're having both a mental health visit and an office visit on the same day.

(Toni Johns): Okay. And we've been told a 59 modifier applies, but I didn't agree with that as the modifiers don't show on the UB. Is that correct.

Janet Lytton: No.

(Toni Johns): That is correct, yes?

Bill Finerfrock: No, that's correct or no that's incorrect?

Janet Lytton: That is correct. They do not show on the UB.

(Toni Johns): No modifier, okay.

Janet Lytton: No CPT codes are required.

(Toni Johns): Okay. My other quick...

((Crosstalk))

Janet Lytton: (Unintelligible) service.

(Toni Johns): Okay. My other quick question is, is I bill for OB services as well, and your occasional Medicare patient that gets pregnant we use a dummy code to record their prenatal visit so a claim doesn't not go out for every prenatal visit unless they have an additional...

((Crosstalk))

Janet Lytton: These are billable on each visit to the provider.

(Toni Johns): I'm sorry?

Janet Lytton: It should. A Medicare patient, each visit is a payable visit through Medicare for a pregnancy. And then the delivery only is charged at the time of delivery. And that's...

(Toni Johns): But our consultant said to send one revenue code with the to/from date of service.

Janet Lytton: No.

(Toni Johns): Okay.

Janet Lytton: Each visit, each day, each time.

(Toni Johns): Okay.

Bill Finerfrock: All right, operator, next call?

Coordinator: The next question is from (Ashley).

Bill Finerfrock: Is this (Ashley) from Louisiana again?

(Pam): Hey. Yes, it is.

Bill Finerfrock: Okay.

(Pam): Well, it's actually (Pam).

Bill Finerfrock: Okay, (Pam).

(Pam): I filed a claim with the G-code of preventive exam, so with a G70.0, but the claim didn't pay in full. Is it supposed to pay in full?

Bill Finerfrock: When you say it doesn't pay in full, you didn't get your encounter right?

(Pam): Well, I did, but it left like 20% for the patient to pay. Is that correct?

Bill Finerfrock: Which - what does the - are we talking the introductory to Medicare physical or the...

(Pam): No, I did the G0439.

Bill Finerfrock: G0439.

Janet Lytton: And the wellness subsequent visit.

(Pam): Yes.

Janet Lytton: What Medicare is doing is they're paying you their 80% of your rates; however, through the cost report, you receive that additional co-pay that you should've gotten paid.

(Pam): Oh, okay. So they don't pay the whole thing in full. Now they would pay it if it was the deductible?

Janet Lytton: Correct.

Bill Finerfrock: Well the deductible is waived.

Janet Lytton: They wouldn't have. The deductible applied.

(Pam): Okay.

Bill Finerfrock: Right. The deductible is waived.

(Pam): Okay, thank you.

Julie Quinn: This is Julie Quinn. I would be skeptical that that G-code is being counted as a preventive service if they are charging a co-insurance on it, because when it gets to, as Mark said, 71S PS&R with the preventive, there's no co-insurance shown on any of the claims that funnel to that preventive PS&R.

I just - if you're seeing a co-insurance on the claim, I don't think it is truly being counted as preventive service.

(Pam): Oh, okay.

Bill Finerfrock: Yes. I was kind of skeptical of that too. Thanks, Julie, because I was under the impression they were supposed to be paying that at 100%, and by using the (unintelligible) code and the - or that code, the co-pay is waived and Medicare pays 100%.

Julie Quinn: And that's what I'm seeing on the back-end. When it gets to the preventive PS&R, you see no co-insurance, no deductibles.

Bill Finerfrock: Right. Okay.

Mark Lynn: Yes, this is Mark again. What Julie said is absolutely right. That's absolutely right. There's no co-pays or deductibles on that. I've never seen one on that PS&R. That's absolutely right.

Bill Finerfrock: Okay.

(Pam): So did I bill it correctly?

Janet Lytton: Well, is the - is your code actually showing on your claim for sure?

(Pam): I don't know. I don't know what it looks like as it goes through. I've never seen it.

Janet Lytton: Okay. Make sure you know what it looks like before - yes.

(Pam): Okay.

Bill Finerfrock: Okay, next caller on the line?

Coordinator: The next question is from (Lisa Ammerman).

Bill Finerfrock: Go ahead, (Lisa). Where you calling from?

(Lisa Ammerman): Mile Bluff Clinic in Mauston, Wisconsin.

Bill Finerfrock: Okay.

(Lisa Ammerman): My question is regarding also the G0101. I was actually on the call with NGS this morning. They had a J6 party Ask the Contractor teleconference, so when I asked the question to them, they told me that CMS has posted that there's a workaround for that code that we're supposed to bill an E&M code with charge for a penny in order to get paid for the G0101.

Bill Finerfrock: What? I've never heard that. Anybody else have ever heard that?

Woman: No.

Mark Lynn: Bill, that's in the SE - they updated the SE1039 - no. No. That's on the rural health clinic - health center Web site. It is on there. That one penny is on there. Note: Here is the website <http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html> (Note: The website address was not included in the oral remarks.)

Bill Finerfrock: The SE1039?

Mark Lynn: No. It's on the - I'm sorry. It's on the RHC Web site, the rural health clinic center Web site. If you - once you go past that little table, if you go down, there's a specific way to bill and they show the example of showing a one penny, and then they drop down and it's on two different lines.

Bill Finerfrock: Yes, that's correct.

Mark Lynn: Yes.

Woman: Wow.

Bill Finerfrock: I saw that too, Mark.

Mark Lynn: Yes.

Bill Finerfrock: Okay.

(Lisa Ammerman): So that is correct for us to do that in order to get paid for that G0101 until they get their systems updated?

Bill Finerfrock: That's right.

(Lisa Ammerman): Okay. Thank you.

Bill Finerfrock: All right. Okay, thanks guys.

Next caller?

Coordinator: The last question I have is from (Mindy Musgrave). Your line is open.

Bill Finerfrock: Okay, (Mindy), and I have a couple that were emailed in we'll try to get to, but go ahead, (Mindy). Where you calling from?

(Mindy Musgrave): Now we have a nurse practitioner that specialized in behavioral health. Should we bill her as rural health clinic for all of her services?

Bill Finerfrock: So you have an NP who is seeing - is doing exclusively mental health visits in the RHC?

(Mindy Musgrave): Yes.

Bill Finerfrock: And you want to know whether those should be billed as rural health clinic visits?

(Mindy Musgrave): Right.

Bill Finerfrock: As opposed to what?

(Mindy Musgrave): As an outpatient of the hospital.

Bill Finerfrock: Well, I'll let you guys answer it. I think I - how I would answer it, but go ahead.

Jeff Johnson: Well this is Jeff from Wipfli. Generally speaking, especially now that the co-insurance and the Medicare - what Medicare pays and the patient's responsibility is equalized to a medical visit now, likely it'll be a - assuming you're a provider-based rural health clinic, correct?

(Mindy Musgrave): Yes, we are.

Jeff Johnson: Okay. Likely, it'll be more beneficial to bill it as rural health clinic encounter; however, depending on the volume of your rural health clinic and a lot of different factors, it may be worth just kind of looking - kind of doing a quick analysis of whether or not it should be billed in the - as an outpatient department. You know, of a mental health outpatient department of the hospital apart from the rural health clinic.

Including those visits, it could have an impact on your productivity screens. It's just without knowing more information, I wouldn't want to give you a direct you

know absolute answer. But most - in most cases, rural health clinic would be more advantageous.

(Mindy Musgrave): And that's billed under the 900 revenue code?

Jeff Johnson: Yes. Psychotherapy - them type of things, yes. I would assume that's the case. And not all...

Mark Lynn: I think that diagnostic services are billed using 0521 and therapeutic services are billed using the 0900 revenue code.

((Crosstalk))

Jeff Johnson: ...psychological services are billed with the - you know, the initial medical evaluation and so forth would be a medical diagnosis which would be billed under the 521 revenue code.

(Mindy Musgrave): Okay.

Jeff Johnson: But for all intents and purposes, it's the same reimbursement.

Mark Lynn: That's what I was going to say was the 0521 you used for the initial diagnosis and then for therapeutic services you're going to use the revenue code 0900. But they're going to pay the same because of the Medicare Equalization Act of whatever it was a few years ago. Those mental health (parity), it's now the same rate as if it was an RHC rate. There's no longer a discount there, so that's good.

Bill Finerfrock: Okay, we have a couple of emailed in questions I'd like to try to get to. First, this particular clinic is being - undergoing a survey audit and they were recently stated during an audit that inactive files had to be audited. How does one audit an inactive chart?

Robin VeltKamp: This is Robin VeltKamp from HSA. And what we typically have found is taking a sampling over the past year of inactive charts, of why people left the practice and doing a summary review in the annual advisory meeting, not just the active charts, but during the annual advisory meeting, that's when some of the key reasons of why people have left and why this particular chart has become inactive.

Is it because it may be kids have left because parents were relocated geographically for work? One of the key things that you also want to know is if people are leaving because of certain dynamics in the office, so that you can use that information to make corrections, or if there's issues with a specific provider, again you can make corrections.

Typically, what I had seen surveyors review upon certification surveys is a sampling of why people have become inactive.

Mark Lynn: Okay, Bill, this is Mark. One - I have always had that question and I've asked several surveyors over the years what exactly, you know, are you shooting for on this inactive? I mean, why do we want to look at that? And nobody's ever given me a good answer.

But I'll tell you what we do is I will look at closed charts. I'll say, "Print me off a listing of everybody that has passed away in the last year," and then also if it's a Quad-A facility, you know they have a rule that says if somebody dies after a surgery that has occurred within your clinic, within 30 days of that you have to report that to Quad-A. So I'll ask them that question if anybody's you know died within a surgery - clinic within 30 days.

And I'm basically looking - anybody that has died within the last year, and we'll look at their charts and just see if there's anything unusual about them and what you're basically looking for is are there a bunch of young folks that are - you know, that are dying in the clinic?

And I've seen a bunch of folks, and what will typically happen is you'll be in a clinic that has a pain management program that is out of control and they're just handing out hydrocodine, whatever those Schedule 2 drugs are, like candy and you're - and so you got some real problems in that clinic and so you start - you'll start with addressing those issues with the providers.

Like, "Okay guys, somebody's going to go to jail if you don't change the way you're doing things."

Just like I said, I look at closed charts. I look at people that have died. And then if I don't have five that have died, then I'll look at the inactive charts and see why people have moved away.

Bill Finerfrock: Okay, another question emailed in. It says, "We are a provider-based RHC in Nebraska. We have one physician, one PA, and two NPs. We're wondering if there's a certain percentage of charts that the physician has to sign off on for our PA?"

Janet Lytton: This is Janet, and I am from Nebraska. No, there is no specific percentage of charts that have to be reviewed; however, you have to review some. So whatever your policy states you have to review, that is - that's your policy.

I've seen in the – in policies where they say they'll review all of them. I would caution against that because once they find one that hasn't been reviewed, the clinic would be out of compliance and receive a deficiency.

So there is no specific percent of charts that have to be reviewed.

Bill Finerfrock: Now let me add on to that. That is at the Federal level. You would need to be in compliance with your state law or state regulatory mechanism. So while that may be the situation in Nebraska, you may be in a state where your state law mandates a particular percentage or number of charts to be reviewed as part of the Medical Practice Act in your state governing PA/physician, NP/physician relationships.

So although there's not a federal minimum, it just says an appropriate number, you would need to verify that your state does not have a minimum that they would want reviewed as part of the State Practice Act.

Mark Lynn: Bill, this is Mark. Just to piggyback off what you just said. You know, effective July 11th of this year, you know of course they changed the medical directorship rules from - on the federal side to where the medical director does not physically have to be onsite once every two weeks, and they basically deferred to the state scope practice laws for those nurse practitioners and PAs.

We have been recommending everybody go back and review those scope of practice laws in detail, making sure that you are getting that percentage - you know, a lot of states it's 20% or 10%, or whatever it is. And then as the federal requirement - that - what we have been using is having a separate quality improvement folder that we set aside and the medical director will review 10 charts per quarter for every nurse practitioner and PA, and that's done separately from that 10% review, and that (unintelligible) is a part of the quality improvement process for the rural health clinic.

So that's how we've been addressing those issues.

Bill Finerfrock: Okay. Well we've certainly taken advantage of your time more than we had initially requested, so I want to thank you all for participating.

As I said, we will put out a list of all the consultants and your email addresses first as a thank you, and then if individuals wish to contact folks who want clarification or any reason you might want to contact.

But just as a reminder, today we've had, and I want to thank, Steve Rousso with HFS Consultants; David James with North American Healthcare Management Services; I didn't hear him, but if Glen Beussink with Midwest Healthcare; Jim

Estes with - okay. Jim Estes with Healthcare Horizons; Mark Lynn with Healthcare Business Specialists; Janet Lytton with Rural Health Development; Robin VeltKamp with Health Services Associates; Julie Quinn with Health Services Associates; and Jeff Johnson with Wipfli.

Thank you all for your participation today. I hope all of you will also think about participating in the - or attending the Rural Health Clinic Conference which will be a little bit later in October in Reno, Nevada. Many of the folks that you've heard today will be speaking at that conference. It's a great opportunity to meet other rural health clinic providers, get some great education and learn a little bit more about the rural health clinic's program.

And, I hope if you didn't get a question answered, I apologize we weren't able to get to it. I would encourage you to consider posting your question on the Rural Health Clinic ListServ. That's also a great place to get your questions answered. Many of these folks are active participants on the ListServ. Or, your rural health clinic colleagues from around the country will also take advantage of that opportunity.

Finally, I'd like to thank the National Organizations of State Office of Rural Health and the Federal Rural Health Policy - Office of Rural Health Policy, who are both supporters of this. If it were not for them, this program would not exist.

Our next rural health clinic call has not yet been scheduled. It'll probably be in a few weeks. The date, time, and subject matter on that will be announced.

But again, I want to thank everybody for their time and - today, and their expertise, and all that you're doing for the rural health clinic's program to make sure that individuals living in rural underserved communities have quality, cost-effective healthcare.

Thanks everybody, and we'll talk to you during our next call.

Coordinator: Thank you. This does conclude today's call. Thank you all for joining. You may disconnect at this time.

END