

STATE OF OHIO

Introduction to Rural Health Clinics

Presented by:
Health Services Associates, Inc
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OBJECTIVES

- ▶ What is a Rural Health Clinic?
 - ▶ What are the benefits of becoming a Rural Health Clinic?
 - ▶ What is the process to become a Rural Health Clinic?
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WHAT IS AN RHC?

- ▶ A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and non-physician practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a non-physician practitioner.
- ▶ An RHC can be fully staffed with just non-physician's as well with a minimum medical director supervision once every 2 weeks (but is currently be relooked at to remove the minimum time all together)

INDEPENDENT RHC

- ▶ **INDEPENDENT RHC**
- ▶ Independent RHCs are generally private physician offices but some hospital owned RHCs can qualify for Independent RHC status.
- ▶ RHC encounters are paid using the current RHC cap. The cap rate in 2013 is \$79.17, increases each year by the MEI (Medicare Economic Index) . (Medicare Independent and PB over 50 beds). Less than 50 beds does not have a cap.
- ▶ Independent RHCs must file an annual cost report, which is due 5 months after the end of each fiscal year. The cost report is filed to be sure the clinic is made 'whole' to the RHC rate for all of the Medicare face to face visits of the clinic.
- ▶ Failure to file timely cost reports can result in an impact of RHC payments.

INDEPENDENT RHC

- ▶ An Independent RHC is generally owned by any person or entity that is legally authorized to own a Medical practice in the state in which the clinic is located.
 - Professional billing is submitted under CLINIC Part A number.
 - Technical billing is submitted under CLINIC Part B number. This can be billed under the group, but each provider must be credentialed with Medicare Part B if they are seeing patients.

PROVIDER BASED RHC

- ▶ **PROVIDER BASED RHC**
- ▶ Provider-based RHCs (PBRHC) are those owned by a parent entity such as a hospital, nursing facility, or home health agency.
- ▶ Claims are billed to the MAC which services the parent entity.
- ▶ PBRHCs owned by a hospital with 50 beds or less qualify for an un-capped RHC rate.
- ▶ All RHCs whether independent, Provider based over 50 bed, provider based under 50 bed are all set at the RHC statewide average rate that is updated each year by the MEI effective 10/1. The current rate for 10/1/12 – 9/30/13 is \$80.18. You must have a Medicaid number established, then submit formal request with CMS cert letter to Roy Sutton to have the rate set for the RHC and he will set up system for you with rate and issue a letter to the clinic that the rate has been set and can begin billing. When the clinic bills a claim to Medicaid, it is paid at the **RHC rate (\$80.18)**. The clinic is also eligible for the RHC rate for the Medicaid managed care plans they have as well and a wrap around payment will be issued to the clinic of the difference of the RHC rate vs. what the Medicaid managed care plan paid.
- ▶ PBRHCs whose parent entity is greater than 50 beds have the same cap as independents.
- ▶ PBRHCs rate is set under the parent entity's cost report.

CONTACT INFORMATION

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PROVIDER BASED RHC

- ▶ Provider based RHC is owned and directed by the hospital, nursing facility, or home health agency.
 - Professional billing is submitted under CLINIC Part A number
 - Technical billing is submitted under HOSPITAL Part A number

WHAT ARE THE BENEFITS OF RHC CERTIFICATION?

- ▶ RHC certification for rural healthcare providers plays a vital role in access to care for rural populations in that it:
 - ▶ Provides access for vulnerable populations in geographic areas that otherwise would not have sustainable health care.
 - ▶ Enhances Medicare and Medicaid reimbursement that may help to stabilize private practices that do not have the resources and support available to hospital or community owned clinics.
 - ▶ Provides financial incentives to recruit and retain providers in rural communities.
 - ▶ Expands professional staffing patterns via utilization of non-physician practitioners.
 - ▶ Offers the potential for other services to be brought to the rural area that otherwise would not be available in a private practitioner's office, such as behavioral health and telehealth services.
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WHAT ARE KEY REQUIREMENTS?

- ▶ **Location**
- ▶ Rural health clinics must be located in communities that are both *rural* and *underserved*. RHCs must be in non-Urbanized areas and RHCs must be in an area that is either a Medically Underserved Area, Health Professional Shortage Area (either population or geographic) or a Governor's designated area.
- ▶ **Eligibility**
- ▶ Non-profit and for profit corporations, public agencies, sole proprietorships, and partnerships are eligible for RHC status. An RHC may be any primary care practice, such as family practice, pediatric, obstetric/gynecology, or internal medicine. An RHC can include specialty services, as long as the RHC can document that its primary purpose is to deliver primary care services. Must be predominately primary care services (51%)

WHAT ARE KEY REQUIREMENTS?

- ▶ **Facility**
- ▶ The Rural Health Clinic program does not place any restrictions on the type of facility that can be designated as an RHC. A Rural Health Clinic may be either a permanent location that is a stand-alone building or a designated space within a larger facility. The clinic can also be a mobile facility that moves from one community to another community. The mobile facility, however, must have fixed scheduled locations, each of which meet the rural and shortage area requirements. Where a facility offers RHC services in both a permanent structure and a mobile unit, each facility must be certified separately as an RHC. This requirement for separate certification is not applicable where a permanent structure provides RHC services off the premises, such as scene of an accident, patient's home, or nursing home.

WHAT ARE KEY REQUIREMENTS?

▶ Staffing

- ▶ An RHC is required to be staffed by at least one nurse practitioner (NP), physician assistant (PA) or certified nurse midwife (CNM) who is on-site and available to see patients at least 50% of clinic operating hours. A physician (MD or DO) must supervise the non-physician practitioner in a manner consistent with state and federal law. There is no specific FTE percentage or employed/contracted agreement for physicians in an RHC. There is, however, a minimum federal RHC requirement that the medical director be present at least once every two weeks to assure quality of care and see patients, if necessary. (Under CMS review for consideration of being decreased/removed completely for minimum as RHC requirement.)

WHAT ARE KEY REQUIREMENTS?

- ▶ **Core Services**
 - ▶ An RHC is required to provide on-site primary health care services, six basic diagnostic laboratory tests and first response emergency services. The clinic is also required to ensure that all patients have ready access to other diagnostic laboratory tests, radiological services and hospital/specialty care by clinic staff or under arrangement with a hospital, hospitalist or other providers.
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WHAT ARE KEY REQUIREMENTS?

- ▶ **Management Procedures**
 - ▶ RHCs are required to conform to a number of management practices that enable the clinic to implement quality assurance and performance improvement plans.
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WHAT ARE KEY REQUIREMENTS?

- ▶ **Reimbursement Mechanisms**
- ▶ The Rural Health Clinic Services Act authorizes special Medicare and Medicaid payment mechanisms that reimburse clinics for actual costs. Unlike a fee-for-service practice where Medicare and Medicaid payment is based on the cumulative charges for all allowable services provided, a rural health clinic is paid on a clinic-specific, all-inclusive rate that is adjusted annually and, in a majority of cases, subject to a limit set by the government. RHC certification affects only Medicare and Medicaid reimbursement.

IS RHC CERTIFICATION RIGHT FOR YOU?

- ▶ **Step 1:** Determine if your clinic is located in an eligible rural area.
- ▶ **Step 2:** Determine if your clinic is located in an eligible underserved area. Must be 4 years current HPSA (pop or geographic), MUA, or governors designation
- ▶ **Step 3:** Determine if your clinic qualifies as an Independent or Provider-based RHC.
- ▶ **Step 4:** Determine if your clinic has the required staffing.

IS RHC CERTIFICATION RIGHT FOR YOU?

- ▶ **Step 5:** Determine if your clinic offers the required core primary care services.
- ▶ **Step 6:** Determine if it makes financial sense for your clinic to become RHC certified.
 - This will be for Medicare and Medicaid enhanced reimbursements of current FFS rates vs. potential RHC rate
 - In Ohio, all RHCs are set at the rate of \$80.18 per visit for Medicaid in comparison to average FFS \$38–45
 - In Ohio Medicare pays the following amounts per CPT for 2013 so the amount would depend on the average of CPT codes billed within the clinic
 - 99211: \$19.48
 - 99212: \$42.30
 - 99213: \$70.65
 - 99214: \$103.82
 - 99215: \$139.20

STEP 1 LOCATION

- ▶ Rural Health Clinics must be located in communities that are both rural and **underserved**.
- ▶ An area is considered **rural** if it meets the U.S. Census Bureau designation as a "non-urbanized area". A non-urbanized area is any area that does not meet the U.S. Census Bureau's definition of "urbanized area" (UA) – an urban area with population over 50,000. (Please note that cities or towns in **urban clusters** – populations greater than 2,500 and less than 50,000 **are eligible for RHC certification**).

STEP 1 LOCATION

- Access the U.S. Census Bureau website at:
<http://www.census.gov/geo/www/ua/2010urbanruralclass.html>
- Go to see the current status of county to see last updated date, if any:
<http://hpsafind.hrsa.gov/HPSASearch.aspx>
- Verify if there is anything that exists with MUA: <http://muafind.hrsa.gov/>
- Use the AM I RURAL TOOL to verify address findings: <http://www.raconline.org/amirural/>
- Go to the urban area listing and search the zip code to see if it's a urban area or not
- Compare all of the above, if area is in a non urban area and is listed as address of clinic in a 4 years current HPSA then ok to file for RHC if not a current 4 year area then contact state HPSA to find out when the area will be resurveyed again or get the survey list to see if there is incorrect info that was used in the ratio
- ▶ The Excel list is presented in alphabetical order. If your service area is not listed, then it is considered a non-urbanized area and your clinic is considered to be located in a rural area. If your service area is listed, then your clinic is NOT eligible for RHC certification.

STEP 2 LOCATION

- ▶ Rural Health Clinics must be located in communities that are both rural and underserved. **REMBEMBER: It must be 4 years current.**
- ▶ An area is considered **underserved** if it is a federally designated Health Professional Shortage Area (HPSA), a federally designated Medically Underserved Area/Population (MUA/P) or an Area designated by the state's Governor as underserved. Please note that even if a County is a designated HPSA or MUA, urban areas are not eligible for RHC certification. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) Shortage Designation Branch develops shortage designation criteria and uses them to decide whether or not a geographic area, population group or facility is a HPSA or an MUA/P.

STEP 2 LOCATION

- ▶ Access the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) website at <http://hpsafind.hrsa.gov/HPSASearch.aspx>.
- ▶ Enter your state in the Select a State drop-down box at the top of the form. When the form refreshes:
 - ▶ Select your County in the County box.
 - ▶ Select Primary Medical Care in the Discipline box.
 - ▶ Select Designated in the Status Box.
 - ▶ Leave all other boxes as they are.
 - ▶ Scroll to the bottom to select “Show me the HPSAs.”

STEP 2 LOCATION

- ▶ If your area is designated as a Primary Care HPSA with a **date that is less than four years old**, then your clinic is located in an underserved area.
- ▶ By law, the shortage area designation must have occurred within the past four years. If the shortage area designation (HPSA, MUA, or Governor) is more than four years old, then the site does not qualify for RHC certification.
- ▶ Please note each state is responsible to submit information to HRSA to determine HPSA designation status. If you believe your area is a HPSA but the data is not current, we recommend that you contact the Primary Care Office in your state; a listing can be obtained at:
<http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffice.s.html>.

STEP 2 LOCATION

- ▶ If your area is **NOT** a HPSA, then you can return to the website <http://hpsafind.hrsa.gov/HPSASearch.aspx> and on the left select MUA/P by State and County and follow the same steps you completed to determine HPSA status. You should also contact your state office and ask if a new application has been or is being submitted for HPSA consideration. Please note if your service area is a HPSA, you do not have to complete this step to determine MUA/P status.

STEP 3 QUALIFY

- ▶ Independent or Free-standing Clinics: Independent RHCs are clinics not designated as provider-based. However, an Independent RHC can be owned and operated by a hospital. (Please note: This is very rare to see happen). In addition to hospitals, independent RHCs can also be owned by physicians, physician assistants, nurse practitioners, certified nurse midwives, skilled nursing facilities, home health agencies, for-profit corporations, not-for-profit corporations, or government entities.
- ▶ Medical entity must follow first the set up of a entity type in their state as all state laws are different on the can do's and don'ts in creating a medical clinic entity for ownership.
- ▶ Also, note that a PA owned practice **MUST** have at least a 1% ownership by another member in order to get a Medicare part b number for the clinic/provider. This is the case not matter what state as it's a Medicare part b issue

STEP 3 QUALIFY

- ▶ Provider-based Clinics: CMS defines a provider-based clinic as: “A clinic which is an integral and subordinate part of a hospital, skilled nursing, or home health agency participating in Medicare and which is operated with other departments of the provider under common licensure, governance, and professional supervision.” This means that the clinic is administratively, professionally, and organizationally accountable to the authority, bylaws, and operating decisions of the hospital, skilled nursing facility, or home health agency in the same manner as other departments of the main entity.

STEP 3 QUALIFY

- ▶ Is the clinic an integral and subordinate part of a hospital, skilled nursing, or home health agency (main entity) participating in Medicare?
- ▶ Is the clinic 100 percent owned by a parent provider?
- ▶ Do the clinic and parent provider have the same governing board?
- ▶ Is the clinic operated under the same organizational documents as the parent provider?
- ▶ Does the parent provider have final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the clinic?

STEP 4 STAFFING

- ▶ An RHC is required to be staffed by the following:
- ▶ At least one non-physician provider (NP, PA, or CNM) who must be on-site and available to provide patient care during at least 50% of the clinic's operating hours. Please note that the total percent of time can be provided by several different non-physician providers as long as their combined time totals 50%. PLEASE NOTE: the non-physician provider must be employed by the RHC and not contracted.
- ▶ A physician (MD or DO) must supervise the non-physician practitioner in a manner consistent with state and federal law.
- ▶ A medical director must be on-site at least once every two weeks. Please note that in most small clinics, the medical director and supervising physician is the same individual. Larger practices or clinics may require more than one individual, based on state restrictions on the number of non-physician practitioner that one provider can supervise. (PLEASE NOTE: This is under review by CMS)

STEP 5 SERVICES

- ▶ An RHC is required to provide on-site primary health care services, six basic diagnostic laboratory tests and first response emergency services. The clinic is also required to ensure that all patients have ready access to other diagnostic laboratory tests, radiological services and hospital/specialty care by clinic staff or under arrangement with a hospital, hospitalist or other providers. The clinic should have written policies describing a referral process that ensures access to these specialty services. If your clinic provides specialty services, you must be able to demonstrate that all core primary care services are available and in accordance with RHC guidelines.

STEP 5 SERVICES

- ▶ Does the clinic provide primary care services, defined as the treatment of acute or chronic medical problems which usually bring a patient to a physician's office?
- ▶ Does the clinic provide on-site access to the following required diagnostic tests:
 - ▶ Chemical examination of urine by stick or tablet?
 - ▶ Hemoglobin and/or hematocrit?
 - ▶ Blood sugar?
 - ▶ Examination of stool specimens for occult blood?
 - ▶ Pregnancy tests?
 - ▶ Primary cultures for transmittal to a certified lab?
- ▶ Does the clinic provide medical emergency procedures as a first response to common life threatening injuries and acute illnesses?
- ▶ Does the clinic provide or have arrangements with other health care providers to furnish inpatient hospital services and specialty care, including radiological services?

STEP 6 FINANCIAL FEASIBILITY

- ▶ We suggest that you complete a Financial Feasibility Assessment to determine whether or not conversion to a Rural Health Clinic makes sound financial sense. Please note that this is not a requirement, but a step that we strongly recommend.
- ▶ Financial benefits for the State of Ohio were discussed in slide 17.

STEP 6 FEASIBILITY

- ▶ **Total Visits by Insurance Type**
- ▶ You will need to look at the most recent full year of service data to calculate the total number of encounters that would be allowable with RHC certification by insurance type: Medicare, Medicaid and all other.
- ▶ For an encounter to be allowable with RHC certification, it must be a face-to-face encounter with a covered provider. For purposes of the RHC program, a covered provider is any of the following: physician; physician assistant; nurse practitioner; certified nurse midwife; psychologist (Phd.); social worker (only CSW/LCSW can be reimbursed).
- ▶ Visits with other non-practitioners (i.e. nurses, medical assistants, etc..) do not qualify as RHC visits and should not be counted.
- ▶ Encounters with more than one health professional and multiple encounters with the same health professional on the same day and at the same location, constitutes a single visit except: 1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or 2) The patient has a medical visit and a clinical psychologist or clinical social worker visit.

STEP 6 FEASIBILITY

- RHC Encounters are NOT:
 - ▶ Non RHC covered services.
 - ▶ Non medical necessity services, such as administration of injection alone, dressing changes, refill of prescriptions, lab tests/results only.
 - ▶ Completion of claim forms.
 - ▶ Care plan oversight.
 - ▶ Please note that CPT code 99211 is not an RHC encounter.
 - ▶ If the clinic has not completed a full year of service, you can estimate the total number of visits by annualizing available data. This can be done by counting the total number of months for which you have data, total all numbers for the months you have, divide by the total number of months you have and then use the resulting average for the remaining months to complete a full year.

SUMMARY OF QUALIFICATIONS

- ▶ Is your clinic located in an eligible rural area?
 - ▶ Is your clinic located in an eligible underserved area?
 - ▶ Does your clinic qualify as an Independent RHC?
 - ▶ Does your clinic qualify as a Provider-based RHC?
 - ▶ Does your clinic have the required RHC staffing pattern?
 - ▶ Does your clinic offer the required core primary care services?
 - ▶ Does the financial feasibility assessment indicate a potential increase in reimbursements?
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HOW TO BECOME CERTIFIED?

- ▶ **Step 1:** Create a policies and procedures manual. Provider Based clinics will be required to have current approved Civil Rights policies
 - ▶ **Step 2:** Establish an Advisory Council.
 - ▶ **Step 3:** Complete and submit required application forms.
 - ▶ **Step 4:** Conduct a “mock survey” to prepare for the site survey.
 - ▶ **Step 5:** Participate in the site survey process.
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CFR 42 491.6

CMS J TAGS

- ▶ **Category for Table of Contents**
- ▶ **J-Tags**
- ▶ Administrative
- ▶ 0003–0005
- ▶ Location of clinic
- ▶ 0006–0018
- ▶ Physical plant and environment
- ▶ 0019–0028
- ▶ Organizational structure
- ▶ 0029–0036
- ▶ Staffing and staff responsibilities
- ▶ 0037–0051
- ▶ Provision of services
- ▶ 0052–0065
- ▶ Patient health records
- ▶ 0066–0075
- ▶ Program Evaluation
- ▶ 0076–0086

REQUIREMENTS

- ▶ CMS requires that all rural health clinics that have been in operation for at least one full year have an established and active Advisory Council to develop, review and monitor a comprehensive Quality Assessment Performance Indicator (QAPI) system and complete an Annual Evaluation.
- ▶ If your clinic has been in operation for at least one year, it is recommended that you have at least one Advisory Council meeting **before** the site survey to comply with J – Tag 56 on the CMS–30 form. J–Tag 56 states: “Patient care policies are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician’s assistants or nurse practitioners. At least one member of the group is not a member of the clinic’s staff.”

REQUIREMENTS

- ▶ Review existing Advisory Council composition or establish an Advisory Council that includes, at a minimum, the individuals listed below.
- ▶ Medical director of the clinic.
- ▶ At least one non-physician clinician.
- ▶ At least one management level staff member (Please note that this is recommended but not required).
- ▶ At least one community member who is not employed by the clinic or by the hospital (if your clinic is provider-based). Ideally, this position is filled by a patient of the clinic, but that is not required. We recommend that you have a confidentiality agreement in place with any community member involved with the Advisory Council.

APPLICATION

- ▶ Collect all documents and complete Form CMS-855A.
 - ▶ Complete Form CMS-588: Electronic Funds Transfer (EFT) Authorization Agreement.
 - ▶ Pay Medicare Enrollment Application Registration Fee.
 - ▶ Submit Medicare Enrollment Application Forms.
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APPLICATION

- ▶ Once you have submitted your application forms submit specific forms required by your state.

STATE APPLICATION FORMS

- ▶ **Most Common Required State Forms**
- ▶ CMS-1561-A: Health Insurance Benefit Agreement – Rural Health Clinic. This form establishes eligibility for payment under Title XVIII of the Social Security Act and details the Clinic's agreement to comply with delineated specifications related to service provision and billing issues. Once the clinic has successfully passed the RHC certification survey and enrolled in the RHC Medicare program, the Secretary of Health and Human Services will sign the originals and one will be sent to the clinic for your files. **You will be required to file two (2) of these forms.**
- ▶ CMS-29: Request To Establish Eligibility To Participate In The Health Insurance For The Aged And Disabled Program To Provide Rural Health Clinic Services. This form is used to verify medical supervision, medical personnel and type of control, i.e., individual, corporation, non-profit, etc.
- ▶ For NEW RHC freestanding and Provider Based applications, you are also required to file OCR forms HHS690.

SURVEY READY

- ▶ Complete a mock survey.
- ▶ Letter to state of readiness or AAAASF.
- ▶ State Survey Agencies perform initial surveys (inspections) and periodic resurveys (including complaint surveys) of all providers. These surveys are conducted to determine if a provider meets applicable requirements for participation in the Medicare and Medicaid programs, and to evaluate performance and effectiveness in providing a safe and acceptable quality of care. New RHC applicants are expected to have all RHC requirements implemented at the time the surveyor is present at the clinic, as a standard of practice. Substantial compliance with each condition and all regulatory requirements is expected.

I PASSED NOW WHAT?

- ▶ Certification letter takes 30–45 days to get from CMS once the state passes the clinic from the survey.
- ▶ While waiting for the letter, All Ohio RHCs should prepare a projected cost report for Medicare rate setting purposes unless you want to keep the \$50.00 interim rate until a FINAL annual cost report is completed, reviewed and applied to increase the rate with Medicare for the clinic closer to/or at the camp rate.
 - Upon receiving your tie-in notice (final approval) the rate setting department will set up a new RHC clinic rate at \$50.00 until a projected cost report is received. (This is for both Independent and Provider Based).
 - Most RHCs would want to file a project cost report to expedite the higher rate but this is not mandatory.
 - If your clinic is getting ready to file the final annual cost report you may opt to not file the projected cost report and then use the final annual report to set the rate higher.

I PASSED NOW WHAT?

- ▶ No need to hold claims for Medicare, but the chosen option is to hold claims for Medicare if the clinic can afford to do so effective the date the clinic passes survey, then get set up as soon as possible to bill Medicare part A and then release the claims to be paid as RHC. The clinic can choose to continue to bill to Medicare part B but a matrix of data will need to be filed with the first filed cost report to Medicare part A to be made whole to the RHC rate. This can only be an option taken for a short period of time.
- ▶ Medicaid billing as RHC – generally you do not need to hold claims, but just begin billing as an RHC with the correct POS info, etc. as the state requires, generally the state will do a retro settlement to make the clinic whole to the RHC rate for those visits billed as a regular FFS claim that were after the RHC cert effective date.

I PASSED—NOW WHAT?

- ▶ **Step 1:** Link RHC National Provider Identifier (NPI) number with RHC taxonomy code.
- ▶ **Step 2:** Verify receipt of certification letter with your MAC.
- ▶ **Step 3** Verify receipt of Electronic Funds Transfer (EFT) enrollment approval.
- ▶ **Step 4** Complete billing software compatibility assessment.
- ▶ **Step 5:** Enroll with Medicaid.
- ▶ **Step 6:** Enroll with Medicare Electronic Data Interchange (EDI).
- ▶ **Step 7:** Enroll for Electronic Remittance Advice (ERA) reports.
- ▶ **Step 8:** Negotiate Medicare and Medicaid reimbursement rates.
- ▶

STEP 1 FOLLOW UP

- ▶ Log onto the NPPES website, navigate to the taxonomy code section and update to RHC billing taxonomy 261QR1300X. To login, you will need your username and password. The site can be accessed at:

<https://nppes.cms.hhs.gov/NPPES/LoginPage.do?userType=PROVIDER>

STEP 2 FOLLOW UP

- ▶ Call your MAC where the Medicare application was filed. You may talk with someone in Provider Enrollment, EDI, or your analyst.
 - ▶ Ask if they received the RHC certification letter from CMS. Typically, it takes up to 10 business days for the MAC to receive the letter and finalize the enrollment file. If the MAC does not have the certification letter, be sure to send them a copy.
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STEP 3 FOLLOW UP

- ▶ When the certification letter is received by the MAC, they will then enroll the clinic with EFT. You will need to be aware that the EFT has been processed. The contact person listed on the EFT form will receive the approval letter. Keep this letter in your files for future reference. Typically the EFT approval letter is received within 15 business days after the MAC receives the CMS certification letter. If you do not have this letter, contact the MAC via phone and ask if they have the form and are processing it or need another copy. It is very unlikely you will need to submit another EFT as it is mandatory upon initial enrollment. We mainly want you to be aware that you will be getting an approval letter for this from the MAC.
- ▶ Once you have verified receipt of the EFT enrollment approval, go to the Chapter 3 Checklist on page 45 and document the date of verification. You can also use the checklist to record dates that actions were approved.

STEP 4 FOLLOW UP

- ▶ Complete billing software compatibility. Make sure that your software is capable of RHC billing and capturing the correct data for cost reporting purposes.

STEP 5 FOLLOW UP

- ▶ CMS has authorized each state to manage the Medicaid claims and reimbursement process. In our experience, the processes implemented by each state range from very simple to very complex, so it is imperative that you understand the process.

STEP 6 FOLLOW UP

- ▶ The Electronic Data Interchange (EDI) Enrollment process provides for collection of the information needed to successfully exchange EDI transactions between Medicare/Medicaid and EDI trading partners and also establishes the expectations for both parties in the exchange.

STEP 7 FOLLOW UP

- ▶ An ERA is an electronic file that contains claim payment and remittance information. It is often referred to by its HIPAA transaction number, 835. It is the electronic version of the Standard Paper Remit (SPR). After Medicare processes a claim, either an ERA or an SPR is sent with final claim adjudication and payment information. One ERA or SPR usually includes adjudication decisions about multiple claims. Itemized information is reported within that ERA or SPR for each claim and/or line to enable the provider to associate the adjudication decisions with those claims/lines as submitted by the provider. The ERA or SPR reports the reason for each adjustment, and the value of each adjustment.

STEP 8 FOLLOW UP

- ▶ **Before you can bill any RHC services, you must have receipt of a rate letter from Medicare and Medicaid. Medicare reimbursement rates are set by the MAC and Medicaid reimbursement rates are set by your state's Medicaid Agency.**
- 

HOW DO I GET REIMBURSED?

- ▶ **Step 1:** Familiarize yourself with Medicare billing procedures.
- ▶ **Step 2:** Familiarize yourself with RHC billing procedures.
- ▶ **Step 3:** Familiarize yourself with RHC billing form UB-04.
- ▶ **Step 4:** Familiarize yourself with Medicaid billing procedures.
- ▶ **Step 5:** Familiarize yourself with annual cost reporting procedures.

HOW DO I GET REIMBURSED?

- ▶ **Step 6:** Create a process to collect information for cost reports.
 - Quarterly credit balance reports need to be filed
 - Vaccine logs kept
 - Consultant to help?
 - Become a member of NARHC : Becoming a member of the National Association of Rural Health Clinics (NARHC) – you can talk with Rhondi Davis or apply on line. Voice of RHCs in Washington , based on members, list serve is hundreds of RHCs talking across the country. You can reach her toll free at 866.306.1961 or complete membership application on line at: http://www.narhc.org/members/membership_application.php
 - Do not need to be RHC, but they might be interested: NHSC application to become an approved site: <http://nhsc.hrsa.gov/sites/index.html>

HOW DO I GET REIMBURSED?

- ▶ **Step 7:** Create a process to conduct time studies.
- ▶ **Step 8:** Create a process to document practitioner productivity.
 - Become familiarized with all of the above while waiting for the CMS certification letter so you understand what to do when you get your approval rates and billing set up to send as RHC claims to both ,Medicare and Medicaid

Q & A

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