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Rural Health Clinic

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CENTERS for MEDICARE & MEDICAID SERVICES

Part A

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Rural Health Clinic Manual

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Rural Health Clinic Manual

RURAL HEALTH CLINIC HISTORY

Creation and Scope of the Program

The Rural Health Clinic (RHC) Services Act (PL 95-210) is a federal law passed in 1977 to help meet the primary and emergency health needs of the rural communities. The interest in rural health services grew in the 1980s for several reasons:

- Many rural hospitals closed due to increased financial pressures.
- In 1987, Congress passed laws improving RHC reimbursement.
- Rural physicians found Medicare and Medicaid reimbursement inadequate, causing limited access to rural medical services.
- An increased demand for primary care services for Medicaid beneficiaries due to expansions in Medicaid benefits.
- Reductions in the National Health Services Corps that caused the number of physicians in the underserved rural areas to drop dramatically.

There are currently more than 3,000 RHCs throughout the nation certified by CMS, which is under the U.S. Department of Health and Human Services.

Roughly 20 percent of the nation's population lives in areas where education, economic, transportation and health services are sparse to non-existent. Because of the scarcity of physicians, rural health services in the clinics may be provided by independent RHCs that are owned and operated by a physician, nurse practitioner, physician's assistant and/or certified nurse midwife, or the RHC may be owned and operated by a Medicare participating provider (hospital, Skilled Nursing Facility (SNF) or home health agency). The RHC may be housed in a permanent or mobile structure.

CERTIFICATION

Certification Criteria

The following are the Rural Health Clinic (RHC) certification criteria:

- An RHC must be in compliance with federal, state and local laws, which include the Americans with Disabilities Act, state medical and nursing practices acts, pharmacy laws, and local fire, sanitation and building codes.
- The clinic may be in a permanent location or a mobile unit with a fixed schedule of locations.
- An RHC must have a physician on staff who provides medical supervision for the clinic's staff. The physician must be present at the clinic at least every two weeks for medical direction, consultation and supervision and be available by telecommunication at all times for assistance with medical emergencies and patient referrals.
- The clinic must employ at least one nurse practitioner, physician assistant or certified nurse midwife who is on duty at least 50 percent of the time the clinic is open and who is under the general direction of the physician. One of these professionals must be present to provide service whenever the clinic is open.
- Other required staff members include:
  - Clinic nurse/aide.
  - Front desk receptionist.
  - Clinic administrator.
  - Billing personnel.
  - Medical records librarian.

  Note: One person may fill several of the above positions, but each position must be listed on the Medicare survey.

The RHC must:

- Provide routine diagnostic and laboratory services such as, chemical examination of urine, hemoglobin/hematocrit, blood sugar, occult blood, pregnancy and primary cultures for transmittal to a certified lab.
- Have written policies and procedures.
- Establish arrangements with providers and suppliers participating in the Medicare and/or Medicaid program to furnish medically necessary services not available at the clinic, such as inpatient hospital care, physician services, and additional or specialized laboratory services.
- Be able to provide first-response emergency care, including necessary drugs.
- Ensure the maintenance and security of patient records.

- Must maintain appropriate health and safety standards, complying with local, state and federal laws.
- Have a mechanism for an annual evaluation of the clinic's program.
- Have policies and procedures in place for transferring patients in need of acute care.

To become Medicare-certified as an RHC, a provider must submit an application to its local Department of Health. If a hospital provides RHC services at more than one site, each site is considered a clinic. The location of the site, rather than the location of the provider hospital, will determine the eligibility of the RHC.

Note: Once the provider's state has certified its clinic, CMS will assign a CMS Certification Number (CCN).

Request for Provider-Based Status

For clinics seeking status as provider-based, the provider will need to furnish documentation to support its claim of provider-based status to the state survey agency.

CMS will no longer make provider-based determinations on RHCs based at hospitals with 50 or more beds; since these hospital-based RHCs are paid the same as freestanding RHCs, there is no reimbursement incentive to be hospital-based. CMS will continue to make provider-based determinations for RHCs based at hospitals with fewer than 50 beds, since these hospital-based RHCs are not subject to the national encounter rate cap (and thus still have a reimbursement incentive to be hospital-based).

CMS Policy Statement

CMS policy states that the following applicable requirements must be met before an entity can be designated as part of a provider for payment purposes:

- The entity is physically located in close proximity to the provider where it is based, and both facilities serve the same patient population (e.g., from the same service or catchment area).
- The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the state separately licenses the provider-based entity).
- The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body) and the accrediting body recognizes the entity as part of the provider.
- The entity is operated under common ownership and control (i.e., common governance) by the provider where it is based as evidenced by the following:
    - The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based.

  - The provider has final responsibility for administrative decisions, final approval for personnel actions and final approval for medical staff appointments in the provider-based entity.
  - The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment and service personnel on a daily basis.
- The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:
  - The director or individual responsible for day-to-day operations at the entity maintains daily reporting and is accountable to the chief executive officer of the provider and reports (through that individual) to the governing body of the provider where the entity is based.
  - Administrative functions of the entity, e.g., records, billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.
- Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:
  - Professional staff of the provider-based entity has clinical privileges in the provider's facility where it is based.
  - The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the chief medical officer or other similar officials of the provider where it is based.
  - All medical staff committees or other professional committees at the provider's facility where the entity is based are responsible for all medical activities in the provider-based entity.
  - Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based.
  - Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services.
  - The provider where it is based integrates patient services provided in the entity into corresponding inpatient and/or outpatient services, as appropriate.
- The entity is held out to the public as part of the provider where it is based (e.g., patients know they are entering the provider and will be billed accordingly).
- The entity and the provider where it is based are financially integrated as evidenced by the following:
  - The entity and the provider where it is based have an agreement for sharing income and expenses.
  - The entity reports its cost in the cost report of the provider where it is based using the same accounting system for the same cost-reporting period as the provider where it is based.

For any questions concerning certification, please contact your state survey and certification department.

HEALTH CARE PROFESSIONALS AND COVERAGE

Rural Health Clinic Covered Services

The services offered in a Rural Health Clinic (RHC) are the type of services that patients receive in a doctor's office, an outpatient clinic or emergency room. Such services are physician's diagnostic, treatment or consultation services. In an RHC, a nurse practitioner, physician's assistant, certified nurse midwife, clinical psychologist or clinical social worker may also provide the services.

Services are covered in an RHC if the following apply:

- They are medically reasonable and necessary.
- They are provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical social worker or clinical psychologist who is employed by or receives compensation from the clinic.
- If not provided by a physician, the service is provided under the general supervision of the physician.
- They are provided in accordance with the clinic's policies, protocols, standing orders or any physician's medical orders for patient care and treatment.
- If not provided by a physician, state law permits the nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist or clinical social worker to provide the service.
- Services not provided by a physician are covered if Medicare would cover the service when performed by a physician.

SERVICES AND SUPPLIES 'INCIDENT TO' THE SERVICES

Services and supplies that are "incident to" the services of the physician, nurse practitioner, physician assistant, clinical psychologist or clinical social worker are also covered in the RHC. This would include services of other clinic employees including registered nurses, licensed vocational nurses, technicians or aides. This also includes supplies such as casts, bandages and splints that are used for these services. Only drugs and biologicals that cannot be self-administered are covered in the RHC.

RHC Services Not Covered

Services not covered in an RHC as clinic services, but may be covered under other Medicare benefits, include:

- Durable Medical Equipment (DME) (whether rented or sold) including iron lungs, hospital beds used in the patient's home, wheelchairs, etc.
- Ambulance services.
- Prosthetic devices, which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care, and the replacement of such devices.

- Leg, arm, back and neck braces and artificial legs, arms and eyes, including replacements required because of a change in the patient's physical condition.
- Physical, speech or occupational therapy with a therapist **not employed** by the RHC.
- Technical components of diagnostic tests.

Contracted non-physician diagnostic or therapeutic services are also excluded from RHC coverage.

Example: If an RHC has an agreement to obtain specialized laboratory or therapy services from an outside agency or individual not employed by the RHC, the service must be billed by the outside agency or individual to its own Medicare contractor. The service cannot be billed through the RHC.

Note: Services related to the terminal illness of a hospice patient cannot be billed as RHC services. If the RHC physician is the hospice patient's attending physician, these hospice-related services can be reimbursed by the hospice service to the physician. RHC physicians and practitioners can bill, as an RHC, only the services not related to the terminal condition of a hospice patient. Condition code 07 must be on the claim to indicate the provider is not treating the patient for the terminal condition and, therefore, is requesting regular Medicare payment.

General Exclusions From Medicare Coverage

No payment can be made under Medicare Part A or Part B for items and services with the following characteristics:

- Not reasonable and necessary.
- No legal obligation to pay for or provide.
- Furnished or paid for by government instrumentalities.
- Not provided within the United States.
- Personal comfort.
- Routine services and appliances.
- Supportive devices for feet.
- Custodial care.
- Cosmetic surgery.
- Charges by immediate relatives or members of household.
- Dental services.
- Paid or expected to be paid under a Medicare Secondary Payer (MSP) provision.
- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital.

Physician Services

Physician services are the professional services performed by a physician for a patient including diagnosis, therapy, surgery and consultation. A service may be considered to be a physician service if the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization is possible by means of X-rays, electrocardiogram (EKG) and electroencephalogram tapes, tissue samples, etc.

Example: The interpretation by a physician of an actual EKG or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of verbal description) is a covered service.

DETERMINING PROFESSIONAL SERVICES

In determining whether the professional services of a physician are RHC services, the following general rules apply:

- The services of a physician performed at the clinic are RHC services and are payable only to the clinic.
- Services by means of a telephone call between a physician and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are not separately billable but can be included as part of another billable visit by the RHC practitioner (e.g., revenue code 0521).
- Visits for the sole purpose of obtaining or renewing a prescription, in which the need was previously determined (so that no examination of the patient is performed), are not covered services.
- Time used in completion of claim forms.
- Care plan oversight is not allowed by either Part A or Part B for RHC providers.

Full-time and part-time physicians who are employees of an RHC, or compensated under agreement by the clinic for providing services furnished to the clinic's patients in a location other than at the clinic, may furnish services to clinic patients at the clinic or in other locations (e.g., in a patient's home). These services are RHC services and are payable only to the clinic. Clinic patients include individuals who receive services at the clinic facility or services provided elsewhere for which the costs are included in the costs of the RHC. A physician who is an employee of an RHC or compensated by the clinic for services in locations other than the clinic may not bill the Medicare Part B program through the contractor for services furnished to Medicare beneficiaries at locations away from the clinic.

If the clinic does not compensate a physician for services furnished to clinic patients in a location other than the RHC location, the physician may bill for Medicare payment under Part B for a location away from the clinic.

Note: Services rendered in hospital settings (inpatient, outpatient, and emergency room) are not considered RHC services. These services must be billed to the contractor on the CMS-1500 claim form.

SERVICES AND SUPPLIES FURNISHED 'INCIDENT TO' THE PROFESSIONAL SERVICES OF THE RHC PRACTITIONER

Services and supplies "incident to" the professional services of an RHC practitioner (physician, physician's assistant, nurse practitioner, nurse midwife or clinical psychologist) are covered as RHC services as long as the services and supplies are:

- Furnished as an incidental, although integral, part of an RHC practitioner's services.
- A type commonly furnished either without charge or included in the RHC's bill.
- A type commonly furnished in a physician's office.
- Services provided by **clinic employees** that are furnished under the direct and personal supervision of an RHC practitioner.
- Furnished by a member of the clinic or staff who is an **employee** of the clinic.

The service or supply must be an integral, although incidental, part of the RHC practitioner's professional services in the course of diagnosis or treatment of an injury or illness. In other words, there must be a practitioner's personal service furnished, of which the clinical staff member's service (or the supply) is an incidental, although integral, part. However, this does not mean that each occasion of service by a clinical staff member (or the furnishing of a supply) must always be the occasion of the actual furnishing of a personal professional service by the RHC practitioner. This requirement is also met for clinic staff services furnished during a course of treatment in which the practitioner performs an initial and subsequent service with a frequency that reflects his active participation in, and management of, the course of treatment. However, the direct and personal supervision requirement must still be met with respect to every clinical staff member's service for it to be covered as an "incident to" service.

Commonly furnished services and supplies are those customarily "incident to" a physician's personal services in the office or in physician-directed clinic settings. The requirement is not met when supplies are clearly types of materials that a physician is not expected to have on hand in his office or where services are a type that are not medically appropriate in the office setting.

Example: The performance of an appendectomy is not a service that is commonly furnished in a physician's office.

Coverage is limited to situations where there is direct supervision of the clinic staff performing the service. Direct and personal supervision does not mean that the RHC practitioner must be present in the same room. However, the practitioner must be on the premises and immediately available to provide assistance and direction throughout the

time the clinical staff is performing services. In other words, if no mid-level practitioner or physician is on the premises, auxiliary staff may not provide any medical services.

To be "incident to," the services must be provided by a member of the clinic's health care staff who is a clinic employee. Services provided by auxiliary personnel **not employed by** the clinic, even if provided on the physician's order or included in the clinic bill (e.g., services of an independently practicing therapist who forwards his bill to the clinic for inclusion in the entity's statement of services), are not covered as "incident to" an RHC practitioner's service. Thus, non-physician diagnostic and therapeutic services that a clinic obtains (i.e., from an independent laboratory or a hospital outpatient department) **are not covered** as RHC services and cannot be billed to Medicare by the RHC.

As with the physician's personal professional service, the services (or supplies) must be furnished without charge or be included in the clinic bill. The patient's financial liability for the incidental services (or supplies) is to the clinic. Therefore, the incidental services (or supplies) must represent an expense incurred by the RHC.

Example: If a patient purchases a drug and the physician administers it, the drug is not covered as an RHC service.

Services and supplies covered under this provision include items such as bandages, gauze and assistance by a nurse to a practitioner performing a covered nurse practitioner's or physician assistant's service, etc. Only drugs and biologicals that cannot be self-administered or are specifically covered by Medicare law (e.g., antigens prepared by a physician for a particular patient) are covered under this provision.

Nurse Practitioner, Physician Assistant and Nurse Midwife Services

Nurse practitioner or physician assistant services (including services furnished by nurse midwives) are covered as RHC services. The services are covered if they are:

- Furnished by a nurse practitioner, physician assistant or certified nurse midwife who is employed by or receives compensation from an RHC (mid-level practitioners cannot be contracted workers; they can only be an employee of the clinic or clinic owner).
- Furnished under the general (or direct, if required by state law) medical supervision of a physician.
- Furnished in accordance with clinic policies and any physician's medical orders for the care and treatment of a patient.
- A type of service that the nurse practitioner, physician assistant or certified nurse midwife is legally permitted to perform by the state in which the service is furnished.
- A type of service that would be covered under Medicare if furnished by a physician.

Nurse practitioner and physician assistant (including certified nurse midwife) services are professional services performed by a nurse practitioner, physician assistant or certified nurse midwife for a patient. Services include diagnosis, treatment, therapy and consultation. The service must be rendered directly by the practitioner (i.e., the practitioner must either examine the patient in person or be able to visualize some aspect of the patient's condition without the interposition of a third person's judgment). Direct visualization is possible by means of X-rays, EKG and electroencephalogram tapes, tissue samples, etc.

In general, Medicare covers services provided by a nurse practitioner, physician assistant and certified nurse midwife that would be considered covered physician services under Medicare, and are permitted by state laws and clinic policies to be furnished by a nurse practitioner, physician assistant or certified nurse midwife. As with physician services under Medicare, a service will not be covered if it is not reasonable and necessary for the treatment of a patient's illness or condition or to improve the functioning of a malformed body member.

To determine whether the professional services of a nurse practitioner, physician assistant or certified nurse midwife are RHC services, the following general rules apply:

- The services of a nurse practitioner or physician assistant (including services furnished by certified nurse midwives) performed at the clinic are RHC services and are payable only to the clinic.
- Services by means of a telephone call between a physician and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are not separately billable but can be included as part of another billable visit by the RHC practitioner (e.g., revenue code 0521).
- Visits for the sole purpose of obtaining or renewing a prescription, the need for which was previously determined (so that no examination of the patient is performed) are not covered services.
- Time used in completion of claim forms is not a billable service.
- Care plan oversight is not allowed either by Part A or Part B for RHC providers.

Full- and part-time physician assistants and nurse practitioners (including nurse midwives) who are employees of an RHC or who are compensated by the clinic for providing services furnished to the clinic's patients in locations other than the clinic may furnish services to clinic patients at the clinic or in other locations, such as the patient's home. These services are RHC services and are reimbursable only to the clinic. Clinic patients include individuals who receive services at the clinic facility or services provided elsewhere. These costs are included in the costs of the RHC.

A physician assistant or nurse practitioner (including nurse midwives) who is an employee of an RHC or who is compensated by the clinic for services in locations other than the clinic may not bill Medicare Part B for services furnished to Medicare

beneficiaries at locations away from the clinic. If the clinic does not compensate a physician for services furnished to the clinic's patients in a location other than at the RHC location, the physician may bill for Medicare payment under Part B for "location away from the clinic."

Note: Services rendered in a hospital setting (inpatient, outpatient and emergency room) are not considered RHC services. These can be charged to the contractor on the CMS-1500.

Under Medicare Part B, non-RHC services of physician assistants are covered in any setting in rural health professional shortage areas, and non-RHC services of nurse practitioners are covered in any non-medical service administration rural setting. Such services are billed to the contractor, and payment may be made directly to the nurse practitioner or the employer of the physician assistant or nurse practitioner. Certified nurse midwives can provide services in any area. Part B contractor payment can be paid directly to the nurse midwife or the employer of the nurse midwife.

State laws concerning services of physician assistants, nurse practitioners and certified nurse midwives vary from state to state. Please contact the contractor in your state for additional information regarding Part B coverage and billing.

VISITING NURSE SERVICES

Visiting nurse services are covered as RHC services if:

- The RHC has received special certification from CMS to provide visiting nurse services because the RHC is located in an area in which CMS has determined there is a shortage of home health agencies (for more information, contact your state Department of Health).
- The services are rendered to patients who are homebound.
- The patient is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC.
- The services are furnished under a written plan of treatment.

Clinical Psychologist Services

REQUIREMENTS

To qualify as a clinical psychologist, a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology from a program in clinical psychology of an educational institution that is accredited by an organization recognized by the Council on Post-Secondary Accreditation.
- Meet licensing or certification standards for psychologists in independent practice in the state in which he practices.

- Have two years of supervised clinical experience, at least one of which is post-degree.

COVERED SERVICES

The diagnostic and therapeutic services of a clinical psychologist and services/supplies furnished "incident to" such services are covered in an RHC. However, the clinical psychologist must be legally authorized to perform the service under applicable licensure laws of the state in which they are furnished.

To be covered "incident to" a clinical psychologist's service, the following services and supplies must be:

- Mental health services that are commonly furnished in a clinical psychologist's office.
- An integral, although incidental, part of professional services performed by the clinical psychologist.
- Performed under the direct and personal supervision of a clinical psychologist (i.e., the clinical psychologist must be physically present and immediately available).

The services of clinical psychologists are not covered if they are otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by state law to perform them. Services at the RHC or away from the RHC are covered (for more information, refer to the previous discussion in "Physician Services").

The clinical psychologist must provide written notification to the patient's designated attending or primary care physician that services are being provided to the patient or must consult directly with the physician to consider medical conditions that may be contributing to the patient's symptoms, unless the patient specifically requests that such notification or consultation not be made.

PSYCHIATRIC LIMITATIONS

All covered therapeutic services furnished by qualified clinical psychologists in an RHC are subject to the outpatient mental health services limitation. This limitation does not apply to diagnostic services.

CMS is phasing out the outpatient mental health treatment limitation over a five-year period (2010–2014). Effective January 1, 2014, Medicare will pay outpatient mental health services at the same rate as other Part B services, which are paid at 80 percent of the Medicare Physician Fee Schedule (MPFS).

Section 102 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that the current 62.5 percent outpatient mental health treatment limitation will be reduced as follows:

- January 1, 2010 – December 31, 2011: The limitation percentage is 68.75 percent (Medicare pays 55 percent and the patient pays 45 percent).
- January 1, 2012 – December 31, 2012: The limitation percentage is 75 percent (Medicare pays 60 percent and the patient pays 40 percent).
- January 1, 2013 – December 31, 2013: The limitation percentage is 81.25 percent (Medicare pays 65 percent and the patient pays 35 percent).
- Beginning January 1, 2014: The limitation percentage is 100 percent (Medicare pays 80 percent and the patient pays 20 percent).

Clinical Social Worker Services

REQUIREMENTS

RHC services include the services provided by a clinical social worker. A clinical social worker must meet the following requirements:

- Possesses a master's or doctorate's degree in social work.
- Has performed at least two years of supervised clinical social work.
- Is either licensed or certified as a clinical social worker by the state in which the services are performed.

Note: If an individual practices in a state that does not provide for licensure or certification, the social worker must have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting, such as a hospital, SNF or clinic.

COVERED SERVICES

Coverage is limited to the services a clinical social worker is legally authorized to perform in accordance with state law (or state regulatory mechanism established by state law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses and services and supplies furnished "incident to" such services.

The services of a clinical social worker may be covered in an RHC if they are:

- The type of services that are otherwise covered if furnished by a physician or "incident to" a physician's service.
- Performed by a person who meets the above definition of clinical social worker.
- Not otherwise excluded from coverage.

Note: Services of a clinical social worker are not covered when furnished to inpatients of a hospital or to inpatients of an SNF if the services furnished in the SNF are those that the SNF is required to furnish as a condition of participation in Medicare. Services at the RHC or away from the RHC are covered (for more information, refer to "Physician Services").

Only the direct “hands-on” services of a clinical social worker are covered. No coverage is available for services and supplies furnished “incident to” the professional services of a clinical social worker.

MEDICARE REQUIREMENTS

CMS Certification Number

All providers will be issued a CMS Certification Number (CCN) by CMS after they complete their state survey. This number will contain the state code and provider specialty ranges. An example of state codes and the CCN ranges are listed below.

State Codes		Freestanding RHC Ranges	Provider-Based RHC Ranges
Colorado	06	3800–3974	3400–3499
New Mexico	32	8900–8999	3975–3999
Oklahoma	37		8500–8899
Texas	45, 67, 74		

National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier. The NPI is a numeric 10-digit identifier consisting of nine numbers plus a check-digit in the 10th position. The NPI replaced health care provider identifiers.

HIPAA-covered entities such as providers completing electronic transactions, health care clearinghouses and large health plans must use only the NPI to identify covered health care providers in standard transactions.

More information on the NPI is available on the CMS Web site at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html.

SUBPARTS

HIPAA-covered entities are legal entities. Often, a health care provider that is an organization may comprise components that function as health care providers somewhat independently of the “parent” (the covered organization health care provider of which they are a part). These components are called “subparts.” Subparts may conduct their own HIPAA standard transactions, be certified by the state separately from their “parent” or be located at the same location as, or a different location from, their “parent.” The covered organization health care provider needs to determine if it consists of any such subparts and, if so, determine if any of those subparts need to

have their own unique NPIs to be identified in HIPAA standard transactions. Many providers enrolled in Medicare are actually subparts. Examples of subparts may include different components of an organization health care provider, such as different departments of a hospital, and separate physical locations of an organization health care provider, such as the different locations of the members of a chain.

TAXONOMY CODES

Institutional providers submitting claims for their primary facility and its subparts (i.e., psychiatric unit, rehabilitation unit, etc.) may report a taxonomy code on all of their claims submitted to the contractor. The taxonomy code assists the provider in differentiating claims submitted for each of its subparts when a provider has chosen not to apply for a unique NPI for those subparts individually.

REPORTING THE NAME AND NPI

On the UB-04 claim form, enter the NPI, physician's last name and initial of the first name in FL 76 (attending/admitting physician ID). Enter the NPI, physician's last name and initial of the first name in FL 78 (other physician ID), if applicable. If no procedure is performed, leave blank.

Type of Bill

All charges submitted by an RHC will appear under Type of Bill (TOB) 71X. The third digit of the TOB is the bill frequency. This digit shows the nature or intent of the bill submitted. Below is a listing of the possible third digits available to an RHC.

Non-payment/zero claim	0
Admit through discharge claim	1
Replacement of prior claim	7
Void/cancel of prior claim	8

Part B Deductible

The Part B annual deductible applies to services covered under the RHC benefit.

Coinsurance

If the item or service is covered as an RHC service, the clinic may not charge the beneficiary more than 20 percent of the charges plus the deductible. The clinic may charge the beneficiary for items and services that are not Medicare-covered services.

Split Billing

All Part B providers must split their outpatient bills for both calendar year-end and fiscal year-end. This will assist in proper cost-reporting information and the correct calculations of Part B deductible amounts on the patient's statements.

CHARGES FOR MISSED APPOINTMENTS

CMS' policy allows physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The amount that the physician or supplier charges for the missed appointment must apply equally to all patients (Medicare and non-Medicare), in other words, the amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount they charge non-Medicare patients (whatever amount that may be).

With respect to Part A providers, in most instances, a hospital outpatient department can charge a beneficiary for a missed appointment without violating its provider agreement and 42 CFR 489.22. Because 42 CFR 489.22 applies only to inpatient services, it does not restrict a hospital outpatient department from imposing charges for missed appointments by outpatients. In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians or other suppliers. Charges to beneficiaries for missed appointments should not be billed to Medicare.

Reporting Line-Level Rendering Physician/Practitioner NPI

Providers who submit a combined claim (claims that include both facility and professional components) will need to report the rendering physician or other practitioner at the line level if it differs from the rendering physician/practitioner reported at the claim level.

Medicare needs to identify primary physicians/practitioners of services not only for use in standard claims transactions, but also for review, fraud detection and planning purposes. To accomplish this, CMS must be able to identify the rendering physician/practitioner for each inpatient/outpatient service billed to Medicare and store that information for data analysis. Prior to the implementation of the 5010 version of the 837I, that information could only be collected at the claim level in the “other provider” field.

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CMS will begin collecting this information at the line level following the implementation of the 5010 version of the 837I. To perform needed data analysis, it is critical that FISS be able to associate physician/practitioner identifying information with each line item on institutional claims and be able to forward that information to the Common Working File (CWF).

Additional information on NPI reporting is available in the following job aid: http://www.trailblazerhealth.com/Publications/Job Aid/CrosswalktotheCMS-1450(UB-04)ClaimForm-version5010.pdf.

RHC Encounters

RHCs are paid on the basis of an encounter. An encounter is defined as "a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist or clinical social worker during which an RHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit," The following exception is possible in rare circumstances: "… except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment."

REIMBURSEMENT

RHCs are reimbursed the lower of the national capped amount or the clinic-specific cost per encounter. The national capped amount is indexed for inflation and can increase each year. RHC payment is subject to the Part B cash deductible. This amount is subject to regulatory change. After the deductible has been satisfied, RHCs are reimbursed 80 percent of the all-inclusive reimbursement rate. The patient is responsible for a coinsurance amount equal to 20 percent of the billed amount.

For newly certified RHCs, the reimbursement rate will be automatically established at 75 percent of the national capped amount. This rate will remain in effect until the provider submits financial data or until the cost report is submitted. A copy of the CMS-222 cost reporting form will be sent with the rate notification letter for providing additional updated information. The cost report can be completed containing, at a minimum, three months of actual data, or the contractor will also accept budget data. Pneumococcal and influenza vaccines are payable through the cost report for both provider-based and freestanding RHCs and cannot be billed.

Payment	Limit Adjustment	Period
$78.54	0.06 percent	01/01/12–12/31/12
$78.07	0.4 percent	01/01/11–12/31/11

Payment	Limit Adjustment	Period
$77.76	1.2 percent	01/01/10–12/31/10
$76.84	1.6 percent	01/01/09–12/31/09
$75.63	1.01 percent	01/01/08–12/31/08
$74.29	2.1 percent	01/01/07–12/31/07
$72.76	2.8 percent	01/01/06–12/31/06
$70.78	3.1 percent	01/01/05–12/31/05
$68.65	2.9 percent	01/01/04–12/31/04
$66.72	3.0 percent	03/01/03–12/31/03
$66.46	2.6 percent	01/01/03–02/28/03
$64.78	2.6 percent	01/01/02–12/31/02
$63.14	2.1 percent	01/01/01–12/31/01

RHC Revenue Coding

RHC clinics are not required to provide HCPCS codes for an Evaluation and Management (E/M) visit. However, they are required to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71X. All charges associated with the patient's visit should be combined into a single dollar amount that is reflected under the appropriate encounter code. The number of units associated with the encounter code is one per visit.

APPLICABLE REVENUE CODES

0001 – Total Charges
0521 – Rural Health – Clinic Visit
0522 – Rural Health – Home Visit
0524 – Visit in an SNF Covered Part A Stay
0525 – Visit in an SNF Non-Covered Part A Stay
0527 – Visiting Nurse Service in Home Health Shortage Area
0528 – Visit to Other Non-RHC Site (Example: Scene of accident)
0780 – Telehealth Originating Site Facility Fee
090X – Psychiatric/Psychological Service
0940 – Peripheral Neuropathy

Charges for the RHC services furnished during an encounter should be reported under the 052X revenue code. It is not appropriate for RHCs to fragment the visit/encounter into unique components, e.g., separate charges for pharmacy, supplies, surgeries, etc. For RHCs, all these services should be combined into one encounter (revenue code

052X or 091X). Charges for the interpretation of diagnostic tests performed by RHC staff (physician or mid-level practitioner) are included with the charges for the encounter under revenue code 052X.

Telemedicine

Revenue code 0780 (telemedicine, general classification) is used to bill for the telehealth originating site facility fee. Telehealth originating site facility fees billed using revenue code 0780 are the only line items allowed on TOBs 71X that are not part of the RHC benefit.

- These line items require use of HCPCS code Q3014 in addition to the revenue code (0780) to indicate the facility fee is being billed.

Additional Reimbursement for the Technical Component

The technical component of a diagnostic procedure is reimbursed outside of the encounter rate. For a provider-based RHC, this reimbursement is made to the mother entity. This billing occurs under the mother entity's type of bill and CCN. For a freestanding RHC, these charges are billed to the contractor on the CMS-1500.

Additional Reimbursement for Diagnostic Laboratory Services

The technical component of a diagnostic procedure is reimbursed outside of the encounter rate. For a provider-based RHC, this reimbursement is made to the mother entity. This billing occurs under the mother entity's type of bill and CCN. For a freestanding RHC, these charges are billed to the contractor on the CMS-1500.

Additional Reimbursement for SNF Services

Reimbursement for RHC services provided in an SNF is outlined in this section.

- When an SNF Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from an RHC, those services are not subject to consolidated billing merely by virtue of being furnished under the auspices of the RHC.
- Services included within the scope of RHC services are excluded from the SNF consolidated billing provision. These services are limited to physician, physician assistant and nurse practitioner services.
- Only these services may be covered and paid through the RHC benefit when furnished to RHC patients in a covered Part A SNF stay.
- The RHC services remain separately billable to the contractor when furnished to an SNF resident during a covered Part A stay.
- When RHC services are provided outside of the RHC's regular business hours to an SNF resident, the RHC should bill the services to the contractor on the CMS-1500.

PREVENTIVE SERVICES

Effective for dates of service on or after January 1, 2011, per Change Request (CR) 7012, coinsurance and deductible are waived for most preventive services as enacted in Section 4104 of the Affordable Care Act.

An additional line item with the appropriate site of service revenue code in the 052X series should be submitted, along with the preventive HCPCS code and the charges for that service. For example, if the total charge is $200 and the preventive service charge is $75, the line items would be reported as follows:

Line	Revenue Code	HCPCS Code	Date of Service	Charges
1	052X		01/01/2011	$125.00
2	052X	Preventive HCPCS	01/01/2011	$ 75.00

The first line item will receive the all-inclusive rate; deductible and coinsurance will apply. The preventive service reported on the second line item will not receive reimbursement, as it is part of the all-inclusive rate. Deductible and coinsurance will not apply.

For a list of the waived preventive services, view the “Waiver of Deductible and Coinsurance for Preventive Services” job aid:

http://www.trailblazerhealth.com/Publications/JobAid/WaiverofDedandCoinsforPrevSvcs.pdf

More information regarding billing preventive services can be found in MLN Matters® article SE1039:

http://www.cms.gov/MLNMattersArticles/Downloads/SE1039.pdf

Professional Components

Professional components of preventive services are part of the overall encounter, and for TOB 71X, have always been billed on lines with revenue code 052X. All RHCs are required to report HCPCS codes for certain preventive services subject to frequency limits. RHCs do not receive any reimbursement on TOBs 71X for technical components of such services.

Most preventive services have HCPCS codes that allow separate billing of professional and technical components, but mammography and Prostate-Specific Antigen (PSA) do not. However, RHCs still must provide the professional component of these services since they are in the scope of the RHC benefit. Such encounters should be billed on line

items using revenue code 052X and no HCPCS coding (dates of service on or after April 1, 2005).

Technical Components

PROVIDER-BASED RHCS

The technical component of a screening or diagnostic mammography for provider-based RHCs is typically furnished by the base provider. The provider of that service bills the contractor under bill type 13X, 22X, 23X or 85X, as appropriate, using their outpatient CCN (not the RHC CCN, since these services are not covered as RHC services). Payment is based on the payment method for the base provider.

INDEPENDENT RHCS

The technical component of a screening or diagnostic mammography is outside the scope of the RHC benefit. The practitioner who renders the technical service bills his contractor on the CMS-1500. Payment is based on the Medicare Physician Fee Schedule.

Initial Preventive Physical Examination

Coverage is available for an Initial Preventive Physical Examination (IPPE) (as defined below) that meets the following requirements:

- Performed by either a physician or a qualified Non-Physician Practitioner (NPP) (as defined below).
- Furnished to an eligible beneficiary who receives the IPPE within six months after the effective date of his first Part B coverage. This is a one-time benefit only per Part B enrollee.
- On or after January 1, 2009, it is furnished to an eligible beneficiary who received the IPPE within the 12-month period of his Part B coverage effective date.

DEFINITION OF IPPE

The IPPE, as defined in 42 CFR 410.16(a), means all of the following services furnished to an individual by a physician or other qualified NPP with the goal of health promotion and disease detection:

- Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection, as those terms are defined below.
- Review of an individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

- Review of the individual's functional ability and level of safety, as described below, based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
- An examination including measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history and current clinical standards.
- Performance and interpretation of an EKG.
  - Effective January 1, 2009, the EKG screening is removed from the mandatory service of the IPPE.
  - The requirement should include education, counseling and referral for an EKG, as appropriate. This is a once-in-a-lifetime screening EKG as a result of a referral from an IPPE.
- Education, counseling and referral as deemed appropriate by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements.
- Education, counseling and referral, including a brief written plan such as a checklist, provided to the individual for obtaining the appropriate screening and other preventive services that are covered as separate Medicare Part B benefits as described individually in Section 1861 of the Social Security Act, including:
  - Pneumococcal, influenza and hepatitis B vaccines and their administration.
  - Screening mammography.
  - Screening Pap smear and screening pelvic examinations.
  - Prostate cancer screening tests.
  - Colorectal cancer screening tests.
  - Diabetes outpatient self-management training services.
  - Bone mass measurements.
  - Screening for glaucoma.
  - Medical nutrition therapy for individuals with diabetes or renal disease.
  - Cardiovascular screening blood tests.
  - Diabetes screening tests.
- Medical history, as defined in 42 CFR 410.16(a), includes, at a minimum, the following:
  - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.
  - Current medications and supplements, including calcium and vitamins.
  - Family history, including a review of medical events in the beneficiary's family, such as diseases that may be hereditary or place the individual at risk.
- Social history, as defined in 42 CFR 410.16 (a), including, at a minimum:
  - History of alcohol, tobacco and illicit drug use.

  - Diet.
  - Physical activities.
- Review of the individual's functional ability and level of safety, as defined in 42 CFR 410.16, including, at a minimum, a review of the following areas:
  - Hearing impairment.
  - Activities of daily living.
  - Risk of falling.
  - Home safety.

The following definitions apply for an IPPE:

- Eligible beneficiary, as defined in 42 CFR 410.16(a), means an individual who receives an IPPE within six months after the effective date of his first Medicare Part B coverage period but only if the first Part B coverage period begins on or after January 1, 2005.
- Physician, as defined in 42 CFR 410.16(a), means a doctor of medicine or osteopathy (as defined in Section 1861(r)(1) of the Act.
- Qualified non-physician practitioner, as defined in 42 CFR 410.16(a), means a physician assistant, nurse practitioner or clinical nurse specialist, as authorized under Sections 1861(s)(2)(K)(i) and 1861(s)(2)(K)(ii) of the Act and defined in Section 1861(aa)(5) of the Act, or in regulations at 42 CFR 410.74, 410.75 and 410.76.

For dates of service on or after January 1, 2009, the IPPE should include:

- Measurement of an individual's body mass index.
- End-of-life planning (upon an individual's consent).

The Medicare Modernization Act of 1999 did not make any provision for the waiver of the Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be applied to the required deductible if the deductible has not been met. The usual coinsurance provisions would apply.

For a Medicare beneficiary who has the IPPE performed on or after January 1, 2009, and it occurs within the 12-month period of the effective date of his initial enrollment in Medicare Part B, the Medicare deductible for the IPPE (HCPCS code G0402) is waived and no longer applies.

IPPE BILLING

These services must be billed on TOB 71X with HCPCS code G0402, and the appropriate site of service revenue code in the 52X revenue code series must be billed.

Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional or multiple encounters with the same health professional that take place on the same day and at a single location are considered a single visit. Payment for the technical component of the EKG is not billed

by the RHC itself. Instead, it is billed by either the base provider or the individual practitioner.

Annual Wellness Visit

Beginning with dates of service on or after January 1, 2011, per CR 7079, if an Annual Wellness Visit (AWV) is provided in an RHC or Federally Qualified Health Center (FQHC), the professional portion of the service is billed to the Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) using TOBs 71X and 77X, respectively, and must include HCPCS code G0438 or G0439. Deductible and coinsurance do not apply.

The CMS MLN Matters® article MM7079 can be viewed at:

http://www.cms.gov/MLNMattersArticles/downloads/MM7079.pdf

For more information concerning billing of preventive services as well as a detailed list of the preventive services allowed, consult the Guide to Medicare Preventive Services at:

http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Vaccines

Administration of influenza virus vaccine and Pneumococcal Pneumonia Vaccine (PPV) does not count as a visit when the only service performed is the administration of PPV and/or influenza vaccine. If there was another reason for the visit, the RHC should bill for the visit without adding the cost of the influenza and PPV to the charge for the visit on the bill.

Payment for the hepatitis B virus vaccine is included in the all-inclusive rate. However, RHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine. As with other vaccines administered during an otherwise payable encounter, no line items specifically for this service should be billed on the RHC claims in addition to the encounter.

SEASONAL INFLUENZA VIRUS VACCINE AND PPV INTERIM REIMBURSEMENT

RHCs are not allowed to bill for the cost and administration of PPV and seasonal influenza virus vaccine at the time of service. These services should not to be billed to the contractor on the UB-04 or the CMS-1500. These charges are reimbursable only through the Medicare cost report.

The data elements of the cost report include:

- Total cost of pneumococcal vaccine.
- Total cost of the seasonal influenza vaccine.
- Number of pneumococcal injections administered.

- Number of seasonal influenza injections.
- Number of Medicare beneficiaries who received the pneumococcal vaccine.
- Number of Medicare beneficiaries who received the seasonal influenza vaccine.

Additional information on filing cost reports may be found on the TrailBlazer Web site at:

http://www.trailblazerhealth.com/Audit - Reimbursement/Filing Cost Reports

BALANCED BUDGET ACT OF 1997

Rural Health Clinic Services (Section 4205)

PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED RHCS

The provision extends the current per visit payments limits applicable to independent RHCs to provider-based clinics (other than clinics based in small rural hospitals with fewer than 50 beds).

ASSURANCE OF QUALITY SERVICES

The provision requires RHCs to have a quality assurance and performance program as specified by the Secretary of the Department of Health and Human Services (DHHS).

WAIVER OF STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM

The provision limits the current authority for the secretary to waive the requirement that a clinic have a mid-level professional available at least 50 percent of the time. The waiver will be applicable only to clinics already providing services under Medicare and not to entities seeking Medicare certification.

REFINEMENT OF SHORTAGE AREA REQUIREMENTS

The provision refines the requirement concerning the area in which an RHC is located. RHCs must be in shortage areas that have been reviewed within the last three years. The Secretary has to find that there are insufficient numbers of needed health care practitioners in the clinic's area (not just primary care physicians). Clinics that no longer meet the shortage area requirements will be permitted to retain their designation only if the Secretary of the DHHS determines they are essential to the delivery of primary care services that would otherwise be unavailable in the area.

DIRECT PAYMENTS TO PHYSICIAN ASSISTANTS IN DECERTIFIED RHCS

Physician assistants are allowed to receive direct Medicare payments for their services if they were previously the owner of an RHC that lost its RHC designation.

REVISION HISTORY

Date	Section	Description of Revision
November 2009	All	Removed IOM and CR references.
	Reimbursement	Per CR 6605, dated November 6, 2009, CMS updated the 2010 payment rate increase.
January 2010	RHC Rules	Renamed this section "Medicare Requirements." Grouped preventive services as a separate section.
	RHC Services Not Covered	Added condition code 07 for treatment of a non-terminal condition for a hospice patient.
	Clinical Psychologist Services	Per CR 6686, dated October 30, 2009, CMS is phasing out the outpatient mental health treatment limitation.
	Non-RHC Services	Removed section.
June 2010	RHC Revenue Coding	Removed requirement for provider-based clinics to report HCPCS codes.
October 2010	Smoking and Tobacco-Use Cessation Counseling Services	Added section for tobacco cessation counseling per CR 7133, dated September 30, 2010.
	H1N1	Removed section per SE1031.
	Influenza Virus Vaccine and PPV Interim Reimbursement	Added the word "seasonal" per SE1031.
January 2011	RHC Encounters	Added 2011 payment rate increase (CR 7101).
	Preventive Services	Added information regarding CR 7012, waiver of deductible and coinsurance for most preventive services. Also added billing example from SE1039.
	Annual Wellness Visit (AWV)	Added information on a new Medicare benefit per CR 7079. Also added link to MM7079 for further information.
	Billing Using the UB-04	Deleted section.
October 2011	Annual Wellness Visit	Deleted link to "Annual Wellness Visit" job aid on TrailBlazer Web site. This information is now contained in the CMS *Guide to Medicare Preventive Services.*
December	Preventive Services	Deleted detailed billing information for

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Date	Section	Description of Revision
2011		smoking cessation counseling. Added link to the Guide to Medicare Preventive Services.
	RHC Encounters	Added upper payment limit for reimbursement for CY 2012.
February 2012	RHC Encounters	Added revised payment limit for reimbursement for CY 2012.
July 2012	*Reporting Line-Level Rendering Physician/ Practitioner NPI*	*Added information pertaining to MM7578.*