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Welcome

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Prepared for the

Illinois Critical Access Hospital Network

Development & Education

Midwest Health Care, Inc.

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Objective

To provide Regulations and Examples of what can go wrong when you don’t have a Rural Health Cheerleader in your organization.

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- Rural Health Clinics-Chapter 13 update as of January 1, 2014 with additional changes in July 2015

  - *RHCs are not paid for services furnished by contracted individuals other than physicians (CFR 42 405.2468(b)(1)). Therefore, nonphysician practitioners must be employed by the RHC, as evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100 percent ownership of the RHC, the W-2 form can be from that entity as long as all the non-physician practitioners in the RHC receive their W-2 from this owner.*

  - *The big announcement recently came out that would allow clinics to pay one qualifier NP or PA, then contract (1099) with all others. In total they still must represent 50% of the RHC hours on-site, Nursing Home or off site services do not count to the 50% requirement.*

  - Ignore all sections for FQHC, discussion.

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- Rural Health Clinics-Chapter 13 update as of January 1, 2014

  - **30.1.2 - Temporary Staffing Waivers**

    A temporary staffing waiver would only be allowed after you try for 90 days to find a replacement of the Nurse Practitioner or Physician Assistant

  - **40.4 Global Billing**

    Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If a RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package*. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.*

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- Rural Health Clinics-Chapter 13 update as of January 1, 2014

- **40.5 - 3-Day Payment Window**

  (Rev. 166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

  Medicare's 3-day payment window applies to outpatient services furnished by hospitals and hospitals' wholly owned or wholly operated Part B entities. The statute requires that hospitals' bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with section 1886 of the Social Security Act.

  RHCs and FQHC services are not subject to the Medicare 3- day payment window requirements.

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40.2 - Hours of Operation

(Rev. 173, Issued: 11-22-13, Effective: 01-01-14, Implementation: 01-06-14)

RHCs and FQHCs are required to post their hours of operations *at or near the entrance in a manner that clearly states the days of the week and the hours that RHC or FQHC services are furnished, and days of the week and the hours that the building is open solely for administrative or other purposes. This information should be easily readable, including by people with vision problems and people who are in wheel chairs. Qualified services provided to a RHC or FQHC patient other than during the posted hours of operation, are considered RHC or FQHC services when both of the following occur:*

- the practitioner is compensated by the RHC or FQHC for the services provided, and
- the cost of the service is included in the RHC or FQHC cost report.

Services furnished at times other than the RHC or FQHC posted hours of operation to Medicare beneficiaries who are RHC or FQHC patients may not be billed to Medicare Part B **if the practitioner's compensation** for these services is included in the RHC/FQHC cost report. Services whose cost is not included in the RHC/FQHC cost report may be billed as Part B services if appropriate *(See Section 90 on Commingling).*

This applies to both full and part time practitioners and to practitioners who are employees, working under contract to the RHC or FQHC, or are compensated by the RHC or FQHC under another type of arrangement. RHCs and FQHCs **should have clear policies regarding the provision of services at other times, and include this in a practitioner's employment agreement or contract.**

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- **70.4 - Productivity Standards (only used to get cost per visit)**

  (Rev. 173, Issued: 11-22-13, Effective: 01-01-14, Implementation: 01-06-14)

  Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in the RHC or FQHC. The current productivity standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent non-physician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined. The FTE on the cost report for providers is the time spent seeing patients or scheduled

  Physician services *that are provided on a short term or irregular basis under agreements are not subject to the productivity standards. Instead of the productivity limitation, purchased physician services are subject to a limitation on what Medicare would otherwise pay for the services*

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- **90 - Commingling**

If a RHC or FQHC practitioner furnishes a RHC or FQHC service at the RHC or FQHC during RHC or FQHC hours, the service must be billed as a RHC or FQHC service. The service cannot be carved out of the cost report and billed to Part B.

If a RHC or FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC or FQHC space must be clearly defined. If the RHC or FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

RHCs and FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC or FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC or FQHC and non-RHC or non-FQHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit a RHC *practitioner from providing on-call services for an emergency room, as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the practitioner with the hospital emergency department would not be a common occurrence.*

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- **90 - Commingling (cont)**

  (Rev. 173, Issued: 11-22-13, Effective: 01-01-14, Implementation: 01-06-14)

  Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

  Duplicate Medicare or Medicaid reimbursement (including situations where the RHC or FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or

  Selectively choosing a higher or lower reimbursement rate for the services.

  RHC and FQHC practitioners may not furnish RHC or FQHC-covered professional services as a Part B provider in the RHC or FQHC, or in an area outside of the certified RHC or FQHC space, such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation.

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Example of Problem:

- Hospital in Missouri, has a large Behavioral Health program and a small clinic. Provider was billing incorrectly for a Professional Councilor (PC) service for Medicare and Medicaid. PC's are **not a covered provider**.
- Remarks: The hospital said "we had been surveyed by the state for 20 years, they never said anything." .... Comments by Glen
- They also had no doors between space of the RHC.
- Remarks: "The providers were moving in and out of the space during the RHC Dedicated Hours." .... Comments by Glen

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Results:

- The state surveyor office would not accept a plan for continuing the RHC in the same space without doors, to prevent further commingling.
- The clinic was shut down and voluntarily terminated.
- The clinic must voluntarily notify Medicare and Medicaid of inappropriate billing.
- The clinics required billing OIG Compliance Plan will need to be updated.
- Most likely there will be a Office of Inspector General work plan.
- The clinic was advised to have a review of all locations by an expert in Rural Health Clinic rules in Missouri.
- Cost: several legal firms, pay backs, in excess of multiple six figures.
- There will be a public release of this information and there will be negative actions on behalf of the press.

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42CFR 491.11 Annual Program Evaluation

In particular, the CFR cites the following regulations, which this annual evaluation process fulfills:

- The clinic carries out, or arranges for, an annual evaluation of its total program.
- The evaluation includes review of: the utilization of clinic services, including at least the number of patients served and the volume of services;
- A representative sample of both active and closed clinical records; and
- The clinic's health care policies.
- Code - J82-85
- The purpose of the evaluation is to determine whether:
  - the utilization of services was appropriate;
  - the established policies were followed; and
  - any changes are needed.
- The clinic staff considers the findings of the evaluation and takes corrective action if necessary.

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Continued:

Additionally, the interpretive guidelines stipulate that the group of professional personnel, which can be the governing body acting as the group, is responsible for an annual review of patient care policies and review of the clinic operations. This report and process, which involved and was prepared by personnel not employed by the clinic, (would it not be a wise move to get help from someone who knows the regulations) is the product of the annual evaluation process. It is the responsibility of the clinic or center staff to consider the findings of this process and take corrective action, if necessary.

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Example of Problem:

Ohio, Hospital based clinics, two clinics, one very small, one large.

The smaller clinic was surveyed, found to be deficient for many things, expired drugs, supplies, no documentation of monthly review, (inspect what you expect policy) and no completed Annual Evaluation, by qualified personnel to conduct the day to day management of the clinic. (Training)

The stress was out of control, which was taking a toll on staffing.

All State Survey Documents are subject to Freedom for Information releases and available to anyone.

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Results:

The clinic had a 20 page citation.
The clinic knew their larger clinic would be soon to come.

The Hospital requested professional help to consult with the Plan of Corrections/Annual Evaluation and Peer Review.

The clinic immediately set up an action plan to correct the deficiencies.

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Continued

- The clinic was cited for not reviewing and understanding the regulations. During the survey an employee stated “they didn’t have the support to attend regular training and educations.”
- Sometimes you need to consider what your ***staff might say in a survey***.
- Hospital administration sometimes get lost in the day to day operations of the main facility. It is becoming apparent that there will be further scrutiny of the clinics. A designated person was placed in a role to follow RHC changes and attend annual meetings for learning.

Lessons learned:

- They needed a full update to the new regulations.
- They completely reviewed the entire RHC organization.
- They needed on-going training and support from Leadership.

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Additional Examples of Problem Rural Health Clinics

- RHC located in MO, had been billing incident to services to Commercial and Government (B) payers under the prior collaboration Nurse Practitioner physicians NPI. This was a Office of Inspector General (OIG) review, due to whistle blower report.
- Results: The Owner had to sell the clinic, the manager/biller was put on the OIG disqualification list and can not ever be associated with an entity who would bill Government plans.

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Additional Examples of Problem Rural Health Clinics

- RHC located in S. Illinois, with multiple clinics
- Physician directed the staff to continue to bill Medicare for injections, minor surgical procedures, etc. This became an OIG Whistle Blower case.

- Results: Physician was forced to shut down several clinics, and had to pay back for false claims act and was fined six figures.

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  - There are ever changing rules and recently new rules have been released. At this time I have not been through the 200 or so pages, but much of this reflects on the FQHC business model with new Prospective Payment Systems Models (PPS). We will post information as we can to our websites at www.mwhc.net or sign up for our semi-monthly notices. Just register on our website.

WWW.MWHC.NET

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You should always be a aware of on-going changes to regulations. This is a fluid business in healthcare today and it is YOUR responsibility to stay abreast of changes. This presentation was given based upon best knowledge today, but is subject to change by interpretation and rulemaking at anytime.

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Call us, We can Help!