Provider Based Clinics and Rural Health Clinics

Payment Methodologies & Reimbursement Issues

John Waltko
Sam Chambers
Cheryl McGee-Waltko

QHR Consulting Services

HCCR
Health Care Compliance & Consulting Resources, Inc.

CAHs and Clinics

- Which setting services the community
  - Which structure satisfies?
    - Community
    - Doctors
    - Minimizes costs
    - Adequate reimbursement
- What are reimbursement issues?
  - Medicare utilization by clinic/ RHC
  - Emergency Room staffing
  - Physician contracts/arrangements

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Reimbursement Objectives

- Minimum use of ER staffing companies
  - At minimum ER staffing contract should be revised/reviewed for “stand by” time study requirements
- Compensate local physicians at lowest possible net costs
- Arrange and design contracts to allow for reasonable reimbursements to avoid cost reporting issues

QHR Consulting Services

HCCR

Payment Methodologies

Service	Physician Reimbursement	Hospital Reimbursement
• Freestanding Clinic	• Fee Schedule	• All Reimb. via Physician Fee Schedule
• Provider-Based Clinic	• Fee Schedule (Reduced)	• Cost Based Reimb.
• Rural Health Clinic	• Fee Schedule for Some Services	• Cost Based Reimb. • Productivity Limit • Cost per Visit Cap • Physician Comp. Allowable Cost

Reimbursement Issues

- Reimbursement Hierarchy
  - Rural Health Clinic — highest reimbursement
  - Provider Based Clinic — high reimbursement
  - Free Standing Clinic — lowest, generally
- Wild Cards
  - Ancillary Services, provided by clinics
  - Medicaid payments/reimb.
    - Medicaid may not recognize PBCs
    - Medicaid rates for RHCs

Payment for Physician Services

Resource-Based Relative Value Scale (RBRVS) Payment Methodology

- Relative Value Unit (RVU) - Separate components for:
  - Work
  - Practice
  - Malpractice
- Each RVU component is updated by a separate Geographic Practice Cost Index (GPCI) for the area.
  - The weighted average of the three GPCIs is called the Geographic Adjustment Factor (GAF)

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Payment for Physician Services

Freestanding Clinic:
CPT-4 Code: 99212

	RVU	GPCI	Product
Work	.45	1.010	.454
Practice Expense	.47	1.040	.4888
Malpractice	.02	.930	0.188
			.9619
Conversion Factor			$38.2581
Medicare Payment			**$36.80**

Payment for Physician Services

Provider-Based Clinic:
CPT-4 Code: 99212

	RVU	GPCI	Product
Work	.45	1.010	.4545
Practice Expense	**.17**	1.040	.1768
Malpractice	.02	.930	0.186
			.6499
Conversion Factor			$38.2581
Medicare Payment	**Part B Services**		**$24.86**

Payment for Physician Services

Provider-Based Clinic in CAH: CPT-4 Code: 99212

		Freestanding	Provider-Based
Charges	Professional Component	$100.00	$50.00
	Facility Charge	NA	$50.00
Total Charges		$100.00	$100.00
Payment for Prof. Service	RBRVS – Medicare Portion	$36.80	$24.86
Hospital Payment for Technical	(50.00 x CCR)	0	Costs

Provider-Based Clinics Reimbursement in CAH

	Clinic Direct Costs	Nurses, Receptionist, etc.
+	Hospital Overhead Costs	AG, Housekeeping, Depreciation
+	Total Overhead Costs	
÷	Total Clinic Charge	Clinic Facility Charges Only!!
=	Cost to Charge Ratio	
x	Medicare Charge	Facility Charge
=	Medicare Reimbursement	

- Clinic is ancillary department on cost report
- Physician still bills Medicare carrier
- Non-Medicare patients carrier billed at full rates as “Physician” services

Provider-Based Rural Health Clinic Reimbursement in CAH

	Clinic Direct Costs	Nurses, Receptionist, etc.
+	Hospital Overhead Costs	AG, Dept., Housekeeping
+	PA & Physician Compensation	
=	Total Clinic Costs	Subject to “Productivity” Limit
÷	Total Visits	All PA & Physician Visits
=	Cost per Visit	
x	Medicare Visit	Covered Visits Only
=	Medicare Reimbursement	

Clinics

Provider Based Clinics: Regulatory Requirements

QHR Consulting Services

HCCR
Health Care Compliance & Consulting Resources, Inc.

Provider-Based Designation

- History of Medicare Rules
  - No definition before 1996
  - 1996 Program Memorandum A-96-7

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider-Based Designation
(Continued)

- Final OPPS Rule
  - Focus - same basic issues
    - Hospital department
  - More complex and stringent
- Other Regulatory Changes
  - BBRA / BIPA
- Now
  - Self Attestation
  - Application

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Designation

- Per FY'03 Inpatient PPS Final Rule:
  - Implementation C/R's beginning on/after July 1, 2003
  - Applications
    - May apply using a self-attestation process
    - CMS recommends full, formal approval
    - Criteria relaxed for joint ventures and management contracts
    - No retroactive recoupment if later found to not meet criteria

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Not Applicable to…

- Ambulatory surgical centers (ASCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Home health agencies (HHAs)
- Skilled nursing facilities (SNFs)
- Hospices
- Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Not Applicable to…

- Independent diagnostic testing facilities furnishing only:
  - Services paid under a fee schedule,
  - Clinical diagnostic laboratory tests or both.
- Facilities furnishing only outpatient physical, occupational, or speech therapy, as long as the $1,500 annual cap remains suspended.
  - $1,500 cap does not apply to hospital O/P departments
  - Does apply to those operating as part of a CAH

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Not Applicable to…

- ESRD facilities
- Overhead or support departments (i.e. laundry, medical records)
- Ambulance services

In general, if there's no difference in reimbursement, there's no need to seek provider-based status

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Definitions

- *Main provider*
  - A provider that creates or acquires another entity to deliver additional health care services under its name, ownership, and financial and administrative control.
- *On-Campus*
  - 250 yards from “main buildings”
  - Exceptions on a case-by-case basis
- *Provider*
  - A hospital

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Definitions

- *Provider-based entity*
  - Created or acquired by a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider.
  - Includes both the specific physical facility and the personnel and equipment needed to deliver the services at that facility.

QHR Consulting Services

HCCR

Provider Based Regulations

- 42 CFR 413.65 (CCH ¶4306)
- Requirements for all provider-based entities:
  - Operate under the same license as the main provider, unless:
    - Entity can be licensed separately
    - State requires separate license, or does not allow the entity to be included under hospital's license
  - Share integrated clinical services

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Requirements for all provider-based entities *(Continued):*
  - Integrated clinical services
    - Medical staff has privileges at main provider
    - Clinical oversight is the same as for all other clinical departments of main provider
    - Medical records "integrated into a unified retrieval system (or cross-reference) of the main provider."
      - CMS says, "Practitioners in either location can obtain relevant information about care in the other setting."

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Requirements for all provider-based entities *(Continued):*
  - Financial Integration
    - Entity is a department or cost center on main provider's books
    - Shared income and expenses

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Requirements for all provider-based entities *(Continued):*
  - Public Awareness
    - Entity must be held out to the public as part of the main provider. Must be obvious to the patient that they're in hospital space.
    - Signs, letterhead, bills, etc. must show main provider's name.

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Off-campus entities
  - Off-campus means located more than 250 yards from “main buildings” of main provider
  - Off-campus sites that provide the same services as a physician office are assumed to be **freestanding**
  - Must meet same requirements as on-campus, plus additional requirements

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Off-campus entities (Continued)
  - Ownership and control by main provider
    - 100% owned by the main provider
      - Can't be owned by parent or sister corp.
    - Same governing body
    - Same organizational documents (bylaws)
    - Main provider has final responsibility for administrative decisions, contracts, personnel actions, personnel policies, and medical staff appointments

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Off-campus entities (Continued)
  - Administration and supervision
    - Same reporting relationship as other departments:
      - Direct supervision by main provider
      - Same monitoring, oversight, reporting relationship as other provider departments
      - Accountable to the governing body of the main provider, in the same manner as any department head of the provider

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Off-campus entities (Continued)
  - Administration and supervision
    - Integration of administrative functions
      - Billing, records, human resources, payroll, employee benefit package, salary structure, and purchasing services.
      - Handled by same employees, under the same contract, or under different contracts where both contracts are held by the main provider.

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Off-campus entities (Continued)
  - Location
    - Within a 35-mile radius of the campus of the main provider, except when
      - Main provider has a DSH adjustment greater than 11.75%, and
      - Is owned or operated by a governmental or quazi-governmental agency, or contracts with state or local government to operate clinics for low-income, non-Medicare or Medicaid patients

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Off-campus entities (Continued)
  - *Location*
  - Serves the same patient population
    - 75% of entity's patients live in the same ZIP codes as 75% of main provider's patients, or
    - 75% of entity's patients who need services offered by main provider are treated by main provider, or
    - If entity was not in operation for 12 months, it is located in one of the ZIP codes that makes up 75% of main provider's business

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Provider Based Regulations

- Off-campus entities (Continued)
  - *Location*
    - Must be located in the same State or adjacent States
    - RHCs attached to hospitals with less than 50 beds are exempt from some of these location criteria

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Seeking CMS Approval

- "A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based."

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Seeking CMS Approval
(Continued)

- The application for provider-based status is called an “attestation”
  - No time limit stated for CMS action
- If main provider bills as a provider-based entity without approval, CMS can recoup any overpayments in all cost reporting years subject to reopening
- Approval is good until there is a “material change”, such as a new management agreement or **relocation** of the entity

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Seeking CMS Approval
(Continued)

- If ***considered*** provider-based on 10/1/2000, it will continue to be provider-based through the hospital's first cost reporting period beginning on or after July 1, 2003.
- "Considered" means:
  - Written determination of provider-based status from CMS, or
  - Entity was billing and being paid as a provider-based department or entity of the hospital

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Seeking CMS Approval
(Continued)

- If located on main provider's campus,
  - Submit an attestation stating that the facility:
    - Meets applicable provider-based criteria and
    - Will fulfill the obligations of hospital outpatient departments and hospital-based entities.
    - Must maintain documentation supporting the attestation and make that documentation available to CMS and FI upon request.

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Seeking CMS Approval
(Continued)

- If located on main provider's campus,
  - Approval is granted effective the date the entity is licensed, staffed, and equipped to treat patients
  - CMS says they won't recoup overpayments if they later determine requirements were not met
    - However, CMS could say that the main provider filed a false attestation and recoup the overpayments!!!

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Seeking CMS Approval
(Continued)

- If located off campus,
  - Submit an attestation stating that the facility:
    - Meets applicable provider-based criteria, and
    - Will fulfill the obligations of hospital outpatient departments and hospital-based entities.
  - Must submit supporting documentation along with attestation

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Seeking CMS Approval
(Continued)

- Exception for "Good Faith Effort"
  - CMS won't recoup overpayments for provider-based entities if:
    - Entity met all applicable requirements
    - Main provider billed for services as if the entity were provider based
    - Correct site of service indicators were used on CMS-1500

QHR Consulting Services

HCCR Health Care Compliance & Consulting Resources, Inc.

Other Provider-Based Issues

- EMTALA
- Bill with correct site of service code
  - 22 for provider-based clinic
  - 11 for freestanding clinic

Other Provider-Based Issues

- Sharing space with other departments or entities
- DRG window applies (Not for CAH)
- Must meet life safety code requirements
  - Could be expensive
- JCAHO
- Ancillary Services
  - Lab
  - X-Ray

Other Provider-Based Issues

- $1,500 cap for O/P therapies will not apply to hospital O/P departments
  - If hospital has a freestanding PT, OT or ST office, consider converting to provider-based before the $1,500 limit takes effect

Other Provider-Based Issues

- At off-campus locations, must give patient a notice of their coinsurance before treatment
  - "If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based."
  - "The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services

Other Provider-Based Issues

- Joint ventures
  - Allowable, if the entity:
    - Is partially owned by at least one provider, and
    - Is located on the campus of a provider that is one of the owners, and
    - Be provider-based to the provider on whose campus the entity is located

Other Provider-Based Issues

- Management Contracts
  - Contract must be held by main provider, not a parent or sister
  - Contract must state:
    - Provider has control
    - Contractor staff are subject to hospital policies and procedures
    - Contractor's policies must be approved by provider
    - Requirement for periodic written reporting
  - If for an off-campus site, the provider's control must be clear and the provider must employ all employees who furnish direct patient care

Clinics

Rural Health Clinics: Conditions of Participation & Operations/Billing Issues

QHR Consulting

HCCR
Health Care Compliance & Consulting Resources, Inc.

Rural Health Clinics

- See Regulations at 42 CFR §491
- Must be located in a rural area
  - Not “urbanized” in the most recent census
  - Includes portions of extended cities determined to be rural by the Census Bureau
- RHC can be provider-based or freestanding; mobile or

Rural Health Clinics

- Must be located in a “shortage area”
  - Medically Underserved Area (MUA)
  - Health Professional Shortage Area (HPSA)
  - Contains a population group with a health professional shortage
  - Designated by the State (and certified by Medicare) as an area with a shortage of personal health services

Rural Health Clinics

- MUAs are being redefined
  - Some may be eliminated
  - If your RHC qualified because it's in an MUA, pay close attention to the final rule, when it’s published
  - http://www.bphc.hrsa.gov/databases/newmua/
- HPSAs are continually updated
  - http://bhpr.hrsa.gov/shortage/

Rural Health Clinics

- **What if you lose your shortage area?**
  - **CMS notifies provider**
  - **Submit an application to update medically underserved designation within 120 days. Can continue as RHC for 120 days.**
  - **HRSA reviews application**

Rural Health Clinics

- **Exception process**
  - **An existing RHC may apply for an exception from disqualification**
    - **Submit written request to CMS regional office within 180 days from the date CMS notifies the RHC that it is no longer located in a shortage area**
  - **CMS RO may grant a 3-year exception**
  - **Can renew essential provider status by submitting written assurances to the CMS regional office that they continue to meet the conditions**

Rural Health Clinics

- **Exception process**
  - **Termination of RHC status is effective the last day of the 6th month from the date CMS notifies the clinic of a final determination of ineligibility (including denial of any exception request submitted).**

Rural Health Clinics

- Staffing
  - Must include one or more physicians, and one or more physician's assistants or nurse practitioners
    - Physicians and mid-level practitioners may be owners, employees or contractors of the RHC
  - May include ancillary staff who are supervised by the professional staff
  - Mid-level practitioner must be available to furnish patient care at least 50 percent of the RHC hours

Rural Health Clinics

- Staffing
  - Physician responsibilities
    - Medical direction, consultation and medical supervision of health care staff
    - Helps develop, execute, and periodically review written policies
    - Reviews patient records, provides medical orders, and provides services to patients
    - Provides medical direction at least once every 2 weeks, and is available for consultation, assistance with medical emergencies, or patient referral.
    - (c) Physician assistant and nurse

Rural Health Clinics

- Staffing
  - Mid-Level Practitioner responsibilities
    - Helps develop, execute, and review written policies
    - Assists with physician's periodic review of patients' records
    - Provides patient care services (not performed by a physician):
      - Provides services in accordance with the clinic's policies
      - Arranges for, or refers patients to, needed services that cannot be provided at the clinic; and
      - Assures that adequate patient health records are maintained and transferred as required

Rural Health Clinics

- **Staffing**
  - Temporary staffing waiver
    - If the RHC has been unable to hire mid-level practitioners to be on site 50% of RHC hours, despite reasonable efforts in the previous 90-day period
    - Waiver is good for 1 year, then CMS will terminate RHC from Medicare program
    - Can re-apply for waiver, but no earlier than 6 months after the expiration of the previous waiver

Rural Health Clinics

- **RHC Services**
  - Services and supplies commonly furnished in a physician's office, clinic or ER
  - Basic lab services:

- Urine
- Hemoglobin/hematocrit
- Blood sugar
- Examination of stool specimens for occult blood;
- Pregnancy tests; and
- Primary culturing for transmittal to a certified laboratory.

Rural Health Clinics

- Agreements and Arrangements
  - RHC has agreements or arrangements to provide:
    - Inpatient hospital care
    - Physician services (regardless where furnished); and
    - Diagnostic and laboratory services not available at the RHC
  - If the agreements are not in writing, there is evidence that patients referred by the clinic or center are being accepted and treated

Rural Health Clinics

- **Quality Assessment and Performance Improvement**
  - Must develop, implement, evaluate, and maintain an effective, ongoing, data-driven QAPI program
  - Must be appropriate for the complexity of the RHC's business, and focus on maximizing outcomes by improving patient safety, quality of care, and patient satisfaction

Rural Health Clinics

- RHC Reimbursement
  - Freestanding RHCs and Provider-Based RHCs at Hospitals with 50 or More Beds
  - Cost based, subject to an "all-inclusive rate" per visit
    - Encounter with more than one health professional = 1 visit
    - Multiple encounters with the same health professional on the same day and location = 1 visit, unless the patient suffers an illness or injury requiring additional diagnosis or treatment after to the first encounter

Rural Health Clinic
All-Inclusive Rates

Calendar 2001	$ 63.14
Calendar 2002	$ 64.78
1/1/03 - 2/28/03	$ 66.46
3/1/03 - 12/31/03	$ 66.72
Calendar 2004	$ 68.65
Calendar 2005	$ 70.78

Rural Health Clinics

- **RHC Reimbursement**
  - Provider-Based RHCs at Hospitals with Less Than 50 Beds
  - Cost based, not subject to “all-inclusive rate”

Rural Health Clinics

- **RHC Reimbursable Costs**
  CMS Pub. 100-04, Ch. 9, §40
  - Compensation for physicians (including supervising physicians), mid-level practitioners, clinical psychologists, and clinical social workers
    - Cost of services and supplies incident to services provided by these health professionals
  - Costs of physician services furnished under contract arrangements
  - RCE Limits doe not apply to physician costs

Rural Health Clinics

- **RHC Reimbursable Costs**
  CMS Pub. 100-04, Ch. 9, §40
  - Overhead costs, including administration, use and maintenance of the facility, and depreciation costs;
  - Cost of visiting nurse services and related supplies, if the RHC is located in an area with a shortage of HHA services

Rural Health Clinics

- **RHC Non-Reimbursable Costs**
  CMS Pub 100-04, Ch. 9, §40.1
  - Items and services not covered under Medicare
    - Dental services, eyeglasses, routine examinations
  - Items and services not included in the definition of RHC services
    - Independent laboratory services, durable medical equipment, and ambulance services

Rural Health Clinics

- **RHC Non-Reimbursable Costs**
  CMS Pub 100-04, Ch. 9, §40.1
  - Cost of covered items and services not considered RHC services
    - Some items and services covered under Part B are not considered RHC services even when furnished by an RHC
    - Durable medical equipment, ambulance services, outside therapy providers, prosthetic devices, etc.

Rural Health Clinics

- **Medicare Bad Debts**
  - RHCs and FQHCs may claim reimbursement for Medicare bad debts
    - Must follow all rules in 42 CFR §413.80.
    - For FQHCs, bad debts are limited to Medicare coinsurance amounts because no deductible is applied to FQHC services
    - FQHC cannot claim waived coinsurance as a Medicare bad debt

Rural Health Clinics

- **Productivity levels**
  - Physicians: 4,200 visits per FTE
  - Mid-Level Practitioners: 2,100 visits per FTE
  - If productivity levels are not met, RHC cost per visit is reduced
  - FI may grant exceptions to productivity levels

Rural Health Clinic Billing

- All charges are billed on UB-92
  - Will show up on the PS&R Summary
  - Professional fees are **not** billed separately on the CMS-1500
  - Physician costs are part of Medicare reimbursable cost, so the related charge must remain

Rural Health Clinic Issues

- Ancillary services at provider-based RHCs should be billed as hospital ancillary
- Not all State Medicaid plans cover RHC services, or may not pay reasonable rates
  - *Be sure to check first!*

Rural Health Clinic Strategies

- **RHCs at hospitals with 50+ beds often lose money**
  - Cost per visit is greater than the limit
- **Condsider converting the RHC to a:**
  - Provider-based clinic
  - Federally Qualified Health Center

Federally Qualified Health Center (FQHC)

- FQHC Qualifying Criteria
  - Furnish services to a medically underserved population, or
  - Be located in a medically underserved area
  - Receives (or is eligible to receive) grant funding under the Public Health Service Act:
    - Migrant health center (§329)
    - Community health center (§330)
    - Homeless health care center (§340)

Federally Qualified Health Center (FQHC)

- **Governing Board –**
  - FQHC boards must have 9 - 25 members
  - A majority of “consumer members”
    - Receive the majority of their health care at the FQHC
    - Non-consumer members should be from professional fields such as legal, financial, health care, and social services
    - No more than 50% of the non-consumer members can earn more than 10% of their income from health care
  - Employees and relatives of employees are ineligible

Federally Qualified Health Center (FQHC)

- **Governing Board –**
  - Must meet at least once a month
  - Establishes general policies, approves the center's annual budget, approves the selection of FQHC director
  - Must carry legal and fiduciary responsibility for clinic operations and grants
  - Must perform periodic strategic planning and evaluate progress

Federally Qualified Health Center (FQHC)

- **Governing Board –**
  - Must have full authority over all aspects of clinic operations
  - No other entity/individual can override or veto governing board decisions
  - Must meet at least once a month

Federally Qualified Health Center (FQHC)

- **FQHC Services**
  - Similar to RHC, but includes certain preventive care services:
    - Medical social services
    - Nutritional assessment and referral
    - Preventive health education
    - Children's eye and ear examinations
    - Prenatal and post-partum care
    - Prenatal services

Federally Qualified Health Center (FQHC)

- **FQHC Reimbursement**
  - Medicare is cost-based, subject to limits
    - Different limits for urban & rural
    - Limits are higher for FQHC than for RHC
    - 50 bed limit does not apply to FQHCs
  - Medicare Part B deductible does not apply for FQHC services
  - Medicaid cost-based programs were phased out

FQHC Limits

	Urban	Rural
Calendar 2001	$ 98.03	$84.28
Calendar 2002	$100.57	$86.47
1/1/03 - 2/28/03	$103.18	$88.71
3/1/03 - 12/31/03	$103.58	$89.06
Calendar 2004	$106.58	$91.64
Calendar 2005	$109.88	$94.48

Clinics

Provider Based Financial Analysis

QHR Consulting

HCCR
Health Care Compliance & Consulting Resources, Inc.

Provider-Based Clinic Studies

- For PPS Hospitals:
  - Calculate difference in RBRVS reimbursement
    - Based on site-of-service code
  - Calculate APC reimbursement
    - Based on CPT code

Provider-Based Clinics Reimbursement Impact

***Example*: Primary care clinic in a PPS Hospital (6,500 Medicare visits)**

	Physician	Hospital
Change in RBRVS Fee Schedule Pmts	$(100,066)	
Outpatient PPS (APC) Reimbursement		$304,328
Net Medicare Impact		$204,262

Provider-Based Clinic Studies

- For Critical Access Hospitals:
  - Calculate difference in RBRVS reimbursement
  - Prepare pro-forma cost report to estimate cost-based reimbursement
    - The tricky part: Allocation of Overhead Costs
    - To be conservative, consider allocating only A&G costs at first, then include other allocations using estimated statistics
    - Provide a range for reimbursement impact

Provider-Based Clinics Reimbursement Impact

Example: Primary care clinic in a Critical Access Hospital (5,300 Medicare visits)

	Physician	Hospital
Change in RBRVS Fee Schedule Pmts	$(46,274)	
Medicare Cost Report Reimbursement		$217,766
Net Medicare Impact		$171,492

Provider-Based Clinic Studies

- For all Hospitals:
  - Obtain Medicare volumes by CPT code for the clinics.
    - Can using an overall payer mix, but the results are not as reliable
    - If that's all you can get, include clear and appropriate disclaimers and caveats
  - Make sure to include ancillary services in the appropriate hospital

Clinics

Issues Specific to Critical Access Hospitals

HCCR
Health Care Compliance & Consulting Resources, Inc.

Clinics in CAHs

- Rural Health Clinics
  - 101% of cost for RHC services
    - Not because you're CAH, but because you're less than 50 beds
    - Cost includes professional services
    - Remember: All Medicare RHC charges are billed on the UB-92 – no split-billing!
  - Productivity limits still apply

Clinics in CAHs

- Provider-Based Clinics
  - 101% of cost for technical (or “facility”) charges
    - Cost excludes professional services
    - Clinic visit charges billed on UB-92
    - Potentially a significant increase in reimbursement
  - How much of a benefit?
    - Clinic payor mix vs. hospital payor mix
    - Run the numbers

CAH Clinic Billing

- Method 1
  - "Split Billing"
  - Professional Fees billed on CMS-1500
    - Reimbursement = RBRVS Fee Schedule
  - Hospital charges (facility fee) billed on UB-92
    - Reimbursement = Reasonable cost

CAH Clinic Billing

- Optional Method 2
  - "Combined Billing"
  - Bill outpatient services *and* professional fees on the UB-92
    - List outpatient on a separate line with appropriate revenue code, HCPCS codes, date of service and charge
      - FL 42 Revenue codes = 96X, 97X or 98X
      - Deductible & coinsurance apply

CAH Clinic Billing

- Optional Method 2
  - Medicare pays:
    - 115% of RBRVS fee schedule for professional fees, *and*
    - Reasonable cost for hospital charges

CAH Clinic Billing

- Optional Method 2
  - CAH must have a copy of the form 855R signed by the individual practitioner
    - The practitioner attests that he/she will not bill the carrier for any services rendered at the CAH
  - CAH is not required to have all physicians/professional practitioners reassign their billing rights

CAH Clinic Billing

- Professional service performed by a non-physician
  - Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist
  - Optional Method 2
    - FL 42 Revenue code = 96X, 97X, 98X
    - FL 44 HCPCS = add modifier GF to designate a non-physician

Clinics: Provider Based, Freestanding, and Rural Health Clinics

Summary Table

HCCR
Health Care Compliance & Consulting Resources, Inc.

Provider-Based Clinics vs. Freestanding Clinics

Issue	Freestanding Clinic	Provider-Based Clinic	RHC
mbursement	■ Based on RBRVS schedule	■ Technical Component reimbursement based on APCs (PPS hospitals) or costs (CAH)	■ Technical & Professional Costs Paid on Costs
	■ RBRVS payment is considered final settlement	■ RBRVS payment decreased due to reduction in Practice RVU	■ Some Professional Services Paid…Fee Schedule. Must "Carve Out" Costs

Provider-Based Clinics vs. Freestanding Clinics (Continued)

Issue	Freestanding Clinic	Provider-Based Clinic	RHC
ng	■ All services billed to Part B carrier on HCFA 1500 ■ Place of service on HCFA 1500 is "11" – office	■ Two bills will be generated: 1) HCFA 1500 for professional services, and 2) UB-92 for technical services ■ Place of service on HCFA 1500 must be a "22" – outpatient hospital ■ May combine bill "Non-Medicare" patients	■ Medicare Billing UB-92. Other Carriers Billed as FS Clinic Service.

Provider-Based Clinics vs. Freestanding Clinics (Continued)

ssue	Freestanding Clinic	Provider-Based Clinic	RHC
undling ervices	■ Unbundling of service is **NOT** prohibited	■ Unbundling of services **IS** prohibited	■ Unbundling prohibited. All services paid per visit
rge cture	■ NA	■ Charges for the same procedure must be consistent between the hospital and the clinic	■ Charge per visit must approximate Cost per visit
licare Bad ts	■ Not reimbursable	■ Deductibles and coinsurance related to facility charge only ■ Reimbursable via cost report along with all other Part B bad debts	

Provider-Based Clinics vs. Freestanding Clinics (Continued)

ssue	Freestanding Clinic	Provider-Based Clinic	RHC
nsurance	■ Coinsurance equals 20% of the professional services amount	■ 20% of hospital technical charge	■ 20% of RHC clinic charge
rhead cation	■ Allocated hospital O/H is not reimbursable	■ Allocation of hospital O/H is included in allowable costs for clinic	■ Overhead cost allowable on RHC Cost Report
sician npensation	■ No additional reimbursement for provider component time	■ Provider component only portion of salary is included in allowable cost for clinic ■ RCE limits do not apply	■ Physicians Compensation allowable ■ Subject to productivity limits ■ Reasonableness Test ■ Carve outs for Prof. Billings

Provider-Based Clinics vs. Freestanding Clinics (Continued)

ssue	Freestanding Clinic	Provider-Based Clinic	RHC
C cedures	■ Only those surgeries listed on the ASC list will be covered	■ Ambulatory surgeries will be covered regardless of whether or not the surgery is on the ASC list	■ Why???
ification	■ Meet criteria for physician clinic only	■ Clinic must meet the same licensure and certification standards as the Hospital	■ Separate COP