



RHC Newsletter



Issue 14

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Billing and Coding Questions from the National Listserve

I would like to share a couple of questions with qualified answers that came across the National Rural Health Clinic Listserve. I know that some of you are on the listserv. If you would like to join it you may do so at www.narhc.org. A word of caution, be discerning about the replies. Remember that an interactive listserv allows the network of membership to reply to posted questions. Some answers reveal some very creative solutions, occasionally there are some incorrect responses; however, if you wait patiently, a number of RHC consultants and NARHC's executive director monitors the responses and they will respond to misinformation.

Question: Despite the fact that we see patients regardless of their ability to pay, may we discharge patients for absolute refusal to pay a penny, even with collection efforts? And if we have a patient who reappears after years of being seen by another practice and has had a prior judgment against them for an extremely large bill, are we obliged to see them again?

Answer from NARHC executive director, Bill Finerfrock:

RHCs are not required to see all patients nor are they required to have a sliding fee scale as a condition of being an RHC. FQHCs are required to see all patients, regardless of their ability to pay, and they are also required to have a sliding fee scale. The principle reason for this distinction is that the FQHCs receive federal grants specifically for the purpose of treating low-income, uninsured individuals and RHCs do not. In essence, FQHCs are being paid to see these patients, RHCs are not.

If, however, an RHC opts to voluntarily obtain a separate "facility" designation from HRSA, which facilitates participation in the National Health Service Corps Scholarship and Loan Repayment programs, then the facility would be required to have a policy of non-discrimination based upon ability to pay and a sliding fee scale. The "RHC Facility" designation is a HRSA designation and not the same as your basic RHC designation which is a Medicare/Medicaid designation.

Important notice: The May 27th RHC constituency call, noon to 1pm (ET) will be presented by Joanie Perkins from JP Consulting, Inc. on *Strategies for Implementing a Sliding Fee Scale in the RHC*. Some of you currently offer a sliding fee scale. We would appreciate hearing about your experiences in utilizing one. Please join in on the call. The call in number is **1-800-791-2345** TeleConference code is **78627#**

Question: Can the RHC bill for an hour long consultation of a wife for her husband who is experiencing a serious depression crisis? It was a face-to-face visit with the wife, but not with the patient.

Answer (Bill Finerfrock): CPT Codes are intended to describe the events that occur in the physician's office and provide a uniform basis upon which a payment by a third party payer can be made. Because the third party payer is not in the room when the service is provided but is financially liable for that service, the payer needs to know what happened. The fact that a code exists to describe something, does not obligate the third party payer to pay for that service. (continued on page 2)

Getting to Know Your Partners in Rural Health

Knightstown Family Health Care is an independent clinic owned by Hancock Regional Hospital.



They are small in numbers; however, they serve their community well. They are strategically located in a building with a bank and dentist. Staff include receptionist Carol, MA Connie, and CFNP Vicki. They also have a student NP that they are preparing for the rural workforce!

New Castle Pediatrics is a RHC specialty (e.g. peds or OB). The clinic is independent owned by and located in Henry County Hospital. The staff includes five pediatricians, a CPNP, counselor, office manager, many support staff and nurses. Office manager, Charlet, described several of the clinic's unique programs including a physician quality incentive program, that focuses on childhood obesity, and on-site



counseling. For years they have used an electronic record system, custom designed for pediatrics. The hospital and ancillary practices will implement the new Next Gen EMR system soon.

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When and whether a particular service will be covered by that 3rd party payer is a separate consideration after the payer knows what went on. This is true whether the service was provided to a Medicare patient, a commercially insured patient or Medicaid.

In the **traditional fee-for-service world**, which is the basis upon which most indemnity insurers pay for care, CPT codes are used as a descriptor of a service and then the fee schedule associated with that CPT code is used as the financial basis upon which payment will be made. Here, the provider notifies Medicare of all services provided during the visit. The Carrier reviews the claim, determine which services (CPT Codes) are covered by Medicare and whether the test of medical necessity was met. Through a separate process controlled by the AMA, each CPT code is assigned a point value. Each third party payer who uses the CPT based value system for payment, establishes a “conversion factor” that effectively translates the points into dollars. Medicare annually adopts a conversion factor to convert the numeric value of a CPT code into a payment amount. This is what we know as the fee schedule.

In the **RHC world**, the provider is not paid by Medicare using the fee-schedule (or service based model) but rather using a cost-based payment methodology. The cost per visit is clinic specific rather than generic as is the case with the fee schedule.

Under a service based model (**traditional fee-for-service world**), the 3rd party payer uses the service as the billable event, in conjunction with the type of health care professional who provided that service. The accumulation of “covered” services is what leads to the total payment for that particular visit. A physician’s income can be directly affected by the volume of services provided or billed. Service can be provided by the physician, or someone working under the supervision of the physician but payment is based upon the billable service.

In both situations, whatever happens between the physician and the patient must be deemed “medically necessary”. Here to, there is a distinction between how you define medically necessary in a **service based world** and a **cost-based world**.

In a **Medicare service based world**, the service is typically deemed medically necessary as long as a physician orders the service and certifies or attests that it is medically necessary. It is not always necessary that the physician personally perform that service. So, for instance, an allergy injection can be deemed medically necessary by the physician and that medically necessary allergy injection can be performed by a nurse and Medicare will cover the SERVICE. In a **cost-based world**, not only must the service meet the same medical necessity requirement, but it must be medically necessary for that provider to deliver

that service PERSONALLY. So using the allergy injection example, in a cost-based system, it would continue to meet the first test, it is deemed medically necessary by the physician, BUT, because it is NOT medically necessary for a physician to personally perform the service, it does not meet Medicare’s billable service test.

Payment from the payer (in this case Medicare) directly relates to the average costs of the practice over the course of a year and NOT linked to individual services provided during any particular visit. Thus, while the “visit” with the family members **does not constitute a billable event in the RHC world** (not medically necessary AND not face-to-face with the patient); however, it **could in the fee-for-service world**. This presumes that the third party payer deems this family visit medically necessary or has adopted other policies that make this a specifically covered service.

Even though there would be no explicit payment for the family consult, the RHC is still being compensated for this time. On the clinics cost report, the time of the physician is captured, the time of the office in which he/she met with the patient is captured, the overhead (heat, electric, etc.) is captured. In other words, time and the value of the physician’s time, is reflected in the clinics average costs which in turn are reflected in the clinics all-inclusive rate.

Where the clinic is in danger of “losing” money is when the practice incurs costs for which there are no corresponding visits, which, in the way cost-based practices are paid, increases the average cost per visit. In a capped/cost-based environment, which is the case for most clinics, anything that has the effect of increasing the average cost per visit increases the likelihood that the clinic’s all-inclusive rate will exceed the statutorily set cap.

Important notice: Studies show that 70-80% of those presenting to the RHC have health problems that caused or aggravated by a mental health problem. During the second day of the IRHA annual conference, there will be two presentations on strategies for implementing mental health services into rural health clinic services. If provided in the RHC by a master level prepared social worker, psychologist or psychiatrist, these services are billable through the RHC. Please attend these two sessions and bring your experiences and questions so that we all might benefit from them.

**Register for the IRHA Annual Conference Today. Contest ends MAY 1st for the drawing for one night’s hotel stay and breakfast.
CEUs
7 educational tracks..over 70 presentations..more than 80 exhibitors.**

Preparedness Topic of the Month: Earthquakes

Obviously, a timely topic for emergency preparedness is earthquakes. Did you feel the 5:37 am morning quake April 18th? I was asleep. One building in Indiana received significant damage. The quake was centered in southeastern Illinois, in the Wabash Valley Fault System, which runs through parts of Illinois, southwestern Indiana and western Kentucky. A second quack occurred at 11:15 am. It was a timely event since I was attending a meeting that day at the ISDH on Emergency Management. I complimented the presenter for going the distance on his presentation!

On a more serious note, most of us consider earthquakes to be a West Coast risk; there are 45 states and territories throughout the United States that are at moderate to high risk from earthquakes. An earthquake is the sudden, rapid shaking of the Earth, caused by the braking and shifting of subterranean rock.

Since it is not dict when an occur, it is es- and your family ahead of time.



possible to pre-earthquake will sential that you are prepared

Prepare for Earthquakes

- Securely fasten shelves to walls.
- Keep large or heavy objects on lower shelves.
- Store breakable items in lower cabinets with doors and latches.
- Inspect and repair electrical wiring and gas connections (potential fire hazards during an earthquake).
- Secure your water heater by strapping it to wall studs and bolting it to the floor.
- Check your home or building for structural defects and repair cracks in your ceiling and foundation.
- Keep toxic and flammable items securely stored in cabinets with doors and latches.
- Identify safe places in your home or office where you will ride out an earthquake. The best protection is under heavy furniture where you are protected from falling debris.
- Learn how to turn off electricity, gas and water.
- Have an [emergency supply kit](#).

Plan to act Quickly

- During or immediately after an earthquake, the best protection is to get under heavy furniture, such as a desk, table or bench, staying away from large windows, mirrors or other glass.
- The greatest danger is directly outside buildings, at exits and along exterior walls, due to falling debris.
- If you are already outside, stay clear of buildings, power lines, overpasses and elevated expressways.
- Most deaths and injuries are due to falling walls, flying glass or debris.
- Expect aftershocks – smaller quakes (and sometimes larger ones) can often follow hours or days after the initial shake, causing further damage to weakened buildings and structures.
- Check for gas leaks – if you smell gas or hear a hissing or blowing noise, open a window and leave the building immediately; turn off the gas at the outside main valve, if possible and call the gas company.

Stay Informed

- Best: NOAA Weather Radio (also good for Hoosier tornados)
- Watch TV
- Listen to the radio

Source: <http://www.ready.gov/america/beinformed/earthquakes.html>

Emergency Preparedness

Rural Health Clinic

IRHA's Emergency Preparedness/RHC Co-ordinator is continuing to visit the clinic to:

- Delivering more N-95 masks.
- Performing fit testing for clinics if needed.
- Reviewing written emergency operations plan or assist clinics in developing one with a simple template.
- Delivering 2 way radios.
- Registering Indiana Health Alert Network Registration and GETS priority calling cards.
- Evacuation Plan Template.
- Sharing NIMS/ICS course opportunities.
- Talking about generators.



Health Benefits of Walking

Our bodies are designed to walk for good health. Regular brisk walking, just thirty minutes a day, can:

- ✦ lower cholesterol and blood pressure
- ✦ strengthen your heart
- ✦ improve your circulation

It also burns calories and helps with weight control - not to mention improving your mental outlook! Walking is a great activity for people of all ages and fitness levels. We often think that a vigorous workout at the gym is the only way to gain the health benefits of exercise, when all we really need to do is the thing that comes naturally - walk!

Beginner's 12 Week Walking Schedule

WEEK	SUN	MON	TUES	WED	THU
FRI	SAT				
3	15 min	25 min	20 min	15 min	25
min	20 min	25 min			

Visit www.inshape.in.gov for more online advice from First Lady Cheri Daniels.

Schedule for Community Walks

DNR Day: Get "INShape" for FREE

When: Saturday, May 3rd

Where: Indiana State Parks and Reservoirs

What: Walks & other events. Events, times & locations vary.

Free INShape IN T-shirts distributed while quantities last. For a complete list of walk locations visit the Division of State Parks and Reservoirs Healthy Parks-Healthy People website at www.in.gov/dnr/healthy/.

Walk with IMPD

When: April 28th - May 23rd, M - F 5:30pm

Kick off festivities @ 5pm Apr. 28 - First 100 receive a free gift!

Where: 3130 E. 30th St. @ Washington Park Trails (1.5 or 2.5 miles)

Details: Contact Annie Kern @ 317.327.6265 to Pre-

Register

The Toyota Spring Day 8K RUN/WALK

When: May 3rd

Where: Princeton

Start ½ and ¼ mile for Kids: 9AM CDT

Start 8K Run and Fitness Walk: 9:30 AM CDT

Start Tulip Tree mile 9:45 AM CDT

Details: [Registration, etc.](#)

Walking Tour: Fountain County

When: May 4th @ 2pm-5pm

Where: Attica

Join Historic Landmarks of Fountain County for a walking tour of historic Ravine Park. Wildflower expert available to identify the wildflowers. Wear clothing appropriate for weather and walking.

Details: Call 765.764.1913. **Free!**

Hike or Bike in Metamora

When: May 4th @ 2pm

Where: Metamora

Hike or Bike the Whitewater Canal Trail. Free parking available in lot on Main Street. ADA compliant trail with interpretive markers, mostly level, 50% shaded. Metamora lies midway between Cincinnati and Indianapolis on US Highway 52, 8 mi. west of Brookville, IN.

Details: Call 765.647.2109. **Free!**

Fort Wayne: "Downtown Treasures"

When: May 2nd @ 1pm

Where: Tours begins at the Convention & Visitors Bureau @ 1021 S. Calhoun St.

Want to know more about the history of Fort Wayne? Then grab your walking shoes for this 1 mile journey that features historic and architectural treasures of the city.

Details: Call Angie Quinn @ 260.426.5117. **Free!**

INShape In Historic Indiana Events

The DNR Division of Historic Preservation is sponsoring a series of statewide walks and other events highlighting Indiana historical landmarks throughout the month of May. For a calendar of more events: http://www.in.gov/inshape/files/Calendar_of_Events.doc

Indiana Rural Health Association

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Upcoming Events

May 27, noon-1 pm Monthly RHC Constituency Call Topic: **How to devise a sliding fee schedule.**

May 27, 2pm EST COCA (CDC) Conference Call: Seasonal and Avian Influenza Update. Details forthcoming via email.

June 11-13 NARHC Summer Institute Sacramento, CA
Topics: Properly Assessing the Performance of PB-Clinics, How to Bring Dent Services into an RHC, Extreme Makeover of Accounting Records for RHC Cost Reports, Telemedicine, EM Documentation & Coding, Medicare Adv., Aligning Employed Physician Incentives, Strategic Planning

June 16-17
IRHA Annual Conference
French Lick, IN
Special RHC track: Update on RHC regulations, Professional Volunteer Program (ESAR-VHP), Strategic National Stockpile and RHCs, An Efficient Front Office, Coding/Medicare with Riverbend, and Implementing Behavioral Health in RHCs.

July NIMS/ICS training: live classroom, creative, interactive, fun!

How Can I Spend \$1,460.00 to 5,110.00 each Year?

Smoking is a costly habit. Smoking costs include money and health.

The average cost of a pack of cigarettes ranges from \$3.50—\$5.00. How much would you spend each year if you smoked? Look at the chart below and see:

# packs	Per month	Per year	10 years
1	\$120.00	\$ 1,460.00	\$14,600.00
1.5	\$180.00	\$ 2,190.00	\$21, 900.00
2	\$240.00	\$ 2,920.00	\$29, 200.00
2.5	\$300.00	\$ 3,650.00	\$36, 500.00
3	\$360.00	\$ 4,380.00	\$43, 800.00
3.5	\$420.00	\$ 5,110.00	\$ 51,100.00

