

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HUTCHINSON RURAL
HEALTH CLINICS**



**MAY 2001
A-07-00-00118**



Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

CIN: A-07-00-00118

May 10, 2001

Mr. Darryl D. Serpan
Associate Administrator
Hutchinson Medical Clinic
2101 North Waldron
Hutchinson, Kansas 67502

Dear Mr. Serpan:

This final report provides you with the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) audit entitled *REVIEW OF HUTCHINSON RURAL HEALTH CLINICS*. The purpose of our audit was to conduct a review of the Hutchinson Rural Health Clinics (Hutchinson Clinics), an independent rural health clinic (RHC). Specifically, we reviewed (1) whether there were improper Medicare payments made to the Hutchinson Clinics or their physicians and (2) their cost reports during the period January 1, 1997 through December 31, 1999.

At the Hutchinson Clinics, we identified \$87,493 in excess Medicare payments where corrective action is needed to comply with applicable laws and regulations. We found that the Hutchinson Clinics:

We identified
\$87,493 in excess
Medicare payments

- received improper Medicare Part B payments totaling \$78,596 for procedures that are included in the RHC encounter rate;
- received improper Medicare RHC encounter payments totaling \$375 for multiple encounter claims;
- received improper cost report payments totaling \$8,522 for injections; and
- did not correctly allocate costs in their cost report.

We recommend Hutchinson Clinics refund the improper Medicare payments totaling \$87,493 and ensure costs are correctly allocated in the cost report. We will provide the fiscal intermediary and carrier with the results of our review.

Hutchinson Clinics did not concur with any of our findings and recommendations. Concerning improper Medicare Part B payments, they believed that the Part B services were allowable because the services were performed at a separate location from the RHC services. In addition, they responded that the other findings "...were minor, resulted from normal course inadvertent payment and reporting errors..." The Hutchinson Clinics' response is included in its entirety as Appendix B.

INTRODUCTION

Background

The Rural Health Clinics Act (Act) was passed by Congress in 1977 and implemented in 1978. The goal of the Act is to encourage the utilization of midlevel practitioners by providing reimbursement for their services to Medicare and Medicaid patients, even in the absence of a full-time physician. The Act created a cost based reimbursement mechanism to generate additional revenue for eligible rural practices.

There are two types of RHCs, independent and provider based. Independent RHCs are defined as freestanding practices that are not part of a hospital, skilled nursing facility, or home health agency. A provider based RHC is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency operated with other departments under common licensure, governance, and professional supervision.

Payments to the RHCs for services to Medicare beneficiaries are made on the basis of an all-inclusive (encounter) rate per covered visit.

Items and services which meet the definition of RHC services are paid for by RHC intermediaries. The RHC services include:

- < physician services;
- < services and supplies incident to physician services;
- < nurse practitioner and physician assistant services that would be covered if furnished by a physician;
- < services and supplies incident to the services of nurse practitioners and physician assistants that would be covered if furnished incident to a physician's services;
- < visiting nurse services to the homebound;
- < clinical psychologist and clinical social worker services; and
- < services and supplies incident to the services of clinical psychologists and clinical social workers.

For independent RHCs, all laboratory services provided at the RHC are considered RHC services and should be included in the encounter rate. Consequently, there is no separate billing for laboratory services and final reimbursement is made through the cost report settlement process.

However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, all laboratory tests (except six basic laboratory tests) performed in the certified Medicare laboratory for RHC and non-RHC beneficiaries will be billed to the Part B carrier.

Part B carriers process claims from independent RHCs for non-RHC services. Non-RHC services include:

- < services furnished in a hospital;
- < durable medical equipment;
- < ambulance services;
- < prosthetic devices;
- < leg, arm, back, and neck braces;
- < artificial legs, arms, and eyes;
- < arranging of physical, speech, or occupational therapy with suppliers not employed by the RHC; and
- < technical component of diagnostic tests such as x-rays and electrocardiograms provided by the RHC physician.

For the cost report, allowable costs are the costs actually incurred by a clinic that are reasonable in amount and necessary and proper to the efficient delivery of services.

The allowability of costs is governed by the applicable Medicare principles of reimbursement for provider costs as set forth in 42 CFR 413 and the Provider Reimbursement Manual. These are general Medicare principles that define allowable costs of hospitals and other facilities paid on a reasonable cost or cost related basis. The lesser of cost or charges principle does not apply to freestanding RHCs.

Allowable costs are limited to amounts which are reasonable. The Health Care Financing Administration (HCFA) has established screening guidelines which intermediaries use to test the reasonableness of a RHC's productivity and a payment limit which the per visit rate may not exceed. Costs for which screening guidelines have not been established by HCFA are disallowed to the extent the intermediary determines they are unreasonable.

Medicare payments for pneumococcal and influenza vaccines and their administration are 100 percent of reasonable cost. The cost for these services is accounted for on the RHC cost report and is not subject to the RHC encounter payment limits.

The Hutchinson Medical Clinics is a professional association operating medical clinics and a pharmacy. Included in the medical clinics are four RHCs that make up the Hutchinson Clinics. They are located in Hutchinson, Kansas; Lyons, Kansas; St. John, Kansas; and Stafford, Kansas. The RHC in Hutchinson consists of a family practice, internal medicine practice, and pediatrics, while the other three RHCs consist of only family practices. There are approximately 20-25 physicians employed at the RHCs combined.

The current intermediary for the Hutchinson Clinics is Riverbend Government Benefits Administrator in Chattanooga, Tennessee. Prior to May 16, 1997, the intermediary was Aetna Life Insurance Company in Petaluma, California. The Part B carrier is Blue Cross and Blue Shield of Kansas in Topeka, Kansas.

Scope

We conducted this audit in accordance with generally accepted government auditing standards. However, the review of internal controls was limited to an understanding of (1) the billing procedures, (2) quality assurance guidelines, and (3) cash receipt policies. Our assessment of the accounting system was limited to evaluating the opinions expressed by the independent auditor in the 1997, 1998, and 1999 audit reports.

The purpose of our audit was to conduct a review of the Hutchinson Clinics. Specifically, we reviewed (1) the cost reports and (2) whether there were improper Medicare payments made to Hutchinson Clinics or their physicians during the period January 1, 1997 through December 31, 1999.

The HCFA regulations regarding RHCs and their cost reports were reviewed and documented.

An analysis of the RHC claims and the Part B claims was performed by running a match between the two files on beneficiary number, date of service, and performing/attending physician. For the claims that matched, we eliminated the line items with the following characteristics:

- , sum of the amount paid to the provider, deductible, and co-insurance are equal to \$0;
- , place of service was in a hospital, emergency room, or skilled nursing facility;
- , procedures where only the technical component was claimed;
- , procedures that were non-RHC services;
- , laboratory procedures (other than the required basic laboratory procedures).

Using only the RHC claims, we extracted those claims that included revenue codes for an encounter. We took these claims and ran a match on the provider number, beneficiary number, date of service, and claim diagnosis in order to determine if there were any multiple claims.

Our field work was performed during the period October 2000 through November 2000 in Hutchinson, Kansas and our field office in Jefferson City, Missouri.

RESULTS OF REVIEW

At the Hutchinson Clinics, we identified \$87,493 in excess Medicare payments where corrective action is needed to comply with applicable laws and regulations. Specifically, we identified three areas which appear to have caused overpayments of Medicare funds and one area that could cause potential overpayments in the future. Based on our analysis, there were RHC encounter claims and Part B claims paid for the same beneficiary on the same date of service with the same performing/attending physician. The Part B claims appear to be for services that are included in the RHC encounter rate. We also found that Hutchinson Clinics were paid for multiple encounter claims for the same beneficiary with the same date of service. In our review of the cost reports, we found the costs of the pneumococcal and influenza injections were miscalculated based on supporting documentation. We also found some costs that were not properly allocated.

We recommend Hutchinson Clinics refund the improper Medicare payments totaling \$87,493 and ensure costs are correctly allocated in the cost report. We will provide the fiscal intermediary and carrier with the results of our review.

Review of RHC/Part B Claims

In our analysis of Hutchinson Clinics, we identified 3,622 Part B claims totaling \$78,596 for procedures (RHC services) that are included in the RHC encounter rate.

According to CFR 405.2412 (a), physician services are defined as follows:

Physicians' services are professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services.

The RHC Manual, HCFA Publication 27, 405.1 and 405.6 B.1. further defines physician services as follows:

...Physician services are the professional services performed by a physician for a patient including diagnosis, therapy, surgery, and consultation...

...A physician who is an employee of an RHC or FQHC, or who is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service...

According to CFR 405.2413, services and supplies incident to a physician's services are defined as follows:

(a) Services and supplies incident to a physician's professional service are reimbursable under this subpart if the service or supply is:

- (1) Of a type commonly furnished in physicians' offices;*
- (2) Of a type commonly rendered either without charge or included in the rural health clinic's bill;*
- (3) Furnished as an incidental, although integral, part of a physician's professional services;*
- (4) Furnished under the direct, personal supervision of a physician; and*
- (5) In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.*

(b) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

The Part B claims were billed to the carrier for beneficiaries with the same date of service and performing/attending physician as the RHC billed for an encounter. The Part B carrier should

not be billed for RHC services on the same date the beneficiary was seen in the RHC for an encounter by the same physician.

The Part B procedures billed to the carrier are summarized below:

<u>Type of Procedure</u>	<u>Procedure Ranges</u>	<u>Number of Procedures</u>	<u>Amount Paid By Part B</u>
Medicine (except Anesthesiology)*	90471-99195	1,932	\$36,492
Surgery	10060-69222	1,000	24,547
Injection of Various Drugs	J0290-J9999 Q0136- Q9930	361	11,345
Procedures/Services	G0004- G0107	194	3,819
Physician Visits	99211-99313	79	1,732
Radiology*	71020-76856	27	549
Travel Allowance	P9604	22	70
Supplies	A4353- A4550	2	27
Catherization	P9612	<u>5</u>	<u>15</u>
Total		<u>3,622</u>	<u>\$78,596</u>
* only the technical component should have been billed			

An example of this type of finding is where a Medicare beneficiary would visit the RHC due to illness. The RHC physician would see the beneficiary and determine that a surgical procedure, such as the removal of a skin lesion, was necessary. The RHC physician would take the beneficiary to the Same-Day Surgery section of the Hutchinson Clinics and perform the surgical procedure. The RHC would then bill the RHC intermediary for the encounter and Part B for the surgical procedure. Based on the criteria that defines physician services, surgical procedures should be included in the encounter rate.

Another example of this type of finding is where a Medicare beneficiary had a x-ray performed as a result of the RHC physician encounter. The RHC billed the encounter to the RHC intermediary and Part B for both the professional and technical components of the x-ray. Based

on the criteria that defines RHC services, only the technical component of the x-ray can be billed to Part B. The professional component, if performed by the same physician who billed for the encounter, is a RHC service.

In addition, we determined that \$18,494 in deductibles and \$31,856 in co-insurance obligations resulted from the improper Part B claims of \$78,596. Deductible and co-insurance represent personal funds that elderly beneficiaries could have used to obtain other goods and services.

Under Part B, beneficiaries must pay an annual deductible and a co-insurance charge for each covered item or service. The beneficiary is responsible for the first \$100 of Part B approved charges in each calendar year. The \$100 payment must be based on Medicare-s approved charges, not the actual charges to the beneficiary. Payments for non-Medicare approved charges and charges in excess of the Medicare approved charges do not apply to the deductible. The co-insurance amount is 20 percent of the Medicare approved charge.

Hutchinson Clinics=Response

In response to our draft report, they stated: "With regard to the RHC/Part B issue, Hutchinson Clinic does not agree with the OIG's legal determination that under no circumstances should the Part B carrier be billed for physician services provided on the same date the beneficiary was also seen in the RHC and for which Medicare was billed for a "patient visit." "Such a conclusion is inconsistent with applicable RHC regulations, HCFA manual provisions governing RHC services, and prior guidance from both HCFA and the intermediary, which references focus not only upon the date of the services, but on the location of those services, for determining whether more than one bill may be submitted."

In addition, they mentioned that the Government Benefits Administrator for the Riverbend intermediary affirmed their interpretations of the law concerning this finding.

OIG Comments

It is still our position that the Part B carrier should not be billed for services performed on the same date for a beneficiary that was previously treated at the RHC for an encounter by the same physician. Our position is supported by the RHC Manual, HCFA Publication 27,405.1 and 405.6B.1. that states *...A physician who is an employee of an RHC or FQHC, or who is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service...* (emphasis added) It should be noted that this reference indicates that the location of services performed by a RHC physician is not relevant in determining if a service is billable under Medicare.

For support of their position, Hutchinson Clinics stated that the Government Benefits Administrator for the Riverbend intermediary, affirmed their interpretation of the law concerning

our review of RHC/Part B Claims. After reading the Hutchinson Clinics' response, we called the Administrator. She indicated that her letter quoted by Hutchinson Clinics supporting their position did not refer to a situation where the same physician provided the RHC and the subsequent Part B services. She is supporting our position concerning this finding.

Review of RHC Multiple Claims

We identified 26 multiple encounter claims totaling \$729. However, documentation was provided showing Hutchinson Clinics refunded eight claims totaling \$354. Therefore, improper payments for the 18 remaining claims totaled \$375.

According to 42 CFR 405.2401 (b), a visit is defined as follows:

Visit means a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner or visiting nurse...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, except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

In reviewing the 26 multiple claims, we found that 22 of the claims were billed only once to the intermediary by Hutchinson Clinics, but paid twice by two different intermediaries. Upon further review, we found that in May 1997 there was a change in intermediaries that appears to have caused the double payment of these claims. Four of these 22 claims were refunded to the intermediary before our review.

The remaining four claims of the 26 multiple claims were billed by Hutchinson Clinics twice and were paid twice by the same intermediary. These claims were also refunded to the intermediary before our review.

Hutchinson Clinics' Response

They indicated these overpayments "...were minor, resulted from normal course inadvertent payment and reporting errors..." They did not address our recommendation.

OIG Comments

Our position regarding this finding remains the same.

Cost Report

Based on our review of the Hutchinson Clinic's cost report, we were able to determine there were costs that supported encounter rates of \$78.74, \$88.40, and \$89.09 for the years 1997, 1998, and

1999 respectively. Each of these rates was significantly above the maximum allowable encounter rates (cap rates) of \$57.77, \$59.04, and \$60.40 for the years 1997, 1998, and 1999 respectively. Comparing the two sets of rates, we determined that Hutchinson Clinics had excess costs of those needed to receive cap rates of \$2,180,381, \$3,030,840, and \$2,984,622 for the years 1997, 1998, and 1999 respectively.

We identified some questionable costs, but nothing material enough to affect the Hutchinson Clinic's encounter rate in any of the three years. Questionable costs identified included the allocation of \$47,739 to Hutchinson Clinics that either should have been shared costs or were not RHC costs. We also found an additional \$400 included in RHC costs that was a portion of membership dues that were identified as lobbying costs. Lobbying costs are not an allowable expenditure for the Medicare program.

We reviewed Hutchinson Clinic's reported costs and supporting documentation for the influenza and pneumococcal injections for 1997, 1998, and 1999. Based on this review, we found that the reported Medicare costs for these injections were overstated by \$2,312 in 1997 and \$6,999 in 1999. We also found that their reported Medicare costs for these injections were understated by \$789 in 1998. Due to these errors in reporting the Medicare costs for influenza and pneumococcal injections, Hutchinson Clinics received a net overpayment of \$8,522. Costs related to pneumococcal and influenza vaccines and their administration are segregated in the cost report and are not considered in the computation of the encounter rate.

Hutchinson Clinics' Response

They indicated these overpayments "...were minor, resulted from normal course inadvertent payment and reporting errors..." They did not address our recommendation.

OIG Comments

Our position regarding this finding remains the same.

Recommendations

We recommend Hutchinson Clinics:

- , Refund the improper Medicare payments totaling \$87,493 that have been identified in this report.
- , Ensure costs are correctly allocated in the cost report.

INSTRUCTIONS FOR AUDITEE RESPONSE

Final determinations as to actions to be taken on all matters reported will be made by the HHS action official identified below. We request that you respond to the recommendations in this report within 30 days from the date of this report to the HHS action official, presenting any comments or additional information that you believe may have a bearing on final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS, reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5).

Sincerely,



James P. Aasmundstad
Regional Inspector General
for Audit Services

Attachments

HHS Action Official:

Joe Tilghman
Regional Administrator
Room 235
601 East 12th Street
Kansas City, Missouri 64106

HUTCHINSON MEDICAL CLINICS
HUTCHINSON, KANSASRESULTS OF REVIEW FOR THE PERIOD
JANUARY 1, 1997 THROUGH DECEMBER 31, 1999

	<u>1997</u>	<u>1998</u>	<u>1999*</u>	<u>Total</u>
Part B/RHC Claims	\$15,781	\$41,351	\$21,464	\$78,596
RHC Multiple Claims	375	0	0	375
Cost Report - Injections	<u>2,312</u>	<u>(785)</u>	<u>6,999</u>	<u>8,522</u>
Total	<u>\$18,468</u>	<u>\$40,562</u>	<u>\$28,463</u>	<u>\$87,493</u>

* The 1999 RHC and Part B data was not complete when the data was extracted.



April 6, 2001

Mr. James P. Aasmundstad
Regional Inspector General for
Audit Services
Office of the Inspector General
Office of Audit Services
Department of Health and Human Services
Region VII
601 East 12th Street, Room 287A
Kansas City, Missouri 64106

Re: Hutchinson Rural Health Clinics
CIN: A-07-00-00118

Dear Mr. Aasmundstad:

The purpose of this letter is to respond to the March 7, 2001 Office of Inspector General, Office of Audit Services' ("OIG/OAS's") Draft Report entitled "Review of Hutchinson Rural Health Clinics" (the "Draft Report"). The Draft Report identifies three bases which are alleged to have caused Hutchinson Clinic to receive excess Medicare funds totaling \$87,493.00 and "where corrective action is needed...."

The primary area of concern involves instances where rural health clinic ("RHC") encounters were billed on the same date of service that a Part B claim was submitted, and where the Part B claim appears to be for a service that was included in the RHC encounter rate (the "RHC/Part B issue"). The RHC/Part B issue accounts for \$78,596.00 of the total alleged overpayment and will be the focus of this response. The other two areas identified in the Draft Report involve a) multiple encounter claims and b) certain cost reporting errors related to pneumonococcal and influenza injections. The overpayments associated with these items were minor, resulted from normal course inadvertent payment and reporting errors, and are not addressed in this response.

With regard to the RHC/Part B issue, Hutchinson Clinic does not agree with the OIG's legal determination that under no circumstances should the Part B carrier be billed for physician services provided on the same date the beneficiary was also seen in the RHC and for which Medicare was billed for a "patient visit." Such a conclusion is inconsistent with applicable RHC regulations, HCFA manual provisions governing RHC services, and prior guidance from both HCFA and the intermediary, which references focus not only upon the date of the services, but on the location of those services, for determining whether more than one bill may be submitted.

A. Factual Background

It is important initially to place this issue in the appropriate factual context. The RHC/Part B claims at issue are the result of instances where a physician would a) see a patient in the RHC, b) determine that the patient required a more complicated medical procedure, (*i.e.*, lesion removal, stress test/echocardiograph, etc.), and c) take the patient to another location (the clinic's Urgent Care area, which is not part of the RHC), to perform the service. This was not a common practice. Rather, only when the more complex, time-consuming procedures were medically indicated would an RHC patient be directed and treated at another non-RHC location of the Clinic. In most instances where, in a single day, a patient would visit the Clinic, be seen by a physician, and undergo a particular diagnostic or therapeutic procedure, it was and is Hutchinson Clinic's routine practice to bill Medicare only the all-inclusive RHC encounter rate.

In those non-routine cases where a patient first seen in the RHC was determined to require a more complicated service, and was thereafter treated in a more appropriate non-RHC location, Hutchinson Clinic appropriately billed Medicare the RHC encounter rate for the RHC visit as well as Part B for the physician's professional service. The applicable Medicare regulations, RHC manuals, as well as the government's previous guidance on this issue, support the appropriateness of billing in this manner. We therefore disagree with the OIG/OAS' Draft Report's conclusion to the contrary.

B. Medicare RHC Regulations

The Draft Report cites initially to the definition of "physician services" in the Medicare RHC regulations (42 CFR § 405.2412(a)) to support the conclusion that overpayments were made for RHC/Part B claims. OIG/OAS' reliance on this specific regulation presents too narrow a view of the RHC regulatory framework. In fact, the Report's analysis of the RHC/Part B issue does not even reference the specific regulatory provision governing payment for RHC services or, most notably,

the detailed regulatory definition of the term "visit." Reference to these provisions is essential to a thorough analysis of this issue.

Initially, 42 C.F.R. § 405.2462 sets forth the general rule for payment to RHCs:

(b) Payment to independent rural health clinics and freestanding Federally qualified home health centers

(1) . . . clinics and centers will be paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. This rate will be determined by the intermediary, in accordance with this subpart and general instructions issued by HCFA.

42 C.F.R. § 405.2462(b)(1) (emphasis added). The regulatory definition of the term "visit" is critical to this analysis. This is particularly so inasmuch as this definition is the only context in which the concept of "same day" services is addressed.

Section 405.2463, entitled "What Constitutes a Visit" states in pertinent part:

(a) Visit

* * * *

(3) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. . . .

In the Hutchinson Clinic RHC/Part B fact scenario, the physician first sees the patient in the RHC, but then performs Part B service (a lesion removal, for example), in the Urgent Care area - a separate and distinct non-RHC location. In this situation, more than a "single (RHC) visit" has occurred according to the regulatory definition set forth above. The mere fact that the RHC visit and the lesion removal may have occurred on the same day is not dispositive. Also determinative is whether the two events occurred at a "single location."

Here, there is no dispute that the physicians initially saw patients at the RCH location and then performed lesion removals, etc., at the Urgent Care Center -

a separate and distinct, non-RHC location. Hutchinson Clinic is not constrained, in this instance, to bill only for a "single visit." The Clinic is permitted to bill for and receive additional Medicare payment for the additional service provided in the non-RHC location.

C. The RHC Manual

The Rural Health Clinic and Federally Qualified Health Center Manual (HCFA-Pub. 27) ("The RHC Manual") lends further support to our position. It does so by clearly and directly tying the all-inclusive rate payment system to the definition of the term "visit":

Payments to you for covered RHC/FQHC services furnished to Medicare beneficiaries are made on the basis of an all-inclusive rate per covered visit. . . The term "visit" 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 and RHC/FQHC 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. . .

RHC Manual, § 504 (emphasis added).

The fact that the patient is also seen by the same RHC physician on the same date of an RHC visit -- the sole basis for the Draft Report's overpayment determination -- is not in and of itself dispositive of whether a second bill may be paid for the subsequent visit. The two events must also occur at the same location in order for the all-inclusive rate to apply. When the two events occur, one at an RHC location and the other at a non-RHC location, the "single location" element of the "visit" definition is not present and something other than a single visit has occurred. In such a circumstance, the clinic is not limited to payment of the all-inclusive rate as its sole source of reimbursement. The clinic is allowed to bill Part B for the additional physician service performed at the separate non-RHC location.

Beyond federal regulatory and Manual analysis, Hutchinson Clinic's interpretation of these provisions provides the only logical manner in which to apply the regulations in a fair and rational way. The OIG/OAS blanket prohibition on payments for any further service rendered on the same day of an RHC visit by the

same treating physician would lead to patient inconvenience, and impact detrimentally on quality and continuity of care. Under the OIG/OAS' interpretation, patients who presented in the RHC on Monday, and were seen and diagnosed by an RHC physician to require removal of a complex lesion, would be required to return on Tuesday in order for that service to be billable. In the alternative, and even more absurdly, the OIG would have the Hutchinson Clinic physician direct the patient to a different physician in another location of the Clinic to have the lesion removed. This makes no sense for the patient, the provider of care, or for the Medicare program.

Such an interpretation would, however, result in a financial windfall to the Medicare program. Under the Part B payment system, the appropriate reimbursement rate for the most common skin lesion removal is approximately \$136. However, if the OIG/OAS' interpretation were correct and the removal were to occur on the same day as an RHC encounter, payment for that same physician service would be included in the RHC encounter rate of \$61.75. The reimbursement discrepancy that would result from such an application of the law would penalize the provider and provide a financial windfall to the Medicare Program.

D. HCFA/Fiscal Intermediary Advice

HCFA directly and through its intermediary agent, has in fact addressed this very issue informally on at least two occasions. On December 5, 2000, in direct response to an issue raised by Hutchinson Clinic during this audit process, the Part A intermediary, Riverbend Government Benefits Administrator affirm Hutchinson's interpretation of the law as set forth above. The intermediary was responding to a question presented to it by Hutchinson Clinic regarding the following factual scenario:

- [The OIG] audit revealed a few cases where we saw the patient, and on the same day took them to our urgent care (not part of the rural health area), removed a lesion or performed a stress test. We billed Part B for the lesion removal, the stress test, etc. We are not referring to x-rays, physical therapy, etc. Rather, something the physician actually performs themselves.
- In this particular situation because the services were provided on the same day the OIG auditors felt the skin lesion should have been part of the per diem and not separately billable to Part B.

(See Exhibit A, November 2, 2000 letter from Mr. Darryl Serpan to Ms. Kelly Scoggins). Given the OIG's concerns noted during the audit, Hutchinson Clinic

queried the intermediary as to the appropriateness of its "same day" billing practice.

In response to this inquiry, the intermediary responded as follows:

In the situation where you have sent the patient to your urgent care center that is not part of the RHC, again the RHC encounter should stand alone. I can understand the concerns that the OIG auditors may have with this type of situation. Operating in this type of arrangement requires extreme caution to ensure that cost of services being provided in the urgent care center are in no way commingled with the RHC cost that will be reflected on the cost report.

(emphasis added). (See Exhibit B, December 3, 2000 letter from Ms. Scoggins to Mr. Serpan). Thus, the intermediary confirms, so long as costs are not commingled (which they are not) even when two treatment events occur on the same day, "the RHC encounter should stand alone."

Ms. Scoggins likely reached this conclusion in further reliance upon information provided to Riverbend the previous year from HCFA. Specifically, in response to an inquiry from the intermediary regarding the permissibility of designating certain areas in a clinic as "non-RHC areas" for physician use, HCFA expressed its concern that such dual use could result in Medicare making "two payments for the administrative cost of services furnished by a particular staff member who had simultaneous assignments" (emphasis added). Nonetheless, HCFA ultimately advised Riverbend as follows:

Consequently, physicians and nonphysician practitioners assigned to the RHC are not permitted to bill Medicare Part B for their services furnished in an RHC space when the RHC is open to furnish services to its patients. However, there may be cases where a physician routinely provides more complicated medical procedures to clinic patients. Under this situation, we believe physicians and nonphysicians can bill Part B as long as they clearly separate their private practices from the RHC.

(See Exhibit C, letter to Mr. Ben Thackston from Mr. Neal Logue).

HCFA's position is consistent with Hutchinson Clinic's interpretation of the regulations and those Manual provisions governing the scope of the RHC benefit: certain physician services provided to RHC clinic patients are not included in the

Mr. James P. Aasmundstad
April 6, 2001
Page 7

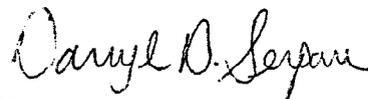
APPENDIX B
Page 7 of 11

RHC encounter rate when a) those services are provided in a non-RHC location and b) provided that the costs associated with those services are not included on the RHC's cost report.

Conclusion

For all the reasons stated above, the \$78,596 in Part B payments identified in the Draft Report as "overpayments" to Hutchinson Clinic should not be so characterized. The claims which resulted in these payments were made for services legitimately provided, and were billed in a manner consistent with rule and regulation, RHC Manual provisions, and fiscal intermediary and HCFA interpretations of the reimbursement requirements governing Rural Health Clinics. We would be pleased to discuss this issue with you further once you have had an opportunity to review and consider our position.

Sincerely,



Darryl Serpan
Associate Administrator

 HUTCHINSON CLINIC, P.A.

November 2, 2000

Kelly Scoggins
Riverbend Government Benefits
730 Chestnut Street
Chattanooga, TN 37402-1790

Fax: (423)763-3651

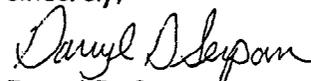
Dear Ms. Scoggins,

This is a follow-up to our earlier conversation discussing appropriate billing protocols for follow-up procedures related to what should or shouldn't be included in the initial visit per diem. The questions we propose are as follows:

- ♦ We both agree it is appropriate to bill the initial rural health encounter and follow-up encounters for obvious medical situations. In other words, if a physician sees a patient for pneumonia and they return in a few days for follow-up care both encounters are independently billable.
- ♦ Our audit revealed a few cases where we saw the patient, and on the same day took them to our urgent care (not part of the rural health area), removed a lesion or performed a stress test. We billed Part B for the lesion removal, the stress test etc. We are not referring to x-rays, lab, physical therapy etc. Rather, something the physician actually performs themselves.
- ♦ In this particular situation, because the services were provided on the same day the OIG auditors felt the skin lesion should have been part of the per diem and not separately billable to Part B.
- ♦ Our physicians are wanting to bill properly but have questions the OIG felt only your area should address. Specifically, when the patient presents themselves for a office visit and its deemed they need a stress test / echo, skin lesion removal or some other item the physician performs, they often have the patient return another day because of the length of time to perform the procedure etc.
- ♦ In the above situation, are both the initial visit and the follow-up procedure or test separate encounters or do you deem the follow-up visit to be included in the initial visit per diem?
- ♦ If you deem it to be part of the initial visit, why would a medical follow-up visit as noted in the first item be different?

Kelly, thanks for taking a look at this and giving us a timely answer. If you need clarifications, let me know. You may fax your questions or return information to my attention at 316-669-2598.

Sincerely,



Darryl D. Serpan
Associate Administrator



Medicare
Provider Reimbursement

Part A Intermediary

(423) 755-5908

December 5, 2000

Mr. Darryl Serpan
Hutchinson Clinic, P.A.
2101 N. Waldron
Hutchinson, KS 67502-1197

RE: Appropriate Billing Protocols

Dear Mr. Serpan:

Thank you for your interest in establishing appropriate billing protocols. In the situations described in your letter dated November 2, 2000, it is our opinion that the encounters occurring in the RHC should stand alone. For example: You see a patient in the RHC on Monday for pneumonia and determine that the patient also needs a lesion removal. If the patient returns on another day to have the lesion removed that will count as another visit if there is a face-to-face encounter with a physician, physician assistant or nurse practitioner. If the lesion removal is done during the initial encounter it is part of the all-inclusive rate and is not separately billable.

In the situation where you have sent the patient to your urgent care center that is not part of the RHC, again the RHC encounter should stand alone. I can understand the concerns that the OIG auditors may have with this type of situation. Operating in this type of arrangement requires extreme caution to ensure that cost of services being provided in the urgent care center are in no way commingled with the RHC cost that will be reflected on the cost report.

You are correct that dietitians are not providers for whose services you can bill. If a dietitian sees a patient during RHC hours without a face-to-face encounter with a physician, physician assistant or nurse practitioner, no encounter is billed. Dietary consults done in conjunction with an encounter are included in the all-inclusive rate and should not be billed to the Part B Carrier.

I hope the above has adequately answered your questions and concerns regarding your billing procedures. If you have additional questions, please contact Cindy Geren, Rural Health Clinic Liaison, at (423) 763-3277.

Sincerely,

Kelly Scoggins
Audit Manager
Provider Reimbursement
Riverbend Government Benefits Administrator

Riverbend Government Benefits Administrator
730 Chestnut Street, Chattanooga, Tennessee 37402-1790
www.riverbendgba.com

A HCFA Contracted Intermediary
NTMAY



Department of Health and Human Services
Health Care Financing Administration
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909
(404) 562-7382

February 12, 1999

Ben Thackston
Medicare Part A
Riverbend Government Benefits Administrator
730 Chestnut Street
Chattanooga, Tennessee 37402

Dear Mr. Thackston:

This is in response to your January 12 letter regarding clarification of HCFA's policy involving Rural Health Clinics (RHCs) and the possibility of designating nonrural health areas. As requested, we have prepared the following information.

You indicated that an RHC has its physicians provide interpretative reports for various diagnostic tests such as EKGs, sleep studies, and pulmonary studies performed at the hospital. The reports are prepared by the physicians while at the RHC. The RHC would like to bill the Medicare Part B carrier for these physician interpretations but exclude these costs from the RHC cost report. The RHC proposes using the nonRHC area to identify such cost as rent, utilities, and insurance and allocating costs such as wages and supplies to be based upon the ratio of physician hours spent providing interpretations and total hours in the RHC.

Question 1: Is it permissible for an RHC to designate an office or exam room within the facility as a nonRHC area for billing purposes involving the commingling of physician interpretation costs and RHC cost report costs?

Response: Although it is acceptable for an RHC to designate an office or exam room within the facility as nonRHC area, it is not permissible for billing and payment purposes to commingle an RHC with a private physician practice. When RHC staff members use RHC space and resources to conduct a private practice, Medicare could provide two payments for the administrative cost of services furnished by a particular staff member who had simultaneous assignments.

We believe that Congress never intended to provide opportunities for RHCs to shift from patient to patient as RHCs and as private physician practices merely to achieve higher Medicare payment. Consequently, physicians and nonphysician practitioners assigned to the RHC are not permitted to bill Medicare Part B for their services furnished in an RHC space when the RHC is open to furnish services to its patients. However, there may be cases where a physician routinely provides more complicated medical procedures to clinic patients. Under this situation, we believe physicians and nonphysicians can bill Part B as long as they clearly separate their private practices from the RHC.

Mr. Ben Thackston

Page 2

Question 2: If these interpretations for diagnostic tests performed in the hospital are for patients, who are RHC patients, can the interpretations be billed as RHC visits rather than to the Medicare Part B carrier even though the RHC physician did not actually see the patients, but rather viewed the output from the patients' diagnostic test?

Response: If the RHC physician interprets these diagnostic tests while at the RHC, then the physician is required to include his interpretations in the RHC cost report, which is billable to the RHC's fiscal intermediary.

We hope this information is of assistance to you. If you have any questions, you may contact me.

Sincerely,

Neal E. Logue
Health Insurance Specialist
Division of Health Plans and Providers