

Commingling in an RHC v.2019

What is Commingling in an RHC? How do we avoid it?

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Commingling in an RHC

What is commingling?

Aren't my Non-RHC services commingling? (No)

Can I share a waiting room? (Yes, but...)

Can I operate a specialty clinic in my RHC? (Yes, but...)

Can I share treatment space with non-RHC patients? (Hard No)



Presentation Topics

- ✓ Commingling Definitions
- ✓ Cost Reporting Considerations
- ✓ Duplicate Reimbursement
- ✓ Non-RHC Hours
- ✓ Non-Rural Health Clinic Services
- ✓ Patient Treatment Areas
- ✓ Specialty Clinics



Commingling - Definitions

commingle verb

com·min·gle | \ kə-'minj-gəl

commingled; commingling; commingles

2 : to combine (funds or properties) into a common fund or stock
Proceeds from the sale have been *commingled* with other funds.



Commingling - Definitions

Commingling *Combining things into one body.*

The term *commingling* is most often applied to funds or assets. When a fiduciary, a person entrusted with the management of funds other than his or her own in trust, mixes trust money with that of others, the fiduciary is commingling funds and thereby breaching his or her fiduciary duty.

A member of a corporation's board of directors commingles funds when he or she mixes personal funds with the funds of the corporation. An attorney who commingles his or her money with money belonging to a client is violating the ethics of the legal profession.

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The RHC Encounter Rate

“In general, the all-inclusive rate (AIR) for an RHC or FQHC is calculated by the MAC/FI by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation.”

(Medicare Benefit Policy Manual. Chapter 13. Section 70.)



RHC Rate and Cost Reporting

- ✓ The RHC Encounter Rate (AIR) is set via the RHC Cost Report.
- ✓ Provider-based clinics file their CR as part of the hospital cost report.
- ✓ *Costs must be appropriately allocated and tracked for the RHC space and personnel.*
- ✓ Provider FTEs should be measured via formal time study.
- ✓ Medical Director, Physician, PA, NP, Nursing FTEs have a major impact on cost reporting.
- ✓ Laboratory Expenses must be allocated and reclassified appropriately.
(RHC vs. Non-RHC)



Section 100: Commingling

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



Cost Report Data

“RHCs and FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors.”



Section 60: Non RHC/FQHC Services

- ✓ RHCs and FQHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit, such as laboratory services or the technical component of an RHC or FQHC service.
- ✓ If these services are authorized to be furnished by the RHC or FQHC and are covered under a separate Medicare benefit category, the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service.



Section 60: Non RHC/FQHC Services - Cost Allocation

RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.



Non RHC/FQHC Services

Section 60: Non-RHC/FQHC Services

Medicare excluded services

Ambulance services

Technical component of an RHC or
FQHC service

Prosthetic devices

Laboratory services

Body Braces

Durable medical equipment

Practitioner services at certain other
Medicare facility

Telehealth distant-site services

Hospice Services

Group Services



Hospital Services

- ✓ Physician services at the hospital are billed to the Medicare Carrier for fee-for-service reimbursement.
- ✓ If the parent-entity is a Critical Access Hospital (CAH) using option II billing – out-patient hospital services are billed to the parent's FI.
- ✓ This is NOT commingling!



Section 100: Duplicate Medicare/Medicaid Reimbursement

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

Selectively choosing a higher or lower re-imbursement rate for the services.



Duplicate Medicare Reimbursement

What would constitute duplicate Medicare reimbursement?

- Billing Venipuncture to Medicare Part B, Physician Fee Schedule (PFS).
- Billing injections/procedures on 1500/PFS during RHC hours.
- Making decisions based on how the service is paid in a particular setting. (Selectively choosing a higher or lower re-imbursement rate for the services.)
- Unbundling/Billing defined RHC professional services (See Treatment Area discussion)



Venipuncture

“Although RHCs and FQHCs are required to furnish certain laboratory services...laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. **This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.**” (MLN Matters® MM8504)



Professional Services

One important source of commingling concern is when we attempt to split “defined RHC services”.

RHC services are:

- Physician Services/Incident-To
- NP/PA/CNM Services/Incident-to
- Medicare Preventive Service Encounters



Section 100: RHC Hours

If an RHC or FQHC practitioner furnishes an RHC or FQHC service at the RHC or FQHC during RHC or FQHC hours, the service must be billed as an RHC or FQHC service.



40.2 - Hours of Operation

Services furnished at times other than the RHC or FQHC posted hours of operation to Medicare beneficiaries who are RHC or FQHC patients may not be billed to Medicare Part B if the practitioner's compensation for these services is included in the RHC/FQHC cost report.

(See MBPM Section 100 on Commingling)



RHC Hours vs Non-RHC Hours

- ✓ Non-RHC hours may be established to provide professional or other services which will NOT be billed as RHC (UB04/AIR Payment).
- ✓ The entire RHC must be non-Rural Health during these hours.
- ✓ Non-RHC hours must be “carved-out” of the cost report.
- ✓ Non-RHC hours must be posted on the front door, and in the RHC manual.
- ✓ State Agency notification is recommended. Most states will say it is required.



Non-RHC Hours: Questions to Ask BEFORE Implementation

- ✓ Why? What is your goal? Is it because these are paid better under non-RHC?
- ✓ Is the carve-out being used to bill services that are incident-to RHC encounters?
- ✓ What is the actual volume and reimbursement of the services that you are seeking to carve-out? Are you comparing clinic charge amounts with the AIR or actual payments?
- ✓ Can these be billed under RHC and eliminate the compliance risk?



Section 100: Payer Contracts

Payer arrangements with local employers, specialty payers, or other contracting arrangements are NOT commingling. Examples are:

- ✓ A local employer contracts with the RHC to provide care to their employees on a specific fee schedule, during RHC hours. This is not commingling.
- ✓ Drug testing services
- ✓ DOT, FAA, employment physicals
- ✓ Special Payer Contracts



Section 100: Treatment Space

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



Section 100: Treatment Space

We cannot have an “island” of non-RHC professional services, within our RHC space.

- ✓ RHC treatment space and patient care areas cannot be shared with non-RHC providers, during RHC hours.
- ✓ ...even for NON-RHC providers owned by the same organization. (Think provider-based clinic offering Occupational Therapy in an adjacent non-RHC space.)
- ✓ This is NOT to be confused with sharing treatment space with defined non-RHC **services** (*i.e. diagnostic testing, lab, etc.*)

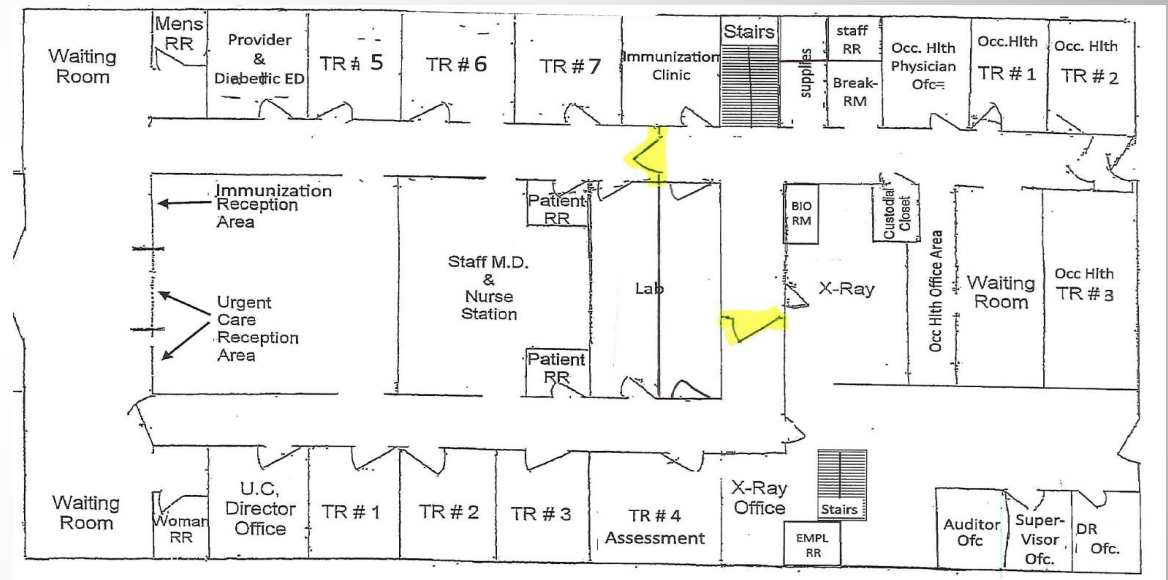


Treatment Space Example

Occupational Health shares space

- ✓ The lab area was used as a common treatment area.
- ✓ Prior to reconfiguration, OccHealth personnel traverse RHC space to get to x-ray.
- ✓ The lab area was closed to non-RHC personnel.
- ✓ Per CMS: Occ. Health personnel cannot pass through RHC treatment space to the x-ray.

Occupational Health

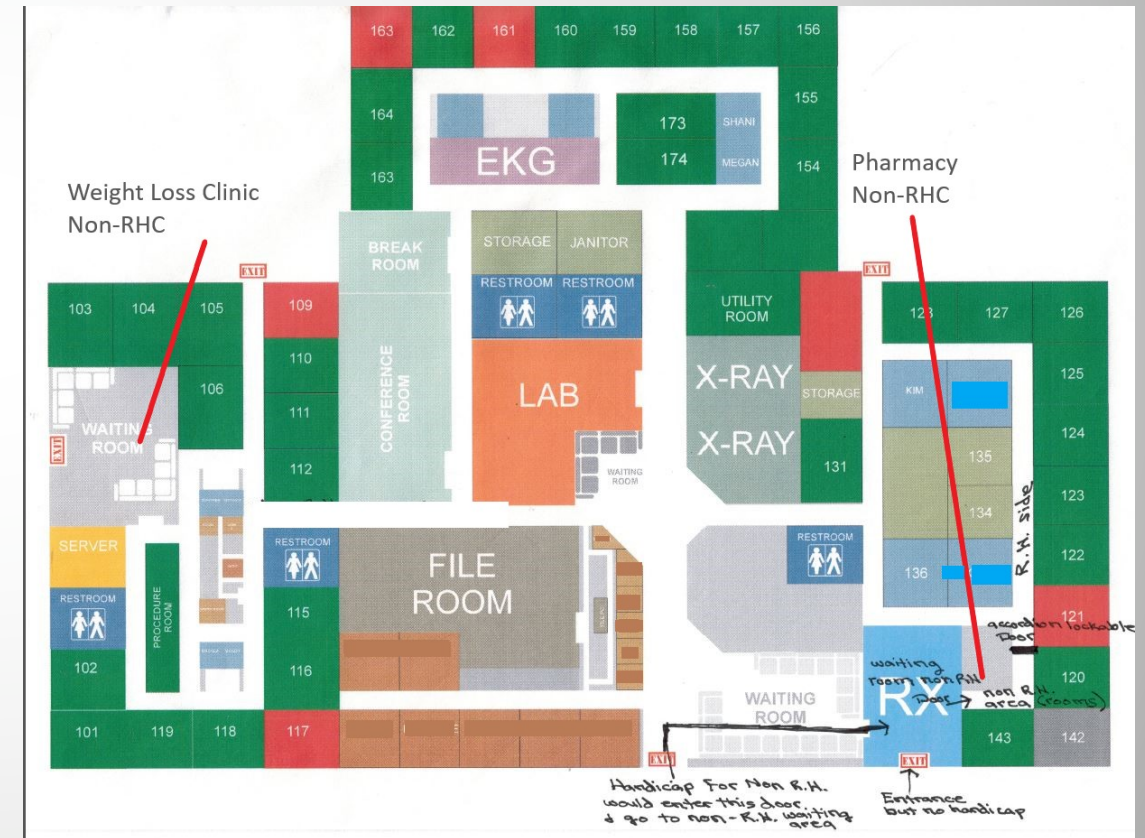


Treatment Space Example

Commingling Issues

- ✓ Non-RHC Weight Loss Clinic Patients cannot share treatment space with the RHC.
- ✓ Non-RHC patients cannot have access to RHC treatment areas.
- ✓ The pharmacy needs to be sequestered from the RHC.
- ✓ The clinic built interior doors at the 'file room' and by the pharmacy to prevent access to the RHC from those areas.

Weight Loss and Pharmacy: Non-RHC



Shared Resources: Waiting Room and Reception Areas

RHCs and FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC or FQHC staff, space, or other resources.

Any shared staff, space, or other resources must be allocated appropriately between RHC or FQHC and non-RHC or non-FQHC usage to avoid duplicate reimbursement.



Shared Resources: Waiting Room and Reception Areas

If an RHC or FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC or FQHC space must be clearly defined.

If the RHC or FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.



Visiting Specialists in an RHC

Any qualified provider (MD, DO, NP, PA) can see patients in an RHC. Specialists in an RHC may, either:

- Bill as RHC providers; no carve-out or service sequestration.
- Rent space; bring staff; performs their own billing; RHC carves out space and overhead from the cost report.
- Signage should indicate that these are NOT RHC providers, but are visiting from an outside practice.



RHC and Specialty Clinic: How-To

- ✓ The RHC shares waiting space and reception areas with specialty providers (from the same organization).
- ✓ The patient treatment areas are totally separate from one another.
- ✓ Each clinic has their own patient registration and check-out personnel, indicated by signage.
- ✓ The clinics function as separate practices, other than sharing waiting and reception space.
- ✓ Costs are accurately tracked, allocated, and allocation method documented.



RHC and Specialty Clinic: Floor Plan Example

Commingling Issues

- ✓ The RHC shares waiting space and reception areas with Behavioral Health and Specialty Clinics. (from the same organization)
- ✓ The patient treatment areas are totally separate from one another.
- ✓ Each clinic has their own patient registration and check-out personnel, indicated by signage.
- ✓ The clinics function operationally as separate practices, other than sharing waiting and reception space.

RHC, Behavioral Health, and Specialty Clinic



Cost Allocation Methods!!

The A/B MAC has the authority to determine acceptable accounting methods for allocation of costs between the RHC or FQHC and another entity.

In some situations, the practitioner's employment agreement will provide a useful tool to help determine appropriate accounting.



CMS Draft Guidance: Co-Located Space

May 3, 2019: QSO-19-13-Hospital

DRAFT ONLY- Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities

“In this guidance, CMS seeks to provide clarity about how CMS and State Agency surveyors will evaluate a hospital’s space sharing or contracted staff arrangements with another hospital or health care entity when assessing the hospital’s compliance with the CoPs.”



CMS Draft Guidance: Co-Located Space

“Hospitals can be co-located with other hospitals or other healthcare entities. These hospitals may be located on the same campus of or in the same building used by another hospital or healthcare facility. The hospital may be co-located in its entirety or only certain parts of the hospital may be co-located with other healthcare entities.”



“Common examples of co-location instances include:

Outpatient department of one hospital is located on the same campus of or in the same building as another hospital or a separately Medicare-certified provider/supplier such as an ambulatory surgical center (ASC), rural health clinic (RHC), federally-qualified healthcare center (FQHC), an imaging center, etc.”

CMS Distinct and Shared Space

“It is expected that the hospital have defined and distinct spaces of operation for which it maintains control at all times. See SOM §2012.

Distinct spaces would include clinical spaces designated for patient care and is necessary for the protection of patients, including but not limited to their right to personal privacy and to receive care in a safe environment under § 482.13(c)(1) and 2 (2), and right to confidentiality of patient records under §482.13(d)



Public vs. Non-Public Paths of Travel

“Shared spaces are considered those public spaces and public paths of travel that are utilized by both the hospital and the co-located healthcare entity. Both entities would be individually responsible for compliance with the CoPs in those spaces.”



Public vs. Non-Public Paths of Travel

Examples of public spaces and paths of travel would include public lobbies, waiting rooms and reception areas (with separate “check-in” areas and clear signage), public restrooms, staff lounges, elevators and main corridors through non-clinical areas, and main entrances to a building.”



DRAFT Guidance: Comments are due July 2, 2019

Comments may be sent to:

HospitalSCG@cms.hhs.gov



RHC - CMS Resources

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

42 CFR § 413.65: Requirements for a determination that a facility or an organization has provider-based status. <https://www.law.cornell.edu/cfr/text/42/413.65>

QSO-19-13-Hospital. “DRAFT ONLY- Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities.” May 3, 2019. Centers for Medicare and Medicaid Services.



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