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Rural Health Clinics Provider Guide

July 1, 2015

Washington State
Health Care Authority

About this guide*

This publication takes effect July 1, 2015, and supersedes earlier guides to this program.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
<u>Are RHCs liable for payments received?</u>	Added "Each RHC is responsible for submitting claims for services provided to eligible clients. The claims must be submitted under the rules and billing instructions in effect at the time the service is provided."	Clarification
<u>How is a change in scope of service rate adjustment requested?</u>	Added "During the 2015 calendar year, the agency may grant exceptions to the 90-day application timeline requirement on a case-by-case basis."	Policy change
<u>How are rates rebased?</u>	Added "The agency will periodically rebase the RHC encounter rates using the RHC cost reports and other relevant data."	Clarification

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

* This publication is a billing instruction.

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's Resources Available web page.
Information about payments, claims processing, denials, or agency managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., Medicaid provider guides, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
Who do I contact if I have questions about enrolling as a medical assistance-certified RHC, overall management of the program, or specific payment rates?	RHC Program Manager Office of Rates Development PO Box 45510 Olympia, WA 98504-5510 Or email: FQHCRHC@hca.wa.gov



Definitions

This list defines terms used in this provider guide.
Refer to the agency's [Medical Assistance Glossary](#) for additional definitions.

APM index – Alternative payment methodology (APM) index is a measure of input price changes experienced by Washington's rural health clinic (RHC) providers. The index is derived from the federal Medicare Economic Index (MEI) and Washington-specific variable measures. The APM index is used to update the APM encounter payment rates on an annual basis.

Base year – The year that is used as the benchmark in measuring a clinic's total reasonable costs for establishing base encounter rates.

Cost report – An annual report that RHCs must complete and submit to Medicare. The cost report is a statement of costs and provider use that occurred during the time period covered by the cost report.

Encounter rate – A cost-based, facility-specific rate for covered RHC services, paid for each valid encounter billed by an RHC.

Freestanding RHC – An independent clinic that is not part of a hospital, skilled nursing facility, or home health agency.

Interim rate – The rate established by the agency to pay an RHC for encounter services prior to the establishment of a permanent rate.

Medicaid certification date – The date that an RHC can begin providing encounter services to Medicaid clients.

Provider-Based RHC (also known as hospital-based RHC) – A clinic that is an integral and subordinate part of a hospital.

Program Overview

What is a rural health clinic (RHC)?

A rural health clinic (RHC) is a provider-based or freestanding facility certified under Code of Federal Regulations (CFR), title 42, part 491. An RHC is located in a rural area designated as a shortage area.

An RHC may be a permanent or mobile unit. If an entity owns clinics in multiple locations, each individual site must be certified in order for that site to receive payment as an RHC.

Note: An RHC is unique only in the methodology by which it is paid for encounter services, not by the scope of coverage for which it is paid.

What are the basic requirements?

- An RHC must furnish all services according to applicable federal, state, and local laws.
- Unless otherwise specified, an RHC's services are subject to the limitations and coverage requirements detailed in the agency's [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#) and other applicable billing instructions. The agency does not extend additional coverage to clients in an RHC beyond what is covered in other agency programs and state law.
- An RHC must be primarily engaged in providing outpatient health services. Clinic staff must provide those diagnostic and therapeutic services and supplies commonly furnished in a physician's office or the entry point into the health care delivery system. These include:
 - ✓ Medical history
 - ✓ Physical examination
 - ✓ Assessment of health status
 - ✓ Treatment for a variety of medical conditions
- An RHC must provide basic laboratory services essential to the immediate diagnosis and treatment of the patient in accordance with federal law (see 42 CFR, Public Health, Chapter IV, section 491.9). These services, which are subject to change as defined by federal RHC regulations, include, but are not limited to:

- ✓ Chemical examination of urine by stick or tablet method or both
 - ✓ Hemoglobin or hematocrit
 - ✓ Blood glucose
 - ✓ Examination of stool specimens for occult blood
 - ✓ Pregnancy tests
 - ✓ Primary culturing for transmittal to a certified laboratory
- An RHC must provide medical emergency procedures as a first response to common life-threatening injuries and acute illness. The RHC must have available commonly used drugs and biologicals, such as:
 - ✓ Analgesics
 - ✓ Anesthetics (local)
 - ✓ Antibiotics
 - ✓ Anticonvulsants
 - ✓ Antidotes and emetics
 - ✓ Serums and toxoids

What are the staffing requirements of an RHC?

[\(42 CFR § 491.7-8\)](#)

- An RHC must be under the medical direction of a physician.
- An RHC must have a health care staff that includes one or more physicians.
- An RHC staff must include one or more physician's assistants (PA) or advanced registered nurse practitioners (ARNP).
- A physician, ARNP, PA, certified nurse-midwife, clinical social worker, or clinical psychologist must be available to provide patient care services within their scope of practice at all times the RHC operates.
- An ARNP, PA, or certified nurse-midwife must be available to provide patient care services at least 50 percent of the time the RHC operates.
- The staff also may include ancillary personnel who are supervised by the professional staff.
- The PA, ARNP, certified nurse-midwife, clinical social worker, or clinical psychologist member of the staff may be the owner or an employee of the RHC, or may provide services under contract to the center.

What are the RHC certification requirements?

To be eligible to offer medical assistance, RHCs must have federal and medical assistance certifications.

Federal certification: RHCs must be federally certified for participation as an RHC by the Department of Health and Human Services (DHHS). The clinic provides the agency with a copy of its certification as an RHC.

Medical assistance certification: A clinic certified under Medicare meets the standards for medical assistance certification.

To obtain medical assistance certification as an RHC, the clinic must complete the online application and supply all necessary documentation to the agency's Provider Enrollment unit.

Note: A clinic must receive federal designation as a Medicare-certified RHC before the agency can enroll the clinic as a medical assistance-certified RHC. Go to <http://www.cms.hhs.gov/home/medicare.asp> for information on Medicare provider enrollment.

When enrolling a new clinic through ProviderOne on-line enrollment application, select the *Fac/Agency/Org/Inst* option from the enrollment type menu and select the RHC taxonomy 261QR1300X from the provider specialty menu. Direct questions regarding enrollment applications to providerenrollment@hca.wa.gov.

What is the effective date of the Medicaid RHC certification?

[\(WAC 182-549-1200 \(2\)\)](#)

The agency uses one of two timeliness standards for determining the effective date of a Medicaid-certified RHC:

- **Medicare's effective date:** The agency uses Medicare's effective date if the RHC returns a properly completed CPA and RHC enrollment packet **within 60 calendar days** from the date of Medicare's letter notifying the clinic of the Medicare certification.
- **The date the agency receives the CPA:** The agency uses the date the signed CPA is received if the RHC returns the properly completed CPA and RHC enrollment packet **61 or more calendar days** after the date of Medicare's letter notifying the center of the Medicare certification.

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Washington Apple Health. For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Health Care Coverage—Program Benefit Packages and Scope of Service Categories](#) web page.

Note: Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org.
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY).
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are managed care enrollees eligible?

(WAC [182-538-060](#), [095](#), and [182-538-063](#))

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care plan, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne. All services must be requested directly through the client's primary care provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for both of the following:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Are clients eligible when enrolled in primary care case management (PCCM)?

If a client has chosen to obtain care with a PCCM provider, eligibility information will be displayed on the client benefit inquiry screen in ProviderOne. PCCM clients must obtain or be referred for services via their PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

Note: To prevent billing denials, check the client's eligibility prior to scheduling services and at the time of the service and make sure proper authorization or referral is obtained from the PCCM provider. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Encounters

What is an encounter?

An encounter is a face-to-face visit between a client and an RHC provider of health care services who exercises independent judgment when providing healthcare services to the individual client. For a health care service to be defined as an encounter, it must meet specific encounter criteria as described below. All services must be documented in the client's file in order to qualify for an encounter. Encounters are limited to one per client, per day except in the following circumstances:

- The client needs to be seen on the same day by different practitioners with different specialties.
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

What services are considered an encounter?

(WAC [182-549-1300](#))

Only certain services provided by an RHC are considered an encounter.

The RHC must bill the agency for these services using HCPCS code T1015 and the appropriate HCPCS or CPT code for the service provided.

The following services qualify for RHC reimbursement:

- Physician services
- Nurse practitioner or physician assistant services
- Visiting nurse services
- Naturopathic physician services as described in the [Physician-Related Services/Health Care Professional Services Provider Guide](#)
- Approved screening, brief intervention, and referral to treatment (SBIRT) provider services as described in the [Physician-Related Services/Health Care Professional Services Provider Guide](#)
- Mental health services as described in the [Mental Health Services Provider Guide](#)

Are surgical procedures considered RHC services?

Effective August 31, 2014, and retroactive to dates of service on or after January 1, 2014, surgical procedures furnished in an RHC by an RHC practitioner are considered RHC services, and the RHC is paid based on its encounter rate for the face-to-face encounter associated with the surgical procedure.

Global billing requirements do not apply to RHCs, except that surgical procedures furnished at locations other than RHCs may be subject to global billing requirements.

If an RHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC must determine if these services have been included in the surgical global billing. RHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service furnished by the RHC was included in the global payment for the surgery, the RHC may not also bill for the same service.

For services not included in the global surgical package, see the [Physician-Related Services/Health Care Professional Services Provider Guide](#).

What services and supplies are incidental to professional services?

Services and supplies incidental to the professional services of encounter-level practitioners are included in the encounter rate paid for the professional services when the services and supplies are:

- Furnished as an incidental, although integral, part of the practitioner's professional services (e.g. professional component of an x-ray or lab).
- Of a type commonly furnished either without charge or included in the RHC bill.
- Of a type commonly furnished in a provider's office (e.g., tongue depressors, bandages, etc.).
- Provided by RHC employees under the direct, personal supervision of encounter-level practitioners.
- Furnished by a member of the RHC staff who is an employee of the RHC (e.g., nurse, therapist, technician, or other aide).

Incidental services and supplies as described above that are included on the RHC's cost report are factored into the encounter rate and will not be paid separately.

Note: The agency excludes drugs and biologicals administered in the provider's office from the list of encounter services. This includes pneumococcal and influenza vaccines. Bill the agency separately for these drugs and biologicals using the appropriate taxonomy for fee-for-service and the appropriate, specific servicing taxonomy (see [Billing and Claim Forms](#) for more details).

How do I determine whether a service is an encounter?

To determine whether a contact with a client meets the encounter definition, all the following guidelines apply:

Services requiring the skill and ability of an encounter-level practitioner

The service being performed must require the skill and ability of an encounter-level practitioner in order to qualify as an encounter. A service does not qualify as an encounter simply because it is performed by one of these practitioners if the service is one that is normally performed by other health care staff.

For example, if a physician performs a blood draw only or a vaccine administration only, these services are not encounters since they are normally performed by registered nurses. These services must be billed as fee-for-service using the appropriate coding.

Services in the clinic

The services of a practitioner performed in the clinic (excluding those listed in [Billing and Claim Forms](#)) are encounters and are payable only to the clinic.

Assisting

The provider must make an independent judgment. The provider must act independently and **not assist** another provider.

Examples:

Encounter:	A mid-level practitioner sees a client to monitor physiologic signs, to provide medication renewal, and uses standing orders or protocols.
Not an Encounter:	A mid-level practitioner assists a physician during a physical examination by taking vital signs, history, or drawing a blood sample.

Services outside the clinic

Services performed in any hospital setting do not qualify as an encounter.

Otherwise, a service that is considered an encounter when performed **in** the clinic is considered an encounter when performed **outside** the clinic (for example, in a nursing facility or in the client's home) and is payable to the clinic. A service that is not considered an encounter when performed **in** the clinic is not considered an encounter when performed **outside** the clinic, regardless of the place of service.

Concurrent care exists when services are rendered by more than one practitioner during a period of time. Consultations do not constitute concurrent care. The reasonable and necessary services of each practitioner rendering concurrent care are covered if each practitioner is required to play an active role in the patient's treatment.

For example, concurrent care may occur because of the existence of more than one medical condition requiring distinct specialized medical services.

Each **individual** provider is limited to one type of encounter per day for each client, regardless of the services provided except in either one of the following circumstances:

- The client needs to be seen by different practitioners with different specialties.
- The client needs to be seen multiple times due to unrelated diagnoses.

Note: Simply making a notation of a pre-existing condition or writing a refill prescription for the condition **is not significant enough** to warrant billing an additional encounter for the office visit.

Serving multiple clients simultaneously

When an individual provider renders services to several clients simultaneously, the provider can count an encounter for each client if the provision of services is documented in **each client's** health record. This policy also applies to family therapy and family counseling sessions. **Bill services for each client on separate claim forms.**

State-only programs

Services provided to clients in state-only programs and reimbursed separately by the state do not qualify for a Medicaid encounter. Clients identified in ProviderOne with one of the following medical coverage group codes are enrolled in a state-only program. RHC clients identified in ProviderOne with one of the following medical coverage group codes and associated recipient aid category (RAC) codes do not qualify for the encounter rate effective January 1, 2014.

Rural Health Clinics

Medical Coverage Group Codes	RAC Code
F06	RACs 1138, 1139 only
F07	RACs 1141, 1142 only
F99	RAC 1040
G01	RACs 1041, 1135-1137, 1145 only
I01	RAC 1050, 1051 only
K03	RACs 1056,1058, 1176-1178 only
K95	RACs 1060, 1064, 1179-1181 only
K99	RACs 1060, 1064, 1179-1181 only
L04	RACs 1077, 1078, 1081, 1082, 1158-1161, 1182-1185 only
L24	RACs 1190-1195 only
L95	RACs 1085, 1087, 1155, 1157, 1186, 1187 only
L99	RACs 1085, 1087, 1090, 1092, 1155, 1157, 1186-1189
M99	RAC 1094 (This is the only RAC for M99)
P05	RAC 1097, 1098 only
P06	All RACs (1099-1100)
S95	RACs 1125, 1127
S99	RACs 1125, 1127
W01	All RACs (1128, 1129, 1170, 1171)
W02	All RACs (1130, 1131, 1172, 1173)
W03	RAC 1132 (This is the only RAC for W03)
N31	RAC 1211 (replaces 1138 and 1139)
N33	RAC 1212, 1213 (replaces 1141, 1142)
A01	RAC 1214 (replaces 1041)
A01	RAC 1215 (replaces 1137)
A05	RAC 1216 (replaces 1145)

Services provided to clients with the following medical coverage group code and RAC code combinations are eligible for encounter payments retroactively effective for dates of service on or after January 1, 2011.

Medical Coverage Group Codes	RAC Code
K03	RAC 1057 (This is not the only RAC for K03.)
K95	RAC 1062 (This is not the only RAC for K95.)
K99	RAC 1062 (This is not the only RAC for K99.)
P04	RAC 1096 (This is the only RAC for P04.)
P99	RAC 1102 (This is the only RAC for P99.)

What services do not qualify as an encounter?

The following services are not billable as encounters. Do not bill using HCPS code T1015 for these services unless there is a qualifying, encounter-eligible service on the claim. The agency covers the following supplies and services and pays for them under fee-for-service:

- Ambulance services
- Dental services
- Diabetes education and management
- Drugs and biologicals including drugs administered in the provider's office (for example, pneumococcal and influenza vaccines)
- Durable medical equipment (whether rented or purchased)
- Eye exams and eyeglasses or contact lenses
- Family planning services
- Hearing exams and hearing aids
- Any service provided in a hospital setting
- Maternity support services
- Outpatient chemical dependency (other than SBIRT)
- Medical supplies listed in the agency's [Physician-Related Services/Healthcare Professional Services Provider Guide](#) as separately billable (for example, cast materials and splints)
- Prosthetic and orthotic devices
- Screening mammography services
- Childbirth in a hospital setting
- Diagnostic tests, such as x-rays and EKGs
- Clinical diagnostic laboratory services, including laboratory tests required for RHC certification
- Administration fees for drugs and vaccines given in the provider's office (except when performed on the same day as an encounter)

The following are examples of services that are not encounter-eligible but are reimbursed fee-for-service.

- Blood draws, laboratory tests, etc., are not encounter-eligible, but these procedures may be provided in addition to other medical services as part of an encounter.
- The administration of drugs and biologicals are not encounter-eligible, these include pneumococcal and influenza vaccines, and other immunizations.
- Delivery and postpartum services provided to pregnant undocumented alien women are not encounter-eligible. Global care must be unbundled. The agency does not pay for an encounter for the delivery or postpartum care or any other service provided once the client is no longer pregnant.

When does the agency pay for RHC services?

(WAC [182-549-1300](#) (2))

The agency pays the RHC for medical services when they are:

- Within the scope of an eligible client's [medical assistance program](#).
- Medically necessary as defined in WAC [182-500-0070](#).

What is the reimbursement structure for RHCs?

The reimbursement structure is explained in detail in WAC [182-549-1400](#).

Medical services not normally provided to Medicare beneficiaries are excluded from the clinic's Medicare cost report, and are not used for the calculation of the clinic's encounter rate. Therefore, they have been excluded from the agency's list of encounter services and are not billable as an encounter.

Also, as described in [Payment](#), many supplies used in a provider's office are considered incidental to the medical service and are included in the encounter rate. Using the appropriate billing taxonomy and appropriate procedure codes, bill only those supplies that are specifically detailed in the agency's [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#) as separately payable.

The agency establishes encounter rates specific to each RHC facility for covered RHC services. Non-RHC services are not qualified to be paid at the encounter rate, and are paid for at the appropriate fee schedule amount.

In Washington state, RHCs have the choice of being reimbursed under the prospective payment system or the alternative payment methodology (APM), in accordance with 42 USC 1396a(bb)(6). APM rates are required to be at least equal to prospective payment system rates. (See WAC [182-549-1400](#), Rural health clinics—Reimbursement and Limitations, for a detailed description of each methodology.)

Are RHCs liable for payments received?

Each RHC is responsible for submitting claims for services provided to eligible clients. The claims must be submitted under the rules and billing instructions in effect at the time the service is provided.

Each RHC is individually liable for any payments received, and must ensure that these payments are for only those situations described in this and other applicable agency provider guides, and federal and state rules. RHC claims are subject to audit by the agency, and RHCs are responsible to repay any overpayments.

Upon request, RHCs must give the agency complete and legible documentation that clearly verifies any services for which the RHC has received payment.

How does the agency pay for encounter-eligible services?

The agency pays RHCs for encounter-eligible services on an **encounter rate** basis rather than a fee-for-service basis. All RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

The agency limits encounters to one per client, per day, except in the following circumstances:

- The visits occur with different healthcare professionals with different specialties.
- There are separate visits with unrelated diagnoses.

Note: The service being performed must require the skill and ability of an encounter-level practitioner as described in [Cost Reporting Requirements](#) in order to qualify for an encounter payment.

Does the agency pay for covered RHC services for clients enrolled in a Managed Care Organization (MCO)?

No. For clients enrolled with a Managed Care Organization (MCO), covered RHC services are paid by the MCO. Only clients enrolled in Title XIX (Medicaid) or Title XXI (CHIP) are eligible for encounter payments. Neither the agency nor the MCO pays the encounter rate for clients in state-only medical programs.

How does an MCO reimburse an RHC for qualified encounters provided to managed care clients?

For managed care clients receiving services at an RHC, total daily reimbursement to the RHC must equal the RHC's specific encounter rate for qualified encounters. Guidelines for qualified encounters are the same as the fee-for-service guidelines outlined in this guide. The agency will provide each RHC's encounter rate to the MCO. To ensure that the appropriate amounts are paid to each RHC, the agency compares the amount actually received by an RHC with the amount due to the RHC, based on its encounter rate multiplied by number of qualifying encounters. If the RHC does not receive its encounter rate from the MCO for qualified services, the agency will notify the MCO of the difference and provide for payment sufficient to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

Change in Scope of Service

[WAC [182-549-1500](#) and 42 U.S.C. 1396a(bb)(3)(B)]

A change in scope of service occurs when there is a change in the type, intensity (the total quantity of labor and materials consumed by an individual client during an average encounter), duration (the length of an average encounter), or amount of services provided by the RHC. When such changes meet the criteria described below, the RHC may qualify for a change in scope of service rate adjustment.

What are the criteria for a change in scope of service rate adjustment?

The agency may authorize a change in scope of service rate adjustment when the following criteria are met:

- The change in the services provided by the RHC meet the definition of RHC services as defined in section 1905(a)(2)(C) of the Social Security Act.
- Changes to the type, intensity, duration, or amount of services have resulted in an increase or decrease in the RHC's cost of providing covered health care services to eligible clients. The cost change must equal or exceed any of the following:
 - ✓ An increase of 1.75 percent in the rate per encounter over one year
 - ✓ A decrease of 2.5 percent in the rate per encounter over one year
 - ✓ A cumulative increase or decrease of 5 percent in the cost per encounter as compared to the current year's cost per encounter
- The costs reported to the agency to support the proposed change in scope rate adjustment are reasonable under applicable state and federal law.

How is a change in scope of service rate adjustment requested?

A change in scope of service rate adjustment may be requested by the agency or by an RHC.

When may the agency request an application for a change in scope of service rate adjustment?

At any time, the agency may require an RHC to file an application for a change in scope of service rate adjustment. The application must include a cost report and "position statement," which is an assertion as to whether the RHC's encounter rate should be increased or decreased due to a change in the scope of service.

- The RCH must file a completed cost report and position statement no later than 90 calendar days after receiving the agency's request for an application.
- The agency reviews the RHC's cost report, position statement, and application for change in scope of service rate adjustment using the criteria listed under *What are the criteria for a change in scope of service rate adjustment?*
- The agency will not request more than one change in scope of service rate adjustment application from an RHC in a calendar year.

When may an RHC request an application for a change in scope of service rate adjustment?

Unless the agency instructs the RHC to file an application for a change in scope of service rate adjustment, an RHC may file only one application per calendar year. However, more than one type of change in scope of service may be included in a single application.

An RHC may apply for a prospective change in scope of service rate adjustment, a retrospective change in scope of service rate adjustment, or both.

An RHC must file an application for a change in scope of service rate adjustment no later than 90 calendar days after the end of the year in which the RHC believes the change in scope of service occurred or in which the RHC learned that the cost threshold was met, whichever is later.

Note: During the 2015 calendar year, the agency may grant exceptions to the 90-day application timeline requirement on a case-by-case basis.

What is a prospective change in scope of service?

A prospective change in scope of service is a change the RHC plans to implement in the future. To file an application for a prospective change in scope of service rate adjustment, the RHC must submit projected costs sufficient to establish an interim rate. If the application for a prospective change in scope of service rate adjustment is approved by the agency, an interim rate adjustment will go into effect after the change takes effect.

The interim rate is subject to a post-change in scope review and rate adjustment.

If the change in scope of service occurs fewer than 90 days after the RHC submits a complete application to the agency, an interim rate takes effect no later than 90 days after the RHC submits the application to the agency.

If the change in scope of service occurs more than 90 days but fewer than 180 days after the RHC submits a complete application to the agency, the interim rate takes effect when the change in scope of service occurs.

If the RHC fails to implement a change in service identified in its application for a prospective change in scope of service rate adjustment within 180 days, the application is void. The RHC may resubmit the application to the agency. The agency does not consider the resubmission of a voided application as an additional application.

Supporting documentation for a prospective change in scope of service rate adjustment

To apply for a change in a prospective scope of service rate adjustment, the RHC must include the following documentation in the application:

- A narrative description of the proposed change in scope of service
- A description of each cost center on the cost report that will be affected by the change in scope of service
- The RHC's most recent audited financial statements, if an audit is required by federal law
- The implementation date for the proposed change in scope of service
- The projected Medicare cost report with supplemental schedules needed to identify the Medicaid cost per visit for the 12-month period following the implementation of the change in scope of service
- Any additional documentation requested by the agency

What is a retrospective change in scope of service?

A retrospective change in scope of service occurs when a change took place in the past and the RHC is seeking to adjust its rate based on that change.

An application for a retrospective change in scope of service rate adjustment must state each qualifying event that supports the application and include 12 months of data documenting the cost change caused by the qualifying event.

If approved, a retrospective rate adjustment takes effect on the date the RHC filed the application with the agency.

Supporting documentation for a retrospective change in scope of service rate adjustment

To apply for a retrospective change in scope of service rate adjustment, the RHC must include the following documentation in the application:

- A narrative description of the proposed change in scope of service
- A description of each cost center on the cost report that was affected by the change in scope of service
- The RHC's most recent audited financial statements, if an audit is required by federal law
- The implementation date for the proposed change in scope of service

- The Medicare cost report with the supplemental schedules necessary to identify the Medicaid cost per visit and the encounter data for the 12 months or the fiscal year following implementation of the proposed change in scope of service.
- Any additional documentation requested by the agency

How does the agency process applications for a change in scope of service rate adjustment?

The agency reviews an application for a change in scope of service rate adjustment for completeness, accuracy, and compliance with program rules.

Within 60 days of receiving the application, the agency notifies the RHC of any deficient documentation or requests any additional information that is necessary to process the application.

Within 90 days of receiving a complete application, the agency sends the RHC:

- A decision stating it will implement an encounter rate change.
- A rate-setting statement.

If the RHC does not receive the items described above within 90 days, the agency has denied the change.

How does the agency set an interim rate for prospective changes in the scope of service?

The agency sets an interim rate for prospective changes in the scope of service by adjusting the RHC's existing rate by the projected average cost per encounter of any approved change.

The agency reviews the projected costs to determine if they are reasonable, and sets a new interim rate based on the determined cost per encounter.

How does the agency set an adjusted encounter rate for retrospective changes in the scope of service?

The agency sets an adjusted encounter rate for retrospective changes in the scope of service by changing the RHC's existing rate by the documented average cost per encounter of the approved change.

Projected costs per encounter may be used if there is insufficient historical data to establish the rate. The agency reviews the costs to determine if they are reasonable, and sets a new rate based on the determined cost per encounter.

If the RHC is paid under an alternative payment methodology (APM), any change in the scope of service rate adjustment requested by the RHC will modify the encounter rate in addition to the APM.

The agency may delegate the duties related to application processing and rate setting to a third party. The agency retains final authority for making decisions related to changes in scope of service.

When does the agency conduct a post change in scope of service rate adjustment review?

The agency conducts a post change in scope of service review within 90 days of receiving the cost report and encounter data from the RHC. If necessary, the agency will adjust the encounter rate within 90 days of the review to ensure that the rate reflects the reasonable cost of the change in scope of service.

A rate adjustment based on a post change in scope of service review will take effect on the date the agency issues its adjustment. The new rate will be prospective.

If the application for a change in scope of service rate adjustment was based on a year or more of actual encounter data, the agency **may** conduct a post change in scope of service rate adjustment review.

If the application for a change in scope of service rate adjustment was based on less than a full year of actual encounter data, the RHC **must** submit the following information to the agency within 18 months of the effective date of the rate adjustment:

- A Medicare cost report with the supplemental schedules necessary to identify the Medicaid cost per visit
- Encounter data for 12 consecutive months of experience following implementation of the change in scope
- Any additional documentation requested by the agency

If the RHC fails to submit the post change in scope of service cost report or related encounter data, the agency provides written notice to the RHC of the deficiency within 30 days.

If the RHC fails to submit required documentation within 5 months of this deficiency notice, the agency may reinstate the encounter rate that was in effect before a change in the scope of service rate was granted. The rate will be effective the date the interim rate was established. Any overpayment to the RHC may be recouped by the agency.

How are rates rebased?

The agency will periodically rebase the RHC encounter rates using the RHC cost reports and other relevant data. RHCs being rebased will submit a Medicare cost report, *Settled as Filed*, to the agency for the most recent fiscal year.

Retrospective change in scope of service requests are not allowed during the periodic rebase process as rebasing adjusts for these changes.

May an RHC appeal an agency action?

Yes. An RHC may appeal an agency action. Appeals are governed by WAC 182-502-0220, except that any rate change begins on the date the agency received the application for a change in scope of service rate adjustment.

What are examples of events that qualify for a rate adjustment due to changes in scope of service?

The following examples illustrate events that would qualify for a rate adjustment due changes in the type, intensity, duration, or amount of service:

- Changes in the patients served, including populations with HIV/AIDS and other chronic diseases; patients who are homeless, elderly, migrant, limited in English proficiency; or other special populations
- Changes in the technology of the RHC, including but not limited to electronic health records and electronic practice management systems
- Changes in the RHC's medical or behavioral health practices, including but not limited to the implementation of patient-centered medical homes, opening for extended hours, or changes in prescribing patterns
- Capital expenditures associated with a modification of any of the services provided by the RHC, including relocation, remodeling, opening a new site, or closing an existing site
- Changes in service delivery due to federal or state regulatory requirements

What are examples of events that do not qualify for a rate adjustment due to changes in scope of service?

The following examples illustrate events that would not qualify for a rate adjustment due to changes in the type, intensity, duration, or amount of service:

- Addition or reduction of staff members not directly related to the change in scope of service
- Expansion or remodel of an existing RHC that is not directly related to the change in scope of service
- Changes to salaries, benefits, or the cost of supplies not directly related to the change in scope of service
- Changes to administration, assets, or overhead expenses not directly related to the change in scope of service
- Capital expenditures for losses covered by insurance
- Changes in office hours, location, or space not directly related to the change in scope of service
- Changes in patient type and volume without changes in type, duration, or intensity of services
- Changes in equipment or supplies not directly related to the change in scope of service

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#).

What special rules are there for RHCs to follow when billing?

- All related services performed on the same day by the same clinician or by the same provider specialty must be billed on the same claim. This includes any services performed during an encounter-eligible visit that are not encounter-eligible. For example, laboratory services performed at the same visit as evaluation and management.
- An encounter-eligible service must be billed with the T1015 procedure code.
- If reprocessing a denied service or a service that was not correctly included when the original claim was billed, the paid claim must be adjusted. If the original claim is not adjusted to add these services, the additional claim may be denied.
- If a non-encounter-eligible service is billed and paid prior to an encounter-eligible claim submission for the same date of service, adjust the paid claim and submit the services together to receive payment.

How do I bill for encounter services?

HCPCS Code	HCPCS/CPT Encounter Service Rendered	Billed Charges
T1015 ¹ (All-inclusive clinic visit/encounter)		Bill \$0.00
	Bill corresponding fee-for-service code(s) of the underlying service being performed	Bill clinic's usual and customary charges for service rendered

¹The position of the T1015 on a claim will not affect claim payment.

Always list an encounter code on the same claim as its related fee-for-service procedure codes.

- When billing the encounter code, bill \$0.00. For services eligible for encounter payments, the system will automatically pay the difference between the RHC's encounter rate and the fee-for-service amount paid.
- For clients in programs eligible for encounter payments, the agency denies Evaluation and Management codes when billed without a T1015.
- When billing for services that do not qualify for encounter payments, do not use an encounter code on the claim form. (See the [What services do not qualify as encounters?](#) section in this guide.)

Note: As client eligibility may change, bill encounter code T1015 on claims for all eligible services. ProviderOne will determine whether the encounter is payable when the claim is processed.

RHC services provided to agency clients must be billed to the agency on an electronic 837P claim form or on a paper CMS-1500 claim form. This includes claims with:

- An Explanation of Benefits (EOB) attachment from an insurance carrier.
- A Medicare Explanation of Medicare Benefits (EOMB) denial.

How do I bill for maternity care?

The following maternity services are eligible for an encounter payment:

- Each pre-natal and postpartum maternity care visit.

- A delivery performed outside a hospital setting.

A delivery performed in any hospital setting does not qualify as an encounter and must be billed as fee-for-service, using the appropriate delivery-only CPT code.

Any time unbundling is necessary, antepartum-only codes and post-partum-only codes must be billed in combination with the T1015 code for the same date of service.

Whenever the client is seen on multiple days for a maternity package fee-for-service code, the T1015 code is billed with a TH modifier, and the units on the encounter line must equal the number of days that the client was seen for encounter eligible services related to the fee-for-service code. See the [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#) for additional instructions.

If the delivery is outside the hospital, the same is true regarding multiple encounter units. However, obstetrical fee-for-service codes must be used when all maternity services to the client are provided through the RHC. When delivery is in the hospital, unbundle and bill the appropriate delivery only fee-for-service code on a separate claim form without an encounter.

What are the rules for telemedicine?

See the [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

How do I bill for more than one encounter per day?

Each individual provider is limited to one type of encounter per day for each client, regardless of the services provided, except in the following circumstances:

- It is necessary for the client to be seen by different practitioners with different specialties.
- It is necessary for the client to be seen multiple times due to unrelated diagnoses.

Each encounter must be billed on a separate claim form. On each claim, to indicate that it is a separate encounter, enter “unrelated diagnosis” and the time of both visits in field 19 on the CMS-1500 claim form, or in the *Comments* field when billing electronically. Documentation for all encounters must be kept in the client’s file.

Note: Only one visit can be billed per claim form. Bill multiple visits on different forms.

What procedure codes must an RHC use?

RHCs **must** submit claims using the appropriate procedure codes listed in one of the following provider guides:

- [Physician-Related Services/Healthcare Professional Services Provider Guide](#)
- Other applicable program-specific provider guides

Can RHCs get paid for noncovered services?

No. Noncovered services are not eligible for payment, including encounter payments. Specific information regarding noncovered services can be found under “*What services are noncovered?*” in the [Physician-Related Services/Healthcare Professional Services Provider Guide](#).

How do I bill taxonomy codes?

- When billing for services eligible for an encounter payment, the agency requires RHCs to use billing taxonomy 261QR1300X at the claim level.
- A servicing taxonomy is also required as follows:
 - ✓ Psychologists and psychiatrists billing for mental health encounters in combination with fee-for-service codes must bill servicing taxonomy appropriate for the service performed by the performing provider.
- If the client or the service does not qualify for an RHC encounter, RHCs may bill regularly as a non-RHC without T1015 on the claim.

How do I bill taxonomy electronically?

When billing electronically:

- Billing taxonomy goes in the 2000A loop.
- Rendering taxonomy goes in the 2310B loop.

For more information on billing taxonomy, refer to the [Health Insurance Portability and Accountability Act](#).

How are the claim forms completed?

Refer to the agency's [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 claim form. The following CMS-1500 claim form instructions relate to RHCs:

Field No.	Entry
24B	Enter Place of Service (for example, "11" or "72")
33a	Billing Provider NPI
33b	RHC Billing Taxonomy 261QR1300X

How do I bill for services paid under the fee-for-service system?

Clinics must bill the agency for services covered under the fee-for-service system using their clinic's NPI and taxonomy, the appropriate servicing NPI and taxonomy, and the service's appropriate CPT or HCPCS procedure code with the appropriate ICD-9-CM diagnosis code. ICD-9-CM diagnosis codes must be listed at the highest level of specificity (for example, to the fourth or fifth digit, if appropriate).

Services covered under the fee-for-service system are subject to the limitations and guidelines detailed in the agency's [Physician-Related Services/Healthcare Professional Services Provider Guide](#).

To access the agency's online billing instructions, visit <http://www.hca.wa.gov/medicaid/Pages/index.aspx>.

How do I bill for clients eligible for both Medicare and Medicaid?

When a client is eligible for both Medicare and Medicaid, Medicare is the primary payer for services provided. After Medicare has adjudicated the claims, they can be sent to the agency for secondary payment. These claims are called Medicare crossover claims. Medicaid payment for valid crossover claims will equal the difference between the Medicare payment amount and each clinic's Medicare per-visit rate. Payment from the agency will not exceed an RHC's Medicare

rate. Crossover claims for encounter services must be billed in an institutional format using the RHC NPI and RHC billing taxonomy 261QR1300X. These crossover claims can also be direct data entered (DDE) in ProviderOne for institutional claims. No Medicare EOB is required to be sent with the claim.

Medicare/Medicaid crossover claims for services that are not eligible as encounters must be billed in the professional format using the RHC's NPI, fee-for-service taxonomy, and appropriate servicing provider NPI and taxonomy. These crossover claims can also be direct data entered (DDE) in ProviderOne for professional claims. No Medicare EOB is required to be sent with the claim.

For more information on billing Medicare/Medicaid crossover claims, see the agency's [ProviderOne Billing and Resource Guide](#).

How do I handle crossover claims in an RHC setting?

See the [ProviderOne Billing and Resource Guide](#) for details on payment methodologies.

RHCs are required to bill crossover claims in the UB04/837I claims format. If Managed Medicare and Medicare Part C plans require services to be billed on a CMS1500/837P and they are paid or the money is applied to the deductible, RHCs must switch the claim information to the UB04/837I format or the claim will not process correctly. These crossover claims must be billed to the agency using the Type of Bill 71X and the RHC taxonomy for the Billing Provider.

Reporting Medicare encounter rates

Medicare encounter/per-visit rates must be reported to the RHC Program Manager promptly upon receipt from Medicare. These rates are necessary to ensure that crossover claims are paid correctly. RHCs are responsible for adjusting claims as necessary due to changes in Medicare rates.

How do I bill for drugs administered in the office along with their administration charges?

If the drug is administered as part of an encounter, the administration is considered bundled within the encounter. However, RHCs may bill the drug itself separately using the appropriate NPI for fee-for-service and the appropriate, specific servicing taxonomy.

If the purpose of the visit is for the administration of a drug only (for example, an injection-only service with no corresponding office visit), bill as follows:

- If the purpose of the injection is for reasons that are not considered encounter services (for example, family planning), RHCs may bill for both the drug itself and the injection using the appropriate CPT and HCPCS procedure codes.
- If the purpose of the injection is for reasons that are considered encounter services (for example, flu shot), RHCs may not bill for the injection itself as the costs of these services are included in the encounter rate. However, RHCs may bill for the drug itself using the appropriate NPI for fee-for-service and the appropriate, specific servicing taxonomy.

How do I complete the UB-04 claim form?

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at <http://www.nubc.org/index.html>.