

Washington State Health Care Authority

Medicaid Provider Guide

Rural Health Clinics
[Refer to Chapter 182-549 WAC]



Washington State
Health Care Authority

A Billing Instruction

About this publication

This publication, by the Health Care Authority (the Agency), supersedes all previous *Rural Health Clinics Billing Instructions* published by the Department of Social and Health Services.

Note: The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
2011-2013 Operating Budget, ch. 50, Laws of 2011, 1st Special Session, § 1109(48) Public Notice # 12-06	Retroactive to Jan. 1, 2011	Encounters D.4	What services do <i>not</i> qualify as an encounter?	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and maternity care—including prenatal care, nonhospital deliveries, and postpartum care—can now be billed as encounters rather than fee for service.
		Payment for Services Provided to Clients Ineligible for Encounters E.4	Payment	Changed name of medical coverage group from General Assistance to Medical Care Services for code G01

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
		Billing and Claim Forms F.2	Billing for Maternity Care	Added a new section clarifying billing for maternity care services, including: <ul style="list-style-type: none"> • Prenatal and postpartum visits, including services eligible for encounter payments. • Deliveries in and outside of hospital settings.
		Various sections	Various sections	Clarified, streamlined, and made housekeeping changes for easier understanding

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How Can I Get Agency Provider Documents?

To download and print Agency Medicaid provider guides and notices, go to the Agency website at <http://hrsa.dshs.wa.gov> (click the *Medicaid Provider Guides and Provider Notices* link).

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Important Contacts

Note: This section contains important contact information relevant to Rural Health Clinics. For more contact information, see the Agency's *Resources Available* web page at:
http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
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 1-360-725-1961 1-360-586-7498 (FAX)
General glossary terms	Online Medical Assistance Glossary at: http://hrsa.dshs.wa.gov/download/medical_assistance_glossary.htm

Definitions and Abbreviations

[Refer to [WAC 182-549-1100](#)]

This section defines terms and abbreviations, including acronyms, used in this Medicaid provider guide. Please refer to the Agency's online Medical Assistance Glossary at http://hrsa.dshs.wa.gov/download/medical_assistance_glossary.htm for a more complete list of definitions.

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

Encounter – A face-to-face visit between a client and a qualified RHC provider (such as a physician, physician assistant, or ARNP) who exercises independent judgment when providing covered rural health clinic services, also known as encounter services, to that client.

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

Enhancement - A monthly amount paid to RHCs for each client enrolled with a Managed Care Organization (MCO). Plans may contract with RHCs to provide services under Healthy Options. RHCs receive enhancements from the Agency in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

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

Interim Rate – The rate established by the Agency to pay a rural health clinic for

encounter services prior to the establishment of a prospective payment system (PPS) rate.

Medicaid Certification Date – The date that a rural health clinic (RHC) can begin providing encounter services to Medicaid clients.

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

Mobile Unit – A mobile structure with fixed, scheduled locations that houses the objects, equipment, and supplies necessary to provide clinic services.

Permanent Unit – A permanent structure that houses the objects, equipment, and supplies necessary to provide clinic services.

Provider-Based RHC (also known as hospital-based RHC) – A clinic that is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency.

Rural Area – An area that is not delineated as an urbanized area by the Bureau of the Census. [[title 42 CFR Chapter IV, 491.2](#)]

Rural Health Clinic (RHC) – A clinic that is:

- Located in a rural area designated as a shortage area.
- Certified by Medicare as a rural health clinic in accordance with applicable federal requirements.
- Not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases (see also Freestanding RHC and Provider-Based RHC). [CFR [title 42, Chapter IV, 491.2](#)]

Shortage Area – A defined geographic area designated by the Department of Health and Human Services as having either a shortage of personal health services [under Section 1302 of the Public Health Service Act] or a shortage of primary medical care manpower [under Section 332 of that act].

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](#). A rural health clinic is located in a rural area that is designated as a shortage area. You may access the CFR online at http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr491_05.html

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.

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 Staffing Requirements of an RHC?

[Refer to [title 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, PA, ARNP, nurse-midwife, clinical social worker, or clinical psychologist must be available to furnish patient care services at all times the clinic operates.
- A PA, ARNP, or certified nurse midwife must be available to furnish patient care services at least 50 percent of the time the clinic operates.
- The staff also may include ancillary personnel who are supervised by the professional staff.

A physician, PA, ARNP, nurse-midwife, clinical social worker, or a clinical psychologist who are also staff members may either:

- Own an RHC; or
- Furnish services under contract to an RHC.

What Are the Certification Requirements of an RHC?

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). DHHS or its representative notifies the State Medicaid agency that it has certified or denied certification to a prospective RHC.

Medical Assistance Certification: A clinic certified under Medicare is considered to meet the standards for medical assistance certification.

To obtain medical assistance certification as an RHC, the clinic must contact the RHC Program Manager directly to obtain the paperwork necessary to enroll with the Agency (see *Important Contacts*).

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.

What Is the Effective Date of the Medicaid RHC Certification?

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

1. Medicare's Effective Date

The Agency uses Medicare's effective date if the RHC returns a complete enrollment packet that:

- Includes a completed RHC Core Provider Agreement and other required paperwork; and
- Is sent to the Agency *within 60 days* of the date of Medicare's letter of notification informing the RHC of its Medicare certification.

-OR-

2. Date the Agency Receives the Core Provider Agreement

The agency uses the date the signed core provider agreement is received if the RHC returns a complete enrollment packet that:

- Includes a completed RHC Core Provider Agreement and other required paperwork; and
- Is sent to the Agency *after 60 days* past the date of Medicare's letter of notification informing the RHC of its Medicare certification.

Client Eligibility

Who Is Eligible for Services Provided in an RHC?

All medical assistance clients are eligible to receive services provided in an RHC. Services provided to clients must be within the scope of the client's Benefits Package.

Note: See Section E for payment limitations for clients not eligible for RHC encounter payments (for example, Family Planning Only clients, TAKE CHARGE clients).

Please see the Agency's *ProviderOne Billing and Resource Guide* at:

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Coverage Chart* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

Are Clients Eligible If Enrolled in an Agency-Managed Care Plan? [Refer to WAC [182-538-060](#) and [182-538-095](#) or WAC [182-538-063](#) for Medical Care Services clients]

YES. If the client is enrolled in an Agency-managed care plan, eligibility can be verified using the Client Benefit Inquiry Screen in ProviderOne. All services¹ 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 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:

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

¹ Services excluded from this requirement include Maternity Support Services/Infant Case Management, Dental, and Chemical Dependency. These services are covered fee-for-service and do not require PCP approval.

Note: To prevent billing denials, please 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 plan. See the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Are Clients Eligible If 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 a 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, please 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. Please see the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Provider Requirements

What Are the Basic Requirements for RHC Services?

- RHCs must furnish all services according to applicable Federal, State, and local laws.
- Unless otherwise specified, RHC services provided are subject to the limitations and coverage requirements detailed in the current Agency's *Physician-Related 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.
- The RHC must be primarily engaged in providing outpatient health services. Clinic staff must furnish 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
- The 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
- The 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

Encounters

What Services Are Considered an Encounter?

Only certain services provided by an RHC are considered an encounter. **The RHC must bill the Agency for these services using Healthcare Common Procedural Coding System (HCPCS) code T1015.**

The services of the following practitioners are billable as encounters if the services meet the criteria listed in this section:

- Physicians
- Physician's assistants (PA) and advanced registered nurse practitioners (ARNP)
- Psychologists or clinical social workers
- Visiting nurses (as described in federal regulation [title 42 CFR §405.2416](#))

Note: To bill mental health encounters, an RHC must be a licensed community mental health center and have a contract with a Regional Support Network (RSN). The Agency pays for mental health encounters only when they are provided by psychiatrists, psychologists, or clinical social workers.² Bill these encounters using your RHC National Provider Identifier (NPI), RHC billing taxonomy 261QR1300X, and HCPCS code T1015.

² Mental health services are subject to the service limitations detailed in the following billing instructions:

- [Mental Health Services for Children Medicaid Provider Guide](#)
- [Physician-Related Services Medicaid Provider Guide](#)
- [Psychologist Medicaid Provider Guide](#)
- [Early Periodic Screening, Diagnosis and Treatment \(EPSDT\) Medicaid Provider Guide](#)

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Are Services and Supplies Incidental to Professional Services Included in Encounter Rates?

Services and supplies incidental to the professional services of physicians, PAs, ARNPs, psychologists, or clinical social workers 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.
- Of a type commonly furnished either without charge or included in the RHC bill.
- Of a type commonly furnished in a provider's office (for example, tongue depressors and bandages).
- Provided by clinic employees under the direct, personal supervision of a physician, PA, NP, psychologist, or clinical social worker.
- Furnished by a member of the clinic's staff who is an employee of the clinic (for example, nurse, therapist, technician, or other aide).

Incidental services and supplies as described above that are included on the clinic'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 and other immunizations. Bill the Agency separately for these drugs and biologicals using your appropriate NPI for FFS and the appropriate, specific servicing taxonomy (see Section F for more details).

What Criteria Are Used to Determine if a Service Is an Encounter?

In determining whether the professional services of a physician, PA, or ARNP are considered encounters, the following general rules apply:

Services that Require the Skill and Ability of a Physician, PA, or ARNP

The service being performed must require the skill and ability of a physician, PA, or ARNP 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, such as registered nurses (RN).

For example, if a physician, PA, or ARNP performs a blood draw only or a vaccine administration only, these services are not encounters since they are normally performed by RNs. These services must be billed as FFS using the appropriate coding.

Services at the Clinic

The services of a practitioner performed at the clinic (excluding those listed in Section F) are encounters and are payable only to the clinic.

Services Away From 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

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.

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What Services Do Not Qualify as an Encounter?

Some services do not qualify as encounters. The Agency may cover these under FFS.

Note: The following services are not billable as encounters. **Do not bill using HCPCS code T1015 for these services;** use the appropriate NPI for FFS along with the appropriate, specific servicing taxonomy, and appropriate procedure code(s).

Note: Effective for dates of service on and after January 1, 2011, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and maternity care, including prenatal care, deliveries, and postpartum care, are eligible for encounter payments.

Effective January 1, 2011, the Agency covers the following supplies and services and pays for them under FFS; they are *not eligible for encounter payments*. These include:

- 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.
- Deliveries in any hospital setting.
- Maternity Support Services.
- Medical supplies listed in the current Agency's *Physician-Related Services Medicaid Provider Guide* as separately billable (for example, cast materials and splints).
- Prosthetic and orthotic devices.
- Screening mammography services.

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- Services provided within a hospital setting.
- Diagnostic tests, such as x-rays and EKGs.
- Clinical diagnostic laboratory services, including laboratory tests required for RHC certification.

Note: Professional 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 Section E, many supplies used in a provider's office are considered incidental to the professional service and are bundled within the encounter rate. Using the appropriate NPI for FFS along with the appropriate, specific servicing taxonomy, and appropriate procedure code(s), bill only those supplies that are specifically detailed in the current Agency's *Physician-Related Services Medicaid Provider Guide* as separately payable.

Payment

Payment for Encounter Services

The Agency pays RHCs for those services that qualify as encounters (see Section D) on an **encounter rate** basis rather than a FFS basis. All RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

The Agency pays for one encounter, per client, per day except in the following circumstances:

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

Note: The service being performed must require the skill and ability of a physician, PA, or ARNP as described in Section D in order to qualify as an encounter service.

The Reimbursement Structure

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 (PPS) or the Alternative Payment Methodology (APM), in accordance with 42 USC 1396a(bb)(6). APM rates are required to be at least equal to PPS rates. (See WAC [182-549-1400](#), Rural Health Clinics—Reimbursement and Limitations, for a detailed description of the each methodology.)

To ensure that the APM pays an amount that is at least equal to the PPS, the annual inflator used to increase the APM rates is the greater of the APM index or the Medicare Economic Index (MEI).

The Agency will rebase the APM rates periodically. The Agency will not rebase rates determined under the PPS.

When rebasing the APM encounter rates, the Agency will apply a productivity standard to the number of visits performed by each practitioner group (physicians and mid-levels) to determine the number of encounters to be used in each RHC's rate calculation. The productivity standards

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will be determined by reviewing all available RHC cost reports for the rebasing period and setting the standards at the levels necessary to allow 95% of RHCs to meet the standards. The encounter rates of the clinics that meet the standards will be calculated using each clinic's actual number of encounters. The encounter rates of the other 5% of clinics will be calculated using the productivity standards. This process will be applied at each rebasing, so the actual productivity standards may change each time encounter rates are rebased.

Payment for Services under the Fee-for-Service (FFS) System

The Agency pays clinics for services not qualified for an encounter rate payment according to the appropriate Agency's billing instructions located at <http://hrsa.dshs.wa.gov/download/BI.html>.

Note: All services, whether qualified for an encounter rate payment or not, are subject to the coverage guidelines, restrictions, and limitations detailed in applicable Agency's billing instructions and Washington Administrative Code (WAC).

Supplemental Payments for Managed Care Clients

Monthly Enhancement Payments for Managed Care Clients

In addition to encounter rate payments and FFS payments, each RHC also receives a supplemental payment (called "an enhancement") each month for each client assigned to them by a managed care organization (MCO). These payments are intended to make up the difference between the MCO payment and an RHC's encounter rate. The enhancements are not billed by the RHC; payments are generated from client rosters submitted to the Agency by the MCOs. Payment is sent directly to the RHCs.

RHCs no longer receive paper Remittance Advices (RAs). To access detailed payment information, RHCs must access ProviderOne.

For more information, refer to:

- The ProviderOne System User Manual at:
<http://hrsa.dshs.wa.gov/ProviderOne/Provider%20System%20User%20Manual.htm>
- The ProviderOne Billing and Resource Guide at:
http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.

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To ensure that the appropriate amounts are being paid to each clinic, the Agency will annually reconcile the enhancement payments to each clinic's encounter rate, starting with payments made in calendar year 2009

(Refer to WAC [182-549-1400](#).)

RHC Service-Based Enhancement Payments

To encourage the RHC to provide maternity services to its assigned managed care clients and to offset the additional costs incurred by the RHC for these services, the Agency makes a payment to the clinic when a qualified RHC provider performs a delivery for a managed care client assigned to the clinic. This payment is known as the "RHC delivery enhancement." If the client is identified in ProviderOne with "BHP+" and "RAC 1095", the Agency pays the clinic an additional payment for the delivery known as the "S-kicker enhancement."

The Agency pays a clinic an RHC delivery enhancement and, if applicable, the S-kicker enhancement only when either of the following scenarios is met:

1. The RHC provider **actually performs the delivery and the RHC** (or any provider under the same tax ID as the RHC) **is the client's assigned Primary Care Provider (PCP)**.

The Agency does not pay the RHC an RHC delivery enhancement payment for a managed care client assigned to the RHC: when a provider who is not affiliated with the client's assigned clinic performs the delivery; or when the RHC provider assists at delivery.

-OR-

2. The **RHC** (or any provider under the same tax ID as the RHC) **is the client's assigned Primary Care Provider (PCP) and the RHC is at "full risk" (fully financially liable) for the cost of the delivery.**

To be considered fully financially liable, the RHC must pay the provider who performs the delivery 100% of the cost of the delivery from its own funds. Participation in "risk pools" **does not** constitute being fully financially liable. The RHC Program Manager will review the RHC's contract with the managed care organization in order to determine whether the RHC is fully financially liable. The Agency will not pay a delivery or S-kicker enhancement without this determination **and** prior approval from the RHC Program Manager.

Do not bill the Agency to receive the service-based enhancements. The payments are automatically generated based on managed care encounter data submitted to the Agency by the MCOs.

For this automatic payment to be triggered, the same NPI must be:

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- Used by the RHC when billing deliveries to the plan.
- Used by the plan(s) on the monthly enhancement file(s) sent to the State.
- Submitted by the plan(s) to the State in the managed care encounter data.

If payments for clients appear to be missing or incorrect, please contact the managed care plan.

Note: If your NPI changes, you must notify the Agency and the MCOs immediately or payments will be interrupted.

Payment for Services Provided to Clients in Programs Ineligible for Encounters

For services provided to clients in programs ineligible for encounters, bill using the appropriate NPI for FFS along with the appropriate, specific servicing taxonomy regardless of the type of service performed. The Agency does not pay the encounter rate or the enhancement for clients enrolled in these programs (see the following table).

Effective January 1, 2011, RHC clients identified in ProviderOne with one of the following medical coverage group codes and associated RAC Code(s) do **not** qualify for the encounter rate or the enhancement:

Medical Coverage Group Codes (In Field 4)	RAC Code	Medical Coverage Group Definitions
F06	RACS 1138 and 1139 Only	Children's Health Program (non-citizen)
F09	All RACS (1034-1037)	Undocumented Aliens
G01	All RACS (1041-1042, 1135-1137 and 1145)	Medical Care Services
M99	RAC 1094 (This is the only RAC for M99)	Psychiatric Indigent Inpatient
P04	RAC 1096 (This is the only RAC for P04)	Undocumented Alien S Women
P05	RAC 1098 Only	Family Planning
P06	All RACS (1099-1100)	TAKE CHARGE
W01	All RACS (1128-1129 and 1170-1171)	ADATSA
W02	All RACS (1130-1131 and 1172-1173)	ADATSA
W03	RAC 1132 (This is the only RAC for W03)	ADATSA

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Changes to RHC Payment Rates

Changes in Scope of Service

For RHCs reimbursed under the prospective payment system (PPS), a change in scope of service is defined as a change in the type, intensity, duration, and/or amount of services provided by the RHC. For RHCs reimbursed under the Alternate Payment Methodology (APM), the Agency considers a change in scope of service to be a change only in the type of services provided by the RHC. For centers paid under the APM, changes in intensity, duration, and/or amount of services will be addressed in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered Medicaid services.

A change in costs alone does not constitute a change in scope of service.

An RHC that has experienced a change in scope of service must request an adjustment to its encounter rate. When the Agency determines that a change in scope has occurred, the RHC's encounter rate will be adjusted accordingly. To request a rate adjustment, the RHC must notify the Agency's RHC Program Manager of the change in writing **no later than 60 days after the effective date of the change**. The RHC must provide the Agency with all relevant and requested documentation pertaining to the change in scope of service.

The Agency will adjust the encounter rate based on the following:

- Review of the RHC's Medicare-audited cost report.
- Other documentation relevant to the change in scope of service.

The adjusted encounter rate will be effective on the date the change of scope of service is effective.

The following steps are necessary to request a change in scope of service:

- The clinic must notify the RHC Program Manager in writing of the change, including the effective date of the change and all other relevant details.
- If the change is the addition of a service, the Agency adjusts the encounter rate by an interim amount to reflect the difference in costs caused by the addition of the service. The Agency determines the interim amount by examining the average costs of the other clinics providing similar services, and/or reviewing a cost estimate, if available, provided by the clinic requesting the change, and/or reviewing the RHC's base year cost report.
- If the change is the subtraction of a service, the Agency determines the corresponding decrease in costs and reduces the encounter rate accordingly. To reconcile encounters paid at the higher rate after discontinuing the service, the clinic sends a lump-sum

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payment to the Agency. Payment arrangements are made with the RHC Program Manager.

- The clinic's enhancement rate will be adjusted accordingly, either increasing to reflect the addition of a service or decreasing due to the elimination of a service.

Payment Liability Reminder

Each RHC is individually liable for any payments received and must ensure that it receives payment for only those situations described in these and other applicable billing instructions. RHC claims are subject to audit, and RHCs are responsible to repay any overpayments.

Upon request, complete and legible documentation must be made available to the Agency that clearly documents any services for which the RHC has received payment.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency's *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

How Do I Bill for Encounter Services?

Note: For claims with Medicare as the primary payer, see page F.3.

Bill the Agency an encounter using **only** the HCPCS code below with the appropriate diagnosis code:

HCPCS Procedure Code	Description
T1015	Clinic visit/encounter, all-inclusive

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

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

Do not use other procedure codes or usual and customary fees.

Note: For audit purposes, all encounters must have the specific procedure documented in the client's chart.

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How Do I Bill for More than One Encounter Per Day?

Encounters are limited to one per client, per day *except* in any of the following circumstances:

- The visits occur with two different doctors with two different specialties.
- There are two separate visits with 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.

How Do I Bill for Maternity Care?

Effective for dates of service on or after January 1, 2011, certain maternity services are eligible for encounter payment as follows:

- 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 fee for service, using the appropriate delivery-only CPT code.

If delivery in hospital setting	If delivery outside of hospital setting (for example, home, birthing center, or clinic)
<p>Wait until all services are provided before billing.</p> <ul style="list-style-type: none"> • Bill all prenatal and postpartum visits on one claim form. <ul style="list-style-type: none"> ✓ Enter a line for each date of service. ✓ Bill 1 unit of T1015 for each line. • Bill the delivery with appropriate FFS delivery-only CPT procedure code on a separate claim form. 	<p>Wait until all services are provided before billing.</p> <ul style="list-style-type: none"> • Bill prenatal, delivery, and postpartum visits on one claim form: <ul style="list-style-type: none"> ✓ Enter a line for each date of service. ✓ Bill 1 unit of T1015 for each line.

How Do I Bill for Services Paid under the FFS System?

Clinics must bill the Agency for services covered under the FFS system using the appropriate NPI for FFS, the appropriate, specific servicing 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 4th or 5th digit, if appropriate).

Services covered under the FFS system are subject to the limitations and guidelines detailed in the current Agency's *Physician-Related Services Medicaid Provider Guide* or other applicable billing instructions.

To access the Agency's online billing instructions, visit <http://hrsa.dshs.wa.gov/download/BI.html>.

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, up to the Medicare rate. Payment from the Agency will not exceed a clinic's Medicare rate. Crossover claims for encounter services must be billed on a UB-04 paper claim form using the RHC NPI and RHC billing taxonomy 261QR1300X. Crossover claims also can 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 on a CMS-1500 Claim Form using the appropriate NPI for FFS and the appropriate, specific servicing taxonomy. These crossover claims also can be direct data entered (DDE) in ProviderOne for professional claims; no Medicare EOB is required to be sent with the claim.

Note: For crossover claims for encounter services, bill the Agency using the RHC NPI and RHC billing taxonomy 261QR1300X. For crossover claims for FFS services, bill the Agency using the appropriate NPI for FFS and the appropriate, specific servicing taxonomy.

For more information on billing Medicare/Medicaid crossover claims, see the Agency's *ProviderOne Billing and Resource Guide* at:

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.

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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. Clinics are responsible for adjusting claims as necessary due to changes in Medicare rates.

Billing Examples

What if a client presents with complaints of pain in his mouth and during the exam, the practitioner identifies a mouth infection requiring the need for a referral to a dentist?

Bill the signs and/or symptoms, such as pain in the mouth or infection, as an encounter service.

What if the client is initially seen at an RHC and the provider decides to admit the client into the hospital?

Per CPT guidelines, any encounter occurring on the same day as a hospital admission is bundled within the hospital call. Therefore, the initial office visit is not billable at all. Bill the hospital admission using the appropriate NPI for FFS and the appropriate, specific servicing taxonomy.

If two different providers see the same client on the same day, may more than one encounter be billed?

Yes. If the visits occur with two different doctors with two different specialties **or** in cases where there are two separate visits with unrelated diagnoses, then more than one encounter may be billed.

If a hospital operates a nursing facility, are visits within the nursing facility considered an encounter service?

Yes. If a hospital also operates a nursing facility, the nursing facility is not considered part of the hospital for RHC purposes; therefore, any visit within the nursing facility is considered an encounter service.

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, you may bill the drug itself separately using the appropriate NPI for FFS 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:

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

Completing the CMS-1500 Claim Form

Note: Refer to the Agency’s *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to Rural Health Clinics:

Field No.	Entry
19	When billing for more than one encounter per client per day, enter (on each claim) “unrelated diagnosis” and the time of both visits.
24B	Enter Place of Service (for example, “11” or “72”).
24D	Enter HCPCS code T1015.
24F	Enter your encounter rate. Do not include dollar signs or decimals in this field. Do not add sales tax.

Completing 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>.

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