Washington State Health Care Authority

Medicaid Provider Guide

Rural Health Clinics

ProviderOne Readiness Edition

A Billing Instruction

About this publication

This publication supersedes all previous Department/HRSA Rural Health Clinic Billing Instructions.

Published by the Health and Recovery Services Administration
Washington State Department of Social and Health Services

Note: The Department 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.

Effective Date

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How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** 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 Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
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 1-360-725-1882 1-360-586-7498 (FAX) FQHC-RHC-PrgrmMngr@dshs.wa.gov (email)

Definitions and Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html 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.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Encounter – A face-to-face visit between a client and a qualified RHC provider (e.g., 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 Department 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 Department to pay a rural health clinic for encounter services prior to the establishment of a prospective payment system (PPS) rate.

Managed Care Organization (MCO) – An organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the department under a comprehensive risk contract to provide prepaid health care services to eligible clients under Department managed care programs.

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

Medical Identification card(s) – See *Services Card*.

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**.**

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Patient Identification Code (PIC) – See *ProviderOne Client ID*.

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.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Rural Area – An area that is not delineated as an urbanized area by the Bureau of the Census. [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; and
- 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 42, Chapter IV, 491.2]

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

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(7) of the Public Health Service Act] or a shortage of primary medical care manpower [under Section 332 of that act].

Taxonomy Code - A unique, 10-digit, alphanumeric code that allows a provider to identify their specialty category. Providers applying for their NPI will be required to submit their taxonomy information. Providers may have one or more than one taxonomy associated to them. Taxonomy Codes can be found at http://www.wpc-edi.com/codes/Codes.asp.

Program Overview

What Is a Rural Health Clinic?

A rural health clinic (RHC) is a provider-based or freestanding facility certified under Code of Federal Regulations (CFR), title 42, part 491.2. A rural health clinic is located in a rural area that is designated as a shortage area. You may access the CFR on-line 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 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 nurse practitioners (NP);
- A physician, PA, NP, nurse-midwife, clinical social worker, or clinical psychologist must be available to furnish patient care services at all times the clinic operates;
- A PA, NP, or certified nurse midwife must be available to furnish patient care services at least 50 percent of the time the clinic operates; and
- The staff may also include ancillary personnel who are supervised by the professional staff.

A physician, PA, NP, nurse-midwife, clinical social worker, or clinical psychologist member of the staff may be the owner or employee of an RHC, or may furnish services under contract to an RHC.

RHC Certification

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 Department (see *Important Contacts*).

Note: A clinic ***must*** receive federal designation as a Medicare-certified RHC before the Department 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 Department uses one of two timeliness standards for determining the effective date of a Medicaid-certified RHC:

- **Medicare's Effective Date:** If the RHC returns a properly completed the Department's Core Provider Agreement and all other necessary paperwork included in the RHC enrollment packet ***within sixty (60) days*** of the date of Medicare's letter notifying the clinic of their Medicare certification, the Department will honor the Medicare effective date.

-OR-

- **Date the Department Receives the Core Provider Agreement:** If the RHC returns a properly completed the Department's Core Provider Agreement and all other necessary paperwork included in the RHC enrollment packet any time ***after sixty (60) days*** past the date of Medicare's certification letter, the RHC's effective date will be the date that the Department receives the properly completed paperwork.

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 Benefit Services Package.

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

Please see the Department/HRSA *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 Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

YES. When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services[1] 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:

- 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 Department/HRSA *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.

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 Department/HRSA *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

Basic Requirements for Services Provided in an RHC

- 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 Department/HRSA *Physician-Related Services Billing Instructions* and other applicable billing instructions. The Department does not extend additional coverage to clients in an RHC beyond what is covered in other Department 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; and
  - ✓ 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 section 353 of the Public Health Service (PHS) Act (http://www.fda.gov/opacom/laws/phsvcact/phsvcact.htm). 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; and
  - ✓ 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; and
  - ✓ Serums and toxoids.

Encounters

What Services Are Considered an Encounter?

Only certain services provided in the clinic are considered an encounter. **The RHC must bill the Department for these services using 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; and
- Visiting nurses, as described in federal regulation 42 CFR §405.2416.

Note: In order 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 Department pays for mental health encounters only when they are provided by psychiatrists, psychologists, or clinical social workers.* Bill these encounters using your RHC NPI, RHC billing taxonomy 261QR1300X, and HCPCS code T1015.

Note: The services listed above are not billable under the FFS system. **See Section E for services billable under the FFS system.**

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

- Inpatient Hospital Services Billing Instructions;
- Mental Health Services for Children Billing Instructions;
- Physician-Related Services Billing Instructions; and
- Psychologist Billing Instructions.

Services and Supplies Incidental to Professional Services

Services and supplies incidental to the professional services of physicians, PAs, NPs, 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 (e.g. professional component of a 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 clinic employees under the direct, personal supervision of a physician, PA, NP, psychologist, or clinical social worker; and
- Furnished by a member of the clinic's staff who is an employee of the clinic (e.g., 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 Departmenet 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 Department separately for these drugs and biologicals using your appropriate NPI for FFS and the appropriate, specific servicing taxonomy (see Section H for more details).

Criteria for Determining if a Service Qualifies as an Encounter

In determining whether the professional services of a physician, PA, or NP 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 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, 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

A service that is considered an encounter when performed **in** the clinic is considered an encounter when performed **outside** the clinic (e.g., 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.

What Services Do Not Qualify as an Encounter?

Some services do not qualify as encounters. The Department may cover these under fee-for-service (FFS). The Department covers the following supplies and services and pays for them 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).

- Ambulance services;
- Dental services;
- Diabetes education and management;
- Drugs and biologicals including drugs administered in the provider's office (e.g., pneumococcal and influenza vaccines);
- Durable medical equipment (whether rented or purchased);
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
- Eye exams and eyeglasses or contact lenses;
- Family Planning services;
- Hearing exams and hearing aids;
- Maternity care, including prenatal care, deliveries, and postpartum care;
- Maternity Support Services;
- Medical supplies listed in the current Department/HRSA *Physician-Related Services Billing Instructions* as separately billable (e.g. cast materials and splints);
- Prosthetic and orthotic devices;
- Screening mammography services;
- Services provided within a hospital setting, except swing bed services.
- Technical component of diagnostic tests such as x-rays and EKGs; and
- Technical component of clinical diagnostic laboratory services, including laboratory tests required for RHC certification;

> **Note:** Professional services that are not normally provided to Medicare beneficiaries are not included on 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 Department'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 Department/HRSA *Physician-Related Services Billing Instructions* as separately payable.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

As referenced on in Section E, EPSDT services are considered FFS. Bill the Department for these services using the appropriate NPI for FFS along with the appropriate, specific servicing taxonomy, and appropriate procedure code(s). However, if during an EPSDT screening exam the provider identifies an abnormality or addresses a pre-existing problem, and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation & Management (E/M) service, then the appropriate E/M code (99211-99215 with modifier 25) must be clearly and separately identified in the medical record. The RHC may then separately bill an encounter for the problem-focused encounter service with the appropriate medical diagnosis using its RHC NPI, RHC billing taxonomy 261QR1300X, and HCPCS code T1015.

> **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.

Payment

Payment for Encounter Services

The Department pays RHCs for those services which qualify as encounters (see Section D) on an **encounter rate** basis rather than fee-for-service (FSS) basis. All RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

The Department 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 Department 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. Refer to WAC 388-549-1400 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 Department will rebase the APM rates no more frequently than every four years starting in 2013. There will be a voluntary rebase in 2010. The Department will not rebase rates determined under the PPS.

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When rebasing the APM encounter rates, the Department 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 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 FFS System

The Department pays clinics for services not qualified for an encounter rate payment according to the appropriate Department/HRSA 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 Department/HRSA billing instructions and Washington Administrative Code (WAC).

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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 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 Department 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%20User%20Manual.htm or the ProviderOne Billing and Resource Guide at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.

To ensure that the appropriate amounts are being paid to each center, the Department will reconcile the enhancement payments to each center's encounter rate.

Refer to WAC 388-549-1400 Rural health clinics – Reimbursement and limitations for a detailed description of the enhancement methodology

RHC Service-Based Enhancement Payments

In order 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 Department 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 Department pays the clinic an additional payment for the delivery known as the "S-kicker enhancement."

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The Department 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 Department 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 Department will not pay a delivery or S-kicker enhancement without this determination **and** prior approval from the RHC Program Manager.

Don't bill the Department to receive the service-based enhancements. The payments are automatically generated based on managed care encounter data submitted to the Department by the MCOs.

In order for this automatic payment to be triggered, the same NPI must be:

- 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, and
- 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 Department and the MCOs immediately or payments will be interrupted.

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Payment for Services Provided to Clients not Eligible for RHC Payment

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

RHC clients identified in ProviderOne with one of the following medical coverage group codes do **not** qualify for the encounter rate or the enhancement:

Medical Coverage Group Codes (In Field 4)	Medical Coverage Group Definitions
F06	Children's Health Program (non-citizen)*
F09	Undocumented Aliens
G01	General Assistance
M99	Psychiatric Indigent Inpatient
P04	Undocumented Alien S Women
P05	Family Planning
P06	TAKE CHARGE
W01 and W02	ADATSA
W03	Detox

*Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for help to determine when a client is an F06 "non-citizen."

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Under What Circumstances Does the Department Change RHC Payment Rates?

Changes in Scope of Service

For RHCs reimbursed under the prospective payments 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 APM, the Department 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 Department 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 Department'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 Department with all relevant and requested documentation pertaining to the change in scope of service.

The Department will adjust the encounter rate based on one or more of the following:

- Review of the RHC's Medicare-audited cost report; or
- 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 Department adjusts the encounter rate by an interim amount to reflect the difference in costs caused by the addition of the service. The Department 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.

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- If the change is the subtraction of a service, the Department 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 payment to the Department. 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 subtraction 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 Department that clearly documents any services for which the RHC has received payment.

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Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

How Do I Bill for Encounter Services?

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

Bill the Department 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 Department clients must be billed to the Department 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.

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

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

- The visits occur with two different doctors with two different specialties; **or**
- 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 Services Paid under the FFS System?

Clinics must bill the Department 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 (e.g. 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 Department/HRSA *Physician-Related Services Billing Instructions* or other applicable billing instructions.

To access Department/HRSA billing instructions on-line, visit http://hrsa.dshs.wa.gov/download/BI.html.

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How Do I Bill for Clients Eligible for both Medicare and Medical Assistance?

When a client is eligible for both Medicare and medical assistance, Medicare is the primary payer for services provided. After Medicare has adjudicated the claims, they can be sent to the Department for secondary payment. These claims are called Medicare crossover claims. Medical assistance 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 Department 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.**

Medicare/medical assistance crossover claims for ***non-encounter*** services must be billed on a paper CMS-1500 Claim Form using the appropriate NPI for FFS and the appropriate, specific servicing taxonomy.

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

For more information on billing Medicare/Medical Assistance crossover claims, see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.

Medicare Encounter Rate Reporting

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 makes an appointment for amenorrhea and/or nausea and vomiting and it is determined that the client is pregnant?

If the obstetric (OB) record is not initiated at this visit, code for the signs and/or symptoms that the client presented with (e.g., amenorrhea and/or nausea and vomiting). In this case, this would be an encounter service as long as the OB record is not initiated at this visit. If the OB record is initiated, the visit would be paid under the FFS system and would be coded with an OB-related diagnosis.

What if the client presents with complaints of pain in his or her mouth and during the exam it is found they have an infection in their mouth 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 (e.g., 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 (e.g. family planning or EPSDT 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 (e.g., 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 Department/HRSA *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 "11" or "72" (either is acceptable).
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, which is automatically calculated by the system and included with your remittance amount.

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.

For more information, read # Memorandum 06-84.