Washington State Health Care Authority

Washington Apple Health (Medicaid)

Rural Health Clinics (RHC) Billing Guide

July 1, 2026

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2026,** and supersedes earlier billing guides to this program. Unless otherwise specified, this program(s) in this guide are governed by chapter 182-549 WAC.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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 HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Health care privacy toolkit

The Washington Health Care Privacy Toolkit is a resource for providers required to comply with health care privacy laws.

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Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the Subject column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Integrated Apple Health Foster Care (AHFC)	Reworded the eligibility list to further clarify when clients may be eligible for this program	Clarification – no policy change
What services do not qualify as an encounter – Administration fees for drugs and vaccines	Added CPT® codes 92650-92653, 90471-90474, 90480	Updated codes to align with the Well-Child Program (EPSDT) Billing Guide
	Removed CPT® code 90750	Belongs under drugs and biologicals
What services do not qualify as an encounter – Drugs and biologicals	Added CPT® codes 90750, 90380-90382 Removed CPT® codes 90756 and 90758	Updated codes to align with the Well-Child Program (EPSDT) Billing Guide

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Subject	Change	Reason for Change
What services do not qualify as an encounter – IUD and Contraceptive Supply Codes	Added HCPCS code J1050	Added code to nonencounter eligible HCPCS code list.
Administration of Department of Health-supplied vaccines for clients age 18 and younger	Added the following language: For vaccines that are available at no cost from the Department of Health (DOH) for children age 18 and younger through the Childhood Vaccine Program and the federal Vaccines for Children (VFC) Program, HCA pays only for the administrative cost of the vaccine, and the vaccine administration codes but not for the vaccines themselves. These vaccines are identified as free from DOH in the comments column of the Professional Administered Drug Fee Schedule. Removed DO NOT bill CPT® codes 90471-90472 for the administration	Clarification For additional information, see the Well-Child Program (EPSDT) Billing Guide.

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See HCA's Billers and Providers webpage
Information about payments, claims processing, denials, or HCA managed care organizations	See HCA's Billers and Providers webpage
Electronic billing	See HCA's Billers and Providers webpage
Finding HCA documents (e.g., Medicaid billing guides, fee schedules)	See HCA's Billers and Providers webpage
Private insurance or third-party liability, other than HCA managed care	See HCA's Billers and Providers webpage
Submit claim denials for review	See HCA's Billers and Providers webpage
Information about ICD-10	Email: ICD10questions@hca.wa.gov
Who do I contact if I have questions about enrolling as a medical assistance certified RHC?	Provider Enrollment PO Box 45562 Olympia, WA 98504-5562 Phone: 800-562-3022 ext. 16137 Fax: 360-725-2144 support.hca.wa.gov
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?	Email: FQHCRHC@hca.wa.gov.

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

APM index – HCA uses the alternative payment methodology (APM) index to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers. The index is derived from the federal Medicare Economic Index (MEI). 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 an RHC's total reasonable costs for establishing base encounter rates.

Behavioral Health Services Only (BHSO) – Means the program in which enrollees receive only behavioral health benefits through a managed care delivery system.

Change in scope – The process by which an RHC's rate(s) can be adjusted due to changes in type, intensity, duration, or amount of services outlined under WAC 182-549-1500.

Cost Center – A category of service approved to be provided by the RHC under WAC 182-549-1200 and reported in the Medicare cost report and supplemental documentation. The categories of services to be provided by the RHC may include medical and dental.

Encounter – A face-to-face or telemedicine (including audio-only telemedicine) visit between an encounter-eligible client and an RHC provider who exercises independent judgment when providing services that qualify for encounter rate reimbursement.

Encounter-eligible client – A client who receives benefits under Title XIX (Medicaid) or Title XXI (CHIP).

Encounter rate – A cost-based, facility-specific rate for covered RHC services.

Enhancements (also called managed care enhancements) – A monthly amount HCA pays to RHCs through a managed care organization (MCO) that has contracted with the RHC to provide services to clients enrolled with the MCO. The enhancement is in addition to the negotiated payment that RHCs receive from the MCO. RHCs participating in the payment method described in WAC 182-549-1450(7)(b) do not receive enhancements.

Fee-for-service – A payment method HCA uses to pay providers for covered medical services provided to Washington apple health clients, which excludes services provided by HCA's contracted managed care organizations and services that qualify for an encounter payment.

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

Integrated Managed Care – Means the program under which a managed care organization provides:

- Physical health services funded by Medicaid; and

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- Behavioral health services funded by Medicaid and other available resources are found in chapters 182-538B, 182-538C, and 182-538D WAC.

Interim rate – The rate HCA establishes to pay an RHC for covered RHC services prior to the establishment of a permanent rate for that RHC.

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

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

Medicare economic index (MEI) – An index published in the Federal Register used in the calculation of changes to determine allowed charges for physician services. HCA adjusts RHC encounter rates and enhancement rates by the MEI each year on January 1st.

Mid-level practitioner – An advanced registered nurse practitioner (ARNP), a certified nurse midwife, a licensed midwife, a woman's health care nurse practitioner, a physician assistant (PA), or a psychiatric ARNP. Services provided by registered nurses are not encounters.

Mobile unit – The objects, equipment, and supplies necessary for provision of the services furnished directly by the RHC are housed in a mobile structure.

Permanent unit – The objects, equipment, and supplies necessary for the provision of the services furnished directly by the RHC are housed in a permanent structure.

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

Rebasing – The process of recalculating encounter rates using actual Medicare cost report data for all rural health clinics listed in the Medicare Cost Report (MCR).

Revalidation – The process state Medicaid agencies are required, in **42 CFR Part 455, Subpart E**, to do once every five years for enrolled Medicaid providers.

Rural health clinic (RHC) services – Outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic or similar setting, including specified types of diagnostic examination, laboratory services, and emergency treatments. See **WAC 182-549-1300**.

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Program Overview

(Chapter 182-549 WAC)

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 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 by Medicare as an RHC in accordance with applicable federal requirements for that site to receive payment as an RHC. RHCs only receive encounter payments for eligible encounters. (See the definition of encounter.)

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 HCA's Physician-Related Services/Healthcare Professional Services Billing Guide and other applicable billing instructions. HCA does not extend additional coverage to clients in an RHC beyond what is covered in other HCA 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 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

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- 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

Who may provide services in an RHC?

The following people may provide RHC services:

- Physicians
- Dentists
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Nurse midwives or other specialized nurse practitioners
- Certified nurse midwives
- Registered nurses or licensed practical nurses
- Mental health professionals – for a list of qualified professionals eligible to provide mental health services, refer to the Which Professional Services Can be Billed in an Outpatient Setting section of HCA's **Mental Health Services Billing Guide**
- Naturopathic physicians – refer to the **Physicians-Related Services/Health Care Professional Services Billing Guide**

> **Note**: Approved screening, brief intervention, and referral to treatment (SBIRT) provider services, which are described in the **Physician-Related Services/Health Care Professional Services Billing Guide**, may also be provided in an RHC.

What are the staffing requirements of an RHC?

RHCs must meet the staffing requirements outlined in **42 CFR 491.7 and 42 CFR 491.8**. For example:

- 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 assistants (PAs) or advanced registered nurse practitioners (ARNP).

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- 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.

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 HCA 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 application and supply all necessary documentation to HCA's Provider Enrollment unit. For a list of required documentation, see HCA's Enroll as a billing provider website.

> **Note**: A clinic must receive federal designation as a Medicare-certified RHC before HCA can enroll the clinic as a medical assistance-certified RHC. Go to the Centers for Medicare and Medicaid Services Rural Health Clinics Center website 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 support.hca.wa.gov.

What is the effective date of the Medicaid RHC certification?

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

- **Medicare's effective date**: HCA uses Medicare's effective date if the RHC returns a properly completed Core Provider Agreement (CPA) and properly completed RHC enrollment packet **within 60 calendar days** from the date of CMS's written notification to the RHC of the Medicare certification.
- **The date HCA receives the Medicare certification letter.** HCA uses the date the Medicare certification letter is received by HCA if the RHC returns either the properly completed Core Provider Agreement (CPA) or properly

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completed RHC enrollment packet after 60 calendar days of the date of Medicare's letter notifying the clinic of the Medicare certification.

Note: The RHC enrollment packet must include: CPA, ownership disclosure form, debarment form, Electronic Funds Transfer (EFT) form, W9, copy of business license, copy of liability insurance information, the Centers for Medicare and Medicaid Services (CMS) approval letter, and any additional information as requested by HCA.

See HCA's **Enroll as a billing provider** website for more information about submitting a properly completed CPA.

Revalidation

Medicaid providers (including RHCs) must revalidate with HCA Provider Enrollment every five years. The revalidation notice is sent to the provider's mailing address listed in ProviderOne. To ensure the revalidation notification reaches the correct office, providers should ensure their contact information is up to date in ProviderOne. The revalidation process could affect the business status, rate setting, encounter payments and enhancement payments for each RHC if not performed in a timely manner. Additional information and instructions on when to revalidate and how to complete revalidation can be found on HCA's website – **Revalidation | Washington State Health Care Authority**.

Upon completion of revalidation, if RHCs have concerns regarding their encounter or enhancement payments, contact FQHCRHC@HCA.WA.GOV

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has 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 HCA will not pay for.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

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Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Let's get started" button. For patients age 65 and older, or on Medicare, go to Washington Connections – select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the Health Benefit Exchange Navigator.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

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

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

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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 HCA-contracted MCO, if appropriate. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exceptions:

- Apple Health Expansion clients are enrolled with an HCA-contracted MCO and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an HCA-contracted MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's Apply for or renew coverage webpage.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

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- Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients may be eligible for physical health services under the fee-for-service program.

If a client is determined to be eligible for physical health services under the fee-for-service program, each HCA-contracted managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not enrolled in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

The following clients in foster care (either Tribal or dependency through the Department of Children, Youth, and Families [DCYF]), Adoption Support, Extended Foster Care (EFC), Alumni, and Unaccompanied Refugee Minors (URM) programs who are enrolled in Coordinated Care's (CCW) Apple Health Core Connections Foster Care (AHCC) program receive both medical and behavioral health services from CCW.

- Clients in foster care or in the URM program may stay covered through the end of the month they turn age 18 or when their dependency dismisses
- Clients who are receiving adoption support may stay covered through the end of the month they turn age 21 or when their adoption support case closes
- Clients who have opted into EFC at age 18 may stay covered through the end of the month they turn age 21. (Clients may opt in and out of EFC through the month they turn age 21.)
- Clients age 18 may stay covered through the end of the month they turn age 26 (Alumni)

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These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract managed care organization. For more information, visit Apple Health Expansion.

Note: RHC's may provide services to clients enrolled in Apple Health Expansion (RAC codes 1284, 1285), however services provided to these clients are not encounter eligible.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit **Reentry from a carceral setting**.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

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If an AI/AN client does not choose a managed care plan, they will be automatically assigned to Apple Health FFS for all their health care services, including comprehensive behavioral health services. See HCA's **American Indian/Alaska Native webpage**.

Early periodic screening, diagnosis, and treatment (EPSDT)

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide; see also the rules for the EPSDT program described in **Chapter 182-534 WAC**. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in **WAC 182-501-0165**.

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Encounters

What is an encounter?

An encounter is a face-to-face or telemedicine (including audio-only telemedicine) visit between an encounter eligible client and an RHC provider of health care services who exercises independent judgment when providing healthcare services that qualify for encounter rate reimbursement.

All services must be documented in the client's file to qualify for an encounter.

HCA limits encounters to one per client per day, except in the circumstances outlined in **WAC 182-549-1450**. See **How do I bill for more than one encounter per day** section of this guide.

What services are considered an encounter?

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

For fee for service claims, the RHC must bill HCA for these services using HCPCS code T1015 and the appropriate HCPCS, CDT® 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 Billing Guide**
- Approved screening, brief intervention, and referral to treatment (SBIRT) provider services as described in the **Physician-Related Services/Health Care Professional Services Billing Guide**
- Mental health services as described in the "Which Professional Services Can be Billed in an Outpatient Setting section" of the **Mental Health Services Billing Guide**

Are surgical procedures considered RHC services?

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. However, 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.

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For services not included in the global surgical package, see the Physician-Related Services/Health Care Professional Services Billing 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 Medicare cost report are factored into the encounter rate and will not be paid separately.

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 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 encounter-eligible services, 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) are encounters and are payable only to the clinic.

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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

Hospital based services are not encounter-eligible. Covered services will be paid as fee-for-service and must not be billed with a HCPCS T1015 encounter code.

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.

Encounters are limited to one type of encounter per day for each client, regardless of the services provided, except in either one of 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.

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Each encounter must be billed on a separate claim. On each claim, to indicate that it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in the *Claim Note* section of the electronic claim. Use an appropriate modifier to bill for the subsequent HCPCS T1015 procedure code.

Documentation for all encounters must be kept in the client's file.

> **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 claims**.

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.

Medical Coverage Group Codes and RAC Codes

Medical Coverage Group Codes	RAC Code
N11	1138, 1139 only
N31	1141, 1142 only
F99	1040
G01	1041, 1135-1137, 1145 only
I01	1050, 1051 only
K03	1056,1058, 1176-1178 only
K95	1060, 1064, 1179-1181 only
K99	1060, 1064, 1179-1181 only

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Medical Coverage Group Codes	RAC Code
L04	1077, 1078, 1081, 1082, 1158-1161, 1182-1185 only
L24	1190-1195 only
L95	1085, 1087, 1155, 1157, 11863, 1187 only
L99	1085, 1087, 1090, 1092, 1155, 1157, 1186-1189
M99	1094 (This is the only RAC for M99)
P05	1097, 1098 only
P06	All RACs (1099-1100), 1272
S95	1125, 1127
S99	1125, 1127
W01	All RACs (1128, 1129, 1170, 1171)
W02	All RACs (1130, 1131, 1172, 1173)
W03	1132 (This is the only RAC for W03)
N31	1211 (replaces 1138 and 1139)
N33	1212, 1213 (replaces 1141, 1142)
A01	1214 (replaces 1041)
A01	1215 (replaces 1137)
A05	1216 (replaces 1145)
A24	1273
N07	1276
N24	1277
N27	1278
N/A	1282, 1283, 1284, 1285
N08	1288

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Services provided to clients with the following medical coverage group code and RAC code combinations are eligible for encounter payments for services prior to delivery.

Medical Coverage Group Codes	RAC Code
K03	1057 (This is NOT the only RAC for K03.)
K95	1062 (This is NOT the only RAC for K95.)
K99	1062 (This is NOT the only RAC for K99.)
P99	1102 (This is the only RAC for P99.)
N23	1209 (Replaces RAC 1096)

Clients identified in ProviderOne with one of the following Barcode (state only) RAC codes for incapacity determination services **do not** qualify for the encounter rate:

Barcode RAC
2000
2001
2002
2003
2004

Categories of encounters

Encounters may be reported for medical and dental services.

Medical encounter

A medical encounter is a face-to-face encounter or telemedicine visit between an approved provider and a client where services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Services provided by approved professionals are considered eligible for an encounter payment if the billing code falls outside the range of codes identified in **What services do not qualify as an encounter**?

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Dental encounter

For an RHC to submit encounters and include costs for dental care in cost reports, the RHC must be approved by HCA and must meet the billing and eligibility requirements as specified in the Dental-Related Services Billing Guide, the Access to Baby and Child Dentistry Billing Guide, and the Orthodontic Services Billing Guide.

A dental encounter is a face-to-face or telemedicine visit between an encounter-eligible client and a qualified dental provider (dentist, dental hygienist, or orthodontist) for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. **Only one encounter is allowed per day unless an exception is met. (See** What is an encounter?**)**.

> **Note**: A dental hygienist may bill an encounter only when providing a service independently -- not jointly with a dentist. Only one encounter per day at a dental clinic is covered.
>
> **Exception**: When a dental service requires multiple visits (e.g., root canals, crowns, dentures), an encounter code must be billed with the number of visits when the dental services are complete.

When fluoride treatment is provided on the same day as an encounter-eligible service, they must be billed on the same claim. If not provided on the same day with an encounter-eligible service, bill directly to HCA to be paid under fee-for-service.

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Reimbursement

When does HCA pay for RHC services?

HCA pays the RHC for medical services when they are:

- Within the scope of an encounter-eligible client's Apple Health program. Refer to WAC 182-501-0060 Health care coverage – Program benefit packages – Scope of service categories.
- 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.

> 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 HCA's Physician-Related Services/Healthcare Professional Services Billing Guide as separately reimbursable. For more information on services that are separately reimbursable, refer to the "What services do not qualify as an encounter?" section of this guide.

HCA 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.)

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What services do not qualify as an encounter?

The services in the table below do not qualify as encounters. If these are the only services provided on a given day, do not bill with a HCPCS T1015 encounter code. HCA will pay up to the maximum allowed amount on the fee schedule for these services.

For example: If an immunization (not encounter-eligible) is the only service performed that day, the RHC will receive up to the maximum allowed amount on the fee schedule.

Services identified in the "Bundled with Encounter" column in the table below must be billed on the same claim as an encounter-eligible service, when performed as part of an encounter. Do not bill using HCPCS code T1015 for these services unless there is a qualifying, encounter-eligible service on the claim.

For example: A claim includes a well-child visit CPT® code 99383 (encounter-eligible) and an immunization administration CPT® code 90707 SL (not encounter-eligible). The RHC will receive one encounter payment.

Services identified in the "Separately-Reimbursable" column of the table below are excluded from the RHC Medicare Cost Report and may be reimbursed separately outside of the encounter.

For example: Some services, such as labs, are allowed to be billed outside the encounter, even if they are performed on the same day as encounter-eligible code. These services are marked with a check mark in the column "Separately Reimbursable" below.

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Service	Procedure Codes (HCPCS/CPT®/CDT®)	Bundled with Encounter	Separately-Reimbursable
Ambulance/transport and other misc. services	HCPCS codes A0021-A9999		√
Dental	CDT® codes D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0460, D1206, D1208, D1351, D1354, D9230, and CPT® code 99188	√	
Administration fees for drugs and vaccines	CPT® codes 90281, 90460, 90461, 92650-92653, 90471-90474, 90480	√	
Drugs and biologicals including drugs administered in the provider's office (for example, pneumococcal and influenza vaccines)	All HCPCS J Codes for drugs and biologicals CPT® codes 90750, 90380-90382	√	
IUD and Contraceptive Supply Codes	For example: HCPCS codes J1050, J7296-J7298, J7300-J7302, J7307		√
Durable medical equipment (rented or purchased)	CPT® code 99070, HCPCS codes E0100-E8002, K0001-K0902		√
Eye exams and eyeglasses or contact lenses	HCPCS code V2xxx, CPT® codes 92002-92499	√	
Family planning services	CPT® codes 11976, 55250, 57170, 58600, 58615, 58670, 58671	√	
Hearing exams and hearing aids	CPT® codes 92502-92597, 92650-92653 & HCPCS codes V5000-V5299	√	
Maternity support services	Maternity Support Services Billing guide and Fee schedule		√
Substance use disorder (other than SBIRT)	Substance Use Disorder Billing Guide and Fee Schedule		√

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Service	Procedure Codes (HCPCS/CPT®/CDT®)	Bundled with Encounter	Separately-Reimbursable
Medical supplies listed in HCA's Physician-Related Services/Healthcare Professional Services Billing Guide as separately billable (for example, cast materials and splints)	HCPCS code T5999, CPT® codes 99070, HCPCS codes	√	
Prosthetic and orthotic devices	All HCPCS "L" codes		√
Screening mammography services	CPT® code 77067		√
Telemedicine	HCPCS code Q3014		√
Teledentistry	CDT® codes D9995-D9996	√	
Diagnostic tests, such as x-rays and EKGs	CPT® codes 70000-79999	√ *when bundled for services with modifier 26	√ *when billed with modifier TC
G codes in the defined range	HCPCS codes G0008-G9140 (Exception: G0101 is encounter-eligible effective January 1, 2018.)	√	
Q codes in the defined range	HCPCS codes Q0000-Q9999 (Exception: Q3014-see above in telemedicine)	√	
S codes in the defined range	All HCPCS "S" codes - except S9436, S9445-S9470 and S9482		√
Clinical diagnostic laboratory services, including laboratory tests required for RHC certification	CPT® codes 80000-89999 HCPCS codes U0001 through U0004, 0202U HCPCS code C9803 CPT® codes 99454, 99457, 99458, and 99091		√

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Service	Procedure Codes (HCPCS/CPT®/CDT®)	Bundled with Encounter	Separately-Reimbursable
Venipuncture/Blood Draws	CPT® codes 36400-36425, 36511-36515, 38204-38215	√	
Collaborative Care	CPT® codes 99492, 99493, 99494 ** HCPCS code G0512 – effective Jan 1, 2026, code discontinued*	√	

Additionally, the following services do not qualify for an encounter and are paid for by HCA through fee-for-service:

- Delivery and postpartum services provided to pregnant undocumented alien women are not encounter-eligible. Global care must be unbundled. HCA does not pay for an encounter for the delivery or postpartum care, or any other service provided once the client is no longer pregnant.
- Health services provided to clients under **state-only programs**.
- Hospital based services. Covered services will be paid as fee-for-service and must not be billed with a HCPCS T1015 encounter code.
- Global services (example: maternity services) must be unbundled and billed following the service coding rules.
- Any services performed in a hospital setting [place of service 21].
- Services performed by an associate level provider are not eligible for encounter payments.

Administration of Department of Health-supplied vaccines for clients age 18 and younger

For vaccines that are available at no cost from the Department of Health (DOH) for children age 18 and younger through the **Childhood Vaccine Program** and the federal **Vaccines for Children (VFC) Program**, HCA pays only for the administrative cost of the vaccine, and the vaccine administration codes but not for the vaccines themselves. These vaccines are identified as free from DOH in the comments column of the **Professional Administered Drug Fee Schedule**.

- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g., CPT® 90707 SL). HCA pays for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., CPT® 90707 SL).

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How does HCA calculate RHC encounter rates for RHC core services?

- Until an RHC submits its first audited or as filed Medicare cost report to HCA, HCA pays the RHC an average encounter rate of other similar RHCs within the state, otherwise known as an interim rate. Similar RHCs are defined as either all hospital-based or all free-standing RHCs.
- Upon the RHC's request to HCA, which must include the submission of their first as filed or audited Medicare cost report, HCA calculates the PPS rates for core services for all RHCs in the Medicare cost report. HCA rebases each RHC's encounter rate(s) by dividing 100 percent of the RHC's costs by the total number of encounters reported in the submitted cost report.
- If the Medicare cost report contains less than 12 months of data for the RHC(s), HCA sets an interim rate. Within 18 months of the effective date of the interim rate adjustment, the RHC must submit a Medicare cost report to HCA, containing 12 months of data for the RHC(s).
- HCA follows the rate structure calculated in the Medicare cost report when setting Medicaid RHC encounter rates. If RHC encounter rates are combined on the Medicare cost report, Medicaid encounter rates will be combined. If the Medicare cost report has separate rates for each RHC on the cost report, Medicaid encounter rates will be separate for each clinic.
- HCA uses the Medicare cost report data and applies Medicaid-specific adjustments such as adding Medicaid services not covered by Medicare and allocating overhead to services not reported in the Medicare cost report (e.g., dental services).
- The encounter rate is effective for all RHCs on the date HCA receives the submitted Medicare cost report from the RHC.
- RHCs receive this rate(s) for the remainder of the calendar year during which the submitted Medicare cost report became available to HCA. HCA then adjusts the encounter rate each January 1st by the percent change in the Medicare economic index (MEI) as reported in the Federal Register.

Are RHCs liable for payments received?

Each RHC is responsible for submitting claims for services provided to all 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 HCA billing guides, and federal and state rules. RHC claims are subject to audit by HCA, and RHCs are responsible to repay any overpayments.

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

How does HCA pay for encounter-eligible services?

HCA pays RHCs for encounter-eligible services on an encounter rate basis rather than a fee-for-service basis.

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All RHC services and supplies incidental to the provider's services are included in the encounter rate payment. (See WAC 182-549-1450(3)).

HCA limits RHC encounter rate reimbursement to one per client, per day, except in the circumstances outlined in WAC 182-549-1450. See section **How do I bill for more than one encounter per day?** in this guide.

> **Note**: The service being performed must require the skill and ability of **an encounter-level practitioner** to qualify for an encounter payment.

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

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 HCA nor the MCO pays the encounter rate for clients in state-only medical programs or Apple Health Expansion.

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. HCA will provide each RHC's encounter rate to the MCO. **42 U.S.C. 1396a (bb)(5)(A)**.

Payment options for managed care clients

Supplemental enhancement payments

> **This section does not apply to clients enrolled in Apple Health Expansion.**

For clients enrolled with an MCO, HCA determines the amount of the supplemental payment for each RHC that is paid in addition to the MCO contracted rate. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with **42 U.S.C. 1396a(bb)(5)(A)**. These enhancements are intended to make up the difference between the MCO payment and an RHC's encounter rate. The enhancement payments are generated from client rosters submitted to HCA by the MCOs. HCA sends the monthly enhancement payments to MCOs to be distributed to the RHCs.

RHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO. It is the RHC's responsibility to perform internal monthly verification to ensure that they have received accurate enhancement payments.

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To ensure that the appropriate amounts are paid to each RHC, HCA performs an annual reconciliation of the enhancement payments. If the RHC was underpaid, HCA will pay the difference. If the RHC was overpaid, HCA will recoup the appropriate amount. For more information on overpayment appeals, refer to WAC 182-549-1600.

For dates of service on and after January 1, 2019, reconciliations will be conducted in the calendar year following the calendar year for which the enhancements were paid. HCA or the clinic will conduct the reconciliations, with final review and approval by HCA. The process of settling over or under payments may extend beyond the calendar year in which the reconciliations were conducted.

Based on the results of the reconciliation, HCA may prospectively adjust the enhancement rate to avoid significant overpayments or underpayments and to lessen the financial impact on HCA and the RHC in accordance with WAC 182-549-1450(7)(a). Additionally, HCA may work with the RHCs to adjust their enhancement rate as needed. If HCA determines a prospective adjustment to the enhancement rate is necessary, HCA notifies the RHC in writing at least 30 calendar days prior to the enhancement rate adjustment. The RHC may also request enhancement rate changes, which depend on HCA final approval. **Note**: HCA uses client rosters to determine total annual enhancement payments as part of the reconciliation process. MCOs and RHCs are responsible for ensuring all client roster adjustments, including retroactive roster adjustments, are submitted to HCA no later than June 10 in the year following the year of the roster assignment. HCA will not accept client assignments for the previous year after the annual deadline.

> **Example**: All client rosters for year 2024, including retro adjustments, must be submitted to HCA on or before June 10, 2025.

What are the methods for performing annual reconciliations of managed care enhancement payments?

Clinics that have elected not to receive their full encounter rate through managed care organizations are required to perform an annual reconciliation with HCA.

In accordance with this section (**Are RHCs liable for payments received?**) and **WAC 182-549-1450**, HCA performs annual reconciliations of managed care enhancement payments with RHCs to ensure they have received their cost-based encounter rates for qualifying RHC services.

Reconciliations include only encounter eligible claims for managed care clients enrolled in Title XIX (Medicaid) or Title XXI (CHIP), including those in which the MCO is not the primary payor.

HCA maintains the right to request updated or additional reconciliation materials submitted by RHCs, as needed, to verify completeness and accuracy.

Reconciliations will be conducted by the clinic or HCA with final review and approval by HCA.

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RHCs may select one of the following methods by which to perform their annual reconciliation:

- **AUP (agreed upon procedures) method** – The AUP method was implemented starting with the 2010 reconciliation year. Per the AUP method, RHCs compile their own managed care claims data of RHC eligible claims using guidelines provided by HCA. RHCs should follow the requirements outlined in the AUP and the Reconciliation Data Summary Template to ensure the data submission is accurate. This will help reduce the impact of auditor findings and facilitate the review process with HCA.

  RHCs contract with independent financial auditors to verify the data prepared by the RHC and to select and test a random sample of RHC claims for each RHC's reconciliation data, per calendar year.

  Examples of tests: verifying that the client in the sample of encounters is a Medicaid managed care client, verifying that the procedure code reported on the claim is an RHC encounter eligible service, etc.

  The auditors submit to HCA a formal report documenting any findings/exceptions discovered during the testing process. HCA reviews the report and the data summary for completeness and accuracy.

  Any findings/exceptions reviewed by HCA are addressed with the RHC and may impact the total under/overpayment amount. After the review and analysis is finalized by HCA, HCA issues the formal letter of under/overpayment to the RHC.

- **RHC submits encounter data to HCA** – RHCs submit encounter data to HCA in a predetermined Excel template. HCA will then validate this data in ProviderOne.

- **HCA performs reconciliation** – HCA performs the reconciliation using data submitted by MCOs. HCA compiles reconciliation encounter and enhancement data from ProviderOne and sends the reconciliation results to the RHC for review.

Full encounter rates through MCO payments

RHCs may participate in a payment option to receive their full encounter rate from MCOs for each encounter-eligible service. If RHCs wish to receive the encounter rate from MCOs, they must notify HCA in writing by November 1st of the year prior to the year of participation. Upon notification, HCA will enroll an RHC in this payment method for the full calendar year, with an opportunity to opt-out the following calendar year.

Clinics under this payment option do not receive monthly enhancement payments. Instead, the full encounter rate will be paid by the MCO for all eligible RHC claims. The MCO will be reimbursed for the HCPCS T1015 portion of encounter-eligible claims via a service-based enhancement (SBE) payment. This SBE payment will be generated through ProviderOne after the MCO submits claims for eligible encounters. The SBE payment is intended to be used for eligible encounter claims and the MCO will at no time be at risk for or have any right to this portion of the claim. The total amount paid by the MCO on an encounter-eligible claim will not exceed the RHC encounter rate.

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HCA will perform an annual reconciliation with the MCO. Reconciliations will ensure that each participating RHC received its full encounter rate for each qualifying claim and that MCOs are not put at risk for, or have any right to, the T1015 portion of the claim.

Note: Clinics receiving their RHC encounter rate through MCOs must bill using the NPI associated with RHC Taxonomy 261QR1300X. All RHC encounter eligible claims must be billed with the RHC billing taxonomy (261QR1300X). Encounter rates will not be paid by MCOs under any other NPI or billing taxonomy.

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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.

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

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

HCA 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(s) 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 HCA to support the proposed change in scope of service rate adjustment are reasonable under applicable state and federal law.
- An approved change in scope includes rate adjustments using the overhead and visit allocation methodology as reported for all RHCs listed in the Medicare cost report. The Medicaid rate may also include the allocation of overhead to Medicaid eligible services not reported in the Medicare cost report (e.g., dental services), as directed by HCA.

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

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

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

At any time, HCA may require an RHC to file an application for a change in scope of service rate adjustment. The application must include a Medicare cost report,

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"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, and other application requirements as follows:

- The RHC must submit to HCA a copy of the most recent finalized Medicare cost report and position statement no later than 90 calendar days after receiving HCA's request for an application.
- HCA reviews the RHC's Medicare cost report, position statement, and other application materials 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**?
- HCA will not request more than one change in scope of service in a calendar year.

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

Unless HCA instructs the RHC(s) to file an application for a change in scope of service rate adjustment, an RHC(s) 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.

The RHC must file a change in scope of service rate adjustment based on the following deadlines, whichever is later:

- Ninety calendar days after the end of the RHC's fiscal year, demonstrating that the change in scope occurred,
- Ninety calendar days after the RHC learned the cost threshold was met during the fiscal Year. See **What are the criteria for a change in scope of service rate adjustment?** for information on cost thresholds.

For RHC change in scope (CIS) application materials and to submit RHC CIS applications, email FQHCRHC@hca.wa.gov. All RHC CIS applications must be submitted in electronic format.

How does HCA use the Medicare Cost Report (MCR) to set RHC Medicaid encounter rates?

When an RHC requests a change in scope of services, HCA rebases encounter rates for all RHCs included in the Medicare Cost Report (MCR).

When an RHC submits an updated MCR, overhead costs are reallocated. Because of the reallocation, costs and visits for all RHCs reported on the MCR must be adjusted when updating RHC encounter rates.

HCA uses the Medicare Cost Report data and applies Medicaid-specific adjustments, such as adding Medicaid services not covered by Medicare and

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allocating overhead to services not reported in the Medicare Cost Report (e.g., dental services, telehealth costs and visits, and pneumococcal costs).

HCA follows the rate structure calculated in the MCR when setting Medicaid RHC encounter rates. If RHC encounter rates are combined on the MCR, Medicaid encounter rates will be combined. If the MCR has separate rates for each RHC on the cost report, Medicaid encounter rates will be separate for each clinic.

HCA requires separate Medicaid RHC encounter rates for dental services. Dental services are not covered by Medicare but are covered as a Medicaid service.

If an RHC is adding dental services as a cost center to their clinic, they must submit the Dental CIS Evaluation Tool as part of their change in scope application. The same documentation is required for an RHC with an existing dental cost center who submits a CIS.

The Dental CIS Evaluation Tool captures costs for dental services, which are not reported in the MCR. For example, the tool captures dental service visits, and the proportion of overhead allocated to dental services.

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's application must be based on one of the following:

- A change the RHC plans to implement in the future. The RHC submits 12 months of projected data and costs sufficient to establish an interim rate; or,
- A change with less than 12 months of experience to support the change reflected in the Medicare cost report. The RHC submits a combination of historical data and projected costs sufficient to establish an interim rate.

If the application for a prospective change in scope of service rate adjustment is approved by HCA, 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 calendar days after the RHC submits a complete application to HCA, an interim rate takes effect no later than 90 calendar days after the RHC submits the application to HCA.

If the change in scope of service occurs more than 90 calendar days but fewer than 180 calendar days after the RHC submits a complete application to HCA, 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 calendar days, the application is void. The RHC may resubmit the application to HCA. HCA does not consider the resubmission of a voided application as an additional application.

If a prospective change in scope is based on a triggering event that already occurred but is supported by less than 12 months of data in the filed Medicare

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cost report, the interim rate takes effect on the date the RHC submitted the completed application to HCA.

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

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

- Medicare cost report.
- A narrative description of the proposed change in scope of service that explains how each proposed change meets the requirements for change in scope of amount, duration, intensity, or type. The narrative should also include all RHC NPIs and the proposed encounter rate for each RHC site included in the Medicare cost report.
- A letter of representation if seeking support from an auditor/representative.
- A description of each cost center on the Medicare cost report that will be affected by the change in scope of service.
- The RHC's most recent audited financial statements for the same time period as the cost reports, 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 the 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 HCA.

RHCs who have an approved prospective change in scope application require a **post change in scope** review within 18 months of the effective date of the rate adjustment.

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 triggering event that supports the application and include 12 consecutive months of actual data documenting the cost change caused by the triggering event.

If approved, a retrospective rate adjustment takes effect on the date the RHC submitted the complete application with HCA.

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Example: If the RHC submits a completed application on September 1, 2022, HCA begins the review process and sets the final rate within 90 days. This rate is effective on September 1, 2022, corresponding with the date HCA received the complete application.

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 email the application to the RHC inbox at FQHCRHC@hca.wa.gov and include the following documentation:

- Medicare cost report.
- A narrative description of the proposed change in scope of service that explains how each proposed change meets the requirements for change in scope of amount, duration, intensity, or type. The narrative should also include all RHC NPIs and the proposed encounter rate for each RHC site included in the Medicare cost report.
- A letter of representation if seeking support from an auditor/representative.
- A description of each cost center on the Medicare cost report that was affected by the change in scope of service.
- The RHC's most recent audited financial statements for the same time period as the cost reports, 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.
- An attestation statement confirming all visits/encounters are included in the Medicaid cost report.
- Any additional documentation requested by HCA.

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

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

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

If the RHC does not provide HCA with the documentation or information requested within 30 calendar days of the request, HCA may deny the application.

Within 90 calendar days of receiving a complete application, including any additional documentation or information that HCA might request, HCA sends the RHC:

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- A decision stating it will implement an encounter rate change; and,
- A rate-setting statement if the rate change is implemented.

The RHC may appeal HCA's decision on the application as outlined in WAC 182-549-1650.

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

HCA 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.

HCA 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 HCA set an adjusted encounter rate for retrospective changes in the scope of service?

HCA 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.

HCA reviews the costs to determine if they are reasonable and accurate, 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 prospective payment system (PPS) rate in addition to the APM.

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

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

HCA conducts a post change in scope of service review within 90 days of receiving the Medicare cost report and encounter data from the RHC. If necessary, HCA will adjust the encounter rate within 90 days of the review to ensure that the rate reflects the reasonable and accurate 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 HCA issues its adjustment. The new rate will be prospective.

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> **Example**: If the RHC submits a completed application on September 1, 2022, HCA begins the review process and sets the final rate within 90 days. If HCA concludes the review on December 1, 2022, the RHC's new rate is effective on December 1, 2022. If HCA concludes this same review on November 1, 2022, the new rate for the RHC is effective on November 1, 2022.

If the approved change in scope rate adjustment was based on a retrospective change in scope application (i.e., based on a year or more of actual encounter data), HCA may conduct a post change in scope of service rate adjustment review for all RHCs listed in the Medicare cost report.

If the approved change in scope rate adjustment was based on a prospective change in scope application (i.e., less than a full year of actual encounter data), the following information is submitted to HCA for each RHC listed in the Medicare cost report within 18 months of the effective date of the rate adjustment:

- A narrative description of the request.
- A description of each cost center on the cost report that was affected by the change in scope.
- The most recent audited or as filed Medicare cost report (in electronic format), 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.
- The RHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law.
- Any additional documentation requested by HCA.

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

If the RHC fails to submit required documentation within 5 months of HCA's written notice, HCA 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 HCA.

How are rates rebased?

HCA 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 HCA 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.

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Can an RHC appeal HCA actions related to change in scope rate adjustments?

Yes. An RHC provider has a right to an administrative appeal of agency action according to WAC 182-549-1650 related to rate setting rules in Chapter 182-549 WAC.

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

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

- Changes in patients served, including populations experiencing chronic diseases such as HIV/AIDS, and 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, behavioral health, or dental practices, including, but not limited to, the implementation of patient-centered medical homes, opening for extended hours, or adding a service.
- 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.

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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.

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Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see HCA's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill HCA 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.
- Record-keeping requirements.

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

- See What services do not qualify as an encounter? for information on which services are separately reimbursable outside of an encounter.
- An encounter-eligible service must be billed with the HCPCS code T1015.
- 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.

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Splitting services that are typically provided on the same day

RHCs must provide services in a single encounter that are typically rendered in a single visit based on clinical guidance and standards of care. As outlined in WAC182-549-1450(4):

- RHCs must not split services into multiple encounters unless there is clinical justification. (For example, fluoride treatment must be provided on the same day as an encounter-eligible service.)
- RHCs must not develop facility procedures or otherwise ask clients to make repeated or multiple visits to complete what is considered a reasonable and typical visit unless it is medically necessary.
- Clinical justification must be based on medical necessity and documented in the client's record.

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Example

If a client's dental visit consists of an exam (D0120), the cleaning (D1110) should be performed in the same visit.

How do I bill for encounter services?

Service Type	HCPCS Code	HCPCS/CPT®/CDT® Encounter Service Rendered	Billing Taxonomy	Billed Charges
Medical/Dental	T1015 *The position of the T1015 on a claim will not affect claim payment. (All-inclusive clinic visit/encounter)	Bill corresponding fee-for-service code(s) of the underlying service being performed.	261QR1300X	Bill $0.00

Always list an encounter code on the same claim as its related CPT® codes.

- When billing the HCPCS T1015 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.
- When billing the HCPCS T1015 encounter code in both the fee-for-service and managed care environment, the RHC taxonomy 261QR1300X is required to generate an encounter payment for encounter-eligible services.

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- To ensure correct payment for the HCPCS T1015 encounter code, all third-party payment information must be reported at the header level of the claim. For more information on third-party billing, refer to the **ProviderOne Billing and Resource Guide**.
- For clients in programs eligible for encounter payments, HCA denies Evaluation and Management codes when billed without an HCPCS T1015 encounter code.

> **Exception:** E&M CPT® code 99211 can be billed without a T1015 encounter code for immunization services provided by registered nurses.

> **Note**: HCA will not reimburse for early (before 39 weeks of gestation) elective deliveries. See the **Physician-Related Services/Health Care Professional Services Billing Guide** for additional instructions.

- When billing for services that do not qualify for encounter payments, do not use an encounter code on the claim. (See **What services do not qualify as an encounter**?)

> **Note**: As client eligibility may change, bill HCPCS 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 HCA clients must be billed to HCA on a professional claim. 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 prenatal 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 HCPCS T1015 code for the same date of service.

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Whenever the client is seen on multiple days for a maternity package fee-for-service code, the HCPCS 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 Pregnancy-Related Services Billing 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 without an encounter.

How do I bill for orthodontic services performed in an RHC?

When billing for orthodontic services, RHCs must follow the same guidelines as non-RHC providers. However, "global" orthodontic codes cover a specific length of time and are billed at the end of the time indicated. There is an exception for the initial placement of the device, which is billed on the date of service. Because RHCs are reimbursed by an encounter payment, they may bill up to the maximum number of encounters. See Comprehensive treatment timeframes and maximum units and the Orthodontic Services billing guide for further guidance. The tables below are effective for claims beginning October 1, 2020.

Comprehensive treatment timeframes and maximum units allowed

Comprehensive treatment CDT® code	Months from appliance placement date	Number of encounters allowed *Total encounters allowed = 21
D8080	0	3
D8670	6	2
D8670	6	2
D8670	9	2
D8670	12	2
D8670	15	2
D8670	18	2
D8670	21	2
D8670	24	2

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Comprehensive treatment CDT® code	Months from appliance placement date	Number of encounters allowed *Total encounters allowed = 21
D8670	27	2
D8670	30	2

An RHC may bill on the date of the appliance placement (CDT® code D8080) for one encounter, and up to a total of three encounters (CDT® code D8670) during the first three months of the appliance placement.

After the first three months, the RHC may bill up to two encounters (CDT® code D8670) in each subsequent three-month period. To bill for more than one encounter (CDT® code D8080) during the first three months, the RHC must bill the encounter (CDT® code D8080), see the client, and document the reason for the encounter in the client's file.

If an RHC chooses to bill in this manner the latest paid claim must be adjusted each time and another encounter is added to the line containing the HCPCS T1015 code. If the claim is not adjusted, the claim will be denied as a duplicate billing.

Limited orthodontic treatment	Months from appliance placement date	Number of encounters allowed *Total encounters allowed = 10
D8030	0	4
D8670	6	2
D8670	9	2
D8670	12	2

An RHC may bill on the date of the appliance placement (CDT® code D8030) for one encounter, and up to a total of four encounters (CDT® code D8670) during the first three months of the appliance placement.

After the first three months, the RHC may bill up to two encounters (CDT® code D8670) in each subsequent three-month period. To bill for more than one encounter (CDT® code D8030) during the first three months, the RHC must bill the encounter (CDT® code D8030), see the client, and document the reason for the encounter in the client's file.

If a clinic chooses to bill in this manner, the latest paid claim must be adjusted, and another encounter is added to the line containing the HCPCS T1015 code. If the claim is not adjusted, the claim will be denied as a duplicate billing.

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Note: **Beginning October 1, 2020,** all new orthodontic cases under CDT® codes D8020, D8030, and D8080 will bill D8020, D8030, or D8080 for the initial three-month visit and bill CDT® code D8670 (periodic visit) for the subsequent three-month visits.

What are the rules for telemedicine?

Refer to HCA's Provider billing guides and fee schedules webpage, under *Telehealth*, for more information on the following:

- Telemedicine policy, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

RHCs are authorized to serve as an originating site for telemedicine services. An originating site is the location of a client at the time the telemedicine service being furnished through a telecommunications system occurs. RHCs that serve as an originating site for telemedicine services are eligible to receive an originating site facility fee if they meet the criteria found in HCA's *Telemedicine clinical policy and billing* (see below). Originating site facility fees are not encounter eligible. Charges for the originating site facility fee may be included on a claim, **but the originating site facility fee may not be included on the Medicare cost report**.

RHCs may receive the encounter rate when billing as a distant site provider if the service being billed is encounter eligible.

Effective August 1, 2022, HCA pays for audio-only telemedicine services for specific procedure codes when provided and billed as directed in HCA provider billing guides. HCA published the list of audio-only codes on HCA's Provider billing guides and fee schedules webpage. RHCs may receive the encounter rate when billing as an audio-only code if the service being billed is encounter eligible.

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

HCA limits encounters to one per client, per day, except in the following circumstances (See WAC 182-549-1450(1)):

- There is a subsequent visit in the same cost center (i.e., medical, dental) that requires separate evaluation and treatment on the same day for unrelated diagnoses; or
- There are separate visits in different types of cost centers that occur with different health care professionals. (For example, a client with a separate medical and dental visit on the same day.)

All services provided within the same cost center, performed on the same day, must be included in the same encounter, except in the circumstances outlined above.

All RHC services and supplies incidental to the provider's services are included in the encounter rate payment (WAC 182-549-1450 (3)).

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RHCs must provide services in a single encounter that are typically rendered in a single visit based on clinical guidance and standards of care.

Each encounter must be billed on a separate claim. On each claim, to indicate that it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in in the *Claim Note* section of the electronic claim. Use an appropriate modifier to bill for the subsequent HCPCS T1015 procedure code.

When billing two different claims for the same date of service, a modifier must be entered on at least one of the claims. The same modifier cannot be used on the first and second claim. HCA must fully process the first claim before the provider submits the second.

Documentation for all encounters must be kept in the client's file.

> **Note**: Only one visit can be billed per claim. Bill multiple visits on different claims.

What procedure codes must an RHC use?

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

- Physician-Related Services/Healthcare Professional Services Billing Guide
- Dental-Related Services Billing Guide
- Access to Baby and Child Dentistry Billing Guide
- Orthodontic Services Billing Guide
- Other applicable program-specific billing guides

Claims must be submitted using the appropriate claim form from HCA's provider billing guides and fee schedules webpage:

- For medical services, use an 837P HIPAA-compliant claim or professional DDE claim.
- For dental services, use an 837D HIPAA-compliant claim or dental DDE claim.

Can RHCs be 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 Billing Guide.

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How do I bill taxonomy codes?

- When billing for services eligible for an encounter payment, HCA 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 HCPCS 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 do I bill diagnosis codes?

HCA requires valid and complete ICD diagnosis codes. HCA reimburses providers only for the covered procedure codes and diagnosis codes that are within their scope of practice. For additional information on diagnosis codes, see the **Physician-Related Services/Health Care Professional Services Billing Guide**, under the diagnosis codes section.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**, under **Learn how to use ProviderOne**, select **Webinars**.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA electronic data interchange (EDI) webpage**.

The following claim instructions relate to RHCs:

Name	Entry
Place of Service	Enter Place of Service (for example, "11" or "72")
Billing Provider	Enter your billing NPI and RHC Billing Taxonomy 261QR1300X

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

Clinics must bill HCA 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 diagnosis code. ICD 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 HCA's **Physician-Related Services/Healthcare Professional Services Billing Guide**.

See HCA's **Billers and Providers webpage** for more information.

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 HCA 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 HCA will not exceed an RHC's Medicare rate. Crossover claims 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 HCA'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 on an electronic institutional claim. If Managed Medicare and Medicare Part C plans require services to be billed on a professional claim, and they are paid or the money is applied to the deductible, RHCs must switch the claim information to an electronic institutional claim, or the claim will not process correctly. These crossover claims must be billed to HCA using the Type of Bill 71X and the RHC taxonomy for the Billing Provider.

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How do I handle Managed Medicare or Medicare Part C crossover claims for dental billing?

Managed Medicare and Medicare Part C plans increasingly offer dental services as a covered service. If a Part C plan makes a payment, RHCs bill HCA on an electronic dental claim. To ensure the claim goes to Coordination of Benefits for proper pricing, indicate on the claim in the *Claim Note* section that this is a Managed Medicare or Medicare Part C service.

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.

Effective April 1, 2021, per the Social Security ACT (SSA), section 1833(f), CMS applied an RHC payment limit per visit. The payment limit per visit applies to RHCs that are independent or are provider-based (connected to a hospital with 50 or more beds). This national payment limit does not apply to grandfathered provider based RHCs (i.e., a hospital with fewer than 50 beds).

When requesting a Medicare crossover rate update, RHCs are responsible for indicating to HCA, in writing, whether their clinic's Medicare All-Inclusive Rate (AIR) is subject to either the national RHC payment limit per visit or if it receives a grandfathered rate.

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 and the drug are considered bundled within the encounter. 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, 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, RHCs may not bill for the injection itself as the costs of these services are included in the encounter rate.

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