Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Department of Social and Health Services
Health and Recovery Services
Administration (HRSA)

Rural Health Clinics
Billing Instructions

Copyright Disclosure

Current Procedural Terminology (CPT™) five digit codes, descriptions, and other data only are copyright 2006 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense services. AMA assumes no liability for data contained or not contained herein.

About this publication

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

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

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

HRSA's Billing Instructions and Numbered Memoranda

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://hrsa.dshs.wa.gov (click *Billing Instructions/Numbered Memoranda*).

Table of Contents

<u>Table of Contents</u> (cont.)

Important Contacts

A provider may use HRSA's toll-free lines or website for questions regarding its programs; however, HRSA's response is based solely on the information provided to HRSA at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [Refer to WAC 388-502-0020]

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/provrel

Click *Sign up to be a DSHS WA state Medicaid provider* and follow the on-screen instructions.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/provrel

- Click *Sign up to be a DSHS WA state Medicaid provider*
- Click *I want to sign up as a DSHS Washington State Medical provider*
- Click *What happens once I return my application?*

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/provrel

- Click *I'm already a current Provider*
- Click *I want to make a change to my provider information*

If I don't have access to the Internet, how do I find information on becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
800.562.3022 (toll free)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Where do I send paper claims?

Division of Healthcare Services
PO Box 9248
Olympia, WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit:
http://hrsa.dshs.wa.gov

Click *Billing Instructions/Numbered Memoranda*

Who do I contact if I have questions regarding…

Enrolling as a medical assistance-certified RHC, overall management of the program, or specific payment rates?

RHC Program Manager
Office of Rates Development
PO Box 45510
Olympia, WA 98504-5510
360.725.1882
360.586.7498 (FAX)

Payments, denials, claims processing, or HRSA managed care organizations?

Visit the Customer Service Center for Providers at:
http://hrsa.dshs.wa.gov/provrel

- Click *I'm already a current Provider*
- Click *Frequently Asked Questions*

or call/fax:
800.562.3022 (toll free)
360.725.2144 (fax)

or write to:
HRSA Customer Service Center
PO Box 45562
Olympia, WA 98504-5562

Private insurance or third-party liability, other than HRSA managed care?

Office of Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Electronic billing?

Call the HRSA/HIPAA E-Help Desk at:
800.562.3022 (toll free) and choose option #2, then option #4

or e-mail to:
hipaae-help@dshs.wa.gov

- or -

Call ACS EDI Gateway, Inc. at:
800.833.2051 (toll free)

or visit:
http://www.acs-gcro.com

How do I find out about Internet billing (electronic claims submission)?

WinASAP and WAMedWeb:
http://www.acs-gcro.com

Click *Medicaid* then *Washington State*.

All other HIPAA transactions:
https://wamedweb.acs-inc.com

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:
http://www.acs-gcro.com

Click *Medicaid*, then *Washington State*, then *Enrollment*.

or call:
800.833.2051 (toll free)

After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 800.833.2051.

Where can I view and download HRSA fee schedules?

> **Visit:**
> http://hrsa.dshs.wa.gov/rbrvs

How do I check on a client's eligibility status?

> **Call ACS at:**
> 800.833.2051 (toll free)
>
> **or call HRSA at:**
> 800.562.3022 (toll free) and choose option #2
>
> **You may also access the WAMedWeb Online Tutorial at**:
> http://hrsa.dshs.wa.gov/wamedwebtutor

This page intentionally left blank.

Definitions and Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Accept Assignment – When a medical provider agrees to accept Medicare payment for a given service or equipment as payment in full, except for specific deductible and coinsurance amounts for which the client is responsible.

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

Client – An applicant for, or recipient of, department medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Core Provider Agreement – The basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in medical assistance.

Department – The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

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

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

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

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-Service System – The Fee-for-Service (FFS) system is a payment method HRSA uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under HRSA's prepaid managed care organizations (MCOs) or as encounter services. Other services are available outside of HRSA (e.g., personal care services, children's therapeutic, COPES, etc.).

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

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Interim Rate – The rate established by HRSA to pay a rural health clinic for encounter services prior to the establishment of a prospective payment system (PPS) rate.

Internal Control Number (ICN) – A 17-digit claim number that appears on the HRSA Remittance and Status Report near the client's name. This number is used as means of identifying the claim.

Managed Care – A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either a managed care organization (MCO) or primary care case management (PCCM) provider. [WAC 388-538-050]

Managed Care Organization (MCO) – An organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the department under a comprehensive risk contract to provide prepaid health care services to eligible clients under the department's managed care programs. [WAC 388-538-050]

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

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has four parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

- "Part C" is the Medicare Risk Contract or HMO program, or Medicare+ Choice created in the Balanced Budget Act of 1997 and adding other alternative treatment programs for Medicare recipients.

- "Part D" is the Medicare program that will allow Medicare to help pay for prescription drugs. In December of 2003, Congress passed the Medicare Modernization Act, which created this benefit.

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

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

Patient Identification Code (PIC) – An alphanumeric code that is assigned to each HRSA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

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

Primary Care Case Management (PCCM) – The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services. [WAC 388-538-050].

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

Provider or **Provider of Service** – An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with HRSA.

Remittance And Status Report (RA) – A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) – Washington State laws.

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

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

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

Shortage Area – A defined geographic area designated by the Department of Health and Human Services as having either a shortage of personal health services [under Section 1302(7) of the Public Health Service Act] or a shortage of primary medical care manpower [under Section 332 of that act].

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Washington Administrative Code (WAC) – Codified rules of the State of Washington.

Program Overview

What is a rural health clinic?

A rural health clinic (RHC) is a provider-based or freestanding facility certified under Code of Federal Regulations (CFR), title 42, part 491.2. A rural health clinic is located in a rural area that is designated as a shortage area. You may access the CFR on-line at http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr491_05.html

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

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

What are the staffing requirements of an RHC?
[Refer to 42 CFR §491.7-8]

- An RHC must be under the medical direction of a physician;
- An RHC must have a health care staff that includes one or more physicians;
- An RHC staff must include one or more physician's assistants (PA) or nurse practitioners (NP);
- A physician, PA, NP, nurse-midwife, clinical social worker, or clinical psychologist must be available to furnish patient care services at all times the clinic operates;
- A PA, NP, or certified nurse midwife must be available to furnish patient care services at least 50 percent of the time the clinic operates; and
- The staff may also include ancillary personnel who are supervised by the professional staff.

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

RHC Certification

Federal Certification: RHCs must be federally-certified for participation as an RHC by the Department of Health and Human Services (DHHS). DHHS or its representative notifies the State Medicaid agency that it has certified or denied certification to a prospective RHC.

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

To obtain medical assistance certification as an RHC, the clinic must contact the RHC Program Manager directly to obtain the paperwork necessary to enroll with HRSA at:

> Office of Rates and Finance
> Attn: RHC Program Manager
> PO Box 45510
> Olympia, WA 98504-5510
> 360.725.1882
> 360.586.7498 (FAX)

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

What is the effective date of my Medicaid RHC certification?

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

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

-OR-

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

Why do I need two different HRSA provider numbers?

Not all services provided in the RHC are paid at the RHC encounter rate. You must bill HRSA using the correct provider number depending upon which services you are billing for.

- **RHC-specific provider number:** Encounter services must be billed to HRSA using the clinic's RHC-specific provider number.

- **HRSA fee-for-service provider number:** Services paid under the fee-for-service (FFS) system must be billed to HRSA using the clinic's HRSA FFS provider number.

> **Note: To be paid the encounter rate, you must bill HRSA using your unique RHC provider number.** Do not bill HRSA for encounter services until HRSA issues you an RHC-specific provider number. You will not be paid for services provided before you receive your RHC provider number.

This page intentionally left blank.

Client Eligibility

Who is eligible for services provided in an RHC?

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

> **Note:** See page G.4 for payment limitations for clients in state-only medical programs (e.g., Family Planning Only clients, TAKE CHARGE clients).

Managed Care Clients

Clients with an identifier in the HMO column on their Medical ID Cards are enrolled with one of the HRSA-contracted managed care organizations (MCO). Clients **must** have all nonemergency services arranged for or provided by their Primary Care Providers (PCP). Clients can contact their MCO by calling the telephone number listed on their Medical ID Cards.

> **Note:** If you treat a managed care client and you are not the client's PCP, or the client was not referred to you by the PCP, *you may not receive payment*. Contact the client's PCP to get a referral. You may also need to get authorization from the plan for the service that you are providing, especially if you are not contracted as a provider with that plan. Call the managed care plan to discuss payment *before* you provide services.

Primary Care Case Management

For clients who have chosen to obtain care with a PCCM provider, the identifier in the HMO column will be "PCCM." These clients must obtain their services through their PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

This page intentionally left blank.

Provider Requirements

Basic Requirements for Services Provided in an RHC

- RHCs must furnish all services according to applicable Federal, State, and local laws.

- Unless otherwise specified, RHC services provided are subject to the limitations and coverage requirements detailed in HRSA's current *Physician-Related Services Billing Instructions* and other applicable billing instructions. HRSA does not extend additional coverage to clients in an RHC beyond what is covered in other HRSA programs and State law.

- The RHC must be primarily engaged in providing outpatient health services. Clinic staff must furnish those diagnostic and therapeutic services and supplies commonly furnished in a physician's office or the entry point into the health care delivery system. These include:

  - ✓ Medical history;
  - ✓ Physical examination;
  - ✓ Assessment of health status; and
  - ✓ Treatment for a variety of medical conditions.

- The RHC must provide basic laboratory services essential to the immediate diagnosis and treatment of the patient in accordance with section 353 of the Public Health Service (PHS) Act. These services, which are subject to change as defined by federal RHC regulations, include, but are not limited to:

  - ✓ Chemical examination of urine by stick or tablet method or both;
  - ✓ Hemoglobin or hematocrit;
  - ✓ Blood glucose;
  - ✓ Examination of stool specimens for occult blood;
  - ✓ Pregnancy tests; and
  - ✓ Primary culturing for transmittal to a certified laboratory.

- The RHC must provide medical emergency procedures as a first response to common life-threatening injuries and acute illness. The RHC must have available commonly used drugs and biologicals such as:

  - ✓ Analgesics;
  - ✓ Anesthetics (local);
  - ✓ Antibiotics;
  - ✓ Anticonvulsants;
  - ✓ Antidotes and emetics; and
  - ✓ Serums and toxoids.

Encounters

What services are considered an encounter?

Only certain services provided in the clinic are considered an encounter. **The RHC must bill HRSA for these services using the RHC provider number and HCPCS code T1015.**

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

- Physicians;
- Physician's assistants (PA) and nurse practitioners (NP);
- Psychologists or clinical social workers; and
- Visiting nurses, as described in federal regulation 42 CFR §405.2416.

> **Note:** In order to bill mental health encounters, an RHC must be a licensed community mental health center and have a contract with a Regional Support Network (RSN). HRSA pays for mental health encounters only when they are provided by psychiatrists, psychologists, or clinical social workers. Mental health encounters are subject to the service limitations detailed in the "Psychiatric Services" section of HRSA's current *Physician-Related Services Billing Instructions* (e.g. 12 psychotherapy visits per client, per calendar year). Bill these encounters using your RHC provider number and HCPCS code **T1015 with modifier HE.**

> **Note:** The services listed above are not billable under the FFS system. **See page F.1 for services billable under the FFS system.**

Services and Supplies Incidental to Professional Services

Services and supplies incidental to the professional services of physicians, PAs, NPs, psychologists, or clinical social workers are included in the encounter rate paid for the professional services when the services and supplies are:

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

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

> **Note:** HRSA excludes drugs and biologicals administered in the provider's office from the list of encounter services. This includes pneumococcal and influenza vaccines and other immunizations. Bill HRSA separately for these drugs and biologicals using your FFS provider number (see page H.10 for more details).

Criteria for Determining if a Service Qualifies as an Encounter

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

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

The service being performed must require the skill and ability of a physician, PA, or NP in order to qualify as an encounter. A service does not qualify as an encounter simply because it is performed by one of these practitioners if the service is one that is normally performed by other health care staff such as registered nurses (RN). For example, if a physician, PA, or NP performs a blood pressure check only or a vaccine administration only, these services are not encounters since they are normally performed by RNs. These services must be billed as FFS using the appropriate coding.

Services at the Clinic

The services of a practitioner performed at the clinic (excluding those listed on page F.1) are encounters and are payable only to the clinic.

Services Away From the Clinic

A service that is considered an encounter when performed **in** the clinic is considered an encounter when performed **outside** the clinic (e.g., in a nursing facility or in the client's home) and is payable to the clinic.

A service that is not considered an encounter when performed **in** the clinic is not considered an encounter when performed **outside** the clinic, regardless of the place of service.

Concurrent Care

Concurrent care exists when services are rendered by more than one practitioner during a period of time. (Consultations do not constitute concurrent care.) The reasonable and necessary services of each practitioner rendering concurrent care are covered if each practitioner is required to play an active role in the patient's treatment. For example, concurrent care may occur because of the existence of more than one medical condition requiring distinct specialized medical services.

What if a service does not qualify as an encounter?

Some services do not qualify as encounters. HRSA may cover these under the FFS system. See Section F for FFS services.

This page intentionally left blank.

Fee-for-Service System

The Fee-for-Service (FFS) system is a payment method HRSA uses to pay providers for covered medical services provided to medical assistance clients, with the exception of encounter services and those services provided under HRSA's prepaid managed care organizations (MCOs). Other services are provided through and paid for by agencies other than HRSA (e.g., personal care services, children's therapeutic services, COPES, etc.,).

What services are paid under the FFS system?

HRSA covers the following supplies and services and pays for them using the FFS system:

> **Note:**   The following services are not billable as encounters. **Do not bill using HCPCS code T1015 for these services**; use your FFS provider number along with the appropriate procedure code.

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

   See **Note** on next page.

> **Note:** Professional services that are not normally provided to Medicare beneficiaries are not included on the clinic's Medicare cost report and are not used for the calculation of the clinic's encounter rate. Therefore, they have been excluded from HRSA's list of encounter services and are not billable as an encounter. Also, as described on page E.2, many supplies used in a provider's office are considered incidental to the professional service and are bundled within the encounter rate. Using your FFS provider number, bill only those supplies that are specifically detailed in the *Physician-Related Services Billing Instructions* as separately payable.

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

As referenced on page F.1, EPSDT services are considered FFS. Bill HRSA for these services using your FFS provider number. However, if during an EPSDT screening exam the provider identifies an abnormality or addresses a pre-existing problem, and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation & Management (E/M) service, then the appropriate E/M code (99211-99215 with modifier 25) must be clearly and separately identified in the medical record. The RHC may then separately bill an encounter for the problem-focused encounter service with the appropriate medical diagnosis using its RHC provider number.

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

Payment

Payment for Encounter Services

HRSA pays clinics for those encounter services described in Section E on an **encounter rate** basis rather than FFS basis. All RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

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

- The visits occur with two different doctors with two different specialties; **or**

- There are two separate visits with unrelated diagnoses.

> **Note:** The service being performed must require the skill and ability of a physician, PA, or NP as described on page E.2 in order to qualify as an encounter service.

Encounter Rate Determination

What is BIPA 2000?

BIPA 2000 is the federal Benefits Improvement and Protection Act (BIPA) of 2000. Section 702 of BIPA 2000 mandates that all state Medicaid agencies pay RHCs using a Prospective Payment System (PPS). BIPA 2000 requires that the base encounter rate is set prospectively using a weighted average of 100 percent of the clinic's total reasonable costs for all Medicaid-covered services for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during calendar year 2001. This base year encounter rate is then inflated on January 1 of each year by the Medicare Economic Index (MEI) for primary care services as published in the Federal Register.

Clinics Certified During 1999 and 2000

For clinics in existence during 1999 and 2000, HRSA used the RHC's audited Medicare cost report to set the clinic's base encounter rate. The encounter rate was determined by dividing the clinic's total allowable costs by the clinic's total encounters for the reporting period. Unlike Medicare, HRSA did not apply a cap to the encounter rates. The clinic's weighted average encounter rate is then increased each January 1st by the MEI for primary care services.

Clinics Certified After 2000

Clinics that are certified after 2000 are paid using either a freestanding or provider-based statewide average encounter rate (depending on the clinic's Medicare designation) until the clinic's first audited Medicare cost report is available. Effective January 1 of the year following HRSA's receipt of the clinic's first audited Medicare cost report, HRSA sets the clinic's base year encounter rate using the uncapped encounter rate detailed in the Medicare cost report. Thereafter, this encounter rate is inflated each January 1 by the MEI for primary care services.

Payment for Services Under the FFS System

HRSA pays clinics for services covered under the FFS system using HRSA's published fee schedules. To view HRSA's current fee schedules, visit HRSA's web site at http://maa.dshs.wa.gov, then click *Billing Instructions/Numbered Memoranda*, then *Accept*, then *Fee Schedules*.

> **Note:** All services, whether encounter or FFS, are subject to the coverage guidelines, restrictions, and limitations detailed in applicable HRSA billing instructions and Washington Administrative Code (WAC).

CPT® codes and descriptions only are copyright 2006 American Medical Association.

Supplemental Payments for Managed Care Clients

Healthy Options enhancement payments for managed care clients

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

RHC delivery enhancement payment

In order to encourage the RHC to provide maternity services to its assigned managed care clients and to offset the additional costs incurred by the RHC for these services, HRSA makes a payment to the clinic when a qualified RHC provider performs a delivery for a managed care client assigned to the clinic. This payment is known as the "RHC delivery enhancement." If the client's Medical ID Card has a "BHP+" indicator in the HO column, HRSA pays the clinic an additional payment for the delivery known as the "S-kicker enhancement."

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

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

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

   -OR-

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

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

CPT® codes and descriptions only are copyright 2006 American Medical Association.

How do I bill for an RHC delivery enhancement?

Bill HRSA for the RHC delivery enhancement payment using either

- The delivery-only CPT code 59409 with modifier UC; or

- CPT code 59514 with modifier UC.

Modifier UC is a payer-defined modifier. HRSA defines modifier UC as "FQHC/RHC Service." Use the ICD-9-CM diagnosis code V68.9 (unspecified administrative purpose).

How do I bill for the S-kicker enhancement?

Submit a separate claim using CPT code 59899 with modifier UC. Enter the following information:

- In field 33, enter the appropriate FQHC/RHC managed care provider ID number (*PIN#*), beginning with 759, and the plan provider number (*GRP#*), beginning with 750; and

- In field 26, enter the Patient's Account No.

Payment for Services Provided to Clients not Eligible for RHC Payment

For services provided to clients in programs not eligible for RHC payment, bill using your FFS provider number regardless of the type of service performed. HRSA does not pay the encounter rate or the enhancement for clients enrolled in these programs (see the following grid and sample Medical ID Card).

RHC clients who present Medical ID Cards with one of the following medical coverage group codes in field 4 do **not** qualify for the encounter rate or the enhancement:

Medical Coverage Group Codes (In Field 4)	Medical Coverage Group Definitions
F08	Children's Health Program
F09	Undocumented Aliens
G01	General Assistance
I01	Institution for the Mentally Diseased (IMD)
M99	Psychiatric Indigent Inpatient
P04	Pregnancy-Related
P05	Family Planning
S07	SSI-Related Undocumented Alien
W01, W02, and W03	ADATSA

CPT® codes and descriptions only are copyright 2006 American Medical Association.

Sample of Medical ID Card for State-Only Client

AU ID:	4246742	**Program:**	General Assistance (GA)
Review End Date:	09/2007	**Coverage Group:**	Med Care Svc Unemployed/GA Unemployed/GA Regular/GA-A/B/D (G01)
Head of Household:		**HoH Client ID:**	
Primary Language:	English (EN)	**NSA?**	No (N)

Medical ID Card Details

Central Reprint Request	Local Reprint Request	View with New Details

Issuance Date:	10/31/2006		
Current Status:	Issued (ID)	**Status Date:**	10/31/2006
Coverage Begin Date:	10/16/2006	**Coverage End Date:**	11/30/2006

Patient Identification Code (PIC)				Medical Coverage Information							
Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other
	032376		A								

GA   [Scope of Care](#)

NO OUT OF STATE CARE

222 ELECTRIC
OLYMPIA WA 9850

CPT® codes and descriptions only are copyright 2006 American Medical Association.

Under what circumstances does HRSA change RHC payment rates?

Changes in Scope of Service

A change in scope of service is defined as a change in the type, intensity or duration of a service provided by the clinic. The RHC must request an adjustment to its encounter rate to reflect a change in scope of service. For example, if a clinic adds an encounter service that was not included in its base years' cost reports, or no longer provides a service that was included in the base years' cost reports, the clinic must request a change in scope of service. For instance, a clinic that begins offering a psychologist's services has experienced a change in the type of services provided and may qualify for a rate adjustment. *A change in costs alone does not warrant a change in scope of service.*

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

- The clinic must notify the RHC Program Manager in writing of the change, including the effective date of the change and all other relevant details.

- The clinic must provide an updated covered services form to the RHC Program Manager, with the service in question marked appropriately and the effective date included.

- If the change is the addition of a service, HRSA adjusts the encounter rate by an interim amount to reflect the difference in costs caused by the addition of the service. HRSA determines the interim amount by examining the average costs of the other clinics providing similar services and/or reviewing a cost estimate, if available, provided by the clinic requesting the change.

- HRSA uses the first Medicare-audited cost report that includes a full year of costs of the new service to determine the final adjustment amount. This amount replaces the interim amount in the rate adjustment, retroactive to the original effective date of the service change. HRSA reconciles all encounters paid at the interim amount by making a lump-sum payment to the clinic.

- If the change is the subtraction of a service, HRSA determines the corresponding decrease in costs and reduces the encounter rate accordingly. To reconcile encounters paid at the higher rate after discontinuing the service, the clinic sends a lump-sum payment to HRSA. Payment arrangements are made with the RHC Program Manager.

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

Payment Liability Reminder

Each RHC is individually liable for any payments received and must ensure that it receives payment for only those situations described in these and other applicable billing instructions.

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

This page intentionally left blank.

CPT[®] codes and descriptions only are copyright 2006 American Medical Association.

Billing

How do I bill for encounter services?

Bill HRSA an encounter using **only** the HCPCS code below:

HCPCS Procedure Code	Description	Billed Charges
T1015	Clinic visit/encounter, all-inclusive	Billed charges must be at least equal to the clinic's HRSA encounter rate.

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

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

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

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

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

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

* The visits occur with two different doctors with two different specialties; **or**

* There are two separate visits with unrelated diagnoses.

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

How do I bill for services paid under the FFS system?

Clinics must bill HRSA for services covered under the FFS system using **their FFS provider number** and the service's appropriate CPT or HCPCS procedure code with the appropriate ICD-9-CM diagnosis code. ICD-9-CM diagnosis codes must be listed at the highest level of specificity (e.g. to the 4th or 5th digit, if appropriate).

Services covered under the FFS system are subject to the limitations and guidelines detailed in HRSA's current *Physician-Related Services Billing Instructions* or other applicable billing instructions.

To access HRSA's billing instructions on-line, visit http://hrsa.dshs.wa.gov, then click *Billing Instructions/Numbered Memoranda*, then *Accept*, then *Billing Instructions*.

CPT® codes and descriptions only are copyright 2006 American Medical Association.

What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in HRSA's billing instructions.

- Providers must submit their claim to HRSA and have an Internal Control Number (ICN) assigned by HRSA within 365 days from any of the following:

  ✓ The date the provider furnishes the service to the eligible client;
  ✓ The date a final fair hearing decision is entered that affects the particular claim;
  ✓ The date a court orders HRSA to cover the services; or
  ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

  > **Note:** If HRSA has recouped a plan's premium, causing the provider to bill HRSA, the billing time limit is 365 days from the date of recoupment by the plan.

- HRSA may grant exceptions to the 365-day time limit for submitting **initial claims** when billing delays are caused by either of the following:

  ✓ DSHS certification of a client for a retroactive[2] period; or
  ✓ Extenuating circumstances as proven.

- HRSA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

---

1 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

  Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

2 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, *except* prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  > **Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

How do I bill for services provided to primary care case management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM provider name in field 17 on the 1500 Claim Form; and

- Enter the seven-digit identification number of the PCCM provider who referred the client for the service(s). If the client is enrolled with a PCCM provider and the PCCM provider referral number is not in field 17a when you bill HRSA, the claim will be denied.

  > **Note:** Services provided to newborns of Healthy Options PCCM clients are paid under the FFS system until a PCCM provider has been chosen.

How do I bill for clients eligible for Medicare and medical assistance?

> **Note:** Bill using a UB-04 claim for Medicare-eligible clients when there is not a Medicare denial EOMB. When there is a Medicare denial EOMB, see page H.1.

When a client is eligible for both Medicare and medical assistance, Medicare is the primary payer for services provided. After Medicare has adjudicated the claims, they can be sent to DSHS for secondary payment. These claims are called Medicare crossover claims. Medical assistance payment for valid crossover claims will equal the difference between the Medicare payment amount and each clinic's Medicare per-visit rate, up to the Medicare rate. Payment from DSHS will not exceed a clinic's Medicare rate. **Crossover claims for encounter services must be billed on a UB-04 paper claim form using your RHC provider number.**

> **Note:** You must first submit a claim to Medicare and accept assignment within Medicare's time limitations before submitting a secondary claim to medical assistance.

HRSA may make an additional payment after Medicare pays you.

- If Medicare pays any portion of the claim, the claim can subsequently be submitted to HRSA as a crossover. The provider must bill HRSA within six months of the date Medicare processes the claims. A Medicare Remittance Notice or EOMB must be attached to each claim form.
- If Medicare denies payment of the claim, the claim subsequently billed to HRSA is considered an initial claim, not a crossover. Providers must meet HRSA's initial 365-day requirement for submitting initial claims.
- Medicare/medical assistance crossover claims for ***non-encounter*** services must be billed on a paper 1500 Claim Form using your FFS provider number.

> **Note:** For crossover claims for encounter services, bill HRSA using your RHC provider number. For crossover claims for FFS services, bill HRSA using your FFS provider number.

Medicare Encounter Rate Reporting

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

QMB (Qualified Medicare Beneficiaries) Program Limitations

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

Services provided to clients who have CNP or MNP identifiers on their medical ID card, in addition to QMB, are paid for as follows:

- If Medicare **and** medical assistance cover the service, HRSA pays only the Medicare deductible and/or coinsurance up to Medicare or HRSA's allowed amount, whichever is less.

- If only Medicare **and not** medical assistance covers the service, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only medical assistance **and not** Medicare covers the service and the service is covered under the CNP or MNP program, HRSA pays for the service.

- If neither Medicare nor medical assistance covers the service, the service is not payable. You must have the client sign a waiver stating that the service is not covered by their insurance prior to billing the client. [WAC 388-502-0160].

> **Note:** When providers accept medical assistance clients, they may not bill, demand, collect or accept payment from a client or anyone on the client's behalf for a covered service. [WAC 388-502-0160]

QMB-Medicare Only

Services provided to QMB-Medicare Only clients are paid for as follows:

- If Medicare **and** medical assistance cover the service, HRSA pays only the deductible and/or coinsurance up to the Medicare or medical assistance allowed amount, whichever is less.

- If only Medicare **and not** medical assistance cover the service, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

> **For QMB-Medicare Only:**
> If Medicare does **not cover** the service,
> HRSA does **not pay** for the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID Card. An insurance carrier's time limit for claim submissions may be different than HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA's fee schedule amount, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA billing as a non-RHC service; and
- Attach the insurance carrier's statement.

If you are rebilling, also attach a copy of the HRSA *Remittance and Status Report* showing the previous denial.

If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available via the Internet at http://hrsa.dshs.wa.gov or by calling the Office of Coordination of Benefits at 800.562.6136.

What must I keep in the client's file? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon request, *for six years from the date of service* or longer if required specifically by federal or state law or regulation.

> **A provider may contact HRSA with questions regarding its programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern DSHS's programs. [WAC 388-502-0020(2)]**

Billing Examples:

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

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

What if the client presents with complaints of pain in his or her mouth and during the exam it is found they have an infection in their mouth requiring the need for a referral to a dentist?

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

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

Per CPT guidelines, any encounter occurring on the same day as a hospital admission is bundled within the hospital call. Therefore, the initial office visit is not billable at all. Bill the hospital admission using your FFS provider number.

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

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

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

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

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

If the drug is administered as part of an encounter, the administration is considered bundled within the encounter. However, you may bill the drug itself separately using your FFS provider number.

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

- If the purpose of the injection is for reasons that ***are not*** considered encounter services (e.g. family planning or EPSDT immunizations), you may bill for both the drug itself and the injection using the appropriate CPT and/or HCPCS procedure codes and your FFS provider number.

- If the purpose of the injection is for reasons that ***are*** considered encounter services (e.g. flu shot), you may not bill for the injection itself as the costs of these services are included in your encounter rate. However, you may bill for the drug itself using your FFS provider number.

How to Bill Electronically

WAMedWeb

The Washington State Department of Social and Health Services HRSA and its providers are able to view and edit Washington State medical assistance information from the WAMedWeb.

Why use WAMedWeb?

Using the WAMedWeb, you can access medical assistance-related content on a 24-hour basis, making it fast, useful, and convenient. The WAMedWeb provides a HIPAA-compliant resource that can result in reduced payment wait times. It also provides you with the ability to conduct client eligibility inquiries, submit claim status inquiries, and review recent medical assistance payment summaries without telephoning HRSA. Other features include electronic claim submission and report access.

Does the web protect my personal information?

Yes! Confidential provider- or patient-related data is not disclosed on public web pages. Private web pages are accessible only by authorized users and may contain protected provider and patient health care information. Data being passed to and from your computer across the Internet is encrypted to protect your confidential provider and patient information. In addition, access to the secure area requires entry of your unique *login* and password.

How do I start using WAMedWeb?

To learn more about WAMedWeb, please access the WAMedWeb tutorial. For more information on what WAMedWeb has to offer your clinic please visit
https://wamedweb.acs-inc.com/wa/general/home.do

This page intentionally left blank.

Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006,** HRSA began accepting the new 1500 Claim Form (version 08/05).

- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

> **Note: HRSA encourages providers to make use of electronic billing options.** For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from HRSA's website at: http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html.

Instructions Specific to Rural Health Clinics

The following 1500 Claim Form instructions relate specifically to rural health clinics. Access HRSA's *General Information Booklet* at the website above to view general 1500 Claim Form instructions.

Field Number	Instructions
19	When billing for more than one encounter per client, per day, enter (on each claim) "unrelated diagnosis" and the time of both visits.
24B	Enter Place of Service "11" or "72" (either is acceptable).
24D	Enter HCPCS code T1015.
24F	Enter your encounter rate. Do not include dollar signs or decimals in this field. Do not add sales tax, which is automatically calculated by the system and included with your remittance amount.

UB-04 Claim Form

Attention! HRSA accepts only the new UB-04 Claim Form.

- **On March 1, 2007**, HRSA began accepting both the new UB-04 and the old UB-92 claim forms.

- **As of May 23, 2007**, HRSA accepts only the new UB-04 claims form. HRSA will return all claims submitted on the UB-92 claim forms.

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

For more information, read # Memorandum 06-84.

To see a sample of the UB-04 Claim Form, see the *General Information Booklet*.