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32 Provider-Based Rural Health Clinics

Rural health clinics are defined as clinics located in a rural area designated by the Bureau of Census as non-urbanized and medically under-served. Rural health clinics are designed to meet the needs of those recipients who might otherwise be unable to access medical attention.

Provider based rural health clinics are clinics that are an integral part of hospital, home health agency, or nursing facility. Provider-based rural health clinics are reimbursed on an encounter rate for services provided to Medicaid recipients.

Refer to the following chapters of the *Alabama Medicaid Agency Administrative Code*:

- Chapter 59 for policy for provider-based rural health clinics
- Chapter 60 for reimbursement policy

32.1 Enrollment

DXC enrolls rural health clinic providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for claims.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

NOTE:
The 10-digit NPI is required when filing a claim.

Rural health clinics are assigned a provider type of 58 and valid specialty is 185.

NOTE:

Physicians affiliated with rural health clinics are enrolled with their own NPI, which links them to the clinic. The provider type for the physician is 58 (Rural Health Clinic). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the rural health clinic, such as physician assistants or nurse practitioners, bill using the clinic NPI, and are not assigned individual NPIs.

Enrollment Policy for Provider-Based Rural Health Clinics

In order to participate in the Title XIX (Medicaid) Program, and to receive Medicaid payment, a provider-based rural health clinic must:

- Receive certification for participation in the Title XVIII (Medicare) Program
- Obtain certification by the appropriate State survey agency
- Comply with the Clinical Laboratory Improvement Amendment (CLIA) testing for all laboratory sites
- Operate in accordance with applicable federal, state and local laws.

All clinics must enroll separately and execute a separate provider contract with Alabama Medicaid.

The effective date of enrollment of a provider-based rural health clinic will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month the enrollment is approved.

The provider based rural health clinic must be under the medical direction of a physician. The physician must be physically present at the clinic for sufficient periods of time to provide medical care services, consultation, and supervision in accordance with Medicare regulations for rural health clinics. A *sufficient period* is defined as follows:

- No less than once every 72 hours for non-remote sites
- At least once every seven days for remote sites

Remote sites are defined as those more than 30 miles from the primary supervising physician's principal practice location.

This requirement must be accommodated except in extraordinary circumstances. The clinic must fully document any extraordinary circumstances that prevent it from meeting this requirement.

When not physically present, the physician must be available at all times through direct telecommunication for consultation, assistance with medical emergencies or patient referral.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Provider Audit Program within the 30 calendar days timeframe of the change of ownership.

- The clinic must be a licensed federally recognized RHC enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, but not limited to, patient management, 24-hour coverage, and other program requirements.
- The RHC and or site must be opened a minimum of 40 hours per week and the physician must practice at the location of 40 hours per week to be considered a Full Time Equivalent (FTE)
- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of a total patient caseload will be allowed based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension. If the clinic is solely run by mid-level practitioners, then the FTP equivalent of those mid-level personnel will be applied against the 1200 maximum caseload.
- The RHC must specify what arrangements have been made for hospital admissions. If physicians within the RHC do not have admitting privileges, then the designee must be specified. If the RHC/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1st** enrollees including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1st** Program should be listed on the enrollment form.

32.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

32.2.1 Covered Services

Rural health clinic visits and inpatient physician services are subject to the same routine benefit limitations as for physicians. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

The following services are covered in the provider-based rural health clinic:

- Medically necessary diagnostic and therapeutic services and supplies that are an incident to such services or as an incident to a physician's service and that are commonly furnished in a physician's office or a physician's home visit.
- Basic laboratory services essential to the immediate diagnosis and treatment of the patient that must include but are not limited to the following six tests that must be provided directly by the rural health clinic:
  - Chemical examinations of urine by stick or tablet methods or both (including urine ketones)
  - Hemoglobin or hematocrit
  - Blood glucose
  - Examination of stool specimens for occult blood
  - Pregnancy tests
  - Primary culturing for transmittal to a certified laboratory
- Medical emergency procedures as a first response to life threatening injuries and acute illness.
- Provider based rural health services may be provided by any of the following individuals:
- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, or registered nurse

The physician, physician assistant, nurse practitioner, certified nurse midwife, or registered nurse must conform to all state requirements regarding the scope or conditions of their practice.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

A nurse practitioner, physician assistant, or certified nurse midwife must furnish patient care services at least fifty (50%) percent of the time the clinic operates.

32.2.2 Reimbursement

PBRHC services are reimbursed by an all-inclusive encounter rate. All services provided for that date of service will be included in the encounter rate. If a recipient only has lab or x-rays, this will also constitute an encounter.

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Surgical procedures performed in place of service 21 (inpatient) or place of service 22 (outpatient) will be reimbursed fee-for-service.

Contacts with one or more health professionals and multiple contacts with the same health care professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

Reimbursement for an enrolled out-of-state PBRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state PBRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

NOTE:

Since PBRHC providers are reimbursed by an all-inclusive encounter rate, PBRHC providers will not receive the case management fee paid to Patient 1st providers nor the capitation fee for lock in recipients.

NOTE:

The dispensing fee for birth control pills is a non-covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First women can go to their local pharmacy to receive their contraceptive method if they choose to do so. The Plan First recipient must receive a prescription from their private provider. A 30-day supply is the maximum that may be dispensed at one time.

The Plan First recipient will still have the option of obtaining family planning services from the Alabama Department of Public Health along with oral contraceptives, the contraceptive ring, or the contraceptive patch. To receive contraceptive product from the Health Department, the Plan First-eligible patient must have been seen first by the health department. A 12 month supply of contraceptive products may be dispensed at one time.

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

Contraceptive counseling will be provided to all patients by the health department. Patients who have not received a risk assessment for care coordination will be offered this service at time of contraceptive pick up.

NOTE:

Effective 5/1/2012, Rural Health Centers may submit claims for Mirena®, Paragard®, and Implanon® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:

Mirena® – J7302

Paragard® – J7300

Implanon® – J7307

In order for PBRHC's to be eligible to bill Plan First visits, they are required to be enrolled in Plan First. The Plan First visit will be reimbursed at the encounter rate when billed.

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

1st Look - The Oral Health Risk Assessment and Dental Varnishing Program

Effective January 1, 2009 Medicaid will cover the application of fluoride varnishes for children 6 months through 35 months of age who have a moderate to high caries risk based on the risk assessment by **Patient 1st medical providers and their clinical staff (RNs, PAs, Nurse Practitioners, LPNs).** This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals, a specialty indicator will be added to the provider file in order for the provider to receive reimbursement.

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

32.3 Prior Authorization and Referral Requirements

Procedure codes billed by rural health providers generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

32.4 Cost Sharing (Copayment)

The copayment amount $3.90 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

Providers may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

NOTE:

Medicaid copayment is NOT a third party resource. Do not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For provider-based rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate established by Medicaid.

32.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Provider-based rural health clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

32.5.1 Time Limit for Filing Claims

Medicaid requires all claims for provider-based rural health clinics to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

32.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

32.5.3 Procedure Codes and Modifiers

NOTE:

Provider based rural health provider should refer to Chapter 28, Physician, for procedure code information.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, or ear stick) and Q0091-90 for collection of Pap smear specimen.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities. Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

Preventive Health

Procedure Code	*Description*
S9445	Prenatal Education (limited to 12 classes per recipient within 2-year period)
99412	Adolescent Pregnancy Prevention Education

32.5.4 Place of Service Codes

The following place of service codes apply when filing claims for provider-based rural health clinics:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility

32.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.8, Required Attachments, for more information on attachments.

32.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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