TABLE OF CONTENTS

CHAPTER EIGHT

INDEPENDENT RURAL HEALTH CLINIC SERVICES

Chapter 8. Independent Rural Health Clinic Services

Rule No. 560-X-8-.01. Independent Rural Health Clinic Services.

(1) Independent Rural Health Clinics must be Medicare certified and contracted with the Alabama Medicaid Program, and be in compliance with Federal, State and Local Laws.

(2) Services covered under the Independent Rural Health Clinic program are any medical service typically furnished by a physician in an office or in a physician home visit. Limits are the same as for the Physician Program.

(3) Independent Rural Health Clinic services are reimbursable if:

(a) performed by a physician,

(b) performed by nurse practitioner, physician assistant, certified nurse midwife, or clinical social worker as an incident to a physicians service,

(c) a physician, nurse practitioner, physician assistant, or certified nurse midwife is available to furnish patient care at all times the clinic operates,

(d) a nurse practitioner, physician assistant, or certified nurse midwife is available to furnish patient care at least 50 percent of the time the clinic operates.

(4) Independent Rural Health Clinic services must also conform to any state requirements for the nurse practitioner, physician assistant, and certified nurse midwife regarding the scope or conditions of their practice.

(5) The Independent Rural Health Clinic must be under the medical direction of a physician. Except in extraordinary circumstances, the physician must be physically present for sufficient periods of times, at least every 72 hours for non-remote sites and every seven (7) days for remote sites (a remote site being defined as a site more than 30 miles away from the primary supervising physician's principal practice location), to provide medical care services, consultation, and supervision in accordance with Medicare regulations for Rural Health Clinics. When not physically present, the physician must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances must be documented in the records of the clinic.

(6) The fiscal agent will be responsible for enrolling all Title XVIII (Medicare) certified Independent Rural Health Centers that wish to enroll as Qualified Medicare Beneficiary (QMB) only providers.

(7) In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment, an Independent Rural Health Clinic (IRHC) must:

(a) Request an enrollment packet from Fiscal Agent as an IRHC Provider. Services to be provided should be identified in the enrollment application.

(b) Submit a copy of the following documentation of Medicare certification; the Centers for Medicare and Medicaid Services (CMS) letter assigning the Medicare Provider number and establishing the initial encounter rate. A copy of the

facilities budget cost report must be sent to Medicaid's Alternative Services Division.

(c) Submit a copy of the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver.

(d) Be operating in accordance with applicable Federal, State, and local laws.

(e) Certify compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and with the Age Discrimination Act of 1975.

(f) Execute a provider contract with the Alabama Medicaid Agency.

(8) The effective date of the enrollment of an IRHC will be the latter of the following: the first day of the month in which the written request for enrollment was received; or the date of Medicare certification.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services
Statutory Authority: State Plan; 42 C.F.R. Section 491.8, Et seq.; Title XIX, Social Security Act; Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360); Section 6213 of the Omnibus Budget Reconciliation Act of 1989.
History: Rule effective October 1, 1982. Rule amended July 13, 1989, June 14, 1990, May 13, 1993, September 11, 1993, March 14, 1996 and August 11, 1997. **Amended:** Filed January 18, 2002; effective April 18, 2002. **Amended:** Filed July 21, 2003; effective October 16, 2003.

Rule No. 560-X-8-.02. Other Ambulatory Services.

(1) The following services are covered as other ambulatory services furnished in an Independent Rural Health Clinic and are not billed as Rural Health Clinic services:

(a) Dental Services;
(b) Eyeglasses;
(c) Hearing aids;
(d) Prescribed devices;
(e) Prosthetic devices; and
(f) Durable medical equipment.

(2) The services listed in Rule No. 560-X-8-.02 (1) are covered separately under the respective program areas reimbursement practices. Refer to the Administrative Code Chapters 15, 17, 19, 13, 14, 43, 11, and 50 respectively for enrollment procedures and policies.

Authority: State Plan; Attachment 3.1-A, Page 1.2.;42 C.F.R. Section 401, et seq.; Section 440.20; Title XIX, Social Security Act. Rule effective October 1, 1982. Rule amended May 13, 1993. Effective date of this amendment is January 12, 1995.

Rule No. 560-X-8-.03. Reimbursement.

Independent Rural Health Clinics will be reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by Medicaid.

Encounters are all-inclusive and all services provided for the visit are included in the reimbursement rate. The only exceptions are claims for laboratory services and for the technical component of EKGs and radiology services.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: 42 C.F.R., Section 447.371, et seq.; State Plan for Medical Assistance, Attachment 4.19-B, page 1.
History: Rule effective October 1, 1982. Amended December 6, 1984, May 13, 1993, and May 16, 2001. Amended: Filed January 18, 2002; effective April 18, 2002.
Amended: Filed May 20, 2005; effective August 16, 2005.

Rule No. 560-X-8-.04. Change of Ownership.
Medicaid must be notified within thirty (30) days of the date of Independent Rural Health Clinic ownership change. The existing contract will be automatically assigned to the new owner, and the new owner shall then be required to execute a new contract with Medicaid as soon as possible after the change of ownership, but in no event later than thirty (30) days after the new owner receives notification of Medicare certification. If the new owner fails to execute a new contract with Medicaid within this time period, then this contract shall terminate.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq.
Rule effective October 1, 1982. Effective date of this amendment is May 13, 1993.

Rule No. 560-X-8-.05. Medicare Deductible and Coinsurance.
Deductible and/or Co-insurance will be reimbursed up to the full amount of the Medicaid encounter rate.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Title XIX, Social Security Act; 42 C.F.R. Section 405.2425.
History: Rule effective October 1, 1982. Amended October 13, 1987. Amended: Filed January 18, 2002; effective April 18, 2002.

Rule No. 560-X-8-.06. Copayment (Cost-Sharing).

(1) Medicaid and Medicare/Medicaid related recipients are required to pay and independent rural health clinics are required to collect the established copayment amount for each clinic encounter.

(2) The cost-sharing requirement does not apply to services provided for the following:

(a) Recipients under 18 years of age;
(b) Emergencies;
(c) Pregnancy;
(d) Family Planning;
(e) Nursing home residents;
(f) America Indians

(3) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: 42 C.F.R. Section 447.50, Section 447.53, Section 447.55, et seq.; State Plan, Attachment 4.18-A.
History: Rule effective June 8, 1985. Effective date of this amendment is May 13, 1993. Amended Filed October 20, 2010; effective February 22, 2011.

Rule No. 560-X-8-.07. Billing Recipients.

(1) A provider agrees to accept as payment in full the amount paid by the State, plus any copayment amount required to be paid by the recipients, for covered items and further agrees to make no additional charge or charges for covered items to the recipient.

(2) A provider may bill the recipient for the copayment amount and for noncovered Medicaid services.

(3) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Authority: 42 C.F.R. Section 447.15; State Plan, Attachment 4.18-A. Rule effective June 8, 1985.