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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

Gainwell 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-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate 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-validate, 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.

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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.

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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 PCP 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)
- 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-**Alabama Coordinated Health Network (ACHN)** 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 **ACHN** Program should be listed on the enrollment form.

School Campus Facility

Provider-Based Rural Health Clinics may enroll as a School Campus Facility using specialty type 082. This is for informational purposes only.

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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.

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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.

As described in Section 1902(aa) of the Social Security Act, PBRHCs will be paid under a prospective payment system rate (PPS rate) effective January 1, 2001. The rate setting period is from October 1 through September 30th. Each PBRHC is entitled to the payment amount (on a per visit basis) to which the PBRHC was entitled to in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the PBRHC during that fiscal year.

If a service has been eliminated, the Health Center must notify Medicaid that they have discontinued a given service. Medicaid must be notified in writing within ninety (90) calendar days of any termination of service(s). The notification of discontinued service must include the 12-month cost report for the discontinued service leading up to the termination of the service. The Agency may request additional documentation. An elimination of a service or services will not result in a rate adjustment unless the elimination has a cost impact of 3%. Failure to notify Medicaid of a termination of service may result in recoupment of paid claims.

PBRHC services and other ambulatory services provided at the PBRHC will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 60, for details.

Change in Scope (CIS)

A PBRHC may request that their PPS rate be adjusted to take into account a change (either increase or decrease) in the scope of services furnished by the PBRHC. A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a PBRHC visit. Change in Scope requests must meet regulatory compliance as required by state and federal law as it relates to the operation of PBRHC services provided under the Alabama Medicaid (“Medicaid”) Program.

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A change in scope request must be sent to the Managed Care Operations Division for review. The request must specifically state what PBRHC service was changed, and specifically detail how the type, intensity, duration, or amount of that service has changed. Medicaid will not review the CIS request until a complete submission is received. A complete submission includes the documentation listed below. The CIS request must be submitted to the Agency no later than 180 days (six months) after the Health Clinic's fiscal year end. The request shall include, at a minimum, the following items clearly labeled and identified documentation:

1. Narrative of the Qualifying Event or Events including a description of the Event or Events and other relevant information such as the locations affected, the date new services began, time period over which the changes took place or how patients are impacted; any relevant supporting documentation should also be provided. The Health Clinic must specify their fiscal year period in the narrative that will be submitted with the CIS request. Failure to disclose the fiscal year in the narrative will result in an incomplete submission.
2. A CIS Medicaid cost report with at least 12-months of actual expenses associated with the requested change in scope
    - The Medicaid cost report must reflect ALL clinic visits. Also, initial supporting documentation must include the following:
        - General Ledger Detail (in excel format) for the period under audit
        - Trial Balance (in excel format)
        - Crosswalk of Trial Balance accounts to Medicaid cost report line item
        - Medicare Cost Report for period(s) consistent with the Medicaid Cost Report
3. The PBRHC's proposed PPS rate with detailed documentation of how the proposed PPS rate was derived or calculated.
4. A listing of deleted services not reported to Medicaid, if applicable. Listing must include the deleted service and the date the service was deleted.

The Medicaid Agency may request more documentation or clarification of the documentation provided. If the PBRHC fails or refuses to provide the documentation requested by the Medicaid Agency, the change in scope request may be denied. PBRHCs may submit one CIS request within 12-months of the last submitted CIS request.

NOTE:

A deletion in service(s) does not count towards the 12-month CIS submission limitation.

The Agency will notify the Health Clinic within seven days of receipt of a CIS request. If the Health Clinic does not receive a response within seven days, it is the Health Clinic's responsibility to reach out to the Agency regarding receipt of the CIS request. The Agency will review the CIS request to determine if the CIS request is complete. The Agency will notify the Health Clinic within 30 days regarding the completion status of the CIS request. The Agency will notify the Health Clinic within 60 days from CIS submission completion date of the

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qualifying events that do or do not meet the definition of a change in the scope of service as defined by Medicaid.

A change in the scope of service occurs if the PBRHC has added or discontinued any service that meets the definition of PBRHC services as provided in Section 1905(a) (2) (B) and (C) of the Act, ***and*** the service is included as a covered Medicaid service under the Alabama Medicaid State Plan. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of services compared to the services offered at the time of the last change of scope rate adjustment.

Type- the FQHC/RHC has added or dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a) (2) (B) and (C) of the Social Security Act or if the service is included as a covered Medicaid service in the State Plan.

Intensity- a change in the characteristics of services offered in an average visit such that the average patient receives a different array of services.

Amount- an increase or decrease in the quantity of services that an average patient receives in an average visit.

Duration- a change in the average length of time it takes medical providers to complete an average patient visit due to changing circumstances.

A change in scope review will not take increased costs or inflation into account. Further, Patient-Centered Medical Home (PCMH) certification will not qualify for a rate adjustment. When the cost of the changed service has been determined, the incremental/decremental rate adjustment to the individual service will be combined into the overall PPS rate thereby calculating a revised encounter rate. Only the services that changed will be included in the PPS rate calculation during the change in scope request review. If the new PPS rate results in an overall increase or decrease of at least 3 percent of the PPS rate at the time Medicaid receives the change in scope request, then the PPS rate will be adjusted. The effective date of the new PPS rate will be the first day of the month that the Medicaid Agency receives a completed CIS request. The Agency will notify the health clinic within 30 days if the CIS request is complete or not. A complete submission includes the documentation listed above.

NOTE:

For example: if a CIS request is received on March 31, but does not contain all required information, it will be returned. On May 15th, the Agency receives the resubmitted CIS request with all required documentation, therefore the effective date will be May 1st.

The PBRHC must demonstrate the following:

- a cost impact per qualifying event or a combination of more than one qualifying event and
- the incremental cost impact per visit to the change in scope of service.

Any costs supporting the rate adjustment must be allowable for PBRHCs under the Administrative Code Chapter 60- Provider-Based Rural Health Clinic

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Reimbursement. The calculated incremental cost per visit of the change in scope will be applied to the PPS rate currently in effect.

A Change in Scope request may take more than a period of one year to process; however, the Agency anticipates processing change in scope requests within 6 months. For additional information, please contact the Managed Care Operations Division.

NOTE:

New PPS rates due to an approved change in scope will be based on the incremental and/or decremental costs of the qualifying event(s) that meet the definition of a change in scope of service.

Family Planning

- Family planning services are services provided to prevent or delay pregnancy.
- The Plan First visit will be reimbursed at the encounter rate when billed.
- Complete guidelines for family planning are in the Provider Billing manual, Appendix C.

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

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 ACHN Program, refer to Chapter 40, to determine whether your services require a referral from the Primary Care Physician (PCP).

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.

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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.

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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.

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

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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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