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36 Rural Health Clinics/Independent

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.

Independent rural health clinics (IRHC) are physician-owned. These clinics are reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by Medicaid.

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

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 8, for policy provisions for independent rural health clinic providers

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

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.

Rural health clinics are assigned a provider type of 58 and specialty of 081.

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Physicians affiliated with rural health clinics are enrolled with a 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's NPI, and are not assigned individual NPIs.

Enrollment Policy for Independent Rural Health Clinics

To participate in the Alabama Medicaid Program, independent rural health clinic (IRHC) providers must meet the following requirements:

- Submit a copy of the following documentation of Medicare certification: the Centers for Medicare and Medicaid Services (CMS) letter assigning the NPI.
- Submit a copy of the clinics budgeted cost report to Medicaid Alternative Services program to establish the reimbursement rate.
- Submit a copy of the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver.
- Operate in accordance with applicable federal, state, and local laws.

The effective date of enrollment of an independent rural health clinic will be the date of Medicare certification. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by Medicaid's Fiscal Agent.

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 30 days of the change of ownership.

School Campus Facility

IRHCs may enroll as a School Campus Facility using specialty type 082. This is for informational purposes only.

36.2 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.

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36.2.1 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.

Independent rural health clinic services are reimbursable if they are provided by any of the following individuals:

- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, registered nurse, or clinical social worker as an incident to a physician's service

The physician, physician assistant, nurse practitioner, certified nurse midwife, registered nurse or clinical social worker 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 for Medicaid reimbursement.

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

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.

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.

36.2.2 Reimbursement

IRHC 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.

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

As described in Section 1902(aa) of the Social Security Act, IRHCs 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 IRHC is entitled to the payment amount (on a per visit basis) to which the IRHC 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 IRHC 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. This decrease in the scope of services furnished will result in a recalculation of the PPS rate. Failure to notify Medicaid of a termination of service may result in recoupment of paid claims.

IRHC services and other ambulatory services provided at the IRHC will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 56, for details.

Change in Scope (CIS)

An IRHC 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 IRHC. A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a IRHC visit. Change in Scope requests must meet regulatory compliance as required by state and federal law as it relates to the operation of IRHC services provided under the Alabama Medicaid (“Medicaid”) Program.

A change in scope request must be sent to the Managed Care Operations Division for review. The request must specifically state what IRHC 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

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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 IRHC'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 IRHC fails or refuses to provide the documentation requested by the Medicaid Agency, the change in scope request may be denied. IRHCs 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 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 IRHC has added or discontinued any service that meets the definition of IRHC 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)

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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 IRHC 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 IRHCs under the Administrative Code Chapter 56. 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.

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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.
- Intrauterine Devices are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.
- The Plan First visit will be reimbursed at the encounter rate when billed.
- For additional information, see Medicaid's Provider Manual Appendix C.

Smoking cessation products (under Family Planning) are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.

Deliveries are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.

Services are billable and reimbursable outside of the encounter rate under the non-IRHC National Provider Identifier (NPI) and on a separate claim include:

- Surgeries with place of service code 21 or 22
- Technical component for: Electrocardiograms (EKG's) and Radiology

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

For IRHCs reimbursement for these services will be included in the office visit and will not be paid separately.

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

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

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36.4 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. Does not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For independent rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate, established by Medicaid. Please refer to Chapter 5, Filing Claims, for additional information.

36.5 Completing the Claim Form

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

Independent 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.

36.5.1 Time Limit for Filing Claims

Medicaid requires all claims for independent 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.

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36.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes.

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.

36.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed 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.

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

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories 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.

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

Labs are billable and reimbursable outside of the encounter rate utilizing the non-IRHC National Provider Identifier (NPI) and on a separate claim.

Encounters are all-inclusive. All services provided for the encounter are included in the reimbursement rate for the encounter.

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

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.

To receive the IRHC encounter rate:

- Itemize the billing services performed
- Utilize the Current Procedure Terminology (CPT) Code Book
- Document medical support in the recipient chart to justify level of care billed
- Submit a clean claim (refer to Provider Manual Chapter 5)
- Utilize the IRHC National Provider Identifier (NPI)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under 21 years of age. See Appendix A in Medicaid's Provider Manual for additional information.

EPSDT Vision Screenings, Hearing Screens, Cognitive Screenings, and Behavioral Assessments are reimbursable utilizing the IRHC National Provider Identifier (NPI). Claims that are billed using the non-IRHC number for reimbursement will be monitored on a post payment review process. Claims that are filed and paid with these procedures outside of the encounter rate will be subject to recoupment.

Vaccines For Children (VFC)

- Refer to Appendix A, EPSDT, for procedure codes for VFC.
- Vaccines are reimbursable outside of the encounter rate utilizing the IRHC National Provider Identifier (NPI) and on a separate claim.

36.5.4 Place of Service Codes

The following place of service codes apply when filing claims for independent rural health clinics:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital

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POS Code	*Description*
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility

36.5.5 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.

36.6 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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