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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 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

HP 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.

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

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

NOTE:

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

Medicaid must be notified within 30 calendar days of the date of an IRHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

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 day timeframe.

Patient 1st Requirements for Independent Rural Health Clinics

- 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 run solely 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.
- Patient 1st caseloads will be assigned to the IRHC assigned provider number (legacy numbers 541xxxxxx) and not the regular Medicaid Provider number assigned used to bill for lab and X-Ray services

NOTE:

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

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.

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 can not 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. (an Administrative Code Change is in the process of changing these guidelines.

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.

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

Effective November 1, 2009, the Plan First Contraceptive Order Form is discontinued. Plan First women will able to 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.

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 comphrensive 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. For Independent Rural Health Centers 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's Dental Chapter 13.

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 Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

36.4 Cost Sharing (Copayment)

The copayment amount is $1.00 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.

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 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.

36.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These

manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 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

Services of the independent rural health clinics are limited to the procedures listed below. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

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.

Visits to a nursing home will be billed using the clinic visit procedure code 99211-SE with the appropriate nursing home place of service. These visits will count against the allowed 14 office visits per year.

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.

The only exception to all-inclusive encounters is claims for laboratory services and for the technical component for EKG's and radiology services. Rural Health Clinic providers should use their regular NPI.

Clinic Visit

Procedure Code	*Description*
99211-SE	Medical Encounter

Inpatient Hospital

Procedure Code	*Description*
99231-SE	Inpatient Hospital Encounter

EPSDT Codes

Procedure Code	*Description*
99381-EP	Initial EPSDT, Normal, under 1 year of age
99382-EP	Initial EPSDT, Normal, 1-4 years of age
99383-EP	Initial EPSDT, Normal, 5-11 years of age
99384-EP	Initial EPSDT, Normal, 12-17 years of age
99385-EP	Initial EPSDT, Normal, 18-20 years of age
99381-EP	Initial EPSDT, abnormal, under 1 year of age
99382-EP	Initial EPSDT, abnormal, 1-4 years of age
99383-EP	Initial EPSDT, abnormal, 5-11 years of age
99384-EP	Initial EPSDT, abnormal, 12-17 years of age
99385-EP	Initial EPSDT, abnormal, 18-20 years of age

Procedure Code	*Description*
99391-EP 99392-EP 99393-EP 99394-EP 99395-EP	Periodic EPSDT, normal, under 1 year of age Periodic EPSDT, normal, 1-4 years of age Periodic EPSDT, normal, 5-11 years of age Periodic EPSDT, normal, 12-17 years of age Periodic EPSDT, normal, 18-20 years of age
99391-EP 99392-EP 99393-EP 99394-EP 99395-EP	Periodic EPSDT, abnormal, under 1 year of age Periodic EPSDT, abnormal, 1-4 years of age Periodic EPSDT, abnormal, 5-11 years of age Periodic EPSDT, abnormal, 12-17 years of age Periodic EPSDT, abnormal, 18-20 years of age
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen
96110	Development Testing; limited; with interpretation and report (refer to Appendix A of the provider manual for specific guidelines)
99391	Interperiodic EPSDT, infant (age under one year) Deleted 12/31/2006
99392	Interperiodic EPSDT, early childhood (age 1-4) Deleted 12/31/2006
99393	Interperiodic EPSDT, late childhood (age 5-11)) Deleted 12/31/2006
99394	Interperiodic EPSDT, adolescent (age 12-17) Deleted 12/31/2006
99395	Interperiodic EPSDT, adult (age 18-20) Deleted 12/31/2006

NOTE:

Effective January 1, 2007 and thereafter, interperiodic screening codes have changed. The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

99211 EP through 99215 EP for office and/or outpatient interperiodic screenings

The new interperiodic screening codes will count against office visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child's primary insurance must be billed first, and then Medicaid as the payor of last resort.

See Appendix A for additional information regarding EPSDT Screening.

NOTE:

EPSDT vision and hearing screenings are performed in conjunction with a complete comprehensive screen and are limited to one per year for children 5-20 years of age.

Family Planning Codes

Procedure Code	*Description*
11975	Implant Insertion (limited to one per 365 days) Deleted as of 6-1-03
11976	Implant Removal (limited to one per 365 days)
11977	Implant Removal with Reinsertion (limited to one every five years) Deleted as of 6-1-03

Procedure Code	Description
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
57170	Diaphragm
58300	IUD Insertion
58301	IUD Removal
99401	HIV Pre-Test Counseling (Must be billed in conjunction with a family planning visit) - Limited to two per recipient per calendar year.
99402	HIV Post-Test Counseling (Must be billed in conjunction with a family planning visit) - Limited to two per recipient per calendar year.
J1055	Depo-Provera Shots 150 mg/ml, limited to one injection every 70 days
J1056	Medroxyprogesterone Acetate/Estradiol Cypionate
J7302	Levonorgestrel-releasing Intrauterine Contraceptive System
99205-FP	Initial Visit (limited to one per recipient per family planning provider)
99214-FP	Annual Visit (limited to one per recipient per calendar year)
99213-FP	Periodic Visit (limited to four services per calendar year)
99347-FP	Home Visit
99212-FP	Extended Family Planning Counseling (limited to one service during 60-day post-partum period)
Z5270	Norplant Capsules Kit Deleted as of 6-1-03
Z5272	Implant Physical with Counseling Visit Deleted as of 6-1-03
S4989	Hormonal IUD (Progestesert)
J7300	Mechanical IUD (Paragard)

Prenatal Description

Procedure Code	Description
99212-HD	Prenatal Clinic Visit deleted 1-1-06
59430	Postpartum Clinic Visit deleted 1-1-06

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

NOTE:

Medical encounter (99211-SE) counts against the physician yearly benefit limitations. More than one encounter may not be billed on the same date of service.

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

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 5.7, 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	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
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