



# **RURAL HEALTH CLINICS**

## ***Chapter Forty of the Medicaid Services Manual***

**Issued December 1, 2010**

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana  
Bureau of Health Services Financing**

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### **OVERVIEW**

The Rural Health Clinic (RHC) program was established through the RHC Act of 1977 to address an inadequate supply of primary health care providers who serve Medicare and Medicaid beneficiaries in rural areas. The program provides qualifying clinics located in rural and medically underserved communities with a prospective reimbursement methodology described under Section 1902(bb) of the Social Security Act.

RHCs may be either provider-based clinics or independent clinics. The provider-based RHC is considered an integral part of a rural hospital, nursing home or home health agency that is a Medicare certified provider. An independent RHC is any other clinic which meets the requirement to be classified as a RHC and is owned and operated by any entity as long as it is not operated as a rehabilitation agency or a facility primarily for care and treatment of mental diseases.

All RHC services provided by qualified individuals employed by or under contract with an RHC are billed using the organization's provider number (e.g., RHC's National Provider Identifier (NPI), RHC's Medicaid identification (ID) number for each location) and Tax Identification Number (TIN).

The purpose of this chapter is to set forth the conditions and requirements that RHCs must meet in order to qualify for reimbursement under the Louisiana Medicaid program. The manual is intended to make available to Medicaid providers of RHC services a ready reference for information and procedural material needed for the prompt and accurate filing of claims for services furnished to Medicaid beneficiaries.

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) is responsible for assuring provider compliance with these regulations.

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**COVERED SERVICES**

A Rural Health Clinic (RHC) agrees to provide those primary care services typically included as part of a physician's medical practice. Services and supplies that are furnished by RHC staff and are incident to the RHC professional service are considered part of the RHC service. An RHC can also provide services related to the diagnosis and treatment of mental illness, and, in certain instances, visiting nurse services.

The following RHC reimbursable services are referred to as core services:

1. Physician services;
2. Services and supplies incident to physician's services;
3. Physician assistant services;
4. Nurse practitioners (NPs) and certified nurse mid-wife services;
5. Services and supplies incident to the services of NPs, physician assistants, and certified nurse mid-wives;
6. Visiting nurse services to the homebound;
7. Clinical psychologist services;
8. Clinical social worker services;
9. Services and supplies incident to the services of clinical psychologists and clinical social workers; and
10. Basic lab services.

**NOTE:** For reimbursement purposes, a service visit must be provided in order for a provider to be paid a Prospective Payment System (PPS) rate. (See Section 40.4 of this manual chapter for more information about reimbursement).

**Physician Services**

Physician services are the professional services performed by a licensed physician for a beneficiary including diagnosis, therapy, surgery, and consultation.

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Physician services are covered if they are professional services performed by a physician at the clinic; or performed away from the clinic if the physician has an agreement with the clinic to be paid for the services. The services must be within the scope of their professional license under Louisiana law.

**Services and Supplies Incident to a Physician's Professional Services**

Services and supplies incident to a licensed physician's professional service are covered if the service or supply is furnished:

1. In a physician's office;
2. Either without charge or included in the clinic's bill;
3. As an incidental, although integral, part of a physician's professional services;
4. Under the direct, personal supervision of a physician; and
5. By a member of the clinic's health care staff who is an employee of the clinic.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

**Physician Assistant Services**

A physician assistant is eligible to enroll in Medicaid and must obtain a provider number and use it on the billing form when performing services or prescribing drugs. Physician assistant services are covered if:

1. Furnished by a licensed physician assistant who is employed by or receives compensation from the clinic and is enrolled in the Louisiana Medicaid program;
2. Identified by placing their provider number in the attending licensed physician space on the CMS 1500;
3. Furnished under the medical supervision of a licensed physician. The physician supervision requirements are met if the conditions specified and any pertinent requirements of state law are satisfied;
4. Furnished in accordance with medical orders for the care and treatment of a patient prepared by a physician;

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5. Consistent with the type of service the physician assistant is legally permitted to perform; and
6. Services are covered by Medicaid.

**Nurse Practitioner and Certified Nurse Mid-wife Services**

Services are covered if the following criteria are met:

1. Furnished by a licensed NP or certified nurse mid-wife who is employed by or receiving compensation from the clinic;
2. Provider is enrolled in Louisiana Medicaid;
3. Provider is identified by placing their provider number in the attending physician space on the CMS 1500;
4. Furnished in collaborative practice with a licensed physician. The physician supervision requirement is met if the conditions specified and any pertinent requirements of State law are satisfied;
5. Furnished in accordance with any medical orders for the care and treatment of a patient prepared by a physician;
6. Performed by a licensed NP or certified nurse mid-wife, who is legally permitted to provide this type of service; and
7. Services are covered by Medicaid.

NPs and certified nurse mid-wives are eligible to enroll in Medicaid and must obtain a provider number and use it on the billing form when performing services or prescribing medications.

**Services and Supplies Incident to Physician Assistant, Nurse Practitioner and Nurse Mid-wife Services**

Services and supplies incident to a NP, nurse mid-wife or physician assistant services are covered if the following criteria are met:

1. Furnished in a licensed medical provider's office;



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2. Rendered either without charge or included in the clinic's bill;
3. Furnished as an incidental, although integral part of professional services furnished by NP, physician assistant or certified nurse mid-wife;
4. Furnished under their direct, personal supervision. The direct personal supervision requirement is met only if the person is permitted to supervise these services under the written policies governing the clinic; and
5. Furnished by a member of the clinic's health care staff who is an employee of the clinic.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

**Visiting Nurse Services**

Part time or intermittent visiting nurse care and related supplies are covered if the following criteria are met:

1. The clinic is located in an area designated by CMS as a home health agency shortage area;
2. The services are rendered to a homebound individual. For purposes of visiting nurse services, "homebound" means a Medicaid beneficiary who is permanently or temporarily confined to their place of residence because of a medical or health condition. The individual may be considered homebound if they leave the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or skilled nursing facility;
3. The services are furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN) or a licensed vocational nurse, who is employed by or received compensation for the services from the clinic; and
4. The services are furnished under a written plan of treatment.

**Plan of Treatment**

The plan of treatment must be established and reviewed at least every 60 days by a supervising physician of the clinic or established by a physician, NP, physician assistant or certified nurse mid-

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wife, or specialized NP. The plan must be signed by the NP, physician assistant, certified nurse midwife or the supervising physician of the clinic.

The plan of treatment must relate visiting nurse services to the beneficiary's condition. The plan must specify the following:

1. Types of services required and a prognosis for changes in the beneficiary's condition;
2. Diagnosis and a description of the beneficiary's functional limitations resulting from the illness or injury;
3. Type and frequency of nursing services needed;
4. Special diets;
5. Activities permitted;
6. Rehabilitation and therapy services;
7. Medical social services;
8. Home health aide services; and
9. Necessary medical supplies.

All changes in orders for controlled substances drugs, must be signed by the licensed physician.

**Clinical Psychologist Services**

Clinical psychologist services refer to services performed by a licensed clinical psychologist for diagnosis and treatment of mental illness which the clinical psychologist is legally authorized to perform under state licensure as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

**Clinical Social Worker Services**

Clinical social worker services refers to services performed by a licensed clinical social worker (LCSW) for diagnosis and treatment of mental illness which the clinical social worker is legally authorized to perform under state licensure and such services as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

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**Services and Supplies Incident to the Services of Clinical Psychologists and Clinical Social Workers**

Services are covered if furnished:

1. In a physician's office;
2. Either without charge or included in the clinic's bill;
3. As an incidental, although integral part of professional services furnished by a Clinical Psychologist or Clinical Social Worker;
4. Under their direct, personal supervision. The direct personal supervision requirement is met only if the person is permitted to supervise these services under the written policies governing the clinic; and
5. By a member of the clinic's health care staff who is an employee of the clinic.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

**Basic Lab Services**

An RHC is required to provide the following minimum lab services on site:

1. Chemical examinations or urine by stick or tablet methods, or both;
2. Hemoglobin or hematocrit;
3. Blood sugar;
4. Examination of stool specimens for occult blood;
5. Pregnancy tests; and
6. Primary culturing for transmittal to a certified laboratory.

If the RHC performs only these six tests, the RHC may obtain a waiver certificate from the regional Clinical Laboratory Improvement Act (CLIA) office.

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If an RHC provides more than the basic lab services on site, it must comply with CLIA requirements for the lab services actually delivered.

**Other Ambulatory Services**

Other ambulatory services that may be provided by a RHC include non-primary care services covered by the Louisiana Medicaid State plan, but not included in the RHC's core services. These services may be provided by the RHC if the RHC meets the same standards as other enrolled providers of those services. Examples include the following:

1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for beneficiaries under the age of 21;
2. Vision care services (for beneficiaries under the age of 21);
3. Speech and language services (for beneficiaries under the age of 21);
4. Hearing services (for beneficiaries under the age of 21);
5. Dental services;
6. Podiatry services;
7. Pregnancy-related services;
8. Perinatal case management;
9. Chiropractic services;
10. Nutrition counseling as part of an encounter;
11. Family planning services;
12. Physical and occupational therapy services;
13. Behavioral health services provided by licensed professional counselors (LPCs) and licensed family and marriage therapists (LMFTs); and
14. Community Health Worker (CHW) services.

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The above services are governed by Medicaid policies and procedures specific to each program. The policies and procedures for the RHC services program do not apply to these “other” ambulatory services. Billing must be submitted according to the policies and procedures for each program. With the exception of CHW services, all other service visits will be reimbursed at the all-inclusive PPS rate per visit. (See Section 40.4 of this manual chapter for more information about reimbursement). CHW services are reimbursed at the rate on file for the date of service, in addition to the PPS rate per visit.

**Diabetes Self-Management Training**

Diabetes self-management training (DSMT) is provided to beneficiaries diagnosed with diabetes. These services are comprised of 1 hour of individual instruction and 9 hours of group instruction on diabetes self-management. Beneficiaries shall receive up to 10 hours of services during the first 12-month period beginning with the initial training date. After the first 12-month period has ended, beneficiaries shall only be eligible for 2 hours of individual instruction on diabetes self-management per calendar year.

**Fluoride Varnish Applications**

Coverage shall be provided for fluoride varnish applications performed in the RHC to beneficiaries from under 21 years of age based on medical necessity. Fluoride varnish applications will be reimbursed when performed in the RHC by:

1. The appropriate dental providers;
2. Physicians;
3. Physician assistants;
4. NPs;
5. RNs;
6. LPNs; or
7. Certified medical assistants.

All participating staff must review the Smiles for Life training module for fluoride varnish and successfully pass the post assessment. All staff involved in the varnish application must be deemed as competent to perform the service by the RHC and be practicing within the licensed practitioner’s scope of practice.

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Fluoride varnish applications shall only be reimbursed to the RHC when performed on the same date of service as an office visit or preventative screening. Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit.

**Services Not Covered**

1. Injections ordered incident to a previous face-to-face encounter (these injections would be incident to the initial encounter and part of the PPS reimbursement of the initial encounter which warranted the injection);
2. Medications provided by a pharmacy that is not part of the RHC;
3. Weight or blood pressure check only;
4. Services for which medical necessity is not clearly established;
5. Information provided to a patient over the telephone;
6. Cosmetic surgery;
7. A visit for the sole purpose of a patient obtaining a prescription when the need for the prescription has already been determined;
8. Canceled visits or for appointments not kept;
9. Foot care such as routine soaking and application of topical medication;
10. Transsexual surgery or a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis; and
11. Tattoo removal.

**Encounter**

Medical (inclusive of DSMT services) encounters are defined as face-to-face visits with a physician, physician assistant, NP, certified nurse mid-wife, or visiting nurse during which a RHC service is rendered. Behavioral health encounters are defined as face-to-face visits with a physician with a psychiatric specialty, NP with a psychiatric specialty, clinical nurse specialist with a psychiatric specialty, licensed clinical psychologist, LCSW, licensed professional counselor,

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LMFT, respectively, during which an RHC behavioral health service is rendered. A behavioral health with the exception of certain provider/specialty combinations identified in Section 40.1 of this manual under “Service Limits.” Specific services must be rendered in order to bill a behavioral health encounter. The submission of an evaluation and management code only will not suffice. A medical and a behavioral health encounter are allowed on the same day of service.

Multiple medical and/or behavioral health encounters, however, with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. When the beneficiary suffers illness or injury requiring additional diagnosis or treatment unrelated to the initial encounter visit, an additional medical and/or behavioral health encounter may be billed.

A dental encounter is defined as a face-to-face visit with a dentist where dental services are rendered. Multiple dental encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

**Multiple Same Day Visits**

Only one medical encounter (inclusive of DSMT encounters) per day per beneficiary, one behavioral health encounter per day per beneficiary, and one dental encounter per day per beneficiary may be billed except in cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

**Service Limits**

There are no annual limits placed on the number of rural health clinic visits (encounters) payable by the Medicaid program for eligible beneficiaries.

Services not defined as an RHC service or other ambulatory service rendered to Louisiana Medicaid beneficiaries are not permitted to be billed to the Louisiana Medicaid program.

Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

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**Exclusions**

Medicaid policy does not provide for payment of follow-up visits occurring on the same date as a previously billed visit, consultation, emergency room care or hospital admission date.

Any services “incident to” an encounter **are not** billable. These include, but are not limited to the following:

1. Injections (allergy, antibiotic, steroids, etc.);
2. Laboratory tests performed on site, Peak Flow and Spirometry, Respiratory Flow Volume Loop, electrocardiogram (EKG) testing and interpretation, and x-rays;
3. Immunizations;
4. Hearing/Vision screenings; and
5. Filling and/or obtaining prescriptions.

**Service Delivery**

Upon presentation at the clinic, a full mental, physical and dental assessment shall be performed that includes a written plan for each identified problem noted in the history and physical exam. Any health problems identified must be addressed to the highest degree possible. Encounters for beneficiaries under the age of 21 shall include all the aspects of a well-child screening visit unless:

1. The provider determines and documents that the child’s medical condition at the time of the visit contraindicates the well-child screening as inadvisable; or
2. The child’s medical record reflects that they are up to date on the well-child screenings in accordance with the Medicaid periodicity schedule.

**NOTE:** Service delivery for beneficiaries under the age of 21 includes the administration of required immunizations.

The medical encounter level of service must include **at a minimum:**

1. An expanded, problem-focused history (chief complaint, brief history of present illness, problem pertinent system review); and



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2. An expanded, problem-focused exam (limited exam of the affected body area or organ system and other symptomatic or related organ systems).

This would be low-level complexity of medical decision making (limited number of diagnoses, limited complexity of data to review, the risk of complications and management options- low).

A new patient medical encounter level of service shall include the following:

1. A detailed history (chief complaint, history of present illness, problem pertinent system review, pertinent past, family, social history); and
2. A detailed exam with low-to moderate complexity decision making.

The dental encounter level of service shall include **at a minimum**:

1. Comprehensive oral healthcare. Comprehensive oral healthcare is defined as all of the covered restorative and therapeutic services described in the *Medicaid Dental Services Manual*.

**NOTE:** Dental health preventive services should be rendered on the same day unless otherwise indicated due to identified medical issues preventing completion of all preventive services.

The behavioral health encounter level of service shall include **at a minimum**:

1. Face-to-face visits with a physician with a psychiatric specialty, NP with a psychiatric specialty, clinical nurse specialist with a psychiatric specialty, licensed clinical psychologist, or LCSW (exclusive of medication management only);
2. Face-to-face visit with a LPC or LMFT (exclusive of medication management only); and
3. A qualified service for the assessment, diagnosis and/or treatment of a behavioral health disorder to include services such as psychotherapy, mental health assessment, psychiatric evaluation, psychological testing. These services may be provided in combination with medication management as well.

**Behavioral Health Specific Service Delivery Limits**

The provider type/specialty combinations below are the only behavioral health providers allowed to be reimbursed for claims including an evaluation and management Healthcare Common Procedure Coding System (HCPCS) code as the only detailed line:

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<b>Provider Type</b>	<b>Provider Specialty</b>	<b>Description</b>
20	26	Psychiatrist
20	2W	Psychiatrist – Addictionologist
78	26	NP – Advanced Practice Registered Nurse (APRN)
93	26	Clinical Nurse Specialist - APRN
94	26	Physician’s Assistant
31	6G	Medical Psychologist

All other behavioral health provider type/specialty combinations require at least one qualified psychiatric service included as a detailed line on the claim.

## **PROVIDER REQUIREMENTS**

### **Location**

A Rural Health Clinic (RHC) must be located in an area defined by the United States Department of Commerce, Census Bureau as non-urbanized. The Census Bureau defines a non-urbanized area as an area outside an urbanized area with a densely settled territory that contains 50,000 or more people.

### **Shortage Area Designation**

A practice is eligible for initial RHC certification if it is located in an area “currently” designated as a Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA). The shortage area designation cannot be more than 3 years old to be considered current.

In order for RHCs to be eligible for HPSA facility designation, the clinic shall:

1. Not deny requested health care services, and shall not discriminate in the provision of services to an individual who is unable to pay for services or whose services are paid by the Medicare, Medicaid, or Children’s Health Insurance Program (CHIP);
2. Prepare a schedule of fees consistent with locally prevailing rates or charges;
3. Prepare a corresponding schedule of discounts (including waivers) to be applied to such fees or payments, with adjustments made on the basis of the patient’s ability to pay;
4. Make every reasonable effort to secure from patients the fees and payments for services, and fees should be sufficiently discounted in accordance with the established schedule of discounts;
5. Enter into agreements with the state Medicaid agency to ensure coverage of beneficiaries; and
6. Take reasonable and appropriate steps to collect all payments due for services.

### **Staffing**

An RHC is required to employ a mid-level provider such as a nurse practitioner (NP) or physician assistant at least 50 percent of the time the practice is open to see patients. RHC primary care services are to be provided by licensed physicians, licensed physician assistants, NPs, or nurse-

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midwives operating under the direct supervision of the RHC physician and within the scope of the physician extender's licensure or certification.

Direct supervision does not mean that the physician must be in the same room when services are rendered; however, the physician must be immediately available (at least by telephone) to provide direction or assistance when necessary.

Services of licensed clinical psychologists and clinical social workers are not required, but can be considered an RHC service when these personnel provide diagnosis and treatment of mental illness. These services must be included in the HPSA scope of service in order to receive reimbursement.

### **Commingling**

Commingling refers to the sharing of RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent the following:

1. Duplicate Medicare or Medicaid reimbursement (including situations where the RHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis); or
2. Selectively choosing a higher or lower reimbursement rate for the services.

RHC practitioners may not furnish RHC-covered professional services as a Part B provider while in the RHC or in an area outside of the certified RHC space, such as a treatment room adjacent to the RHC, during RHC hours of operation.

If an RHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC space must be clearly defined. If the RHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC and non-RHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit an RHC physician from providing on-call services for an emergency room, as long as the RHC would

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continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the physician with the hospital emergency department would not be a common occurrence.

The fiscal intermediary (FI) has the authority to determine acceptable accounting methods for allocation of costs between the RHC and another entity. In some situations, the practitioner's employment agreement will provide a useful tool to help determine appropriate accounting.

**Medicaid Enrollment Criteria**

To be eligible for enrollment in the Louisiana Medicaid program, the RHC must be an entity:

1. Receiving certification for participation in the Medicare program;
2. Receiving licensure/certification from the Louisiana Department of Health (LDH), Health Standards Section (HSS); and
3. Complying with the Clinical Laboratory Improvement Amendment (CLIA) for all laboratory sites, if applicable.

The FI will verify CMS enrollment via the Provider Enrollment, Chain, and Ownership System (PECOS).

The RHC must provide to the FI's provider enrollment unit a list of the names of all physicians and other practitioners who will be providing medical services at the center and include the practitioners':

1. National Provider Identifier (NPI); and
2. Assigned Medicaid provider number, if they are enrolled in Medicaid.

All enrollments of any practitioner in any Medicaid category of service, other than the RHC program, must be submitted to the FI's provider enrollment unit.

**NOTE:** The FI's provider enrollment unit must be notified immediately of any change in the above. Failure to maintain current information with the provider enrollment unit may result in a loss of reimbursement for services provided by those practitioners not identified as RHC staff.

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All practitioners providing patient services must be enrolled with the FI's provider enrollment unit and be linked to the RHC at the time of enrollment in order for the facility to receive reimbursement.

**NOTE: The effective date of enrollment shall not be prior to the date of receipt of a completed enrollment packet and the PECOS enrollment effective date.**

**Services**

The RHC agrees to provide those primary care services typically included as part of a physician's medical practice. The RHC must provide, either directly or by referral, a full range of primary diagnostic and therapeutic services and supplies which include the following:

1. Medical history;
2. Physical examination;
3. Assessment of health status and treatment of a variety of conditions amenable to medical management on an ambulatory basis by a physician or a physician extender;
4. Evaluation and diagnostic services to include the following:
  - a. Radiological services; and
  - b. Laboratory and pathology services.
5. Services and supplies incident to a physician's or a physician extender's services such as:
  - a. Pharmaceuticals; and
  - b. Supplies.

In addition, an RHC can provide services related to the diagnosis and treatment of mental illness, and in certain instances, visiting nurse services.

**Billing**

The RHC agrees to bill its usual and customary charge for each RHC-related service using applicable diagnoses and procedure codes. RHC services must be billed using the RHC's NPI and

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Medicaid provider number assigned to the specific RHC location and Tax Identification Number (TIN) of the specific RHC location where the services were provided and/or the rendering provider is based, as required by each health plan and/or the FI.

“Usual and customary” is defined as the fee charged to private paying patients for the same procedure during the same period of time. Records on both Medicaid eligible and private pay patients must be maintained for a minimum of 5 years in order to verify compliance with this policy. The RHC shall also furnish its authorized representative or contractual agents, with all information that may be requested regarding “usual and customary” fees.

The RHC must ensure that no staff or contract provider will seek separate reimbursement from Medicaid for specific services that are ordered and/or performed in the RHC and are billable under the RHC program. Laboratory, pathology, radiological and other services ordered by the RHC staff, but provided by an organization independent of the RHC, must be billed by the provider of the service and not the RHC.

**Diabetes Self-Management Training**

In order to receive Medicaid reimbursement for diabetes self-management training (DSMT) services, the RHC must have a DSMT program that meets the quality standards of one of the following accreditation organizations:

1. The American Diabetes Association;
2. The American Association of Diabetes Educators; or
3. The Indian Health Service.

All DSMT programs must adhere to the national standards for diabetes self-management education. Each member of the instructional team must:

1. Be a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educators; or
2. Have recent didactic and experiential preparation in education and diabetes management.

At a minimum, the instructional team must consist of one of the following professionals who is a CDE:

1. A registered dietician;

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2. A registered nurse (RN); or
3. A pharmacist.

All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

**Satellite Clinics**

Satellite clinics must enter into a separate provider agreement from the parent center and obtain its own provider number for billing and reimbursement purposes.

**Mobile Clinics**

An RHC is prohibited from enrolling a mobile clinic in the Louisiana Medicaid program. Services rendered at the mobile clinic must be billed using the stationary clinic's provider number.

**NOTE: All mobile clinics must be HRSA approved facilities.**

**Out of State RHCs in Trade Areas**

An RHC located in the trade areas designated by the Department that wishes to enroll in the Louisiana Medicaid program, must meet the provider enrollment requirements of an RHC located in Louisiana and include a letter from the RHCs home state verifying its reimbursement rate.

**Change in Ownership**

When there is a change in ownership, Medicaid must be notified within 30 calendar days of the date of the RHC ownership change. The new owner is required to enter into a new provider agreement with the Louisiana Medicaid program. Failure to enter into a new provider agreement following a change in ownership will result in the clinic's termination as a Louisiana Medicaid provider.

**Change of Address**

RHCs are required to report address changes. Providers must complete a file update form to submit to Provider Enrollment along with documentation from HRSA of the address change.



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**Cost Reports**

RHCs are required to file an annual cost report with appropriate addenda within 5 months of the clinic's fiscal year end. Failure to submit cost reports by the due date may result in Medicaid payments being suspended. (See Appendix A for contact information).

**Medicare Certification**

RHCs are required to submit proof on an annual basis of Medicare certification as a RHC. Failure to submit the annual certification may result in disenrollment or payments being suspended.

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**SECTION 40.3: RECORD KEEPING****PAGE(S) 2**

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**RECORD KEEPING**

The Rural Health Clinic (RHC) must maintain all clinical and fiscal records in accordance with written policies and procedures. The records must readily distinguish one type of service from another that is provided.

A designated member of the professional staff must be responsible for maintaining the records to ensure that they are complete, accurately documented, readily accessible, and systematically organized.

For each beneficiary receiving health care services, the center must maintain a record that includes the following as applicable:

1. Identification and social data, consent forms, pertinent medical history, assessment of the health status and health care needs of the beneficiary, and a brief summary of the episode, disposition, and instructions to the beneficiary; and
2. Reports of physical examinations, diagnostic and laboratory test results, consultative findings, physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the beneficiary's progress, as well, as the physician or health care professional's signature.

**Record Maintenance and Availability**

The clinic is responsible for the following:

1. Maintaining adequate financial and statistical records in the form that contains the data required by the Bureau of Health Services Financing (BHSF) and fiscal intermediary (FI) that supports the payment and distinguishes the type of service provided to the beneficiary;
2. Making the records available for verification and audit by BHSF or its contracted auditing agent; and
3. Maintaining financial data on an accrual basis, unless it is part of a governmental institution that uses a cash basis of accounting. In the latter case, depreciation on capital assets in accordance with Health Insurance Manual 15 (HIM-15) is required. (See Appendix A for information about the HIM-15).

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**Protection of Record Information**

The center must maintain the confidentiality of records, provide safeguards against loss, destruction or unauthorized use, govern removal of records from the center and the conditions for release of information. The beneficiary's written consent must be obtained before the release of information not authorized by law.

**Adequacy of Records**

Reimbursement may be suspended if the center does not maintain records that provide an adequate basis to support payments. The suspension will continue until the center demonstrates to the satisfaction of the BHSF it does, and will continue to, maintain adequate records.

**Retention of Records**

Records must be retained for at least 6 years from the date of service or longer if required by state statute.

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**SECTION 40.4: REIMBURSEMENT****PAGE(S) 12**

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**REIMBURSEMENT**

Reimbursement for Rural Health Clinic (RHC) services is made for those primary care services provided to Medicaid beneficiaries by enrolled RHC providers. These services are of the type normally provided as part of a primary care physician's (PCP's) practice as described in Section 40.1 – Covered Services. RHCs are reimbursed for Medicaid covered services under an all-inclusive Prospective Payment System (PPS) as specified under Section 1902(bb) of the Social Security Act (SSA).

Payments specified as the PPS rates are all inclusive of professional, technical and facility charges, including evaluation and management, routine surgical and therapeutic procedures and diagnostic testing (including laboratory/pathology and radiology) capable of being performed on site at the RHC and must be billed utilizing the facilities' provider identification (ID) and Tax Identification Number (TIN).

1. Laboratory/pathology, radiology and medications administered are not separately reimbursable. To the extent that the provider has the capabilities to provide these services and has historically provided these services, the RHC shall continue to provide such services; and
2. The bundling of therapeutic and diagnostic testing services in the PPS rate is not meant to imply that the RHC shall vend or refer out such ancillary services to other providers merely for the purpose of maximizing reimbursement.

Services and supplies incidental to a service visit include those services commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications, supplies used in a patient service visit. Section 40.1 – Covered Services of this manual chapter has a list of "incident to" services. Services provided incidental to a service visit must be furnished by an employee and must be furnished under the direct supervision of an RHC health care practitioner, meaning the health care practitioner must be immediately available when necessary, even if by telephone.

Laboratory/pathology, radiological and other services ordered by the RHC staff, but provided by an organization independent of the RHC, must be billed by the provider of the service and not the RHC.

**NOTE:** Professional services performed in the RHC will be subject to recoupment if billed under a physician/practitioner's individual Medicaid number.

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**Rates****Determination of Rate**

Payments for Medicaid covered services will be made under a PPS and paid on a per visit basis.

For an RHC which enrolls and receives approval to operate, the facility's initial PPS per visit rate shall be determined through a comparison to other RHCs in the same town/city/parish. The scope of services shall be considered in determining which proximate RHC most closely resembles the new provider. If there are no RHCs in the proximity, comparison shall be made to the nearest RHC offering the same scope of service. The rate will be set to that of the RHC comparative to the new provider.

**Alternative Payment Methodologies**

Effective July 1, 2008, any provider-based RHC licensed as part of a small rural hospital as of July 1, 2007 may elect to be reimbursed at 110 percent of reasonable cost as reported from the RHC's latest filed cost report.

In accordance with Section 1902(bb)(6) of the SSA, no interim or alternative payment methodologies will be imposed on an RHC without approval from the entity, and payment methodologies must result in payment to the RHC that is at least equal to the amount required to be paid to the RHC without the alternate payment methodology.

**Adjustment of Rate**

PPS rates are adjusted effective July 1 of the state fiscal year by the published Medicare Economic Index (MEI) as prescribed in Section 1902(bb)(3)(A) of the SSA.

PPS rates are adjusted to take into account any change (increase or decrease) in the scope of services furnished by the RHC. A change in scope is an addition, removal or relocation of service sites, and the addition or deletion of specialty and non-primary services that were not included in the base line rate calculation.

**The RHC is responsible for notifying BHSF, in writing, of any increases or decreases in the scope.** If the change is for the inclusion of an additional service or deletion of an existing service/site, the RHC shall include the following in the notification:

1. The current, approved organization budget and a budget for the addition or deletion of services/sites; and
2. An assessment of the impact on total visits and Medicaid visits associated with the change of scope of services.

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A new interim rate will be established based upon the reasonable allowed cost contained in the budget information. The final PPS rate will be calculated using the first 2 years of audited Medicaid cost reports, which include the change in scope.

**Out of State/Trade Area RHC**

An out-of-state RHC in the trade area will be reimbursed the lesser of the Louisiana statewide average or the PPS rate assigned to that RHC in its state's location.

**Notice of Rate Setting**

BHSF will send written notice to the RHC notifying the RHC of the reimbursement rate per encounter and the methodology used to establish the rate.

BHSF, or its contracted auditing agency, will reconcile the initial PPS rates for provider based RHCs to the final audited PPS rates and inform the RHC of the rate determination and any reconciling amounts owed or due to/from the RHC.

**Appeals**

RHCs requesting to appeal the established PPS rate must submit their request in writing. (See Appendix A for contact information).

**Cost Report Submission**

RHCs are required to file a Medicaid annual cost report with appropriate addenda within 5 months of the RHC's fiscal year end. Failure to submit cost reports by the due date may result in a suspension of Medicaid payments. (See Appendix A for information on where to send cost reports).

A written request for an extension on submission of the cost report may be granted if received by the RHC Program Manager within 30 or more calendar days prior to the due date. No extension will be granted unless the RHC provides evidence of extenuating circumstances beyond its control that have caused the report to be submitted late.

**Audits**

All cost reports are subject to audit, including desk audits and field audits.

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**Encounter Visits**

An RHC can be reimbursed for only one medical, one behavioral health, and one dental encounter per day. Core service encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same date of service, at a single location, constitute a single visit, and are limited to one billable encounter per day except when one of the following conditions exists:

1. After the first encounter, the beneficiary suffers illness or injury requiring additional diagnosis or treatment; or
2. The beneficiary has a medical visit or dental visit on the same day. Behavioral health benefits are subject to the requirements outlined Section 40:1 - Covered Services of this provider manual chapter.

Services and supplies that are furnished by RHC staff and incidental to an RHC professional service as commonly furnished in a physician's office and ordinarily rendered without charge or are included in the practice's bill, such as laboratory/pathology services, radiology services, ordinary medications and supplies used in a patient service visit are considered part of the RHC service.

Fluoride varnish applications shall only be reimbursed to the RHC when they are performed on the same date of service as an office visit or preventative screening. Separate encounters for fluoride varnish application services are not permitted and the application of fluoride varnish alone does not constitute an encounter visit.

Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician.

**Alternative Payment Methodology**

Louisiana Medicaid has established several alternative payment methodologies (APM) for services provided within a RHC. Reimbursement for these services are made in addition to the PPS rate, as an add-on payment, on the same day as another all-inclusive rate reimbursement. The RHC APMs include payment for adjunct services.

**Payment for Adjunct Services**

Reimbursement will be made for adjunct services in addition to the encounter rate paid for professional services when these services are rendered during the evening, weekend or holiday

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hours as outlined in the *Current Procedural Terminology* (CPT) manual under “Special Services, Procedures and Reports”.

To facilitate beneficiary access to services during non-typical hours and to reduce the inappropriate use of the hospital emergency department, the reimbursement provided by use of the adjunct codes is intended to assist with covering the additional administrative costs associated with staffing during these times. RHCs are not to alter their existing business hours for the purpose of maximizing reimbursement.

The reimbursement is a flat fee in addition to the reimbursement for the associated encounter. Reimbursements for adjunct services are only billable for services on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m., Monday through Friday. Documentation must include the time the services were rendered.

**NOTE:** Payment for adjunct services is not allowed when the encounter is for dental services only.

**Long Acting Reversible Contraceptives**

RHCs will receive reimbursement outside of their prospective payment system rate for long acting reversible contraceptives (LARC). Reimbursement for LARCs will be the lesser of the Medicaid fee for service rate on file or the actual acquisition cost (AAC), for entities participating in the 340B program. The rates for LARCs are located on the Durable Medical Equipment (DME) fee schedule on [www.lamedicaid.com](http://www.lamedicaid.com).

RHC providers must submit the medical encounter and required detail line(s) for services provided to the beneficiary on the date of service according to current policy. The procedure code for the appropriate LARC and LARC insertion must be included in the detail lines of the claim. Detail lines for the LARC and LARC insertion cannot be the only detail lines on the claim or the claim will deny. The procedure code for the services listed will pay accordingly. All other detail lines on the claim will pay at zero.

**Dental Services**

RHCs will receive an additional payment at the PPS rate for dental services that are provide on the same day as medical and behavioral health services.

**Behavioral Health Services**

RHCs will receive an additional payment at the PPS rate for behavioral health services that are provided on the same day as medical and dental services.



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**Licensed Professional Counselors and Licensed Marriage and Family Therapist**

LPC and LMFT services are not core services. The services are other ambulatory services rendered in the RHC. These services follow the Medicaid policy in Chapter 2 of the Medicaid Services Manual, Behavioral Health Services Provider Manual for these providers. Reimbursement is at the all-inclusive reimbursement rate on file for the date of service.

**Community Health Worker Services**

RHCs will receive the rate on file for community health worker services in addition to the all-inclusive encounter rate payment on the same date of service. These services follow Medicaid policy in Chapter 5 of the Medicaid Services Manual, Professional Services Provider Manual for these providers.

**Encounter Billing Guidelines**

Reimbursement for medical, behavioral health and dental encounters include all services provided to the beneficiary on a specific date of service and any services on a subsequent day incidental to the original encounter visit. In addition to the appropriate encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines of the claim.

A visit to pick up a prescription or a referral is not considered a billable encounter. Laboratory or x-ray services with no “face-to-face” encounter with a covered RHC provider do not constitute an RHC visit and will not be reimbursed separately as they are part of the original encounter, which warranted these additional services.

If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), providers must refer to Chapter 5 the Professional Services Provider Manual chapter on [www.lamedicaid.com](http://www.lamedicaid.com) for specific billing instructions.

**Medical Encounters**

Medical services provided in RHCs are reimbursed as encounters. These encounter visits must be billed on a CMS-1500 using procedure code T1015. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and zero or usual/customary charges for each service provided on subsequent lines

For obstetrical services, RHCs must bill the encounter code T1015 with modifier TH and all services performed on that date of service.

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**NOTE:** Professional services not covered through the Professional Services Program are not covered through the RHC Program.

**Behavioral Health/Psychiatric Service Encounters**

For behavioral health services provided during an encounter, and administered by a physician with a psychiatric specialty, a nurse practitioner (NP) or clinical nurse specialist with a psychiatric specialty, a licensed clinical social worker (LCSW), a clinical psychologist, a licensed professional counselor (LPC), or a licensed marriage and family counselor (LMFT), the RHC provider identification number (PIN) must be placed as the billing provider.

The practitioner's PIN must be placed as the attending provider with the appropriate detail line procedure codes on the claim. These services should be billed on the CMS-1500 using procedure code H2020 as the first line of the claim. A behavioral health specific service must be rendered in order to bill a behavioral health encounter. The submission of an evaluation and management code alone is only allowed for specific provider types and provider specialty combinations. In addition, an RHC cannot bill an encounter, and be paid the PPS rate, when only a group session is provided to a beneficiary.

Louisiana Medicaid reimburses professional service providers for select procedure codes specific to psychiatric services delivered in the office or other outpatient facility setting. This policy is applicable to physician services in the Professional Services program and mental health services provided in an RHC. RHC providers should enter the appropriate psychiatric procedure codes as encounter detail lines when submitting claims for the following services:

1. Psychiatric diagnostic or evaluative interview procedures;

**NOTE:** Procedure codes are reimbursable once per 365 days per attending provider.

2. Psychiatric therapeutic procedures; and
3. Psychological testing.

Psychological testing is reimbursable once per 365 days per attending provider. All applicable units of service related to this procedure code should be billed on one date of service and the units should not be divided among multiple dates of service or claim lines.

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**NOTE:** Should nationally approved changes occur to CPT codes at a future date that relate to psychiatric services, providers are to follow the most accurate coding available for covered services for that particular date of service, unless otherwise directed.

In order to receive reimbursement from Louisiana Medicaid for behavioral health services, the RHC's HRSA approval must include behavioral health services as a part of the RHC's scope of service. In addition, the RHC shall notify LDH by completing a new Facility Survey (see Appendix E) and submitting it to the Department. The RHC is not required to obtain a Behavioral Health Service provider (BHSP) license from LDH Health Standards. A RHC will be reimbursed the all-inclusive PPS rate for these services and must follow RHC rules, policies, and manuals when billing. Practitioners who meet the above criteria can provide behavioral health services in the RHC if they are one of the below:

1. Physicians with a Psychiatric Specialty;
2. NPs or Clinical Nurse Specialists with a Psychiatric Specialty;
3. LCSWs; or
4. Licensed Clinical Psychologists.

**Physicians with a Psychiatric Specialty**

The RHC Medicaid ID number must be listed as the billing provider and the physician's individual Medicaid ID number must be listed as the attending provider on the claim for behavioral health services rendered by a physician with a psychiatric specialty.

**Nurse Practitioners or Clinical Nurse Specialists with a Psychiatric Specialty**

The RHC Medicaid ID number must be listed as the billing provider and the NP or clinical nurse specialist's individual Medicaid ID number must be listed as the attending provider on the claim for behavioral health services rendered by a NP or clinical nurse specialist.

**Licensed Clinical Social Workers**

The RHC Medicaid ID number must be listed as the billing provider and the LCSW's Medicaid ID as the attending provider on the claim for mental health services provided in an RHC.

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**Licensed Clinical Psychologists**

A licensed clinical psychologist must list the RHC Medicaid ID number as the billing provider and the clinical psychologist's provider number as the attending provider on the claim for mental health services provided in an RHC.

**NOTE:** Reimbursement for services for the above providers will be at the prospective payment system (PPS) rate on file on the date of service. Behavioral health services provided by a LPC or LMFT are considered other ambulatory services in the clinic and are reimbursed at the PPS rate on file.

**Other Mental Health Providers Rendering Services in a FQHC**

If the RHC provides specialized mental health rehabilitation services, i.e. community psychiatric support and treatment (CPST), crisis intervention (CI), and/or psychosocial rehabilitation (PSR) without the service being included in their HRSA scope of service approval, or if services are delivered by an individual who is not a psychiatrist, an advanced practice registered nurse (APRN) with psychiatric specialty, a LCSW or a licensed clinical psychologist, licensed professional counselor, or a LMFT, the entity is required to obtain a BHSP license issued by LDH Health Standards. The entity must enroll as an appropriate Specialized Behavioral Health Service (SBHS) provider, obtain a unique National Provider Identifier (NPI), have an active BHSP license issued by LDH Health Standards and meet qualifications and requirements established in the Medicaid Behavioral Health Services Provider Manual chapter, rules, laws and regulations. The entity must bill using its unique BHSP NPI in accordance with the SBHS Medicaid rules, policies and manuals.

**NOTE:** If Behavioral Health or Mental Health Rehabilitation services outside the ones addressed in this provider manual are delivered by an individual who is not a psychiatrist, an APRN with psychiatric specialty, a LCSW, a licensed clinical psychologist, licensed professional counselor or a LMFT, the practitioner should review the Behavioral Health manual for Medicaid reimbursement.

**Billing of an encounter on the same day as a residential treatment procedure code is not allowed in most cases. An exception would be if the beneficiary were seen on the day of admission to a treatment facility.**

**Dental Encounters**

All dental services must be billed on the 2006 ADA claim form using the encounter code D0999. In addition to the encounter code, providers must list the specific dental services provided by entering the procedure code for each service rendered on subsequent lines. The provider should also include zero or usual/customary charges for each service provided.

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**Adjunct Services**

RHC adjunct services should be billed with the T1015 encounter code, the appropriate detail procedure, along with the adjunct service procedure code. The adjunct service procedure code may not be submitted as the only “detail line” for the encounter.

These adjunct codes are reimbursed in addition to the reimbursement for outpatient evaluation and management services when the services are rendered in settings other than hospital emergency departments:

1. Between the hours of 5 p.m. and 8 a.m. Monday through Friday;
2. On weekends between 12 a.m. Saturday through midnight on Sunday; and
3. State proclaimed legal holidays, 12 a.m. through midnight.

Providers are instructed to bill usual and customary charges. (See Appendix A for information on accessing the fee schedule).

Only one of these adjunct codes may be submitted by a billing provider per day. Providers are to select the code that most accurately reflects their situation. Adjunct codes are reported with another code or codes describing the service related to that beneficiary’s visit or encounter. For example:

1. If the existing office hours are Monday-Friday 8 a.m. – 5 p.m. and the physician treats the beneficiary in the office at 7 p.m., then the provider may report the appropriate basic service (Evaluation/Management (E/M) visit code or encounter) and adjunct code; or
2. If a beneficiary is seen in the office on Saturday during existing office hours, the provider may report the appropriate basic service (E/M visit code or encounter) and adjunct code.

Documentation in the medical record relative to this reimbursement must include the time that the services were rendered. Should there be a post payment review of claims, providers may be asked to submit documentation regarding the existing office hours during the timeframe being reviewed.

RHC providers will receive fee-for-service reimbursement for the adjunct services codes separate from, but in addition to, the PPS reimbursement for the associated encounter (T1015).

For RHC providers whose services meet the guidelines outlined in this policy:

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1. The encounter and required detail line(s) for services provided to the beneficiary on a date of service should be reported as directed in current RHC policy;
2. If appropriate, the adjunct services code may also be reported as a detail line, but it may not be submitted as the only “detail line” for an encounter;
3. The adjunct code will be reimbursed fee-for-service in addition to the payment for the encounter; and
4. The adjunct codes are not reimbursable for dental encounters.

Payments to all RHCs/providers are subject to post payment review and recovery of overpayments.

**Early and Periodic Screening, Diagnostic and Treatment Screening Services**

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Services must be billed using the CMS 1500/837P Professional format using encounter code T1015 with modifier EP.

It is necessary to indicate the specific preventive screening services provided to support the T1015-EP encounter by entering the individual procedure code for each service rendered as the appropriate detail line. This includes but is not limited to immunizations, vision and hearing screening, developmental screening, and perinatal depression screening performed at the time of the EPSDT preventive visit. All claims billed using the T1015-EP must include the supporting detail procedure codes representing the services provided on the same date as the encounter.

The physician, APRN, or physician assistant listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse, or other ancillary staff in a provider’s office, is subject to Medicaid’s ‘incident to’ policy and must only be providing services within the scope of their license or certification.

In addition to the billing instructions above, providers must refer to and adhere to Medicaid Services Manual, Chapter 5, Professional Services Provider Manual on [www.lamedicaid.com](http://www.lamedicaid.com) for all EPSDT screening policies.

**NOTE:** The dental encounter, D0999, may be billed on the same date of services as the encounter codes T1015, T1015 TH (OB encounter), T1015 EP (EPSDT screening) and/or H2020 (Behavioral Health encounter).

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**Medicare/Medicaid Dual Eligible Billing**

Medicaid pays the Medicare co-insurance, up to the Medicaid established encounter rate, for beneficiaries who are eligible for Medicare and Medicaid. RHCs should first file claims with the regional Medicare fiscal intermediary (FI)/carrier, ensuring the beneficiary's Medicaid ID number is included on the Medicare claim form, before filing with Medicaid.

After the Medicare claim has been processed, then Medicaid should be billed. Providers must bill these claims on the UB92/UB04 and include the Medicare Explanation of Benefits (EOB), a copy of the Medicare claims and put the Medicaid provider number and Medicaid ID number in the appropriate form locators. (See Appendix A for information on where to send the claim).

**NOTE:** This is the only instance where Louisiana Medicaid may be billed using the UB92/UB04 for RHC services. Medicaid only claims must be processed on the CMS-1500 claim form.

**Outpatient Services**

For all services rendered at the RHC, in a nursing home or during home visits, the RHC provider identification number must be used as the billing provider number in the appropriate place on the CMS 1500 claim form.

**Inpatient Services**

Physician inpatient services are billed through the physician's individual provider number as the billing provider. Physicians are not allowed to bill through their RHC group number for inpatient services.

**CHAPTER 40: RURAL HEALTH CLINICS****APPENDIX A: CONTACT INFORMATION****PAGE(S) 1****CONTACT INFORMATION**

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Louisiana Department of Health (LDH)	Receives annual notice of Medicare certification as a Rural Health Clinic (RHC)	LDH Bureau of Health Services Financing (BHSF) Medicaid Policy and Compliance P.O. Box 91030 Baton Rouge, LA 70821-9030
Gainwell Technologies Prior Authorization Unit (PAU)	Receives prior authorization (PA) requests for extension of beneficiary's maximum allowed annual outpatient visits	Gainwell Technologies Prior Authorization Unit P.O. Box 14919 Baton Rouge, LA 70898-4919
Gainwell Technologies Provider Relations Unit	Provides assistance with questions regarding billing information	Gainwell Technologies Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821
Gainwell Technologies Claims Processing Unit	Processes Medicare crossover claims	Gainwell Technologies P. O. Box 91023 Baton Rouge, LA 70821
Medicaid Eligibility Verification System (MEVS)/Recipient Eligibility Verification System (REVS)	Verifies beneficiary eligibility	<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>
Division of Administrative Law – Health and Hospitals Section	Receives appeal requests	Division of Administrative Law - Health and Hospitals Section P. O. Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 Fax: (225) 219-9823 Phone for oral appeals: (225) 342-5800
LeBlanc, Robertson, Chisholm & Associates, LLC (LRCA, LLC)	Receives annual cost reports	<a href="http://lrcaudit.com">http://lrcaudit.com</a>
Professional Services Fee Schedule	Reimbursement information relative to adjunct codes	<a href="http://www.lamedicaid.com">www.lamedicaid.com</a> following "Fee Schedules" then "Professional Services" links

See <http://www.cms.hhs.gov/Manuals/PBM/list.asp> for information concerning the Health Insurance Manual 15 (HIM-15).



## FORMS AND LINKS

Form Description	Link
Service Facility Survey	<a href="https://www.lamedicaid.com/provweb1/Forms/FQHC_Services_Facility_Survey.pdf">https://www.lamedicaid.com/provweb1/Forms/FQHC_Services_Facility_Survey.pdf</a>
CMS 1500	<a href="https://www.lamedicaid.com/provweb1/billing_information/CMS_1500_RHC_FQHC.pdf">https://www.lamedicaid.com/provweb1/billing_information/CMS_1500_RHC_FQHC.pdf</a>

## GLOSSARY

**Adjunct Services** – Services provided by the Rural Health Clinic (RHC) on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m. Monday through Friday.

**Bureau of Health Services Financing (BHSF)** – The Bureau within Louisiana Department of Health (LDH) responsible for the administration of the Louisiana Medicaid Program.

**Change in Scope** – A Health Resources Services Administration (HRSA) approved addition, removal and relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the baseline rate calculation.

**CMS** – The Center for Medicare and Medicaid Services is the Federal agency in the Department of Health and Human Services (DHHS) responsible for administering the Medicaid Program and overseeing and monitoring of the State’s Medicaid Program.

**Department of Health and Human Services (DHHS)** – The federal agency responsible for administering the Medicaid Program and public health programs.

**Encounter** – A face-to-face visit with a physician, physician assistant, nurse practitioner (NP), nurse midwife, visiting nurse, clinical psychologist, clinical social worker, or any other State plan approved ambulatory provider during which an RHC core or other ambulatory service is rendered. Multiple medical encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the beneficiary, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

**Enrollment** – A determination made by LDH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other LDH-funded services. This is also referred to as provider enrollment.

**Fiscal Intermediary (FI)** – Is the private fiscal agent with which LDH contracts to operate the Medicaid Management Information System (MMIS). It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

**Health Professional Shortage Area** – An urban or rural area, population group, or public or nonprofit private medical facility which the Secretary of DHHS determines has a shortage of health professionals.

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CHAPTER 40: RURAL HEALTH CLINICS

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## APPENDIX C: GLOSSARY

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**Health Resources Services Administration** – An office within DHHS whose mission is to improve access to healthcare services for the uninsured, isolated, or medically vulnerable through leadership and financial support.

**Louisiana Department of Health (LDH)** – The state agency responsible for administering the Medicaid Program and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services. In this manual the use of the word “department” will mean LDH.

**Medicaid** – A federal-state financed entitlement program which provides medical services primarily to low-income individuals under a State Plan approved under Title XIX of the Social Security Act.

**Medically Underserved Area** – Areas designated by HRSA as having too few primary care providers.

**Medically Underserved Population** – Areas designated by HRSA as having high infant mortality, high poverty, and/or high elderly population.

**Medicare** – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

**Medicaid Management Information System (MMIS)** – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

**Prospective Payment System (PPS)** – Method of reimbursement in which payment is made on a predetermined, fixed amount. Section 1902(bb) of the Social Security Act (SSA) describes the methodology used to determine the PPS for RHCs.

**Provider Enrollment** – Another term for enrollment.

**Rural Health Clinic (RHC)** – An outpatient primary care clinic seeking or possessing certification by the Health Care Financing Administration (HCFA) as a rural health clinic and licensed by the department, which provides diagnosis and treatment to the public by a qualified mid-level practitioner and a licensed physician. The clinic must be located in a medically underserved area that is not urbanized as defined by the U.S. Bureau of Census.

**Secretary** – The Secretary of LDH or any official to whom they have delegated the pertinent authority.

**Satellite Clinics** – Separate clinics of the primary RHC.

**Service Site** – Any place where a health center provides primary health care services to a geographic service area or population.

**Trade Areas** – Counties in the states of Texas, Arkansas, and Mississippi that physically share a border with Louisiana border.

## **CLAIMS RELATED INFORMATION**

This appendix contains the following information:

1. Instructions for billing using the CMS-1500 Claim Form;
2. Samples of the CMS-1500 Claim Form;
3. Instructions for adjusting or voiding a CMS-1500 claim;
4. Samples of a CMS-1500 Claim Form Adjustment;
5. Instructions for billing using the American Dental Association (ADA) Dental Claim Form;
6. Sample of the ADA Dental Claim Form;
7. Instructions for adjusting or voiding an ADA claim using the 209 Adjustment/Void Form;
8. Sample of the 209 Adjustment/Void Form;
9. Instructions for adjusting or voiding an ADA claim using the 210 Adjustment/Void Form; and
10. Sample of the 210 Adjustment/Void Form.

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APPENDIX D: CLAIMS RELATED INFORMATION

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**CMS 1500 (02/12) Billing Instructions for RHC Services**

Hard copy billing of Rural Health Clinics (RHC) services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

**Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

**Situational** information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Gainwell Technologies  
P.O. Box 91020  
Baton Rouge, LA 70821

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
2. The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

**NOTE:** Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com), directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and samples of completed CMS-1500 claim forms; and

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

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## APPENDIX D: CLAIMS RELATED INFORMATION

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## CMS-1500 (02/12) Billing Instructions for RHC Services

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's Identification (ID) Number	<b>Required</b> – Enter the beneficiary's 13 digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through Medicaid Eligibility Verification System (MEVS), eMEVS or Recipient Eligibility Verification System (REVS).  <b>NOTE:</b> The beneficiary's 13-digit Medicaid ID number <u>must</u> be used to bill claims. The card control number (CCN) number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	<b>Required</b> – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Date of Birth (DOB)  Sex	<b>Situational</b> – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only 1 digit in this field, precede that digit with a 0 (for example 01 02 07).  Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	<b>Situational</b> – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	<b>Situational</b> – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	Reserved for National Uniform Claims Committee (NUCC) Use	<b>Leave Blank.</b>	
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	



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Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	<p><b>Situational</b> – If beneficiary has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the state assigned 6-digit third-party liability (TPL) carrier code is <b>required</b> in this block. This carrier code is indicated on the MEVS response as the Network Provider Identification Number.</p> <p>Make sure the explanation of benefits (EOB) or EOBs from other insurance(s) are attached to the claim.</p>	<b>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</b>
9b	Reserved for NUCC Use	<b>Leave Blank.</b>	
9c	Reserved for NUCC Use	<b>Leave Blank.</b>	
9d	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	<b>Situational</b> – Complete if appropriate or leave blank.	
11	Insured's Policy Group or Federal Employees Compensation Act (FECA) Number	<b>Situational</b> – Complete if appropriate or leave blank.	
11a	Insured's DOB Sex	<b>Situational</b> – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	<b>Leave Blank.</b>	
11c	Insurance Plan Name or Program Name	<b>Situational</b> – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	<b>Situational</b> – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	<b>Situational</b> – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
13	Patient's or Authorized Person's Signature (Payment)	<b>Situational</b> – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	<b>Optional.</b>	
15	OTHER DATE	<b>Leave Blank.</b>	
16	Dates Patient Unable to Work in Current Occupation	<b>Optional.</b>	
17	Name of Referring Provider or Other Source	<p><b>Situational</b> – Complete if applicable.</p> <p>In the following circumstances, entering the name of the appropriate physician block is <b>required</b>:</p> <p>If the beneficiary is a lock-in beneficiary and has been referred to the billing provider for services, enter the lock-in physician's name.</p>	
17a	Unlabeled	<b>Leave Blank.</b>	
17b	National Provider Identifier (NPI)	<b>Leave Blank.</b>	
18	Hospitalization Dates Related to Current Services	<b>Leave Blank.</b>	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	<b>Leave Blank.</b>	
20	Outside Lab?	<b>Optional.</b>	

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Locator #	Description	Instructions	Alerts
21	International Classification of Diseases (ICD) Indicator  Diagnosis or Nature of Illness or Injury	<p><b>Required</b> – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM</p> <p><b>Required</b> – Enter the most current ICD diagnosis code.</p> <p><b>NOTE:</b> The ICD-10 External Cause of Injury Codes, the “V”, “W”, “X”, and “Y” diagnosis series codes are allowable as non-primary diagnoses codes when completing claims to be submitted to Medicaid.</p>	<p><b>The most specific diagnosis codes must be used. General codes are not acceptable.</b></p> <p><b>ICD-10 diagnosis codes must be used on claims for dates of service 10/1/15 forward.</b></p> <p><b>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (<a href="http://www.lamedicaid.com">www.lamedicaid.com</a>)</b></p>
22	Resubmission Code and/or Original Reference Number	<p><b>Situational.</b> If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice (RA) in the “Original Ref. No.” portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>VOIDS</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p><b>To adjust or void a claim, only the encounter line should be adjusted/voided since all payment is made on this line. The internal control number of the encounter line is used.</b></p>

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Locator #	Description	Instructions	Alerts
23	Prior Authorization (PA) Number	<p><b>Situational</b> – Complete if appropriate or leave blank.</p> <p>If the services being billed must be prior authorized, the 9 digit numeric PA number is <b>required</b> to be entered.</p>	
24	Supplemental Information	<p><b>Situational</b> – Applies to the detail lines for drugs and biologicals only.</p> <p><b><u>CURRENTLY, THIS IS NOT A REQUIREMENT FOR RHC PROVIDERS.</u></b></p> <p>In addition to the procedure code, <b>the National Drug Code (NDC)</b> is <b>required</b> by the Deficit Reduction Act of 2005 for <b>physician-administered drugs</b> and <b>shall be entered</b> in the <b>shaded</b> section of 24A through 24G. <b><u>Claims for these drugs shall include the NDC from the label of the product administered.</u></b></p> <p>To report additional information related to Healthcare Common Procedure Coding System (HCPCS) codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the <b>Qualifier N4</b> followed by the <b>11-digit NDC</b>. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.</p> <p>Providers should then leave one space then enter the appropriate <b>Unit Qualifier</b> (see below) and the <b>actual units administered</b>. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.</p> <p>The following qualifiers are to be used when reporting NDC units:</p> <p>F2 International Unit ML Milliliter GR Gram UN Unit</p>	<p><b>RHCs who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A – 24G of appropriate detail lines only. This information must be entered in addition to the procedure code(s)</b></p>
24A	Date(s) of Service	<p><b>Required</b> -- Enter the date of service for each procedure.</p> <p>Either 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.</p>	

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Locator #	Description	Instructions	Alerts
24B	Place of Service	<b>Required</b> -- Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (EMG)	<b>Situational</b> – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	<p><b>Required</b> -- Enter the procedure code(s) for services rendered.</p> <p>Enter the appropriate encounter procedure code on the first line.</p> <p><b>Encounter Codes:</b></p> <ol style="list-style-type: none"> <li>1. RHC encounter visit: T1015</li> <li>2. RHC obstetrical service: T1015 w/TH modifier.</li> <li>3. RHC Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) service: T1015 w/EP modifier.</li> <li>4. RHC Behavioral Health encounter visit : H2020</li> </ol> <p><b>In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered.</b></p>	<p><b>If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 (above) is required.</b></p> <p><b>For claims involving TPL, a claim line with the encounter code and the encounter rate must be added to the claim.</b></p>
24E	Diagnosis Pointer	<p><b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A” “B”, etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
24F	\$Charges	<b>Required</b> -- Enter usual and customary charges, or zero when appropriate, for the service rendered.	
24G	Days or Units	<b>Required</b> -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	<b>Situational</b> – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	ID Qualifier	<b>Optional.</b>	

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Locator #	Description	Instructions	Alerts
24J	Rendering Provider ID	<b>Situational</b> – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is <b>required</b> .  Entering the Rendering Provider’s NPI in the non-shaded portion of the block is <b>optional</b> .	
25	Federal Tax ID Number	<b>Optional</b> .	
26	Patient’s Account Number	<b>Situational</b> – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the RA. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<b>Optional</b> . Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	
29	Amount Paid	<b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor.  Enter ‘0’ if the third party did not pay.  If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	<b>Leave Blank</b> .	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Optional</b> . – The practitioner or the practitioner’s authorized representative’s original signature is no longer required.  <b>Required</b> -- Enter the date of the signature.	
32	Service Facility Location Information	<b>Situational</b> – Complete as appropriate or leave blank.	
32a	NPI#	<b>Optional</b> .	
32b	Other ID#	<b>Optional</b> .	
33	Billing Provider Info & Phone #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	

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Locator #	Description	Instructions	Alerts
33a	NPI#	Optional	
33b	Other ID#	<b>Required</b> – Enter the billing provider’s 7-digit Medicaid ID number.  <b>ID Qualifier - Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	<b>The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.</b>


Sample forms on the following pages

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## Sample of RHC CMS-1500 Claim Form with ICD-10 Diagnosis Code



**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA ☐ ☐ PICA ☐ ☐

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S ID. NUMBER (For Program in Item 1) <b>1234567890123</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>LOU, JANNIE</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>06 19 85</b> SEX M F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? YES NO 10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I, the undersigned, authorize the release of my medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED DATE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10 <b>0</b> A. <b>Z30011</b> B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-10 QUAL I. RENDERING PROVIDER ID. #			
1 10 10 15 10 10 15 11 T1015 A 160.00 NPI 1236549875			
2 10 10 15 10 10 15 11 99213 A 0.00 NPI 1236549875			
3 N400703680101 UN150.00 DEPO-ROVERA INJ 10 10 15 10 10 15 11 J1050 A 0.00 NPI 1236549875			
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <b>Ima Biller</b> DATE <b>10/15/15</b>		32. SERVICE FACILITY LOCATION INFORMATION a. b. 33. BILLING PROVIDER INFO & PH# (800) 222-3333 ALWAYS OPEN RHC/FQHC CLINIC 123 MAIN ST ANY TOWN, LA 70000 a. 1326547895 b. 1234567	

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)



### Sample of a Claim Form

[https://www.lamedicaid.com/provweb1/billing\\_information/CMS\\_1500\\_RHC\\_FQHC.pdf](https://www.lamedicaid.com/provweb1/billing_information/CMS_1500_RHC_FQHC.pdf)

### Adjustments and Voids

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.**

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the RA, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; and
2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment, with the exception of the Provider Identification Number and the Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

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## APPENDIX D: CLAIMS RELATED INFORMATION

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**Adjustments/Voids Appearing on the RA**

When an Adjustment/Void Form has been processed, it will appear on the RA under *Adjustment or Voided Claim*. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the RA.


**Sample forms are on the following pages.**

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## APPENDIX D: CLAIMS RELATED INFORMATION

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## Sample of a Claim Form Adjustment with ICD-10 Diagnosis Code

 **HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA ☐ ☐ ☐ PICA ☐ ☐ ☐

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK/LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890123</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>LOU, JANNIE</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>06 19 85</b> SEX M F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER <b>TPL Code if applicable</b> b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M SEX F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED DATE SIGNED			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY QUAL.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? \$ CHARGES YES NO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE <b>A 02</b> ORIGINAL REF. NO. <b>5299198798700</b>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b> A. <b>Z30011</b> B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. PREP Pen I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 10 10 15 10 10 15 11 T1015 A 160 00 NPI 1236548 1236549875			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claim, see back) X YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <b>Ima Biller</b> DATE <b>10/15/15</b>		32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (800) 222-3333 <b>ALWAYS OPEN RHC/FQHC CLINIC</b> <b>123 MAIN ST</b> <b>ANY TOWN, LA 70000</b> a. <b>1326547895</b> b. <b>1234567</b>	

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

## ADA Claim Form Billing Instructions for RHC Services

### Medicaid EPSDT Dental and Adult Denture Program Services

The 2006 ADA Claim Form is the only hardcopy dental claim form accepted for Medicaid reimbursement of services provided under the Medicaid EPSDT Dental Program or Adult Denture Program. These claim forms may be obtained by contacting the ADA or your dental supply company.

The following billing instructions correspond to the 2006 ADA Claim Form.

**Required** information must be entered to ensure claims processing.

**Situational** information may be required only in certain situations as detailed in each instruction item.

Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form.

EPSDT Dental Program and Adult Denture Program claims should be submitted to:

Gainwell Technologies  
P. O. Box 91022  
Baton Rouge, LA 70821

## CHAPTER 40: RURAL HEALTH CLINICS

## APPENDIX D: CLAIMS RELATED INFORMATION

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## ADA Claim Form Billing Instructions for RHC Services

Locator #	Description	Instructions	Alerts
1	Type of Transaction	<p><b>Required</b> -- Check applicable box to designate whether the claim is a statement of actual services or a request for PA.</p> <p><b>Situational</b> – Check box marked “EPSDT Title XIX” if patient is Medicaid eligible and under 21 years of age.</p> <p>If block is not checked, the claim will be processed as an adult claim.</p>	<p>If a claim is being submitted for payment, you must mark “Statement of Actual Services” in Block 1 of the claim form.</p> <p>Claims for payment that are sent to Gainwell Technologies should never include radiographs.</p>
2	Predetermination / Preauthorization Number	<b>Situational</b> – Enter the PA number assigned by Medicaid when submitting a claim for services that require PA.	
3	Company / Plan Name, Address, City, State, Zip Code	<b>Situational</b> – Enter the primary payer information if applicable.	
4	Other Dental or Medical Coverage?	<b>Situational</b> – If yes, complete Block 9.	
5	Name of Policyholder/Subscriber in #4 (Last, First, MI, Suffix)	<b>Situational.</b>	
6	DOB (MM/DD/CCYY)	<b>Situational.</b>	
7	Gender	<b>Situational.</b>	
8	Policyholder/Subscriber ID	<b>Situational.</b>	

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9	Plan/Group Number	<p><b>Situational –</b></p> <p>If there is other coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block. This code is returned through MEVS beneficiary eligibility inquiries as the Network Plan Identifier. The MEVS application is located on the secure portal of the web site, <a href="http://www.lamedicaid.com">www.lamedicaid.com</a>. (The carrier code list can be found at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> under the <b>Forms/Files</b> link)</p> <p>If the provider has chosen to bill the third party and Medicaid, an EOBs must be attached to the claim filed with Medicaid.</p>	
Locator #	Description	Instructions	Alerts
10	Patient's Relationship to Person Named in #5	<b>Situational.</b>	
11	Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code	<b>Situational.</b>	
12	Policyholder/Subscriber Name (Last, First, MI, Suffix) Address, City, State, Zip Code	<p><b>Required --</b> Enter the beneficiary's last name, first name, and MI exactly as verified through REVS or MEVS.</p> <p>Beneficiary's address is <b>optional</b>.</p>	
13	DOB (MM/DD/CCYY)	<b>Required --</b> Enter the beneficiary's 8-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only 1 digit in a field, precede that digit with a 0.	
14	Gender	<b>Optional –</b> Check appropriate block.	
15	Policyholder/Subscriber ID	<p><b>Required --</b> Enter the 13-digit Medicaid ID number as obtained from REVS or MEVS.</p> <p>Do not use the 16-digit CCN from the beneficiary's Medicaid card.</p>	
16	Plan / Group Number	<b>Situational.</b>	
17	Employer Name	<b>Situational.</b>	
18	Relationship to Policyholder/Subscriber in #12 above.	<b>Situational.</b>	
19	Student Status	<b>Situational.</b>	
20	Name (Last, First, MI, Suffix) Address, City, State, Zip Code	<p><b>Situational.</b> This field should be used only when other private insurance is primary.</p> <p><b>Note:</b> The Medicaid beneficiary's name is required to be entered in Block 12.</p>	

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21	DOB (MM/DD/CCYY)	<b>Situational.</b>	
22	Gender	<b>Situational.</b>	
23	Patient ID / Account # (Assigned by Dentist)	<b>Optional</b> – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the RA.  The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.	
24	Procedure Date (MM/DD/CCYY)	<b>Required</b> -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only 1 digit in a field, precede that digit with a 0.  A service must have been performed/delivered before billing Medicaid for payment.	

Locator #	Description	Instructions	Alerts
25	Area of Oral Cavity	<b>Situational</b> – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific <b>requirements</b> regarding oral cavity designator.  If an oral cavity designator is <b>required</b> by Medicaid, do not enter a tooth number or letter in Block 27.	Only 1 tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
26	Tooth System	<b>Leave Blank</b>	

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## APPENDIX D: CLAIMS RELATED INFORMATION

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27	Tooth Number(s) or Letter(s)	<p><b>Situational</b> – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific <b>requirements</b> regarding tooth number or letter.</p> <p><u>If a tooth number or letter is <b>required</b> by Medicaid, do not enter an oral cavity designator in Block 25.</u></p>	Only 1 tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.
28	Tooth Surface	<p><b>Situational</b> – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to 5 of the following codes:</p> <p>B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial, and O = Occlusal</p> <p>Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.</p>	



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Locator #	Description	Instructions	Alerts
29	Procedure Code	<b>Required</b> – Enter the all-inclusive encounter code (D0999) on the first line then enter the appropriate dental procedure codes from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.	REMINDER: The all-inclusive encounter code (D0999) must be entered on the first line of the claim form. Tooth number/letter, surface or oral cavity designator is not required for this line. In addition to the encounter information, it is necessary to indicate on subsequent lines of the claim form, the specific dental services provided by entering the individual procedures, including all appropriate line item information for each service rendered.
30	Description	<b>Required</b> – Enter the description of the service performed.	
31	Fee	<b>Required</b> -- Enter the dentist's full (usual and customary) fee for the dental procedure reported.	
32	Other Fee(s)	<b>Leave Blank</b>	
33	Total Fee	<b>Required</b> – Total of all fees listed on the claim form.	

## CHAPTER 40: RURAL HEALTH CLINICS

## APPENDIX D: CLAIMS RELATED INFORMATION

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34	(Place an 'X' on each missing tooth)	<p><b>Situational</b> – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an “X”. Indicate teeth to be extracted with an “/”.</p> <p>In the following circumstances, this information is <b>required</b>:</p> <p>If the claim is for the Adult Denture Program.</p> <p>If the claim is for the EPSDT Dental Program when requesting a prosthetic, space maintainer or root canal therapy.</p>	
Locator #	Description	Instructions	Alerts
35	Remarks	<p><b>Situational</b> – Enter the amount paid by the primary payor if block 9 is completed.</p> <p>Write the words “Carrier Paid” and the amount that was paid by the carrier (including zero [\$0] payment) in this block.</p> <p>Enter any additional information <b>required</b> by Medicaid regarding requested services (including description of the patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include).</p> <p>For PA requests, if the information <b>required</b> in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the beneficiary’s name and Medicaid ID # and the provider’s name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for PA, should be kept in the patient’s treatment record.</p>	
36	Authorizations	<b>Optional.</b>	
37	Authorizations	<b>Optional.</b>	
38	Place of Treatment	<p><b>Situational</b> – Check the applicable box if services are to be, or were provided, at a location other than the address entered in Block 48.</p> <p>If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is <b>required</b>.</p>	

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39	Number of Enclosures	<b>Situational</b> – Enter 00 to 99 in applicable boxes.  Claims submitted for PA are <b>required</b> to contain the identified attachments.  Claims submitted for payment should not contain any of the attachments listed in Block 39.	
40	Is Treatment for Orthodontics?	<b>Situational</b> – Complete if applicable.  Claims requesting comprehensive orthodontic services are <b>required</b> to enter information in this block.  Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.	

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Locator #	Description	Instructions	Alerts
41	Date Appliance Placed	<b>Situational.</b>	
42	Months of Treatment Remaining.	<b>Situational.</b>	
43	Replacement of Prosthesis	<b>Situational</b> – Check appropriate box if applicable; if checked, complete Block 44 if known.	
44	Date Prior Placement	<b>Situational</b> – If Block 43 is checked and if known, enter the appropriate 8-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	<b>Situational</b> – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is <b>required</b> . Check the appropriate box.	
46	Date of Accident (MM/DD/CCYY).	<b>Situational.</b> If Block 45 is completed, then this block is <b>required</b> . Enter the 8-digit date in month, day and year (MM/DD/CCYY).	
47	Auto Accident State	<b>Situational.</b> If Auto Accident is checked in Block 45, this block is <b>required</b> . Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	<b>Required.</b> Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group.  Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	<b>Optional</b> – Enter the billing provider's 10-digit NPI number.	
50	License Number	<b>Optional.</b>	
51	Social Security Number (SSN) or Tax Identification Number (TIN)	<b>Optional.</b>	
52	Phone Number	<b>Required</b> -- Enter the phone number for the billing dental provider.	
52A	Additional Provider ID	<b>Required</b> – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	
53	Signature	<b>Optional.</b>	
54	NPI	<b>Optional</b> – Enter the 10-digit NPI of the treating (attending) dental provider	

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55	License Number	<b>Required</b> – Enter the license number of the treating (attending) dental provider.	
<b>Locator #</b>	<b>Description</b>	<b>Instructions</b>	<b>Alerts</b>
56	Address, City, State, Zip Code	<b>Situational</b> – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48.	
56A	Provider Specialty Code	<b>Optional.</b>	
57	Signature	<b>Optional.</b>	
58	NPI	<b>Optional</b> – Enter the 10-digit NPI of the treating (attending) dental provider	

## CHAPTER 40: RURAL HEALTH CLINICS

## APPENDIX D: CLAIMS RELATED INFORMATION

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## Sample of ADA Claim Form

[illegible]

### **EPSDT Dental Services Adjustment/Void (209) and Adult Dental Services Adjustment/Void (210) Form**

The EPSDT Dental Services 209 Adjustment/Void form (revision date 10/04) must be used when submitting adjustments/voids for EPSDT Dental Program services for all dates of service.

Additionally, when submitting adjustments/voids for the Adult Denture Program for all dates of service, dental providers must use the Adult Dental Services 210 Adjustment/Void form (revision date 10/04).

For both adjustment/void forms, the Form Locator 15 has been renamed as “Patient I.D./Account# Assigned by Dentist”. If the patient’s account (medical record) number is entered here, it will appear on the Medicaid RA. It may consist of letters and/or numbers, and it may be a maximum of 20 positions.

Providers can obtain these forms from Gainwell Technologies or through the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com). Instructions for completing the forms can also be obtained on the Medicaid website or within this document.

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## Instructions for Completing 209 Adjustment/Void Form (EPSDT)

Locator #	Description	Instructions	Alerts
1	Adjust/Void	Check the appropriate box.	
2 3 4	Patient's Last Name, First Name, MI	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
7	DOB	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
8	Sex	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider No.	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required.	



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19	Treatment Necessitated By	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
Locator #	Description	Instructions	Alerts
20	Payment Source Other Than Title XIX	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
21, 22		Leave these spaces blank.	
23	Diagram	Not required.	
24	Examination and Treatment Plan	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
25	Paid or Payable by Other Carrier	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero (\$0). <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
26	Control Number	Enter the control number assigned to the claim on the RA that reported the claim as paid/approved.	
27	Date of RA	Enter the date of the RA that paid or denied claim.	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for PA	Enter the 9-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires PA.	
32	Attending Dentist's Provider Number	<b>The provider number must be entered.</b>	

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If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Gainwell Technologies for adjustment. If the code was submitted on the original invoice, and PA was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

## CHAPTER 40: RURAL HEALTH CLINICS

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### Sample of 209 Adjustment/Void Form (EPSDT)

<b>PREAUTHORIZATION MAIL TO:</b> Louisiana Department of Health MEDICAL DENTAL PROGRAM P.O. BOX 980 BATON ROUGE, LA 70821-0090		<b>FOR PAYMENT REMIT TO:</b> DXC TECHNOLOGY P.O. BOX 91022 BATON ROUGE, LA 70821 (800) 473-2783 (225) 924-5040		LOUISIANA DEPARTMENT OF HEALTH BUREAU OF HEALTH SERVICES FINANCING MEDICAL ASSISTANCE PROGRAM PROVIDER BILLING FOR EPD/D DENTAL SERVICES		Patient ID/Account Number <div style="font-size: 2em; font-weight: bold; color: blue;">SAMPLE</div>																															
<div style="float: right; text-align: right;">FOR OFFICE USE ONLY</div>																																					
<b>1 NO.</b> <input checked="" type="checkbox"/> <b>X</b> <b>VOID</b> <input type="checkbox"/>		<b>2 PATIENT'S LAST NAME (PRINT)</b> <span style="font-size: 1.2em;">Smith</span>		<b>3 FIRST NAME</b> <span style="font-size: 1.2em;">Sally</span>		<b>4 SEX</b> <span style="font-size: 1.2em;">L</span>																															
<b>5 MEDICAL ASSISTANCE ID NUMBER</b> <div style="display: flex; justify-content: space-between;"> <span>1</span><span>2</span><span>3</span><span>4</span><span>5</span><span>6</span><span>7</span><span>8</span><span>9</span><span>0</span><span>1</span><span>2</span><span>3</span> </div>																																					
<b>6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)</b> <div style="display: flex; justify-content: space-between;"> <span>7 DATE OF BIRTH</span> <span>8 SEX</span> </div>																																					
<div style="display: flex; justify-content: space-between;"> <span>9 REFERRING AGENCY NO.</span> <span>10 DATE OF REFERRAL</span> <span>11 REFERRED FOR: <input type="checkbox"/> EMERGENCY <input checked="" type="checkbox"/> BASIC SCREENING</span> <span>12 DENTIST OR GROUP REFERRED TO: NAME _____ ADDRESS _____ TEL. NO. _____</span> </div>																																					
<div style="display: flex; justify-content: space-between;"> <span>13 REFERRED BY (SIGNATURE)</span> <span>14 TELEPHONE NO.</span> <span>15 PATIENT'S ACCOUNT # ASSIGNED BY DENTIST</span> </div>																																					
<div style="display: flex; justify-content: space-between;"> <span>16 PAY TO: DENTIST OR GROUP NAME _____ ADDRESS _____ CITY _____ ST. _____ ZIP _____</span> <span>17 PAY TO: DENTIST OR GROUP PROVIDER NO. <span style="font-size: 1.2em;">1800000</span></span> </div>																																					
<div style="display: flex; justify-content: space-between;"> <span>18 ARE X-RAYS ENCLOSED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NUMBER OF X-RAYS _____</span> <span>19 TREATMENT NECESSARY BY: A. EMPLOYMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO B. ACCIDENT/INJURY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</span> </div>																																					
<div style="display: flex; justify-content: space-between;"> <span>20 PAYMENT SOURCE OTHER THAN TITLE XXXI, CARRIER CODE: 1. _____ 2. _____ 3. _____</span> </div>																																					
<div style="display: flex; justify-content: space-between;"> <span>21 IF PROGRESSIVE, IS THIS THE INITIAL PLACEMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</span> <span>22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OHS DENTAL PROGRAM <input type="checkbox"/></span> </div>																																					
<b>23 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.</b>																																					
<table border="1" style="width: 100%; border-collapse: collapse; font-size: 0.8em;"> <thead> <tr> <th>A. TOOTH # OR LETTER</th> <th>B. SURFACE</th> <th>C. PROCEDURE CODE</th> <th>D. DESCRIPTION OF SERVICE</th> <th>E. UNITS</th> <th>F. DATE SERVICE PERFORMED MO DAY YR</th> <th>G. ADJUSTED FEE (FOR STATE USE ONLY)</th> <th>H. USUAL AND CUSTOMARY FEE</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><span style="font-size: 1.2em;">16</span></td> <td></td> <td style="text-align: center;"><span style="font-size: 1.2em;">D2931</span></td> <td style="text-align: center;"><span style="font-size: 1.2em;">Stainless Steel Crown</span></td> <td></td> <td style="text-align: center;"><span style="font-size: 1.2em;">02 16 12</span></td> <td></td> <td style="text-align: center;"><span style="font-size: 1.2em;">135 00</span></td> </tr> <tr> <td colspan="4" style="text-align: center;">H. ORAL CAVITY</td> <td></td> <td colspan="2"></td> <td></td> </tr> <tr> <td colspan="6"></td> <td>25 PAID OR PAYABLE BY OTHER CARRIER</td> <td>\$</td> </tr> </tbody> </table>						A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	E. UNITS	F. DATE SERVICE PERFORMED MO DAY YR	G. ADJUSTED FEE (FOR STATE USE ONLY)	H. USUAL AND CUSTOMARY FEE	<span style="font-size: 1.2em;">16</span>		<span style="font-size: 1.2em;">D2931</span>	<span style="font-size: 1.2em;">Stainless Steel Crown</span>		<span style="font-size: 1.2em;">02 16 12</span>		<span style="font-size: 1.2em;">135 00</span>	H. ORAL CAVITY														25 PAID OR PAYABLE BY OTHER CARRIER	\$
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H. ORAL CAVITY																																					
						25 PAID OR PAYABLE BY OTHER CARRIER	\$																														
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>26 CONTROL NUMBER</b>  <div style="border: 1px solid black; height: 30px; width: 100%;"></div> </div> <div style="width: 50%; font-size: 0.7em;">             THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVISE IS ALWAYS REQUIRED.)           </div> </div>																																					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>27 REASONS FOR ADJUSTMENT</b>  <div style="margin-top: 10px;"> <input checked="" type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY  <input type="checkbox"/> 02 PROVIDER CORRECTIONS  <input type="checkbox"/> 03 FISCAL AGENT ERROR  <input type="checkbox"/> 90 STATE OFFICE USE ONLY - RECOVERY  <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN           </div> </div> <div style="width: 35%;"> <div style="color: blue; font-weight: bold;">Billed wrong tooth #; should be tooth #16, not 15.</div> <hr/><hr/><hr/><hr/><hr/><hr/><hr/><hr/> </div> </div>																																					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>28 REASONS FOR VOID</b>  <div style="margin-top: 10px;"> <input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT  <input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER  <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN           </div> </div> <div style="width: 35%;"> <hr/><hr/><hr/><hr/><hr/><hr/><hr/><hr/> </div> </div>																																					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>29 I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.</b>  <b>30 REQUEST FOR AUTHORIZATION - SEND TO LDH DENTAL PROGRAM</b>  <div style="margin-top: 10px;">             ATTENDING DENTIST'S SIGNATURE _____              PROVIDER NUMBER _____ DATE _____           </div> </div> <div style="width: 35%;"> <div style="text-align: center;">APPROVED - YES <input type="checkbox"/> NO <input type="checkbox"/> W/EXCEPTIONS <input type="checkbox"/></div> <div style="text-align: center; margin-top: 10px;"> <span style="font-weight: bold; color: blue;">PA 123456780</span>              AUTHORIZED SIGNATURE _____ DATE _____           </div> </div> </div>																																					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>31 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)</b>  <div style="margin-top: 10px;">             ATTENDING DENTIST'S SIGNATURE _____              PROVIDER NUMBER _____ DATE _____           </div> </div> <div style="width: 35%;"> <div style="text-align: center;">DR DDS</div> <div style="text-align: center; margin-top: 10px;"> <span style="font-weight: bold; color: red;">1888888</span>              PROVIDER NUMBER _____           </div> </div> </div>																																					

## CHAPTER 40: RURAL HEALTH CLINICS

## APPENDIX D: CLAIMS RELATED INFORMATION

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## Instructions for Completing 210 Adjustment/Void Form (Adult)

Locator #	Description	Instructions	Alerts
1	Adjust/Void	Check the appropriate box.	
2 3 4	Patient's Last Name First Name MI	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
5	Medical Assistance ID Number	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
6	Patient's Address	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
7	DOB	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
8	Sex	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
9-14		Not Required.	
15	Patient ID/Account Number (Assigned By Dentist)	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
16	Pay to Dentist or Group	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
17	Pay to Dentist or Group Provider No.	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
18	Are X-Rays Enclosed	Not required.	
19	Treatment Necessitated By	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	

## CHAPTER 40: RURAL HEALTH CLINICS

## APPENDIX D: CLAIMS RELATED INFORMATION

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Locator #	Description	Instructions	Alerts
20	Payment Source Other Than Title XIX	<b>Adjust</b> - Enter the information exactly as it appeared on the original invoice, unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. <b>Void</b> - Enter the information exactly as it appeared on the original invoice.	
21		Not required,	
22		Leave blank,	
23	A-G	<b>Adjust</b> – Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. <b>Void</b> - Enter the information exactly as it appeared on the original invoice,	
24	Paid of Payable by Other Carrier	<b>Adjust</b> – Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero (\$0). <b>Void</b> - Enter the information exactly as it appeared on the original invoice,	
25	Other Information	Leave blank,	
26	Control Number	Enter the control number assigned to the claim on the RA that reported the claim as paid/approved.	
27	Date of RA	Enter the date of the RA that paid or denied claim,	
28, 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.	
30	Request for Authorization	Leave this space blank.	
31	Request for PA	Enter the 9-digit PA number assigned by Medicaid on the authorized signature line when submitting for a service that requires PA.	
32	Attending Dentist's Provider Number	The provider number must be entered.	

**CHAPTER 40: RURAL HEALTH CLINICS****APPENDIX D: CLAIMS RELATED INFORMATION****PAGE(S) 35**

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If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Gainwell Technologies for adjustment. If the code was submitted on the original invoice, and PA was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

## CHAPTER 40: RURAL HEALTH CLINICS

## APPENDIX D: CLAIMS RELATED INFORMATION

PAGE(S) 35

## Sample of 210 Adjustment/Void Form (Adult)

FOR PREAUTHORIZATION MAIL TO: LSU SCHOOL OF DENTISTRY MEDICAID DENTAL PROGRAM 1100 FLORIDA AVE., BOX 510 NEW ORLEANS, LA 70119		FOR PAYMENT REMIT TO: DXC Technology P.O. BOX 01002 BATON ROUGE, LA 70821 (800) 473-2700 (225) 524-5040		LOUISIANA DEPARTMENT OF HEALTH BUREAU OF HEALTH SERVICES FINANCING MEDICAL ASSISTANCE PROGRAM PROVIDER BILLING FOR ADULT DENTAL SERVICES		Patient ID/Account Number <b>SAMPLE</b>	
<b>1</b> ADJ. <input checked="" type="checkbox"/> VOID <input type="checkbox"/>		<b>2</b> PATIENT'S LAST NAME (PRINT) <b>Que</b>		<b>3</b> FIRST NAME <b>Susie</b>		<b>4</b> MI <b>L</b>	
<b>5</b> PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.)		<b>6</b> DATE OF BIRTH <b>06 19 1955</b>		<b>7</b> SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		<b>8</b> MEDICAL ASSISTANCE I.D. NUMBER <b>1 2 3 4 5 6 7 8 9 0 1 2 3</b>	
<b>9</b> REFERRING AGENCY NO.		<b>10</b> DATE OF REFERRAL		<b>11</b> DENTIST OR GROUP REFERRED TO: NAME ADDRESS TEL. NO.		<b>12</b> PAY TO: DENTIST OR GROUP PROVIDER NO. <b>180000</b>	
<b>13</b> REFERRED BY: (SIGNATURE)		<b>14</b> TELEPHONE NO.		<b>15</b> TREATMENT NECESSITATED BY: A. EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. ACCIDENT/INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>16</b> ARE X-RAYS ENCLOSED? <input type="checkbox"/> YES <input type="checkbox"/> NO NUMBER OF X-RAYS <b>23</b> PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODE: 1. _____ 2. _____ 3. _____	
<b>17</b> IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>18</b> PAY TO: DENTIST OR GROUP PROVIDER NO. <b>180000</b>		<b>19</b> TREATMENT NECESSITATED BY: A. EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. ACCIDENT/INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>20</b> ARE X-RAYS ENCLOSED? <input type="checkbox"/> YES <input type="checkbox"/> NO NUMBER OF X-RAYS <b>23</b> PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODE: 1. _____ 2. _____ 3. _____	
<b>21</b> PROCEDURE CODE <b>D0999</b>		<b>22</b> DESCRIPTION OF SERVICE <b>Encounter All Inclusive</b>		<b>23</b> DATE SERVICE PERFORMED MO. <b>01</b> DAY <b>20</b> YEAR <b>12</b>		<b>24</b> ADJUSTED FEE (FOR STATE USE ONLY) <b>125 00</b>	
<b>25</b> ORAL CAVITY		<b>26</b> TOOTH #		<b>27</b> PAID OR PAYABLE BY OTHER CARRIER \$		<b>28</b> USUAL AND CUSTOMARY FEE <b>125 00</b>	
<b>29</b> (1) IS THE PATIENT EDENTULOUS? MAXILLARY: NO <input type="checkbox"/> YES <input type="checkbox"/> DATE OF LAST EXTRACTIONS MANDIBULAR: NO <input type="checkbox"/> YES <input type="checkbox"/> DATE OF LAST EXTRACTIONS (2) DOES PATIENT PRESENTLY WEAR A DENTURE? MAXILLARY: NO <input type="checkbox"/> YES <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> MO. _____ YR. _____ MANDIBULAR: NO <input type="checkbox"/> YES <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> MO. _____ YR. _____ COMMENTS: _____ _____ _____ INFORMATION FROM PATIENT (1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER _____ LOWER _____ (2) NAME AND ADDRESS OF DENTIST (3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>30</b> CONTROL NUMBER <b>2131198765400</b>		<b>31</b> THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVISE IS ALWAYS REQUIRED.)		<b>32</b> DATE OF REMITTANCE ADVISE THAT LISTED CLAIM WAS PAID. <b>05/08/12</b>	
<b>33</b> REASONS FOR ADJUSTMENT <input checked="" type="checkbox"/> 01 THIRD PARTY LIABILITY RECOVERY <input type="checkbox"/> 02 PROVIDER CORRECTIONS <input type="checkbox"/> 03 FISCAL AGENT ERROR <input type="checkbox"/> 00 STATE OFFICE USE ONLY - RECOVERY <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN <b>Billed wrong charge amount. Initially billed \$12.50 instead of 125.00</b>		<b>34</b> REASONS FOR VOID <input type="checkbox"/> 10 CLAIM PAID FOR WRONG RECIPIENT <input type="checkbox"/> 11 CLAIM PAID TO WRONG PROVIDER <input type="checkbox"/> 99 OTHER - PLEASE EXPLAIN		<b>35</b> I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.		<b>36</b> REQUEST FOR AUTHORIZATION - SEND TO OPS DENTAL PROGRAM APPROVED YES <input type="checkbox"/> NO <input type="checkbox"/> W/EXCEPTIONS <input type="checkbox"/>	
<b>37</b> REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY) ATTENDING DENTIST'S SIGNATURE PROVIDER NUMBER DATE		<b>38</b> REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY) APPROVED YES <input type="checkbox"/> NO <input type="checkbox"/> W/EXCEPTIONS <input type="checkbox"/>		<b>39</b> ATTENDING DENTIST'S SIGNATURE <b>Dr. DDS DR DDS</b> <b>1888888 05/20/12</b> PROVIDER NUMBER		<b>40</b> PROVIDER NUMBER	

DXC - 210  
02/2020





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**CHAPTER 40: RURAL HEALTH CLINICS**

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**APPENDIX F: RESERVED**

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