
CHAPTER 40: RURAL HEALTH CLINICS

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REIMBURSEMENT

Rural Health Clinics (RHC) 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.

Rates**Determination of Rate**

To determine the baseline rate for RHCs enrolled in Louisiana Medicaid prior to January 1, 2001, each clinic's 1999 and 2000 allowable costs were taken from the RHC's filed 1999 and 2000 Medicaid cost reports. These costs were totaled and divided by the total number of Medicaid patient visits in the cost report years. The baseline calculation included all Medicaid coverable services provided by the RHC regardless of existing methods of reimbursement for said services.

For RHCs beginning operation in 2000 and having only a 2000 cost report available for determining the interim PPS rate, the 2000 allowable cost was divided by the total number of Medicaid patient visits for 2000. Upon receipt of the 2001 cost report, the rate methodology was applied using 2000 and 2001 costs and Medicaid patient visits to determine the baseline rate.

Any RHC that begins operation on or after January 1, 2001 and enrolls in Louisiana Medicaid will have their rates established through comparison of a clinic located in the same area or adjacent area with a similar case load or in the absence of such clinics, in accordance with the regulations establishing the baseline PPS rates for RHCs.

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% of their cost as reported from their latest filed cost report.

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

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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 Social Security Act.

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 the BHSF Program Operations Section, 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:

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

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 two 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 state-wide average or the PPS rate assigned to that RHC in its state's location.

Notice of Rate Setting

The BHSF Program Operations Section will send written notice to the clinic notifying the clinic of the reimbursement rate per encounter and the methodology used to establish the rate.

The Program Operations Section or its contracted auditing agency will reconcile the initial PPS rates for provider based RHCs to the final audited PPS rates and inform the clinic of the rate determination and any reconciling amounts owed or due to/from the clinic.

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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 five months of the clinic'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 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.

Encounter Visits

An RHC provider is limited to reimbursement of one medical (inclusive of mental health services) encounter and one dental encounter per day, except when a recipient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

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.

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 hours. The reimbursement is a flat fee in addition to the reimbursement for the associated encounter. Reimbursement is limited to 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 is not allowed when the encounter is for dental services only.

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Billing**Medical/Behavioral Encounters**

Medical/behavioral health services are reimbursed as encounters. Encounter visits must be billed on a CMS-1500 using encounter code T1015. The encounter reimbursement includes all services provided to the recipient on that date of service and any services on a subsequent day incident to the original encounter visit. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service provided on subsequent lines.

When behavioral health services are the only services provided during an encounter, and they are administered by a licensed clinical social worker or a clinical psychologist, the RHC provider identification number must be placed as both the billing and attending provider with the appropriate modifiers and detail line procedure codes on the claim.

A visit to pick up a prescription or a referral is not considered a billable encounter. Lab 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 medical encounter which warranted these additional services.

If a covered service is provided via an interactive audio and video telecommunications system (telemedicine), it must be identified on the claims form by appending the Health Insurance Portability and Accountability Act (HIPAA) 1996 complaint modifier “GT” to the appropriate procedure code.

For obstetrical services, providers must bill the encounter code T1015 with modifier TH and all services performed on that date of service. When this modifier is used, the visit is not counted in the 12 office and other outpatient visit limit for recipients 21 years and older.

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

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. Providers should bill their usual and customary charges for payment of the adjunct procedure code.

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Services

EPSDT screening services must be billed using the 837P Professional format using encounter code T1015 with modifier EP.

It will be necessary to indicate the specific screening services provided by entering the individual procedure code for each service rendered on the appropriate line. If a registered nurse performs the screening, the appropriate procedure code must be entered followed by the modifier TD.

If immunizations are given at the time of the screening, then those codes continue to be billed on the CMS-1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and modifier EP must include supporting detail procedures. Only a physician doing a screening should bill with no modifier.

Dental Encounters

All dental services must be billed on the 2006 ADA claim form using the encounter code D0999. It will be necessary for providers to indicate the specific dental services provided by entering the procedure code for each service rendered on subsequent lines. All claims billed using D0999 must include supporting detail procedures.

The Recipient Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain recipient eligibility information. Providers should keep hardcopy proof of eligibility from MEVS on file. Medicaid eligibility verification is also available on the web. (See Appendix A for web information)

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

Medicare/Medicaid Dual Eligible Billing

Medicaid pays the Medicare co-insurance, up to the Medicaid established encounter rate, for recipients who are eligible for Medicare and Medicaid. Providers should first file claims with the regional Medicare fiscal intermediary/carrier, ensuring the recipient's Medicaid 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, a copy of the Medicare claims and put the Medicaid provider number and Medicaid recipient number in the appropriate form locators. (See Appendix A for information on where to send the claim)

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Note: This is the only instance where Louisiana Medicaid may be billed using the UB92/UB04 for RHC services. Straight Medicaid 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.