CHAPTER 522—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

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DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal laws and regulations.

CHAPTER 522–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive scope of medically necessary medical and behavioral health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of services provided by Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to eligible WV Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of services by RHC and FQHC facilities in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia State Code.

522.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of services provided by RHCs and FQHCs as described in this chapter.

Physician Assistant - An individual who meets the applicable education, training experience and other requirements of 42 CFR 491.2 and applicable WV requirements governing the qualifications of physician assistants as promulgated in West Virginia Code § 30-3-16, the provisions of which are implemented by West Virginia Legislative Rule 11 CSR 1B.

Rural Health Clinic (RHC) - A class of providers authorized by Section 1102 of the Social Security Act, September 19, 1978, which are located in designated medical shortage areas, employing nurse practitioners and/or physician assistants under the supervision of physicians.

Rural Health Clinic/Federally Qualified Health Center Services - The services furnished by a physician within the scope of practice of his/her profession under State law and services furnished by a physician assistant, nurse practitioner, nurse midwife, and licensed clinical social worker or licensed clinical psychologist, who is duly authorized to perform such services under state law. Such services may be furnished in the RHC/FQHC location or away from the clinic by one of the above mentioned practitioners who has an agreement with the clinic that the practitioner will be paid by the clinic for such services.

522.2 PROVIDER PARTICIPATION REQUIREMENTS

In addition to requirements established in Chapter 300, RHCs and FQHCs must meet the specific requirements below in order to participate in and receive payment from BMS:

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- Be certified by the Centers for Medicare and Medicaid Services (CMS) as a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)
- Submit the CMS certification notice to BMS or designated fiscal agent.
- Submit the State licensure documentation to BMS or designated fiscal agent.
- Submit the reimbursement rate as determined by the federally designated fiscal intermediary
- RHCs and FQHCs must either directly employ or contract the services of legally credentialed professional staff who are authorized within their scope of practice under state law to provide the services for which claims are submitted to Medicaid. Those professional staff includes physicians, physician assistants, nurse practitioners, nurse midwifes, licensed clinical psychologists, and licensed clinical social workers. Professional staff contracted or employed by the FQHC or Rural Health Clinic will be required to individually enroll with the Bureau for Medical Services and will be affiliated with the facility which employs them. The reimbursement for the services rendered at or on behalf of the RHC or FQHC will be made to the facility. It should be noted that this provider enrollment and reimbursement process in no way changes the Bureau for Medical Services' policy with regard to reimbursement of practitioners. Licensed clinical social workers and physician assistants are still not eligible for direct reimbursement as practitioners. Their services are recognized for reimbursement only, to their employers in those clinical settings in which they are currently approved to render services.
- The RHC/FQHC may only be reimbursed for those services defined in Section 522.4.5. If the facility chooses to provide other Medicaid State Plan covered ambulatory services which are not included in the RHC/FQHC definition, the practitioners of those services, dentists, optometrists, pharmacists, etc., must be individually enrolled as participating providers and bill for those services over their assigned provider number, consistent with program coverage limitations and billing procedures described by the Bureau.
- The application and required certification, licensing, reimbursement documentation and any other information required by the Bureau must be returned to:

  Unisys Provider Enrollment
  P.O. Box 625
  Charleston, West Virginia 25322

522.3 MEMBER ELIGIBILITY

Payment for covered medically necessary and medically appropriate services provided by RHCs and FQHCs is available on behalf of all Medicaid members subject to the conditions and limitations that apply to these services.

522.4 COVERED SERVICES

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The Bureau will reimburse RHCs and FQHCs on a per visit basis for covered medically necessary and appropriate professional services rendered to eligible Medicaid members by their affiliated, enrolled practitioners: (Reference Section 522.10).

522.4.1 PHYSICIAN SERVICES

Physician services are defined as professional services performed by a physician at the RHC or FQHC or away from the clinic by a physician whose agreement with the clinic provides that he/she will be paid by the clinic for such services.

522.4.2 OTHER PRACTITIONER SERVICES

Nurse Practitioner services and Physician Assistant services are professional services furnished by a nurse practitioner, physician assistant, or nurse midwife who are employed by or receiving compensation from the RHC or FQHC for such services performed under the medical direction or oversight of a physician in accordance with established protocols or medical orders for the care and treatment of a member.

522.4.3 LICENSED CLINICAL PSYCHOLOGIST AND LICENSED CLINICAL SOCIAL WORKER SERVICES

Licensed clinical psychologist and licensed clinical social worker services are professional behavioral health services furnished by a licensed clinical psychologist or licensed clinical social worker, who is duly authorized to perform such services under state law, when said services are performed at or on behalf of the RHC or FQHC by a licensed clinical psychologist or licensed social worker employed by or receiving compensation from the RHC or FQHC.

522.4.4 SERVICES/SUPPLIES INCIDENTAL TO PRACTITIONER SERVICES

The reimbursement for professional services includes services/supplies incidental to the services being rendered. Such supplies are:

- commonly furnished in the practitioner's office
- commonly furnished without charge or included in the RHC or FQHC's private pay bill
- furnished as an incidental, though integral part, of a practitioner's professional service by the practitioner or a member of the clinic's staff
- a drug or biological that cannot be self administered, including vaccinations

522.4.5 FACILITY SERVICES

RHC and FQHC services are covered on a per visit basis established by a face-to-face encounter between a clinic, patient (Medicaid member), and a practitioner.

- Encounters with more than one medical healthcare practitioner, or multiple encounters with the same medical healthcare practitioner that take place on the same date of service and at a single location, constitute a single visit. Reimbursement will be available for two visits per day only when the member has a medical visit/encounter and a behavioral health visit, or the member has two medical encounters that are unrelated See **Attachment 1** for the procedures considered to be included in a medical visit. See

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Attachment 2 for the procedures considered to be included in the behavioral health visit.

- A medical visit is a face-to-face encounter between the patient and a physician, nurse practitioner, nurse midwife, or physician's assistant.
- A behavioral health visit is a face-to-face encounter between the patient and the clinical psychologist or clinical social worker.

522.5 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual. In addition, the following limitations and requirements apply to services provided by RHC and FQHC facilities:

- If two unrelated medical encounters occur on the same day, documentation must be provided with (accompany) the claims and mailed directly to the Bureau's claims processing provider relations department. In an RHC, if a member is seen in the clinic and subsequently admitted on the same day as the clinic visit, the above rules apply. FQHC services are not covered in a hospital as defined in 1861E1 of the Social Security Act.
- Psychologist and social worker services are limited to those services furnished to members at or on behalf of the clinic or center. Behavioral health visits are limited to ten occurrences per eligible member per calendar year.
- Supplies and materials, and any drugs that are administered to the member, are considered a part of the physician's or other health care practitioner's service and are included in the per-visit rate.
- Laboratory procedures performed by a RHC or FQHC (not an independently certified enrolled laboratory) are considered part of the health care practitioner's service and are included in the per-visit rate.

522.6 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, BMS will not pay for the following services:

- Duplicating and providing medical records requested by the U.S. Department of Health and Human Services (DHHS) for eligibility determination purposes. The cost for providing such records is an administrative cost to the RHC or FQHC which is included in the per visit rate and not reimbursable as a separate service.
- Telephone consultations, including, but not limited to, information or services provided to a member
- Failed appointments, including, but not limited to, appointments that are cancelled
- Time spent in preparation of reports
- A copy of a medical report when the DHHR or the Bureau paid for the original service

522.7 PRIOR AUTHORIZATION REQUIREMENTS

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RHC/FQHC visits, whether medical or behavioral health, are not subject to prior authorization. Other state plan covered services which the RHC/FQHC chooses to provide are subject to all applicable Medicaid regulations which govern the provision and coverage for that service. Ref. Section 522.10.1. Services rendered to HMO members are subject to the HMO rules with regard to prior authorization requirements and service limitations.

522.8 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

RHC and FQHC facilities must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information; Chapter 300, Provider Participation; and Chapter 800, General Administration of the Provider Manual.

- Must maintain documentation that substantiates the nature and scope of services rendered and for which these providers submit claims to the WV Medicaid Program, which includes at a minimum a service note describing the activity performed, the date of service, signature and title of person providing the service.
- Must make such documentation and information available to the Bureau or designated representatives upon request.

522.9 BILLING PROCEDURES

Claims for services rendered to Medicaid members must be filed by the RHC/FQHC on the UB92 claim form or the ASC X12N 837 (004010X096A1) electronic claim format. Claims must be filed within 12 months of the date of service. The encounter code is T1015, billed with Revenue Code 52X for a medical visit. For a behavioral health visit, the encounter code is billed with the behavioral health program modifier (T1015 HE) and Revenue Code 91X. The RHC/FQHC claim must list actual CPT/HCPCS procedure codes and appropriate revenue codes (as defined by the Medicare carrier) to identify the services included in the encounter. The facility may bill the actual charge or indicate a charge of zero for those individual services, but must bill the total charge for the encounter.

522.10 RHC/FQHC REIMBURSEMENT METHODOLOGY

Reimbursement is based on an all-inclusive per visit rate as determined by the Medicare fiscal intermediary. The behavioral health visit is reimbursed at 62.5 (62.5%) percent of the facility's Medicare (medical) encounter rate.

Ambulatory services not included in the encounter rate and covered by the West Virginia Medicaid State Plan are reimbursed at the rate set for each service. The professional practitioners (i.e. dentists, optometrists, etc.) providing those services, must be individually enrolled as participating providers and bill for those services. Both RHC and FQHC services are subject to year-end cost reconciliation and cost settlement.

522.10.1 MEDICAID MANAGED CARE REIMBURSEMENT

The West Virginia Medicaid Managed Care Program reimburses RHC and FQHC facilities using the per visit rate established by Medicare for the medical visits. Effective with services rendered on and after July 1, 2004, Mountain Health Trust HMOs will begin to use the same reimbursement methodology to pay for the medical visit. This change in policy and reimbursement methodology will eliminate the need for the supplemental or wrap-around payment from BMS to reimburse facilities directly for the difference between the encounter rate.

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Behavioral health visits are not reimbursed by the HMOs. Behavioral health visits for Medicaid members must be billed directly to the Medicaid Program.

If a member is enrolled in an HMO, the prior authorization requirements of the member's HMO must be followed. If a member is participating in the PAAS Program, the PCP on the member's card is responsible for treatment or referrals for reimbursement. Medicaid will not reimburse providers when these requirements are not followed.

522.11 REPORTING REQUIREMENTS

RHC and FQHC facilities must file a copy of their annual cost report, as submitted to the Medicare fiscal intermediary, with the Bureau for Medical Services. That cost report must be submitted annually to:

Bureau for Medical Services
Department of Health and Human Resources
Division of Rate Setting
350 Capitol Street Room 251
Charleston, West Virginia 25301

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CHAPTER 522
RHC & FQHC SERVICES
JULY 1, 2004

ATTACHMENT 1
SERVICES INCLUDED
IN MEDICAL VISIT
PAGE 1 of 3

Services Included in the Encounter Rate of FQHC and RHC

E/M SERVICES
99201
99202
99203
99204
99205
99211
99212
99213
99214
99215

PREVENTIVE SERVICES/EPSDT
99381
99382
99383
99384
99385
99391
99392
99393
99394
99395
92551
96110 EP

W0001
99178
W2292

LABS
Any CLIA Waived designated test performed by the facility that is billed in conjunction with a face to face visit is considered inclusive of the encounter rate. A list of CLIA Waived designated tests are found on CMS' website at www.cms.hhs.gov/clia.

SURGICAL
10000 - 69999

VACCINES (ADMININSTRATION OF)
90471 - 90749 BILLED IN CONJUNCTION WITH EPDST OR E/M SERVICE

MEDICAL SUPPLIES
Any supply defined within the procedure code definition as included in the professional service
For Example:
A4570 – Splint
A4565 – Slings
A4580 - Cast Supplies
A4590 - Special Casting Material

MEDICAL SUPPLIES
A4550 - Surgical Trays
Considered incidental and inclusive of the encounter rate

ELIGIBILITY EXAMS
Prior to 7/1/04
W1500
W1505
W1507

On or after 7/1/04
99450
99456
96100

PRENATAL CARE
W5948 / 99213 TH

INJECTABLES
J0000 - J9999
When billed in conjunction with a face to face encounter,

MEDICINE :
Ophthalmological (92002 -92499)
Otorhinolaryngologic (92502 - 92700)
Cardiovascular (92950 - 93990)
Pulmonary (94010 -94799)
Health & Behavior Assessment/Intervention (96150 - 96155)
Allergy & Clinical Immunology (95004-95199)

FAMILY PLANNING
Family planning encounters including supplies are inclusive of the encounter rate

SERVICES EXCLUDED FROM THE ENCOUNTER RATE
Radiology
Lab (except for those services listed as inclusive when billed in conjunction with a face to face encounter)
Pathology
Physical Therapy
Occupational Therapy
Speech Therapy
Inpatient Hospital
Emergency room services
Observation
Dental
EKG / EEG /ECG (Technical portion only)
Fetal Non-Stress Test (Technical portion only)
Prosthethic Devices
DME
Nursing Home Services
Optometric Services

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RHC & FQHC SERVICES
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ATTACHMENT 2
BEHAVIORAL HEALTH

The following lists the allowable procedure codes for RHC/FQHC Behavioral Health Visit.

96150 Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

96151 Re-assessment

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual

96153 Group (2 or more patients)

96154 Family (with the patient present)

96155 Family (without the patient present)