MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Rural Health Clinics 02-04

Issued: September 1, 2002

Subject: Rural Health Clinic Manual Revision

Effective: October 1, 2002

Programs Affected: Medicaid

The attached Rural Health Clinic (RHC) Manual revisions detail policy and procedure changes for the Michigan Rural Health Clinic program. These manual pages update and supersede current policies and procedures.

Pursuant to the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the Michigan Department of Community Health will eliminate the Balanced Budget Refinement Act of 1999 phase-down effective October 1, 2000. Section 702 of BIPA requires the Department to implement the new prospective payment system for services provided by RHCs on and after January 1, 2001 during fiscal year 2001. BIPA is implemented with Fiscal Year 2001 reconciliations.

Manual Maintenance

The Rural Health Clinic should **DISCARD** the entire Rural Health Clinic manual and replace it with the attached pages.

Questions

Any questions regarding this bulletin should be directed to: Provider Support, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved

James K. Haveman, Jr.
Director

Patrick Barrie
Deputy Director
Health Programs Administration

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FOREWORD

Following is the Medicaid Manual for Rural Health Clinics (RHCs). This manual gives instructions unique for the RHCs and is to be used in combination with other Medicaid provider manuals, especially the Medical Services Administration's Medicaid Practitioner Manual, Chapters I, II, III and IV.

GENERAL PROGRAM INFORMATION

The Centers for Medicare and Medicaid Services (CMS), within the United States Department of Health and Human Services, determines which providers qualify as Rural Health Clinics (RHCs).

In compliance with the Rural Health Clinic Services Act of 1977 (Public Law 95-210), the Medicaid Program administered by the Michigan Department of Community Health (DCH) will reimburse a qualified Rural Health Clinic (RHC).

RURAL HEALTH CLINIC AND DCH AGREEMENTS

The DCH may enter into agreements with RHCs. The signed agreements will supersede any corresponding policy in the RHC manual.

MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT ACT (BIPA) OF 2000

Effective January 1, 2001, the Rural Health Clinics receive a payment for RHC services in an amount (calculated on a per visit basis) that is compliant with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

The per visit payment will be based on the average of the RHC's reasonable costs of providing Medicaid services during FY 1999 and FY 2000. Reasonable costs are defined as the per visit amount paid by Medicare.

ENTRY INTO PROGRAM

Providers qualifying as RHCs after April 1, 1990 must submit an acceptable reconciliation report to the DCH. If DCH does not receive an acceptable reconciliation report within the required time limit (including approved extensions), the RHC waives its rights to the prospective payment reimbursement for that year.

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MEDICAID ENROLLMENT

The RHC must enroll in the Medicaid Program each employed or subcontracted RHC physician, dentist, optometrist, podiatrist, chiropractor, certified nurse practitioner (who has a collaborative agreement with a physician), and certified nurse-midwife in order for these providers to bill a prospective payment system on behalf of the RHC. This requirement also applies to any off-site location under contract to the RHC. As stated in the Michigan Department of Community Health (DCH) Medicaid Practitioner Manual, each provider must have a completed and signed Medical Assistance Provider Enrollment Agreement (DCH-1625) on file with the Provider Enrollment Unit to be reimbursed for covered services rendered to Medicaid eligible beneficiaries.

The RHC must enroll in the Medicaid Program any new physician, dentist, optometrist, podiatrist, chiropractor, certified nurse practitioner (who has a collaborative agreement with a physician), certified nurse-midwife, or subcontractor joining the RHC by completing and submitting a Medical Assistance Provider Enrollment Agreement (DCH-1625) and attaching a copy of its Centers for Medicare and Medicaid Services (CMS) approval letter and Michigan Department of Community Health Reimbursement Confirmation Letter.

The RHC must give notice to the DCH (to both the Provider Enrollment Unit and the Hospital & Health Plan Reimbursement Division) of any physician, dentist, optometrist, podiatrist, chiropractor, certified nurse practitioner (who has a collaborative agreement with a physician), certified nurse-midwife, or subcontractor who terminates employment with the RHC. This notice must be in letter listing the provider's name, 9-digit Medicaid provider identification number (2-digit provider type followed by 7-digit billing number), and termination date.

See Chapter II, Section 4, for non-enrolled providers (e.g., social workers, psychologists, etc.).

The DCH’s Provider Enrollment Unit does not issue a group provider identification number to the RHC. As described above, each eligible provider within the RHC must enroll as a Medicaid provider. Each service rendered by a provider in the RHC must be billed using that provider's identification number. An RHC with several CMS-approved locations must have provider identification numbers for each eligible provider at those locations. Provider enrollment inquiries may be directed to the Provider Enrollment Unit at (517) 335-5492.

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PROVIDER-BASED RHC

When a hospital, nursing home, or home health agency owns and administers a RHC and the RHC is located in the hospital, nursing home, or home health agency, the following instructions apply:

1. The hospital must not bill for RHC services under its hospital identification number. Rather, RHC services must be billed only under the medical professional's provider type MD, DO, DDS, DPM, DC, OD, CNP, CNM, medical clinic, or dental clinic identification number. RHC services, including the overhead costs as an RHC, will be reimbursed only under the medical professional's 9-digit identification number (2-digit provider type followed by 7-digit billing number), and through use of the prospective payment system methodology.

2. The RHC that is an integral and subordinate part of a hospital, nursing home, or home health agency must be able to identify and separate the RHC's costs, encounters, and revenue from the non-RHC operations of the governing hospital, nursing home, or home health agency in accordance with 42 CFR Section 413.20 and Section 413.24. A prospective payment system per visit rate must be established and in use by the time the clinic begins billing as a certified RHC. If the hospital, nursing home, or home health agency is unable to meet these requirements to the satisfaction of DCH, the RHC will be paid as a non-RHC provider (i.e., fee-for-service).

3. Medicaid providers furnishing services as RHC providers must be enrolled with the Medicaid Program as RHC providers. The RHC and the provider will be jointly and severally responsible for any overpayments resulting from incorrect billing.

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RHC BENEFITS

RHC benefits are defined in the Social Security Act, Section 1902(a)(10)(A) and Section 1905(a)(2)(C) and in the Code of Federal Regulations at 42 CFR Section 440.20(b), as follows:

- physician services (MD, DO);
- podiatrist services (DPM);
- chiropractor services (DC);
- optometrist services (OD);
- services and supplies incidental to physician services (MD, DO, DPM, DC, OD), including certain drugs and biologicals that cannot be self-administered, immunizations and their administration;
- licensed physician assistant services (PA);
- certified family nurse practitioner (CFNP) and certified pediatric nurse practitioner (CPNP) services;
- certified nurse-midwife (CNM) services;
- services and supplies incidental to a licensed physician assistant, certified nurse practitioner, and certified nurse-midwife services as would otherwise be furnished by, or incidental to physician services;
- clinical psychologist services;
- clinical social worker services;
- services and supplies incidental to clinical psychologist and clinical social worker services as would otherwise be furnished by, or incidental to physician services;
- dental services, and services and supplies incidental to dental services.

PRIMARY CARE SERVICES

Primary care services that are reimbursed under the prospective payment system are defined as:

- RHC professional services provided in a place of service that is the RHC's office or clinic, patient's home, skilled nursing facility, domiciliary facility or nursing facility by a provider type MD, DO, medical clinic, DPM, DC, OD, CNP, CNM, PA, DDS, and dental clinic.
- Clinical social worker and clinical psychologist services provided at the RHC's office or clinic, patient's home, domiciliary facility, or nursing facility.
- Drug costs and supplies incidental to professional services, which cannot be self-administered, and are billed under the 9-digit provider identification number.
- Professional components of x-rays and other diagnostic tests provided within the walls of the RHC.

SERVICES EXCLUDED FROM THE RHC REIMBURSEMENT

Payment for any other Medicaid covered services not defined above as primary care services are covered by the Medicaid Program under fee-for-service rules described in the Medicaid Provider Manuals. Services not listed as primary care services are excluded from the RHC reimbursement.

Prescriptions dispensed by pharmacy providers and free pharmaceutical samples will not be included in the prospective payment system reimbursement or the RHC's reconciliation.

INPATIENT

Inpatient services provided to hospital patients by RHC practitioners (including emergency room services) are not RHC-covered services, i.e. they are not subject to the prospective payment system reimbursement. This non-coverage also applies to surgical procedures performed within the inpatient hospital and outpatient hospital.

OUTPATIENT

Outpatient services not included in the definition of primary care services are excluded from the reconciliation.

SERVICES AND SUPPLIES INCIDENTAL TO AN RHC VISIT

Services and supplies incidental to an RHC visit are included in the prospective payment system reimbursement if the service or supply is:

- Of a type commonly furnished in a physician's office
- Of a type commonly rendered either without charge or included in the professional bill
- Furnished as an incidental, although integral part of professional services furnished by a physician, certified nurse practitioner, certified nurse-midwife, or licensed physician assistant
- Furnished under the direct personal supervision of a physician (MD, DO, DPM, DC, OD, DDS), certified nurse practitioner, certified nurse-midwife, or licensed physician assistant
- In the case of a service, furnished by a member of the clinic’s health care staff who is an employee of the clinic

The direct personal supervision requirement is met in the case of a certified nurse practitioner, certified nurse-midwife, or licensed physician assistant only if such a person is permitted to supervise such services under the written policies governing the RHC.

BLOOD LEAD TESTS

The blood draw in which drawing, packaging, and mailing of a blood sample are the only services provided is included in the prospective rate. Blood lead tests will not be included in the prospective payment system reimbursement because the State Blood Lead Laboratory bills the Michigan Department of Community Health directly for tests performed on Medicaid fee-for-service beneficiaries.

FLUORIDE WATER TESTS

The State Drinking Water Laboratory’s charge for fluoride water testing as part of a protocol to prescribe fluoride drops for infants and children is included in the prospective payment system reimbursement as a cost incurred by the RHC as incidental to a physician, certified nurse practitioner or nurse-midwife, or licensed physician assistant service.

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DEFINITION OF ENCOUNTERS

The following definition applies to both "Encounters for Total Facility" and "Encounters for Medicaid Beneficiaries."

A medical service encounter is a face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the provision of the health service must be recorded in the patient's medical record. A medical service encounter to any patient should be counted in the total count of all encounters regardless of payment source (or lack of payment).

Types of encounters are:

1. The provider of an encounter can be a licensed MD, DO, DDS, DPM, DC, OD, CNP, CNM, PA, or dental hygienist.
2. The provider of an encounter can be a clinical psychologist or clinical social worker.

The following criteria help to define an encounter:

- To meet the encounter criterion for independent judgment, the provider must be acting independently and not be assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling/dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may accompany professional services performed by physician, dental, or other health providers that do constitute encounters.
- An RHC may bill for encounters by the same health professional on the same day. For example, the beneficiary suffers illness or injury requiring additional diagnosis or treatment on the same date of service, or a patient sees a physician for flu symptoms early in the day and then later the same day sees the same physician for a broken leg--those visits may be classified as two encounters. The patient’s medical record must document the circumstances of the two encounters.
- An RHC may bill for encounters by different health professionals on the same day. For example, a patient first sees a physician at the RHC and then sees a dentist--those visits may be classified as two encounters.
- An encounter may take place in the RHC or at an approved location.
- The same billing limitation explained in Chapter I of the Medicaid Provider manuals pertaining to claim submission is required of encounters.

The encounter criteria are not met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.

- When the only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.
- A nurse taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling or dispensing prescriptions.
- Calling in prescriptions, filling out insurance forms, etc..
- Allergy injection(s).

MEDICAID ENCOUNTERS

The following define Medicaid encounters that are subject to the prospective payment system (PPS) methodology:

- **Medicaid (MA):** Rural Health Clinic primary care services are encounters covered by the Medicaid Program.
- **State Medical Program (SMP):** Services and costs for State Medical Program (SMP) beneficiaries are not Medicaid RHC services and are not subject to the prospective payment system. SMP beneficiaries are identified in Chapter II of the Provider Manual.
- **Qualified Medicare Beneficiaries (QMBs):** For a QMB for which Medicaid is billed co-insurance and deductibles, the services covered by Medicare count as an encounter.
- **Healthy Kids:** Services for beneficiaries who are eligible for Medicaid Program Code L, Healthy Kids, are Medicaid encounters. The beneficiary's Medicaid identification card will identify Program Code L. (NOTE: There is another program called Maternity Outpatient Medical Services [MOMS] for pregnant women without Medicaid. Services to these women do not count as Medicaid encounters.)
- **Medicaid Health Plan (MHP) or Children's Special Health Care Services Special Health Plan (SHP) Enrollees:** Medicaid-covered services provided by a Rural Health Clinic (RHC) to Medicaid-eligible beneficiaries enrolled with a MHP or a SHP are Medicaid encounters if the following conditions are met:
  - ➢ The RHC and MHP or SHP must be signatories to a contract that concerns the RHC providing Medicaid-covered services to the MHP or SHP enrollee.
  - ➢ The contract must provide for the MHP or SHP to reimburse the RHC at a fair market rate for similarly situated beneficiaries served by a non-RHC provider. The MHP or SHP must implement a level of payment equal to, or above, that of other subcontracting arrangements when entering into a subcontract with a RHC.
  - ➢ The RHC must file a schedule with the Michigan Department of Community Health (DCH), Hospital & Health Plan Reimbursement Division in a format determined by DCH showing encounters and payments of Medicaid beneficiaries enrolled with MHP or SHP.
  - ➢ The RHC is not able to bill for MHP or SHP beneficiaries, and the DCH will give RHCs a prospective quarterly payment in order to pay its share of reimbursement.

- Annually, given verifications of the fair market rate by the Hospital & Health Plan Reimbursement Division, the difference between RHC prospective rate and MHP and/or SHP payments will be included in the quarterly payment and reconciled by the DCH.
- The contract and all RHC and MHP or SHP services are subject to audit and verifications.
- MHP enrollees are identified by a Level of Care Code 07 or 11 on the beneficiary's Medicaid identification card.

- **Healthy Kids Dental:** Dental services to Medicaid beneficiaries enrolled by Delta Dental for the Healthy Kids Dental program are eligible for the prospective rate. Beneficiaries are identified on the Delta Dental identification card as group 8444-1000 or 8444-7000. The RHC should report Medicaid information on encounters and revenue in the annual reconciliation report. The RHC will receive the difference between the prospective rate and the revenue received as part of the annual reconciliation.
- **Medicare/Medicaid:** Medicaid covered primary care services provided to Medicare/Medicaid dual eligibles are considered Medicaid encounters.

Not subject to PPS: If an individual does not have Medicaid eligibility, i.e., is eligible for SMP, CSHCS or MOMS only, then the services and costs are not Medicaid RHC services. SMP, CSHCS or MOMS may be paid fee-for-service rates only.

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NON-ENROLLED PROVIDERS

RHC clinical social workers, clinical psychologists, and licensed physician assistants professional services are reimbursed under the prospective payment system. However, these providers are not enrolled in the Medicaid Program and, accordingly, do not have their own Medicaid provider identification numbers. Bill their services under the supervising physician's Medicaid identification number. The supervising physician is responsible for the medical necessity and appropriateness of these services. The clinical psychologist and clinical social worker services are billed with the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or HCPCS codes.

All RHCs may bill the clinical social worker and clinical psychologist services but are limited to 20 visits per beneficiary per calendar year. Visits beyond the maximum of 20 visits per beneficiary per calendar year will be rejected. Services to enrollees of a MHP must be prior authorized by the health plan.

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SPECIAL BILLING CONDITIONS

Global fees reimburse a package of services and are billed one time only, e.g., maternity care. The Medicaid Program is billed fee-for-service one time even though the beneficiary has multiple primary care encounters to complete the follow-up work. **NOTE:** The global obstetric package codes include routine prenatal care, delivery and post-partum care. These codes will be paid only on a fee-for-service basis if billed. If the RHC wishes to receive encounter payment for the prenatal care only, then the prenatal only code should be billed, and the delivery code can be billed separately.

The following package prenatal codes will be assigned a number of encounters per code when billed. The RHC may accept the average of encounters or submit documentation of an actual count of prenatal encounters with the reconciliation.

59425 4-6 prenatal visits=5 encounters

59426 7 or more prenatal visits=10 encounters

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BILLING RURAL HEALTH CLINIC SERVICES

Rural Health Clinic services are billed on the HCFA 1500 claim form for paper professional claims or ASC X12N 837 professional electronic format. RHCs must refer to the Practitioner Manual, Chapter IV, for information needed to submit professional claims to the Michigan Department of Community Health (DCH) for Medicaid, as well as information about how DCH processes claims and notifies the RHC of its actions. Policies for specific services are found in Chapter III of the appropriate manuals.

DCH STRONGLY ENCOURAGES ELECTRONIC SUBMISSION OF CLAIMS.

The DCH approved claims will be subject to audit and verifications. Evidence of fraud will be forwarded to the Attorney General's Health Care Fraud Division for investigation.

EVALUATION & MANAGEMENT SERVICES

Providers should refer to the CPT explanations, coding conventions, and definitions for evaluation and management (E/M) services. When reporting RHC office visits, the allowable place code is 72. For services that are not to be billed with place code 72, bill with the appropriate place code listed in the Practitioner Manual, Chapter IV.

Most E/M services are payable once per day for the same patient. E/M code descriptors state "per day" in many of the categories of service; therefore, the code may be billed only once even though the patient may be seen multiple times. Only one office or outpatient visit will be reimbursed on one day for the same patient unless the visits were for unrelated reasons at different times of the day (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident). If different levels of service are provided, report each on separate lines. If the same level of service is provided both times, report on one claim line with modifier 22. The time of day for each visit must be reported on the claim.

RHCs may provide Medicaid covered services in other than the RHC office, patient's home, nursing facility or domiciliary facility, but these services are not included in the prospective payment system. These services will be reimbursed at fee-for-service rates.

COORDINATION OF BENEFITS

It is the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to the provision of a service. Providers must bill third party payers and receive payment to the fullest extent possible before billing the DCH. Private health care coverage and accident insurance, including coverage held by, or on behalf of, a Medicaid beneficiary is considered primary and must be billed according to the rules of the specific commercial plan.

The DCH is not liable for payment of services that would have been covered by the private payer if applicable rules of that private plan had been followed. The beneficiary must seek care from network providers, and authorization or referrals must be obtained as required. If the provider does not participate with the commercial carrier, the provider is expected to refer the beneficiary to a participating provider.

Some private commercial managed care plans involve a capitation rate and fixed co-pay amount. In this instance, it is impossible to determine a specific other insurance payment. The DCH will pay a fixed co-pay amount up to our maximum allowable fee for the service.

OTHER INSURANCE AND COVERAGE PAYMENTS

All other insurance payments received for services rendered to a Medicaid beneficiary must be reported on the HCFA 1500 paper form or the ASC X12N 837 professional electronic format. Even if the other insurance payment for a specific service exceeds the amount the Program would have paid, the RHC must still bill the fee-for-service procedure code to receive credit for an encounter. See Chapter IV of the Practitioner Manual, or the 837 Professional Transaction Set and MDCH 837 Professional Clarification Document for specific billing guidelines.

MEDICARE AND MEDICAID CROSSOVER CLAIMS

If a Medicaid beneficiary has Medicare and Medicaid, the RHC must follow the billing instructions in the Practitioner Manual, Chapter IV, Third Party Billing, or the 837 Professional Transaction Set and MDCH 837 Professional Clarification Document for specific billing guidelines for Medicare. Even if the Medicare payment exceeds the DCH fee screen, the RHC must still bill the fee-for-service procedure code to receive credit for an encounter.

CO-PAYMENTS

Medicaid co-payments for chiropractic, dental, podiatry, and vision services are waived under the Rural Health Clinic benefit as part of the reconciliation. (Services requiring co-payments are listed in the Medicaid Provider manuals, Chapter I, page 21.)

ADA VERSION 2000

RHCs submitting paper claims must submit the American Dental Association (ADA) Version 2000 claim form for Medicaid Program reimbursement. RHCs must refer to the DCH Dental Manual, Chapter IV, for information regarding prior authorization instructions and claims completion.

Dentists may purchase the ADA Version 2000 claim form directly from the American Dental Association or through ADA-approved vendors. The ADA claim forms will not be supplied by the Medicaid Program.

ELECTRONIC VERSION

Dental providers interested in submitting claims electronically should contact the Automated Billing Unit via e-mail at AutomatedBilling@michigan.gov for further information on electronic claims and a listing of approved service bureaus.

GLOBAL DENTAL PACKAGES

The RHC may accept the average of encounters or submit documentation of an actual count of dental encounters with the reconciliation, e.g., complete or partial denture encounters. The quarterly payment will include as revenue an estimate of the encounters needed to reimburse for global dental packages.

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RISK CONTRACTS

All RHCs may enter into risk contracts with Medicaid Health Plans (MHPs) or Children's Special Health Care Services Special Health Plans (SHPs) for non-primary care services. However, these contracts will not be included in the reconciliation process. All RHC reconciliations will be for primary care services only and subject to the Maximum Payment per Encounter limitation established by the Centers for Medicare and Medicaid Services (CMS). Other Medicaid services provided by RHCs that are not included in the definition of primary care services will continue to be reimbursed at fee-for-service rates.

INCREASE/ DECREASE IN SCOPE OF SERVICE

The prospective payment may be adjusted for an increase or decrease in scope of service.

An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform covered medical that no current professional staff is licensed to perform.

A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease in scope of service **does not** result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- An increase, decrease or change in number of staff working at the clinic;
- An increase, decrease or change in office hours;
- An increase, decrease or change in office space or location;
- The addition of a new site that provides the same set of services;
- An increase, decrease or change in equipment or supplies;
- An increase, decrease or change in the number or type of patients served.

NOTICE OF INTENT TO CHANGE SCOPE OF SERVICE

If an RHC intends to change its scope of service (see above for definition), it must notify the Michigan Department of Community Health (DCH) Hospital & Health Plan Reimbursement Division 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. It is the responsibility of the RHC to notify the DCH of an increase or decrease in scope of service. Notification should include the following documentation:

- Complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.

- An estimate of the change in number of encounters.
- Estimates of the cost change on the current Medicaid encounter rate.
- The proposed customary charges for this service by the clinic.
- The customary charges for this service by other providers in the area served by this clinic.
- The amount to be paid by an MHP or SHP for this service for various programs (Medicare/Medicaid).
- The current Medicare encounter rate.
- Medicare fee screen for this service for non-full cost providers.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc.), and type (MHP, SHP, fee screen/contracted amount).
- Estimated change in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from Michigan Department of Consumer & Industry Services, Centers for Medicare and Medicaid Services, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, encounters or approvals/denials of the change.
- Other information as requested by the Hospital & Health Plan Reimbursement Division.

After a review of the information submitted, the Hospital & Health Plan Reimbursement Division will determine if a rate change will be made and the effective date of any change.

RECONCILIATION REPORTING

Medicaid RHC Reconciliation Reports must be completed by each Rural Health Clinic (RHC) operating in the State of Michigan and seek prospective payment under the provisions of RHCs.

The RHC must file the following documents at the end of its fiscal year for full cost reimbursement:

1. A copy of its filed Medicare Cost Report and Trial Balance.

2. A completed copy of the Medicaid Reconciliation Report.

3. Additional documentation as requested.

FILING OF RECONCILIATION REPORT

The RHC must file annually, with the DCH Hospital & Health Plan Reimbursement Division, the RHC Reconciliation Report. The RHC Reconciliation Report and supplemental documents are due consistent with the Medicare Cost Report filing requirement. Notice of any extension granted by Medicare will be honored by DCH if submitted to Medicaid by the original due date. The RHC Reconciliation Report should be for the same fiscal period and cover the same sites as the Medicare Cost Report.

The reconciliation report will be the basis for determining future quarterly payments and the current year's reconciliation. Improperly completed or incomplete filings will be returned to the facility for proper completion and must be resubmitted to DCH within 30 days.

The required RHC Reconciliation Report and related Medicaid supplemental documents must be original(s) and signed by the authorized individual who normally signs the RHC's federal income tax return or similar reports.

Once the RHC has been accepted in the Medicaid Program, yearly filing of the RHC Reconciliation Report and supplemental documents is mandatory. If the required reconciliation report and supplemental documents are not submitted within the required time limit (including approved extensions), all interim and fee-for-service payments will be suspended. This action will remain in effect until proper submission of all the required documents.

If the RHC fails to submit a reconciliation report, DCH will recover all money paid to the RHC except for fee-for-service and capitated payments.

REASONABLE COSTS

The DCH defines reasonable costs as the per visit amount approved and paid by Medicare.

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ACCOUNTING AND RECORD KEEPING

The RHC must maintain for a period of not less than six years from the end of the fiscal year of the RHC Reconciliation Report, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the information reported. If there are unresolved issues at the end of this six-year period, the records must be maintained until these issues are resolved.

The DCH Hospital & Health Plan Reimbursement Division will retain each required RHC Reconciliation Report and supplemental documents submitted by the RHC for six years after issuance of a final decision. In the event there are unresolved issues at the end of this six-year period, the report will be maintained until such issues are resolved.

The financial and clinical records of the RHC must be available for review by authorized personnel of the DCH. If requested, the records must be made available to personnel of the Health Care Fraud Division of the Michigan Department of Attorney General, the Michigan State Auditor General, the United States Department of Health and Human Services, or federal authorities whose duties and functions are related to state programs of medical assistance under Title XIX in conformity with the provisions of the Social Security Act.

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ANNUAL RECONCILIATION

An annual reconciliation is made to assure that the prospective payment rate is paid to the RHC for all eligible encounters. The reconciliation process begins with the receipt of the RHC's Reconciliation Report and supplemental documents and ends with the issuance of the Notice of Amount of Program Reimbursement.

DESK REVIEWS AND FIELD AUDITS

The desk review may include procedures that will:

- verify the completeness and mathematical accuracy of all schedules in the report,
- compare the Reconciliation Report with DCH paid claim and encounter data,
- identify the need for supporting documentation and arrange to receive same,
- identify the need for a field audit examination necessary to conclude final reconciliation calculations, and
- compare reported data with industry norms as an aid to the audit scope determination.

Field audits may be conducted to verify information on the Reconciliation Report.

MEDICARE AUDIT

The Medicare intermediary may perform audits of the RHC. These audit results may also be used to verify information or for statistical purposes.

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RATE SETTING

The RHC is reimbursed on a per visit basis for RHC services. The per visit payment is equal to 100 percent of the average of the RHC's reasonable costs of providing Medicaid services during fiscal years 1999 and 2000.

The per visit amount will be adjusted each year beginning on October 1, 2001 by 100 percent of the Medicare Economic Index for the prior calendar year, i.e. the adjustment effective October 1, 2001 will reflect the index for calendar year 2000.

The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the RHC. An adjustment to the per visit amount based upon a change in the scope of services will be prospective and will become effective as determined by the DCH.

ESTABLISHING RATES FOR NEW CLINICS

An entity that first qualifies as an RHC after fiscal year 2000 is paid a per visit amount equal to 100 percent of the reasonable costs of furnishing such services during that fiscal year based on the rates established under the Prospective Payment System (PPS) for the fiscal year for other RHCs located in the same or adjacent county with a similar caseload. If there is no other RHC similarly situated, the newly-established RHC will be paid a per-visit amount based on an estimate of its reasonable costs of providing such services and will be reconciled at the end of its first fiscal year of operation.

ALTERNATE PAYMENT METHODOLOGY

The State and the RHC may agree to an alternative payment methodology that provides reimbursement at least equal to that which an RHC would receive under the PPS.

QUARTERLY SUPPLEMENTAL PAYMENTS

RHCs that provide services under a contract with a Medicaid Health Plan (MHP) or Children's Special Health Care Services Special Health Plan (SHP) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the RHC receives from the MHP or SHP and the payments the RHC would have received under the PPS. At the end of each RHCs fiscal year, the total amount of quarterly and MHP or SHP payments received by the RHC will be reviewed against the amount that the actual number of visits provided under the RHC's contract with one or more MHPs or SHPs would have yielded under the PPS. If a newly-established RHC enters into contracts with one or more MHPs or SHPs, it will be eligible for quarterly supplemental payments. For RHCs that have a fiscal year ending other than September 30, the PPS rate for MHP and SHP encounters will be prorated based on the number of months in each period covered by a different prospective rate.

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MEDICAID HEALTH PLAN (MHP) OR CHILDREN'S SPECIAL HEALTH CARE SERVICES SPECIAL HEALTH PLAN (SHP) RECONCILIATION

A reconciliation will be calculated annually to insure that the amounts paid to the RHC for Medicaid managed care encounters are equal to the prospective rate.

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INITIAL RECONCILIATION

An initial reconciliation will be calculated after the annual reconciliation report is received. The initial reconciliation will be processed approximately four months after the reconciliation report is received with the payment or recovery made at that time. Future quarterly payments will be adjusted based on the information in the initial reconciliation.

UNDERPAYMENTS TO AN RHC

DCH will pay or recover the full amount of the reconciliation through a gross adjustment. DCH retains the right to withhold a portion of any initial payment based on individual circumstances.

OVERPAYMENTS TO AN RHC

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and shall be recovered by DCH. The recovery will start approximately 30 days after notification to the RHC. The gross adjustment will stop all payments to the RHC's physician(s) until the amount is recovered.

MEDICARE SETTLEMENT(S)

Any issues left unresolved due to the Medicare audit and/or Medicare adjustment process must be appealed through the proper Medicare process before any changes can be made to the Medicaid reconciliation.

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AUDIT ADJUSTMENT REPORT

The Audit Adjustment Report contains a descriptive list of all Program data adjustments made to the Medicaid Reconciliation Report by DCH audit staff.

RHC ACCEPTS AUDIT ADJUSTMENT REPORT

If the RHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the RHC should sign the report and mail it to:

Michigan Department of Community Health
Budget and Finance Administration
Hospital & Health Plan Reimbursement Division
PO Box 30479
Lansing MI 48909-7979

A Notice of Amount of Program Reimbursement will then be mailed to the RHC. No further administrative appeal rights will be available for the adjustments contained in the Audit Adjustment Report.

NOTICE OF AMOUNT OF PROGRAM REIMBURSEMENT

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

RHC DOES NOT RESPOND TO AUDIT ADJUSTMENT REPORT

The Audit Adjustment Report must be accepted or rejected by the RHC within 30 calendar days of its mailing date. If the RHC has not responded within this time period, DCH shall issue a Notice of Amount of Program Reimbursement that is the final determination of an adverse action. No further administrative appeal rights are available.

RHC REJECTS AUDIT ADJUSTMENT REPORT

If the RHC rejects any or all of the findings contained in the Audit Adjustment Report, the RHC may request a Post-Audit Conference within 30 calendar days of the mailing date of the Audit Adjustment Report.

The Post-Audit Conference is an informal process where the Hospital & Health Plan Reimbursement Division staff and the RHC may resolve differences prior to an appeal and/or formal hearing. The process is initiated by the RHC after the receipt of the Audit Adjustment Report. The RHC must request in writing a Post-Audit Conference with the Hospital & Health Plan Reimbursement Division and indicate in that letter the area(s) of disagreement.

The letter shall state the appropriate regulation and/or other appropriate decisions that support the RHC's position. The letter must be sent to:

Michigan Department of Community Health
Budget and Finance Administration
Hospital & Health Plan Reimbursement Division
PO Box 30479
Lansing MI 48909-7979

The RHC or its representative must present, either before or at the time of the Post-Audit Conference, the audit staff with the documents and arguments that support its position relative to the disputed issue(s). Likewise, the audit staff shall explain to the RHC the basis for its findings. This step will not stop the recovery of monies due the Medicaid Program.

The RHC has the right to appeal any adverse action taken by the Department of Community Health unless that adverse action resulted from an action over which the Department of Community Health had no control (e.g., Medicare termination, license revocation). The appeal process is outlined in the "Department's Medicaid Provider Reviews and Hearings" rules, R400.3401 through R400.3424, filed with the Secretary of State on March 7, 1978. Any questions regarding this appeal process should be directed to the Administrative Tribunal and Appeals Division at 517-335-8911.

PRELIMINARY CONFERENCE

If the RHC does not agree with the audit adjustments after receiving DCH's Post-Audit Conference response, the RHC may request, in writing, a Preliminary Conference with a DCH representative. The request for a Preliminary Conference must be made within 30 calendar days of the date of the Post-Audit Conference response. The request must describe the issue(s) being contested, the reason why the issue(s) is being contested, and the relief sought. Send the request for a Preliminary Conference to:

Michigan Department of Community Health
Administrative Tribunal and Appeals Division
PO Box 30195
Lansing Michigan 48909-7695

Upon receipt of a timely and acceptable appeal request, a DCH representative will schedule a Preliminary Conference to discuss the initial findings with the RHC representative(s). A report of the initial findings of the Preliminary Conference will be issued by DCH within 10 calendar days following the conclusion of that conference. The RHC will also be notified of its right to a Bureau Conference if it still disagrees with the Preliminary Conference findings.

BUREAU CONFERENCE

If the RHC does not agree with the findings of the Preliminary Conference, the RHC may request a Bureau Conference with a DCH delegate. The request for a Bureau Conference must be made within 20 calendar days of the date of issuance of the Preliminary Conference report. The request for a Bureau Conference must be sent to the same address as the request for a Preliminary Conference. Upon receipt of a timely and acceptable Bureau Conference request, a DCH delegate will schedule a conference to discuss the Preliminary Conference findings with the RHC representative(s). A report of the findings of the Bureau Conference, and DCH's decision whether it will take an adverse action, will be issued by DCH within 30 calendar days following the conclusion of that conference. The RHC will also be notified of its right to an administrative hearing if it disagrees with the Bureau Conference findings and decision.

APPEAL OF THE NOTICE OF PROGRAM REIMBURSEMENT

The RHC may also appeal its Notice of Program Reimbursement if the contested issue(s) are other than those precluded by the failure to timely appeal adjustment(s) in the Audit Adjustment Report. Appeals accepted as appropriate will also be governed by the aforementioned Department Provider Reviews and Hearings rules.

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Billing problems regarding physician services may be directed to the Provider Inquiry Line at 1-800-292-2550.

Any lengthy or unusual problems may be mailed to Research and Analysis. Research and Analysis researches and responds to written inquiries relating to billing and reimbursement problems.

MAIL: Program Support Unit
Medicaid Payments Division
Attn.: Research and Analysis
PO Box 30479
Lansing MI 48909-7979

Any rate setting/cost settlement related questions may be directed to the Hospital & Health Plan Reimbursement Division (HHPRD). The HHPRD numbers are (517) 335-5330 and FAX (517) 241-7408. Written inquiries regarding rate setting/cost settlement/cost reporting may be mailed to the HHPRD.

MAIL: Hospital & Health Plan Reimbursement Division
Budget and Finance Administration
PO Box 30479
Lansing MI 48909-7979

The Medicaid Provider Enrollment Unit maintains provider enrollment information. Provider enrollment inquiries may be directed to Provider Enrollment at (517) 335-5492 or FAX (517) 335-5570.

MAIL: Provider Enrollment Unit
Budget and Finance Administration
PO Box 30238
Lansing MI 48909-7738

To apply for RHC status, contact the Michigan Department of Consumer and Industry Services at (517) 241-4160

MAIL: Michigan Department of Consumer and Industry Services
Bureau of Health Systems
Licensing and Certification Division
Attn.: RHC Application
PO Box 30664
Lansing MI 48909-8164

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