

**Distribution:** Rural Health Clinic 02-02

**Issued:** January 29, 2002

**Subject:** Rural Health Clinic Services (RHC) Uniform Billing

**Effective:** March 1, 2002

**Programs Affected:** Medicaid

The purpose of the Uniform Billing Project (UBP) is to change how the Michigan Department of Community Health (MDCH) receives, processes, and pays Medicaid claims. This is a move toward complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the published rules regarding health care transactions and code sets. This bulletin and manual pages update and supersede current policies and procedures.

The attached Chapter II manual page revisions are necessary for the UBP and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. BIPA eliminates full-cost and enacts a prospective payment system (PPS). Any language referring to full-cost was changed to reflect PPS.

Providers are encouraged to keep claims up-to-date in their systems. The current proprietary electronic format, and Medicaid unique paper claim forms (MSA-1600 and MSA-1653) will not be accepted for any claims received by MDCH on and after February 1, 2002. Any RHC professional service billed after February 1, 2002 must be converted to the HCFA 1500 paper professional claim form or the National Electronic Data Interchange Transaction Set Health Care Claim Professional 837 ASC X12N version 3051 or the Michigan Medicaid interim version 4010 (not HIPAA compliant).

February 1, 2002 marks the implementation of Current Procedural Terminology (CPT) and HCPCS Codes for RHC professional claims. Local codes are eliminated to the extent possible so coding is consistent with industry standards. Local procedure codes for RHCs will be end-dated upon implementation of this policy bulletin.

The changes related to the Uniform Billing Project for professional services are extensive and completely replace the previous non-standard billing instructions. As a reminder, the following are some of the changes that RHCs must note in the revision of the Practitioner Manual, Chapter IV (Billing and Reimbursement for Health Care Professionals) and Bulletins MSA 01-09 and MSA 01-23:

- The Federal Employer ID or Social Security number (FE# or SSN) must be reported on all claims and must match the number on the Medicaid Provider Enrollment file associated with the billing provider ID #.
- Two-digit place of service codes are required.
- Each service reported must be billed on an individual service line for the date of service. "Series billing" is not allowed.
- Information reported to other third party payers and to MDCH is reported using the same claim format and code structure.
- MDCH relies more on CPT definitions and Centers for Medicare and Medicaid Services (CMS) guidelines for claim adjudication for many types of services. These are also consistent with other payer's standards.

### Manual Maintenance

Retain this bulletin for future reference.

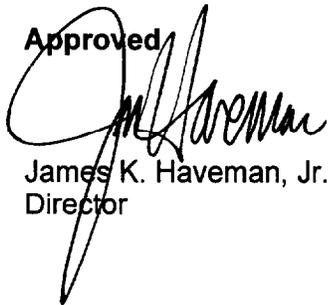
**Discard** Chapter I, Section 2, pages 1-2; Section 3, pages 1-2, Section 4, pages 1-2; and Chapter II.

**Insert** Chapter I, Section 2, pages 1-2; Section 3, pages 1-2, and Chapter II.

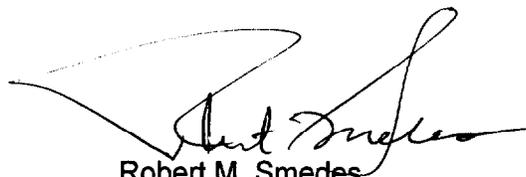
### Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at [ProviderSupport@michigan.gov](mailto: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



Robert M. Smedes  
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MANUAL TITLE <b>RURAL HEALTH CLINIC</b>		CHAPTER <b>I</b>	SECTION <b>2</b>	PAGE <b>1</b>
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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 (MDCH) 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 MDCH (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 MDCH'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 MDCH, 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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CHAPTER TITLE	<b>COVERAGE AND LIMITATIONS</b>	SECTION TITLE	<b>RHC BENEFITS</b>	
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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.



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### 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.



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**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. For example, 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.



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**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.
- The following services are not classified as nurse encounters: 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. are not encounters.
- Allergy injection(s) are not encounters.

### MEDICAID ENCOUNTERS

The following define Medicaid encounters that are subject to the prospective payment system 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 (MDCH), Hospital & Health Plan Reimbursement Division in a format determined by MDCH showing encounters and payments of Medicaid beneficiaries enrolled with MHP or SHP.



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- The RHC is not able to bill for MHP or SHP beneficiaries, and the MDCH 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 MDCH.
- 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 or CSHCS or MOMS only, then the services and costs are not Medicaid RHC services. SMP or 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 Practitioner Manual, Chapter IV for information needed to submit professional claims to the Michigan Department of Community Health (MDCH) for Medicaid, as well as information about how MDCH processes claims and notifies the RHC of its actions. Policies for specific services are found in Chapter III of the appropriate manuals.

### **MDCH STRONGLY ENCOURAGES ELECTRONIC SUBMISSION OF CLAIMS.**

The MDCH 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 MDCH. 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.



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The MDCH 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 MDCH 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.

### **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 for Medicare. Even if the Medicare payment exceeds the MDCH 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.)



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### 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 MDCH 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](mailto: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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CHAPTER TITLE <b>COVERAGE AND LIMITATIONS</b>	SECTION TITLE <b>DENTAL CLAIMS</b>	DATE <b>RHC 02-02 03-01-02</b>	

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