Administrative Code

Title 23: Medicaid
Part 212
Rural Health Clinics

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Title 23: Division of Medicaid

Part 212: Rural Health Clinics

Part 212 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. In order to participate in the Medicaid program, an organization must be approved as a Rural Health Clinic (RHC) by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid provider agreement. To be approved, a Rural Health Clinic must meet requirements and conditions for approval as established by state and federal regulations and must provide the following six (6) laboratory services on site:

1. Chemical examinations of urine by stick or tablet method or both, including urine ketones,

2. Hemoglobin or hematocrit,

3. Blood glucose,

4. Examination of stool specimens for occult blood,

5. Pregnancy tests, and

6. Primary culturing for transmittal to a certified laboratory.

B. If the RHC performs only these six (6) tests, it may obtain a waiver certificate from the regional Clinical Laboratory Improvement Amendments (CLIA) office. If an RHC provides other tests on site, it must comply with CLIA requirements for the lab services actually provided.

C. Medicaid must receive a copy of the letter and Provider Tie-in Notice from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), which states approval of the Rural Health Clinic (RHC) before an agreement can be established.

D. RHC providers must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:

1. National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),

2. A copy of the interim rate notice or current rate letter from CMS,

3. Copy of the nurse practitioner's protocol and license to practice. If the nurse practitioner is not enrolled with Medicaid as a provider, the nurse practitioner must complete a

provider application and obtain an individual provider number, and

4. CLIA Information form and current CLIA certificate, if applicable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 491; 42 CFR 440.20(b)(c); 42 CFR 455, Subpart E

Rule 1.2: Service Limits

Medicaid covers a total of twelve (12) visits per state fiscal year in any office, nursing facility, or clinic setting. When a beneficiary has exhausted these visits, payment will no longer be made for services provided in the office or clinic setting.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Covered Services

A. Medicaid defines an encounter as services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services and supplies, including drugs and biologicals that are not usually self-administered by the patient, furnished as an incident to a professional service. When services, supplies, drugs or biologicals are included in the clinic's encounter rates, the clinic cannot send the beneficiary to another provider that will bill Medicaid for the covered service, supply, drug or biological.

B. When a beneficiary sees more than one (1) provider type, either medical, dental, optometry, or mental health, at the same Rural Health Center on the same date, the clinic will be reimbursed as noted below. The exception is a case in which the patient, subsequent to the first encounter, suffers illness or injury requiring an additional diagnosis or treatment.

    1. Physician, nurse practitioner, and/or nurse midwife are reimbursed for one (1) medical encounter per day.

    2. Dentists are reimbursed for one (1) dental encounter per day.

    3. Optometrists are reimbursed for one (1) optometry encounter per day.

    4. Clinical psychologists and/or clinical social workers are reimbursed for one (1) mental health encounter per day.

C. The maximum number of encounters that can be paid to the same RHC for the same beneficiary on the same date is four (4). An exception shall be made when:

    1. The beneficiary has visits with all the core service types on the same day, and

2. The beneficiary has to return to the clinic for an injury or illness requiring additional diagnosis or treatment.

D. Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

E. All ambulatory services performed by a center employee or contractual worker for a center patient is covered. This includes services provide in the clinic, skilled nursing facility, nursing facility or other institution used as a patient's home. Medicaid covers for visits at multiple places of service for a beneficiary. Services performed by an outside lab are covered for the outside lab.

F. Non-covered services:

1. Rural Health Center services are not covered when performed in a hospital, neither inpatient nor outpatient.

2. Medicaid does not pay fee-for-service rates for services (on same or separate dates) in a RHC.

3. Medicaid does not cover the cost of a subdermal implant.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 491; OBRA (1990), § 4161; 42 CFR 440.20 (b) – (c)

Rule 1.4: Reimbursement Methodology

A. Medicaid uses the Prospective Payment System (PPS) method of reimbursement for RHC's. All ambulatory services provided in the RHC will be reimbursed an encounter rate on a per visit basis. Refer to Part 212, Rule 1.3. A for the definition of a visit and the rule related to the encounter rate per visit reimbursement methodology.

B. All services provided in an inpatient hospital setting outpatient hospital setting, and an emergency room hospital will be paid on a fee-for-service basis. If a physician employed by an RHC provides physician services at the hospital, inpatient or outpatient, the applicable claim form must be billed under the individual physician's Medicaid provider number. Payment will be made directly to the physician, and a 1099 form will be provided to the physician for tax purposes. The financial arrangement between the physician and the RHC should be handled through the agreement.

C. For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the average of the RHC's reasonable costs of providing Medicaid covered services during fiscal years 1999 and 2000. If a RHC first enrolls during fiscal year 2000, the rate will only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory

services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during fiscal year 2001.

D. When a new provider first qualifies as a RHC after January 1, 2001, the initial PPS rate shall be based on the rates established for other clinics located in the same or adjacent area with a similar caseload. In the absence of such clinics, the rate assigned by the provider's Medicare intermediary will be used as an interim rate (on a per visit basis). After the RHC's initial year, a Medicaid cost report must be filed. The final settlement cost report will be desk reviewed and a rate shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the RHC's reasonable costs of providing Medicaid covered services.

E. Beginning in calendar year 2002, and for each calendar year thereafter, the RHC is entitled to the payment amount, on a per visit basis, to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

F. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of service as follows:

   1. The addition of a new service, either dental, EPSDT, or optometry, not previously provided by the RHC, and/or

   2. The elimination of an existing service provided by the RHC.

G. However, a change in the scope of service does not mean the addition or reduction of staff members to or from an existing service. Also, a change in the cost of a service is not considered in and of itself a change in the scope of service.

H. It is the responsibility of the RHC to notify Medicaid of any change in the scope of service and provide proper documentation of said change.

I. Cost Reports

   1. All clinics must submit to Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5th) month following the close of its Medicare cost-reporting year. All filing requirements shall be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the State Plan for reimbursement of Rural Health Clinics. The clinic's cost report should

include information on all satellite clinics. A copy of the Plan is available upon written request.

2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty may only be waived by the Executive Director of the Division of Medicaid.

3. A RHC that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at Medicaid's discretion.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 491; OBRA (1990), § 4161; 42 CFR 440.20 (b) – (c)

Rule 1.5: Documentation Requirements

Medicaid requires RHC facilities to maintain auditable records that will substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. Date of service,

B. Patient's presenting complaint,

C. Provider's findings,

D. Treatment rendered, and

E. Provider's signature or initials.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 491; 42 CFR 440.20 (b) – (c)

Rule 1.6: Co-Mingling

Medicaid defines co-mingling as the simultaneous operation of an RHC and another physician practice, thereby mixing the two (2) practices. The two (2) practices share hours of operation, use of the space, professional staff, equipment, supplies, and other resources. To prevent co-mingling, physicians and non-physician practitioners cannot operate a private Medicare or Medicaid practice during RHC hours of operation using clinic resources.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 491

Rule 1.7: Pregnancy Related Eligibles

A. Women, who are eligible for Medicaid only because of pregnancy, are covered only for those services which are related to:

1. Pregnancy, including prenatal, delivery, postpartum, and family planning services; and

2. Other conditions which may complicate pregnancy.

B. Dental and vision services are not covered for women in eligibility categories in Part 212, Chapter 1 Rule 1.7 A.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 491; 42 CFR 440.20 (b) – (c)

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121