

Washington Apple Health (Medicaid)

Rural Health Clinics Billing Guide

April 1, 2020

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect April 1, 2020, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, call 1-800-562-3022. People who have hearing or speech disabilities call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Entire Guide	General housekeeping, including typographical and hyperlink corrections.	To improve usability
<u>What services do not qualify as an encounter?</u>	Added telemedicine procedure codes D9995 – D9996.	Added new teledentistry code to align with dental program.
	Added Q Codes Q0000-Q0009 with the exception of Q3014.	To clarify policy and billing instructions
	Added procedure codes U0001 and U0002.	New procedure codes
	Replaced procedure code 90749 with 90750.	To clarify policy and billing instructions
<u>What is a prospective change in scope of service?</u>	Revised language regarding supporting documentation for a prospective change in scope of service rate adjustments.	To clarify policy and billing instructions
<u>What is a retrospective change in scope of service?</u>	Revised language regarding supporting documentation for a retrospective change in scope of service rate adjustments.	To clarify policy and billing instructions

COVID-19 BILLING

See the Health Care Authority’s [Information about novel coronavirus \(COVID-19\) webpage](#) for updated information regarding COVID-19.

COVID-19 clinical policy and billing instructions, including RHC-specific instructions and encounter eligible CPT codes, can be found in the agency’s [Apple Health \(Medicaid\) clinical policy and billing for COVID-19, Frequently Asked Questions](#).

Refer to the “[What are the rules for telemedicine?](#)” section of this guide for RHC-specific telemedicine policy and billing instructions.

How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) webpage.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) webpage.

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Washington Apple Health Billers and Providers webpage
Information about payments, claims processing, denials, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., Medicaid billing guides, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
Submit claim denials for review	See the Billers and Providers webpage
Information about ICD-10	Email: ICD10questions@hca.wa.gov
Who do I contact if I have questions about enrolling as a medical assistance-certified RHC?	Provider Enrollment PO Box 45562 Olympia, WA 98504-5562 Ph.: 800-562-3022, ext. 16137 Fax: 360-725-2144 providerenrollment@hca.wa.gov
Who do I contact if I have questions about enrolling as a medical assistance-certified RHC, overall management of the program, or specific payment rates?	Email: FQHCRHC@hca.wa.gov

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to [Chapter 182-500 WAC](#) for a complete list of definitions for Washington Apple Health.

APM index – Alternative payment methodology (APM) index is a measure of input price changes experienced by Washington’s rural health clinic (RHC) providers. The index is derived from the federal Medicare Economic Index (MEI) and Washington-specific variable measures. The APM index is used to update the APM encounter payment rates on an annual basis.

Base year – The year that is used as the benchmark in measuring a clinic’s total reasonable costs for establishing base encounter rates.

Cost report – An annual report that RHCs must complete and submit to Medicare. The cost report is a statement of costs and provider use that occurred during the time period covered by the cost report.

Encounter – A face-to-face visit between a client and a qualified RHC provider (e.g., a physician, physician assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

Enhancements (also called managed care enhancements) – A monthly amount paid for each client enrolled with a managed care organization (MCO). MCOs may contract with rural health clinics (RHCs) to provide services under managed care programs. RHCs receive enhancements from the Medicaid agency in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

Fee-for-service – A payment method the agency uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the agency’s prepaid managed care organizations, or those services that qualify for an encounter rate.

Freestanding RHC – An independent clinic that is not part of a hospital, skilled nursing facility, or home health agency.

Interim rate – The rate established by the agency to pay an RHC for encounter services prior to the establishment of a permanent rate.

Medicaid certification date – The date that an RHC can begin providing encounter services to Medicaid clients.

Mid-level practitioner – An advanced registered nurse practitioner (ARNP), a certified nurse midwife, a licensed midwife, a woman’s health care nurse practitioner, a physician’s assistant (PA), or a psychiatric ARNP. Services provided by registered nurses are not encounters.

Provider-based RHC (also known as hospital-based RHC) – A clinic that is an integral and subordinate part of a hospital.

Rebasing – The process of recalculating encounter rates using actual cost report data.

Program Overview

What is a rural health clinic (RHC)?

A rural health clinic (RHC) is a provider-based or freestanding facility certified under Code of Federal Regulations (CFR), title 42, part 491. An RHC is located in a rural area designated as a shortage area.

An RHC may be a permanent or mobile unit. If an entity owns clinics in multiple locations, each individual site must be certified in order for that site to receive payment as an RHC.

Note: An RHC is unique only in the methodology by which it is paid for encounter services, not by the scope of coverage for which it is paid.

What are the basic requirements?

- An RHC must furnish all services according to applicable federal, state, and local laws.
- Unless otherwise specified, an RHC's services are subject to the limitations and coverage requirements detailed in the agency's [Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide](#) and other applicable billing instructions. The agency does not extend additional coverage to clients in an RHC beyond what is covered in other agency programs and state law.
- An RHC must be primarily engaged in providing outpatient health services. Clinic staff must provide those diagnostic and therapeutic services and supplies commonly furnished in a physician's office or the entry point into the health care delivery system. These include:
 - ✓ Medical history
 - ✓ Physical examination
 - ✓ Assessment of health status
 - ✓ Treatment for a variety of medical conditions

- An RHC must provide basic laboratory services essential to the immediate diagnosis and treatment of the patient in accordance with federal law (see 42 CFR, Public Health, Chapter IV, section 491.9). These services, which are subject to change as defined by federal RHC regulations, include, but are not limited to:
 - ✓ Chemical examination of urine by stick or tablet method or both
 - ✓ Hemoglobin or hematocrit
 - ✓ Blood glucose
 - ✓ Examination of stool specimens for occult blood
 - ✓ Pregnancy tests
 - ✓ Primary culturing for transmittal to a certified laboratory
- An RHC must provide medical emergency procedures as a first response to common life-threatening injuries and acute illness. The RHC must have available commonly used drugs and biologicals, such as:
 - ✓ Analgesics
 - ✓ Anesthetics (local)
 - ✓ Antibiotics
 - ✓ Anticonvulsants
 - ✓ Antidotes and emetics
 - ✓ Serums and toxoids

Who may provide services in an RHC?

(WAC [182-549-1300](#) (3) and RCW 18.36A.040)

The following people may provide RHC services:

- Physicians
- Dentists
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Nurse midwives or other specialized nurse practitioners
- Certified nurse midwives
- Registered nurses or licensed practical nurses
- Mental health professionals – for a list of qualified professionals eligible to provide mental health services, refer to the *Which Professional Services Can be Billed in an Outpatient Setting* section of the agency's [Mental Health Services Billing Guide](#)

- Naturopathic physicians – refer to the [Physicians-Related Services/Health Care Professional Services Billing Guide](#)

Note: Approved screening, brief intervention, and referral to treatment (SBIRT) provider services, which are described in the [Physician-Related Services/Health Care Professional Services Billing Guide](#), may also be provided in an RHC.

What are the staffing requirements of an RHC?

([42 CFR 491.7-8](#))

- An RHC must be under the medical direction of a physician.
- An RHC must have a health care staff that includes one or more physicians.
- An RHC staff must include one or more physician’s assistants (PA) or advanced registered nurse practitioners (ARNP).
- A physician, ARNP, PA, certified nurse-midwife, clinical social worker, or clinical psychologist must be available to provide patient care services within their scope of practice at all times the RHC operates.
- An ARNP, PA, or certified nurse-midwife must be available to provide patient care services at least 50 percent of the time the RHC operates.
- The staff also may include ancillary personnel who are supervised by the professional staff.
- The PA, ARNP, certified nurse-midwife, clinical social worker, or clinical psychologist member of the staff may be the owner or an employee of the RHC, or may provide services under contract to the center.

What are the RHC certification requirements?

To be eligible to offer medical assistance, RHCs must have federal and medical assistance certifications.

Federal certification: RHCs must be federally certified for participation as an RHC by the Department of Health and Human Services (DHHS). The clinic provides the agency with a copy of its certification as an RHC.

Medical assistance certification: A clinic certified under Medicare meets the standards for medical assistance certification.

To obtain medical assistance certification as an RHC, the clinic must complete the application and supply all necessary documentation to the agency's Provider Enrollment unit. For a list of required documentation, see the agency's [Enroll as a billing provider](#) website.

Note: A clinic must receive federal designation as a Medicare-certified RHC before the agency can enroll the clinic as a medical assistance-certified RHC. Go to <http://www.cms.hhs.gov/home/medicare.asp> for information on Medicare provider enrollment.

When enrolling a new clinic through ProviderOne on-line enrollment application, select the *Fac/Agency/Org/Inst* option from the enrollment type menu and select the RHC taxonomy 261QR1300X from the provider specialty menu. Direct questions regarding enrollment applications to providerenrollment@hca.wa.gov.

What is the effective date of the Medicaid RHC certification?

([WAC 182-549-1200](#) (2))

The agency uses one of two timeliness standards for determining the effective date of a Medicaid-certified RHC:

- **Medicare's effective date:** The agency uses Medicare's effective date if the RHC returns a properly completed Core Provider Agreement (CPA) and RHC enrollment packet **within 60 calendar days** from the date of Medicare's letter notifying the clinic of the Medicare certification.
- **The date the agency receives the CPA:** The agency uses the date the signed CPA is received by HCA FQHC/RHC program staff if the RHC returns the properly completed CPA and complete RHC enrollment packet **61 or more calendar days** after the date of Medicare's letter notifying the center of the Medicare certification.

Note: The RHC enrollment packet must include: CPA, ownership disclosure form, debarment form, Electronic Funds Transfer (EFT) form, W9, copy of business license, copy of liability insurance information, the Centers for Medicare and Medicaid Services (CMS) approval letter, and any additional information as requested by the agency.

See the agency's [Enroll as a billing provider](#) website for more information about submitting a properly completed CPA.

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's [Apple Health managed care page](#) for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Apple Health. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at:
www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in [WAC 182-502-0160](#).

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:**
Go to [Washington HealthPlanFinder website](#).
- **Available to all Apple Health clients:**
 - ✓ Visit the [ProviderOne Client Portal website](#):
 - ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
 - ✓ Request a change online at [ProviderOne Contact Us](#) (this will generate an email to Apple Health Customer Service). Select the topic “Enroll/Change Health Plans.”

For online information, direct clients to HCA’s [Apple Health Managed Care](#) webpage.

Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care; or
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS]).

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on integrated managed care, see the agency's [Apple Health managed care webpage](#) and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients qualified for managed care enrollment and living in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency’s [Apple Health managed care webpage](#).

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
“Coordinated Care Healthy Options Foster Care.”

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer?*

Encounters

What is an encounter?

An encounter is a face-to-face visit between a client and an RHC provider of health care services who exercises independent judgment when providing healthcare services to the individual client. For a health care service to be defined as an encounter, it must meet the specific encounter criteria below. All services must be documented in the client's file to qualify for an encounter.

Encounters are limited to one type of encounter per day for each client, regardless of the services provided, except in either one of the following circumstances:

- It is necessary for the client to be seen by different practitioners with different specialties.
- It is necessary for the client to be seen multiple times due to unrelated diagnoses.

For instructions on billing these claims, see [How do I bill for more than one encounter per day?](#)

What services are considered an encounter?

(WAC [182-549-1300](#))

Only certain services provided by an RHC are considered an encounter.

The RHC must bill the agency for these services using HCPCS code T1015 and the appropriate HCPCS or CPT code for the service provided.

The following services qualify for RHC reimbursement:

- Physician services
- Nurse practitioner or physician assistant services
- Visiting nurse services
- Naturopathic physician services as described in the [Physician-Related Services/Health Care Professional Services Billing Guide](#)
- Approved screening, brief intervention, and referral to treatment (SBIRT) provider services as described in the [Physician-Related Services/Health Care Professional Services Billing Guide](#)

- Mental health services as described in the *Which Professional Services Can be Billed in an Outpatient Setting* section of the [Mental Health Services Billing Guide](#)

Are surgical procedures considered RHC services?

Surgical procedures furnished in an RHC by an RHC practitioner are considered RHC services, and the RHC is paid based on its encounter rate for the face-to-face encounter associated with the surgical procedure.

Global billing requirements do not apply to RHCs. However, surgical procedures furnished at locations other than RHCs may be subject to global billing requirements.

If an RHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC must determine if these services have been included in the surgical global billing. RHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service furnished by the RHC was included in the global payment for the surgery, the RHC may not also bill for the same service.

For services not included in the global surgical package, see the [Physician-Related Services/Health Care Professional Services Billing Guide](#).

What services and supplies are incidental to professional services?

Services and supplies incidental to the professional services of encounter-level practitioners are included in the encounter rate paid for the professional services when the services and supplies are:

- Furnished as an incidental, although integral, part of the practitioner's professional services (e.g. professional component of an x-ray or lab).
- Of a type commonly furnished either without charge or included in the RHC bill.
- Of a type commonly furnished in a provider's office (e.g., tongue depressors, bandages, etc.).
- Provided by RHC employees under the direct, personal supervision of encounter-level practitioners.
- Furnished by a member of the RHC staff who is an employee of the RHC (e.g., nurse, therapist, technician, or other aide).

Incidental services and supplies as described above that are included on the RHC's Medicare cost report are factored into the encounter rate and will not be paid separately.

How do I determine whether a service is an encounter?

To determine whether a contact with a client meets the encounter definition, all the following guidelines apply:

Services requiring the skill and ability of an encounter-level practitioner

The service being performed must require the skill and ability of an encounter-level practitioner in order to qualify as an encounter. A service does not qualify as an encounter simply because it is performed by one of these practitioners if the service is one that is normally performed by other health care staff.

For example, if a physician performs a blood draw only or a vaccine administration only, these services are not encounter-eligible services, since they are normally performed by registered nurses. These services must be billed as fee-for-service using the appropriate coding.

Services in the clinic

The services of a practitioner performed in the clinic (excluding those listed in [Billing](#)) are encounters and are payable only to the clinic.

Assisting

The provider must make an independent judgment. The provider must act independently and **not assist** another provider.

Examples:

Encounter:	A mid-level practitioner sees a client to monitor physiologic signs, to provide medication renewal, and uses standing orders or protocols.
Not an Encounter:	A mid-level practitioner assists a physician during a physical examination by taking vital signs, history, or drawing a blood sample.

Services outside the clinic

Hospital based services are not encounter-eligible. Covered services will be paid as fee-for-service and should not be billed with a T1015 encounter code.

Otherwise, a service that is considered an encounter when performed **in** the clinic is considered an encounter when performed **outside** the clinic (for example, in a nursing facility or in the client's home) and is payable to the clinic. A service that is not considered an encounter when performed **in** the clinic is not considered an encounter when performed **outside** the clinic, regardless of the place of service.

Concurrent care exists when services are rendered by more than one practitioner during a period of time. Consultations do not constitute concurrent care. The reasonable and necessary services of each practitioner rendering concurrent care are covered if each practitioner is required to play an active role in the patient's treatment.

For example, concurrent care may occur because of the existence of more than one medical condition requiring distinct specialized medical services.

Encounters are limited to one type of encounter per day for each client, regardless of the services provided, except in either one of the following circumstances:

- It is necessary for the client to be seen by different practitioners with different specialties.
- It is necessary for the client to be seen multiple times due to unrelated diagnoses.

Each encounter must be billed on a separate claim. On each claim, to indicate that it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in the *Claim Note* section of the electronic claim. Use an appropriate modifier to bill for the subsequent T1015 procedure code.

Documentation for all encounters must be kept in the client's file.

Note: Simply making a notation of a pre-existing condition or writing a refill prescription for the condition **is not significant enough** to warrant billing an additional encounter for the office visit.

Serving multiple clients simultaneously

When an individual provider renders services to several clients simultaneously, the provider can count an encounter for each client if the provision of services is documented in **each client's** health record. This policy also applies to family therapy and family counseling sessions. **Bill services for each client on separate claims.**

State-only programs

Services provided to clients in state-only programs and reimbursed separately by the state do not qualify for a Medicaid encounter. Clients identified in ProviderOne with one of the following medical coverage group codes are enrolled in a state-only program. RHC clients identified in ProviderOne with one of the following medical coverage group codes and associated recipient aid category (RAC) codes do not qualify for the encounter rate.

Medical Coverage Group Codes	RAC Code
F06	RACs 1138, 1139 only
F07	RACs 1141, 1142 only
F99	RAC 1040
G01	RACs 1041, 1135-1137, 1145 only
I01	RAC 1050, 1051 only
K03	RACs 1056,1058, 1176-1178 only
K95	RACs 1060, 1064, 1179-1181 only
K99	RACs 1060, 1064, 1179-1181 only
L04	RACs 1077, 1078, 1081, 1082, 1158-1161, 1182-1185 only
L24	RACs 1190-1195 only
L95	RACs 1085, 1087, 1155, 1157, 1186, 1187 only
L99	RACs 1085, 1087, 1090, 1092, 1155, 1157, 1186-1189
M99	RAC 1094 (This is the only RAC for M99)
P05	RAC 1097, 1098 only
P06	All RACs (1099-1100), 1272
S95	RACs 1125, 1127
S99	RACs 1125, 1127
W01	All RACs (1128, 1129, 1170, 1171)
W02	All RACs (1130, 1131, 1172, 1173)
W03	RAC 1132 (This is the only RAC for W03)
N31	RAC 1211 (replaces 1138 and 1139)
N33	RAC 1212, 1213 (replaces 1141, 1142)
A01	RAC 1214 (replaces 1041)
A01	RAC 1215 (replaces 1137)
A05	RAC 1216 (replaces 1145)

Services provided to clients with the following medical coverage group code and RAC code combinations are eligible for encounter payments for services prior to delivery.

Medical Coverage Group Codes	RAC Code
K03	RAC 1057 (This is not the only RAC for K03.)
K95	RAC 1062 (This is not the only RAC for K95.)
K99	RAC 1062 (This is not the only RAC for K99.)
P99	RAC 1102 (This is the only RAC for P99.)
N23	RAC 1209 (Replaces RAC 1096)

Clients identified in ProviderOne with one of the following Barcode (state only) RAC codes for incapacity determination services do **not** qualify for the encounter rate:

Barcode RAC
2000
2001
2002
2003
2004

Categories of encounters

Encounters may be reported for medical and dental services.

Medical encounter

A medical encounter is a face-to-face encounter between an approved provider and a client where services are provided for the prevention, diagnosis, treatment, or rehabilitation of illness or injury. Services provided by approved professionals are considered eligible for an encounter payment as long as the billing code falls outside the range of codes identified in [What services do not qualify for an encounter?](#)

Dental encounter

For an RHC to submit encounters and include costs for dental care in cost reports, the RHC must be approved by the agency and must meet the billing and eligibility requirements as specified in the [Dental-Related Services Billing Guide](#), the [Access to Baby and Child Dentistry Billing Guide](#), and the [Orthodontic Services Billing Guide](#).

A dental encounter is a face-to-face encounter between a dentist, dental hygienist, or orthodontist and a client for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. **Only one encounter is allowed per day.**

Note: A dental hygienist may bill an encounter only when providing a service independently -- not jointly with a dentist. Only one encounter per day at a dental clinic is covered.

Exception: When a dental service requires multiple visits (e.g., root canals, crowns, dentures), an encounter code must be billed with the number of visits when the dental services are complete.

When fluoride treatment and sealants are provided on the same day as an encounter-eligible service, RHCs must bill them on the same claim. If fluoride treatment and sealants are not provided on the same day with an encounter-eligible service, bill them directly to the agency to be paid under fee-for-service.

What services do not qualify as an encounter?

The services in the table below do not qualify as encounters. If these are the only services provided on a given day, do not bill with a T1015 encounter code. The agency will pay up to the maximum allowed amount on the fee schedule for these services.

For example: If an immunization (not encounter-eligible) is the only service performed that day, the RHC will receive up to the maximum allowed amount on the fee schedule.

Services identified in the “Bundled With Encounter” column in the table below must be billed on the same claim as an encounter-eligible service, when performed as part of an encounter. Do not bill using HCPCS code T1015 for these services unless there is a qualifying, encounter-eligible service on the claim.

For example: A claim includes a well-child visit CPT code 99383 (encounter-eligible) and an immunization administration CPT code 90707 SL (not encounter-eligible). The RHC will receive one encounter payment.

Services identified in the “Separately-Reimbursable” column of the table below are excluded from the RHC Medicare Cost Report and may be reimbursed separately outside of the encounter.

For example: Some services, such as labs, are allowed to be billed outside the encounter, even if they are performed on the same day as encounter-eligible code. These services are marked with a check mark in the column “Separately Reimbursable” below.

Service	Procedure Codes	Bundled with Encounter	Separately-Reimbursable
Ambulance services	HCPCS A0021- A4205		√
Dental	D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0460, D0501, D1206, D1208, D1351, 99188	√	
Drugs and biologicals including drugs administered in the provider’s office (for example, pneumococcal and influenza vaccines)	All J Codes	√	

Rural Health Clinics

Service	Procedure Codes	Bundled with Encounter	Separately-Reimbursable
IUD Supply Codes	For example: J7300-J7302, J7296-J7298		√
Durable medical equipment (rented or purchased)	99070, E0100-E8002, K0001, K0902		√
Eye exams and eyeglasses or contact lenses	HCPCS V2xxx, 92002-92499	√	
Family planning services	CPT codes 11976, 55250, 57170, 58300, 58301, 58600, 58615, 58670, 56871,	√	
Hearing exams and hearing aids	CPT codes 92502-92597 & HCPCS V5000-V52999,	√	
Maternity support services	Maternity Support Services Billing guide and Fee schedule		√
Substance use disorder (other than SBIRT)	Substance Use Disorder Billing Guide and Fee Schedule		√
Medical supplies listed in the agency's Physician-Related Services/Healthcare Professional Services Billing Guide as separately billable (for example, cast materials and splints)	T5999, 99070, A4206-A9999	√	
Prosthetic and orthotic devices	HCPCS Lxxxx, K0672		√
Screening mammography services	HCPCS 77057 and G0202		√

Rural Health Clinics

Service	Procedure Codes	Bundled with Encounter	Separately-Reimbursable
Telemedicine	Q3014, D9995 – D9996		√
Diagnostic tests, such as x-rays and EKGs	70000-79999	√ *when bundled for services with modifier 26	√ *when billed with modifier TC
G codes in the defined range	G0008-G9140 (Exception: G0101 is encounter-eligible effective January 1, 2018.)	√	
Q codes in the defined range	Q0000-Q9999 (Exception: Q3014-see above in telemedicine)		
Clinical diagnostic laboratory services, including laboratory tests required for RHC certification	80000-89999 U0001 and U0002		√
Venipuncture/Blood Draws	HCPCS codes 36400-36425, 36511-36515, 38204-38215	√	
Administration fees for drugs and vaccines given in the provider's office	90281-90750, 90471-90474	√	
Collaborative Care	G0512	√	

Additionally, the following services do not qualify for an encounter and are paid for by the agency through fee-for-service:

- Delivery and postpartum services provided to pregnant undocumented alien women are not encounter-eligible. Global care must be unbundled. The agency does not pay for an encounter for the delivery or postpartum care or any other service provided once the client is no longer pregnant.
- Health services provided to clients under [state-only programs](#).
- Hospital based services. Covered services will be paid as fee-for-service and should not be billed with a T1015 encounter code.
- Global services (example: maternity services) must be unbundled and billed following the service coding rules.
- Any services performed in a hospital setting [place of service 21]

Collaborative care model (CoCM) services

Collaborative care is a specific type of integrated care that treats common mental health conditions, such as depression and anxiety, that require systematic follow-up due to their persistent nature. These services may be performed in the RHC setting by qualified medical professionals but are not encounter-eligible. These services must be billed through fee-for-service using procedure code G0512. Additional CoCM registry and billing information is located in the [Physician-Related Services/ Health Care Professional Services Billing Guide](#).

Administration of Department of Health-supplied vaccines for clients age 18 and younger

No-cost immunizations from the Department of Health (DOH) are available for clients age 18 and younger. See the [Professional Administered Drug Fee Schedule](#) for a list of free immunizations from DOH. The agency pays only for administering the vaccine.

- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). The agency pays for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).
- DO NOT bill procedure codes 90471-90472 for the administration.

When does the agency pay for RHC services?

(WAC [182-549-1300](#) (2))

The agency pays the RHC for medical services when they are:

- Within the scope of an eligible client's [medical assistance program](#).
- Medically necessary as defined in WAC [182-500-0070](#).

What is the reimbursement structure for RHCs?

The reimbursement structure is explained in detail in WAC [182-549-1400](#).

Many supplies used in a provider's office are considered incidental to the medical service and are included in the encounter rate. Using the appropriate billing taxonomy and appropriate procedure codes, bill only those supplies that are specifically detailed in the agency's [Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide](#) as separately reimbursable. For more information on services that are separately reimbursable, refer to the "[What services do not qualify as an encounter?](#)" section of this guide.

The agency establishes encounter rates specific to each RHC facility for covered RHC services. Non-RHC services are not qualified to be paid at the encounter rate, and are paid for at the appropriate fee schedule amount.

In Washington state, RHCs have the choice of being reimbursed under the prospective payment system or the alternative payment methodology (APM), in accordance with 42 USC 1396a(bb)(6). APM rates are required to be at least equal to prospective payment system rates. (See WAC [182-549-1400](#), Rural health clinics—Reimbursement and Limitations, for a detailed description of each methodology.)

Are RHCs liable for payments received?

Each RHC is responsible for submitting claims for services provided to eligible clients. The claims must be submitted under the rules and billing instructions in effect at the time the service is provided.

Each RHC is individually liable for any payments received, and must ensure that these payments are for only those situations described in this and other applicable agency billing guides, and federal and state rules. RHC claims are subject to audit by the agency, and RHCs are responsible to repay any overpayments.

Upon request, RHCs must give the agency complete and legible documentation that clearly verifies any services for which the RHC has received payment.

How does the agency pay for encounter-eligible services?

The agency pays RHCs for encounter-eligible services on an **encounter rate** basis rather than a fee-for-service basis. All RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

The agency limits encounters to one per client, per day, except in the following circumstances:

- The visits occur with different healthcare professionals with different specialties.
- There are separate visits with unrelated diagnoses.

Note: The service being performed must require the skill and ability of [an encounter-level practitioner](#) in order to qualify for an encounter payment.

Does the agency pay for covered RHC services for clients enrolled in a Managed Care Organization (MCO)?

For clients enrolled with a Managed Care Organization (MCO), covered RHC services are paid by the MCO. Only clients enrolled in Title XIX (Medicaid) or Title XXI (CHIP) are eligible for encounter payments. Neither the agency nor the MCO pays the encounter rate for clients in state-only medical programs.

How does an MCO reimburse an RHC for qualified encounters provided to managed care clients?

For managed care clients receiving services at an RHC, total daily reimbursement to the RHC must equal the RHC's specific encounter rate for qualified encounters. Guidelines for qualified encounters are the same as the fee-for-service guidelines outlined in this guide. The agency will provide each RHC's encounter rate to the MCO. 42 U.S.C. 1396a (bb)(5)(A).

Payment options for managed care clients

Supplemental enhancement payments

For clients enrolled with an MCO, the agency determines the amount of the supplemental payment for each RHC that is paid in addition to the MCO contracted rate. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a(bb)(5)(A). These enhancements are intended to make up the difference between the MCO payment and an RHC's encounter rate. The payments are generated from client rosters submitted to the agency by the MCOs. The agency sends the monthly enhancement payments to MCOs to be distributed to the RHCs.

The RHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO. To ensure that the appropriate amounts are paid to each RHC, the agency performs an annual reconciliation of the enhancement payments. If the RHC was overpaid, the agency will recoup the appropriate amount. If the RHC was underpaid, the agency will pay the difference. It is the RHC's responsibility to perform internal monthly verification that it has received all payments.

For dates of service on and after January 1, 2018, reconciliations will be conducted in the calendar year following the calendar year for which the enhancements were paid. The agency or the clinic will conduct the reconciliations, with final review and approval by the agency. The process of settling over or under payments may extend beyond the calendar year in which the reconciliations were conducted.

Based on the results of the reconciliation, the agency may adjust the enhancement rate to avoid significant overpayments or underpayments and to lessen the financial impact on the agency and the RHC. In addition, the RHC can request agency approval for an enhancement rate change.

Note: HCA uses client rosters to determine total annual enhancement payments as part of the reconciliation process. MCOs and RHCs are responsible for ensuring all client roster adjustments, including retroactive roster adjustments, are submitted to HCA no later than June 15 in the year following the year of the roster assignment. HCA will not accept client assignments for the previous year after the annual deadline.

Example: All client rosters for year 2018, including retro adjustments, must be submitted to HCA on or before June 15, 2019.

Full encounter rates through MCO payments

RHCs may participate in a payment option to receive their full encounter rate from MCOs for each encounter-eligible service. If RHCs wish to receive the encounter rate from MCOs, they must notify the agency in writing by November 1st of the year prior to the year of participation. Upon notification, the agency will enroll an RHC in this payment method for the full calendar year, with an opportunity to opt-out the following calendar year.

Clinics under this payment option do not receive monthly enhancement payments. Instead, the full encounter rate will be paid by the MCO for all eligible RHC claims. The MCO will be reimbursed for the T1015 portion of encounter-eligible claims via a service-based enhancement (SBE) payment. This SBE payment will be generated through ProviderOne after the MCO submits claims for eligible encounters. The SBE payment is intended to be used for eligible encounter claims and the MCO will at no time be at risk for or have any right to this portion of the claim.

The agency will perform an annual reconciliation with the MCO. Reconciliations will ensure that each participating RHC received its full encounter rate for each qualifying claim and that MCOs are not put at risk for, or have any right to, the T1015 portion of the claim.

Note: Clinics receiving their RHC encounter rate through MCOs must bill using the NPI associated with RHC Taxonomy 261QR1300X. Encounter rates will not be paid by MCOs under any other NPI.

Change in Scope of Service

[WAC [182-549-1500](#) and [42 U.S.C. 1396a\(bb\)\(3\)\(B\)](#)]

A change in scope of service occurs when there is a change in the type, intensity (the total quantity of labor and materials consumed by an individual client during an average encounter), duration (the length of an average encounter), or amount of services provided by the RHC. When such changes meet the criteria described below, the RHC may qualify for a change in scope of service rate adjustment.

Note: A change in costs alone does not constitute a change in scope of service.

What are the criteria for a change in scope of service rate adjustment?

The agency may authorize a change in scope of service rate adjustment when the following criteria are met:

- The change in the services provided by the RHC meet the definition of RHC services as defined in section 1905(a)(2)(C) of the Social Security Act.
- Changes to the type, intensity, duration, or amount of services have resulted in an increase or decrease in the RHC's cost of providing covered health care services to eligible clients. The cost change must equal or exceed any of the following:
 - ✓ An increase of 1.75 percent in the rate per encounter over one year
 - ✓ A decrease of 2.5 percent in the rate per encounter over one year
 - ✓ A cumulative increase or decrease of 5 percent in the cost per encounter as compared to the current year's cost per encounter
- The costs reported to the agency to support the proposed change in scope rate for adjustment are reasonable under applicable state and federal law.

How is a change in scope of service rate adjustment requested?

A change in scope of service rate adjustment may be requested by the agency or by an RHC.

When may the agency request an application for a change in scope of service rate adjustment?

At any time, the agency may require an RHC to file an application for a change in scope of service rate adjustment. The application must include a cost report, “position statement,” which is an assertion as to whether the RHC’s encounter rate should be increased or decreased due to a change in the scope of service, and other application requirements as follows:

- The RHC must submit to HCA a copy of the most recent finalized Medicare cost report and position statement no later than 90 calendar days after receiving the agency’s request for an application.
- The agency reviews the RHC’s Medicare cost report, position statement, and application for change in scope of service rate adjustment using the criteria listed under [What are the criteria for a change in scope of service rate adjustment?](#)
- The agency will not request more than one change in scope of service rate adjustment application from an RHC in a calendar year.

When may an RHC request an application for a change in scope of service rate adjustment?

Unless the agency instructs the RHC to file an application for a change in scope of service rate adjustment, an RHC may file only one application per calendar year. However, more than one type of change in scope of service may be included in a single application.

An RHC may apply for a prospective change in scope of service rate adjustment, a retrospective change in scope of service rate adjustment, or both.

An RHC must file an application for a change in scope of service rate adjustment no later than 90 calendar days after the end of the year in which the RHC believes the change in scope of service occurred or in which the RHC learned that the cost threshold was met, whichever is later.

What is a prospective change in scope of service?

A prospective change in scope of service is a change the RHC plans to implement in the future. To file an application for a prospective change in scope of service rate adjustment, the RHC must submit projected costs sufficient to establish an interim rate. If the application for a prospective change in scope of service rate adjustment is approved by the agency, an interim rate adjustment will go into effect after the change takes effect.

The interim rate is subject to a post-change in scope review and rate adjustment.

If the change in scope of service occurs fewer than 90 days after the RHC submits a complete application to the agency, an interim rate takes effect no later than 90 days after the RHC submits the application to the agency.

If the change in scope of service occurs more than 90 days but fewer than 180 days after the RHC submits a complete application to the agency, the interim rate takes effect when the change in scope of service occurs.

If the RHC fails to implement a change in service identified in its application for a prospective change in scope of service rate adjustment within 180 days, the application is void. The RHC may resubmit the application to the agency. The agency does not consider the resubmission of a voided application as an additional application.

Supporting documentation for a prospective change in scope of service rate adjustment

To apply for a change in a prospective scope of service rate adjustment, the RHC must include the following documentation in the application:

- A narrative description of the proposed change in scope of service that explains how each proposed change meets the requirements for change in scope of amount, duration, intensity, or type. The narrative should also include all RHC NPIs and the proposed encounter rate for each RHC site included in the Medicare cost report.
- A description of each cost center on the cost report that will be affected by the change in scope of service
- The RHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law
- The implementation date for the proposed change in scope of service
- The projected Medicare cost report with the supplemental schedules needed to identify the Medicaid cost per visit for the 12-month period following the implementation of the change in scope of service.
- Any additional documentation requested by the agency.

What is a retrospective change in scope of service?

A retrospective change in scope of service occurs when a change took place in the past and the RHC is seeking to adjust its rate based on that change.

An application for a retrospective change in scope of service rate adjustment must state each qualifying event that supports the application and include 12 months of data documenting the cost change caused by the qualifying event.

If approved, a retrospective rate adjustment takes effect on the date the RHC filed the application with the agency.

Example: If the RHC submits a completed application on September 1, 2017, the agency begins the review process and sets the final rate within 90 days. This rate is effective on September 1, 2017, corresponding with the date the agency received the complete application.

Supporting documentation for a retrospective change in scope of service rate adjustment

To apply for a retrospective change in scope of service rate adjustment, the RHC must include the following documentation in the application:

- A narrative description of the proposed change in scope of service that explains how each proposed change meets the requirements for change in scope of amount, duration, intensity, or type. The narrative should also include all RHC NPIs and the proposed encounter rate for each RHC site included in the Medicare cost report.
- A description of each cost center on the cost report that was affected by the change in scope of service
- The RHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law
- The implementation date for the proposed change in scope of service
- The Medicare cost report with the supplemental schedules necessary to identify the Medicaid cost per visit and the encounter data for the 12 months or the fiscal year following implementation of the proposed change in scope of service.
- An attestation statement confirming all visits/encounters are included in the Medicaid cost report.
- Any additional documentation requested by the agency

How does the agency process applications for a change in scope of service rate adjustment?

The agency reviews an application for a change in scope of service rate adjustment for completeness, accuracy, and compliance with program rules.

Within 60 days of receiving the application, the agency notifies the RHC of any deficient documentation or requests any additional information that is necessary to process the application.

Within 90 days of receiving a complete application, the agency sends the RHC:

- A decision stating it will implement an encounter rate change.
- A rate-setting statement.

If the RHC does not receive the items described above within 90 days, the agency has denied the change.

How does the agency set an interim rate for prospective changes in the scope of service?

The agency sets an interim rate for prospective changes in the scope of service by adjusting the RHC's existing rate by the projected average cost per encounter of any approved change.

The agency reviews the projected costs to determine if they are reasonable, and sets a new interim rate based on the determined cost per encounter.

How does the agency set an adjusted encounter rate for retrospective changes in the scope of service?

The agency sets an adjusted encounter rate for retrospective changes in the scope of service by changing the RHC's existing rate by the documented average cost per encounter of the approved change.

Projected costs per encounter may be used if there is insufficient historical data to establish the rate. The agency reviews the costs to determine if they are reasonable, and sets a new rate based on the determined cost per encounter.

If the RHC is paid under an alternative payment methodology (APM), any change in the scope of service rate adjustment requested by the RHC will modify the prospective payment systems (PPS) rate in addition to the APM.

The agency may delegate the duties related to application processing and rate setting to a third party. The agency retains final authority for making decisions related to changes in scope of service.

When does the agency conduct a post change in scope of service rate adjustment review?

The agency conducts a post change in scope of service review within 90 days of receiving the cost report and encounter data from the RHC. If necessary, the agency will adjust the encounter rate within 90 days of the review to ensure that the rate reflects the reasonable cost of the change in scope of service.

A rate adjustment based on a post change in scope of service review will take effect on the date the agency issues its adjustment. The new rate will be prospective.

Example: If the RHC submits a completed application on September 1, 2017, the agency begins the review process and sets the final rate within 90 days. If the agency concludes the review on December 1, 2017, the RHC's new rate is effective on December 1, 2017. If the agency concludes this same review on November 1, 2017, the new rate for the RHC is effective on November 1, 2017.

If the application for a change in scope of service rate adjustment was based on a year or more of actual encounter data, the agency **may** conduct a post change in scope of service rate adjustment review.

If the application for a change in scope of service rate adjustment was based on less than a full year of actual encounter data, the RHC **must** submit the following information to the agency within 18 months of the effective date of the rate adjustment:

- A Medicare cost report with the supplemental schedules necessary to identify the Medicaid cost per visit
- Encounter data for 12 consecutive months of experience following implementation of the change in scope
- The RHC's most recent audited financial statements for the same time period as the cost reports, if an audit is required by federal law
- Any additional documentation requested by the agency

If the RHC fails to submit the post change in scope of service cost report or related encounter data, the agency provides written notice to the RHC of the deficiency within 30 days.

If the RHC fails to submit required documentation within 5 months of this deficiency notice, the agency may reinstate the encounter rate that was in effect before a change in the scope of service rate was granted. The rate will be effective the date the interim rate was established. Any overpayment to the RHC may be recouped by the agency.

How are rates rebased?

The agency will periodically rebase the RHC encounter rates using the RHC cost reports and other relevant data. RHCs being rebased will submit a Medicare cost report, *Settled as Filed*, to the agency for the most recent fiscal year.

Retrospective change in scope of service requests are not allowed during the periodic rebase process as rebasing adjusts for these changes.

May an RHC appeal an agency action?

Yes. An RHC may appeal an agency action. WAC 182-502-0220 governs appeals. If an appeal is granted, any rate change will begin no sooner than the date the agency received the complete application for change in scope of service rate adjustment.

What are examples of events that qualify for a rate adjustment due to changes in scope of service?

The following examples illustrate events that would qualify for a rate adjustment due changes in the type, intensity, duration, or amount of service:

- Changes in the patients served, including populations with HIV/AIDS and other chronic diseases; patients who are homeless, elderly, migrant, limited in English proficiency; or other special populations
- Changes in the technology of the RHC, including but not limited to electronic health records and electronic practice management systems
- Changes in the RHC's medical, behavioral health, or dental practices, including, but not limited to, the implementation of patient-centered medical homes, opening for extended hours, or adding a service.
- Capital expenditures associated with a modification of any of the services provided by the RHC, including relocation, remodeling, opening a new site, or closing an existing site
- Changes in service delivery due to federal or state regulatory requirements

What are examples of events that do not qualify for a rate adjustment due to changes in scope of service?

The following examples illustrate events that would not qualify for a rate adjustment due to changes in the type, intensity, duration, or amount of service:

- Addition or reduction of staff members not directly related to the change in scope of service
- Expansion or remodel of an existing RHC that is not directly related to the change in scope of service
- Changes to salaries, benefits, or the cost of supplies not directly related to the change in scope of service
- Changes to administration, assets, or overhead expenses not directly related to the change in scope of service
- Capital expenditures for losses covered by insurance
- Changes in office hours, location, or space not directly related to the change in scope of service
- Changes in patient type and volume without changes in type, duration, or intensity of services
- Changes in equipment or supplies not directly related to the change in scope of service

Billing

All claims must be submitted electronically to the agency, except under limited circumstances.

For more information about this policy change, see [Paperless Billing at HCA](#).

For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill the agency for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record-keeping requirements.

What special rules are there for RHCs to follow when billing?

- See [What services do not qualify as an encounter?](#) for information on which services are separately reimbursable outside of an encounter.
- An encounter-eligible service must be billed with the T1015 procedure code.
- If reprocessing a denied service or a service that was not correctly included when the original claim was billed, the paid claim must be adjusted. If the original claim is not adjusted to add these services, the additional claim may be denied.
- If a non-encounter-eligible service is billed and paid prior to an encounter-eligible claim submission for the same date of service, adjust the paid claim and submit the services together to receive payment.

How do I bill for encounter services?

Service Type	HCPCS Code	HCPCS/CPT/CDT Encounter Service Rendered	Billed Charges
Medical	T1015 ¹		Bill \$0.00
Dental	(All-inclusive clinic visit/encounter)		
		Bill corresponding fee-for-service code(s) of the underlying service being performed	Bill clinic's usual and customary charges for service rendered

¹The position of the T1015 on a claim will not affect claim payment.

Always list an encounter code on the same claim as its related CPT codes.

- When billing the encounter code, bill \$0.00. For services eligible for encounter payments, the system will automatically pay the difference between the RHC's encounter rate and the fee-for-service amount paid.
- To ensure correct payment for the T1015 encounter code, all third party payment information must be reported at the header level of the claim.
- For clients in programs eligible for encounter payments, the agency denies Evaluation and Management codes when billed without a T1015.

Note: The agency will not reimburse for early (before 39 weeks of gestation) elective deliveries. See the [Physician-Related Services/Health Care Professional Services Billing Guide](#) for additional instructions.

- When billing for services that do not qualify for encounter payments, do not use an encounter code on the claim. (See [What services do not qualify as encounters?](#))

Note: As client eligibility may change, bill encounter code T1015 on claims for all eligible services. ProviderOne will determine whether the encounter is payable when the claim is processed.

RHC services provided to agency clients must be billed to the agency on a professional claim. This includes claims with:

- An Explanation of Benefits (EOB) attachment from an insurance carrier.
- A Medicare Explanation of Medicare Benefits (EOMB) denial.

How do I bill for maternity care?

The following maternity services are eligible for an encounter payment:

- Each prenatal and postpartum maternity care visit.
- A delivery performed outside a hospital setting.

A delivery performed in any hospital setting does not qualify as an encounter and must be billed as fee-for-service, using the appropriate delivery-only CPT code.

Any time unbundling is necessary, antepartum-only codes and post-partum-only codes must be billed in combination with the T1015 code for the same date of service.

Whenever the client is seen on multiple days for a maternity package fee-for-service code, the T1015 code is billed with a TH modifier, and the units on the encounter line must equal the number of days that the client was seen for encounter eligible services related to the fee-for-service code. See the [Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide](#) for additional instructions.

If the delivery is outside the hospital, the same is true regarding multiple encounter units. However, obstetrical fee-for-service codes must be used when all maternity services to the client are provided through the RHC. When delivery is in the hospital, unbundle and bill the appropriate delivery only fee-for-service code on a separate claim without an encounter.

How do I bill for orthodontic services performed in an RHC?

When billing for orthodontic services, RHCs must follow the same guidelines as non-RHC providers. However, “global” orthodontic codes cover a specific length of time and are billed at the end of the time indicated. There is an exception for the initial placement of the device, which is billed on the date of service. Because RHCs are reimbursed by an encounter payment, they may bill up to the maximum number of encounters. See [Comprehensive treatment timeframes and maximum units](#).

Comprehensive treatment timeframes and maximum units allowed

	Comprehensive treatment (D8080)										Total encounters allowed
Months from Appliance Placement date	0	6 *	9	12	15	18	21	24	27	30	
Number of encounters allowed	0	5**	2	2	2	2	2	2	2	2	21

* The date of service on the claim is the same as the appliance placement date.

** RHC records must document the five separate visits.

During the first six months of an appliance placement, an RHC may bill on the date of the appliance placement for one unit and up to a total of five units. To bill for more than one unit during the first six months, the RHC must see the client and document the encounter in the client’s file. If an RHC bills in this manner instead of waiting the full six months, the RHC must adjust the latest paid claim each time and add another unit to the line containing the T1015 code. If the RHC does not adjust the claim, it will be denied as a duplicate billing.

The chart below is similar to the comprehensive treatment chart but is for limited orthodontic treatment.

	Limited orthodontic treatment (D8030)					Total Encounters allowed
Months from appliance placement date	0	3*	6	9	12	
Number of encounters allowed	0	4**	2	2	2	10

* Use the appliance placement date for billing.

** Clinic records must document four separate visits.

An RHC may bill on the date of the appliance placement for one unit and up to a total of four units during the first three months of the appliance placement. To bill for more than one unit during the first six months, the RHC must see the client and document the encounter in the client’s file. If a clinic bills in this manner instead of waiting the full three months, the RHC must adjust the latest paid claim each time and add another unit to the line containing the T1015 code. If the RHC does not adjust the claim, the claim will be denied as a duplicate billing.

What are the rules for telemedicine?

RHCs are authorized to serve as an originating site for telemedicine services. An originating site is the location of a client at the time the telemedicine service being furnished through a telecommunications system occurs. RHCs that serve as an originating site for telemedicine services are paid an originating site facility fee. Charges for the originating site facility fee may be included on a claim, but **the originating site facility fee may not be included on the cost report.**

RHCs may receive the encounter rate when billing as a distant site provider if the service being billed is encounter eligible. Clients enrolled in an agency-contracted MCO must contact the MCO regarding whether or not the plan will authorize telemedicine coverage.

For billing information see the agency's [Physician-Related/Professional Services Billing Guide](#).

How do I bill for more than one encounter per day?

Encounters are limited to one type of encounter per day for each client, regardless of the services provided, except in either one of the following circumstances:

- It is necessary for the client to be seen by different practitioners with different specialties.
- It is necessary for the client to be seen multiple times due to unrelated diagnoses.

Each encounter must be billed on a separate claim. On each claim, to indicate that it is a separate encounter, enter “unrelated diagnosis” and the time of both visits in in the *Claim Note* section of the electronic claim. Use an appropriate modifier to bill for the subsequent T1015 procedure code.

Documentation for all encounters must be kept in the client’s file.

Note: Only one visit can be billed per claim. Bill multiple visits on different claims.

What procedure codes must an RHC use?

RHCs **must** submit claims using the appropriate procedure codes listed in one of the following billing guides:

- [Physician-Related Services/Healthcare Professional Services Billing Guide](#)
- [Dental-Related Services Billing Guide](#)
- [Access to Baby and Child Dentistry Billing Guide](#)
- [Orthodontic Services Billing Guide](#)
- Other applicable program-specific billing guides

Claims must be submitted using the appropriate claim form from [the agency's provider billing guides and fee schedules webpage](#):

- For medical services, use an 837P HIPAA-compliant claim or professional DDE claim
- For dental services, use an 837D HIPAA-compliant claim or dental DDE claim

Can RHCs be paid for noncovered services?

No. Noncovered services are not eligible for payment, including encounter payments. Specific information regarding noncovered services can be found under “*What services are noncovered?*” in the [Physician-Related Services/Healthcare Professional Services Billing Guide](#).

How do I bill taxonomy codes?

- When billing for services eligible for an encounter payment, the agency requires RHCs to use billing taxonomy 261QR1300X at the claim level.
- A servicing taxonomy is also required as follows:
 - ✓ Psychologists and psychiatrists billing for mental health encounters in combination with fee-for-service codes must bill servicing taxonomy appropriate for the service performed by the performing provider.
- If the client or the service does not qualify for an RHC encounter, RHCs may bill regularly as a non-RHC without T1015 on the claim.

How do I bill taxonomy electronically?

When billing electronically:

- Billing taxonomy goes in the 2000A loop.
- Rendering taxonomy goes in the 2310B loop.

For more information on billing taxonomy, refer to the [Health Insurance Portability and Accountability Act](#).

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency’s [Billers and Providers webpage](#), under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\) webpage](#).

The following claim instructions relate to RHCs:

Name	Entry
Place of Service	Enter Place of Service (for example, “11” or “72”)
Billing Provider	Enter your billing NPI and RHC Billing Taxonomy 261QR1300X

How do I bill for services paid under the fee-for-service system?

Clinics must bill the agency for services covered under the fee-for-service system using their clinic’s NPI and taxonomy, the appropriate servicing NPI and taxonomy, and the service’s appropriate CPT or HCPCS procedure code with the appropriate ICD diagnosis code. ICD diagnosis codes must be listed at the highest level of specificity (for example, to the fourth or fifth digit, if appropriate).

Services covered under the fee-for-service system are subject to the limitations and guidelines detailed in the agency's [Physician-Related Services/Healthcare Professional Services Billing Guide](#).

See the agency's [Billers and Providers webpage](#) for more information.

How do I bill for clients eligible for both Medicare and Medicaid?

When a client is eligible for both Medicare and Medicaid, Medicare is the primary payer for services provided. After Medicare has adjudicated the claims, they can be sent to the agency for secondary payment. These claims are called Medicare crossover claims. Medicaid payment for valid crossover claims will equal the difference between the Medicare payment amount and each clinic's Medicare per-visit rate. Payment from the agency will not exceed an RHC's Medicare rate. Crossover claims must be billed in an institutional format using the RHC NPI and RHC billing taxonomy 261QR1300X. These crossover claims can also be direct data entered (DDE) in ProviderOne for institutional claims. No Medicare EOB is required to be sent with the claim.

Medicare/Medicaid crossover claims for services that are not eligible as encounters must be billed in the professional format using the RHC's NPI, fee-for-service taxonomy, and appropriate servicing provider NPI and taxonomy. These crossover claims can also be direct data entered (DDE) in ProviderOne for professional claims. No Medicare EOB is required to be sent with the claim.

For more information on billing Medicare/Medicaid crossover claims, see the agency's [ProviderOne Billing and Resource Guide](#).

How do I handle crossover claims in an RHC setting?

See the [ProviderOne Billing and Resource Guide](#) for details on payment methodologies.

RHCs are required to bill crossover claims on an electronic institutional claim. If Managed Medicare and Medicare Part C plans require services to be billed on professional claim, and they are paid or the money is applied to the deductible, RHCs must switch the claim information to an electronic institutional claim or the claim will not process correctly. These crossover claims must be billed to the agency using the Type of Bill 71X and the RHC taxonomy for the Billing Provider.

How do I handle Managed Medicare or Medicare Part C crossover claims for dental billing?

Managed Medicare and Medicare Part C plans increasingly offer dental services as a covered service. If a Part C plan makes a payment, RHCs bill the agency on an electronic dental claim. To ensure the claim goes to Coordination of Benefits for proper pricing, indicate on the claim in the *Claim Note* section that this is a Managed Medicare or Medicare Part C service.

Reporting Medicare encounter rates

Medicare encounter/per-visit rates must be reported to the RHC Program Manager promptly upon receipt from Medicare. These rates are necessary to ensure that crossover claims are paid correctly. RHCs are responsible for adjusting claims as necessary due to changes in Medicare rates.

How do I bill for drugs administered in the office along with their administration charges?

If the drug is administered as part of an encounter, the administration and the drug are considered bundled within the encounter. If the purpose of the visit is for the administration of a drug only (for example, an injection-only service with no corresponding office visit), bill as follows:

- If the purpose of the injection is for reasons that are not considered encounter services, RHCs may bill for both the drug itself and the injection using the appropriate CPT and HCPCS procedure codes.
- If the purpose of the injection is for reasons that are considered encounter services, RHCs may not bill for the injection itself as the costs of these services are included in the encounter rate.