Rural Health Clinics (RHCs)

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41.1 Enrollment
To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare.

A 9-digit provider identifier is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA are not reimbursed for laboratory services.

Important: All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: “Provider Enrollment” on page 1-3 for more information.

“Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2.

“Managed Care” on page 7-1

41.2 Record Retention
Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

41.3 Reimbursement
Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with 1 TAC §355.8101.

41.4 Benefits and Limitations
The services listed in the table below may be reimbursed to RHC providers. General services are billed using the RHC’s National Provider Identifier (NPI). For all other services, providers must bill using their NPI and benefit code. Place of service 72 must be used on the CM1500 claim form when billing for services other than general medical.

<table>
<thead>
<tr>
<th>General Medical Services</th>
<th>T1015</th>
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</thead>
<tbody>
<tr>
<td>General medical services must be billed using one of the appropriate modifiers AJ, AH, AM, SA, TD, TE, TH, or U7.</td>
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<table>
<thead>
<tr>
<th>Texas Health Steps (THSteps) Medical Services</th>
</tr>
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<tbody>
<tr>
<td>99381</td>
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<tr>
<td>99391</td>
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<tr>
<td>THSteps medical services must be billed using modifier EP and one of the following modifiers AM, SA, TD, or U7.</td>
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<thead>
<tr>
<th>Family Planning Services</th>
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<tbody>
<tr>
<td>99204*</td>
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<tr>
<td>*Family planning services must be billed using modifier FP.</td>
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<table>
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<tr>
<th>Copayments</th>
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<tr>
<td>CP001</td>
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Refer to: “Physician” on page 36-1.

“Texas Health Steps (THSteps)” on page 43-1.

“Family Planning Services” on page 20-1.

“HMO Copayments” on page 5-79.

41.4.1 Telemedicine Services
Remote site providers are limited to physicians (doctors of medicine [MDs] and doctors of osteopathy [DOs]), physician assistants (PAs), nurse practitioners (NPs) certified nurse-midwives (CNMs), Federally Qualified Health Centers (FQHCs), and RHCs.

RHC telemedicine providers must submit their claims using the appropriate encounter code and modifiers. Modifier U7, AM, or SA is to be used in the first modifier field on the claim form together with the modifier GT in the second modifier field on the claim form.

Refer to: “Physician” on page 36-1 for more information.

41.4.2 Freestanding and Hospital-Based RHC Services
An RHC must be located in an area designated by the federal government as a health-care shortage area. The following are benefits of RHCs under Texas Medicaid:

• Physician services
• Services and supplies furnished as incidental to physician services
• Services provided by an NP, a CNM, a clinical social worker, or PA services
• Services and supplies furnished as incidental to the NP’s or PA’s services
• Visiting nurse services on a part-time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies. A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or skilled nursing facility, because of a medical condition.

When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client’s treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved by the supervising physician of the clinic at least every 60 days.

A visit is a face-to-face encounter between an RHC client and a physician, PA, NP, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

• After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.

• The RHC client has a medical visit and an other health visit.

An other health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

For freestanding RHCs, all laboratory services provided in the RHC’s laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed for RHC and non-RHC clients can be billed to Medicaid. The claim should be filed under their independent laboratory Medicaid provider identifier and using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes.

41.4.2.1 Freestanding Rural Health Clinic Services

The services listed below cannot be reimbursed to freestanding RHCs using the RHC 9-digit provider identifier. Use of the RHC provider identifier for billing these services causes claims to deny. Services in any of these three categories must be billed using the appropriate practitioner’s group/individual, Texas Health Steps (THSteps), or family planning agency Medicaid 9-digit provider identifier:

• THSteps medical checkups

• Family planning services (including implantable contraceptive capsules provision, insertion, or removal)

• Immunizations, unless they are billed outside of a THSteps medical checkup

These services must be billed with an AJ, AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology. When billing on the CMS-1500 claim form, use the appropriate national place of service code (POS) (72) for an RHC setting.

Physicians’ supplies are not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician Medicaid 9-digit provider identifier.

Exception: If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may bill for a second visit.

Freestanding RHCs bill an all-inclusive encounter for services provided.

All services provided that are incidental to the encounter must be included in the total charge for the encounter. They are not billable as a separate encounter.

Exception: When billing for immunizations outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be used. This is the only circumstance in which a freestanding RHC can bill for a procedure other than T1015.

All services provided during a freestanding RHC encounter must be billed using procedure code T1015. The total billed amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code 1-T1015 to designate the health-care professional providing the services: AJ, AM, or SA with POS 2, TH, or U7.

Reminder: The primary initial contact is defined as “the health-care professional who spends the greatest amount of time with the client during that encounter.”

If more than one health-care professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP or a PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

If the encounter is for antepartum or postpartum care, use modifier TH. FQHCs and RHCs must continue to use a TD or TE modifier if billing for visiting nurse services in a client’s home or if billing THSteps for a service performed by a nurse.
41.4.2.2 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate.

One of the following modifiers must be billed for general medical services: AJ, AM, or SA with POS 2, or U7.

The services listed below cannot be reimbursed to hospital-based RHCs using the RHC 9-digit provider identifier. Use of the RHC 9-digit provider identifier for billing these services causes claims to deny. Services in any of these three categories must be billed using the appropriate practitioner’s group/individual, THSteps, or family planning agency provider identifier:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

These services must be billed with an AM, U7, or SA modifier if performed in an RHC setting. Claims are paid under the PPS reimbursement methodology. When billing on the CMS-1500 claim form, use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician provider identifier.

Hospital-based RHCs should bill pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

41.4.2.3 FQHC/RHC After-Hours

After-hours care for FQHCs and RHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m. Monday through Friday.

PCCM clients (see “PCCM” on page 7-31) can access health-care services at FQHCs and RHCs when services are provided outside the normal business hours, including weekends or holidays, without a referral from the client’s primary care provider.

After-hours care provided by FQHCs and RHCs do not require a referral from the client’s primary care provider. FQHCs and RHCs that provide after-hours services to PCCM clients must submit claims with modifier TU.

41.4.2.4 Copayments for FQHCs and RHCs

Copayment procedure codes CP001, CP002, CP005, and CP006 may be considered for reimbursement by Texas Medicaid for FQHCs, RHCs, and associated providers.

41.5 Cost Report Submission

All RHCs are required to submit a copy of their Medicare audited cost report within 15 days of receipt from Medicare for fiscal years ending on or after January 1, 2001, to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

41.6 Claims Information

Freestanding and hospital-based RHC services must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 claim form. Providers may purchase UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for information on electronic claims submissions.

“Claims Filing” on page 5-1 for general information about claims filing.

“UB-04 CMS-1450 Claim Filing Instructions” on page 5-33. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

41.6.1 National Drug Codes (NDC)

All RHCs must submit an NDC for professional or outpatient electronic and paper claims submitted with physician-administered prescription drug procedure codes listed. Codes in the A-code series do not require an NDC.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

The unit of measurement codes for all three forms are:

- F2 - International unit
- GR - Gram
- ML - Milliliter
- UN - Unit

Unit quantities must also be provided on the claim. Depending on the claim type, the NDC information must be submitted as indicated below:
### UB-04 CMS-1450

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Revenue codes and description</td>
<td>Enter N4, the 11-digit NDC number (number on the package or container from which the medication was administered), the unit of measurement code, and the unit quantity with a floating decimal for fractional units (limited to 3 digits). Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025</td>
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### CMS-1500

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>24A</td>
<td>Date(s) of service</td>
<td>In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, services, or supplies</td>
<td>In the shaded area, enter a 1-through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.</td>
</tr>
<tr>
<td>24G</td>
<td>Days or units</td>
<td>In the shaded area, enter the NDC unit of measurement code.</td>
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</table>

### Family Planning 2017

#### 41.6.2 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Page Number</th>
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<tbody>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>xiii</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>3-1</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Claim Filing Instructions</td>
<td>5-33</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>5-15</td>
</tr>
<tr>
<td>Communication Guide</td>
<td>A-1</td>
</tr>
<tr>
<td>Rural Health Clinic Freestanding Claim Example</td>
<td>D-31</td>
</tr>
<tr>
<td>Rural Health Clinic Hospital-Based Claim Example</td>
<td>D-32</td>
</tr>
<tr>
<td>Acronym Dictionary</td>
<td>F-1</td>
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</tbody>
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