34-000 RURAL HEALTH CLINICS (RHC's)

34-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), a Rural Health Clinic must be certified by the Centers for Medicare and Medicaid Services (CMS) for participation in the Medicare program.

34-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

34-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;
2. Abortions: As currently defined, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and
3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed according to the Nebraska Medicaid Practitioner Fee Schedule.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider ~~shall~~ must provide services only under arrangement with the HMO.

34-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider ~~shall~~ must obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As define under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and
2. Abortions: As currently defined, abortions require prior authorization by NMAP.

34-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP ~~shall~~ must authorize the services to be provided by the approved provider as needed with the following exceptions:

1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers ~~shal~~l must contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner ~~shall~~ must send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.
2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 ~~shall~~ must bill that service on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837), using CPT procedure codes. These services require referral/ authorization from the client's PCP. The provider shall contact the PCP before providing these services. If a client requires hospitalization for these services, the provider ~~shall~~ must contact the PCP for referral/authorization.
3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

34-002.03 Mental Health and Substance Abuse Services Mental health and substance abuse services (MH/SA) are provided through the MH/SA managed care plan for all NHC clients. The plan includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization from the plan. All other MH/SA services must be prior authorized as directed by the plan.

34-003 Covered RHC Services: NMAP covers services provided by RHC's on or after July 1, 1990, under this chapter. NMAP defines covered ~~r~~Rural ~~h~~Health ~~c~~Clinic services as the following services provided by a ~~c~~Certified ~~r~~Rural ~~h~~ Health ~~c~~ Clinic:

1. Services provided by a physician within the scope of practice under state law, if the physician performs the services in the clinic or the services are provided away from the clinic and the physician has an agreement with the clinic provided that s/he will be paid by the clinic for the services;
2. Services provided by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner if the services are provided in accordance with Medicare requirements;
3. Services and supplies that are provided as an incident to professional services provided by a physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner;
4. Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if -
   a. The clinic is located in an area in which the ~~Secretary of the Department of Health and Human Services~~ Centers for Medicare and Medicaid Services has determined that there is a shortage of home health agencies;
   b. The services are provided by a registered nurse or licensed practical nurse or a licensed vocational nurse who is employed by, or otherwise compensated for services by the clinic;
   c. The services are provided under a written plan of treatment that is established and reviewed at least every 60 days by a physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner and review and approved at least every 60 days by a supervising physician of the clinic; and
   d. The services are provided to a "homebound" client. For the purposes of visiting nurse care, a "homebound" client is one who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. The client may be considered homebound if the client leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or skilled nursing facility.

34-004 Payment for Rural Health Clinic Services: NMAP will pay for services provided by Rural Health Clinics in compliance with Section 1902 (bb) of the Social Security Act. The Department assures that payments to all RHCs will result in a payment to the clinic in the amount which is at least equal to the Prospective Payment System.

~~34-004.01 Payment for Services Provided by Provider-Based Rural Health Clinics (RHCs): NMAP pays for RHC services provided by provider-based RHCs associated with hospitals of 50 beds or more at the reasonable cost rate per visit as established by Medicare. NMAP pays for RHC services provided by provider-based clinics that are associated with hospitals under 50 beds at the lower of cost or charges as established by Medicare. For those non-RHC services (see other ambulatory services in 471 NAC 34-003.01) for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.~~

~~A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised by departments of the facility.~~

~~34-004.02 Payment for Services Provided by Independent Rural Health Clinics (IRHCs): NMAP pays for services to IRHCs at the reasonable cost rate per visit as established by Medicare. For those non-RHC services (see other ambulatory services in 471 NAC 34-003.01) for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.~~

~~34-004.03 Cost Settlement for Provider-Based RHCs Associated with Hospitals of 50 Beds or More and IRHCs: The annual cost settlement will be calculated for each such clinic by multiplying its Medicare approved Encounter Rate by the number of encounters (all services per recipient per day equals one encounter). This figure is compared to the total amount paid for services during the cost settlement period.~~

~~34-004.04 Payment of Medicare Deductibles and Co-Insurance: For clients who are eligible for Medicare and Medicaid, NMAP shall pay the deductibles and co-insurance as determined by Medicare.~~

~~34-005 Billing for RHC Services: All RHCs shall bill for rural health services as defined in 471 NAC 34-003 on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).~~

~~IRHC's and provider-based RHCs associated with hospitals of 50 or more beds shall not bill radiology services. Payment for such services are included in the encounter fee.~~

~~IRHC's and provider-based RHCs associated with hospitals of 50 or more beds shall use Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) to bill NMAP for clinical laboratory services using the non-rural health clinic numbers.~~

~~Provider-based RHCs associated with hospitals under 50 beds shall use Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) to bill NMAP for clinical laboratory services and radiology services using the hospital provider number.~~

~~Providers shall use current HCPCS/CPT procedure codes when billing NMAP.~~

~~Effective 1/1/2001 payment for clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization is made at the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare.~~

34-004.01 Definitions means the following definitions apply within this chapter:

Encounter means a face-to-face visit between a Medicaid-eligible patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the say day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

Encounter Payments means PPS rate paid to the RHC by the Department multiplied by the number of encounters billed.

Encounter Rate means the all-inclusive PPS rate that the Department reimburses the RHC for an encounter.

Independent Rural Health Clinic means a clinic that is free standing with no association to a hospital, nursing facility, or home health agency.

Medicare Cost Report means the report filed by each RHC provider with its Medicare intermediary as required by Chapter 9 of the Medicare Rural Health Clinic and Federal Qualified Health Center Manual.

Prospective Payment System (PPS) means the payment system where in a reimbursement rate is paid for services provided.

Provider-Based Rural Health Clinic means a rural health clinic that is an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed and supervised by the facility.

34-005 Prospective Payment System

34-005.01 Payment for Services Provided by Provider-Based Rural Health Clinics Associated with Hospitals Having 50 Beds or Greater: The Department will compute the Prospective Payment System (PPS) base rate as follows:

1. Combine reasonable costs from the RHC fiscal year 1999 and 2000 cost reports; then
2. Divide the cost by the combined Total Adjusted Visits from the two fiscal year cost reports (Form CMS-222-92 Worksheet C, Part 1, Line 6; or Form CMS-2552-96 Worksheet M-3, Line 6).

Effective October 1, 2001, the Department will update the PPS base rate annually using the Medicare Economic Index (MEI).

34-005.02 Payment for Services Provided by Provider-Based RHCs Associated with Hospitals Having Less Than 50 Beds: NMAP pays for RHC services provided by provider-based clinics that are associated with hospitals of less than 50 beds at the lower of cost or charges as established by Medicaid.

34-005.03 Payment for Services Provided by Independent Rural Health Clinics (IRHCs): The Department will compute the PPS base rate for IRHCs as follows:

1. Combine reasonable costs from the RHC fiscal year 1999 and 2000 cost reports; then
2. Divide the cost by the combined total adjusted visits from the two fiscal year cost reports.

Effective October 1, 2001, the Department will update the PPS base rate annually using the Medicare Economic Index (MEI).

34-005.04 Rates for New RHCs: The Department will establish rates for a new RHC entering the program after 1999 as follows:

1. For the initial year, the interim rate will be an average of the PPS rate of all RHCs in Nebraska. The interim rate will be retroactively settled based on the RHC's initial cost report.
2. The RHC's individual PPS base rate will be computed using its initial cost report.
3. Once the PPS base rate has been established, it will be updated annually based on the Medicare Economic Index (MEI).

34-005.05 RHC Managed Care Payment: RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payment the RHC receives from the MCE(s) and the payments the RHC would have received under the PPS methodology.

34-005.05 A At the end of each RHC fiscal year, the Department will compare:

1. The total amount of supplemental and MCE payments received by the RHC; to
2. The amount that the actual number of visits provided under the RHC's contract with the MCE(s) would have yielded under the PPS methodology.

The Department will pay the RHC the difference between item 1 and item 2 if the PPS amount exceeds the total amount of supplement and MCE payments. The RHC must refund the difference between item 1 and item 2 if the PPS payment is less than the total amount of the supplemental and MCE payments.

34-006 Payment for Non-RHC Services: For those non-RHC services, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

34-007 Payment for Telehealth Services: Payment for telehealth services will be the Medicaid rate for the comparable in-person service. RHC core services provided via telehealth technologies are not covered under the encounter rate.

34-007.01 Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs related to non-core services will be the lower of:

1. The provider's submitted charge; or
2. The maximum allowable amount.

The Department will pay for transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmissions (see 471 NAC 1-006).

34-008 Cost Reports: Providers participating with NMAP as RHCs must submit an annual cost report to the Department. The RHC must report and supply the Department with necessary documentation regarding, cost reports, and any other documentation when requested.

The Medicare cost report form CMS-222-92 can be found in the Provider Reimbursement Manual-Part 2 (Pub.15-2), Chapter 29 located at http://www.cms.gov/maunals/PBM/list.asp on the CMS website.

Hospital-based RHCs associated with hospitals of 50 beds or greater must complete Worksheet M of Form CMS-2552-96. Hospital and Hospital Complex Cost Report Found in provider reimbursement manual-Part 2 (Pub. 15-2), Chapter 36, located at http://www.cms.hhs.gov/Manuals/PBM/list.asp on the CMS website.

34-009 Billing for RHC Services: All RHCs must bill for ~~r~~ Rural ~~h~~ Health ~~s~~ Services as defined in 471 NAC 34-003 on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). RHCs will use the appropriate HCPCS/CPT procedure codes and revenue codes when billing for all services.

IRHCs must use Form CMS-1500 (see 471-000-58) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) to bill NMAP for clinical radiology/laboratory services using the non-Rural Health Clinic provider number.

All Provider-Based RHCs must use Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) to bill NMAP for clinical laboratory services and radiology services using the hospital provider number.