Rural Health Clinic Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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eManual Contents		
Please send comments to ePubs_updates@jfs.ohio.gov		
Miscellaneous Medicaid Handbook Transmittal Letters	**Medical Assistance Letters**	**OAC Rules Related to Rural Health Clinics**

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 is maintained in the General Information e-book.

MHTL 3336-10-01 (Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-10-01 is maintained in the Physician Services e-book.

Medical Assistance Letters

MAL 583 (Medicaid Pharmacy Coverage for Dual Eligibles Effective January 1, 2013)

Medical Assistance Letter (MAL) 583 is maintained in the Pharmacy Services e-book.

MAL 582 (Pharmacy Program Changes Effective October 1, 2012)

Medical Assistance Letter (MAL) 582 is maintained in the Pharmacy Services e-book.

MAL 569 (Changes to the Medicaid Preferred Drug List Effective October 1, 2010)

Medical Assistance Letter (MAL) 569 is maintained in the Pharmacy Services e-book.

MAL 566 (Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule)

Medical Assistance Letter (MAL) 566

January 22, 2010

TO: All Eligible Rural Health Clinics

FROM: Douglas E. Lumpkin, Director

SUBJECT: Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule **5101:3-4-12** Immunizations.

Rule **5101:3-4-12** specifies immunizations that are covered for the Medicaid population. The rule is being proposed for amendment to include the Current Procedural Technology (CPT) code 90663 (Influenza virus vaccine, pandemic formulation) to the list of designated free vaccines so that providers may bill for immunizations against the pandemic influenza virus, H1N1. The Department will reimburse $10 for the administration of each dose of this vaccine needed for both children and adults. The rule also specifies how Medicaid providers can obtain the pandemic influenza vaccine free of charge from the Ohio Department of Health. It is also being modified for five-year rule review, to update date references and to clarify existing policy.

Web Page:

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Most current Medicaid maximum reimbursement rates are listed in rule **5101:3-1-60** or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers";

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Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461
Telephone 800-686-1516

MAL 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies)

Medical Assistance Letter No 561 is maintained in the Pharmacy Services e-book.

MAL 555 (Pregnancy Prevention/Contraceptive Management Services [Family Planning])

Medical Assistance Letter (MAL) 555

July 10, 2009

TO: All Eligible Rural Health Clinic Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Pregnancy Prevention/Contraceptive Management Services (Family Planning)

This letter provides information regarding the rescission, amendment, and issuance of Ohio Administrative Code (OAC) rules related to pregnancy prevention and contraceptive management services ("family planning services").

Important elements of these rules include:

1. Family planning means preventing or delaying pregnancy.
2. Family planning services means pregnancy prevention/contraceptive management services.
3. Family planning services are not subject to a co-payment, regardless of gender.
4. Infertility services are not Medicaid covered.
5. Hysterectomies and voluntary sterilizations are Medicaid covered services.
6. Providers must include valid Medicaid-covered CPT and/or HCPCS procedure codes and a valid contraceptive management diagnosis code (V25.0 through V25.9) on claims for pregnancy prevention/contraception services.

OAC rule 5101:3-1-09 is titled "Medicaid co-payment program [except for Medicaid consumers enrolled in the Medicaid managed health care program]." This rule establishes co-payment requirements for Medicaid consumers. Paragraph (C)(5) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that these services are not subject to a co-payment, regardless of gender. This rule is also amended to update a rule reference and correct grammatical errors.

OAC rule 5101:3-4-02 is titled "Scope of coverage." This rule establishes the requirements of physician supervision of services provided by nonphysicians. Paragraph (D)(2)(d) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update rule references, improve sentence structure, delete an out of date reference to registered nurses, and include a reference to occupational therapists.

OAC rule 5101:3-4-07 is titled "Family planning services." This rule is rescinded and replaced with rules 5101:3-21-02, 5101:3-21-02.1, and 5101:3-21-02.2.

OAC rule 5101:3-4-13 is titled "Therapeutic injections (including trigger point injections) and prescribed drugs." This rule sets forth requirements related to Medicaid coverage of therapeutic injection services. Paragraph (A)(3)(a)(iii) of this rule is amended to clarify that infertility treatment services are not Medicaid covered.

OAC rule 5101:3-4-28 is titled "Noncovered services." This rule describes services that are not covered by Medicaid. Paragraphs (E) and (F) are removed to clarify that hysterectomies and voluntary sterilizations are Medicaid covered services. Paragraphs (G) and (H) are amended to clarify that infertility treatment services are not Medicaid covered. This rule is also amended to remove redundant language and to update a rule reference.

OAC rule 5101:3-4-34 is titled "Preventive medicine services." This rule defines preventive medicine as services that prevent disease, maintain good health, and proactively avoid disease, disability and death. This rule specifies which preventive medicine services are covered under the Ohio Medicaid program. Paragraph (B)(4)of this rule is amended to clarify that family planning services means pregnancy

prevention/contraceptive management services. This rule is also amended to update rule references and correct formatting errors.

OAC rule 5101:3-13-01.5 is titled "Fee-for-service ambulatory health care clinics (AHCCs): family planning clinics." This rule outlines requirements that apply to all fee-for-service family planning AHCCs. This rule is amended to clarify definitions in paragraph (A) and to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update a rule reference.

OAC rule 5101:3-21-01 is titled "Sterilization." This rule sets forth requirements regarding Medicaid coverage of permanent sterilization and hysterectomy procedures. This rule is rescinded and replaced with new rule 5101:3-21-02.2, "Medicaid covered reproductive health services: permanent contraception/sterilization services."

OAC rule 5101:3-21-01 is titled "Medicaid covered reproductive health services: preconception care services." This new rule describes Medicaid coverage of services that are provided for the primary purpose of achieving optimal outcome of future pregnancies.

OAC rule 5101:3-21-02 is titled "Medicaid covered reproductive health services: pregnancy prevention/contraception services overview." This new rule replaces, in part, rescinded rule 5101:3-4-07 and describes Medicaid coverage of services that are provided for the primary purpose of pregnancy prevention/contraceptive management.

OAC rule 5101:3-21-02.1 is titled "Medicaid covered reproductive health services: temporary pregnancy prevention/contraception services." This new rule replaces, in part, rescinded rule 5101:3-4-07 and describes Medicaid coverage of services provided for the primary purpose of temporary pregnancy prevention/contraceptive management.

OAC rule 5101:3-21-02.2 is titled "Medicaid covered reproductive health services: permanent contraception/sterilization services." This new rule replaces, in part, rescinded rule 5101:3-21-01 and in part, rescinded rule 5101:3-4-07. This new rule describes Medicaid coverage of services that are provided for the purpose of permanent pregnancy prevention/contraceptive management (sterilization).

OAC rule 5101:3-21-03 is titled "Medicaid covered reproductive health services: infertility services." This new rule describes Medicaid coverage of infertility services.

OAC rule 5101:3-29-01 is titled "Eligible providers." This rule describes Medicaid requirements pertaining to provider enrollment as an "outpatient health facility" (OHF). Paragraph (E) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that such services are considered preventive in nature. This rule is also amended to update a rule reference, correct spelling and grammatical errors, and incorporate terminology consistent with Chapter 5101:3-4 of the Administrative Code.

OAC rule 5101:3-29-04 is titled "Billable services." This rule specifies Medicaid requirements pertaining to services provided by outpatient health facilities. Paragraph (B) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and to clarify that such services are considered preventive in nature. This rule is also amended to restructure paragraph (B)(1)(c) and correct spelling and grammatical errors.

These rules do not include detailed information regarding Medicaid coverage of pharmacy, durable medical equipment, and laboratory services as they relate to pregnancy prevention/contraceptive management services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to these topics.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided in hospitals. Please refer to Chapter 5101:3-2 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to facility providers.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided under managed care. Please refer to Chapter 5101:3-26 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to Medicaid managed care.

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Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

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Questions:

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Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MAL 552 (Physician Assistants)

Medical Assistance Letter (MAL) 552

February 19, 2009

TO: All Eligible Rural Health Clinic Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Physician Assistants

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-4-02, "Scope of coverage" and the rescission and adoption of new OAC rule 5101:3-4-03, "Physician assistants."

OAC rule 5101:3-4-02 is titled "Scope of coverage." This amended rule outlines the requirements regarding physician supervision of non-physicians when non-physicians provide Medicaid reimbursable services. This rule is amended to incorporate changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This amended rule updates the reference to the required level of physician supervision of physician assistants so that such reference is consistent with proposed rule 5101:3-4-03, "Physician assistants," of the Administrative Code.

Specifically, this rule removes paragraph (C)(2)(c), which indicated that physician assistants must be "under the general supervision of the physician" in order for Medicaid to reimburse eligible providers for provision of physician assistant services. This amended rule includes a new reference, paragraph (D), to rule 5101:3-4-03 and Chapter 4730-1 of the Administrative Code, "Physician assistants." This referenced rule addresses the required level of physician supervision of physician assistants in order for Medicaid to reimburse eligible providers for provision of physician assistant services.

OAC rule 5101:3-4-03 is titled "Physician Assistants." This new rule incorporates changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This new rule explains the conditions under which Ohio Medicaid will reimburse Medicaid providers for physician assistant services.

This new rule:

- Provides new and updated definitions as well as definitions by reference;
- Provides updated references to the Section 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code that govern the practice of Physician Assistants in Ohio;
- Removes requirements that a patient new to a physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant;
- Removes requirements that an established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition;
- Removes requirements that medical records for patients new to a physician's practice and medical records for established patients with a new condition must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant;
- Clarifies that Medicaid providers will not be reimbursed for visits provided on the same date of service by both a physician assistant and his/her supervising physician, employing physician, employing physician group practice, or employing clinic; and
- Clarifies that direct reimbursement is not available for services provided by a hospital employed physician assistant. The reimbursement for the services provided by the physician assistant is bundled into the facility payment made to the hospital.

This rule does not include information regarding Medicaid coverage of Pharmacy, Durable Medical Equipment, and Laboratory Services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for Ohio Medicaid requirements related to these topics.

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Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

800-686-1516

MAL 546 (March 20, 2008 - Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms)

Medical Assistance Letter No 546 is maintained in the Pharmacy Services e-book.

MAL 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516)

Medical Assistance Letter No 522 is maintained in the General Information e-book.

MAL 516 (November 9, 2006 - Employee Education About False Claims Recovery)

Medical Assistance Letter No 516 is maintained in the General Information e-book.

MAL 512 (Information about NPI)

Medical Assistance Letter (MAL) 512

September 22, 2006

To: Rural Health Centers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Re: Information about the National Provider Identifier (NPI)

In accordance with federal regulations (45 CFR § 160.103 and 45 CFR § 162.404), health care providers that conduct business in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) will be required to obtain a unique, ten-digit National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES). The deadline for providers to begin using their NPI to bill and receive payments electronically from Medicare and Medicaid is May 23, 2007. This MAL provides direction to Rural Health Centers (RHCs) on how to enumerate through NPPES to ensure successful Medicaid billing and reimbursement in Ohio using the NPI.

RHCs need to enumerate through NPPES prior to the May 23, 2007 deadline. To obtain a National Provider Identifier, RHCs should contact NPPES directly **at http://nppes.cms.hhs.gov or by phone at 1-800-465-3203** (1-800-692-2326 (TTY)). Providers can apply for an NPI electronically or by paper.

I. Background: NPI Enumeration to Support Medicaid Reimbursement

Provider Type 05 - Prospective Payment RHC Claims

Currently, RHCs bill and receive payment based on a prospective payment established by the Department. The advent of the NPI enumeration process will not change this payment method, and new RHCs will continue to be assigned a seven-digit Medicaid provider number upon enrollment. In the future, ODJFS will refer to the Medicaid provider number as the legacy number. To maintain this method of reimbursement, each RHC must have and use a NPI number.

Provider Type 50 - Fee-for-Service Clinic Claims

Currently, RHCs use a second Medicaid provider number to bill for non-PPS covered services. They bill as a type 50 fee-for-service clinic when they bill for the following:

1.) Disability Medical Assistance claims;

2.) Medicare crossover claims not paid through the automatic crossover process; and,

3.) Inpatient hospital surgery, visits, or consultation claims.

It will be necessary for each RHC to separately apply for and receive a second NPI number to continue to bill and be reimbursed for non-PPS services.

II. NPI Details

As described above, RHC sites that have two Medicaid provider numbers will need to acquire two NPI numbers. One NPI number will be used to submit type 05 RHC PPS claims; the other NPI number will be used to submit type 50 fee-for-service clinic claims.

RHC sites can receive two different NPI numbers by submitting **two different applications** to NPPES using a different taxonomy code in each application. The taxonomy codes to use are:

261QR1300X for RHC (type 05) claims; and,

261QP2300X for fee-for-service (type 50) claims. (This taxonomy refers to a primary care clinic.)

RHCS should use these codes when completing Section D of the NPI applications when asked for the "provider taxonomy code."

The requirement for an NPI number applies both to an existing RHC and to any RHC enrolling for the first time. The Department has updated the Medicaid provider application to capture the ten-digit NPI number from new RHCs enrolling for the first time. The NPI number should be submitted on page two of the provider application.

The NPI number should be used as soon as it is received. When billing ODJFS electronically, **RHCs should use the NPI number in conjunction with the Medicaid provider number.** (Instructions how follow below.) The NPI number must be used to adjudicate EDI claims on and after May 23, 2007, the NPI deadline date.

Billing NPI on EDI Claims

The NPI number should be entered in the primary identifier field on ASCII X12 837 health care transactions. (Note: RHCs are required to bill Ohio Medicaid on the 837 Professional (P) transaction.)

When submitting EDI claims with the NPI, RHCs should use the qualifier XX in the primary identification qualifier location NM108 and use the NPI in the primary identification location NM109. RHCs should continue to submit their Medicaid provider number with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid provider number in the secondary identification location REF02 until May 23, 2007 as directed in the NPI Final rule. RHCs will submit their provider identifiers in the 2010AA loop of the 837 P transaction. RHCs are not required to send the rendering provider loop in the 837. If a rendering provider loop 2310B is submitted in the 837, errors in reimbursement will occur.

Billing on Paper Claims or by Tape

RHCs should continue to use their Medicaid provider number when submitting claims in formats that use only the Medicaid provider number, e.g., the current CMS 1500 paper claim.

III. Changes in Crossover Claims Processing

Medicaid is working on being able to receive Medicare crossover claims automatically from the fiscal intermediary used by RHCs, i.e, Riverbend Government Benefits Administrator. When this happens, crossover claims will be processed using the type 05 RHC provider number. To avoid the possibility of duplicate claims payment, RHCs should check to determine whether payment has already been made under the type 05 RHC provider number before submitting crossover claims using the type 50 fee-for-service clinic number. The claim may have already crossed over to ODJFS and been paid.

ODJFS appreciates the attention of RHCs to this matter and as a result of their cooperation, anticipates a successful transition to NPI.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MAL 507 (Rural Health Clinics Policy/Rule Updates)

Medical Assistance Letter (MAL) 507

July 12, 2006

TO: All Eligible Providers of Rural Health Clinic (RHC) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Rural Health Clinics Policy/Rule Updates

EFFECTIVE July 1, 2006

The purpose of this Medical Assistance Letter (MAL) is to announce updates to the rules governing RHCs and to provide reminders regarding existing policy. Note: The rules relating to these policy changes are scheduled to be effective for dates of service on or after July 1, 2006, pending approval by the Centers for Medicare and Medicaid Services (CMS).

Rules 5101:3-16-01, 5101:3-16-03, 5101:3-16-05 and 5101:3-16-06 of the Ohio Administrative Code (OAC) are amended to fulfill five year rule review requirements. Rule 5101:3-16-02 is rescinded and replaced with new rule 5101:3-16-02 to fulfill five year rule review requirements. 5101:3-16-04 is rescinded to fulfill five year rule review requirements.

The full text of each of these rule changes can be found on the Department's web site at http://emanuals.odjfs.state.oh.us/emanuals in the Rural Health Clinic Services handbook. The Department encourages providers to visit the website and review the full text of the amended RHC provider rules.

Key points of interest in the amended rules are:

- Updates for consistency with language used in Chapter 5101:3-28 of the Administrative Code, as appropriate.
- Inclusion of paragraphs regarding the co-payment program and outpatient hospital services.
- Clarification by striking references to invalid local level codes and updating terminology and rule references.

Rule 5101:3-16-01, "Rural health clinics (RHCs): definitions and eligibility."

This rule provides definitions of terms used in Chapter 5101:3-16 of the Administrative Code. Changes include updates to the title for consistency purposes, clarification and addition of definitions, and inclusion of cross references to other Administrative Code rules when applicable. Other changes include updates for consistency with language used in Chapter 5101:3-28 of the Administrative Code, such as the definition of "encounter."

Rule 5101:3-16-02, "Rural health clinics (RHCs): covered services."

This rule replaces former rule 5101:3-16-02. This rule defines covered RHC services for the purposes of Medicaid reimbursement. Changes from the rescinded rule include updates to the title for consistency purposes and clarification of the definition of RHC services, including cross references to other Administrative Code rules when applicable. Other changes include updates for consistency with language used in Chapter 5101:3-28 of the Administrative Code, such as the definition of covered "other ambulatory services," and inclusion of paragraphs regarding the co-payment program and outpatient hospital services.

Rule 5101:3-16-03, "Rural health clinics (RHCs): limitations and noncovered services."

This rule defines limitations and noncovered services for the purposes of Medicaid reimbursement. Changes include updates to the title for consistency purposes, removal of references to Chapter 5101:3-13 of the Administrative Code and including cross references to other Administrative Code when applicable. Other

changes include updates for consistency with language used in Chapter 5101:3-28 of the Administrative Code, such as coverage limitations.

5101:3-16-05, "Rural health clinics (RHCs): supplemental payments."

This rule defines supplemental payments for the purposes of Medicaid reimbursement when an RHC receives payment from a medicaid managed care plan for RHC services. Changes include updates to the title for consistency purposes and clarification by striking references to invalid local level codes and updating terminology and rule references. Other changes include updates for consistency with language used in Chapter 5101:3-28 of the Administrative Code, such as billing instructions and reference to managed care prior authorization requirements.

Rule 5101:3-16-06, "Rural health clinics (RHCs): prospective payment system (PPS)."

This rule addresses how the Ohio Department of Job and Family Services (ODJFS) complies with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Changes include updates to the title for consistency purposes, addition of definitions, and removal of references to cost report filing. Other changes include updates for consistency with language used in Chapter 5101:3-28 of the Administrative Code, such as removing references to phase one of the medicaid prospective payment system (PPS), updating language regarding the establishment of PPS rates, and including language regarding the establishment of PPS rates for Rural Health Clinics (RHC).

This rule defines the billing process for RHCs. Changes include updates to the title for consistency purposes and clarification regarding existing policy by updating references to the website for ODJFS electronic manuals and adding a reference to claims submission and prior authorization requirements for RHCs in managed care settings, as described in managed care rules 5101:3-26-03.1 and 5101:3-26-05.1 of the OAC.

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(2) Select "Rural Health Clinic Services Handbook."

(3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired MAL number.

(4) Scroll through the MAL to the desired rule number highlighted in blue and select the rule number.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of updates to the RHC rules, please complete the attached JFS 03400 and either mail it or fax it to the address on the form.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MAL 473 (September 2, 2004 - Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation)

Medical Assistance Letter No 473 is maintained in the Pharmacy Services e-book.

MAL 460 (December 18, 2003 - Consumer co-payments for prescription medication requiring prior authorization)

Medical Assistance Letter No 460 is maintained in the Pharmacy Services e-book.

MAL 456 (September 15, 2003 - PDL Information)

Medical Assistance Letter No 456, is maintained in the Pharmacy Services e-book.

MAL 450-A (July 28, 2003 - Prenatal care reimbursement- Important Billing Change)

Medical Assistance Letter No 450-A is maintained in the Physician Services Handbook.

MAL 447 (March 6, 2003 - PDL Information)

Medical Assistance Letter No 447 is maintained in the Physician Services Handbook.

MAL 440 (Billing Changes Due to H.I.P.A.A.)

Medical Assistance Letter (MAL) No. 440

March 4, 2003

TO: Rural Health Centers

Directors, County Department of Job and Family Services

FROM: Thomas Hayes, Director

SUBJECT: Billing Changes Due to the Health Insurance Portability and Accountability Act (H.I.P.A.A.)

BILLING CHANGES EFFECTIVE OCTOBER 1, 2003

This is an advance notice of billing changes necessary because of provisions in the Health Insurance Portability and Accountability Act (H.I.P.A.A.). First, H.I.P.A.A requires all payers to use standard code sets. The standard code sets include the AMA CPT coding system and the Health Care Procedural Coding System (HCPCS).

Second, if electronic claims are billed, H.I.P.A.A requires that all payers accept standard electronic transactions. One of these transactions is the claim transaction called the 837 transaction. There are claim transactions for professional providers called the 837 P (professional) transaction and a related but separate transaction for institutional providers called the 837 I (institutional) transaction. Both of these issues (standard code sets and claim transactions) cause Ohio Medicaid to revise its billing procedures for Rural Health Centers (RHCs) as well as for other providers.

This MAL addresses the changes for RHCs. We want to give RHCs plenty of time to review your billing system to accommodate these changes.

- Billing changes:

  For services provided on or after October 1, 2003, follow the billing instructions applicable for services provided on and after that date. The RHC may choose to submit a paper claim or an electronic transaction:

  (1) If the RHC chooses to submit a paper claim, the RHC must submit a CMS 1500 claim form. The JFS 6780 claim form is being discontinued.

  (2) If the RHC chooses to submit an electronic transaction, the RHC must submit an 837 professional transaction.

- Coding Changes:

  For services provided on or after October 1, 2003, submit the following data elements unique for RHC billings:

  (1) Enter the code T1015. The W code is not H.I.P.A.A. compliant and can no longer be used.

  (2) Modify the code to specify the type of encounter provided, e.g. T1015U1 (no spaces, no dashes):

  For a medical encounter, use the modifier U1.

  (3) Enter all the procedure codes that describe the services provided during the encounter.

- Code crosswalk:

  Current local level code: New code and modifier after HIPAA:

  W0020 - Medical - T1015U1

The Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In state toll free telephone number 1-800-686-6108

Out-of-state telephone number 614-728-3288

MAL 401 (New Rural Health Clinic Reimbursement Policies)

Medical Assistance Letter (MAL) No. 401

November 8, 2001

TO: All Providers of Rural Health Clinic Services
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: New Rural Health Clinic Reimbursement Policies

RURAL HEALTH CLINIC SERVICES

NEW PROSPECTIVE PAYMENT SYSTEM RETROACTIVE TO JANUARY 1, 2001

The purpose of this Medical Assistance Letter (MAL) is to announce changes to the reimbursement methodology rule specific to Rural Health Clinic services. This methodology has been revised to comply with the federal Benefits Improvement and Protection Act of 2000 (BIPA) which is retroactive to January 1, 2001. The reimbursement policy section describes both the new prospective payment system (PPS) for Rural Health Clinics as well as the supplemental payment for managed care services required under the federal BIPA Act. The reimbursement provisions described in this MAL have been approved by the Center for Medicare and Medicaid (CMS).

Attached are the Rural Health Clinic (RHC) rules. These rules are effective on October 15, 2001 but the provisions are retroactive to January 1, 2001. Revised billing instructions are also attached as well as a revision to the material serving as a provider handbook for RHCs.

I. New Reimbursement Policies

For service provided **on and after** January 1, 2001 the following provisions apply:

A. Prospective Payment System (PPS):

Definitions:

- "Change in scope of service" means an addition or deletion of a new category of service.
- "Category of service" means the following different types of service:

  Medical;

  Dental;

  Physical therapy;

  Podiatry;

  Optometry;

  Chiropractic;

  Speech therapy and audiology;

  Mental health specifically services of a clinical psychologist or clinical social worker; and

  Transportation.
- "Increase of decrease in the scope of services" means the addition or deletion of a new category of service.

Cost report filing:

Any RHCs with a change in the scope of service as defined in this MAL, must submit two cost reports in accordance with the instructions specified in JFS 3421. This cost report can be obtained by calling the Financial Management Unit of Health Plan Policy at ODJFS at 614-466-6420. The cost report must be filed

within 90 days after the close of one full year of operation of the new category of service. The first cost report must be completed for the year prior to the change in the scope of service and the second cost report must detail the costs after one full year of operation of the new service.

Phase One of the new Medicaid PPS system

For dates of service January 1, 2001 through September 30, 2001 (the first phase of the new prospective payment system) the department will pay current RHCs one hundred percent of the average of their costs for providing Medicaid-covered services during fiscal year 1999 and fiscal year 2000 which are reasonable and related to the costs of furnishing services as determined by the Medicare intermediary.

The Department will take the Medicare reimbursement rate per visit (used currently by the Department) to reimburse RHCs for fiscal year 1999 and fiscal year 2000 and take the average of these rates for each RHC to arrive at the rate for each RHC for January 1, 2001 through September 30, 2001.

The resulting average rate will be adjusted, if necessary, to take into account any increase or decrease in the scope of services as defined in this MAL furnished during fiscal year 2001.

- As an interim step, RHCs which have a change in the scope of services will be given a start-up rate for the new service which will be the RHC's medical rate.
- After one full year of operation of that service, the RHC must file two cost reports which documents their costs as described earlier in this MAL.
- The Department will analyze the impact that the addition of the new category of service has had on the RHC's costs by comparing the two cost reports and adjusting the RHC's rate if necessary.

RHCs will receive payments for the period January 1 through September 30, 2001 based on their new PPS rate retroactively. During this interim period, RHCs will continue to be paid using the interim rate set for the current state fiscal year.

Beginning October 1, 2001 , and for each fiscal year thereafter, each RHC will have rates established on a per visit basis type based on the rate established by the principles defined in this MAL increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services available on September 30th of that year.

- The resulting rate will be adjusted, if necessary, to take into account any increase or decrease in the scope of services furnished during fiscal year 2001 by the RHC as described in this MAL.

Newly qualified RHCs after fiscal year 2000 will have their initial rates set based on the rates established for other RHCs in the nearest adjacent area. After the initial year, rates for these RHCs will be set using the MEI method used for other RHCs.

B. Supplemental Payments:

Definitions:

- "MCP" means a managed care plan defined in rule 5101: 3-26-01 of the Administrative code which reimbursed a rural health clinic for services provided by the RHC.
- "Encounter" is a face-to-face contact between a patient and a provider of services.
- "Enrollee" otherwise known as a member, means each eligible individual enrolled in a MCP.

Currently it is the Department's understanding that there are no RHCs participating in Medicaid managed care. However, should there be RHCs participating in Medicaid managed care in the future, the Department will make the supplemental payment system established under the federal BIPA legislation available to RHCs. Should an RHC begin seeing Medicaid managed care patients, effective for services furnished on and after January 1, 2001, to receive the supplemental payment, an RHC first must bill the MCP and receive the MCP payment for services provided. Then the RHC must submit, for **each** encounter provided to an MCP enrollee by the RHC, a claim to the Department following the Ohio Medicaid provider billing instructions.

Either through electronic submission or on a claim form, the RHC must document the following information relevant to the supplemental payment. These items are in addition to completion of the other portions of the claim form.

(1) The local level code (W0020) which signifies the type of encounter provided by the RHC;

(2) A detailed CPT code listing of all services provided during the encounter;

NEW (3) In the block entitled "Other Source" enter the "Other source code" of "8", "Supplemental (Wraparound) Payment".

NEW (4) In the block entitled "Referral number", enter the Medicaid identification number of the MCP which paid the initial claim to the RHC. See attached list of Medicaid MCPs with their identification numbers or check the ODJFS web site for the latest listing of MCPs. The web site address for this document is http://www.state.oh.us/odjfs/ohp/bmhc/mcplistprov.PDF.

NEW (5) In the block entitled "Other Source Amount", enter the amount collected from all sources other than Medicare. Enter the addition of the dollar amount the FQHC was paid by any MCP for the service(s) provided to the Medicaid recipient listed on the claim; and any amount received by the RHC from any other third party insurance. If the amount collected from all sources other than Medicare exceed the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment.

(6) In the block entitled, " Net charge", enter the difference between the total charge and the amount received from other sources.

The Department's supplemental payment obligation will be determined using the baseline payment that the RHC would have received under cost-based reimbursement as described in 5101: 3-16-04 and 5101: 3-16-06 (new described in the first part of this MAL) of the Administrative Code without regard to the effects of any financial incentives (positive or negative) that are linked to utilization outcomes or other reductions in patient costs.

Upon receipt of the claim, the Department will pay any difference between the amount paid by the MCP to the RHC minus any incentive payments received from the MCP and any amount collected from another third party insurance and the amount due the RHC based on their cost-based rate approved by the Department. While this payment will be on a claim-by-claim basis, the payment will be no less frequently than every 4 months from the date the RHC submitted the claim.

If a claim is not submitted by an RHC to the Department within the standard time frames specified for claims submission, no supplemental payment(s) will be made by the department to the RHC.

II. Billing Instructions

A new set of billing instructions is attached. The billing packet includes some new billing forms not included in the current RHC billing instructions which might be used to request an adjustment to a paid claim (ODJFS 6767), to request a claim credit reversal (ODJFS 6768), and to request assistance in getting a previously submitted claim corrected.

RHCs will use the ODJFS 6780 claim form when billing a paper claim. The instructions pertaining to the 6780 form have been revised to clarify issues discussed in the new or amended RHC rules discussed in this MAL including:

- If your facility is billing for the new managed care supplemental payment, you must complete item 11 "Referral number" and enter the Medicaid identification number of the MCP from which you received a managed care payment.
- For the supplemental payment, you must also complete Item 15 "Other Source" and mark "8" if you are billing for the managed care supplemental payment.
- For the supplemental payment, , also complete Item 22 "Other Source Amount" following the directions shown for Item 22.
- In addition, the instructions for Column B "Service code" have been updated to clarify that any RHC billing for ambulatory services other than medical services must reference the fee-for-service clinic billing instructions and bill for these services using their second provider number as a fee-for-service clinic (not cost-based).

RHCs billing for services provided to Disability Assistance patients, for Medicare crossover patients, or for inpatient surgery, must bill for these services using their second provider number as a fee-for-service clinic (not cost-based).

If you have questions about your new prospective payment system rates, please call Roy Sutton of our reimbursement unit at 614-466-6420.

Questions pertaining to this MAL should be addressed to:

The Ohio Department of Jobs and Family Services

Bureau of Plan Operations

The Provider Network Management Section

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Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MAL 386 (Revised Rural Health Clinic Policies)

Medical Assistance Letter (MAL) No. 386

July 16, 2001

TO: All Providers of Rural Health Clinic Services
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Greg Moody, Director

SUBJECT: Revised Rural Health Clinic Policies

RURAL HEALTH CLINIC SERVICES

REVISIONS TO EXISTING POLICIES EFFECTIVE JULY 1, 2001

The purpose of this Medical Assistance Letter (MAL) is to announce changes to cost-based rural health clinic (RHC) providers of clinic policies as a result of review of existing RHC rules mandated by state law.

The policies relating to the new federal law (supplemental payment and the new prospective payment system) will not take effect until the Department receives final approval from HCFA on our State Plan Amendment relating to the federal Benefits Improvement and Protection Act (BIPA) of 2000. Therefore, policies relating to the new prospective payment system and the managed care supplemental payment rules will be transmitted once the Department has received final Plan approval.

Attached are the revised Rural Health Clinic rules. These rules are still in a proposed status but are scheduled to be effective July 1, 2001.

Revisions to Existing Rural Health Clinic Rules

Definitions:

- "Visit" The definition of a "visit" has been revised to omit the term "specialized nurse practitioner" since this term is no longer appearing in the federal Code of Regulations as a practitioner practicing at an RHC.
- "Nurse Practitioner" This definition has been revised to define a "nurse practitioner" as they are defined in other Medicaid regulations. For the purposes of the Medicaid program, a "nurse practitioner" means a registered nurse who:

Is currently certified as a nurse practitioner in accordance with section 4723.41 of the Revised Code and holds a valid certificate of authority issued by the Ohio Board of Nursing to practice as an advanced practice nurse; and

Is certified by a national certifying organization approved by the Board of Nursing.

- "Clinical social worker" This definition has been revised to accurately reference section 4757.28 of the Revised Code which delineates the licensure requirements for social workers.

Covered Services:

- The covered services for RHCs remain the same. However the Department has made the following clarifications to rule 5101:3-16-02, the Covered Services rule:

The term "specialized nurse practitioner" is no longer appearing as a practitioner who's service is covered since the federal code of regulations no longer lists this specialty for RHCs.

The Department has clarified its coverage for diagnostic and therapeutic services which may be provided by a clinical psychologist at an RHC using the identical language used in Medicare's RHC manual.

- Services that are provided by a clinical psychologist include:

Diagnostic and therapeutic service that the clinical psychologist is legally authorized to perform in accordance with chapter 4732. of the Revised Code;

Services and supplies furnished incident to a clinical psychologist's services are covered if the requirements that apply to services incident to a physician's service are met.

To be covered, these services and supplies must be:

- Mental health services that are commonly furnished in a clinical psychologist's office (reference rule 5101:3-8-02 of the administrative code);
- An integral, although incidental, part of professional services performed by a clinical psychologist; and
- Performed under the direct personal supervision of the clinical psychologist.

- The Department is clarifying its current billing policy regarding services other than physician services which may be provided at an RHC. This is not a change in policy. The following services must be billed by an RHC but under their Medicaid provider number as an ambulatory health care clinic provider **not** under their cost-based RHC number:

Physical medicine services

Speech pathology services

Dental services

Podiatric services

Optometric and/or optical services

Chiropractic services

Clinical psychology services (testing)

Claims for Disability Assistance patients

Medicare crossover claims

Physician fee for inpatient surgery.

Reimbursement Policy:

- Rule 5101:3-16-04 has been amended to clarify that the current reimbursement policy is effective for services prior to January 1, 2001 when HCFA approves Ohio's State Plan Amendment. However, the current reimbursement policy described in this rule will remain in effect until the Department's methodology on a new prospective payment system has been approved by HCFA.

Questions pertaining to this MAL should be addressed to:

The Ohio Department of Jobs and Family Services

Bureau of Plan Operations

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OAC Rules Related to Rural Health Clinics

5160-16-01 Rural Health Clinics (RHCs): Definitions and Eligibility

Formerly **5101:3-16-01 Rural Health Clinics (RHCs): Definitions and Eligibility**

MAL 507

Effective Date: July 1, 2006

Most Current Prior Effective Date: **July 1, 2001**

~~As~~The following terms as used in Chapter 5101:3-16 of the Administrative Code~~, the following terms~~ are defined ~~below~~as follows:

(A) An "alternative payment clinic" is an outpatient health facility (OHF), federally qualified health center (FQHC), or rural health clinic (RHC). Medicaid providers may be enrolled as only one type of alternative payment clinic.

(B) "Billable services" for RHCs are services identified in rule 5101:3-16-02 of the Administrative Code and provided in accordance with Chapter 5101:3-16 of the Administrative Code.

(C) A "federally qualified health center (FQHC)" is defined in accordance with rule 5101:3-28-01 of the Administrative Code.

(D) An "outpatient health facility (OHF)" is defined in accordance with rule 5101:3-29-01 of the Administrative Code.

~~(A)~~(E) A "rural health clinic (RHC)" is a clinic ~~which is~~ certified by the Ohio department of health (ODH) as meeting the conditions of certification for rural health clinics under Title XVIII ~~medicare~~ of the Social Security Act (medicare)~~and which has filed an agreement with the U.S. department of health and human services to provide rural health clinic services under medicare~~.

(1) Requirements for RHCs are listed in 42 C.F.R. part 491, effective October 1, 2005.

(2) The centers for medicare and medicaid services (CMS) deems that RHCs approved for medicare participation meet the standards for certification under medicaid.

~~(B)~~(F) ~~"Visit" means a face-to-face encounter between a clinic patient and a physician, physician's assistant, nurse practitioner, nurse midwife, or visiting nurse.~~ An "encounter" is defined as a face-to-face contact between a patient and provider(s) of covered services, except for transportation services. Encounters ~~with~~ involving more than one health professional for the same unit of service, and multiple ~~encounters~~interactions with the same health professional~~, which~~ that take place on the same day and at a single location constitute a single ~~visit~~encounter, except ~~for cases in which~~when the patient, ~~subsequent to~~after the first ~~encounter~~interaction, suffers illness or injury requiring additional diagnosis or treatment. Encounters shall be documented in the patient health record.

~~(C)~~(G) "Nurse practitioner" means ~~a registered~~an advanced practice nurse, as defined in accordance with rule 5101:3-8-20 of the Administrative Code~~ who is:~~.

~~(1) Currently certified as a nurse practitioner in accordance with section 4723.41 of the Revised Code and holds a valid certificate of authority issued by the board of nursing to practice as an advanced practice nurse; and~~

~~(2) Certified by a national certifying organization approved by the board of nursing.~~

~~(D)~~(H) ~~"Physician's~~"Physician assistant" ~~means a person who meets the applicable state requirements specified in Chapter 4730. of the Revised Code governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:~~is defined in accordance with rule 5101:3-4-03 of the Administrative Code.

~~(1) Is currently certified by the "National Commission on Certification of Physician Assistants" to assist primary care physicians; or~~

~~(2) Has satisfactorily completed a program for preparing physician's assistants that:~~

~~(a) Was at least one academic year in length;~~

~~(b) Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instructions directed toward preparing students to deliver health care; and~~

~~(c) Was accredited by the "American Medical Association's Committee on Allied Health Education and Accreditation"; or~~

~~(3) Has satisfactorily completed a formal educational program (for preparing physician's assistants) that does not meet the requirements of paragraph (D)(2)(b) of this rule and has been assisting primary care physicians for a total of twelve months during the eighteen-month period immediately preceding the Effective Date of February 8, 1978.~~

~~(E)~~(I) "Nurse~~-~~midwife" ~~means a registered~~is an advanced practice nurse, as defined in rule 5101:3-8-20 of the Administrative Code ~~who is currently licensed to practice in the state and who is currently certified as a nurse midwife in accordance with section 4723.42 of the Revised Code~~.

~~(F)~~(J) A "clinical social worker" means an individual who:

(1) Possesses a master's or ~~doctor's~~doctoral degree in social work;

(2) After obtaining such degree has performed at least two years of supervised clinical social work; and

(3) Is licensed to practice as a "licensed independent social worker" in accordance with division (B) of section ~~4757.28~~4757.27 of the Revised Code or as a "licensed social worker" in accordance with division (A) of section 4757.28 of the Revised Code and who is supervised by a licensed independent social worker, psychologist or physician.

~~(G)~~(K) A "clinical psychologist" means an individual who:

(1) Holds a ~~doctor's~~doctoral degree in psychology from a program in clinical psychology of an educational institution that is accredited by an organization recognized by the "Council on Post-Secondary Accreditation";

(2) Is licensed in accordance with division (B) of section 4732.10 of the Revised Code; and

(3) Possesses two years of supervised clinical experience, at least one of which is postdegree.

~~(H) "Visiting nurse services" means part-time or intermittent nursing care and related medical supplies (other than drugs or biologicals) furnished by a registered nurse or licensed practical nurse to a homebound patient.~~

~~(I) "Part-time nursing care" means nursing care that is required on less than a full-time basis, that is, less than eight hours a day or forty hours a week.~~

~~(J)~~(L) "Physician supervision" ~~means that the physician:~~is defined in accordance with rule 5101:3-4-02 of the Administrative Code. For the purposes of Chapter 5101:3-16 of the Administrative Code, physician supervision also includes:

(1) ~~Provides medical~~Medical direction for the ~~clinic's~~RHC's health care activities and consultation for, and medical supervision of, the health care staff;

(2) In conjunction with the physician's assistant and/or nurse practitioner member(s), ~~participates in~~ developing, executing, and periodically reviewing the ~~clinic's~~RHC's written policies and the services provided to federal program patients; ~~and~~

(3) ~~Periodically~~Periodic reviews of the ~~clinic's~~RHC's patient records, ~~provides~~provision of medical orders, and ~~provides~~provision of medical care services to patients of the clinic; and

(4) ~~Is present~~Attendance, for sufficient periods of time, at least once in every two-week period (except in extraordinary circumstances), to provide the medical direction, medical care services, consultation and supervision described in paragraph ~~(J)(1)~~(M)(1) of this rule, and ~~is available~~availability, through direct telecommunication for consultation, for assistance with medical emergencies~~,~~ or patient referral. The extraordinary circumstances are documented in the records of the ~~clinic~~RHC.

Replaces: 5101:3-16-04

Effective: 07/01/2006

R.C. 119.032 review dates: 03/30/2006 and 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2006

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/1/80, 6/1/91, 7/1/01

5160-16-02 Rural Health Clinics (RHCs): Covered Services

Formerly **5101:3-16-02 Rural Health Clinics (RHCs): Covered Services**

MAL 507

Effective Date: July 1, 2006

Most Current Prior Effective Date: **July 1, 2001**

RHCs are required to provide a core set of services. The scope of the services furnished by RHCs is comparable to services provided in a physician's office. Services furnished by RHCs may be provided by physicians and mid-level practitioners, including physician assistants, nurse practitioners, and certified nurse-midwives. Services also include outpatient mental health services furnished by clinical psychologists and clinical social workers.

(A) Covered RHC services are:

(1) Services furnished by a physician, physician assistant, nurse practitioner, or nurse-midwife:

(a) In accordance with Chapter 5101:3-4 of the Administrative Code; and

(b) Within the scope of practice of his or her profession under state law.

(2) Services furnished by a clinical psychologist and:

(a) Defined in accordance with paragraph (B)(8) of rule 5101:3-28-03 of the Administrative Code; and

(b) In accordance with the limitations specified in rule 5101:3-8-05 of the Administrative Code.

(3) Services by a clinical social worker for the diagnosis and treatment of mental illness and:

(a) Billable under physician supervision in accordance with rule 5101:3-4-29 of the Administrative Code;

(b) Defined in accordance with paragraph (B)(8) of rule 5101:3-28-03 of the Administrative Code; and

(c) In accordance with the limitations specified in rule 5101:3-16-03 of the Administrative Code.

(4) Services and supplies furnished as incident to professional services and services furnished by a physician and services and supplies furnished as incident to services provided by a physician assistant, nurse practitioner, nurse-midwife, clinical psychologist, or clinical social worker, as would otherwise be covered if furnished as incident to a physician service(s).

(5) Visiting nurse services if:

(a) The RHC is located in an area in which the United States secretary of health and human services has determined that there is a shortage of home health agencies;

(b) The services are furnished by a registered nurse or a licensed practical nurse employed by, or otherwise compensated for the services by, the RHC;

(c) The services are furnished to a homebound individual; and

(d) The services are furnished under a written plan of treatment that is established and reviewed at least every sixty days by a supervising physician of the RHC or that is established by a physician, physician assistant or nurse practitioner and reviewed at least every sixty days by a supervising physician of the RHC and signed by the physician, physician assistant, nurse practitioner, or supervising physician

(B) The following services are not billable under a provider's RHC provider number. These services should be billed by an RHC under a different medicaid provider number as a fee-for-service ambulatory clinic provider:

(1) Inpatient hospital surgery;

(2) Inpatient hospital visits or consultations;

(3) Medicare crossover claims that are not paid through the automatic medicare crossover process in accordance with rule 5101:3-1-05 of the Administrative Code;

(4) Disability assistance program claims;

(5) Take home drugs shall be billed through the pharmacy program as described in Chapter 5101:3-9 of the Administrative Code; and

(6) Durable medical equipment (DME) for take-home use shall be billed through the DME program in accordance with rule 5101:3-10 of the Administrative Code

(C) For dates of service on and after January 1, 2006, the Ohio department of job and family services (ODJFS) shall institute a co-payment program under medicaid in accordance with rule 5101:3-1-09 of the Administrative Code. This co-payment program shall also apply to services rendered by an RHC. Specific information regarding implementation of co-payments in managed care settings are located in Chapter 5101:3-26 of the Administrative Code

(D) Provisions regarding outpatient hospital services identified in rule 5101:3-2-03 of the Administrative Code also apply to RHCs.

Replaces: 5101:3-16-02

Effective: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2006

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/1/80, 6/1/91, 7/1/01

5160-16-03 Rural Health Clinics (RHCs): Limitations and Noncovered Services

Formerly **5101:3-16-03 Rural Health Clinics (RHCs): Limitations and Noncovered Services**

MAL 507

Effective Date: July 1, 2006

Most Current Prior Effective Date: **August 1, 2001**

~~The coverage limitations set forth in rule 5101:3-13-05 of the Administrative Code are applicable to both rural health clinic services and other ambulatory services provided by rural health clinics. In addition, certain specific limitations apply to services provided by a physician's assistant, nurse practitioner, or nurse midwife. Such professional~~RHC services are reimbursable only if:

(A) Furnished by a ~~qualified nurse practitioner, physician assistant, or nurse midwife, as defined, respectively in paragraphs (C), (D), (E) and (F) of rule 5101:3-16-01~~physician as defined in accordance with rule 5101:3-4-01 of the Administrative Code~~.~~;

(B) Furnished by a nurse practitioner~~, physician's assistant,~~ or nurse~~-~~midwife, defined in accordance with rule 5101:3-8-21 of the Administrative Code, who is ~~employed by, or receives compensation from the rural health clinic.~~:

(1) Under the medical supervision of a physician as defined in paragraph (L) of rule 5101:3-16-01 of the Administrative Code;

(2) Performing such services in accordance with Chapter 4723. of the Revised Code; and

(3) Employed by, or receives compensation from, the RHC.

~~(C) Furnished under the medical supervision of a physician as defined in paragraph (J) of rule 5101:3-16-01 of the Administrative Code.~~

~~(D) Relative to nurse practitioners or nurse midwives, such services must be performed in accordance with section 4723.56 of the Revised Code.~~

~~(E)~~(C) ~~Relative to physicians' assistants, such services must be performed in accordance with section 4730.16 of the Revised Code which sets forth the allowable scope of duties and functions of a physician's assistant. Pertinent parts of this section stipulate that a physician's assistant must function under the supervision and control of a physician and may provide services only to those patients who are patients of the employing physician or physicians. The extent of services which a particular physician's assistant may perform depends on the terms of that physician assistant's registration.~~Furnished by a physician assistant, defined in accordance with rule 5101:3-4-03 of the Administrative Code, who is:

(1) Under the medical supervision of a physician as defined in paragraph (L) of rule 5101:3-16-01 of the Administrative Code;

(2) Performing such services in accordance with Chapter 4730. of the Revised Code; and,

(3) Employed by, or receives compensation from, the RHC.

(D) Furnished by a clinical psychologist, in accordance with rule 5101:3-8-05 of the Administrative Code.

(E) Furnished by a clinical social worker, in accordance with rule 5101:3-4-29 of the Administrative Code.

(F) Relative to visiting nurse services, such services are covered if~~:~~ provided in accordance with rule 5101:3-16-02 of the Administrative Code.

~~(1) The rural health clinic is located in an area in which the secretary has determined that there is a shortage of home health agencies. A shortage of home health agencies exists if the secretary determines that the rural health clinic:~~

~~(a) Is located in a county, parish, or similar geographic area in which there is no participating home health agency or adequate home health services are not available to patients of the rural health clinic;~~

~~(b) Has patients whose permanent residence are not within the area serviced by a participating home health agency; or~~

~~(c) Has patients whose permanent residences are not within a reasonable traveling distance, based on climate and terrain, of a participating home health agency.~~

~~(2) The services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, or receives compensation for the services from the clinic.~~

~~(3) The services are furnished under a written plan of treatment that is:~~

~~(a) Established and reviewed at least every sixty-two days by a supervising physician of the rural health clinic or established by a nurse practitioner, physician assistant, or nurse midwife, and reviewed at least every sixty-two days by supervising physician; and~~

~~(b) Signed by the nurse practitioner, physician assistant, nurse midwife, or supervising physician of the clinic.~~

~~(4) The nursing care covered by this rule includes:~~

~~(a) Services that must be performed by a registered nurse, licensed practical nurse, or licensed vocational nurse if the safety of the patient is to be assured and the medically desired results achieved; and~~

~~(b) Personal care services, to the extent covered under medicare as home health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to take medications.~~

~~(c) This benefit does not cover household and housekeeping services or other services that would constitute custodial care.~~

~~(d) The services rendered to a homebound individual. For the purposes of this rule "homebound" means an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or long-term care facility.~~

(G) Coverage limitations in RHCs.

(1) Coverage limitations set forth in Chapter 5101:3-4 of the Administrative Code apply to RHC services provided by physicians and physician assistants.

(2) Coverage limitations set forth in rule 5101:3-8-23 of the Administrative Code also apply to advanced practice nurse services provided under the auspices of an RHC.

(3) Coverage limitations set forth in rules 5101:3-8-05 and 5101:3-4-29 of the Administrative Code also apply to mental health services provided under the auspices of an RHC.

(H) RHC billable services.

(1) RHC services shall be billed on an encounter basis, in accordance with rule 5101:3-4-02 of the Administrative Code.

(2) All billable encounters shall be documented in the patient health record in accordance with rule 5101:3-1-27 of the Administrative Code.

(3) For consumers in the medicaid managed care program, claims submission requirements, including prior authorization requests for RHC services as defined in Chapter 5101:3-16 of the Administrative Code, are specified in rules 5101:3-26-03.1 and 5101:3-26-05.1 of the Administrative Code.

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Prior Effective Dates: 4/1/80, 8/1/01

5101:3-16-04 Reimbursement - Rural Health Clinics

Effective Date: July 1, 2001

(A) FOR SERVICES PROVIDED PRIOR TO JANUARY 1, 2001, THE DEPARTMENT'S REIMBURSEMENT METHODOLOGY IS DESCRIBED IN PARAGRAPHS (B)(1) TO (B)(2) OF THIS RULE.

(B) For provider clinics, payment will be made on the basis of the principles specified in the medicare regulations. A "provider clinic" is a clinic that is an integral part of an institutional provider (hospital, skilled nursing facility, or home health agency) that is participating in medicare and is operated under common licensure, governance and professional supervision, and professional supervision with other departments of the institution.

~~(A)~~ (1) For any clinic that is not a provider clinic, services identified as rural health clinic services in paragraph (A) of rule 5101:3-16-02 of the Administrative Code, payment will be made at the medicare reimbursement rate per visit. An all-inclusive rate will be determined by the medicare carrier at the beginning of the reporting period and will be determined by dividing the estimated total allowable costs by estimated total visits for rural health clinic services. The rate determination will be subject to any tests of reasonableness that may be established.

~~(B)~~(2) For any clinic that is not a provider clinic, payment for other ambulatory services identified in paragraph (B) of rule 5101:3-16-02 of the Administrative Code will be made in accordance with provisions set forth in rule 5101:3-13-06 of the Administrative Code.

Effective Date: July 1, 2001

Review Date: 16 APRIL 2001, 16 APRIL 2006

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Prior Effective Dates: 4/1/80

5160-16-05 Rural Health Clinics (RHCs): Supplemental Payments

Formerly **5101:3-16-05 Rural Health Clinics (RHCs): Supplemental Payments**

MAL 507

Effective Date: July 1, 2006

Most Current Prior Effective Date: **August 6, 2001**

(A) Definitions:

(1) "MCP" means a managed care plan as defined in rule 5101:3-26-01 of the Administrative Code ~~which reimbursed~~that reimburses a rural health clinic (RHC) for services provided by the RHC to a medicaid recipient enrolled in the MCP.

(2) "Encounter" is defined in accordance with rule ~~5101:3-28-04~~5101:3-16-01 of the Administrative Code.

(3) "Enrollee," otherwise known as a member, means each eligible individual enrolled in an MCP as specified in rule 5101:3-26-01 of the Administrative Code.

(B) Effective for services furnished on or after January 1, 2001, RHCs that have received payment from an MCP for RHC services identified in rule 5101:3-16-02 of the Administrative Code are eligible to receive a supplemental payment from the department~~. RHCs are eligible to receive a supplemental payment~~ if the amount the RHC was paid by ~~a~~an MCP for services provided to an MCP enrollee is less than the amount the RHC would have received under the ~~cost-based~~ prospective payment system (PPS) reimbursement method described in rule ~~5101:3-16-04~~5101:3-16-06 of the Administrative Code.

(C) ~~Effective for services furnished on and after January 1, 2001, to~~To receive the supplemental payment for an encounter provided to ~~a~~an MCP enrollee, an RHC must submit a claim to the department following the Ohio medicaid provider billing instructions utilized by RHCs for fee-for-service medicaid consumers with third party insurance.

(1) These billing instructions require an RHC to report the following on the claim:

(a) The ~~local level code (W0020) which signifies~~encounter code and the appropriate modifier to signify the type of encounter provided by the RHC~~; and~~.

(i) RHCs that choose to submit a paper claim must submit the standard professional claim form.

(ii) RHCs that choose to submit a claim via an electronic transaction shall submit the transaction in an electronic format recognized by the department in accordance with the department's billing instructions.

(b) A detailed CPT code listing reflecting all services provided during the encounter.

(2) RHCs seeking supplemental payments must also report the following information on the claim:

(a) The third party indicator for the medicaid supplemental payment;

(b) The medicaid identification number of the MCP ~~which~~that paid the RHC in the referring physician field; and

(c) The sum of the dollar amount the RHC was paid by any MCP for the service(s) provided to the medicaid recipient listed on the claim, minus any incentive payments received from an MCP and any amount received by the RHC from any other third party insurance.

(3) The data elements submitted for a supplemental payment claim are dependent on whether the claim is a paper claim or an electronic transaction.

(a) RHCs that choose to submit a paper claim shall submit the data elements outlined in paragraphs (C)(1) and (C)(2) of this rule; and

(b) RHCs that choose to submit a claim via an electronic transaction shall use the "837" transaction and report the data elements unique for supplemental claims, including:

(i) The name of the MCP provider under the "other payer name" field;

(ii) The "identification code," as assigned by the Ohio department of job and family services (ODJFS), of the MCP payer that initially paid for the services; and

(iii) The sum of the dollar amount the MCP paid the RHC for services without regard to the effects of any financial incentive payments (positive or negative) received from the MCP plus any amount received from any other third party insurance, in "monetary amount" under the "other payer" field.

(D) Calculation of supplemental payments:

(1) Using the methodology described in paragraph (C) of this rule, the department will pay the RHC no less frequently than every four months.

(2) For dates of service on and after January 1, 2001, upon receipt of the claim the department will pay any difference between the amount paid by the MCP to the RHC and the amount due the RHC based on ~~their cost-based~~its PPS rate approved by the department for the specific claim submitted. ~~These payments will occur no less frequently than every four months.~~

The department's supplemental payment obligation will be determined using the baseline payment that the RHC would have received under ~~cost-based~~PPS reimbursement as described in rule ~~5101:3-16-04~~5101:3-16-06 of the Administrative Code, without regard to the effects of any financial incentives (positive or negative) received from the MCP that are linked to utilization outcomes or other reductions in patient costs.

(E) If a claim is not submitted by an RHC to the department within the standard time frames ~~specified~~required for claims submission ~~as specified~~ in accordance with ~~paragraph (G) of~~ rule 5101:3-1-19.3 of the Administrative Code, no supplemental payment(s) will be made by the department to the RHC.

~~(F) The provisions of this rule are contingent upon approval of the department's state plan amendment by the health care financing administration (HCFA).~~

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5160-16-06 Rural Health Clinics (RHCs): Prospective Payment System (PPS)

Formerly **5101:3-16-06 Rural Health Clinics (RHCs): Prospective Payment System (PPS)**

MAL 507

Effective Date: July 1, 2006

Most Current Prior Effective Date: **October 15, 2001**

(A) Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires states to establish a ~~new~~ medicaid prospective payment system (PPS) for RHCs. This rule addresses how the department ~~will comply~~complies with BIPA requirements.

(B) ~~Definition~~Definitions:

(1) "Base rate" is the initial PPS rate assigned to an RHC.

~~(1)~~(2) For the purposes of Chapter 5101:3-16 of the Administrative Code, "~~Change~~change in scope of service" ~~means an addition or deletion of a category of service.~~is defined in accordance with paragraph (A)(1)(b) of rule 5101:3-28-09 of the Administrative Code. For the purposes of Chapter 5101:3-16 of the Administrative Code, references to federally qualified health centers in paragraph (B) of rule 5101:3-28-09 of the Administrative Code also apply to RHCs.

~~(2) "Category of service" means the following different types of services:~~

~~(a) Medical;~~

~~(b) Dental;~~

~~(c) Mental health specifically services of a clinical psychologist or clinical social worker;~~

~~(d) Physical therapy;~~

~~(e) Podiatry;~~

~~(f) Optometry;~~

~~(g) Chiropractic;~~

~~(h) Speech therapy and audiology; and~~

~~(i) Transportation.~~

~~(3) "Increase or decrease in the scope of services" means the addition or deletion of a new category of service.~~

~~(C) Cost report filing:~~

~~Any RHCs with a change in the scope of service as defined in paragraph (B) of this rule, must submit two cost reports in accordance with the instructions specified in JFS 03420. One cost report must be completed for the year prior to the change in the scope of service and the second cost report must detail costs for the year after one full year of operation of the additional category of service was added. The cost reports must be filed within ninety days after the close of one full year of operation of the new service.~~

~~(D) Phase one of the new medicaid PPS system~~

~~For dates of service January 1, 2001 through September 30, 2001 (the first phase of the new prospective payment system) the department will pay current RHCs one hundred per cent of the average of their costs which are reasonable and related to the costs of furnishing services as determined by the medicare intermediary for providing services during fiscal year 1999 and fiscal year 2000.~~

~~(1) For each RHC the department will use the medicare reimbursement rate per visit for fiscal year 1999 and fiscal year 2000 and take the average of these rates to arrive at the rate for each RHC for January 1, 2001 through September 30, 2001.~~

~~(2) The resulting average rate will be adjusted, if necessary, to take into account any increase or decrease in the scope of services as defined in paragraph (B) of this rule furnished during calendar year 2001 by the RHC.~~

~~(a) As an interim step, RHCs will have a change in the scope of the service, will be given a start-up rate which will be the medical rate for the RHC.~~

~~(b) After one full year of operation of the service which has changed in scope, the RHC must file two cost reports as described in paragraph (C) of this rule which documents their total costs.~~

~~(c) The department will analyze the impact that the change in the scope of service has had on the RHCs costs by comparing the two cost reports and adjusting the RHCs rate if necessary.~~

(C) Establishment of PPS rates for RHCs:

(1) For RHCs in operation during their fiscal year 1999, the base rate is the average of that RHC's medicare reimbursement rate per visit for its fiscal years 1999 and 2000.

(2) For RHCs beginning operation after their fiscal year 2000, the base rate is the same as the rate(s) established for other RHCs in the nearest adjacent area that are similar in size, caseload, and scope of services. If there is not an RHC in an adjacent area that is similar in size, caseload, and scope of services, the state-wide sixtieth percentile rate will be assigned to the new RHC as the start-up PPS rate.

(3) On October 1 of each subsequent year of operation, all PPS rates in effect for RHCs on September 30th will be increased by the percentage increase in the latest available medicare economic index (MEI).

~~(E) RHCs will receive payments for the period January 1, 2001 through September 30, 2001 based on their new prospective payment system rate retroactively. During this interim period, RHCs will continue to be paid using the interim rate set for state fiscal year 2001.~~

~~(F) Beginning October 1, 2001, and for each fiscal year thereafter, each RHC will have rates established on a per visit basis type based on the rate established by the principles defined in paragraph (D) of this rule increased by the percentage increase in the medicare economic index (MEI) for primary care services.~~

~~The resulting rate will be adjusted, if necessary, to take into account any increase or decrease in the scope of services furnished during fiscal year 2001 by the RHC as described in paragraph (D)(2) of this rule.~~

~~(G) Newly qualified RHCs after fiscal year 2000 will have their initial rates set based on the rates established for other RHCs in the nearest adjacent area. After the initial year, rates for these RHCs will be set using the MEI method used for other RHCs.~~

~~(H) The provisions of this rule are contingent upon approval of the department's state plan amendment by the health care financing administration (HCFA).~~

(D) An RHC may request a PPS rate review upon incurring a change in scope of services. Provisions regarding review of change of scope of service for federally qualified health centers (FQHCs) in paragraph (C) of rule 5101:3-28-09 also apply to RHCs, with the exception that RHCs shall utilize the independent rural health clinic and freestanding federally qualified health center cost report form (CMS-222-92), dated 1/2005, for the purpose of filing cost reports, rather that the JFS 03421, as described in paragraph (C)(7)(e) of rule 5101:3-28-09 of the Administrative Code.

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