Chapter 29

Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC)

Billing Information – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

This chapter refers to services provided by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) and applies to only those programs outlined in your organization's participation agreement with South Country Health Alliance (South Country), for more detailed information, providers are encouraged to visit:

- Centers for Medicare and Medicaid Services (CMS):
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/RHCs.html
- Minnesota Health Care Programs (MHCP):
  - http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_155131

FQHCs and RHCs provide covered services to South Country members in a manner similar to other physician clinics. However, federal mandates and guidelines apply specifically to FQHCs and RHCs.

Covered Services

Payments for covered RHC/FQHC services furnished to South Country members are made based on an all-inclusive rate per covered visit. South Country covers one medical encounter and one dental encounter per day. This must include a face-to-face encounter between the patient and an eligible health care provider. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. An exception occurs in cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

Individual providers within the enrolled FQHC or RHC may include the following:

- Chiropractor
- Clinical psychologist
- Clinical social worker
- Dentist
- Nurse practitioner
- Nurse midwife
- Physician
- Advanced dental therapist

- Dental therapist
- Physician assistant
- Qualified mental health professional

RHC/FQHC covered services include the following:

- Physicians' services
- Dental services provided in compliance with dental service guidelines
- Drugs and biologicals (incidental to an FQHC or RHC professional service only if they cannot be self-administered)
- FQHC or RHC professional services inpatient visits
- FQHC or RHC surgical visits
- RN or LPN part-time or intermittent nursing care
- Mental health care
- Obstetrical or perinatal care
- Pharmaceuticals
- Services and supplies (incidental to FQHC or RHC professional services if they are commonly furnished in physicians' offices, commonly rendered either without charge or included in the bill and provided by a member of the clinic's healthcare staff under the supervision of a physician)
- Vaccines (incidental to FQHC or RHC professional services)

Additional information may be found in the CMS Internet Only Manual (IOM) or the MHCP Provider Manual.

RHC services are covered when furnished to a patient at the clinic or center, the patient's place of residence, or elsewhere (e.g., the scene of an accident).

Non-Covered Services

Services that are provided outside of the scope of an RHC/FQHC are not covered under the RHC/FQHC benefit. If these services are covered under another Medicare benefit category, they may be separately billable to the Medicare carrier/intermediary as appropriate.

The following services are not covered under RHC/FQHC benefit:

- Durable Medical Equipment (DME) (whether rented or sold) including crutches, hospital beds and wheelchairs used in the patient's place of residence
- Ambulance services
- Technical component of Services (the professional component is an RHC service if performed by an RHC/FQHC physician or non-physician practitioner)
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care, and the replacement of such devices
- Leg, arm, back, and neck braces and artificial legs, arms and eyes, including replacements (if required because of a change in the patient's physical condition)
- Services covered by the Consolidated Chemical Dependency Treatment Fund (CCDTF)

- Any non-covered service by MHCP

No payment can be made under Medicare Part A or Part B for items and services with the following characteristics:

- Not reasonable and necessary
- No legal obligation to pay for or provide
- Furnished or paid for by other government entities
- Not provided within the United States
- Personal comfort
- Routine services and appliances
- Supportive devices for feet
- Custodial care
- Cosmetic surgery
- Charges by immediate relatives or members of household.
- Dental services
- Paid or expected to be paid under a Medicare Secondary Payer (MSP) provision
- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital

RHC/FQHC Services for Hospital Inpatient and Outpatient

Payment may not be made to practitioners for services provided to hospital inpatients and outpatients for practitioners who are compensated under the RHC/FQHC agreement. If the practitioner isn't compensated under the RHC/FQHC agreement they may seek payment for those services from South Country.

Skilled Nursing Facility Services

Payment may be made to the RHC for services provided to a South Country member in a Part A stay in a Medicare certified Skilled Nursing Facility (SNF).

General Billing Requirements

RHC and FQHCs are required to bill Medicaid Services (PMAP, MNCare and SNBC programs without Medicare Coverage) using the 837P (CMS 1500) or 837D format.

Providers are required to bill services using the 837I (UB04) format for services provided to South Country member on any of the Medicare programs (AbilityCare, SharedCare - SNBC or SeniorCare Complete - MSHO).

FQHC and RHC Medicare crossover claims

Any FQHC and RHC Medicare-denied (for non-coverage) 837I crossover claims received will be denied. FQHCs and RHCs must resubmit 837I Medicare-denied crossover claims using the 837P format.

Claims processing Jurisdiction for FQHC and RHC Managed Care Organization (MCO) Carve-out

The following are carve-out process exclusions:

1. Medicare claims follow standard Medicare billing practices. South Country handles final resolution and does not forward claims to DHS.

2. Claims in which a third-party insurer (TPL) paid the claim in full

3. Behavioral and Medical Health Care Home claim procedure codes S0280 and S0281. South Country will continue to pay these claims directly to the provider.

4. South Country pays directly for all MinnesotaCare member claims

Effective for service dates beginning July 1, 2019, FQHCs must submit claims for South Country members directly to MHCP for payment. RHCs must continue to follow the MCO carve-out process. All South Country claims submission must continue to follow South Country's prior authorization, benefit limits, and copays requirements.

FQHC full MCO carve-out effective July 1, 2019

All MHCP claims submission rules apply to the full MCO carve-out process, including prior authorizations, benefit limits, copays, and interpreter services. Referrals for South Country restricted recipient program (RRP) members from a designated provider requesting to be seen by an FQHC that is not the member's designated provider, should continue to be submitted to South Country for review.

The following are carve-out process exclusions:

1. Medicare claims follow standard Medicare billing practice. South Country handles final resolution.

2. Behavioral and Medical Health Care Home claim procedure codes S0280 and S0281. South Country will continue to pay these claims directly to the provider.

3. All MinnesotaCare claims.

Additional details from MHCP Provider Manual regarding this carve-out can be found on the Minnesota Department of Human Services (DHS) Federally Qualified Health Center and Rural Health Clinics web page.