MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 212
Rural Health Clinics

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Title 23: Division of Medicaid

Part 212: Rural Health Clinics

Part 212 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. To participate as a Rural Health Clinic (RHC) in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an RHC.

B. RHC providers must comply with the requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:

   1. National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),

   2. A copy of the interim rate notice or current rate letter from CMS,

   3. Copy of the nurse practitioner's protocol and license to practice. If the nurse practitioner is not enrolled with the Division of Medicaid as a provider, the nurse practitioner must complete a provider application and obtain an individual provider number, and

   4. Clinical Laboratory Improvement Amendments (CLIA) Information form and current CLIA certificate, if applicable.

C. Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid Medicaid provider agreement.

D. The effective date of the Medicaid provider enrollment will be:

   1. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

   2. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment packet if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

Source: 42 CFR § 440.20 (b); 42 CFR Part 455, Subpart E; 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2014. Updated Miss. Admin. Code Part 212, Rule 1.1A. 05/01/13 to include 04/01/2012 compilation omission.

Rule 1.2: Service Limits

A. The Division of Medicaid limits reimbursement to a RHC to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

   1. A physician, physician assistant, nurse practitioner, or nurse midwife,

   2. A dentist,

   3. An optometrist, or

   4. A clinical psychologist or clinical social worker.

B. An exception to Miss. Admin. Code Part 212, Rule 1.2.A. is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

Source: 42 CFR § 440.230; Miss. Code Ann. § 43-13-121; SPA 2013-033.

History: Revised to correspond with SPA 2013-033 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered and Non-Covered Services

A. The Division of Medicaid defines an RHC encounter as a face-to-face visit for the provision of services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers.

   1. An RHC's encounter rate covers the beneficiary's visit to the RHC, which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

   2. The RHC cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the RHC's encounter.

   3. Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

B. The Division of Medicaid covers ambulatory services performed by an RHC employee or contractual worker for an RHC beneficiary at multiple sites, including, but not limited to:

   1. The RHC,

   2. A skilled nursing facility,

3. A nursing facility, or

4. Other institution used as a beneficiary's home.

C. An RHC must provide the following six (6) laboratory services on site. These services are included in the encounter rate:

1. Chemical examinations of urine by stick or tablet method or both, including urine ketones,

2. Hemoglobin or hematocrit,

3. Blood glucose,

4. Examination of stool specimens for occult blood,

5. Pregnancy tests, and

6. Primary culturing for transmittal to a certified laboratory.

D. If the RHC performs only the six (6) tests listed in Miss. Admin. Code Part 212, Rule 1.3.C., a waiver certificate from the regional Clinical Laboratory Improvement Amendments (CLIA) office must be obtained. If an RHC provides other laboratory tests on site, it must comply with CLIA requirements for the laboratory services actually provided.

E. The Division of Medicaid reimburses an outside laboratory for laboratory services not listed in Miss. Admin. Code Part 212, Rule 1.3.C. outside the encounter rate.

F. The Division of Medicaid does not cover:

1. RHC services when performed in an inpatient or outpatient hospital setting.

2. The cost of a subdermal implant as a separate service.

Source: OBRA (1990) § 4161; 42 CFR § 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-033.

History: Revised eff. 06/01/2015.

Rule 1.4: Reimbursement Methodology

A. The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for Rural Health Centers (RHCs) which include:

1. A PPS rate per encounter as described below:

a) For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the average of the RHC's reasonable costs of providing the Division of Medicaid covered services during fiscal years 1999 and 2000. If an RHC first enrolls during fiscal year 2000, the rate will only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during fiscal year 2001.

b) Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

c) Beginning in calendar year 2002, and for each calendar year thereafter, the RHC is entitled to the payment amount, on a per visit basis, to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

d) New clinics that qualify for the RHC program after January 1, 2001, will be reimbursed the initial PPS rate which will be based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of comparable RHC, the rate for the new provider will be based on projected costs. The clinic's Medicare final settlement cost report for the initial cost report period year will be used to calculate a PPS base rate that is equal to one hundred percent (100%) of the clinic's reasonable costs of providing Medicaid covered services. If the initial cost report period represents a full year of RHC services, this final settlement rate will be considered the base rate. If the initial RHC cost report period does not represent a full year, then the rate from the first full year cost report will be used as the clinic's base rate. For each subsequent calendar year, the payment rate will be equal to the rate established in the preceding calendar year, increased by the percentage increase in the MEI for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. If a clinic's base year cost report is amended, the clinic's PPS base rate will be adjusted based on the Medicare final settlement amended cost report. The clinic's original PPS base rate and the rates for each subsequent fiscal year will be recalculated per the payment methodology outlined above. Claims payments will be adjusted retroactive to the effective date of the original rate.

2. An alternate payment methodology, effective November 1, 2013, which is an additional fee for certain services provided outside the Division of Medicaid's regularly scheduled office hours.

a) The Division of Medicaid defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Miss. Admin. Code, Part 212, Rule 1.4.A.2 as "office hours".

b) The Division of Medicaid permits RHCs to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Miss. Admin. Code, Part 212, Rule 1.4.A.2. as "RHC established office hours".

c) The RHC must maintain records indicating RHC established office hours and any changes including:

1) The date of the change,

2) The RHC established office hours prior to the change, and

3) The new RHC established office hours.

d) The Division of Medicaid reimburses a fee in addition to the encounter rate when the encounter:

1) Occurs during the RHC established office hours which are set outside of the Division of Medicaid's office hours, or

2) Occurs outside of office hours or the RHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or RHC established office hours.

e) The Division of Medicaid reimburses only the appropriate encounter rate for an encounter scheduled during office hours or RHC established office hours but not occurring until after office hours or RHC established office hours.

3. An additional fee per completed transmission, for telehealth services provided by the RHC acting as the originating site, which meets the requirements in Miss. Admin. Code Part 225, Chapter 1, effective January 1, 2015.

B. All services provided in an inpatient hospital setting, outpatient hospital setting, or a hospital's emergency room will be reimbursed on a fee-for-service basis. If a physician employed by an RHC provides physician services at an inpatient, outpatient, or emergency room hospital setting, the services must be billed under the individual physician's Medicaid provider number and payment will be made directly to the physician. The financial arrangement between the physician and the RHC must be handled through an agreement.

C. An RHC must request an adjustment to its PPS rate whenever there is a documented change in the scope of services. The adjustment will be granted only if the change in scope of services results in at least a five percent (5%) increase or decrease in the clinic's PPS rate for

the calendar year in which the change in scope of service took place.

1. The Division of Medicaid defines a change in the scope of service as a change in the type, intensity, duration and/or amount of services including:

   a) The addition of a new service, including, but not limited to dental, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), optometry, obstetrics/gynecology (OB/GYN), laboratory, radiology, pharmacy, outreach, case management, transportation, which were not previously provided by the RHC, and/or

   b) The elimination of an existing service provided by the RHC.

2. A change in the scope of service does not mean:

   a) The addition or reduction of staff members to or from an existing service and/or

   b) An increase or decrease in the number of encounters.

3. A change in the cost of a service is not considered in and of itself a change in the scope of service.

4. It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of service(s) and provide required documentation to support the rate change. Such required documentation should include, at minimum, a detailed working trial balance demonstrating the increase or decrease in the RHC's PPS rate as a result of the change in scope of service(s). The Division of Medicaid may require the RHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid may also request additional information as it sees fit in order to sufficiently determine whether any change in scope of service(s) has occurred.

D. Cost Reports

1. All RHCs must submit to the Division of Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5th) month following the close of its Medicare cost-reporting year. All filing requirements shall be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the State Plan for reimbursement of RHCs. The RHC's cost report should include information on all satellite RHCs.

2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty can only be waived by the Executive Director of the Division of Medicaid.

3. An RHC that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.

Source: OBRA (1990) § 4161; 42 CFR §§ 440.20 (b) - (c), 447.371, Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-033; SPA 15-003.

History: Added Miss. Admin. Code Part 212, Rule 1.4.A.3. to correspond with SPA 15-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-033 (eff. 11/01/13) eff. 06/01/2015.

Rule 1.5: Documentation Requirements

The Division of Medicaid requires RHCs to maintain auditable records that will substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. Date of service,

B. Beneficiary's presenting complaint,

C. Provider's findings,

D. Treatment rendered, and

E. Provider's signature.

Source: 42 CFR § 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121.

Rule 1.6: Co-Mingling

A. The Division of Medicaid does not allow co-mingling which is defined as the simultaneous operation of an RHC and another physician practice where the two (2) practices share:

1. Hours of operation,

2. Use of the space,

3. Professional staff,

4. Equipment,

5. Supplies, and

6. Other resources.

B. Physicians and non-physician practitioners cannot operate a private Medicare or Medicaid practice during RHC hours of operation using the RHC's resources.

Source: 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

Rule 1.7: Pregnancy Related Eligibles

The Division of Medicaid covers women who are eligible for Medicaid only because of pregnancy for full Medicaid benefits during the course of their pregnancy and for sixty (60) days following delivery including any remaining days in the month in which the sixtieth (60th) day occurs.

Source: 42 CFR §§ 435.116, 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121; SPA 13-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.