MO HealthNet Managed Care
(Medicaid)

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# Rural health clinic billing guide

# Rural health clinic (RHC) billing procedures

- **Provider-based RHCs** (PBRHC) bill the appropriate CPT® or HCPCS procedure codes on the outpatient claim form. The appropriate revenue code, 521 or 900, should also be billed.

- **Independent RHCs** (IRHC) bill visit code T1015 on the outpatient claim form. Visit code T1015 must be entered in the HCPCS/rates field of the outpatient claim form in order to receive reimbursement-based established all-inclusive rate for each visit. The appropriate revenue code, 521 or 900, should also be billed.

* Each service provided must also be shown in the *Principal Procedure Code* and *Other Procedure Code* fields on the claim form. This allows us to be aware of services the member received for reporting purposes.

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# Multiple visits on the same day

- If it should become necessary to provide services on the same day, which constitutes a separate visit in accordance with Medicaid guidelines:
  - **PBRHCs** should skip one line and show a second procedure code.
  - An **IRHC** should bill the T1015 code and two units.

- Per the *MO HealthNet Billing Manual*, if it should become necessary to provide services on the same day, which constitutes a separate visit in accordance with Medicaid guidelines, an IRHC should bill the T1015 code on one line with a quantity of two. A completed *Certificate of Medical Necessity* must be attached to the *UB-04 Claim Form*.

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# Lab and X-ray services

- **Lab and X-ray services for IRHCs** are billed on a *1500 Claim Form*. Claims should be billed with non-RHC NPI in box 33.

- **Lab and X-ray services billing for PBRHCs** have two options:
  1. For claims billed on a *1500 Claim Form*, follow the billing instructions for IRHC lab and X-ray services.
  2. For claims billed on a *UB-04 claim form*, bill under the hospital's NPI number in box 56 and in box 1 bill the hospital's billing information (for example, address, name, etc.). Billing information must match in order to correctly process claims under the hospital information.



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# Providing detailed visit information — IRHC

- IRHC claims **must** include details of all services provided during the clinic visit to be reimbursed.
- IRHCs must bill visit code T1015 on the *UB-04 Claim Form* to trigger reimbursement. Visit code T1015 must be entered in the HCPCS/rates field of the *UB-04 Claim Form* in order to receive reimbursement-based established all-inclusive rate for each visit. The appropriate revenue code, 521 or 900, should also be billed.
- For additional codes billed beyond T1015, please bill a charge amount on the added UB line(s) — even if it is $0.01. Healthy Blue will not reimburse any additional amount above the clinic visit rate, regardless of the amount billed on the added UB line. Only the line with the T1015 code will be reimbursed. Any claim lines with a code other than T1015 will generate a denial reason.

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# Providing details for HEDIS-specific measures

It is critical that each clinic visit claim also include lines detailing the service(s) provided during that visit. For HEDIS®-specific measures, please refer to *HEDIS At-A-Glance* for coding recommendations.

The additional claim information on services is needed to accurately:

1. Measure HEDIS performance for IRHC care provided to our members.
2. Ensure the PCP receives credit for the service provided as part of our P4Q (Pay-for-Quality) program.
3. Reflect open care gaps.
4. Capture and report Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams for state reporting.

The service-specific information will also help the filing of any secondary claims with Healthy Blue as it would align with primary insurance remittance information.





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# Vaccines for Children (VFC) administration billing

**VFC administration billing:**
Please bill a charge amount on the added claim line(s) — even if it is $0.01. Healthy Blue in Missouri will not reimburse for the VFC administration code.

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# IRHC T1015 tips

**IRHCs:**

1. If the service is a full or partial EPSDT/Healthy Children and Youth (HCY) screening, enter procedure code T1015 EP on the first line and add the EPSDT/HCY procedure code on second line.
2. Please bill a charge amount on the added UB line — even if it is $0.01.
3. We won't reimburse any additional amount above the clinic visit rate, regardless of the amount billed on the added UB line. Only the T code will be reimbursed.
4. One of the following codes must be shown as the primary diagnosis in field 67:
   - Z00.110
   - Z00.111
   - Z00.121
   - Z00.129



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# T1015 claim examples

The below claim example shows T1015 billed on an *UB Claim Form* for an IRHC claim. This is needed in order for:

- The provider to receive credit for the service provided as part of our P4Q program.
- Healthy Blue in Missouri to report to the State for EPSDT exams provided for our members.

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED |
|---|---|---|---|---|---|---|---|
| 1 | 521 | | T1015 EP | 04/27/18 | 1 | 20 00 | |
| 2 | 521 | | 99391 | 04/27/18 | 1 | 20 00 | |



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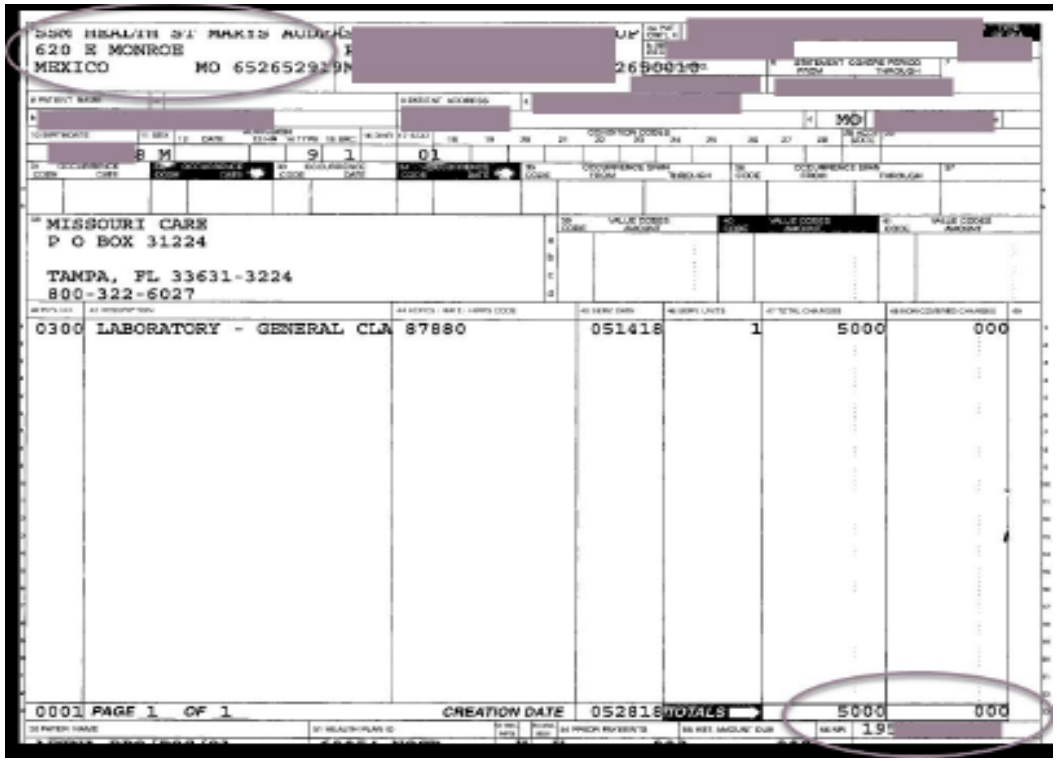
# Claim examples — PBRHC lab and radiology billing

The below claim example shows a lab service billed on a uniform billing (UB) claim form under the hospital's name with the hospital's NPI number in box 56.

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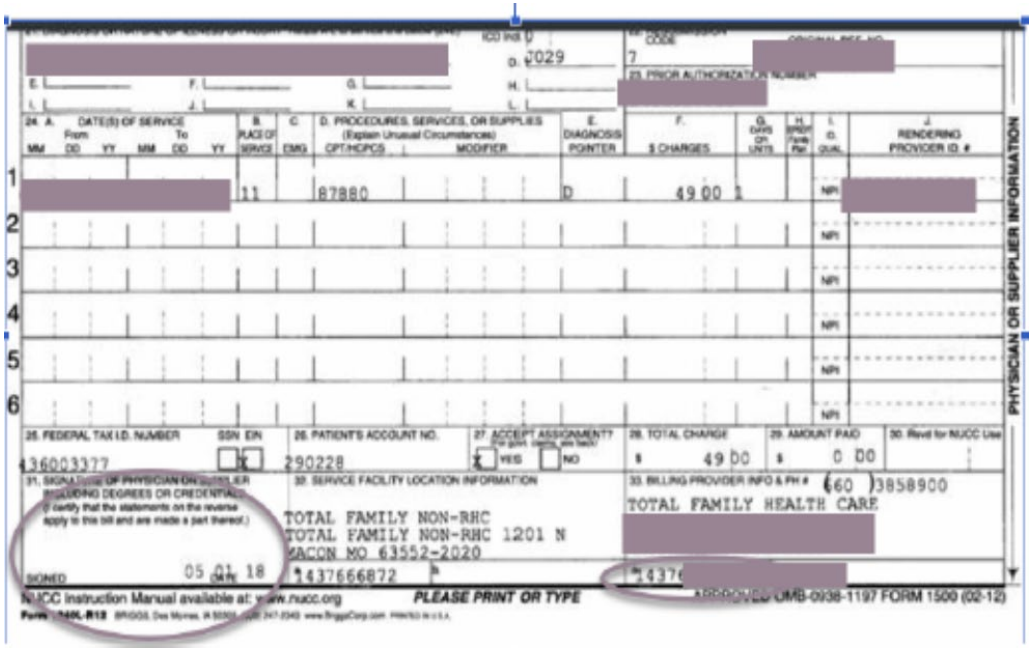
# Claim examples — PBRHC lab and radiology billing (cont.)

The below claim example shows a lab service billed on a professional *1500 Claim Form* under the applicable name and non-RHC NPI number in box 33.



# Surgeries/procedures performed in a hospital setting

- Services provided by RHC practitioners in the hospital setting are outside of the RHC benefit. This includes services provided in all types of hospital settings, such as inpatient, outpatient, off-campus outpatient and the emergency room.

- Surgeries/procedures performed in the hospital setting must be billed with the practitioner's private practice NPI number or as performing provider of a non-RHC clinic/group. Payment is determined by the MO HealthNet fee schedule.



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# HCY/EPSDT screening (well-child visit)

HCY/EPSDT screening:

- A **full screen** must include **all** of the components listed below. If all of the components are not included, a provider **cannot** bill for a **full screen** and is to bill for a **partial screen**, which includes the **first five** components below:

| Components | |
|---|---|
| 1. Interval history | 6. Development personal-social language |
| 2. Unclothed physical examination | 7. Fine motor/gross motor skills |
| 3. Anticipatory guidance | 8. Hearing screening |
| 4. Lab/immunizations (lab and administration of immunizations are reimbursed separately) | 9. Vision screening |
| 5. Lead assessment (provider must use the *HCY Lead Assessment Form*) | 10. Dental screening |

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# HCY/EPSDT screening (well-child visit) billing tips

**We follow the *MO HealthNet Billing Manual* regarding EPSDT screening services:**

- The EPSDT visit must be billed with ICD-10 codes Z00.110, Z00.111, Z00.121 or Z00.129 and **must** be shown as the primary diagnosis.
- The complete EPSDT visit must be billed with modifier EP.
- The EPSDT visit can be billed with an office visit and the office visit must be billed with an illness ICD-10 diagnosis code and modifier 25. Documentation must support two distinct services.
- School physicals should be billed as an EPSDT visit with modifiers 52 EP to indicate a partial screening.

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