MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid

Provider Reference Guide

For Part 212

Rural Health Clinics

This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.

TABLE OF CONTENTS

RURAL HEALTH CLINICS INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified citizens. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

In order to participate in the Mississippi Medicaid program, an organization must be approved as a Rural Health Clinic (RHC) by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid provider agreement. To be approved, a Rural Health Clinic must meet requirements and conditions for approval as established by state and federal regulations, and must provide the following six laboratory services on site:

- Chemical examinations of urine by stick or tablet method or both (including urine ketones)
- Hemoglobin or hematocrit
- Blood glucose
- Examination of stool specimens for occult blood
- Pregnancy tests
- Primary culturing for transmittal to a certified laboratory

If the RHC performs only these six tests, it may obtain a waiver certificate from the regional CLIA office. If an RHC provides other tests on site, it must comply with CLIA requirements for the lab services actually provided.

Upon satisfactory completion of the provider enrollment application and provider agreement, Medicaid may approve enrollment of the clinic as a Medicaid provider.

A Rural Health Clinic provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed personal health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers and sending notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

PROVIDER ENROLLMENT REQUIREMENT

When DOM receives a copy of the letter and Provider Tie-in Notice from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), which states approval of the Rural Health Clinic (RHC), the following steps will be taken by the Medicaid program:

1. A Mississippi Medicaid Provider Enrollment packet, Medical Assistance Participation Agreement and a direct deposit authorization/agreement form will be sent to the clinic for completion upon request. If DOM does not receive a Tie-in Notice from CMS, the RHC must request a Medicaid Enrollment Application packet

2. The provider will be required to send the following documents, along with the return of the above mentioned documents:

    - Certified copy of board minutes or notarized Board of Director's Resolution form authorizing the person(s) who signs the agreements and other documents to do so on behalf of the corporation

    - A copy of the interim rate notice from the Medicare intermediary

    - Voided check or blank deposit slip attached to the direct deposit form.

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

    - W-9 Request for Taxpayer Number and Certification

    - Verification from the IRS of the tax identification number

    - CLIA Information form and current CLIA certificate if applicable

3. When the above materials are received, it will be reviewed for completeness and, if complete, submitted to the Executive Director of DOM for approval or disapproval.

4. If approved, the Executive Director will sign both agreements; one (1) will be returned to the facility and one (1) will be filed in the facility's Medicaid provider file. The clinic will be notified in writing of the effective date and the encounter rate. The effective date is the date the Executive Director signs the agreement. The Medicaid provider enrollment forms, along with the signed provider agreement, will be sent to the fiscal agent with a copy of the approval letter. The fiscal agent will then assign a Medicaid provider number and implement the rate for payment of claims.

5. If disapproved the facility will be notified in writing. The reasons for the disapproval will be clearly stated and information will be given on how to appeal the decision.

The provider agreement will be in effect until the clinic ceases to qualify as a Medicaid RHC provider.

CHANGE OF OWNERSHIP OR CHANGE OF ORGANIZATIONAL STRUCTURE

Refer to Administrative Code Part 200, Chapter 4, for Change of Ownership and Tax ID.

SERVICE LIMITS

Visits by beneficiaries are limited to a total of twelve (12) per fiscal year in any office, nursing facility, or clinic setting. When a beneficiary has exhausted these visits, payment will no longer be made for services provided in the office or clinic setting. The encounter codes subject to the limitation are:

- 99201 – 99205
- 99212 – 99215

The procedure code 99211 may be used to allow a visit to the center when a patient is seen for follow-up care, such as blood pressure check, injections, etc. This procedure does not accumulate toward the 12-visit limit. However, once the limit has been reached, the procedure is no longer reimbursable.

All service limits of the Mississippi Medicaid Program are applicable.

OBSTETRICAL

Medicaid covers codes 99201 through 99215, 59425, and 59426 for antepartum visits as listed below.

(A) Only one (1) CPT code per antepartum visit in the 99201 through 99215 range for visits one (1) or two (2) or three (3).

(B) Only the CPT code 59425 per antepartum visit four (4), five (5), or six (6).

(C) Only the CPT code 59426 per antepartum visit seven (7) or more.

The antepartum visit number is defined as the number of the visit(s) to a particular physician. For example, if a beneficiary goes to Dr. A then goes to Dr. B, Dr. A will bill the appropriate evaluation and management code for each antepartum visit one (1), two (2), three (3) and four (4). Dr. B will bill for antepartum visits starting with visit number one (1), etc.

Services provided in the inpatient or outpatient hospital setting are not payable to the RHC provider. These services must be billed by the physician on his/her Medicaid provider number. Claims billed by a RHC provider with the following place of service will be denied:

POS 21 Inpatient hospital

POS 22 Outpatient hospital

POS 23 Emergency room hospital

Medicaid covers CPT code 59430 for postpartum visits only when the clinic physician was not the delivering physician.

Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. Refer to Part 222, Chapter 1, Rule 1.5 C regarding service limitations.

Refer to Maternity, Part 222 of the Title 23 Administrative Code for additional rules related to maternity services.

CO-MINGLING

Co-mingling is defined as the simultaneous operation of an RHC and another physician practice, thereby mixing the two practices. The two practices share hours of operation, use of the space, professional staff, equipment, supplies, and other resources. To prevent co-mingling, physicians and non-physician practitioners may not operate a private Medicare or Medicaid practice during RHC hours of operation using clinic resources.