

# Rural Health Clinic Services

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WISCONSIN **Medicaid**  
and BadgerCare  
Information for Providers  
Department of Health and Family Services

# Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility:

Service	Information Available	Telephone Number	Hours
<b>Automated Voice Response (AVR) System</b> (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
<b>Personal Computer Software and Magnetic Stripe Card Readers</b>	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
<b>Provider Services</b> (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
<b>Direct Information Access Line with Updates for Providers (Dial-Up)</b> (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
<b>Recipient Services</b> (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 5:00 p.m. (M-F)

\*Please use the information exactly as it appears on the recipient's identification (ID) card or the EVS to complete the patient information section on claims and other documentation.

Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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# Preface

The Wisconsin Medicaid and BadgerCare Rural Health Clinic Services Handbook is issued to Rural Health Clinic providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2002, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

While this handbook does not provide claims submission and coverage policy for Medicaid HMOs, it does provide guidance on the inclusion of Medicaid HMO encounters for the Medicaid RHC cost report.

## Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides

eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility.

## Handbook Organization

The Rural Health Clinic Services Handbook consists of the following chapters:

- General Information.
- Covered Services.
- Medicaid Reimbursement.

In addition to the Rural Health Clinic Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

## Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

### Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

## Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and

much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

[www.dhfs.state.wi.us/medicaid/](http://www.dhfs.state.wi.us/medicaid/)  
[www.dhfs.state.wi.us/badgercare/](http://www.dhfs.state.wi.us/badgercare/).

## Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

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# General Information

## Provider Information

### The Rural Health Clinic Benefit

The rural health clinic (RHC) Medicaid benefit is based on the Rural Health Clinic Services Act of 1977, Federal Public Law 95-210.

An RHC is a primary care clinic serving a rural, underserved area and is eligible for cost-based reimbursement from Wisconsin Medicaid for specific services, known as RHC services. In addition, RHCs provide a range of medical and surgical services for which they may be reimbursed based on the appropriate Wisconsin Medicaid provider-specific maximum allowable fee schedule.

Cost-based reimbursement is based on an RHC's "reasonable costs." Reasonable costs are determined using Medicare reasonable cost principles. Generally, RHCs report reasonable costs on an annual cost report, which is used to generate an average rate per visit, also known as an *encounter rate*. The encounter rate is applied to recipient visits that meet the encounter criteria to generate a settlement amount. The settlement amount is paid to the RHC in a lump sum. (Refer to the Medicaid Reimbursement chapter of this handbook for further information about cost-based reimbursement.)

### Definitions

A *rural health clinic*, according to Wisconsin Medicaid:

- Is an outpatient health clinic located in a rural area designated by the U.S. Department of Health and Human Services (DHHS) as a rural shortage area.
- Is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.
- Complies with all other appropriate federal, state, and local laws.

- Meets all other requirements of RHC certification.

A *rural area* is an area that is not delineated as an urbanized area by the U.S. Bureau of Census.

A *rural shortage area* is a defined geographic area designated by the DHHS under the Public Health Services Act as having either a shortage of personal health services or a shortage of primary medical care providers.

### Types of Rural Health Clinics

Rural health clinics can be privately or publicly owned. The two types of RHCs, as designated by Medicare RHC regulations, are:

- *Independent RHCs:* These RHCs are freestanding and are not part of a hospital, skilled nursing facility, or home health agency.
- *Provider-Based RHCs:* These RHCs are part of a hospital, skilled nursing facility, or home health agency, and may be either located with the parent organization or satellite clinic.

Clinics are subject to different cost-based reimbursement methods depending on their type. Wisconsin Medicaid recognizes the Medicare classification of RHCs.

## Provider Certification

### Certification of Rural Health Clinics

Rural health clinics must meet the following requirements listed in HFS 105.35, Wis. Admin. Code, for Medicaid certification:

- The clinic must be Medicare certified as an RHC.
- The clinic and clinic staff must be licensed, certified, or registered according to all appropriate state and local laws and regulations.

Wisconsin Medicaid encourages clinics to apply for Medicare and Medicaid certification simultaneously.

#### *Individual Provider Certification*

For Wisconsin Medicaid's purposes, rural health clinics are certified as billing providers for fee-for-service reimbursement. Each RHC performing provider must be individually certified.

The types of reimbursable RHC services that require individual performing provider certification are:

- Physician services.
- Physician assistant services.
- Nurse practitioner services.
- Certified nurse midwife services.
- Outpatient mental health/substance abuse services.
- Other services, as necessary.

For provider-specific information about certification, refer to Wisconsin Medicaid's handbooks for these services.

#### **Types of Provider Numbers**

Wisconsin Medicaid issues providers (whether individuals, agencies, or institutions) an eight-digit provider number to request reimbursement from Wisconsin Medicaid for services provided to eligible Medicaid recipients. A provider number belongs solely to the person, agency, or institution to whom it is issued. It is illegal for providers to submit claims using a provider number belonging to another provider.

A provider keeps the same provider number if he or she relocates, changes specialties, or voluntarily withdraws from Wisconsin Medicaid and later chooses to be reinstated. Provider numbers are never reissued to other providers in the event of termination from Wisconsin Medicaid.

#### *Group Billing Number*

Rural health clinics are issued a group billing number and receive one reimbursement and one Remittance and Status Report for RHC services performed by individual providers within the RHC.

Claims submitted by the RHC under the group billing number must identify a Medicaid-certified *performing* provider on the claim form. A claim submitted with only an RHC group billing number is denied reimbursement. An RHC may submit claims for most services (including physician, physician assistant, nurse practitioner, and nurse midwife services) using its group billing provider number and an appropriate performing provider number. Claims for services that are not RHC services may be submitted under the individual performing provider's number or under a separate physician/clinic group billing number issued to the facility.

Wisconsin Medicaid does not reimburse RHCs for providing outpatient mental health/substance abuse services performed by a master's-level therapist when using the RHC group billing number. Clinics must use the appropriate billing number(s) for these services (i.e., outpatient mental health/substance abuse clinic group billing provider numbers).

Claims for outpatient mental health/substance abuse services performed by a Master's-level provider must be submitted using the outpatient mental health/substance abuse clinic group billing number. Claims for home health services must be submitted using a home health agency group billing number. Refer to the Medicaid Reimbursement chapter of this handbook for further information.

### *Billing/Performing Provider Number*

Wisconsin Medicaid issues a billing/performing provider number to physicians, nurse practitioners, nurse midwives, psychiatrists, and psychologists that allows them to identify themselves on the CMS 1500 claim form as either the biller or the performer of services when a clinic or group is submitting claims for the services.

Wisconsin Medicaid issues a nonbilling/performing provider number to physician assistant and Master's-level psychotherapists, as they must practice under the professional supervision of a physician to be eligible providers.

### **Change of Ownership**

Wisconsin Medicaid requires providers to report in writing any change in licensure, certification, group affiliation, corporate name, or ownership before the effective date of the change, in accordance with HFS-105.02(1), Wis. Admin. Code. Changes of ownership include mergers, consolidations, and other legal transactions that meet the state or federal definitions of a change in ownership.

Wisconsin Medicaid may require the RHC to complete a new provider application and a new provider agreement when a change in status occurs. Refer to the Provider Certification section of the All-Provider Handbook for further information on change of ownership.

## **Recipient Information**

### **Recipient Eligibility Verification**

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Recipients in the following benefit categories have limitations to their Medicaid coverage:

- Illegal (undocumented) aliens.
- Presumptive Eligibility.
- Qualified Medicare Beneficiary Only.
- Qualified Working Disabled Individual.
- Specified Low Income Medicare Beneficiary only.
- Tuberculosis-related.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information about these restricted categories and other eligibility issues, such as lock-in status.

Eligibility information for specific recipients is available from Wisconsin Medicaid's Eligibility Verification System (EVS). The EVS is used by providers to verify recipient eligibility, including whether the recipient is enrolled in a Medicaid HMO, has private health insurance coverage, or is in a restricted benefit category. For telephone numbers, refer to the page of Important Telephone Numbers at the beginning of this handbook.

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# Covered Services

## Covered Services Information for Cost Reporting

Rural health clinics (RHCs) are primary care clinics that provide a range of services defined as RHC services.

Rural health clinics must adhere to guidelines in the most current service-specific handbooks and *Wisconsin Medicaid and BadgerCare Updates* for the services they provide.

### Rural Health Clinic Services Defined

Wisconsin Medicaid defines RHC services as the following services:

- Physician and physician assistant services.
- Services and supplies incidental to physician and physician assistant services.
- Nurse practitioner and nurse midwife services.
- Services and supplies incidental to the services of nurse practitioners and nurse midwives.
- Intermittent visiting nurse care and related medical supplies, other than drugs and biologicals, if:
  - √ The clinic is located in an area where there is a shortage of home health agencies.
  - √ The services are furnished by a registered nurse (RN) or licensed practical nurse (LPN) employed by, or under contract with, the RHC.
  - √ The services are furnished to a homebound recipient, as defined in HFS 107.11(2), Wis. Admin.Code.
- Other ambulatory services included in the written plan of treatment that meet specific Medicaid state plan requirements for furnishing those services. These services include outpatient mental health/substance abuse services, such as those provided by a clinical psychologist or clinical social worker.

Wisconsin Medicaid reimburses only for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost effective.

Providers should refer to the appropriate service-specific handbooks for complete information about certification requirements, covered services, reimbursement methods, and claims submission.

### Encounter Definition

An RHC-allowable encounter is defined as a face-to-face visit between a recipient and a Medicaid-certified provider to perform an RHC service. To be included as an encounter on the cost report, claims for the service provided must have been submitted and paid. (Refer to the Medicaid Reimbursement chapter of this handbook for complete information about annual settlements, encounters, and the Medicaid RHC cost report).

### Medicaid-Covered Services That Are Not Rural Health Clinic Services

There are items and services covered and reimbursable by Wisconsin Medicaid that do not fall under the definition of RHC services and may not be claimed as RHC service costs or encounters on the cost report. (Refer to the Medicaid Reimbursement chapter of this handbook for a definition of an encounter and further information about the RHC cost report.) Nevertheless, RHCs may be reimbursed by Medicaid fee-for-service for these services if they are appropriately certified and have the appropriate Wisconsin Medicaid billing provider number. Further information concerning coverage and payment procedures for non-RHC services may be obtained from the appropriate service-specific handbook.

Items or services covered by Wisconsin Medicaid, which cannot be included in the cost report as RHC service costs or encounters, include, but are not limited to:

- Ambulance services.
- Charges for hearing aids or eyeglasses.
- Diagnostic tests, unless an interpretation of the test is provided by an RHC physician.
- Durable medical equipment (whether rented or sold), including oxygen tents, hospital beds, and wheelchairs used in the patient's place of residence.
- Drugs routinely self-administered.
- Home health therapy or aide services.
- Laboratory services, diagnostic and screening.
- 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 provided to inpatient or outpatient hospital recipients.

### Prior Authorization

According to HFS 107.02(3), Wis. Admin. Code, Medicaid requires prior authorization (PA) for certain services. Providers are required to obtain PA for these services before providing them.

For information about services requiring PA, refer to the appropriate service-specific handbook. For general information about PA, refer to the Prior Authorization section of the All-Provider Handbook. For general information, call Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

### Medicaid Noncovered Services

Wisconsin Medicaid does not reimburse for services and procedures listed in HFS 107.03, Wis. Admin. Code. Refer generally to HFS 107, Wis. Admin. Code, and to service-specific handbooks for information on covered and noncovered services. Services that are not

covered by Wisconsin Medicaid are not allowable costs on the RHC cost report.

## Rural Health Clinic Services

### Physician and Physician Assistant Services

Wisconsin Medicaid reimburses for professional services performed by Medicaid-certified physicians and physician assistants employed or under contract with an RHC. However, cost-based RHC reimbursement is allowed only for RHC physician and physician assistant services.

Physicians who perform outpatient mental health/substance abuse services, psychotherapy, vision services, or who dispense drugs should obtain the appropriate provider publications. Wisconsin Medicaid's Web site at [www.dhfs.state.wi.us/medicaid](http://www.dhfs.state.wi.us/medicaid) contains publications that may be downloaded, including *Wisconsin Medicaid and BadgerCare Updates* and handbooks. Or, to order publications, call Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

### Supervision

Physician assistants must be supervised by a physician to the extent required under state regulation and licensing statutes, medical practices statutes, and Med. 8, Wis. Admin. Code.

Clinics that are not physician directed must arrange with a physician to provide supervision and guidance to physician assistants, in accordance with established clinic policies and procedures. The arrangement must be consistent with Wisconsin state law. The physician must be a doctor of medicine or osteopathy.

In the case of a physician-directed clinic, one or more clinic staff physicians must perform general supervision of physician assistants.



### Covered Services

Physician and physician assistant services are covered by Wisconsin Medicaid when they are:

- Provided by a physician or physician assistant employed by or under contract with the RHC.
- Medically necessary, appropriate, and, to the extent that alternative sources are available, the most cost-effective.

Physician services covered by Wisconsin Medicaid are:

- Diagnostic services.
- Preventive services.
- Therapeutic services.
- Rehabilitative services.
- Palliative services.

Refer to the Wisconsin Medicaid Physician Services Handbook and *Updates* for complete information on Medicaid-covered physician services.

### Ancillary Providers

Wisconsin Medicaid reimburses counseling and coordination of care services provided by ancillary providers as RHC services (e.g., dietitians, genetics counselors, nutritionists) when those services are provided pursuant to a plan of care, are under the direct, immediate, on-site supervision of a physician, nurse practitioner, or certified nurse midwife, and are not included in the supervising provider's E&M reimbursement. Submit claims for services performed by ancillary providers under the supervising provider's number using the appropriate E&M *Current Procedural Terminology* code.

Since ancillary providers are not Medicaid-eligible providers, claims for these services must be submitted under the supervising provider's Medicaid provider number.

"On-site" means that the supervising provider is in the same building in which services are being provided and is immediately available for consultation, or, in the case of emergencies, for direct intervention. The provider is not required

to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

### Reimbursement

Reimbursement is limited to lower level established patient office/outpatient visits (CPT procedure codes 99211, 99212) for counseling and coordination services delivered by ancillary providers.

Wisconsin Medicaid does not separately reimburse ancillary provider counseling and care coordination services provided incidental to a physician, nurse practitioner, or certified nurse midwife visit in which the provider has direct face-to-face contact with the recipient. In that case, face-to-face time refers to the time with the physician, nurse practitioner, or certified nurse midwife only.

Counseling by other staff is not considered to be part of the face-to-face physician, nurse practitioner, or certified nurse midwife encounter time for the purposes of reimbursement. Therefore, time spent by the other staff is not considered in selecting the appropriate level of service for the physician, nurse practitioner, or certified nurse midwife service provided.

### Nurse Practitioner and Nurse Midwife Services

Wisconsin Medicaid covers nurse practitioner and nurse midwife services as RHC services when the services are:

- Provided by a nurse practitioner or nurse midwife employed by or under contract with an RHC.
- Performed under the general supervision of a physician.
- Provided in accordance with clinic policies for a patient's care and treatment.
- Performed within the legal scope of practice as defined under the Wisconsin Board of Nursing licensure or certification.
- Included in the individual nurse practitioner's protocols or a collaborative

relationship with a physician as defined by the Board of Nursing.

Nurse practitioner and nurse midwife services include diagnosis, treatment, therapy, and consultation performed directly by a nurse practitioner or nurse midwife.

### *Certification*

Nurse practitioners who treat Wisconsin Medicaid recipients are required to be certified by Wisconsin Medicaid. This applies to nurse practitioners whose services are reimbursed under a physician's or clinic's Medicaid billing provider number, as well as those who independently submit claims to Wisconsin Medicaid. This does not apply to ancillary providers who practice under the direct on-site supervision of a physician. Refer to the Nurse Practitioner and Nurse Midwife provider handbooks for complete Medicaid certification information.

### *Supervision*

Medicaid-certified nurse practitioners who work under the general supervision of a physician are required to be supervised to the extent required pursuant to Board of Nursing Chapter N 6.02(7), Wis. Admin. Code. Chapter N 6 defines general supervision as the regular coordination, direction, and inspection of the practice of another and does *not* require the physician to be on-site.

Pursuant to Board of Nursing Ch. N 8.10(7), Wis. Admin. Code, advanced practice nurse prescribers work in a collaborative relationship with a physician. The collaborative relationship means an advanced practice nurse prescriber works with a physician, "in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise."

Clinics that are not physician directed must arrange with a physician to provide supervision and guidance to nurse practitioners and nurse midwives, according to protocols and

established clinic policies and procedures. The arrangement must be consistent with Wisconsin state law. The physician must be a doctor of medicine or osteopathy.

In the case of a physician-directed clinic, one or more clinic staff physicians must perform general supervision of nurse practitioners and nurse midwives.

### *Covered Services*

Wisconsin Medicaid covers medically necessary nurse practitioner and nurse midwife services that are covered physician services under Wisconsin Medicaid.

Certified nurse midwives are limited to providing the following categories of Medicaid-covered services:

- Family planning services.
- Laboratory services.
- Obstetric services.
- Office and outpatient visits.
- Tuberculosis (TB)-related services.

The practice of nurse midwifery means the management of women's health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse Midwives and the education, training, and experience of the nurse midwife (Board of Nursing s.441.15, Wis.Stats.). Only antepartum and postpartum visits and outpatient treatment of complications are eligible for cost-based reimbursement.

Nurse midwives should refer to the Nurse Midwife Handbook for complete information about covered services. Nurse midwives who also qualify as nurse practitioners should refer to the Nurse Practitioner Handbook.

### **Home Health Services**

Wisconsin Medicaid covers intermittent visiting nurse care and related medical services, other



than drugs and biologicals, as RHC services when:

- The clinic is located in an area where there is a shortage of home health agencies.
- Services are provided by an RN or LPN.
- The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the RHC or established by a physician, physician assistant, or nurse practitioner and reviewed and approved every 60 days by a supervising physician of the RHC.

Rural health clinics interested in providing home health services should call Provider Services at (800) 947 9627 or call (608) 221-9883 and ask to speak with the Division of Health Care Financing RHC Analyst.

#### *Covered Services*

Refer to the Private Duty Nursing and Home Health Services section of the Home Health Handbook and related *Wisconsin Medicaid and BadgerCare Updates* for complete information on covered services and PA.

#### **Other Ambulatory Services**

Wisconsin Medicaid covers as RHC services other ambulatory services that are included in a written plan of treatment and meet state plan requirements for furnishing those services, such as outpatient mental health/substance abuse services. Other ambulatory services furnished by an RHC are not subject to the physician supervision requirements under HFS 105.35, Wis. Admin. Code.

#### *Outpatient Mental Health/Substance Abuse Services*

Wisconsin Medicaid covers outpatient mental health/substance abuse services as RHC services when all of the following are met:

- The services must be provided by a psychiatrist, Ph.D. psychologist, HFS

61.91 to 61.98, Wis. Admin. Code, -certified outpatient mental health clinic or an HFS 75.13 or 75.15, Wis. Admin. Code, -certified substance abuse clinic.

- Psychiatrists, Ph.D. psychologists, Master's-level therapists, and AODA counselors must be individually certified by Wisconsin Medicaid and be either an RHC employee or under contract with the RHC.
- The certified outpatient mental health clinic or substance abuse clinic must also be certified by Wisconsin Medicaid.
- Outpatient psychotherapy services are provided in accordance with HFS 107.13(2) and 107.13(3), Wis. Admin. Code.
- Outpatient substance abuse services are provided in accordance with HFS 75.13 or 75.15, Wis. Admin. Code.

#### **Medicaid Certification**

Providers must be Medicaid certified in accordance with HFS 105.22 and/or HFS 105.23, Wis. Admin. Code. Refer to the Mental Health/Substance Abuse Handbook or the Medicaid certification application packet for additional certification information.

#### **Covered Services**

Allowable RHC services include mental health and substance abuse evaluations, psychotherapy, and substance abuse counseling. Covered services are those described in HFS 107.13(2) and 107.13(3), Wis. Admin. Code. Refer to the Mental Health & Alcohol and Other Drug Abuse Services Handbook and *Updates* for complete information on covered outpatient mental health/substance abuse services.

#### **Noncovered Services**

The following services are not covered outpatient mental health services:

- Collateral interviews with persons not stipulated in par.(c)1. of HFS 107.13(2), Wis. Admin. Code, and consultations, except as provided in HFS 107.06(4)(c), Wis. Admin. Code.

- Court appearances, except when necessary to defend against commitment of the recipient.
- Outpatient mental health services for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention.
- Outpatient mental health services provided in a person's home.
- Self-referrals. "Self-referral" means that a provider refers a recipient to an agency in which the provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice.

The following services are not covered outpatient substance abuse services:

- Collateral interviews and consultations, except as provided in HFS 107.06(4)(c), Wis. Admin. Code.
- Court appearances except when necessary to defend against commitment of the recipient.
- Detoxification provided in a social setting, as described in HFS 75.09, Wis. Admin. Code.

For more information on noncovered services, see HFS 107.03, Wis. Admin. Code.

### *Cost Reporting*

Psychiatrists and Ph.D. psychologists who are Medicaid certified and are either employed by or under contract with an RHC may submit claims for outpatient mental health or substance abuse services under the RHC billing number. These services are eligible for cost-based reimbursement. Master's-level therapists and AODA counselors must work in a certified mental health or substance abuse clinic and may submit claims for services only through a licensed, Medicaid-certified outpatient mental health or substance abuse clinic. An RHC must become certified as an outpatient mental health or substance abuse clinic to use the services of a master's level therapist and report them as RHC service costs and encounters on the Medicaid cost report.

### *Limitations*

Refer to the Mental Health Handbook for complete information on limitations to covered Medicaid outpatient mental health/substance abuse services.

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# M Medicaid Reimbursement

## Claims Submission

Through the Wisconsin Medicaid rural health clinic (RHC) annual cost report, RHCs may claim cost-based reimbursement for recipient visits that meet Wisconsin Medicaid's encounter criteria. Encounters are based on paid Medicaid HMO and fee-for-service claims. Therefore, it is important for RHCs to submit claims to Wisconsin Medicaid properly to ensure identification of all eligible encounters. Refer to service-specific handbooks and *Wisconsin Medicaid and BadgerCare Updates* for complete claims submission information and instructions.

All claims, whether electronic or paper, are subject to the same Wisconsin Medicaid processing and legal requirements. Claims submission questions should be directed to Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

### Electronic Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid provides software for submitting claims electronically. For more information on electronic claims submission:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

If you are currently using the software and have technical questions, please contact Wisconsin Medicaid's software customer service at (800) 822-8050.

## Paper Claims Submission

Providers submitting paper claims must use the CMS 1500 claim form or the UB-92 claim form, as appropriate. Providers should refer to their service-specific handbooks to determine which claim form to use.

Wisconsin Medicaid denies claims for services submitted on any paper claim form other than the CMS 1500 claim form or the UB-92 claim form.

Wisconsin Medicaid does not provide claim forms. Providers may obtain the forms from any vendor who sells federal forms.

## Where to Send Your Claims

Mail completed claim forms for reimbursement to the following address:

Wisconsin Medicaid  
Claims and Adjustments  
6406 Bridge Rd  
Madison WI 53784-0002

## Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days of the date the service was provided. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claims submission deadline, requirements for submission to Late Billing Appeals, and adjustment information can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook online at [www.dhfs.state.wi.us/medicaid/](http://www.dhfs.state.wi.us/medicaid/).

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## Claim Components

### Billed Amounts

Providers are required to submit claims indicating their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Wisconsin Medicaid a higher fee for the same service than that charged to a private pay patient. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

### Procedure Codes

Use the single five-character *Current Procedural Terminology* (CPT) procedure code, Healthcare Common Procedure Coding System (HCPCS) code, approved local procedure code, or revenue code that best describes the service performed, as appropriate. Wisconsin Medicaid denies claims without an appropriate procedure code. Providers should refer to service-specific handbooks and *Updates* for current procedure code information.

Do not use multiple procedure codes to describe a single service.

### Diagnosis Codes

All claims submitted for RHC services must include an appropriate diagnosis code from the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) coding structure. Wisconsin Medicaid denies claims received without an appropriate ICD-9-CM coding structure.

Refer to the Provider Resources section of the All-Provider Handbook for information about ordering the ICD-9-CM code book.

### Claim Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge and the maximum allowable fee established by the Department of Health and Family Services.

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code.

To obtain a provider-specific maximum allowable fee schedule, providers may:

- Download an electronic version from Wisconsin Medicaid's Web site at [www.dhfs.state.wi.us/medicaid/](http://www.dhfs.state.wi.us/medicaid/).
- Purchase a paper schedule by using the order form located in the Claims Submission section of the All-Provider Handbook or by writing to:  
Wisconsin Medicaid  
Provider Maintenance  
6406 Bridge Rd  
Madison WI 53784-0006

### Medicare Crossover Claims

Some recipients are considered dual entitlements. That is, they are eligible for both Medicare and Medicaid. Dual entitlements are eligible for Medicaid coverage of the coinsurance and deductible on all services allowed by Medicare, regardless of whether the services are covered by Wisconsin Medicaid.

When Medicare covers the service, an RHC should submit a claim to Medicare first. Medicare then crosses the claim over to Wisconsin Medicaid for potential payment of the Medicare coinsurance and deductible amounts.

For services *not* covered by Medicare under any circumstance, the provider should submit a claim directly to Medicaid. In these instances:

- Do *not* submit a claim to Medicare first.
- Do *not* indicate a Medicare disclaimer code on the claim.

Rural health clinics should submit Medicare claims on the UB-92 claim form to the appropriate Medicare fiscal intermediary. Refer to the Coordination of Benefits section of the All-Provider Handbook for further information on crossover claims.

## Cost-Based Reimbursement

The federal Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 repealed the reasonable cost-based reimbursement provisions of the Social Security Act and replaced them with a prospective payment system (PPS) for RHCs. Under the Act, states may reimburse clinics using an alternative method if the alternative method does not reimburse less than the amount that would have been paid to the RHC under the PPS.

### Approved Alternative Method

In accordance with the Act, Wisconsin Medicaid’s cost settlement method is Wisconsin’s approved alternative method. To ensure that the cost settlement method does not pay less than the PPS, Wisconsin Medicaid has constructed a baseline PPS rate for each clinic using clinic fiscal year 1999 and 2000 audited cost report data.

### Rates

At the end of each clinic fiscal year, Wisconsin Medicaid determines the PPS rate for a clinic’s upcoming fiscal year by adjusting the current PPS rate for each clinic by the following:

1. The Medicare Economic Index (MEI) in effect at the end of the clinic fiscal year.
2. Changes in the scope of services provided to Medicaid patients at the clinic based on the audited annual cost report.

3. Wisconsin Medicaid will notify the clinic each year of its PPS rate for the upcoming year.

### *Changes in Scope of Services*

Staffing and service provision changes should be reported on the clinic’s annual cost report as changes to full-time employees (FTEs) employed by, or contracting with, the clinic to provide RHC services and their costs. Report additions or deletions of staff providing RHC services under item 6 of the RHC Statistical Data, “Medicaid-Certified Providers Employed by or Contracted by the Clinic.” Costs associated with these providers, i.e., salary and benefits, should be reported as part of the Facility Health Care Staff Costs (Lines 1-11) on the RHC Trial Balance of Expenses, Reclassifications, and Adjustments.

### *Depreciation*

Provider-based RHCs report capital expenditures related to the provision of RHC services on Line 15 “Depreciation — Medical Equipment” and Line 27 “Depreciation (non-medical)” of the RHC Trial Balance of Expenses, Reclassifications, and Adjustments. For independent RHCs, Wisconsin Medicaid gathers this information from the clinic’s annual Medicare cost report.

The adjusted PPS rate is compared to the settlement rate for that clinic fiscal year, and Wisconsin Medicaid pays the clinic the greater of the two. For clinics for which the PPS rate is the higher of the two, Wisconsin Medicaid uses the PPS rate as the encounter rate when determining a clinic’s interim and annual settlement payments using the cost settlement method. Refer to “Cost Settlement Method” in this chapter for further information.

### *New Clinics*

For clinics that qualified for RHC status after clinic fiscal year 2000, Wisconsin Medicaid uses the PPS rate from a clinic in the same or



adjacent area with a similar caseload. This rate is compared to the rate paid by the cost settlement method, and Wisconsin Medicaid pays the higher of the two rates.

### Managed Care Supplemental Payments

Rural health clinics that provide services under a contract with a Medicaid HMO receive state supplemental payment for the cost of providing these services. These supplemental payments are an estimate of the difference between the payment the RHC receives from the HMO(s) and the payments the RHC would have received under the alternative cost settlement method.

At the end of each RHC fiscal year, the total amount of supplemental and HMO payments received by an RHC is reviewed against the payment amount that the number of visits provided under the RHC's contract with the HMO would have yielded under the alternative method. The RHC is paid the difference between the amount calculated using the alternative cost settlement method and the actual number of visits and the total amount of supplemental and HMO payments received by the RHC, if the alternative amount exceeds the total amount of supplemental and HMO payments.

If the alternative amount is less than the total amount of supplemental and HMO payments, Wisconsin Medicaid will recoup the difference.

### Non-Consolidated Cost Reports

As part of the PPS rate determination, Wisconsin Medicaid requires affiliated clinics or clinics under common ownership to submit cost reports that clearly identify the costs associated with each individual clinic. The PPS requires that rates for each individual clinic be determined using its own cost data, except for the initial PPS rate for a clinic established after clinic fiscal year 2000.

## Cost Settlement Method

### Annual Settlements

Rural health clinics may receive a cost-based annual settlement if they submit an annual Medicaid RHC cost report (referred to as the "annual cost report") to Wisconsin Medicaid each fiscal year. The annual cost report is used by Wisconsin Medicaid to determine that year's annual settlement and the following year's quarterly encounter rate for an RHC.

To receive an annual settlement, RHCs are required to submit the following documents to Wisconsin Medicaid:

1. A copy of the RHC's trial balance and filed Medicare RHC cost report.
2. A completed copy of the annual cost report. (Refer to Appendices 2 through 11 of this handbook for annual cost report forms and completion instructions.)
3. Additional documentation as requested by Wisconsin Medicaid.

The annual cost report consists of the following forms:

- Statistical Data.
- Trial Balance of Expenses, Reclassifications, and Adjustments (provider-based RHCs only).
- Settlement Determination.
- Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs.
- Medicaid Encounters Submitted to Medicaid HMOs.

If necessary, additional information may be attached to the cost report.

The total Medicaid annual cost settlement amount is determined by multiplying the Medicaid encounter rate by the number of Medicaid encounters for the reporting period. This total is reduced by the following payments that have already been made to the RHC:

- Medicaid payments on crossover claims.
- Medicaid fee-for-service payments.

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- Medicaid recipient copayments received and copayments due, but not received.
- Medicaid HMO payments.
- Medicaid quarterly payments.
- Commercial insurance payments.

When determining an annual settlement, if the total reimbursement due to the RHC for allowable costs exceeds the total payments received by an RHC, the amount is a balance due to the RHC from Wisconsin Medicaid. If the total allowable costs are less than the total payments received by the RHC, the amount is a balance due to Wisconsin Medicaid by the RHC. Wisconsin Medicaid is authorized to recover overpayments, in accordance with s.49.45(2)(a)(10), Wis. Stats., and HFS 108.02(9), Wis. Admin. Code.

### Quarterly Payments

When a clinic has provided services as an RHC for 12 continuous months, it has the option of receiving quarterly payments by submitting quarterly Medicaid RHC cost reports (referred to as “quarterly cost reports”) in addition to the annual cost report. Wisconsin Medicaid’s quarterly payments enable RHCs to increase cash flow throughout the year. Refer to Appendix 12 of this handbook for completion instructions and Appendix 13 of this handbook for the Rural Health Clinic Quarterly Cost Report.

### Report Submission

The Medicaid annual cost report and supplemental documents are due 30 days after the Medicare cost report due date, as determined in the Medicare Rural Health Clinic and Federally Qualified Health Center Manual. A 30-day extension of the Wisconsin Medicaid due date may be granted if Wisconsin Medicaid receives a written request before the original due date expires. If an extension is requested, Wisconsin Medicaid provides a written response to the request.

Failure to submit the annual cost report and supplemental documents within the specified timeframe will result in suspension of all cost

settlement payments, including quarterly payments, for that year only.

Quarterly cost reports must be submitted within three months of the quarter’s end.

Submit annual and quarterly cost reports and requests for extensions to:

Rural Health Clinic Auditor  
Bureau of Health Care Program Integrity  
Division of Health Care Financing  
PO Box 309  
Madison WI 53701-0309

### Fiscal Period and Clinic Sites

The annual cost report should cover the same fiscal period and sites as the Medicare RHC cost report.

Quarterly cost reports should cover the quarters in the RHC fiscal year.

### Signature

The annual and quarterly cost reports and related Medicaid supplemental documents must be signed by the authorized individual who signs the Medicare RHC cost reports.

## Medicaid Cost Report Components

A clinic’s annual settlement payment is a function of the clinic’s allowable costs, which are used to generate an encounter payment rate and eligible encounters. Refer below for a summary of the Medicaid cost report components.

### Medicaid-Allowable Costs

Medicaid-allowable costs are essentially those costs incurred by an RHC in the provision of RHC services. Wisconsin Medicaid determines if costs are allowable by applying Medicare cost reimbursement principles. Allowable costs are defined by federal regulations in 42 CFR Part 413 and the Medicare Provider Reimbursement Manual.

These general Medicare principles define allowable costs of hospitals and other facilities paid on a reasonable-cost or cost-related basis.

### Nonallowable Costs

The following costs are not allowed in the annual or quarterly cost reports:

- Costs of services provided to Wisconsin Medicaid recipients for which the RHC has not submitted a claim and has not been reimbursed by Medicaid fee-for-service or by a Medicaid HMO.
- Direct or indirect costs of providing services to any non-Medicaid eligible patients at the time the services were provided.
- Group or mass information programs, health education classes, or group education activities, including media productions and publications.
- Operational costs not allowed by federal and/or state regulations.

Encounters associated with categories of nonallowable costs should be indicated as part of the clinic's total encounter count on Line 10 of Part A of the RHC Settlement Determination. Refer to Appendix 7 of this handbook for a copy of the Settlement Determination.

### Encounters

An RHC *encounter* is a face-to-face visit between a recipient and a Medicaid-certified provider to perform a Medicaid-covered RHC service. To be included as an encounter on the cost report, claims for the service provided must have been submitted and paid.

Visits with more than one health professional, or multiple visits with the same health professional on the same day at one location for a single diagnosis or treatment regimen comprise a single encounter. If, after the initial encounter, the recipient suffers an illness or injury requiring additional diagnosis or

treatment, the visit is recorded as a separate, additional encounter.

### Encounter Criteria

The following criteria may define an allowable encounter:

- The service may be provided at the RHC or at any location where health center activities occur. Examples include mobile vans and private residences.
- The service provided must be a Medicaid-covered RHC service.

The encounter criteria are not met in the following circumstances:

- A provider participates in a community meeting or group session that is not designed to provide health services.
- The only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.
- A provider consults with a recipient over the phone.
- A service is provided to a recipient who is a hospital inpatient or an emergency room patient.
- Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, or filling/dispensing prescriptions are not considered encounters.

Encounters are based on claims submitted and paid. Given that clinics have 365 days from the date of service (DOS) to submit a claim (including all corrected claims and adjustments to claims), the Wisconsin Medicaid RHC audit will generally take place after 365 days from the end of the clinic's fiscal year. Since clinics submit their Medicaid annual cost report before the 365 days have passed, there may be an adjustment to the number of encounters at the time of audit compared to the number submitted in the cost report.



## Cost Settlement Documentation

### Accounting Method

Rural health clinics are required to:

- Maintain cost data on the accrual basis of accounting (i.e., revenue and expenses are identified with specific periods of time to which they apply regardless of when revenue is received or an expense is paid).
- Use generally accepted accounting principles.

### Settlement Reclassifications

Rural health clinics that maintain their records on a cash basis of accounting need to adjust items from the cash basis to accrual basis for the cost report. (Rural health clinics using the cash basis of accounting record revenues and expenses when they are received and when they are paid, without regard to the period to which they apply.) These adjustments do not need to be recorded in the formal accounting records, but may be made in supplementary records. Adjustments are necessary, for example, if the RHC:

- Pays expenses applicable to future periods.
- Incurs expenses in one reporting period that are not paid until the next period.
- Purchases supplies to be used in subsequent periods.
- Records expenses for capital asset expenditures rather than the allowable depreciation on such assets.

### Financial Record Keeping

Wisconsin Medicaid requires RHCs to maintain medical and financial records and documentation in accordance with HFS 106.02(9), Wis. Admin. Code. These regulations require the RHC to:

- Maintain adequate cost data based on financial and statistical records that can be verified by qualified auditors.

- Develop cost information that is current, accurate, and in sufficient detail to support payments made for services rendered to Medicaid recipients. This includes all ledgers, records, and original evidences of cost (e.g., purchase requisitions, purchase orders, vouchers, payroll vouchers), which pertain to the determination of reasonable cost.
- Maintain financial and statistical records in a consistent manner from one period to another.

### Record Retention

Wisconsin Medicaid requires all providers (including RHCs and Medicaid HMOs) to maintain records that fully document the basis of charges upon which all claims for reimbursement are made, in accordance with HFS 106.02(9), Wis. Admin. Code. Wisconsin Medicaid requires RHCs to retain records for a minimum of *six* years from the date of reimbursement. (*Note:* Wisconsin Medicaid requires most providers to retain records for a minimum of *five* years from the date of reimbursement.) Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional information on records retention requirements.

## Audits

An RHC shall permit access to medical or financial records by Wisconsin Medicaid for the purposes of inspection, review, audit, or reproduction in accordance with HFS 106.02(9)(e)(4), Wis. Admin. Code.

### Medicare Audit

The Medicare intermediary may perform audits of the RHC. Medicare audit results may affect the results of the RHC's Medicaid annual settlement. Wisconsin Medicaid may reopen the settlement and determine an additional cash payout to the RHC or recoupment to Wisconsin Medicaid.

## Annual Settlement Adjustments

An RHC has 60 days to request an adjustment after receiving notification of its settlement or recoupment amount from Medicaid. The adjustment request may include additional expenses and/or allowable encounters. To be included in an adjustment, an encounter must have been submitted to and paid by Wisconsin Medicaid within 365 days of the DOS, as required by state law, and the DOS (not the paid date) of the encounter must fall within the clinic fiscal year for which the settlement report was submitted.

If the RHC does not ask for an adjustment within 60 days of notification of the original settlement payment or recoupment, Wisconsin Medicaid considers the settlement final. An RHC should verify that all expenses and encounters have been included in the settlement before the 60-day deadline. Wisconsin Medicaid may adjust the settlement based on Medicare's final audit of an RHC.

Rural health clinics are responsible for verifying that all expenses and encounters are included in the cost report. A settlement cannot be reopened once it has been finalized (i.e., after the 60-day adjustment request period), except in cases where an audit requires Wisconsin Medicaid to revise the settlement.

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## Appendix 1

### Instructions for Submitting Claims and Reporting for Obstetric Care Services

Rural health clinic (RHC) providers may choose to submit claims for obstetric (OB) services using either the separate OB component procedure codes as they are performed or the appropriate global OB procedure code with the date of delivery as the date of service (DOS).

*Note:* Only antepartum and postpartum care services are considered RHC services (i.e., they can be included on the annual and quarterly Medicaid RHC cost reports).

Deliveries, while they may be covered by Medicaid, are not RHC services, and, therefore, they cannot be included on the cost report.

Wisconsin Medicaid will not reimburse individual antepartum care or postpartum care codes if a provider also submits a claim for global OB care codes for the same recipient during the same pregnancy or delivery.

### Separate Obstetric Care Components

Providers should use the following guidelines when submitting claims for separate OB components and reporting them on the Medicaid RHC cost report.

#### Antepartum Care

Providers should refer to the table that follows as a guide for submitting claims for a specific number of antepartum care visits. Providers should provide all antepartum care visits before submitting a claim to Wisconsin Medicaid.

Providers should use local procedure codes W6000 — “antepartum care; initial visit” — and W6001 — “antepartum care; two or three visits” — when submitting claims for the first through third antepartum care visits with a provider or provider group. For example, if a total of two to three antepartum care visits is performed, the provider should indicate procedure code W6000 and a quantity of “1.0” for the first DOS. For the second and third visits, the provider should indicate procedure code W6001 and a quantity of “1.0” or “2.0,” as indicated in the table to the right. The date of the last antepartum care visit is the DOS.

*Note:* Do not use evaluation and management procedure codes when submitting claims for the first three antepartum

care visits. Use of these codes may result in improper reimbursement.

Similarly, for *Current Procedural Terminology* (CPT) codes 59425 — “antepartum care only; 4-6 visits” — and 59426 — “antepartum care only; 7 or more visits” — the provider should indicate the date of the last antepartum care visit as the DOS. The quantity indicated for these two codes may not exceed “1.0.”

Occasionally, a provider may be unsure of whether a recipient has had previous antepartum care visits with another provider. If the recipient is unable to provide this information, the provider should assume the first time he or she sees the recipient is the first antepartum visit.

*Note:* Reimbursement for procedure codes W6000, W6001, 59425, and 59426 is limited to once per pregnancy, per recipient, per billing provider. A telephone call between patients and providers does not qualify as an antepartum visit.

Antepartum Care Claims Submission Guide			
Total Visit(s)	Procedure Code*	Description	Quantity
1	W6000	Antepartum care; initial visit	1.0
2	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	1.0
3	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	2.0
4-6	59425	Antepartum care only; 4-6 visits	1.0
7+	59426	7 or more visits	1.0
*Claims for these codes should be submitted with the following types of service (TOS): <ul style="list-style-type: none"> <li>Physicians, physician assistants, and nurse practitioners use TOS “2.”</li> <li>Assistant surgeons during delivery use TOS “8.”</li> <li>Nurse midwives use TOS “9.”</li> </ul>			

## Appendix 1 (Continued)

### Postpartum Care

Postpartum care includes all routine management and care of the postpartum patient including exploration of the uterus, episiotomy and repair, repair of obstetrical lacerations and placement of hemostatic packs or agents. These are part of both the post-delivery and post-hospital office visits, both of which must occur in order to receive reimbursement for postpartum care or global obstetric care.

Wisconsin Medicaid reimbursement for postpartum care includes hospital *and* office visits following vaginal or cesarean delivery. In accordance with the standards of the American College of Obstetricians and Gynecologists, postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit. Post-delivery hospital care alone is included in the reimbursement for delivery. When submitting claims for postpartum care, the DOS is the date of the post-hospital discharge office visit. To receive reimbursement, the recipient *must* be seen in the office. The length of time between a delivery and the office postpartum visit should be dictated by good medical practice. Wisconsin Medicaid does not dictate an “appropriate” period for postpartum care; however, the industry standard is six to eight weeks following delivery. A telephone call between patients and providers does *not* qualify as a postpartum visit.

### Reporting Antepartum Care and Postpartum Care Encounters on the Cost Report

To report encounters when claims for antepartum care and postpartum care only procedure codes have been submitted, include:

- The actual number of encounters.
- 100% of fee-for-service payments received.

### Global Obstetric Care

Providers may submit claims using global OB codes. However, the delivery component (although covered by Medicaid) is not an allowable RHC service.

Providers choosing to submit claims for global OB care must perform all of the following:

- A minimum of six antepartum visits.
- Vaginal or cesarean delivery.
- The post-delivery hospital visit and a minimum of one postpartum office visit.

When submitting claims for total OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service. Use the date of delivery as the DOS.

All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global OB care. If fewer than six antepartum visits have been performed, the provider performing the delivery may submit a claim using the appropriate delivery procedure code and, as appropriate, antepartum and postpartum visit procedure codes.

If the required postpartum office visit does not occur following claims submission for the global delivery, the provider must adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the patient’s medical record. (Refer to the section on postpartum care.)

### Group Claims Submission for Global Obstetric Care

When several OB providers in the same clinic or medical/surgical group practice perform the delivery and provide antepartum and postpartum care to the same recipient during the period of pregnancy, the clinic may choose to submit a claim using a single procedure code for the service. When submitting the claims, providers should indicate the group Medicaid billing number and identify the primary OB provider as the performing provider.

## Appendix 1 (Continued)

### Reporting Global Obstetric Care Encounters on the Cost Report

To report encounters in the cost report when claims for OB services have been submitted using global OB codes, providers should use the following guidelines.

Report the actual number of antepartum and postpartum visits as encounters. Report the difference between the global OB procedure code reimbursement and the maximum fee for delivery as the amount reimbursed by Wisconsin Medicaid for the antepartum and postpartum

care encounters. Refer to the “Global OB Care CPT codes and their Corresponding Delivery CPT Codes” chart below to determine which delivery code to use with the global OB codes.

When reporting encounters associated with a global OB code, use the date of delivery as the DOS.

For a maximum fee schedule, refer to Wisconsin Medicaid’s Web site at [www.dhfs.state.wi/medicaid/](http://www.dhfs.state.wi/medicaid/).

<b>Global Obstetric (OB) Care <i>Current Procedural Terminology</i> (CPT) Codes and their Corresponding Delivery CPT Codes</b>			
<b>Global OB CPT Codes</b>		<b>Corresponding Delivery CPT Codes</b>	
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	59514	Cesarean delivery only
59610	Route obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps)
59618	Routine obstetric care, following attempted vaginal delivery after previous cesarean delivery	59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

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Appendix 2  
Rural Health Clinic Statistical Data Instructions (for photocopying)

(A copy of the Rural Health Clinic Statistical Data Instructions is located on the following page.)

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**WISCONSIN MEDICAID  
RURAL HEALTH CLINIC STATISTICAL DATA INSTRUCTIONS**

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

**INSTRUCTIONS:** The Rural Health Clinic Statistical Data form is to be completed by provider-based and independent rural health clinics (RHCs) and submitted to Wisconsin Medicaid along with the following forms, which constitute the annual cost report:

- Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments form (for provider-based RHCs *only*).
- Rural Health Clinic Settlement Determination form (for provider-based and independent RHCs).
- Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form (for provider-based and independent RHCs).
- Rural Health Clinic Medicaid Encounters Submitted to Medicaid HMOs form (for provider-based and independent RHCs).

**1. Reporting Period.**

Enter the inclusive dates covered by this report.

**2. Rural Health Clinic Information**

Clinic Name, Address, and Medicaid Provider Number(s) — List the full name, address, the RHC Medicaid billing provider number, and any non-RHC Medicaid billing provider numbers.

**3. Contact(s):**

- a) List the name, title, telephone number, and fax number of the individual who should receive notices of adjustments, settlements, and other correspondence.
- b) Preparer of Report: List the name, title, telephone number, and fax number of an individual to be contacted if more information or clarification of the report is required.

**4. Medicaid-Certified Providers Employed or Contracted by the Clinic**

List the name, specialty, and Medicaid performing provider number of all providers employed by or contracted with the clinic during this reporting period. Include information for all Medicaid-certified providers. Add more sheets if needed.

**5. Certification by Officer or Administrator of the Clinic**

After the annual Medicaid RHC cost report has been completed in its entirety, it must be certified by the authorized individual who signs the Medicare RHC cost report.

**Appendix 3**  
**Rural Health Clinic Statistical Data (for photocopying)**

(A copy of the Rural Health Clinic Statistical Data is located on the following pages.)

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**WISCONSIN MEDICAID  
RURAL HEALTH CLINIC STATISTICAL DATA**

<b>1. REPORTING PERIOD</b>	Date from	Date to
----------------------------	-----------	---------

**2. RURAL HEALTH CLINIC INFORMATION**

Name — Rural Health Clinic (RHC)	RHC Medicaid Provider Number	Non-RHC Medicaid Provider Number(s)		
Address (Street / P.O. Box)	City	State	Zip Code	

**3. CONTACT(S)**

Individual who should receive notices of adjustments, settlements, and other correspondence

Name	Title	Telephone Number	Fax Number
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Individual who can be contacted if information is required concerning details of this cost report

Name	Title	Telephone Number	Fax Number
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**4. MEDICAID-CERTIFIED PROVIDERS EMPLOYED OR CONTRACTED BY THE CLINIC**

List the name, provider specialty, and Medicaid performing provider number of all providers employed or contracted by the clinic during this reporting period. Include information for all Medicaid-certified providers.

Note: Any new enrollments or changes (terminations or corrections) should be made by contacting Wisconsin Medicaid at the following address:

Wisconsin Medicaid  
Provider Maintenance  
6406 Bridge Rd  
Madison WI 53784-0006

Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number
Name — Provider	Specialty	Individual Medicaid Provider Number

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**5. CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC**

I hereby certify that I have examined this cost report and accompanying forms for the period noted. To the best of my knowledge and belief it is a true, correct, and complete statement prepared from the books and records of the RHC, in accordance with applicable instructions, except as noted.

<b>SIGNATURE</b> — Officer or Administrator of Clinic	Date Signed
---	-------------

**Appendix 4**  
**Rural Health Clinic Trial Balance of Expenses, Reclassifications, and**  
**Adjustments Instructions (for photocopying)**

(A copy of the Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments Instructions is located on the following pages.)

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## WISCONSIN MEDICAID RURAL HEALTH CLINIC TRIAL BALANCE OF EXPENSES, RECLASSIFICATIONS, AND ADJUSTMENTS INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

**INSTRUCTIONS:** The Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments form is **to be completed by provider-based rural health clinics (RHCs) only** and submitted to Wisconsin Medicaid along with the following forms, which constitute the annual cost report:

- Rural Health Clinic Statistical Data form (for provider-based and independent RHCs).
- Rural Health Clinic Settlement Determination form (for provider-based and independent RHCs).
- Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form (for provider-based and independent RHCs).
- Rural Health Clinic Medicaid Encounters Submitted to Medicaid HMOs form (for provider-based and independent RHCs).

Use this form to record the trial balance expense accounts from the RHC's accounting books and any necessary reclassification and adjustments to these accounts. All reporting must be made on an accrual basis. For end-of-year cost reports, use the RHC's actual trial balance.

### Cost Centers

Rural health clinic cost centers are divided into the following groups:

- Facility health care staff costs: On Lines 1-11, record the costs of employing staff to provide services to eligible Medicaid recipients. Not all of the listed cost centers will apply to each RHC. If the form does not provide sufficient space, enter aggregate amounts under "Other" (Lines 10 and 11), where appropriate, and provide a supporting schedule to list items included in the aggregate amounts.
- Other health care costs: On Lines 13-20, record the costs of medical services that are "incidental to" physician, physician assistant, nurse practitioner and nurse midwife providers.
- Costs other than RHC services: On Lines 41-47, record costs for providing Medicaid-covered services that are non-RHC services.
- Nonreimbursable costs: List any costs that are not covered by Medicaid.

Round all figures to the nearest whole dollar.

### Columns 1 through 3: Compensation/Other

The expenses in these columns must be listed in accordance with the RHC's accounting books and records.

Enter on the appropriate lines in Columns 1 and 2 the total expenses incurred for the period of the report. Detail the expenses between Compensation (Column 1) and Other (Column 2). Column 3 equals the sum of Columns 1 and 2.

To the extent possible, amounts listed on the Trial Balance of Expenses, Reclassifications, and Adjustments form, Columns 1 and 2, and/or the total in Column 3, should agree with the RHC's audited trial balance. If the RHC's trial balance is in a format that does not conform with the Trial Balance of Expenses, Reclassifications, and Adjustments form's format, prepare a separate bridging worksheet that shows how the amounts reported on Trial Balance of Expenses, Reclassifications, and Adjustments form, Columns 1 and 2, were determined. Retain the bridging worksheet, as Wisconsin Medicaid may request to review it.

### Column 4: Reclassifications

Use this column to reclassify expenses within the cost centers for proper grouping of expenses. Reclassifications are used in instances where the expenses applicable to more than one of the cost centers listed on the form are maintained in the RHC's accounting books and records in one cost center.

For example, if a physician performs some administrative duties, the appropriate portion of his or her compensation and applicable payroll taxes and fringe benefits, would need to be reclassified from "Facility health care staff costs" to "Other health care costs — administrative salaries."

Rural health clinics must provide a worksheet explaining the reclassifications with the completed cost report.

Show reductions to expenses in brackets. The net total of the entries in Column 4 must equal zero.

### Column 5: Reclassified Trial Balance

Column 5 is the net balance of Columns 3 and 4. The total of Column 5 on Line 53 must equal the total of Column 3 on Line 53.

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**Appendix 5**  
**Rural Health Clinic Trial Balance of Expenses, Reclassifications, and**  
**Adjustments (for photocopying)**

(A copy of the Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments is located on the following pages.)

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**WISCONSIN MEDICAID**  
**RURAL HEALTH CLINIC TRIAL BALANCE OF EXPENSES, RECLASSIFICATIONS, AND ADJUSTMENTS**

(Provider-Based RHCs **only** must complete this worksheet. **Independent RHCs:** Do *not* complete this worksheet.)

Cost Center	Per Trial Balance		(Total of Columns 1 and 2)	Reclassifications	Reclassified Trial Balance (Total of Columns 3 and 4)	Adjustments Increases (Decreases)	Net Expenses
	Compensation	Other					
	1	2	3	4	5	6	7
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1. Physician							
2. Physician assistant							
3. Nurse practitioner / nurse midwife							
4. Home health licensed practical nurse							
5. Home health registered nurse							
6. Outpatient mental health / substance abuse services provider (Ph.D. level)							
7. Outpatient mental health / substance abuse services provider (Master's level)							
8. Laboratory Technician (for dates of service before January 1, 2001)							
9. Clerical							
10. Other (specify)							
11. Other (specify)							
12. SUBTOTAL — Facility health care staff costs (Sum of Lines 1 to 11.)							
<b>OTHER HEALTH CARE COSTS</b>							
13. Medical supplies							
14. Transportation (health care staff)							
15. Depreciation — medical equipment							
16. Professional liability insurance							
17. Medical equipment rental							
18. Medical equipment repairs and maintenance							
19. Other (specify)							
20. Other (specify)							
21. SUBTOTAL — Other health care costs (Sum of Lines 13-20)							
22. TOTAL — Sum of facility health care staff costs and other health care costs. (Sum of Lines 12 and 21.)							

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(Provider-Based RHCs *only* must complete this worksheet. Independent RHCs: Do *not* complete this worksheet.)

Cost Center	Per Trial Balance		(Total of Column 1 and 2)	Reclassifications	Reclassified Trial Balance (Total of Columns 3 and 4)	Adjustments Increases (Decreases)	Net Expenses
	Compensation	Other					
	1	2	3	4	5	6	7
<b>OVERHEAD</b>							
23. Rent							
24. Insurance							
25. Interest on mortgage or loans							
26. Utilities							
27. Depreciation (non-medical)							
28. Housekeeping and maintenance							
29. Property tax							
30. Dietary							
31. Laundry							
32. Administrative salaries							
33. Office supplies							
34. Legal							
35. Accounting							
36. Telephone							
37. Non-medical equipment rental							
38. Other (specify)							
39. Other (specify)							
40. TOTAL — Facility overhead (sum of Lines 23 to 39)							
<b>COSTS OTHER THAN RHC SERVICES</b>							
41. Pharmacy							
42. Dental							
43. Radiology							
44. Laboratory (for dates of service from January 1, 2001)							
45. Other (specify)							
46. Other (specify)							
47. TOTAL — Costs other than RHC services (sum of Lines 41 to 47)							
<b>NON-REIMBURSABLE COSTS</b>							
48. (Specify)							
49. (Specify)							
50. (Specify)							
51. TOTAL — Nonreimbursable costs (sum of Lines 48-50.)							
52. TOTAL COST (sum of Lines 22, 40, and 51.)							

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**Appendix 6**  
**Rural Health Clinic Settlement Determination Instructions**  
**(for photocopying)**

(A copy of the Rural Health Clinic Settlement Determination Instructions is located on the following page.)

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**WISCONSIN MEDICAID  
RURAL HEALTH CLINIC SETTLEMENT DETERMINATION INSTRUCTIONS**

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

**INSTRUCTIONS:** The Rural Health Clinic Settlement Determination form is to be completed by provider-based and independent rural health clinics (RHCs) and submitted to Wisconsin Medicaid along with the following forms, which constitute the annual cost report:

- Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments (for provider-based RHCs *only*).
- Rural Health Clinic Statistical Data Form (for provider-based and independent RHCs).
- Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs Form (for provider-based and independent RHCs).

This form determines the:

1. Allowable overhead and total cost of RHC services — provider-based RHCs only (Part A).
2. Medicaid rate per encounter (Part B).
3. Summary of RHC settlement (Part G).

**Part A: Total Cost of Rural Health Clinic Services**

*Only* provider-based RHCs should complete Part A. Independent RHCs, begin at Part B.

Part A determines the total costs, including applicable overhead costs, of RHC services provided within the reporting period. Part A requires information from the Trial Balance of Expenses, Reclassifications, and Adjustments form, which is completed by provider-based RHCs only.

**Part B: Medicaid Encounter Rate Determination**

Part B determines the RHC rate per encounter.

Use the following guidelines for Line 3:

- Provider-based RHCs in hospitals with fewer than 50 beds: Enter the cost-based rate per encounter from Part A, Line 11.
- Provider-based RHCs in hospitals with 50 or more beds: Enter the maximum payment rate from Part B, Line 2, for all dates of service (DOS).
- Independent RHCs: Refer to the Medicare cost report, HCFA Form 222-92, and enter the amount from Worksheet C, Part II, Line 10.

**Part C: Medicaid-Only Encounter Reimbursement**

Part C determines the net reimbursement for Medicaid-only encounters with DOS within the reporting period.

Use the following guidelines for Lines 2 and 3:

- Report encounters submitted to Wisconsin Medicaid or Medicaid HMOs separately.
- Report commercial insurance-primary/Medicaid-secondary encounters with no commercial insurance payments, even if the recipient's record indicates third-party insurance.

For Lines 6a and 6b, report Medicaid fee-for-service payments and Medicaid HMO payments separately.

**Part D: Medicare/Medicaid Crossover Encounter Reimbursement**

Part D determines the net reimbursement for Medicare/Medicaid crossover encounters with DOS within the reporting period.

On Line 2, report Medicare/Medicaid crossover encounters.

Lines 4, 5, 6, and 7a calculate the allocation of Medicare payments for encounters based on the Medicare cost report.

On Line 7b, report Medicaid fee-for-service payments received for Medicare/Medicaid crossover encounters.

**Part E: Commercial Insurance-Primary/Medicaid-Secondary Encounter Reimbursement**

Part E determines the net reimbursement for commercial insurance-primary/Medicaid-secondary encounters with DOS within the reporting period.

Refer to the RHC Provider Summary Report (PSR) and complete the Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form to prepare encounter data for Part E.

On Lines 1 and 2, report commercial insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid and to Medicaid HMOs separately.

On Lines 3 and 4, the allowable cost is the lesser of the charge or encounter rate for each individual encounter. On Line 3, refer to the PSR for the total allowable costs for commercial insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid.

On Line 4, insert the sum of the total of Column 9 for the Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form.

On Line 6a, report commercial insurance payments from commercial insurers. Refer to the PSR for the total of commercial payments received for insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid. Add this amount to the total of Column 10 from the Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form.

On Lines 6b and 6c, include Medicaid payments received for encounters with dates of service within the reporting period. Refer to the PSR for the sum of Medicaid payments received for commercial insurance-primary/Medicaid-secondary encounters submitted to Wisconsin Medicaid, and add this amount to the total of Column 11 of the Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form.

**Part F: Commercial Insurance-Primary/Medicare/Medicaid Encounter Reimbursement**

Part F determines the net reimbursement for commercial insurance-primary/Medicare/Medicaid encounters with dates of service within the reporting period.

Refer to the PSR to prepare encounter data for Part F.

On Line 1, enter the total number of commercial insurance-primary/Medicare/Medicaid encounters submitted to Wisconsin Medicaid.

On Line 2, the allowable cost is the lesser of the charge or encounter rate for each individual encounter. Refer to the PSR for the total allowable costs for commercial insurance-primary/Medicare/Medicaid encounters submitted to Wisconsin Medicaid.

On Line 4a, report commercial insurance payments from commercial insurers. Refer to the PSR for this information.

For Line 4b, report Medicaid fee-for-service payments received for commercial insurance-primary/Medicare/Medicaid encounters. Refer to the PSR for this information.

Line 4c calculates the allocation of Medicare payments for encounters within the reporting period based on the Medicare cost report.

**Part G: Summary Rural Health Clinic Settlement**

Part G represents the balance due to (or from) the provider for the reporting period.

Lines 1 through 4 represent net reimbursement by encounter type.

On Line 5a, enter the total sum of quarterly payments received from Wisconsin Medicaid.

On Line 5b, enter the total amount due to the provider in copayments from Medicaid recipients. This amount may be different from the amount actually received by the provider if all copayments have not been paid.

Line 6 represents the year-end settlement amount and indicates the balance due to (or from) the provider.

**Appendix 7**  
**Rural Health Clinic Settlement Determination (for photocopying)**

(A copy of the Rural Health Clinic Settlement Determination is located on the following pages.)

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WISCONSIN MEDICAID

RURAL HEALTH CLINIC SETTLEMENT DETERMINATION

**PART A — TOTAL COST OF RURAL HEALTH CLINIC SERVICES**

This part is to be completed by Provider-Based RHCs only. **Independent RHCs: Begin at Part B.**

1. Cost of covered services excluding overhead (insert amount from Trial Balance of Expenses Worksheet, Column 7, Line 22)	
2. Costs other than RHC services (insert amount from Trial Balance of Expenses Worksheet, Column 7, Line 47)	
3. Nonreimbursable RHC costs excluding overhead (insert amount from Trial Balance of Expenses Worksheet, Column 7, Line 52)	
4. Costs of all services excluding overhead (Sum of Lines 1, 2, and 3)	
5. Ratio of costs other than RHC services and nonreimbursable RHC costs to costs of all services excluding overhead (sum of Line 2 and Line 3, divided by Line 4)	
6. Total overhead (insert amount from Trial Balance of Expenses Worksheet, Column 7, Line 40)	
7. Overhead applicable to services other than RHC services (Line 5 multiplied by Line 6)	
8. Overhead applicable to RHC services (Line 6 less Line 7)	
9. Total cost of RHC services (Sum of Line 1 and Line 8)	
10. Total RHC encounters (refer to clinic records)	
11. RHC rate per encounter (Line 9 divided by Line 10)	

**PART B — MEDICAID ENCOUNTER RATE DETERMINATION (Independent RHCs: Begin here)**

	Prior to Jan 1	On or after Jan 1	Total
1. Reporting period			
2. Federal maximum payment rate per encounter (refer to the Centers for Medicare and Medicaid (CMS), formerly HCFA, regulations for current maximum rate) (Provider-Based RHCs <i>only</i> Independent RHCs, move to Line 3)			
3. Medicaid encounter rate for period Provider-Based RHCs in hospitals with fewer than 50 beds: insert amount from Part A, Line 11 Provider-Based RHCs in hospitals with 50 or more beds: insert amount from Line 2 (federal maximum payment rate per encounter) Independent RHCs: insert amount from Medicare cost report, HCFA Form 222-92, Worksheet C, Part II, Line 10			
4. Health Personnel Shortage Area (HPSA) bonus percentage			
5. HPSA bonus per encounter (Line 3 multiplied by Line 4)			
6. Portion of reporting period to which rate applies, e.g., prior to Jan 1 = 75%, on or after Jan 1 = 25%			
7. Encounter rate multiplied by portion of reporting period to which rate applies (sum of Lines 3 and 5 multiplied by Line 6)			
8. Medicaid rate per encounter (sum of Line 7, Columns 1 and 2)			

**PART C — MEDICAID-ONLY ENCOUNTER REIMBURSEMENT**

1. Medicaid rate per encounter (insert amount from Part B, Line 8, above)	
2. Medicaid encounters submitted to Wisconsin Medicaid (refer to clinic records)	
3. Medicaid encounters submitted to Medicaid HMOs (refer to clinic records)	
4. Total Medicaid-only encounters (sum of Lines 2 and 3)	
5. Maximum reimbursement for Medicaid-only encounters (Line 1 multiplied by Line 4)	
6. Less:	
a) Fee-for-service payments received from Wisconsin Medicaid for Medicaid-only encounters (refer to clinic records)	
b) Payments received from Medicaid HMOs for Medicaid-only encounters (refer to clinic records)	
7. Net reimbursement for Medicaid-only encounters (Line 5, less Lines 6a and 6b)	

**PART D — MEDICARE / MEDICAID CROSSOVER ENCOUNTER REIMBURSEMENT**

1.	Medicaid rate per encounter. (insert amount from Part B, Line 8, above)	
2.	Total Medicare / Medicaid crossover encounters submitted to Wisconsin Medicaid	
3.	Maximum reimbursement for Medicare / Medicaid crossover encounters (Line 1 multiplied by Line 2)	
4.	Total Medicare encounters (Provider-based RHCs: insert amount from Medicare cost report, HCFA Form 2552-96, Worksheet M-3, Line 10; Independent RHCs: insert amount from Medicare cost report HCFA Form 222-92, Worksheet C, Part I, Line 11)	
5.	Ratio of Medicare / Medicaid encounters to Medicare encounters (Line 2 divided by Line 4)	
6.	Medicare payments (Provider-based RHCs: insert amount from Medicare cost report, HCFA Form 2552-96, Worksheet M-3, Line 19; Independent RHCs: insert amount from Medicare cost report, HCFA Form 222-92, Worksheet C, Part II, Line 19)	
7. Less:	a) Total Medicare payments for Medicare / Medicaid crossover encounters (Line 5 multiplied by Line 6)	
	b) Total fee-for-service payments by Wisconsin Medicaid for Medicare / Medicaid crossover encounters	
8.	Net reimbursement for Medicare / Medicaid crossover encounters (Line 3, less Lines 7a and 7b)	

**PART E — COMMERCIAL INSURANCE-PRIMARY / MEDICAID-SECONDARY ENCOUNTER REIMBURSEMENT**

1.	Commercial-insurance-primary / Medicaid-secondary encounters submitted to Wisconsin Medicaid (refer to Provider Summary Report (PSR))	
2.	Commercial-insurance-primary / Medicaid-secondary encounters submitted to Medicaid HMOs (total of encounters from Insurance-Primary / Medicaid-Secondary Encounters Submitted to Medicaid HMOs Worksheet)	
3.	Allowable costs for all encounters reported on Line 1 (refer to PSR)	
4.	Allowable costs for all encounters reported on Line 2 (insert figure from Insurance-Primary / Medicaid-Secondary Encounters Submitted to Medicaid HMOs Worksheet, total of Column 9)	
5.	Total allowable costs (sum of Lines 3 and 4)	
6. Less:	a) Commercial insurance payments (refer to PSR for total of insurance-primary / Medicaid-secondary encounters submitted to Wisconsin Medicaid, and add this amount to the total of Column 10 and from Insurance-Primary / Medicaid-Secondary Encounters Submitted to Medicaid HMOs Worksheet, total of Column 10)	
	b) Fee-for-service payments by Wisconsin Medicaid for commercial insurance-primary / Medicaid-secondary encounters (refer to PSR)	
	c) Payments by Medicaid HMOs for commercial insurance-primary / Medicaid-secondary encounters (insert amount from Insurance-Primary / Medicaid-Secondary Encounters Submitted to Medicaid HMOs Worksheet, total of Column 11)	
7.	Net reimbursement for commercial insurance-primary / Medicaid-secondary encounters (Line 5, less Lines 6a through 6c)	

**PART F — COMMERCIAL INSURANCE-PRIMARY / MEDICARE / MEDICAID ENCOUNTER REIMBURSEMENT**

1.	Total commercial insurance-primary / Medicare / Medicaid encounters submitted to Wisconsin Medicaid (refer to PSR for total commercial insurance-primary / Medicare / Medicaid encounters)	
2.	Total allowable costs for encounters reported on Line 1 (refer to PSR)	
3.	Ratio of commercial insurance-primary / Medicare / Medicaid encounters to Medicare encounters (Line 1 divided by Part D, Line 4))	
4. Less:	a) Commercial insurance payments	
	b) Fee-for-service payments by Wisconsin Medicaid for commercial insurance-primary / Medicare / Medicaid encounters (refer to PSR)	
	c) Total Medicare payments for commercial insurance-primary / Medicare / Medicaid encounters (Line 3 multiplied Part D, Line 6)	
5.	Net reimbursement for commercial insurance-primary / Medicare / Medicaid encounters (Line 2, less Lines 4a through 4c)	

**PART G — SUMMARY RURAL HEALTH SETTLEMENT**

1.	Amount entered on Part C, Line 7	
2.	Amount entered on Part D, Line 8	
3.	Amount entered on Part E, Line 7	
4.	Amount entered on Part F, Line 5	
5.	Less:	
	a) Total quarterly payments from Wisconsin Medicaid	
	b) Total copayments due from Medicaid recipients	
6.	Balance due to (or from) Provider (sum of Lines 1 through 4, less Lines 5a and 5b)	

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**Appendix 8**  
**Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs Instructions (for photocopying)**

(A copy of the Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs Instructions is located on the following page.)

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**WISCONSIN MEDICAID**  
**RURAL HEALTH CLINIC COMMERCIAL INSURANCE-PRIMARY/MEDICAID-SECONDARY**  
**ENCOUNTERS SUBMITTED TO MEDICAID HMOs INSTRUCTIONS**

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

**INSTRUCTIONS:** The Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs form is to be completed by provider-based and independent rural health clinics (RHCs) and submitted to Wisconsin Medicaid along with the following forms, which constitute the annual cost report:

- Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments form (for provider-based RHCs *only*).
- Rural Health Clinic Statistical Data form (for provider-based and independent RHCs).
- Rural Health Clinic Settlement Determination form (for provider-based and independent RHCs).
- Rural Health Clinic Medicaid Encounters Submitted to Medicaid HMOs form (for provider-based and independent RHCs).

This form calculates the reimbursement for commercial insurance-primary/Medicaid-secondary encounters submitted to Medicaid HMOs.

**Guidelines**

Use the following guidelines for reporting encounters on the form for commercial health insurance encounters:

Include encounters where commercial health insurance has paid less than the Medicaid encounter rate and less than the charge.

Exclude encounters where commercial insurance has:

- √ Paid an amount greater than the Medicaid encounter rate.\*
- √ Paid the full amount of the charge.\*

\*It is not necessary to submit a claim to Wisconsin Medicaid or to a Medicaid HMO.

Exclude encounters where commercial insurance has not paid any amount for the service, even when the recipient has commercial insurance-primary/Medicaid-secondary coverage. Report these encounters as Medicaid-only encounters on Part C of the Settlement Determination form.

**Appendix 9**  
**Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs (for photocopying)**

(A copy of the Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs is located on the following page.)

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**Appendix 10**  
**Rural Health Clinic Medicaid-Primary Encounters Submitted to Medicaid  
HMOs Instructions (for photocopying)**

(A copy of the Rural Health Clinic Medicaid-Primary Encounters Submitted to  
Medicaid HMOs instructions is located on the following page.)

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**WISCONSIN MEDICAID  
RURAL HEALTH CLINIC MEDICAID-PRIMARY ENCOUNTERS SUBMITTED TO WISCONSIN  
MEDICAID HMOs INSTRUCTIONS**

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

**INSTRUCTIONS:** The Rural Health Clinic Medicaid Encounters Submitted to Medicaid HMOs form is to be completed by provider-based and independent rural health clinics (RHCs) and submitted to Wisconsin Medicaid along with the following forms, which constitute the annual cost report:

- Rural Health Clinic Trial Balance of Expenses, Reclassifications, and Adjustments form (for provider-based RHCs *only*).
- Rural Health Clinic Statistical Data form (for provider-based and independent RHCs).
- Rural Health Clinic Settlement Determination form (for provider-based and independent RHCs).
- Rural Health Clinic Commercial Insurance-Primary/Medicaid-Secondary Encounters Submitted to Medicaid HMOs.

This form calculates the reimbursement for Medicaid encounters submitted to Medicaid HMOs.

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**Appendix 11**  
**Rural Health Clinic Medicaid-Primary Encounters Submitted to Medicaid  
HMOs (for photocopying)**

(A copy of the Rural Health Clinic Medicaid-Primary Encounters Submitted to Medicaid HMOs is located on the following page.)

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Appendix 12  
Rural Health Clinic Quarterly Cost Report Instructions (for photocopying)

(A copy of the Rural Health Clinic Quarterly Cost Report Instructions is located on the following page.)

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**WISCONSIN MEDICAID  
RURAL HEALTH CLINIC QUARTERLY COST REPORT INSTRUCTIONS**

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary, but providers must collect and maintain all information on the form in some format if they wish to submit a cost report.

**INSTRUCTIONS:** The Rural Health Clinic Quarterly Cost Report form may be completed by provider-based and independent rural health clinics (RHCs) and submitted to Wisconsin Medicaid.

**Quarterly Cost Report Completion and Deadlines**

Rural health clinics (RHCs) are responsible for accurate completion and submission of the quarterly RHC cost reports. To receive a quarterly reconciliation payment, submit a quarterly cost report to:

Rural Health Clinic Auditor  
Bureau of Health Care Program Integrity  
Division of Health Care Financing  
PO Box 309  
Madison WI 53701-0309

For all lines, report encounters with dates of service within the reporting period only.

**1. Reporting Period**

Enter the quarterly reporting period dates.

**2. Rural Health Clinic Information**

List the full name of the clinic, the clinic's address, the RHC billing provider number, and any non-RHC Medicaid billing provider numbers held by the clinic or its providers.

**3. Contacts**

- a) List the name, title, telephone number, and fax number of the individual who should receive notices of adjustments, settlements, and other correspondence.
- b) Preparer of Report: List the name, title, telephone number, and fax number of an individual to be contacted if more information or clarification of the report is required.

**4. Quarterly Settlement Determination**

Line 1: Report the encounter rate used on the most recently audited cost report submitted to Wisconsin Medicaid. (*Note:* Quarterly cost reports can only be submitted after a clinic has operated as an RHC continuously for 12 months.)

Line 2: Report Medicaid encounters submitted to Wisconsin Medicaid or Medicaid HMOs for which payments have been received.

Lines 4a and 4b: Report Medicaid fee-for-service and Medicaid HMO payments received separately.

Line 4c: Report Medicare payments received for Medicare/Medicaid encounters.

Line 4d: Report commercial insurance payments.

Line 4e: Report total copayments due to the provider from Medicaid recipients. This amount may be different from the amount actually received by the provider if all copayments have not been paid.

Line 5: Represents the quarterly payment due to the provider.

**5. Certification by Officer or Administrator of Clinic**

Enter the name, telephone number, and signature of the individual who prepared this report and who can be contacted if more information or clarification is required.

The authorized individual who signs the annual Medicaid RHC cost reports must sign this cost report.

**Appendix 13**  
**Rural Health Clinic Quarterly Cost Report (for photocopying)**

(A copy of the Rural Health Clinic Quarterly Cost Report is located on the following page.)

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**WISCONSIN MEDICAID  
 RURAL HEALTH CLINIC QUARTERLY COST REPORT**

<b>REPORTING PERIOD</b>	Date from	Date to
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**RURAL HEALTH CLINIC INFORMATION**

Name — Rural Health Clinic (RHC)	RHC Group Billing Number	Phone Number	Fax Number
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**QUARTERLY SETTLEMENT DETERMINATION**

1. Medicaid rate per encounter (apply the rate used on the most recently audited cost report submitted to Wisconsin Medicaid).	
2. Number of Medicaid encounters submitted to Wisconsin Medicaid or Medicaid HMOs for which payment was received. [Refer to clinic records.]	
3. Maximum reimbursement for Medicaid-only encounters. [Line 1 multiplied by Line 2.]	
4. Less:	
a) Fee-for-service payments by Wisconsin Medicaid.	
b) Payments by Medicaid HMOs.	
c) Medicare payments.	
d) Commercial insurance payments.	
e) Total copayments due from Medicaid recipients.	
5. Quarterly payment due to provider. [Line 3, less Lines 4a through 4e.]	

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC**

To the best of my knowledge and belief, the information on this worksheet is correct and was prepared from clinic records.

Name — Officer or Administrator of Clinic (please print)	Telephone Number
<b>SIGNATURE</b> — Officer or Administrator of Clinic	Date Signed

# Glossary of Common Terms

## Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

## Allowed claim

A Medicaid or Medicare claim that has at least one service that is reimbursable.

## BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or “crowding out” private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients’ health care is administered through the same delivery system.

## CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

## CPT

*Current Procedural Terminology.* A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and Wisconsin Medicaid.

## Crossover claim

A Medicare-allowed claim for a dual entitlee submitted to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

## DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state’s Medicaid plan. The state’s Medicaid plan is a comprehensive description of the state’s Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

## DHFS

Department of Health and Family Services. The DHFS administers Wisconsin Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

## DHHS

Department of Health and Human Services. The United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

## DOS

Date of service. The calendar date on which a specific medical service is performed.

## Dual entitlee

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

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## ECS

Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

## Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual.

## EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and notifies the Medicaid provider of the status or action taken on a claim.

## EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

## Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

## Fiscal agent

The Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services (DHFS) to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid Web site.

## HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are

developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. Formerly known as HCFA Common Procedure Coding System.

## HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

## ICD-9-CM

*International Classification of Diseases, Ninth Revision, Clinical Modification*. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

## Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a given provider type and the maximum allowable fee and relative value units (RVUs) Wisconsin Medicaid assigns to each procedure code.

## Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

## Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a service that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
  1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
  2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;

3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

**Payee**

Party to whom checks are made payable. The payee's address is used as the mailing address for checks and Remittance and Status (R/S) Reports.

**POS**

Place of service. A single-digit code which identifies the place where the service was performed.

**QMB Only**

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. These recipients are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims.

**Qualifying circumstances**

Conditions that complicate the rendering of anesthesia services, including the extraordinary condition of the patient, special operative conditions, and unusual risk factors.

**R/S Report**

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

**RVU**

Relative value unit. A number assigned by Wisconsin Medicaid to indicate the relative clinical intensity and difficulty of the surgical, diagnostic, or therapeutic procedure code for which anesthesia services were performed. Relative value units are not necessarily equivalent to either federal or American Society of Anesthesiologists RVUs. Relative value units are indicated on the Physician Maximum Allowable Fee Schedule.

**TOS**

Type of service. A single-digit code which identifies the general category of a procedure code.

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