



ADMINISTRATIVE RULES OF MONTANA



37.86.4406 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, SERVICE REQUIREMENTS

- (1) The Montana Medicaid program will cover and reimburse under the RHC or FQHC programs only those services that are RHC services or FQHC services as defined in ARM 37.86.4401 and subject to the provisions of this subchapter.
- (2) The Montana Medicaid program will not reimburse an RHC or FQHC for RHC or FQHC services that are services covered by a health maintenance organization for an enrolled member, as provided in ARM Title 37, chapter 86, subchapter 50, except as provided in ARM 37.86.4414.
- (3) RHC or FQHC services are covered by Montana Medicaid when provided in accordance with these rules to a member in an outpatient setting, including the RHC or FQHC, other medical facility (including a dental office), or a member's place of residence. A member's place of residence may be a nursing facility or other institution.
- (4) Services provided to a member in a hospital setting are not reimbursed in accordance with these rules.
- (5) The Montana Medicaid program will cover and reimburse RHC or FQHC services only if the services are provided in accordance with the same requirements that would apply if the service were provided by an individual or entity other than an RHC or an FQHC, except as specifically provided otherwise in this subchapter. These requirements include but are not limited to the following:
 - (a) The health professional providing the RHC or FQHC service must meet the same requirements that would apply if the health professional were to enroll directly in the Montana Medicaid program in the category of service to be provided. Such requirements include but are not limited to applicable licensure, certification and registration requirements, and applicable restrictions upon the form of entity or category of individual provider that may provide particular services. The health professional is not required to enroll separately as a Medicaid provider.
 - (b) The RHC or FQHC services are subject to any applicable limitations on the amount, scope, or duration of services covered by the Medicaid program, e.g., scope of practice restrictions under state licensure law, coverage exclusions, e.g., noncoverage of physical therapy maintenance services, limits on the number of hours, visits, or other units of service covered in a particular period or on the frequency of services covered, limits on the type of items or services covered within a particular category, medical necessity requirements, including specific medical necessity criteria applicable to a particular item or service, and early and periodic screening, diagnostic and treatment services (EPSDT) program requirements and restrictions.

- (c) In addition to general record requirements under ARM 37.85.414, RHCs and FQHCs must comply with any additional particular record or documentation requirements applicable to the particular category or type of service, e.g., requirements for documentation of compliance with supervision and protocol requirements, requirements for written documentation of prescription or referral, requirements for written care plans and prerequisites for receipt of a particular item or service by a particular recipient.
 - (d) Providers must bill for RHC or FQHC services using the revenue codes specified in the department's RHC/FQHC services provider manual. The department must provide 30 days prior written notice to providers of any changes in revenue codes.
 - (e) RHCs and FQHCs must comply with requirements for Medicaid program authorization prior to provision of services or prior to payment, as applicable to the particular category of services being provided.
 - (f) Reimbursement will be made to RHCs and FQHCs for RHC and FQHC services as provided in ARM 37.86.4412 through 37.86.4414, 37.86.4420, 37.86.4408, 37.86.4409, and 37.86.4410, rather than as provided in the rules applicable to the particular category of services. This rule does not permit reimbursement of services provided by health professionals under ARM 37.86.4412 through 37.86.4414, 37.86.4420, 37.86.4408, 37.86.4409, and 37.86.4410 when the services are not provided as an RHC or FQHC service and when the health professional is separately enrolled in and providing services under a particular Medicaid service category, subject to the rules applicable to the particular service category.
- (6) A provider must notify the department, in writing, of a change in the scope of service offered by the RHC or FQHC to Medicaid members, in accordance with 37.86.4408, 37.86.4409, and 37.86.4410.
 - (7) The opening of new or additional service locations absent of a change in scope of service will be assigned the same baseline PPS rate as the primary RHC or FQHC.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

History: NEW, 1998 MAR p. 2045, Eff. 7/31/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2043, Eff. 10/12/01; AMD, 2005 MAR p. 975, Eff. 6/17/05; AMD, 2007 MAR p. 1680, Eff. 10/26/07; AMD, 2015 MAR p. 761, Eff. 7/1/15; AMD, 2019 MAR p. 1866, Eff. 10/19/19.