SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

# RURAL HEALTH CLINIC (RHC) SERVICES PROVIDER MANUAL

APRIL 1, 2025

**South Carolina Department of Health and Human Services**

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# 1 PROGRAM OVERVIEW

## PROGRAM DESCRIPTION

The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of Rural Health Clinic (RHC) services delivered to Healthy Connections Medicaid members via the following programs:

- Fee-for-Service (FFS)
- Managed Care Organization (MCO)

The RHC Services Provider Manual supplements SCDHHS's general policies and procedures detailed in the Provider Administrative and Billing Manual. It provides policies and requirements specific for RHC providers for the FFS program. For services delivered to MCO members, providers must follow the member's MCO's policies and requirements.

The policies outlined in the RHC Services Provider Manual are based around procedure codes as defined in the Code of Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) nomenclatures and descriptors, or as indicated in the SCDHHS policy.

For general policy and clinical criteria of a physician service providers must refer to the Physician Services Provider Manual. For general policy and clinical criteria of a behavioral health service providers must refer to the Rehabilitative Behavioral Health Services Provider Manual.. Policies specific to RHC providers are listed within this manual.

For the purpose of this manual, RHC services are defined as services furnished by RHC providers meeting all applicable Medicaid provider qualifications, Health Resources and Services Administration (HRSA) Health Center Program and Centers for Medicare and Medicaid Services (CMS) Statute and Regulations, and any applicable state licensure regulations for rendering providers affiliated with RHCs as specified by the authorizing state agency.

Providers must review, reference, and comply with both the RHC Services Provider Manual and the Provider Administrative and Billing Manual.

**NOTE:** References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- Provider Administrative and Billing Manual
- Provider Manual List | SCDHHS
- Forms

# 2 COVERED POPULATIONS

## ELIGIBILITY/SPECIAL POPULATIONS

### Beneficiary Requirements

Healthy Connections Medicaid Beneficiaries with full benefits and those enrolled in the Family Planning limited benefit program are eligible to receive services in an RHC.

- Children (beneficiaries under the age of 21 years)
- Adults (beneficiaries ages 21 years and older)
- Beneficiaries in the Family Planning Limited Benefit (Family Planning is a limited benefit available to men and women who meet the appropriate federal poverty level income percentage and who are ineligible for full Medicaid benefits under another eligibility category. This benefit provides coverage for preventive health care, family planning services, and family planning-related services.)

### Verifying Beneficiary's Eligibility

Participating Healthy Connections providers must access beneficiary eligibility information through the SCDHHS' Web Portal or Customer Service Center. Beneficiaries must be eligible on the date of service for payment to be made. Additional details on verifying an individual's Medicaid eligibility is described in the SCDHHS Provider Administrative and Billing Manual.

# 3 ELIGIBLE PROVIDERS

## PROVIDER QUALIFICATIONS

An eligible RHC is a CMS-certified entity located in a rural area identified as a shortage area, is not a rehabilitation agency or mental health facility [in accordance with 42 CFR Part 405, Subpart X and 42 CFR Part 491, Subpart A and under the authority of Sections 1102, 1861(aa)(2) and 1871 of the Social Security Act] with a written participation agreement in effect with SCDHHS to provide medical, remedial, pharmacy and behavioral health services to beneficiaries enrolled in the Healthy Connections program pursuant to the South Carolina State Plan for Medical Assistance and in accordance with Title XIX of the Social Security Act, as amended.

RHCs must conform to federal and state laws, rules and regulations.

For general information regarding provider qualifications and enrollment in the South Carolina Healthy Connections Medicaid program refer to the Provider Administrative and Billing Manual. For general requirements on provider enrollment refer to SCDHHS's website at: https://www.scdhhs.gov/providers/become-provider. In addition to meeting general provider qualification and enrollment requirements, the RHC must:

- Provide the required primary and approved additional health services through staff and supporting resources of the center or through contracts or cooperative arrangements.
- Provide the health services of the center so that such services are available and accessible promptly, as appropriate, and in a manner that will assure continuity of service to the residents of the center's catchment area.
- Utilize staff who are qualified by training and experience and practicing within the scope of practice to carry out the activities of the clinic.
- Each permanent site at which an RHC offers services must be certified by CMS and enrolled separately as a Medicaid provider. To enroll as a Healthy Connections Medicaid provider, the clinic must submit the following information to the Provider Enrollment Department at SCDHHS:
    1) An enrollment application,
    2) CMS Certification Letter and
    3) CMS Rate Letter.

  RHCs must also enroll in Medicare; providers are encouraged to enroll in Medicare and Medicaid concurrently.

- Meet at minimum the following staffing requirements:
    - ***Medical Direction and Oversight:*** RHCs must be under the medical direction of a physician licensed by the appropriate state licensing agency and have a health care staff that includes one or more physicians and one or more NPs or PAs. The medical

supervision and physician involvement of midlevel practitioners and related medical services performed in the clinic must be in accordance with the governing laws of the appropriate state agency and standard medical practice.

- ***Additional Staff:*** The RHC may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient in numbers to provide services essential to the operation of the clinic or the center.
- ***Clinical Staff:*** A physician, NP, nurse midwife or PA must be available to furnish patient care services during the RHC's hours of operation. The NP, nurse midwife or PA must be available for at least 50% of the RHC's clinical hours. The RHC and clinical staff must follow applicable federal, state and local laws for licensure, certification and/or registration.

### Rendering Providers

SCDHHS reimburses RHCs for services rendered by the following qualifying practitioners:

- Physician
- Physician Assistant
- Advanced Practice Registered Nurse (APRN)
- Licensed Midwife
- Licensed Psychologist
- Licensed Independent Social Worker-Clinical Practice
- Licensed Professional Counselor (LPC)
- Licensed Clinical Addiction Counselor (LAC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Registered Dietitian

Additional professions that may provide RHC services include:

- Chiropractor
- Podiatrist
- Optometrist

All practitioners qualified to perform services in the RHC, who are eligible for enrollment in Healthy Connections Medicaid, must be enrolled in Medicaid, and their individual National Provider Identifiers (NPIs) must be linked to the RHC provider.

Enrolled providers are prohibited from using their NPI to bill Medicaid for services rendered by a non-enrolled, terminated or excluded provider.

# 4 COVERED SERVICES AND DEFINITIONS

## DEFINITIONS

1. **Covered Service** means a service, including those coverable through the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, meeting the following criteria:
   a. Is medically necessary.
   b. Is provided to an eligible beneficiary by a participating provider.
   c. Is the most appropriate supply or level of care consistent with professionally recognized standards of medical practice within the service area and applicable policies and procedures.
   d. Is not rendered for convenience, cosmetic or experimental purposes.

2. **Provider** means an individual, firm, corporation, association or institution providing, or approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act, as amended.

3. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** is a benefit for persons under age 21 [pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a)(4)(B) and 1396d(r), and 42 C.F.R. Part 441, Subpart B] to ascertain a child's individual physical and mental status and conditions discovered by screening services, whether or not such services are covered.

4. **Medically Reasonable and Necessary** means procedures, treatments, medications or supplies, (the provision of which may be limited by specific provisions, bulletins and other directives [42 CFR 440.230 (d) and SC Code of Regulations 126-300 (D)]), ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury which per [S.C. Code of Regulations 126-425(9)]:
   a. Must be provided at appropriate facilities, at the appropriate levels of care and in the least costly setting required by the beneficiary's condition.
   b. Must be administered in accordance with recognized and acceptable standards of medical and/or surgical discipline at the time the beneficiary receives the service.
   c. Must comply with standards of care and not for the beneficiary's convenience, experimental or cosmetic purposes.
   d. Medical necessity or any referral information must be documented in the beneficiary's health record and must include a detailed description of services rendered. The fact that a provider prescribed a service or supply does not deem it medically necessary.

## COVERED SERVICES

In compliance with Authority: Sections 1861(aa), 1102 and 1871, of the Social Security Act, and at 42 CFR Part 405, Subpart X; 42 CFR Section 440.20(b); and 42 CFR Part 491, Subpart A, RHCs provide the following services:

- Required primary health services
- Substance use disorder services
- Behavioral health services
- Additional (supplemental) health services

All RHC services are subject to a medical necessity determination by SCDHHS through established utilization management policies based on the application of industry standards of medical practice, and through applications of reasonable limitations and criteria, as defined in their respective SCDHHS provider manuals (such as the Physician Services Provider Manual and Rehabilitative Behavioral Health Services Provider Manual).

Medically necessary RHC services are covered as follows:

### State Plan Services

Rural Health Center (RHC) services are:

- Procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, clinical social worker, incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services.
- Procedures performed by a visiting nurse in areas with shortages of home health agencies. In certain cases, services to a homebound Medicaid patient may be provided.
- Any other ambulatory service included in the State Plan is considered a covered service, if the RHC offers such a service.
- RHC providers are eligible to serve as referring site or consulting site providers for services delivered via telehealth.

### EPSDT Benefit

- Children under the age of twenty-one (21) are eligible for medically necessary services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Federal law at 42 U.S.C.§1396d(r), §1905(r) of the Social Security Act (SSA)] requires state Medicaid programs to provide EPSDT services for recipients under 21 years of age. The scope of EPSDT benefits under the federal law covers services that are medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether the service is covered under the State Plan. EPSDT benefit includes services provided at intervals that meet reasonable standards of medical practice and at intervals necessary to determine the existence of a suspected illness or condition. EPSDT benefit is detailed on the SCDHHS EPSDT website at EPSDT | SCDHHS.

- SCDHHS has adopted the Bright Futures/American Academy of Pediatrics (AAP) Medical Periodicity Schedule for medical, hearing and vision screenings as well as age-appropriate assessment, procedures and immunization.
- SCDHHS has also developed an Oral Health Section of the Medical Periodicity Schedule for oral screenings and oral health services performed by medical providers.
- Refer to the EPSDT services section of the Physician Services Provider Manual for coverage details.

### Family Planning Services

Family planning services are defined as preconception services that prevent or delay pregnancies and do not include abortion or abortion-related services. Family Planning is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage in order to be eligible and who are ineligible for full Medicaid benefits under another eligibility category. This program provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventive health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a limited set of services, including biennial physicals, family planning services, and family planning-related services. Any services provided to a beneficiary enrolled in Family Planning not specifically outlined as a covered service are the sole responsibility of the beneficiary. Refer to the Family Planning section of the Physician Services Provider Manual for coverage details.

## NON-COVERED SERVICES

Services provided in an inpatient or outpatient hospital department, including critical access hospital, or a facility with specific requirements excluding RHC visits are not considered RHC services. The South Carolina Healthy Connections Medicaid program does not cover health education, social work, or other related ancillary services unless noted in this section. Services provided to members with Emergency Only Limited benefit are not considered RHC services.

# 5 UTILIZATION MANAGEMENT

For general policies regarding Program Integrity, Utilization Management, Fraud, Waste and Abuse providers must refer to the Provider Administrative and Billing Manual.

## AUTHORIZATION

Authorizations are a utilization tool that require participating providers to submit documentation associated with certain services for a beneficiary either before the service is rendered (prior authorizations) or after service is rendered but prior to payment. Participating providers will not be paid if this documentation is not furnished to SCDHHS or its designee. Participating providers must hold the beneficiary and SCDHHS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization.

Failure to comply with these requirements may result in denial or recoupment of payment.

- Providers must file a prior authorization request for RHC services that require an approval prior to rendering the service. The Prior authorization request must be submitted with appropriate documentation that supports medical necessity for the service(s).

- Payment for services that exceed frequency limitations must be justified through an EPSDT examination and pre-approved by SCDHHS or its designee.

- Providers must submit proper documentation with the claim for RHC services that require review by SCDHHS or its designee for determination of medical necessity prior to reimbursement for the procedures. These claims are subject to pre-payment edits. If a pre-payment edit is received, providers must file a new claim and submit documentation to support medical necessity.

- Beneficiaries with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier denied the service, or the service is considered not covered. This is applicable only for services that require prior authorization by Medicaid.

- For medical and behavioral health services, all prior authorization requests must be submitted by the Quality Improvement Organization (QIO). All applicable forms for requests for prior authorizations are posted to QIO website https://scdhhs.kepro.com.

  QIO Customer Service Phone: (855) 326-5219
  QIO Fax #: (855) 300-0082
  Provider Issues Email: atrezzoissues@Kepro.com

- For physician administered drugs that require prior authorization, providers must file the authorization request to Prime Therapeutics Specialty at:

  Prime Therapeutics Management LLC
  Website: https://mrxgateway.com/
  Telephone: (866) 254-1669

For beneficiaries enrolled in a MCO, refer to the individual MCO plan regarding its services and authorization policies.

# 6 REPORTING/DOCUMENTATION

General policies for Medicaid beneficiaries' health records documentation, reporting and signature requirements are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, RHC providers must comply with specific policies for health records requirements and documentation detailed below.

## HEALTH RECORDS

In addition to providers' compliance with state and federal laws and regulations regarding health record retention requirements [e.g., Social Security Act 1902(a)(27), 42 CFR 431.107]. SCDHHS requires RHC providers to retain health records on site. For Medicaid purposes all health and fiscal records must be retained for a minimum period of four (4) years after the last payment was made for services rendered, to facilitate audits and reviews of the beneficiary's health record. No other documentation (except for hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, ledger cards, claim forms, and computer records.

### Health Record Compliance Requirements

Providers must:

- Document the rationale and justification of medical necessity for services, including all findings, diagnosis and supporting information.

- Detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the Current Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) nomenclatures and descriptors, or as indicated in the SCDHHS policy.

- Ensure that health records are signed and dated at the time of service, or the rendering provider must attest to the date and time as appropriate to the media (e.g., paper or electronic signature); and information, including rendering provider, date, and time of the service, must be verifiable.

Medicaid services that are not properly documented in clinical notes are subject to denial or recoupment. All required documentation must be present in the health record before the provider files claims for reimbursement. All services performed must be recorded in the beneficiary's health record, which must be available as required by the Participating Provider Agreement.

## MEDICAL SERVICE DOCUMENTATION

Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Documentation of services must comply with

guidelines set forth within the Physician Services Manual or RBHS Manual for each specific service. At minimum, adequate documentation reflects:

- Services performed
- Medical necessity
- Performing provider and supervising provider (when required)
- Time period the services were performed
- Treatment plan if applicable

### Referrals

When the RHC refers a patient to another provider who is responsible for the treatment plan and billing for the services provided, information from the referral visit should be provided back to the RHC for appropriate follow-up care and included in the patient's medical records. In addition, the process for how patients are referred for services outside of the RHC and tracking and referring patients back to the RHC for appropriate follow-up care (for example, exchange of patient record information, receipt of lab results) should be specified when referrals are made. See the Provider Administrative and Billing Manual for specific information on referral requirements.

### Procedure Codes

RHC providers are required to submit the applicable Current Procedural Terminology (CPT) codes as defined in the CPT reference guide, Healthcare Common Procedure Coding System (HCPCS) or International Classification of Diseases, 10th Revision (ICD-10) or as otherwise specified by SCDHHS in this manual.

# 7 Billing Guidance

General billing guidance, such as Usual and Customary Rates; Timely Filing; Third Party Liability and Coordination of Benefits (COB); Adjustments and Refunds; Remittance Advices; and Electronic Fund Transfer, is detailed in the Provider Administrative and Billing Manual. Additional billing guidance specific to RHC services is detailed in this manual.

Providers must follow the National Correct Coding Initiative (NCCI) edits and its related coding policy, unless otherwise indicated in this manual. For detailed information about the NCCI, refer to the Provider Administrative and Billing Manual.

## RHC ENCOUNTERS

### Encounters

A valid RHC encounter is defined as a face-to-face and one-on-one visit between a Healthy Connections Medicaid member and a qualifying performing practitioner (see the Rendering Providers section) at an RHC or other qualifying, nonhospital setting (refer to Place of Service allowed below). For billing purposes, SCDHHS has deemed a “visit” as an “encounter”.

Only one encounter code may be billed per day, except for the Psychiatry and Counseling Encounter, which can be billed in addition to another encounter on the same day. The most appropriate encounter code must be billed based on the service(s) provided. All supplies, injections, surgical procedures (unless noted in the Special Clinic Services section of this manual), etc., are included in the encounter code reimbursement. The only fragmented services billable on an FFS basis is listed under Special Clinic Services.

RHC services are covered when furnished to patients at the clinic, in a skilled nursing facility, or at the client’s place of residence.

RHC facilities are required to submit fee-for-service claims for valid encounters as follows:

- Report valid medical encounters on the professional claim (CMS-1500 claim form, Portal professional claim or 837P transaction) using HCPCS encounter code T1015 – Clinic, visit/ encounter, all-inclusive. RHC services are allowed to be performed in the following settings:
    - Telehealth
    - Homeless Shelter
    - Home
    - Assisted Living Facility
    - Skilled nursing facility
    - Nursing facility
    - Rural Health Clinic

*Note:* Modifier GT is required for all services provided via telehealth and must be recorded secondary to any other applicable modifiers.

Providers must bill for RHC services utilizing the procedure codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT). Procedure codes that deviate in description from the HCPCS/CPT assigned description, are indicated in the respective provider manuals for that service. For additional information on procedural coding, refer to the Provider Administrative and Billing Manual.

### Supplies and Ancillary Services

Supplies and ancillary services such as drawing blood, collecting urine specimens, giving injections (except vaccine and vaccine administration), or providing optician services do not, in and of themselves, constitute encounters.

These services and supply costs are included in the encounter rate when provided during a physician, PA, NP, CNM, chiropractor, clinical psychologist, and/or clinical social worker visit. If these services are not performed in conjunction with an encounter, they cannot be billed to Medicaid. They are included in the facility's cost report. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office.
- Commonly provided either without charge or included in the RHC's bill.
- Provided as incidental, although an integral part of the above provider's services.
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies.
- Provided by a clinic employee.
- Not self-administered (drug, biological).

### Encounters on Consecutive Dates of Service

Providers can bill only one unit of T1015 on a single detail line of the claim. Providers should break down consecutive service dates so that they bill each day on a separate line.

### Multiple Encounters on the Same Date of Service

SCDHHS allows reimbursement for only one medical encounter code (T1015) per Medicaid member, per billing provider, per day – unless the primary diagnosis code differs for each additional encounter. Multiple T1015 encounter claims from the RHC for a member on the same date of service that do not include a different primary diagnosis code will be denied.

If a member visits an office twice on the same day with two different diagnoses, a second claim can be submitted for the second visit, using a separate professional claim form or electronic claim submission. However, this policy does not allow a provider to bill multiple claims for a single visit with multiple diagnoses by separating the diagnoses on different claims. When two valid practitioners, such as a physician and a psychologist, see the same patient in the same day, the principal diagnoses must not be the same.

*Note:* RHCs must strictly follow proper billing guidelines when submitting multiple diagnosis codes on a single claim. Diagnosis codes must be listed according to their importance, with the first code

being the primary diagnosis – that is, the one that most strongly supports the medical necessity of the service:

The diagnosis code submitted in field 21A on the CMS-1500 claim form is considered the primary diagnosis for determining duplicate claims.

### Claim Form

SCDHHS requires RHC providers to submit all claims on a professional CMS 1500 claim form.

### RHC Provider Number

All encounter services and ancillary services described in this section of the manual must be billed under the RHC provider number

### National Correct Coding Initiative

Providers must follow the National Correct Coding Initiative (NCCI) edits and its related coding policy, unless otherwise indicated in this manual. For detailed information about the NCCI, refer to the Provider Administrative and Billing Manual.

## TYPES OF ENCOUNTERS

### Medical Encounter

All medical encounters must be billed using the appropriate encounter code unless otherwise specified. A medical "visit" (encounter) is defined as a face-to-face and one-on-one encounter between a patient and an eligible rendering provider during which the RHC core service is provided. RHC providers will be reimbursed their contracted encounter rate, and are allowed only one medical encounter per day, even if the patient sees more than one professional at the visit or on that day.

At a minimum, one of the following services must occur during the visit for it to be considered a medical encounter:

| Procedure Codes | Encounter Type | Core Service Type | Criteria |
|---|---|---|---|
| 99202-99205;<br>99212-99215;<br>99242-99245;<br>99341-99345;<br>99347-99350;<br>99381-99387;<br>99391-99397; | Medical | Physician Services; or Podiatry Services; | Members with full benefit are eligible for these encounters. |
| 98940-98942; | Medical | Chiropractic Services | Members with full benefit are eligible for these encounters |

| | | | |
|---|---|---|---|
| 92002; 92004; 92012; 92014; | Medical | Ophthalmology Services | Members with full benefit are eligible for these encounters |
| 99304-99310; 99315-99316; | Medical | Skilled Nursing Facility Services | Members with full benefit are eligible for these encounters |

### Maternal Encounter

All maternal care encounters must be billed with the appropriate encounter code with a TH modifier. RHC providers will be reimbursed their contracted rate for all maternal services rendered. IUDs, the Technical Component (TC) of ultrasounds, and Fetal Non-Stress test (NST) may be billed separately. Refer to Family Planning and Special Clinic Services coding guidelines below.

At a minimum, one of the following services must occur during the visit for it to be considered a maternal encounter:

| Procedure Codes | Encounter Type | Core Service Type | Criteria |
|---|---|---|---|
| 99202-99205; 99212-99215; 99242-99245; 99347-99350; 99384-99386; 99394-99396; 59430; 96160; 96161; | Maternal | Physician Services; Postpartum Care; | Pregnant or postpartum women with full benefit are eligible for these encounters |

### Behavioral Health Encounter

A mental health visit is defined as a face-to-face and one-on-one encounter between the RHC beneficiary and the eligible rendering provider. Only one behavioral health encounter code is allowed per day. All behavioral health encounters must be billed using procedure code T1015 with the HE modifier, mental health program. This code is not intended for billing case management services.

At a minimum, one of the following services must occur during the visit for it to be considered a behavioral health encounter:

| Procedure Codes | Encounter Type | Core Service Type | Criteria |
|---|---|---|---|
| 90791; 90792; 90832-90834; 90836-90839; 90853; 90847; 96130; 96136; | Behavioral Health | Behavioral Health Services | Members with full benefit are eligible for these encounters. |

### Cancer Treatment or HIV Encounter

SCDHHS allows RHCs to bill for HIV and cancer-related services using the appropriate encounter code, with the P4 modifier. Charges for such services will be reimbursed at the contract rate.

At minimum, one of the following services must occur during the visit for it to be considered a cancer and HIV encounter:

| Procedure Codes | Encounter Type | Core Service Type | Criteria |
|---|---|---|---|
| 99202-9925; 99212-99215; 99242-99245; 99341-99345; 99347-99350; 99381-99387; 99391-99397; | Cancer & HIV | Physician Services | Members with full benefit with a diagnosis of cancer or HIVare eligible for these encounters. |

### EPSDT Screening Encounter

All EPSDT screenings (periodic and inter-periodic screenings) must be billed as an encounter at the RHC contract rate, however, the appropriate CPT screening codes must be billed for reimbursement. A screening and an encounter code may not be billed on the same date of service. RHCs must bill under their RHC provider number.

At minimum, one of the following services must occur during the visit for it to be considered an EPSDT encounter:

| Procedure Codes | Encounter Type | Core Service Type | Criteria |
|---|---|---|---|
| 99381-99385; 99391-99395; | EPSDT | Physician Services | Members with full benefit under the age of 21 years are eligible for these encounters. |

Prior authorizations are NOT required for periodic or inter-periodic screening services.

### Family Planning Encounter

A family planning encounter is defined as the visit where family planning services are provided as a face-to-face and one-on-one encounter between the RHC beneficiary and the eligible rendering provider. Family planning encounter may be billed when rendered to beneficiaries with the following eligibility category:

- Full Medicaid benefits
- Family Planning Limited benefit

All family planning encounters must be billed with the appropriate encounter code with a FP modifier. RHC providers will be reimbursed their contracted rate for all family planning services rendered. Only one encounter code can be billed in a day.

Beneficiaries enrolled in the Family Planning Limited benefit are eligible for a limited set of family planning services. Refer to the E&M services for Family Planning benefit in the Physician Services Provider Manual for more details on this coverage and services required during each family planning visit.

There are four types of encounters covered for beneficiaries enrolled in the Family Planning Limited Benefit:

- Biennial (once every two years) physical examinations
- Annual family planning visit
- Periodic family planning visit
- Contraceptive counseling

At a minimum, one of the following services must occur during the visit for it to be considered a Family Planning encounter:

| Procedure Codes | Encounter Type | Core Service Type | Criteria |
|---|---|---|---|
| 99385-99387;<br>99395-99397; | Family Planning | Family Planning Biennial Physical Examination | Members enrolled in the Family Planning Limited Benefit are eligible for these encounters. |
| 99202-99205;<br>99212-99215;<br>99341-99345;<br>99347-99350; | Family Planning | Annual Family Planning Visit | Members enrolled in the Family Planning Limited Benefit are |

| | | | |
|---|---|---|---|
| | | | eligible for these encounters. |
| 99212-99215; 99347-99350; | Family Planning | Periodic Family Planning Visit | Members enrolled in the Family Planning Limited Benefit are eligible for these encounters. |
| 99401-99402; | Family Planning | Family Planning Counseling | Members with full benefit; or thhose enrolled in the Family Planning Limited Benefit are eligible for these encounters. |

Beneficiaries enrolled in the Family Planning Limited Benefit have Medicaid coverage for a limited set of services. This coverage does not include treatment, medication, or office visits for many of the conditions that the RHC provider may identify during the physical examination or annual family planning visit. If a problem or condition is identified during the physical examination or annual family planning visit, the RHC provider should schedule a follow-up visit with the patient in order to address the problem. Medicaid will not reimburse for any fees associated with follow-up visits. All follow-up visits for uninsured Family Planning beneficiaries should follow the RHC provider's established policies and procedures for treating uninsured patients. For data collection and monitoring purposes, SCDHHS requires that RHCs report positive screening results when a problem or condition is identified during the physical examination or annual family planning visit. The instructions that follow describe the process for reporting these positive screenings:

When a problem or condition requiring follow-up care is identified, RHCs should include the Positive Screening Code along with one or more of the modifiers listed below as a separate line on the Encounter Claim Form.

RHCs must use the appropriate modifier from the list below. Up to four modifiers can be used for the Positive Screening Code (e.g., if a patient is scheduled to receive a follow-up visit for more than one positive screening, include modifiers for all positive screenings):

- If scheduling a follow-up visit for a patient for a positive diabetes screen, use modifier P1.
- If scheduling a follow-up for a patient for a positive cardiovascular screen, use modifier P2.
- If scheduling a follow-up visit for a patient for any positive cancer screen, use modifier P3.
- If scheduling a follow-up visit for a patient for any mental or behavioral health screens, use modifier P4.

- If scheduling a follow-up visit for a patient for any other condition or problem, use modifier P5.

## Telehealth Overview

The Centers for Medicare and Medicaid Services (CMS) defines telehealth as the use of electronic information and telecommunications technologies to extend care when a provider and a patient are not in the same place at the same time.

Services rendered via telehealth may be rendered synchronously or asynchronously using a telecommunication system (audio/video) that permits interactive communications between a provider and a patient. The telecommunication system must be Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant. DHHS only reimburses services conducted synchronously with both audio and video components unless otherwise specified.

Services rendered via telehealth are not an addition to Medicaid-covered services but a mode of delivery of certain covered services. Quality of health care must be maintained regardless of the mode of delivery.

**Telehealth Definitions:**

*Synchronous Telehealth* is real-time, audio-video communication that connects physicians and patients in different locations (referring site and consulting site).

*Referring Provider* is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment.

*Consulting provider* is the provider who evaluates the beneficiary via telehealth upon the recommendation of the referring provider.

**Eligible Providers**

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for covered Medicaid services via telehealth in accordance with SCDHHS coverage policies and the provider's scope of practice. Both the referring and the consulting providers must be enrolled in the South Carolina Medicaid program.

*Referring Site* (also called the patient site) is the location of an eligible Medicaid beneficiary at the time the telehealth session. Medicaid beneficiaries are eligible to receive services via telehealth only if they are presented from a referring site located in the South Carolina Medicaid Service Area (SCMSA). Referring site presenters may be required to facilitate the delivery of the service. Referring site presenters must be a knowledgeable person on how the equipment works and able to

provide clinical support if needed during a session. Patient residence may be considered a referring site.

*Consulting Sites* (also called the distant site) is the site at which the provider is located during the telehealth session. The provider performing the medical care must be enrolled in the South Carolina Medicaid program and provide services in accordance with the licensing board and their scope of practice.

*Criteria and Requirements for Telehealth*

Office visits that are conducted via telehealth are counted towards the applicable benefit limits for these services.

Medicaid allows the service to be delivered via telehealth when the service meets the following criteria:

- The beneficiary must be present and participating in the telehealth visit.
- The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
- Interactive audio and video telecommunication must be used, permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted.
- The telehealth equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Any staff involved in the telehealth visit must be trained in the use of the telehealth equipment and competent in its operation.
- A trained healthcare professional at the referring site (patient site presenter) is required to present the beneficiary to the provider at the consulting site and remain available as clinically appropriate (this condition is waived when the referring site is the patient home).
- If the beneficiary is a minor (under 18 years old), a parent and/or guardian must present the minor for telehealth service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telehealth session unless attendance is therapeutically appropriate.
- The beneficiary retains the right to withdraw from the telehealth visit at any time.
- All telehealth activities must comply with the requirements of HIPAA: Standards for Privacy of individually identifiable health information and all other applicable State and Federal Laws and regulations.
- The beneficiary has access to all transmitted medical information, except for live interactive video, as there is often no stored data in such encounters.
- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need.
- The medical care can be safely furnished.
- No equally effective, more conservative or less costly treatment is available Statewide.

### Services rendered via Telehealth

Telehealth generally involves two-way, interactive technology that permits communication between the practitioner and patient, who are not at the same location at the time the service is delivered. RHCs can provide certain services via telehealth to extend care when a patient is in a different place.

### Referring/Originating Site

RHCs may be eligible to receive reimbursement for a facility fee when operating as the referring site. Claims must be submitted with the HCPCS code for telehealth referring site facility fee. RHCs cannot bill the encounter code when serving as the referring/originating site, nor can they bill for both an encounter and referring site on the same date of service. Billing for referring site facility fee is not allowed when other services are performed on the same date of service.

### Consulting Site

RHCs may operate as the consulting site. If the visit is done via telehealth RHCs must bill the appropriate procedure code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

## SPECIAL CLINIC SERVICES

Special clinic services include services that are excluded from the RHC encounter rate and may be billed and reimbursed separately from the encounters. Providers must use the appropriate CPT/HCPCS code when billing for the special clinic services. Some services as indicated below cannot be billed under the RHC NPI and must be billed under the provider group NPI.

The special clinic services include the following:

| Service Category | Procedure Code(s) | Criteria and Limitations |
|---|---|---|
| Fetal Non-Stress Test (NST) | 59025 | Only the technical component is billed outside of the encounter. Services must be billed with TC modifier. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist or other provider for interpretation, the specialist's services are reimbursed under the FFS program following Medicaid policy for their specialty. This service must be billed under the RHC NPI. |

| | | |
|---|---|---|
| Radiology/Imaging | 70000-79999*;<br>92250; 93880; 93970; | Only the technical component is billed outside of the encounter. Services must be billed with TC modifier. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist or other provider, for interpretation, the specialist's services are reimbursed under the FFS program following Medicaid policy for their specialty.<br><br>*Only services within the range that are in scope for RHC setting are allowed.<br>These services must be billed under the provider group NPI. |
| Electrocardiography (EKG) | 93005; 93017; 93041;<br>93225; | Only the technical component is billed outside of the encounter. Services must be billed with TC modifier. The professional component is reimbursed through the encounter code that may be billed (if appropriate). If the patient is referred to a radiologist or other provider, for interpretation, the specialist's services are reimbursed under the FFS program following Medicaid policy for their specialty.<br>These services must be billed under the provider group NPI. |
| Immunization and Vaccine Administration | 90375-90756<br>Q2035-Q2039;<br>91304; 91318-91322 | Adult reimbursement only, VFC reimburses for vaccines for children. Child reimbursement is limited to vaccine administration only.<br><br>These services must be billed under the provider group NPI. |
| Vision | 92340 | These services must be billed under the provider group NPI. |
| Substance Abuse Services | Q9991; Q9992; J2315; | These services must be billed under the provider group NPI. |
| Long-Lasting Reversible Contraceptive (LARC) | ; 11981; 58300; 58301;<br>A4261; A4264; A4266-<br>A4269; J1050; J7296;<br>J7297, J7298; J7300;<br>J7301; J7307; | These services must be billed under the provider group NPI. |
| Telehealth Originating Site | Q3014 | These services must be billed under the provider group NPI. This is allowed when the RHC is not delivering other services. |

| | | |
|---|---|---|
| After Hours | 99050; 99051 | These services must be billed under the provider group NPI. |
| Evaluation and Management via Telehealth | G2010;<br>98012-98016;<br>99202-99204;<br>99212-99214<br>99382-99385*;<br>99392-99395* | These services must be billed under the provider group NPI. These services are allowed via telehealth only when performed by a physician, nurse practitioner or physician assistant.<br>* Providers rendering services to children 24 months or younger must follow the American Academy of Pediatrics (AAP) recommendations to deliver the visit in person whenever possible. A justification as to why the visit could not be performed in person must be documented in the patients record. |
| Fluoride Varnish Application | 99188 | Application of fluoride varnish may be billed separately from the encounter. Procedure must be billed under the provider group NPI. |
| Laboratory Testing | 80000-89999;<br>80305; 80307; G0480;<br>0202U; 86328; 86769; 87426; 87428; 87635; 87636; 87637; 87811; U0001; U0002; | All laboratory services (including the six laboratory tests required for RHC certification), as well as covid testing and drug testing, must be billed to Medicaid under the FFS Medicaid provider identification number. Laboratory services cannot be billed using the RHC provider number. These services must be billed under the provider group NPI. |
| Nutritional Counseling | 97802; 97803; 97804 | RHC's are allowed to separately bill for nutritional counseling under their group provider ID not their assigned Rural Health Clinic number. Refer to the Physician Services Provider Manual for additional information and clinical criteria. Medical nutrition therapy is not allowed to be billed using the encounter rate. Group nutritional therapy is allowed in an RHC setting. |
| Behavioral Health Screening SBIRT | H0002; H0004 | |
| Peer Support | H0038 | Allowed via telehealth for established patients only. |

## CLINIC-BASED PHYSICIAN (CBP) SERVICES IN HOSPITAL SETTING

RHC services may not be provided in a hospital setting. The following policy describes billing procedures for clinicians employed by both a RHC and a hospital. The CBP services are services rendered at a hospital by an RHC physician, CNM, or NP.

All services provided to hospital patients (including ER services) by a RHC provider must be billed under the CBP policy. These services must be billed using Physician's CPT codes and will not be cost-settled.

Providers must bill for these services using the CBP provider number (Section 33) and rendering physician, CNM or NP's Medicaid provider number (Section 24K) on the CMS-1500 claim form.

## RHC MEDICARE/MEDICAID DUAL ELIGIBILITY CLAIMS

Claims for RHC services must be filed initially to the Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare. Medicaid will pay the difference up to the provider's RHC rate.

## RHC CROSSOVERS

Crossover claims must be filed initially to the assigned RHC Medicare intermediary. Upon payment from Medicare, the claim must be filed to Medicaid on the CMS-1500 claim form showing the payment received from Medicare.

## REIMBURSEMENT AND CHARGE LIMITS

For general policies regarding charge limits and reimbursements, providers must refer to the Provider Administrative and Billing Manual. Reimbursement and Charge limits specific to RHC providers are addressed in this section of the manual.

- Payment for all approved services must be accepted as payment in full.
- Providers must check the beneficiary's eligibility and service history.
- Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition, providers may not charge the beneficiary for the primary insurance carrier's co-payment.
- Billing covered procedures prior to the date of service is prohibited.
- Providers are prohibited from billing the beneficiary for any service that the beneficiary is eligible to receive under the Healthy Connections Medicaid program. Medicaid payments may be made only to a provider, a provider's employer or an authorized billing entity. Payments will not be reimbursed to a beneficiary. Therefore, seeking payment from a beneficiary is prohibited.
- Providers are prohibited from billing a beneficiary for coverable services denied due to the following:
    - untimely filing (refer to the Provider Administrative and Billing Manual)
    - insufficient/lack of medical necessity documentation
    - claims filed with clinical and/or administrative errors

    - failure to obtain prior authorization (when applicable)
- Providers are prohibited from billing a beneficiary while the prior authorization process is ongoing.
- Providers are prohibited from billing a beneficiary during an appeals process. Beneficiaries have the right to appeal any decision that delays, denies, or reduces a covered benefit.
- Provider must inform the beneficiary if services requested through prior authorization were deemed by SCDHHS as not medically necessary, therefore:
    - no claim will be filed with Medicaid and no reimbursement is expected from Medicaid for the service(s), and
    - provider and beneficiary may agree to forego with the service delivery, or
    - provider and beneficiary agree to proceed with the service delivery without Medicaid reimbursement.

## Reimbursement and Cost Reports

SCDHHS administers a cost-based, retrospective, reimbursement payment methodology. Reimbursement for medically necessary services shall be made at 100% of the all-inclusive rate per encounter as obtained from the Medicare intermediary. Actual cost information, to include Medicare annual RHC rate caps, shall be obtained from the Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than 50 beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

## Wrap-Around Payment Methodology

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection ACT of 2000 (BIPA) require the determination of supplemental payments for RHCs contracting with Medicaid MCOs. These supplemental payments are calculated and paid to ensure that these providers receive reimbursement for their services to Medicaid MCO beneficiaries at least equal to the payment that would have been received under the traditional FFS methodology. These determinations, generally referred to as wrap-around payments, are mandated by BIPA 2000 to be completed at least every four months. SCDHHS performs these determinations quarterly and prepares a final reconciliation at the provider's year-end. Submission of quarterly and annual MCO encounter data and payment information that is required for these wrap-around payment determinations is the responsibility of each MCO contracting with RHCs. The quarterly and annual reconciliation processes are incorporated into the agency's State Plan for Medical Assistance, Attachment 4.19-B.

Questions relating to the RHC reimbursement methodology or wrap-around payments should be directed to the SCDHHS Division of Ancillary Reimbursements at +1 803 898 1040

# 8 BENEFIT CRITERIA AND LIMITATIONS

The policies outlined in the RHC Services Provider Manual are based around procedure codes as defined in the Code of Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) nomenclatures and descriptors, or as indicated in the SCDHHS policy.

For general policy and clinical criteria of a physician service providers must refer to the Physician Services Provider Manual.

For general policy and clinical criteria of a behavioral health service providers must refer to the Rehabilitative Behavioral Health Services Provider Manual..

Policies specific to RHC providers are listed within this manual.

***Healthy Connections*** providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Refer to the "Patient Record" and "Documentation Required" sections listed in the respective provider manuals for additional detail.

The ***Healthy Connections*** Covered RHC services are defined as follows:

1. State Plan Covered Services
2. EPSDT Services (Non-State Plan Covered Services)
3. Family Planning Benefit Services

## STATE PLAN COVERED SERVICES

The subsections below outline a list of services referred to as RHC core services. Core services are reimbursed using encounter codes.

### Encounter Services

Currently the definition of a visit is a face-to-face and one-on-one encounter between a RHC patient and RHC provider, during which a Medicaid-covered RHC core service is furnished. The South Carolina Medicaid program does not cover health education, social work, or other related ancillary services unless noted in this section. For billing purposes, SCDHHS has deemed a "visit" as an "encounter". Physicians and practitioners providing services under the RHC program must meet the regular Medicaid enrollment requirements to provide services to Medicaid patients.

Only one encounter code is allowed per day, except for the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day. RHC services are covered when furnished to patients at the center, in a Skilled Nursing Facility, or at the client's place of residence. Services provided to hospital patients, including ER services, are not considered RHC services.

### Services and Supplies

Supplies, injections (excluding vaccinations), etc., are not reimbursable services. These services and supply costs are included in the encounter rate when provided during a visit. The types of services and supplies included in the encounter are:

- Commonly provided in a physician's office.
- Commonly provided either without charge or included in the RHC's bill.
- Provided as incidental, although an integral part of the above provider's services.
- Provided under the physician's direct, personal supervision to the extent allowed under written center policies.
- Provided by a clinic employee.
- Not self-administered (drug, biological).

### Physician Services

Physician services refer to the professional services (diagnosis, treatment, therapy, surgery and consultation) performed by or under the supervision of a physician for the RHC center. For detailed policies, criteria and limitations of physician services, refer to the Physician Services Provider Manual.

### Medical or Other Remedial Care Provided by Licensed Practitioners

Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM) services refer to the medical or remedial care or services, other than physicians' services, provided by the licensed practitioners under a physician's general or direct medical supervision within the scope of practice as defined under State law. For detailed policies, criteria and limitations of PA, NP or CNM services, refer to the Physician Services Provider Manual.

### Chiropractor Services

Chiropractic services are those which are limited to manual manipulation of the spine for the purpose of correcting subluxation demonstrated on x-ray. For the purpose of this program, subluxation means an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically that is demonstrable on a radiographic film (x-ray). Chiropractic services must conform to policies, guidelines and limitations as specified in the Chiropractic Services Manual. Chiropractic providers are licensed practitioners and provide services within the scope of practice as defined under state law and in accordance with the requirements of CFR 440.60(a).

For detailed policies, criteria and limitations of chiropractor services, refer to the Physician Services Provider Manual.

### Podiatry Services

Podiatry services must be medically necessary and conform to the guidelines and limitations as specified under the Physician Services Provider Manual. Podiatry providers are licensed practitioners and provide services within the scope of practice as defined under state law and in

accordance with the requirements of 42 CFR 440.60(a). Podiatry services are those services that are responsible and necessary for the diagnosis and treatment of foot conditions. These services are limited to the specialized care of the foot as outlined under the laws of the State of South Carolina.

For detailed policies, criteria and limitations of podiatry services, refer to the Physician Services Provider Manual.

### Dietitian Services

For detailed policies, criteria and limitations of dietitian services, refer to the Physician Services Provider Manual.

### Diagnostic, Screening and Preventive Services

"*Diagnostic services,*" includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, to enable him/her to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.

"*Screening services*" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies, individuals suspected of having certain diseases.

"*Preventive services*" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under state law to:

- Prevent disease, disability, and other health conditions or their progression;
- Prolong life; and
- Promote physical and mental health and efficiency.

For detailed policies, criteria and limitations of diagnostic, screening and preventive services, refer to the Physician Services Provider Manual.

### Immunization

Providers must follow the Advisory Committee on Immunization Practices (ACIP) recommendations on vaccines for both children and adults available at ACIP Vaccine Recommendations when administering vaccines to full benefit Healthy Connections Medicaid Members.

For immunizations for Family Planning Limited benefit members, refer to the Family Planning section of the Physician Services Provider Manual.

### Vision Services

Vision care services are those which are reasonable and necessary for the diagnosis and treatment of conditions of the visual system and the provision of lenses and/or frames as applicable. Optometry providers are licensed practitioners and provide services within the scope of practice as defined under state law and in accordance with the requirements of CFR 440.60(a)

For detailed policies, criteria and limitations of vision services, refer to the Physician Services Provider Manual.

### Behavioral Health Services

"Rehabilitative services," includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to the best possible functional level.

Behavioral health services allowed to be performed by an FQHC provider include:

- Diagnostic Assessment Services
- Psychological Testing with Interpretation and Report
- Individual Psychotherapy
- Peer Support Services
- Family Psychotherapy
  - Billing for telephone calls is not allowed
  - Must not be billed in conjunction with pharmacological management
  - Allowed one session per day (not based on time increments)
  - If several family members are present during family psychotherapy, one session is allowed for the individual identified as the recipient of service.
- Psychotherapy for Crisis
  - The Psychotherapy for Crisis code is used to report the first 30–74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other qualified health care professional is not continuous on that date. The beneficiary must be present for all or some of the service.

Policy criteria and limitations for behavioral health services are detailed in the Rehabilitative Behavioral Health Services Provider Manual.

### Other Laboratory and Radiology Services

These are professional and technical laboratory and radiological services which are provided at the RHC center, ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of practice as defined by state law.

Policy criteria and limitations for laboratory and radiology services are detailed in the Physician Services Provider Manual.

### EPSDT Services

Refer to EPSDT services policies within the Physician Services Provider Manual.

### Family Planning Services

Family Planning services are available to all Medicaid recipients and include all medical and counseling services related to alternatives of birth control and pregnancy prevention services prescribed and rendered by physicians, hospitals, clinics, pharmacies and other practitioners and other Medicaid providers recognized by state and federal laws and enrolled as Medicaid Providers. Refer to Family Planning services policies within the Physician Services Provider Manual.