CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 166	**Date: January 31, 2013**
	Change Request 7824

SUBJECT: Reorganization of Chapter 13

I. SUMMARY OF CHANGES: Chapter 13 of the Benefit Policy Manual has been reorganized and updated

EFFECTIVE DATE: March 1, 2013
IMPLEMENTATION DATE: March 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal: 166	Date: January 31, 2013	Change Request: 7824

SUBJECT: Reorganization of Chapter 13

Effective Date: March 1, 2013
Implementation Date: March 1, 2013

I. GENERAL INFORMATION

A. Background: Chapter 13 of the Medicare Benefit Policy Manual, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, is reorganized for easier use and updated to include more comprehensive information.

B. Policy: There are no new policies contained in the manual.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7824.1	Contractors shall be aware of the reorganization and content of Pub. 100-02, Chapter 13	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7824.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction.	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Captain Corinne Axelrod/corinne.axelrod@cms.hhs.gov/410-786-5620

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)* and *Carriers*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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(Rev.166, Issued: 01-31-13)

10 - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) General Information

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

10.1 - RHC General Information

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Rural Health Clinics were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas. RHCs have been eligible to participate in the Medicare program since March 1, 1978, and are paid an all-inclusive rate per visit for qualified primary and preventive health services.

RHCs are defined in section 1861(aa)(2) of the Social Security Act (the Act) as facilities that are engaged primarily in providing outpatient services that are typically furnished in a physician's office. RHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services; and
- Services and supplies furnished incident to an NP, PA, CNM, CP, or CSW services.

RHC services may also include nursing visits to homebound individuals furnished by a registered professional nurse or a licensed professional nurse when certain conditions are met.

To be eligible for certification as an RHC, a clinic must be located in a non-urbanized area, as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary of the Department of Health and Human Services (DHHS) in any one of the four types of shortage area designations that are accepted for RHC certification.

In addition to the location requirements, an RHC must:

- Employ an NP or PA;
- Have an NP, PA, or CNM working at the clinic at least 50% of the time the clinic is operating as an RHC;
- Directly furnish routine diagnostic and laboratory services;

- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC;
- Have available drugs and biologicals necessary for the treatment of emergencies;
- Meet all health and safety requirements;
- Not be a rehabilitation agency or a facility that is primarily for mental health treatment;
- Furnish onsite all of the following six laboratory tests:
    - Chemical examination of urine by stick or tablet method or both;
    - Hemoglobin or hematocrit;
    - Blood sugar;
    - Examination of stool specimens for occult blood;
    - Pregnancy tests; and
    - Primary culturing for transmittal to a certified laboratory;
- Not be concurrently approved as an FQHC, and
- Meet other applicable State and Federal requirements.

RHCs can be either independent or provider-based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI). They are assigned a provider number in the range 3800-3974 or 8900-8999. Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH)), skilled nursing facility (SNF), or a home health agency (HHA). They are assigned a provider number in the range 3400-3499, or 3975-3999, or 8500-8899.

The statutory requirements for RHCs are found in section 1861(aa)(2) of the Act. Many of the regulations pertaining to RHCs can be found at 42 CFR 491 Subpart A and following, and 42 CFR 405.2400 Subpart X and following.

For detailed information on claims processing, refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 9, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

For detailed information on Survey and Certification, refer to Pub. 100-07, Medicare State Operations Manual, Appendix G, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_Appendicestoc.pdf

10.2 - FQHC General Information

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Federally Qualified Health Centers were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act of 1990 and were effective beginning on October 1, 1991. As with RHCs, they are also facilities that are primarily engaged in providing outpatient services that are typically furnished in a physician's office, and are paid an all-inclusive rate for qualified primary and preventive health services.

FQHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies furnished incident to an NP, PA, CNM, CP, or CSW services; and
- Outpatient diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease.

The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in section 1861(aa)(4) of the Act. No Part B deductible is applied to expenses for services that are payable under the FQHC benefit. An entity that qualifies as an FQHC is assigned a provider number in the range 1800-1989.

FQHC services also include certain preventive primary health services. The law defines Medicare-covered preventive services provided by an FQHC as the preventive primary health services that an FQHC is required to provide under section 330 of the Public Health Service (PHS) Act. Medicare may not cover some of the preventive services that FQHCs provide, such as dental services, which are specifically excluded under Medicare law.

There are 3 types of organizations that are eligible to enroll in Medicare as FQHCs:

- Health Center Grantees: Organizations receiving grants under section 330 of the Public Health Service (PHS) Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers;

- Health Center Look-Alikes (LAL) Organizations that have been identified by HRSA) as meeting the definition of "Health Center" under section 330 of the PHS Act, but not receiving grant funding under section 330; and

- Outpatient health programs/facilities operated by a tribe or tribal organization (under the Indian Self-Determination Act) or by an urban Indian organization (under Title V of the Indian Health Care Improvement Act).

NOTE: Information in this chapter applies to FQHCs that are Health Center Grantees and Health Center Look-Alikes. It does not necessarily apply to tribal or urban Indian FQHCs.

An FQHC must:

- Provide comprehensive services and have an ongoing quality assurance program;

- Meet other health and safety requirements;

- Not be concurrently approved as an RHC; and

- Meet all requirements contained in section 330 of the Public Health Service Act, including:

    - Serve a designated Medically-Underserved Area or medically-Underserved Population;

    - Offer a sliding fee scale to persons with incomes below 200% of the federal poverty level; and

    - Be governed by a board of directors, of whom a majority of the members receive their care at the Health Center.

Additional information on these and other section 330 requirements can be found at http://bphc.hrsa.gov/.

Per 42 CFR 413.65(n), only FQHCs that were operating as provider-based clinics prior to 1995 and either a) received funds under section 330 of the PHS Act or b) were determined by CMS to meet the criteria to be a look-alike clinic, are eligible to be certified as provider-based FQHCs. Clinics that do not already have provider-based status as an FQHC are not permitted to receive the designation.

For detailed information on claims processing, refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 9, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf, and Pub. 100-07, State

Operations Manual chapter 2, sections 2825 and 2826, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf.

20 - RHC and FQHC Location Requirements

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

20.1 - RHC Location Requirements

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

To be eligible for certification as an RHC, a clinic must be located in 1) a non-urbanized area, as determined by the U.S. Census Bureau, and 2) an area designated or certified within the previous 4 years by the Secretary of the Department of Health and Human Services in any one of the four types of shortage area designations that are accepted for RHC certification as listed in section 20.1.2.

A clinic applying to become a Medicare-certified RHC must meet both the rural and underserved location requirements. Mobile clinics must have a fixed schedule that specifies the date and location for services, and each location must meet the location requirements.

20.1.1 - Non-Urbanized Area Requirement

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

The U.S. Census Bureau determines if an area is an urbanized area (UA). Any area that is not in a UA is considered a non-urbanized area. A clinic located in an area that is not a UA would meet the RHC requirement for being in a non-urbanized area. Information on whether an area is in an urbanized area can be found at http://factfinder.census.gov; or http://www.raconline.org; or by contacting the appropriate CMS Regional Office (RO) at http://www.cms.gov/RegionalOffices/.

20.1.2 - Designated Area Requirement

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

The HRSA designates areas as Medically Underserved Areas and/or Health Professional Shortage Areas. To be eligible for RHC certification, a clinic must be located in an area that has one of the following types of shortage area designations:

- Geographic Primary Care Health Professional Shortage Area (HPSA);
- Population-group Primary Care HPSA;
- Medically-Underserved Area (this does not include the population group Medically Underserved Population designation); or
- Governor-Designated and Secretary-Certified Shortage Area.

No other type of shortage area designation is accepted for purposes of RHC certification. The designation cannot be more than 4 years old in order to meet the requirement of being in a currently designated area. For RHC purposes, the age of the designation is calculated as the last day of the year 4 years from the date of the original designation, or the date the area was last designated. For example, a clinic that is located in an area that was most recently designated or updated on June 1, 2010, would be considered as meeting this location requirement through December 31, 2014.

Areas that are listed as "proposed for withdrawal" are considered designated. The designation date is the date that the area was last updated, not when the area was proposed for withdrawal. To determine the designation date of an area that is listed as "proposed for withdrawal", contact HRSA's Shortage Designation Branch at sdb@hrsa.gov or call 1-888-275-4772.

20.2 - FQHC Location Requirements

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

FQHCs may be located in rural or urban areas. FQHCs that are Health Center Grantees or Look-Alikes must be located in or serve a HRSA-designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP).

30 - RHC and FQHC Staffing Requirements

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

30.1 - RHC Staffing

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

30.1.1 - Requirements

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

In addition to the location requirements, an RHC must:

- Employ an NP or PA; and
- Have an NP, PA, or CNM working at the clinic at least 50% of the time the clinic is operating as an RHC.

The employment may be full or part time. The following situations would NOT satisfy this requirement:

- An NP or PA who is employed by a hospital that has an ownership interest in the RHC but is not physically present and working in the RHC;
- A CNM who is employed by the RHC; or

- An NP or PA who is a locum tenens.

An RHC practitioner is a physician, NP, PA, CNM, CP, or CSW. At least one of these practitioners must be present in the RHC and available to furnish patient care at all times the RHC is in operation. A clinic that is open solely to address administrative matters or to provide shelter from inclement weather is not considered to be in operation during this period and is not subject to the staffing requirements.

An NP, PA, or CNM must be available to furnish patient care at least 50 percent of the time that the RHC is open to provide patient care. This requirement can be fulfilled through any combination of NPs, PAs, or CNMs as long as the total is at least 50 percent of the time the clinic is open to provide patient care. Only the time that an NP, PA, or CNM spends in the clinic is counted towards the 50 percent and does not include services furnished to a patient in a location outside the clinic (home, SNF, etc.).

Information must be posted at or near the entrance that clearly states the days of the week and the hours that RHC services are furnished, and days of the week and the hours that the building is open solely for administrative or other purposes. This information should be easily readable, including by people with vision problems and people who are in wheel chairs.

If a patient presents at the clinic with an emergency when the clinic is not open for patient care because a physician, NP, PA, CNM, CP, or CSW is not present, other staff may attend to the patient until care of the individual can be transferred. Any care provided in this situation must be within the individual's ability, training, and scope of practice, and in accordance with State laws, and would not be considered an RHC service.

A clinic located on an island that otherwise meets the requirements for RHC certification is not required to employ an NP or PA, although it is still required to have an NP or PA at least 50% of the time that the RHC is in operation (OBRA '89, Sec 4024). An island is a body of land completely surrounded by water, regardless of size and accessibility (e.g., bridges).

It is the responsibility of the RHC to assure that all staffing requirements are met and that RHC practitioners provide services in accordance with State and Federal laws and regulations.

See section 70.4 of this chapter for information on productivity standards for RHC staff.

30.1.2 - Temporary Staffing Waivers

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

An existing RHC may request a temporary staffing waiver if the clinic met the staffing requirements before seeking the waiver, and either or both of the following occur:

- An NP or PA is not currently employed by the RHC

- An NP, PA, or CNM is not furnishing patient care at least 50% of the time the clinic operates.

To receive a temporary staffing waiver, a clinic must demonstrate that it has made a good faith effort to recruit and retain the required provider(s) in the 90 day period prior to the waiver request. Recruitment activities should begin as soon as the clinic becomes aware that they will no longer be in compliance with this requirement. Good faith efforts can include activities such as advertising in an appropriate newspaper or professional journal, conducting outreach to an NP, PA, or CNM school, or other activities.

Staffing waivers are for a period not to exceed 1 year. The waiver cannot be extended beyond 1 year, and another waiver cannot be granted until a minimum of 6 months have elapsed since the prior waiver expired. RHCs should continue their recruitment activities during the waiver period to avoid termination when the waiver period ends.

30.1.3 - Termination

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

An RHC will be terminated if any of the following occur:

- The RHC does not meet the staffing requirements and does not request a temporary staffing waiver;

- The RHC requests a temporary staffing waiver and the request is denied due to a lack of good faith effort to meet the requirements;

- The RHC does not meet the staffing requirements and is not eligible for a temporary staffing waiver because less than 6 months have passed since the expiration of the previous waiver;

- The RHC reaches the expiration date of the temporary staffing waiver and has not come into compliance; or

- Other non-compliance issue.

30.2 - FQHC Staffing

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

FQHCs must have a core staff of appropriately trained primary care clinicians and meet other clinical requirements. It is the responsibility of the FQHC to assure that all staffing requirements are met and that FQHC practitioners provide services in accordance with State and Federal laws and regulations. Additional information on statutory requirements can be found at: http://bphc.hrsa.gov/about/requirements/index.html.

See section 70.4 of this chapter for information on productivity standards for FQHC staff.

40 - RHC and FQHC Visits

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

An RHC or FQHC visit is defined as a medically-necessary, face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered. An Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV) can also be considered an RHC or FQHC visit.

An RHC or FQHC visit can also be a visit between a home-bound patient and a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN) under certain conditions. See section 180 of this chapter for information on visiting nursing services to home-bound patients.

Under certain conditions, an FQHC visit also may be provided by qualified practitioners of outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) when the FQHC meets the relevant program requirements for provision of these services.

An RHC or FQHC patient includes:

- Individuals who receive services at the RHC or FQHC;
- Individuals who receive services at a location other than the RHC or FQHC for which the RHC or FQHC bills for the service or is financially responsible for the provision of the service; or
- Individuals whose cost of care is included in the cost report of the RHC or FQHC.

40.1 - Location

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

An RHC or FQHC visit may take place in the RHC or FQHC, the patient's residence, an assisted living facility, a Medicare-covered Part A SNF, the scene of an accident, or any other location except:

- an inpatient or outpatient hospital, including CAHs, or
- a facility which has specific requirements that preclude RHC or FQHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).

Qualified services provided to an RHC or FQHC patient in a location other than the RHC or FQHC facility are considered RHC or FQHC services if:

- the practitioner is compensated by the RHC or FQHC for the services provided, and

- the cost of the service is included in the RHC or FQHC cost report.

This applies to full and part time practitioners, and it applies regardless of whether the practitioner is an employee of the RHC or FQHC, or working under contract to the RHC or FQHC, or is compensated by the RHC or FQHC under another type of arrangement. RHCs and FQHCs should have clear policies regarding the provision of services in other locations and include this in a practitioner's employment agreement or contract.

RHC and FQHC practitioners who are compensated by the RHC or FQHC for services furnished in other locations may not bill Medicare Part B for these services. If the RHC or FQHC includes the costs of these services on their cost report, the services may not be billed to Medicare Part B. Services furnished to patients in any type of hospital setting (inpatient, outpatient, or emergency department) are statutorily excluded from the RHC/FQHC benefit and, if appropriate, the service may be billed to Medicare Part B. Services that are billed to Medicare Part B cannot be claimed as an RHC or FQHC cost.

Except for hospital settings, services furnished in a location other than the RHC or FQHC (either during the posted hours of operation or during another time), and services furnished to RHC or FQHC patients (either those seen previously in the RHC or FQHC or those not previously seen), are billed as an RHC or FQHC visit when the RHC or FQHC includes the practitioner's compensation for these services in the RHC or FQHC cost report. If the cost of a service is not included on the RHC or FQHC cost report, the service may be billed to Part B if appropriate. Only compensation paid for RHC or FQHC services can be claimed on the cost report.

40.2 - Hours of Operation

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs are required to post their hours of operations. Qualified services provided to an RHC or FQHC patient other than during the posted hours of operation, are considered RHC or FQHC services when both of the following occur:

- the practitioner is compensated by the RHC or FQHC for the services provided, and

- the cost of the service is included in the RHC or FQHC cost report.

Services furnished at times other than the RHC or FQHC posted hours of operation to Medicare beneficiaries who are RHC or FQHC patients may not be billed to Medicare Part B if the practitioner's compensation for these services is included in the RHC/FQHC cost report. Services whose cost is not included in the RHC/FQHC cost report may be billed as Part B services if appropriate.

This applies to both full and part time practitioners and to practitioners who are employees, working under contract to the RHC or FQHC, or are compensated by the RHC or FQHC under another type of arrangement. RHCs and FQHCs should have clear policies regarding the provision of services at other times, and include this in a practitioner's employment agreement or contract.

40.3 - Multiple Visits on Same Day

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit, regardless of the length or complexity of the visit or whether the second visit is a scheduled or unscheduled appointment. This would include situations where an RHC or FQHC patient has a medically-necessary face-to-face visit with an RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner (including a specialist) for evaluation of a different condition on the same day.

More than one medically-necessary face-to-face visit with an RHC or FQHC practitioner on the same day is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (2 visits), or

- The patient has a medical visit and a mental health visit on the same day (2 visits), or

- The patient has his/her IPPE and a separate medical and/or mental health visit on the same day (2 or 3 visits). The IPPE, also known as the "Welcome to Medicare Visit", is a one-time exam that must occur within the first 12 months following the beneficiary's enrollment.

The AWV can be billed as a visit if it is the only medical service provided on that day with an RHC or FQHC practitioner. If it is furnished on the same day as a medical visit, it is not a separately billable visit. If the AWV is provided on the same day as a mental health visit with an RHC or FQHC provider, then two visits can be billed.

For FQHCs only, a patient may have a DSMT/MNT visit in addition to any combination of the above exceptions which can result in two or more visits.

40.4 - Global Billing

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services. For RHC or FQHC services, the RHC or FQHC is paid based on its all-inclusive rate and is not subject to the Medicare global billing requirements.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If an RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package.

Services not included in the global surgical package are listed in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 40.1.B, and include (but are not limited to): initial consultation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed (unless the visit occurs due to complications of the surgery); treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery; etc.

For additional information on global billing, see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

40.5 - 3-Day Payment Window

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Medicare's 3-day payment window applies to outpatient services furnished by hospitals and hospitals' wholly owned or wholly operated Part B entities. The statute requires that hospitals' bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with section 1886 of the Social Security Act.

RHCs and FQHC services are not subject to the Medicare 3- day payment window requirements.

For additional information on the 3 day payment window, see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7502.pdf

50 - RHC and FQHC Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

50.1 - RHC Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHC services include:

- Physicians' services, as described in section 100;
- Services and supplies incident to a physician's services, as described in section 110;
- Services of NPs, PAs, and CNMs, as described in section 120;
- Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 130;
- CP and CSW services, as described in section 140;
- Services and supplies incident to the services of CPs and CSWs, as described in section 150; and
- Visiting nurse services to the homebound as described in section 180.

RHC services also include certain preventive services when specified in statute or when established through the National Coverage Determination (NCD) process and not specifically excluded. These services include, but are not limited to:

- Influenza, Pneumococcal, and Hepatitis B vaccinations;
- Initial Preventive Physical Exam (IPPE) (also known as the "Welcome to Medicare Physical Exam");
- Annual Wellness Visit; and
- Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B as appropriate for the individual.

50.2 - FQHC Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

FQHC services include all of the RHC services listed in section 50.1 of this chapter. While the following services may also be furnished in an RHC, the statute specifically lists certain services as FQHC services, including but not limited to:

- Screening mammography;
- Screening pap smear and screening pelvic exam;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- Diabetes outpatient self-management training (DSMT) services;
- Diabetes screening tests;
- Medical nutrition therapy (MNT) services;
- Bone mass measurement;
- Screening for glaucoma;
- Cardiovascular screening blood tests; and
- Ultrasound screening for abdominal aortic aneurysm.

50.3 - Emergency Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs provide outpatient services that are typically furnished in a physician's office or clinic and are not set up for emergency care. Neither independent nor hospital-based RHCs are subject to Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. However, RHC practitioners are required to provide medical emergency procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. The definition of a "first response" is a service that is commonly provided in a physician's office.

During their regular hours of operations, FQHC practitioners are required to provide medical procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biological commonly used in life-saving procedures. After their operating hours, FQHCs must provide telephone access to an

individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open.

60 - Non RHC/FQHC Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs may furnish services that are beyond the scope of the RHC or FQHC benefit. If these services are covered under a separate Medicare benefit category, the services must be billed separately to the appropriate MAC/FI under the payment rules that apply to the service. Since these services are not RHC or FQHC services, all costs associated with these services, such as space, equipment, supplies, facility overhead, and personnel, must be identified and removed from allowable costs on the Medicare RHC or FQHC cost report.

60.1 - Description of Non RHC/FQHC Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Certain services are not considered RHC or FQHC services either because they 1) are not included in the RHC or FQHC benefit, or 2) are not a Medicare benefit. Non-RHC/FQHC services include, but are not limited to:

Medicare excluded services - Includes routine dental care, hearing tests, eye exams, etc. For additional information, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf

Technical component of an RHC or FQHC service - Includes diagnostic tests such as x-rays, EKGs, and certain preventive services authorized by Medicare statute or the NCD process. These services may be billed to the FI/AB MAC. (The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner).

Laboratory services - Although RHCs and FQHCs are required to furnish certain laboratory services ((for RHCs see section 1861(aa)(2)(G) of the Act), and for FQHCs see section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report.

Durable medical equipment - Includes crutches, hospital beds, and wheelchairs used in the patient's place of residence, whether rented or sold.

Ambulance services

Prosthetic devices - Includes items which replace all or part of an internal body organ (e.g., artificial legs, arms and eyes) and supplies directly related to the care and replacement of such devices (e.g., ostomy supplies).

Body Braces – Includes leg, arm, back, and neck braces and their replacements.

Practitioner services at certain other Medicare facility – Includes services furnished to inpatients or outpatients in a hospital (including CAHs), ambulatory surgical center, Medicare Comprehensive Outpatient Rehabilitation Facility, etc., or other facility whose requirements preclude RHC or FQHC services. (Note: Covered services provided to a Medicare beneficiary by an RHC or FQHC practitioner in a SNF may be an RHC or FQHC service.)

Auxiliary services – Includes language interpretation, transportation, security, etc. (Although FQHCs may be required to furnish some of these services, they are not included within the scope of the FQHC visit).

Telehealth distant-site services - See section 190 of this chapter for additional information on telehealth services in RHCs and FQHCs.

Hospice Services – See section 200 of this chapter for additional information on hospice services in RHCs and FQHCs.

70 - RHC and FQHC Payment Rate and Exceptions

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs are paid an all-inclusive rate (AIR) for medically-necessary, face- to-face (one-on-one) visits with an RHC or FQHC practitioner (as defined in section 30) for RHC or FQHC services (as defined in section 50). The rate is subject to a payment limit, except for RHCs that have an exception to the payment limit (see section 70.1). An interim rate is established based on the RHC's or FQHC's anticipated average cost for direct and supporting services. At the end of the reporting period, the MAC/FI determines the total payment due and reconciles payments made during the period with the total payments due.

In general, the AIR for an RHC or FQHC is calculated by the MAC/FI by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation. Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC or FQHC services.

Services furnished incident to an RHC or FQHC professional service are included in the per-visit payment and are not billed as a separate visit. The costs of covered services provided incident to a billable visit may be included on the RHC or FQHC cost report.

70.1 - RHC Per-Visit Payment Limit and Exceptions

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

The RHC payment limit was set by Congress in 1988 and is adjusted yearly based on the Medicare Economic Index (MEI). The payment limit in 2012 is $78.54 for independent RHCs and provider-based RHCs that do not have an exception to the payment limit.

A provider-based RHC that is an integral and subordinate part of a hospital (including a CAH) can receive an exception to the per-visit payment limit if:

- the hospital has fewer than 50 beds as determined at 42 CFR 412.105(b); or
- the hospital's average daily patient census count of those beds described in 42 CFR 412.105(b) does not exceed 40 and the hospital meets both of the following conditions:
    - it is a sole community hospital as determined in accordance with 42 CFR 412.92 or an essential access community hospital as determined in accordance with 42 CFR 412.109(a), and
    - it is located in a level 9 or level 10 Rural-Urban Commuting Area (RUCA). (For additional information on RUCAs, see http://depts.washington.edu/uwruca/

70.2 - FQHC Per-Visit Payment Limit

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

There is a payment limit for rural FQHCs and a payment limit for urban FQHCs. The payment limit in 2012 is $109.90 for rural FQHCs and $126.98 for urban FQHCs. The FQHC payment limits are adjusted annually based on the MEI. There are no payment limit exceptions for FQHCs.

FQHCs that are located within a Core-Based Statistical Area (CBSA) or New England County Metropolitan Area (NECMA) are considered urban FQHCs. FQHCs that are not in an MSA or an NECMA are considered rural FQHCs. Rural FQHCs cannot be reclassified as an urban FQHC for purposes of the FQHC payment limit.

70.3 - Cost Reports

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs are required to file a cost report annually in order to determine their payment rate and reconcile interim payments. If an RHC or FQHC is in its initial reporting period, the MAC/FI calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed. RHCs and FQHCs may file consolidated cost reports if approved by the MAC/FI.

Independent RHCs and FQHCs

Use form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report.

Provider Reimbursement Manual–Part 2 (Pub.15-2), chapter 29 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html on the CMS Website.

Provider-based RHCs and FQHCs

Use worksheet M of Form CMS-2552-96, Hospital and Hospital Complex Cost Report (RHCs based in other types of providers must complete the appropriate set of RHC worksheets on the cost report filed by the parent provider).

Provider Reimbursement Manual–Part 2 (Pub. 15-2), chapter 36 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html on the CMS Website.

70.4 - Productivity Standards

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in the RHC or FQHC. The current productivity standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent non-physician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined. The FTE on the cost report for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time.

The MAC/FI has the discretion to make an exception to the productivity standards for an RHC or FQHC based on individual circumstances. All visits (Medicare, Medicaid, Managed Care, etc.) are included in determining the productivity standards for the cost report.

At the end of an RHC or FQHC's cost reporting year, the MAC/FI re-calculates the all-inclusive visit rate by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If the RHC or FQHC has furnished fewer than expected visits based on the productivity standards, the MAC/FI substitutes the expected number of visits for the denominator and use that instead of the actual number of visits. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator). In this example, this would have the effect of lowering the all-inclusive visit rate.

Physician services under agreements are not subject to the productivity standards. Instead of the productivity limitation, purchased physician services are subject to a

limitation on what Medicare would otherwise pay for the services (under the Physician Fee Schedule), in accordance with 42 CFR 405.2468(d)(2)(v).

80 - RHC and FQHC Patient Charges

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

In general, Medicare pays 80 percent of the RHC or FQHC's all-inclusive rate, subject to a per-visit payment limit. The beneficiary in an RHC must pay the deductible and coinsurance amount. The beneficiary in an FQHC must pay the coinsurance amount (there is no Part B deductible in FQHCs for FQHC-covered services).

80.1 - Charges and Waivers

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs must charge Medicare beneficiaries the same rate that non-Medicare beneficiaries are charged. FQHCs may waive collection of all or part of the copayment, depending on the beneficiary's ability to pay. RHCs may waive the copayment and deductible after a good faith determination has been made that the patient is in financial need, provided the waivers are not routine and not advertised. (See 42 U.S.C. 1320a-7a(6)(A))

80.2 - Sliding Fee Scale

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs may establish a sliding fee scale if it is uniformly applied to all patients. An RHC that chooses to offer a sliding fee scale must post the policy so that all patients are aware of the policy. If the payment policy is based on an individual's income, the RHC must document that income information from the patient was obtained in order to determine that the patient qualified. Copies of their wage statement or income tax return are not required, and self-attestations are acceptable.

FQHCs approved by HRSA are required to establish a sliding fee scale in accordance with statutory and HRSA requirements.

90 - Commingling

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC or FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or

- Selectively choosing a higher or lower reimbursement rate for the services.

RHC and FQHC practitioners may not furnish RHC or FQHC-covered professional services as a Part B provider in the RHC or FQHC, or in an area outside of the certified RHC or FQHC space, such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation.

If an RHC or FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC or FQHC space must be clearly defined. If the RHC or FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

RHCs and FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC or FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC or FQHC and non-RHC or non-FQHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit an RHC physician from providing on-call services for an emergency room, as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the physician with the hospital emergency department would not be a common occurrence.

The MAC/FI has the authority to determine acceptable accounting methods for allocation of costs between the RHC or FQHC and another entity. In some situations, the practitioner’s employment agreement will provide a useful tool to help determine appropriate accounting.

100 - Physician Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

The term “physician” includes a doctor of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractic who is licensed and practicing within the licensee’s scope of practice, and meets other requirements as specified.

Physician services are professional services furnished by a physician to an RHC or FQHC patient and include diagnosis, therapy, surgery, and consultation. The physician must either examine the patient in person or be able to visualize directly some aspect of the patient’s condition without the interposition of a third person’s judgment. Direct visualization includes review of the patient’s X-rays, EKGs, tissue samples, etc.

Telephone or electronic communication between a physician and a patient, or between a physician and someone on behalf of a patient, are considered physicians' services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Services that are not medically appropriate in the office setting (e.g., appendectomy, etc.) or not commonly furnished in a physician's office are not considered physician services in an RHC or FQHC.

Qualified services furnished at an RHC or FQHC by an RHC or FQHC physician are payable only to the RHC or FQHC. RHC and FQHC physicians are paid according to their employment agreement or contract (where applicable).

100.1 - Dental, Podiatry, Optometry, and Chiropractic Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare statute and can provide RHC or FQHC services that are within their scope of practice and not excluded from coverage (e.g., Medicare coverage of chiropractic services is limited to manual manipulation of the spine for a demonstrated subluxation).

RHCs and FQHCs are required to primarily provide primary health care. Since dentists, podiatrists, optometrists, and chiropractors are not considered primary care physicians, they do not meet the requirements to be either i) a physician medical director or ii) the physician or non-physician practitioner (NP, PA, or CNM) that must be available at all times the clinic is open. Therefore, a dentist, podiatrist, optometrist, or chiropractor can provide a medically necessary, face-to-face visit with an RHC or FQHC patient only when the statutory and regulatory staffing requirements are otherwise met.

For additional information on these services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 on Covered Medical and Other Health Service at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

100.2 - Treatment Plans or Home Care Plans

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Treatment plans and home care oversight provided by RHC or FQHC physicians to RHC or FQHC patients are considered part of the RHC or FQHC visit and are not a separately billable service.

100.3 - Graduate Medical Education

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs may receive direct graduate medical education (GME) payment for residents if the RHC or FQHC incurs all or substantially all of the costs for the training program. "All or substantially all" means the residents' salaries and fringe benefits

(including travel and lodging expenses where applicable), and the portion of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education. Allowable costs incurred by the RHC or FQHC for GME are paid on a reasonable cost basis and are not subject to the payment limit. RHCs and FQHCs may claim allowable costs only while residents are on their RHC or FQHC rotation.

RHCs and FQHCs that are receiving GME payment may not separately bill for an RHC or FQHC visit provided by a resident, as the cost of these practitioners is included in the GME payment. A medically-necessary, face-to-face encounter with a teaching physician who is an RHC or FQHC practitioner may be a billable visit if applicable teaching physician supervision and documentation requirements are met.

For additional information refer to 42 CFR 405.2468 (f) and 42 CFR 413.75(b).

110 - Services and Supplies Furnished Incident to Physician's Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Services and supplies that are an integral, though incidental, part of the physician's professional service:

- Commonly rendered without charge or included in the RHC or FQHC bill;
- Commonly furnished in a physician office or clinic;
- Furnished under the physician's direct supervision; and
- Furnished by a member of the RHC or FQHC staff.

Incident to services and supplies include:

- Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal);
- Bandages, gauze, oxygen, and other supplies; or
- Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician.

Drugs that must be billed to the DME MAC or to Part D are not included.

NOTE: Payment for Medicare-covered Part B drugs that are not usually self-administered and are furnished by an RHC or FQHC practitioner to a Medicare patient are included in the RHC and FQHC all-inclusive rate. However, Section 1861(s)(2)(G) of the Act provides an exception for RHCs when a physician prepares a specific formulation of an antigen for a patient if the antigen is "forwarded to another qualified person (including a rural health clinic) for administration to such patient…, by or under

the supervision of another such physician." An RHC provider (physician, NP, PA, or CNM) acting within their scope of practice may administer the drug and the cost of the administration may be included on the RHC's cost report as an allowable expense. The cost of the antigen prepared by a physician outside of the RHC is not included in the RHC all-inclusive rate. Physicians who prepare an antigen that is forwarded to an RHC should submit a claim for the antigen in accordance with instructions from the contractor that processes their part B claims and applicable CMS requirements.

110.1 - Provision of Incident to Services and Supplies

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physician's visit must result from the patient's encounter with the physician and be furnished in a medically appropriate timeframe. More than one incident to service or supply can be provided as a result of a single physician visit.

Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC or FQHC to provide services. Services or supplies provided by individuals who are not employed by or under direct contract with the RHC or FQHC, even if provided on the physician's order or included in the RHC or FQHC's bill, are not covered as incident to a physician's service. An example of services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the clinic for inclusion in the entity's statement of services, services provided by an independent laboratory or a hospital outpatient department, etc.

Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service. Direct supervision does not mean that the physician must be present in the same room. However, the physician must be in the RHC or FQHC and immediately available to provide assistance and direction throughout the time the practitioner is furnishing services.

110.2 - Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Services furnished incident to a physician's visit by RHC or FQHC auxiliary personnel in the patient's home or location other than the RHC or FQHC must have direct supervision by the physician. For example, if a nurse on the staff of an RHC or FQHC accompanies the physician on a house call and administers an injection, the nurse's services would be considered incident to the physician's visit. If the same nurse makes the call alone and administers an injection, the services are not incident to services since the physician is not providing direct supervision. The availability of the physician by telephone and the presence of the physician somewhere in the building does not constitute direct

supervision. (This rule applies only to the incident to provision. It does not apply to visiting nursing services described in section 180.) For additional information on supervision requirements for Part B services incident to physician services see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 60.1.

110.3 - Payment for Incident to Services and Supplies

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Services that are covered by Medicare but do not meet the requirements for a medically necessary visit with an RHC or FQHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.

Incidental services or supplies must represent an expense incurred by the RHC or FQHC. For example, if a patient purchases a drug and the physician administers it, the cost of the drug is not covered and cannot be included on the cost report.

If a Medicare-covered Part B drug is furnished by an RHC or FQHC practitioner to a Medicare patient, the drug is covered and paid for as an RHC or FQHC service. The cost of the drug is an allowable cost and is part of the clinic's all-inclusive rate calculation.

120 - Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Professional services furnished by an NP, PA, or CNM to an RHC or FQHC patient are services that would be considered covered physician services under Medicare (see section 100), and which are permitted by State laws and clinic or center policies. Services may include diagnosis, treatment, and consultation. The NP, PA, or CNM must directly examine the patient, or directly review the patient's medical information such as X-rays, electrocardiogram (EKG) and electroencephalograms, tissue samples, etc. Telephone or electronic communication between an NP, PA, or CNM and a patient, or between such practitioner and someone on behalf of a patient, are considered NP, PA, or CNM services, and are included in an otherwise billable visit. They do not constitute a separately billable visit.

120.1 - Requirements

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Services performed by NPs, PAs, and CNMs must be:

- Furnished by an employee of the RHC or FQHC;

- Furnished under the general (or direct, if required by State law) medical supervision of a physician;

- Furnished in accordance with RHC or FQHC policies and any physician medical orders for the care and treatment of a patient;

- A type of service which the NP, PA, or CNM who furnished the service is legally permitted to furnish by the State in which the service is rendered;

- Furnished in accordance with State restrictions as to setting and supervision;

- Furnished in accordance with written RHC or FQHC policies that specify what services these practitioners may furnish to patients; and

- A type of service which would be covered under Medicare if furnished by a physician.

120.2 - Physician Supervision

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs which are not physician-directed must have an arrangement with a physician that provides for the supervision and guidance of NPs, PAs, and CNMs. The arrangement must be consistent with State law and provide for at least one onsite supervisory visit by the physician every 2 weeks (except in extraordinary circumstances). The physician must be a doctor of medicine or osteopathy. See Pub. 100-07, State Operations Manual, for examples of extraordinary circumstances.

120.3 - Payment to Physician Assistants

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Section 1842(b)(6)(C) of the Social Security Act prohibits PAs from enrolling in and being paid directly for Part B services. Therefore, Medicare Part B payment can only be made to a PA's employer (unless the employer is a PA or a group of PAs), and an RHC that is owned by a PA may not directly bill Medicare Part B for Medicare-covered services that are not included in the RHC benefit.[1]

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[1] The only exception to this is found in Section 4205(d)(3)(B) of the Balanced Budget Act (BBA), which amended Section 1842(b)(6)(C) of the Act to allow Medicare to directly pay a PA when the PA was the owner of an RHC for a continuous period beginning before the date of the enactment of the BBA, and ending on the date the Secretary determines the RHC no longer meets the requirements of Section 1861(aa)(2) of the Act, for services furnished before January 1, 2003.

130 - Services and Supplies Incident to NP, PA, and CNM Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Services and supplies that are incident to an NP, PA, or CNM service must be:

- A type of service commonly furnished in physician's offices;
- Furnished as an incidental, though integral, part of professional services furnished by an NP, PA, or CNM;
- Furnished under the direct supervision of an NP, PA, or CNM; and
- Furnished by a member of the RHC or FQHC staff who is an employee of the RHC or FQHC.

NOTE: The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC.

Services and supplies covered under this provision are generally the same as described in section 110 as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.

140 - Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

A CP is an individual who:

- Holds a doctoral degree in psychology from a program in clinical psychology of an educational institution that is accredited by an organization recognized by the Council on Post-Secondary Accreditation;
- Meets licensing or certification standards for psychologists in independent practice in the State in which he or she practices; and
- Has had 2 years of supervised clinical experience, at least one of which is post-degree.

A CSW is an individual who:

- Holds a master's or doctor's degree in social work;
- Has performed at least 2 years of supervised clinical social work; and

- Is licensed or certified as a clinical social worker by the State in which the services are performed; or, in the case of an individual in a State that does not provide for licensure or certification, has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, SNF, or clinic.

Services may include diagnosis, treatment, and consultation. The CP or CSW must directly examine the patient, or directly review the patient's medical information. Telephone or electronic communication between a CP or CSW and a patient, or between such practitioner and someone on behalf of a patient, are considered CP or CSW services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service. Services that a hospital or SNF is required to provide to an inpatient or outpatient as a requirement for participation are not included.

Services performed by CPs and CSWs must be:

- Furnished by an employee of the RHC or FQHC;
- Furnished in accordance with clinic or center policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the CP or CSW who furnished the service is legally permitted to furnish by the State in which the service is rendered; and
- Furnished in accordance with State restrictions as to setting and supervision, including any physician supervision requirements.

150 - Services and Supplies Incident to CP and CSW Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Services and supplies that are incident to a CP or CSW service must be:

- A type of service or supply commonly furnished in a CP or CSW's office;
- Furnished as an incidental, though integral, part of professional services furnished by a CP or CNM;
- Furnished under the direct supervision of the CP or CSW; and
- Furnished by an employee of the clinic or center.

NOTE: The direct supervision requirement is met in the case of a CP or CSW who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC.

Services and supplies covered under this provision are generally the same as described in section 110 as incident to a physician's services and include services and supplies incident to the services of a CP or CSW.

160 - Outpatient Mental Health Treatment

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Since the inception of the Medicare Part B program, most covered services furnished by qualified practitioners for the treatment of mental, psychoneurotic, and personality disorders have been subject to an outpatient mental health treatment limitation of 62.5 percent of the Medicare approved amount for those services. This limitation is being phased out and will achieve parity with other services in 2014. The yearly percentage of the limitation is as follows:

- January 1, 2010 – December 31, 2011 - 68.75%. (Medicare pays 55% and the patient pays 45%).

- January 1, 2012 – December 31, 2012, the limitation percentage is 75%. (Medicare pays 60% and the patient pays 40%).

- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%. (Medicare pays 65% and the patient pays 35%).

- January 1, 2014 – onward, the limitation percentage is 100%. (Medicare pays 80% and the patient pays 20%).

For additional details concerning the outpatient mental health treatment limitation, see Pub. 100-04, Medicare Claims Processing Manual, chapter 9, section 60 and chapter 12, section 210.

170 - Physical and Occupational Therapy

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Physical Therapy (PT) and Occupational Therapy (OT) may be provided in the RHC or FQHC directly by a physician, NP, or PA, if included in the practitioner's scope of practice. A physician, NP, or PA may also supervise the provision of PT and OT services provided incident to their professional services in the RHC or FQHC by a PT or OT therapist.

PT and OT therapists who provide services incident to a physician, NP, or PA visit must be an employee of the RHC or FQHC or have an employment agreement where the RHC or FQHC controls and dictates the individual's hours and working conditions. A

therapist in private practice or contracted to the RHC or FQHC by another provider or supplier cannot provide PT or OT services incident to a visit with an RHC or FQHC practitioner.

PT and OT services are included in the charges for an otherwise billable visit if all of the following occur:

- The PT or OT is furnished by a qualified therapist incident to a professional service as part of an otherwise billable visit,
- The service furnished is within the scope of practice of the therapist, and
- The therapist is employed by or has an employment agreement with the RHC or FQHC.

If the services are furnished on a day when no otherwise billable visit has occurred, the PT or OT service provided incident to the visit would become part of the cost of operating the RHC or FQHC. The cost would be included in the costs claimed on the cost report and there would be no billable visit.

If a PT or OT therapist in private practice furnishes services in an RHC or FQHC, all associated costs must be carved out of the cost report.

180 - Visiting Nursing Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

180.1 - Description of Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

A visiting nurse provides skilled nursing services. The determination of whether a service requires the skills of a nurse is based on the complexity of the service (e.g., intravenous and intramuscular injections or insertion of catheters), the condition of the patient (e.g., a non-skilled service that, because of the patient's condition, can only be safely and effectively provided by a nurse), and accepted standards of medical and nursing practice. All services must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition.

A service that can be safely and effectively self-administered or performed by a nonmedical person without the direct supervision of a nurse, is not considered a skilled nursing service, even if provided by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. Where the patient needs the skilled nursing care and there is

no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

The determination of whether visiting nurse services are reasonable and necessary is made by the physician based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

180.2 - Requirements

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

All of the following requirements must be met for visiting nurse services to be considered an RHC or FQHC visit:

- The patient is considered homebound as defined in chapter 7, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf;

- The RHC or FQHC is located in an area that has a shortage of home health agencies;

- The services and supplies are provided under a written plan of treatment;

- Nursing services are furnished on a part-time or intermittent basis only; and

- Drugs and biological products are not provided.

180.3 - Home Health Agency Shortage

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

A shortage of home health agencies exists if an RHC or FQHC is located in a county, parish or similar geographic area in which the Secretary has determined that:

- There is no participating home health agency under Medicare, or adequate home health services are not available to clinic patients even though a participating home health agency is in the area; or

- There are patients whose homes are not within the area serviced by a participating home health agency; or considering the area's climate and terrain, whose homes are not within a reasonable traveling distance to a participating home health agency.

180.4 - Authorization for Visiting Nursing Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs located in an area that has not been determined to have a current home health shortage and are seeking to provide visiting nurse services must make a written request to the State agency along with written justification that the area it serves meets the required conditions.

FQHCs located in an area that has not been determined to have a current home health shortage and are seeking to provide visiting nurse services must make a written request to the CMS RO along with written justification that the area it serves meets the required conditions.

180.5 - Treatment Plans

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

For services and supplies that require a treatment plan, the treatment plan must be written and reviewed by a supervising physician, NP, PA, CNM, CP, or CSW, as appropriate, at least once every 60 days; and meet other documentation requirements. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated for the purpose of Medicare coverage unless:

- the supervising physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient, or

- it is clear from the facts in the case that nursing visits are required at intervals less frequently than once every 60 days, but the intervals are predictable, e.g., it is predictable that a visit is required only every 90 days for the purpose of changing a silicone catheter.

Home nursing visits furnished before the plan is put into writing are covered if authorized in writing by the supervising physician.

190 - Telehealth Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

RHCs and FQHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. RHCs and FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

Although FQHC services are not subject to the Medicare deductible, the deductible must be applied when an FQHC bills for the telehealth originating site facility fee, since this is not considered an FQHC service.

RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner, and may not bill or include the cost of a visit on the cost report. For more information on Medicare telehealth services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, and Pub. 100-04, Medicare Claims Processing Manual, chapter 12.

200 - Hospice Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

The hospice statute specifies that Medicare beneficiaries who elect the Medicare hospice benefit may choose either an individual physician or NP to serve as their attending practitioner. That individual must be enrolled in and bill Medicare Part B for attending services. A physician or NP who works for an RHC or FQHC may provide hospice attending services during a time when he/she is not working for the RHC or FQHC (unless prohibited by their RHC or FQHC contract or employment agreement). The physician or NP would bill for services under regular Part B rules using his/her own provider number. These services would not be considered RHC or FQHC services. Any service provided to a hospice beneficiary by an RHC or FQHC practitioner must comply with Medicare prohibitions on commingling. (See section 90 of this chapter).

RHCs and FQHCs can treat hospice beneficiaries for any medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from an RHC or FQHC related to his/her terminal illness, the RHC or FQHC cannot be reimbursed for the visit, even if it is a medically necessary, face-to-face visit with an RHC or FQHC provider, since that would result in duplicate payment for services.

210 - Preventive Health Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Preventive services can be professional services, technical services, or both. Only the professional component of a preventive service is an RHC or FQHC service.

210.1 - Preventive Health Services in RHCs

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

210.1.1 - Pneumococcal and Influenza Vaccines

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Pneumococcal and influenza vaccines and their administration are paid at 100 percent of reasonable cost. When an RHC practitioner (physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the cost of the vaccines and administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should not be reported on an RHC claim when billing for RHC services, and the beneficiary pays no Part B deductible or coinsurance for these services.

210.1.2 - Hepatitis Vaccines

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Hepatitis vaccines and their administration are included in the RHC visit and are not separately billable. The cost of the vaccines and administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the RHC provides.

210.1.3 - Diabetes Counseling and Medical Nutrition Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Diabetes counseling or medical nutrition services provided by a registered dietician or nutritional professional at an RHC may be considered incident to a visit with an RHC provider provided all applicable conditions are met. DSMT and MNT provided under the Medicare coverage requirements are covered services when provided in an RHC. However, the actual delivery of these services does not constitute an RHC visit for purposes of billing, although the cost may be allowable on the cost report. DSMT and MNT services provided in an RHC are not eligible for payment as a visit.

Separate payment to RHCs for registered dieticians and nutritional professionals and services continues to be precluded. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates.

210.1.4 - Copayment and Deductible for Preventive Health Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Payment for the professional component of allowable preventive services is made under the AIR when all of the program requirements are met. The Affordable Care Act (ACA) waives the deductible and copayment for certain preventive services with a recommendation grade of A or B by the USPSTF. In addition, the ACA waives the deductible and coinsurance/copayment for the IPPE and AWV.

The ACA also waives the deductible for planned colorectal cancer screening tests that become diagnostic. HCPCS coding is required to allow for the coinsurance and deductible to be waived for the IPPE and AWV, and for those Medicare-covered preventive services recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual.

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment and deductible. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment and deductible is based on $100 of the total charge. If no other

RHC or FQHC service took place along with the preventive service, there would be no copayment or deductible applied.

Not all preventive services recommended by the USPSTF have a grade of A or B. In cases where they do not have this grade, the deductible and coinsurance may be waived on another basis, such as the waiver of deductible and coinsurance that currently applies to all diagnostic clinical laboratory tests.

The following Medicare covered preventive services do not comply with the USPSTF recommendation requirement (that is, the USPSTF does not recommend them with a grade of A or B): digital rectal examination provided as a prostate screening service; glaucoma screening; DSMT services; and barium enema provided as a colorectal cancer screening service. However, the deductible does not apply to barium enemas provided as colorectal cancer screening tests because colorectal cancer screening tests are explicitly excluded from the deductible under another section of the statute.

210.2 - Preventive Health Services in FQHCs

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

210.2.1 - General

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

FQHCs must provide preventive health services on site or by arrangement with another provider. These services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW. Other services that must be provided directly by an FQHC or by arrangement with another provider include: preventive dental services, mental health and substance abuse services , transportation services necessary for adequate patient care, hospital and specialty care.

Section 330(b)(1)(A)(i)(III) of the Public Health Service (PHS) Act required preventive health services can be found at http://bphc.hrsa.gov/policiesregulations/legislation/index.html, and include:

- prenatal and perinatal services;
- appropriate cancer screening;
- well-child services;
- immunizations against vaccine-preventable diseases;
- screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- voluntary family planning services; and
- preventive dental services.

NOTE: The cost of providing these services may be included in the FQHC cost report but they do not by themselves constitute a billable visit.

210.2.2 - Pneumococcal and Influenza Vaccines

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Pneumococcal and influenza vaccines and their administration are paid at 100 percent of reasonable cost. When an FQHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the FQHC may not bill for a visit; however, the costs of the vaccine and its administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should be reported on an FQHC claim when billing for FQHC services, and the beneficiary pays no coinsurance for these services.

210.2.3 - Hepatitis Vaccines

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Hepatitis vaccines and their administration are included in the FQHC visit and are not separately billable. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the FQHC provides.

210.2.4 - Diabetes Counseling and Medical Nutrition Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

DSMT and MNT provided under the Medicare coverage requirements are covered services when provided in an FQHC. Since January 1, 2006, these services qualify as an FQHC visit when they are provided in a one-on-one, face-to-face encounter and billed using the appropriate HCPCS and site of service revenue codes. Other diabetes counseling or medical nutrition services provided by a registered dietician at the FQHC may be considered incident to a visit with an FQHC provider.

Program requirements for DSMT services are set forth in 42 CFR 410 Subpart H for DSMT and in part 410, Subpart G for MNT services, and additional guidance can be found at Pub. 100-02, chapter 15, section 300.

DSMT and MNT services may be provided in a group setting, but do not meet the criteria for a separate qualifying visit and, therefore, cannot be billed as a visit. The cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate.

210.2.5 - Copayment and Deductible for Preventive Services

(Rev.166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

Payment for the professional component of allowable preventive services is made under the AIR when all of the program requirements are met. HCPCS coding is required to allow for the coinsurance to be waived for IPPE, the annual wellness visit, and those

Medicare covered preventive services recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual.

When one or more preventive services that meet the specified criteria is provided as part of an FQHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment and deductible. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment is based on $100 of the total charge. If no other FQHC service took place along with the preventive service, there would be no copayment applied.

The ACA waives the deductible and copayment for certain preventive services with a recommendation grade of A or B by the USPSTF. In addition, the ACA waives the deductible and coinsurance/copayment for the IPPE and annual wellness visit.

Not all preventive services recommended by the USPSTF have a grade of A or B. In cases where they do not have this grade, the deductible and coinsurance may be waived on another basis, such as the waiver of deductible and coinsurance that currently applies to all diagnostic clinical laboratory tests.

The following Medicare covered preventive services do not comply with the USPSTF recommendation requirement (that is, the USPSTF does not recommend them with a grade of A or B): digital rectal examination provided as a prostate screening service; glaucoma screening; DSMT services; and barium enema provided as a colorectal cancer screening service. However, the deductible does not apply to barium enemas provided as colorectal cancer screening tests because colorectal cancer screening tests are explicitly excluded from the deductible under another section of the statute.