

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 217	Date: December 31, 2015
	Change Request 9442

SUBJECT: Rural Health Clinic and Federally Qualified Health Center - Medicare Benefit Policy Manual Update

I. SUMMARY OF CHANGES: Chapter 13 of the Benefit Policy Manual has been updated to include information on payment for chronic care management services, payment for Grandfathered Tribal Federally Qualified Health Centers, removal of obsolete provisions, and reorganization of some sections.

EFFECTIVE DATE: February 01, 2016

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

IMPLEMENTATION DATE: February 01, 2016

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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R	13/Index of Acronyms
R	13/10.1/RHC General Information
R	13/10.2/FQHC General Information
R	13/20/RHC and FQHC Location Requirements
R	13/20.1/Non-Urbanized Area Requirement for RHCs
D	13/20.1.1/Non-Urbanized Area Requirement
D	13/20.1.2/Designated Shortage Area Requirement for RHCs
R	13/20.2/Designated Shortage Area Requirement for RHCs
R	13/30.1/RHC Staffing Requirements
D	13/30.1.1/Requirements
D	13/30.1.2/Temporary Staffing Waivers
R	13/30.2/RHC Temporary Staffing Waivers
N	13/30.3/FQHC Staffing Requirements
R	13/40/RHC and FQHC Visits

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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N	13/80.4/RHC Productivity Standards
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N	13/90.1/Charges and Waivers
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R	13/120.1/Provision of Incident to Services and Supplies

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N	13/220.4/Copayment for FQHC Preventive Health Services

III. FUNDING:

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 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.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 217	Date: December 31, 2015	Change Request: 9442
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SUBJECT: Rural Health Clinic and Federally Qualified Health Center - Medicare Benefit Policy Manual Update

EFFECTIVE DATE: February 01, 2016

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IMPLEMENTATION DATE: February 01, 2016

I. GENERAL INFORMATION

A. Background: The 2016 update of the Medicare Policy Manual, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act.

B. Policy: The 2016 update of the Medicare Benefit Policy Manual, Chapter 13 includes new information on payment for chronic care management services and payment for Grandfathered Tribal FQHCs. It also includes clarifying information on RHC and FQHC cost report requirements, physician services, mental health services, and removal of obsolete provisions.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility							
		A/B MAC		D M E M A C	Shared- System Maintainers			Other	
		A	B		H H H	F M V C M W	C M S F		
9442.1	Contractors shall be aware of the update to the Medicare Benefit Policy Manual - Chapter 13.	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC		D M E M A C	C E D I	I
		A	B			
9442.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters"	X				

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C M E D I
		A	B	H H H		
	listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Corinne Axelrod, 410-786-5620 or corinne.axelrod@cms.hhs.gov , Simone Dennis, 410-786-8409 or simone.dennis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

Medicare Benefit Policy Manual

Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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Index of Acronyms

(Rev. 217, 12-31-15)

AIR – all inclusive rate
AWV – annual wellness visit
CCM – chronic care management
CCN – CMS certification number
CNM – certified nurse midwife
CP – clinical psychologist
CSW – clinical social worker
DSMT – diabetes self-management training
EKG – electrocardiogram
EMTALA - Emergency Medical Treatment and Active Labor Act
FQHC – Federally qualified health center
FTE – full time equivalent
GAF – geographic adjustment factor
GME – graduate medical education
HCPCS – Healthcare Common Procedure Coding System
HHA – home health agency
HHS – Health and Human Services
HPSA – Health Professional Shortage Area
HRSA – Health Resources and Services Administration
IPPE – initial preventive physical exam
LPN – licensed practical nurse
MAC – Medicare Administrative Contractor
MEI – Medicare Economic Index
MNT – medical nutrition therapy
MSA – metropolitan statistical area
MUA – Medically-Underserved Area
MUP – Medically-Underserved Population
NCD – national coverage determination
NECMA – New England County Metropolitan Area
NP – nurse practitioner
PA – physician assistant
PPS – prospective payment system
PHS – Public Health Service
RHC – rural health clinic
RN – registered nurse
RO – regional office
RUCA – Rural Urban Commuting Area
TCM – transitional care management
UA – urbanized area
USPSTF – U.S. Preventive Services Task Force

10.1 - RHC General Information

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Rural Health Clinics (RHCs) 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 (AIR) per visit for primary health services and qualified 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 services that are typically furnished in an outpatient clinic. 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 (RN) or a licensed professional nurse (LPN) when certain conditions are met.

To be eligible for certification as a 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, Health and Human Services (HHS), in any one of the four types of shortage area designations that are accepted for RHC certification.

In addition to the location requirements, a RHC must:

- Employ an NP or PA;
- Have an NP, PA, or CNM working at the clinic at least 50 *percent* of the time the clinic is operating as a 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 a 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 (A/B MAC). They are assigned a CMS Certification Number (CCN) 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 CCN in the range 3400-3499, 3975-3999, or 8500-8899. (**NOTE:** A provider-based CCN is not an indication that the RHC has a provider-based determination for purposes of an exception to the payment limit.)

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 405.2400 Subpart X](#) and following, and [42 CFR 491 Subpart A](#) 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 certification requirements, see Pub. 100-07, Medicare State Operations Manual, Chapter 2, and Appendix G, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html?redirect=/SurveyCertificationGenInfo/PMSR/list.asp>

10.2 - FQHC General Information

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Federally Qualified Health Centers (FQHCs) 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 services that are typically furnished in an outpatient clinic. FQHCs *were* paid an AIR for primary health services and qualified preventive health services *until* October 1, 2014, *when they began to* transition to the FQHC prospective payment system (PPS). *Beginning on January 1, 2016, all FQHC are paid under the provisions of the FQHC PPS*, as required by Section 10501(i)(3)(B) of the Affordable Care Act.

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 (DSMT) and medical nutrition therapy (MNT) 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 a FQHC is assigned a CCN in the range 1800-1989 and 1000-1199.

FQHC services also include certain preventive primary health services. The law defines Medicare-covered preventive services provided by a FQHC as the preventive primary health services that a 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 Program Grantees: Organizations receiving grants under section 330 of the PHS Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers;
- Health Center Program Look-Alikes: 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 Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to tribal or urban Indian FQHCs *or grandfathered tribal (GFT) FQHCs*.

A FQHC must:

- Provide comprehensive services and have an ongoing quality assurance program;
- Meet other health and safety requirements;
- Not be concurrently approved as a RHC; and
- Meet all requirements contained in section 330 of the Public Health Service Act, including:
 - Serve a designated Medically-Underserved Area (MUA) or Medically-Underserved Population (MUP);
 - Offer a sliding fee scale to persons with incomes below 200 *percent* 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 FQHC.

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 a FQHC are no longer 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. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

To be eligible for certification as a 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, HHS, in any one of the four types of shortage area designations that are accepted for RHC certification as listed in section 20.2.

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.

Existing RHCs are not currently required to continue to meet the location requirements. RHCs that plan to relocate or expand should contact their Regional Office (*RO*) to determine their location requirements.

FQHCs may be located in rural or urban areas. FQHCs that are Health Center Program Grantees or Look-Alikes must be located in or serve people from a HRSA-designated MUA or MUP.

20.1 - Non-Urbanized Area Requirement for RHCs

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 RO at <http://www.cms.gov/RegionalOffices/>.

20.2 - Designated Shortage Area Requirement for RHCs

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

The HRSA designates areas as MUAs/MUPs and/or Health Professional Shortage Areas (HPSAs). 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 HPSA;
- Population-group Primary Care HPSA;
- MUA (this does not include the population group MUP designation); or
- Governor-Designated and Secretary-Certified Shortage Area (*this does not include a Governor's Medically Underserved Population designation*).

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.

30.1 - RHC Staffing *Requirements* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

In addition to the location requirements, a RHC must:

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

The employment may be full or part time, and is evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100 percent ownership of the RHC, the W-2 form can be from that entity as long as all the non-physician practitioners employed in the RHC receive their W-2 from this owner.

The following are examples of situations that 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;
- An Advanced Practice Registered Nurse who is not an NP or PA; or
- An NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician.

A 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 RHC, *or the time spent directly furnishing patient care in another location as a RHC practitioner*, is counted towards the 50 percent *time*. It does not include *travel time to another location, or time spent not furnishing patient care when in another location* outside the RHC (e.g. home, SNF, etc.).

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 *percent* 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).

As of July 1, 2014, RHCs may contract with non-physician practitioners (PAs, NPs, CNM, CPs or CSWs) as long as at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at section 1861(aa)(7) of the Act).

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 *80.4* of this chapter for information on productivity standards for RHCs.

30.2 – RHC Temporary Staffing Waivers *(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)*

An existing RHC may request a temporary staffing waiver if the RHC 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 *percent* of the time the clinic operates.

To receive a temporary staffing waiver, a RHC must demonstrate that it has made a good faith effort to recruit and retain the required practitioner(s) in the 90 day period prior to the waiver request. Recruitment activities should begin as soon as the RHC 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.

A 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.

30.3 - FQHC Staffing Requirements *(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)*

FQHCs must have a core staff of appropriately trained primary care practitioners 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>.

40 - RHC and FQHC Visits *(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)*

A RHC or FQHC visit is defined as a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a 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. A Transitional Care Management (TCM) service can also be a RHC or FQHC visit. *Services furnished must be within the practitioner's state scope of practice.*

A RHC or FQHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions. See section *190* of this chapter for information on visiting nursing services to home-bound patients.

Under certain conditions, a FQHC visit also may be provided by qualified practitioners of outpatient DSMT and MNT when the FQHC meets the relevant program requirements for provision of these services.

A list of qualifying visits for *RHCs and FQHCs* is located on the *RHC web page at <https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>*, and the *FQHC web page at <https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>*.

A 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 (see location information below) 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. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

A 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 (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1) or the scene of an accident. RHC and FQHC visits may not take place in either of the following:

- an inpatient or outpatient department of a hospital, including a CAH, 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 a 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;
- the cost of the service is included in the RHC or FQHC cost report; and
- other requirements for furnishing services are met.

This applies to full and part time practitioners, and it applies regardless of whether the practitioner is an employee of the RHC or FQHC, 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. RHCs and FQHCs providing RHC or FQHC services in locations other than the RHC or FQHC

facility must continue to meet all certification and cost reporting requirements. Services in other locations may be subject to review by the A/B MAC.

RHC and FQHC practitioners that are compensated by the RHC or FQHC for services furnished in other locations may not bill Medicare Part B for these services. RHC or FQHC 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.

40.2 - Hours of Operation

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

RHCs and FQHCs are required to post their hours of operations at or near the entrance in a manner that clearly states the days of the week and the hours that RHC or FQHC services are furnished, and days of the week and the hours that the building is open solely for administrative or other purposes, if applicable. This information should be easily readable, including by people with vision problems and people who are in wheel chairs. Qualified services provided to a RHC or FQHC patient other than during the posted hours of operation are considered RHC or FQHC services when the practitioner is compensated by the RHC or FQHC for the services provided, and *when* the cost of the service is included in the RHC's 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 (See Section 100 on Commingling).

This applies to full and part time practitioners, practitioners who are employees, practitioners working under contract to the RHC or FQHC, and practitioners who 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. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where a RHC or FQHC patient has a medically-necessary face-to-face visit with a 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.

Exceptions are for the following circumstances only:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC). *In this situation only, the RHC or FQHC would use modifier 59 on the claim to attest that the conditions being treated are totally unrelated (2 billable visits);*
- The patient has a medical visit and a mental health visit on the same day (2 *billable* visits); *or*

- For RHCs *only*, the patient has his/her initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 *billable* visits).

NOTE: These exceptions do not apply to grandfathered tribal FQHCs.

40.4 - Global Billing

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Surgical procedures furnished in a RHC or FQHC by a RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. *If a procedure is associated with a qualified visit, the charges for the procedure go on the claim with the visit. Payment is included in the AIR when the procedure is furnished in a RHC, and payment is included in the PPS methodology when furnished in a FQHC.* The Medicare global billing requirements do not apply to RHCs and FQHCs, *and global billing codes are not accepted for RHC or FQHC billing or payment.*

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If a 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. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.

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>

50.1 - RHC Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

RHC services include:

- Physicians' services, as described in section *110*;
- Services and supplies incident to a physician's services, as described in section *120*;
- Services of NPs, PAs, and CNMs, as described in section *130*;
- Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section *140*;
- CP and CSW services, as described in section *150*;
- Services and supplies incident to the services of CPs and CSWs, as described in section *160*; and
- Visiting nurse services to the homebound as described in section *190*.

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 (see section 220 – Preventive Health Services). These services include:

- Influenza, Pneumococcal, Hepatitis B vaccinations;
- IPPE;
- Annual Wellness Visit; and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.

Except for influenza and pneumococcal vaccines and their administration, which are paid through the cost report, RHCs are paid for the professional component of these services based on their AIR.

50.2 - FQHC Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 a 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.

Except for influenza and pneumococcal vaccines and their administration, which are paid through the cost report, FQHCs are paid for the professional component of these services based on the lesser of the FQHC's charge or the PPS rate for the specific payment code (see section 70.4 - Payment Codes for FQHCs).

60 - Non RHC/FQHC Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

RHCs and FQHCs may furnish services that are beyond the scope of the RHC or FQHC benefit. If these services are authorized to be furnished by a RHC or FQHC and covered under a separate Medicare benefit category, the services must be billed separately to the appropriate A/B MAC under the payment rules that apply to the service. *RHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC services such as space, equipment, supplies, facility overhead, and personnel.*

60.1 - Description of Non RHC/FQHC Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 physical checkups, dental care, hearing tests, routine 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 a RHC or FQHC service - Includes diagnostic tests such as x-rays, electrocardiograms (EKGs), and other tests authorized by Medicare statute or the NCD process. These services may be billed separately to the A/B MAC by the facility. (The professional component is a RHC or FQHC service if performed by a RHC or FQHC practitioner or furnished incident to a RHC or FQHC service).

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. This does not include venipuncture, which is included in the AIR when furnished in a RHC by a RHC practitioner or furnished incident to a RHC service, and it is included in the per-diem payment when furnished in a FQHC *by a FQHC practitioner or furnished incident to a FQHC service.*

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

Ambulance services - *The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat the patient's condition, and any other methods of transportation are contraindicated. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services, for additional information on covered ambulance services.*

Prosthetic devices - Prosthetic devices are included in the definition of "medical and other health services" in section 1861(s)(8) of the Act and are defined as devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. Other examples of prosthetic devices include cardiac pacemakers, cochlear implants, electrical continence aids, electrical nerve stimulators, and tracheostomy speaking valves.

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 a RHC or FQHC practitioner in a SNF may be a RHC or FQHC service.)

Telehealth distant-site services - See section **200** of this chapter for additional information on telehealth services in RHCs and FQHCs.

Hospice Services – See section **210** of this chapter for additional information on hospice services in RHCs and FQHCs.

Group Services – Includes group or mass information programs, health education classes, or group education activities, including media productions and publications.

70.1 - RHCs Billing Under the AIR

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Medicare pays 80 percent of the RHC AIR, subject to a payment limit, for medically-necessary medical, and qualified preventive, face-to-face (one-on-one) visits with a RHC practitioner (as defined in section 30) for RHC services (as defined in section **50.1**), unless otherwise noted. The rate is subject to a payment limit, except for RHCs that have an exception to the payment limit (see section **70.2**). An interim rate for newly certified RHCs is established based on the RHC's anticipated average cost for direct and supporting services. At the end of the reporting period, the A/B MAC determines the total payment due and reconciles payments made during the period with the total payments due.

In general, the AIR for a RHC is calculated by the A/B MAC 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 services.

Services furnished incident to a RHC 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 cost report. Auxiliary services are included on the cost report.

70.2 - RHC Per-Visit Payment Limit and Exceptions

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

The RHC payment limit was set by Congress in 1988 and is adjusted annually based on the MEI. The payment limit is released annually via Recurring Update Notifications.

A provider-based RHC that is an integral and subordinate part of a hospital (including a CAH), as described in regulations at **42 CFR** 413.65, 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/>.)

70.3 – FQHC PPS Payment Rate and Adjustments *(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)*

Medicare pays 80 percent of the lesser of the FQHC's charge or the **FQHC** PPS payment rate for the specific payment code, unless otherwise noted. *Except for grandfathered tribal FQHCs, the FQHC* PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment based on the location where services are furnished, and other applicable adjustments as described below. The **FQHC** PPS base rate *is* updated annually by the MEI or by a FQHC market basket.

Geographic Adjustment: The PPS base rate *is* adjusted for each FQHC based on its location by the FQHC Geographic Adjustment Factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished. Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs can be found at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html>.

New Patient Adjustment: The PPS payment rate *is* adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

IPPE and AWW Adjustment: The PPS payment rate *is* adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary.

NOTE: These adjustments do not apply to grandfathered tribal FQHCs.

70.4 – Payment Codes for FQHCs *(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)*

FQHCs must include a FQHC payment code on their claim for payment. FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G code *based on a typical bundle of services that they would furnish per diem to a Medicare beneficiary*. The FQHC should maintain records of the services included in each FQHC G code and the charges associated with the service at the time the service was furnished. *Each FQHC decides what documentation is appropriate to record the services included in each G-code pursuant to its own determination*. Charges must be *reasonable and* uniform for all patients, *regardless of insurance status*. *G code services and charges can be changed by the FQHC, but must be the same for all patients and cannot be changed retrospectively*.

The five specific payment codes to be used by FQHCs submitting claims are:

1. G0466 – FQHC visit, new patient: A medically-necessary medical, or a qualified preventive health, face-to-face encounter (one-on-one) between a new patient (as defined in section 70.3), and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
2. G0467 – FQHC visit, established patient: A medically-necessary medical, or a qualifying preventive health, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
3. G0468 – FQHC visit, IPPE or AWW: A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.

4. G0469– FQHC visit, mental health, new patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient (as defined in section 70.3), and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

5. G0470 – FQHC visit, mental health, established patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

80 – RHC and FQHC Cost Reports

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

80.1 – RHC and FQHC Cost Report Requirements

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

RHCs are required to file a cost report annually in order to determine their payment rate and reconcile interim payments, including adjustments for GME payments, bad debt, and influenza and pneumococcal vaccines and their administration. If a RHC is in its initial reporting period, *the RHC submits a budget that estimates the allowable costs and number of visits expected during the reporting period.* The A/B MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

FQHCs are required to file a cost report annually and are paid for the costs of GME, bad debt, and influenza and pneumococcal vaccines and their administration through the cost report.

RHCs and FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors.

RHCs and FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.80. RHCs may claim unpaid coinsurance and deductible, and FQHCs may claim unpaid coinsurance. RHCs and FQHCs that claim bad debt must establish that reasonable efforts were made to collect these amounts. Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed.

80.2 – RHC and FQHC Consolidated Cost Reports

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

RHCs and FQHCs with more than one site may file consolidated cost reports if approved by the A/B MAC in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC/FQHC may not revert to individual reporting without the prior approval of the A/B MAC.

80.3 – RHC and FQHC Cost Report Forms

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

RHCs and FQHCs use one of the following cost report forms:

Independent RHCs and Freestanding FQHCs: Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report.

Provider-based RHCs and FQHCs:

Hospital-based: Worksheet M of Form CMS-2552-10, Hospital and Hospital Care Complex Cost Report.

Skilled Nursing Facility based: Worksheet I series of form CMS-2540-10, “Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report”.

Home Health Agency based: Worksheet RF series of Form CMS-1728-94, “Home Health Agency Cost Report”.

Information on these cost report forms is found in Chapters 29, 32, 40, and 41 and 32, respectively, of the “Provider Reimbursement Manual - Part 2” (Publication 15-2), which can be located on the CMS Website at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>.

80.4 – RHC Productivity Standards (Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. 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 A/B MAC has the discretion to make an exception to the productivity standards 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 the cost reporting year, the A/B MAC re-calculates the AIR 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 fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses 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 AIR.

Physician services that are provided on a short term or irregular basis 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\(d\)\(2\)\(v\)](#). Practitioners working on a regular, ongoing basis are subject to the productivity standards, regardless of whether they are paid as an employee or independent contractor.

FQHCs are not subject to the productivity standards.

90 - RHC and FQHC Patient Charges, Coinsurance, Deductible, and Waivers (Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Except for certain preventive services for which the coinsurance is statutorily waived, the beneficiary in a RHC must pay the deductible and coinsurance amount, and the beneficiary in a FQHC must pay the coinsurance amount (there is no Part B deductible in FQHCs for FQHC-covered services). For RHCs, the coinsurance is 20 percent of the total charges. For FQHCs, the coinsurance is 20 percent of the lesser of the FQHC’s charge for the specific payment code or the PPS rate. *For claims with a mix of waived and non-waived services, applicable coinsurance and deductibles are assessed only on the non-waived services.*

90.1 - Charges and Waivers (Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Charges for services furnished to Medicare beneficiaries must be the same as the charges for non-Medicare beneficiaries. 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\(6\)\(A\)](#))

90.2 - Sliding Fee Scale

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

RHCs may establish a sliding fee scale if it is uniformly applied to all patients. A 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 *that are* approved by HRSA are required to establish a sliding fee scale in accordance with statutory and HRSA requirements.

100 - Commingling

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 a RHC or FQHC practitioner furnishes a RHC or FQHC service at the RHC or FQHC during RHC or FQHC hours, the service must be billed as a RHC or FQHC service. The service cannot be carved out of the cost report and billed to Part B.

If a 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 a RHC practitioner 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 practitioner with the hospital emergency department would not be a common occurrence.

The MAC 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.

110 - *Physician Services*

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 a 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.

Except for services that meet the criteria for a TCM visit *or the requirements for chronic care management (CCM) services*, 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 (e.g., appendectomy, etc.) or not commonly furnished in an outpatient clinic setting are not considered physician services in a RHC or FQHC.

Qualified services furnished at a RHC or FQHC by a 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).

110.1 - *Dental, Podiatry, Optometry, and Chiropractic Services*

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare statute, *and qualified services furnished by physicians are billable visits in a RHC or FQHC. These practitioners* 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).

A RHC or FQHC can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is on the list of qualifying visits for RHCs and FQHCs and all other requirements are met. All services furnished must be within the state scope of practice for the practitioner, and all HCPCS codes must reflect the actual services that were furnished.

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 a 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>.

110.2 - Treatment Plans or Home Care Plans

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Except for comprehensive care plans that are a component of CCM services, 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.

110.3 - Graduate Medical Education

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 a RHC or FQHC visit provided by a resident, as the cost of these practitioners is included in the GME payment. A medically-necessary medical, or a qualifying preventive health, face-to-face encounter with a teaching physician who is a 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\(b\)](#).

110.4 - Transitional Care Management (TCM) Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Effective January 1, 2013, RHCs and FQHCs can bill for qualified TCM services furnished by a RHC or FQHC practitioner. TCM services must be furnished within 30 days of the date of the patient’s discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or *community mental health center*.

Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT code 99495), or within 7 days of discharge for high complexity decision making (CPT code 99496). The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-discharge period. The TCM visit is subject to applicable copayments and deductibles.

TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

110.5 – Chronic Care Management (CCM) Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Effective January 1, 2016, RHCs and FQHCs are paid for CCM services when a minimum of 20 minutes of qualifying CCM services during a calendar month is furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CCM is a RHC and FQHC benefit, but is paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. Coinsurance is applied as

applicable to FQHC claims, and coinsurance and deductibles are applied as applicable to RHC claims. The RHC and FQHC face-to-face requirement is waived for CCM services.

RHCs and FQHCs may not bill for CCM services for a patient if another practitioner or facility has already billed for CCM services for the same beneficiary during the same time period.

RHCs and FQHCs may not bill for CCM and TCM services, or another program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment), for the same beneficiary during the same time period.

The CCM requirements include the beneficiary's agreement to receive CCM services from the RHC or FQHC, development of a comprehensive care plan, management of care transitions and coordination of care with other providers, secure messaging capabilities, and health IT requirements. All CCM requirements must be met for CCM payment. For more information on Medicare CCM requirements, see <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>.

120 - Services and Supplies Furnished "Incident to" Physician's Services **(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)**

"Incident to" refers to services and supplies that are an integral, though incidental, part of the physician's professional service and are:

- Commonly rendered without charge or included in the RHC or FQHC bill;
- Commonly furnished in an outpatient clinic setting;
- 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);
- Venipuncture;
- 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.

Supplies and drugs that must be billed to the DMEPOS 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 a RHC or FQHC practitioner to a Medicare patient are included in the RHC AIR or the FQHC's PPS per diem payment. 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." A RHC practitioner (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 AIR. Physicians who prepare an antigen that is forwarded to

a 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.

120.1 - *Provision of Incident to Services and Supplies* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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 RHC or FQHC 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.

120.2 - *Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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 a 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 190.) 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.

120.3 - *Payment for Incident to Services and Supplies* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with a 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 a RHC or FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the RHC's AIR or the FQHC's PPS payment. RHCs and FQHCs cannot bill separately for Part B drugs or other incident to services or supplies.

130 - Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

Professional services furnished by an NP, PA, or CNM to a RHC or FQHC patient are services that would be considered covered physician services under Medicare (see section 110), and which are permitted by *state* laws and RHC or FQHC 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, EKGs 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.

130.1 - NP, PA, and CNM Requirements ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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

- 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.

130.2 - Physician Supervision ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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.

130.3 - Payment to Physician Assistants ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

Section 1842(b)(6)(C) of the 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 a 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

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 a RHC for a continuous period

140 - *Services and Supplies Incident to NP, PA, and CNM Services*
(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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

- A type of service commonly furnished in an outpatient clinic setting;
- 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 **120** as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.

150 - *Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services*
(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

A CP is an individual who:

- Holds a doctoral degree in psychology, and
- Is licensed or certified, on the basis of the doctoral degree in psychology, by the *state* in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

A CSW is an individual who:

- Possesses a master's or doctor's degree in social work;
- After obtaining the degree, 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, meets the requirements listed in 410.73(a)(3)(i) and (ii).

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 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 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.

160 - *Services and Supplies Incident to CP and CSW Services* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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 CSW;
- 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 *120* as incident to a physician's services and include services and supplies incident to the services of a CP or CSW.

170 - *Mental Health Visits* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

A mental health visit is a medically-necessary face-to-face encounter between a RHC or FQHC patient and a RHC or FQHC practitioner during which time one or more RHC or FQHC mental health service is rendered. Mental health services that qualify as stand-alone billable visits are listed on the FQHC center website, <http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>, and the RHC center website, <https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>. Services furnished must be within the practitioner's state scope of practice.

Medicare covered mental health services furnished incident to a RHC or FQHC visit are included in the payment for a medically necessary mental health visit when a FQHC or RHC practitioner furnishes a mental health visit. Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in a FQHC or RHC.

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and for FQHCs, an appropriate FQHC mental health payment code. For detailed information on reporting mental health services and 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>

Medication management, or a psychotherapy “add on” service, is not a separately billable service in a RHC or FQHC. Rather, they are included in the payment of a RHC or FQHC medical visit. For example, when a medically-necessary medical visit with a RHC or FQHC practitioner is furnished, and on the same day medication management or a psychotherapy add on service is also furnished by the same or a different RHC or FQHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code. For FQHCs, a FQHC mental health payment code is not required for reporting medication management or a psychotherapy add on service furnished on the same day as a medical service.

180 - Physical and Occupational Therapy

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 may be an employee of the RHC or FQHC or contracted to the RHC or FQHC.

PT and OT services furnished by a RHC or FQHC practitioner acting within their state scope of practice may be billed as a RHC or FQHC visit.

PT and OT services furnished incident to a visit with a RHC or FQHC practitioner are not billable visits but the charges are included in the charges for an otherwise billable visit if both 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, and
- The service furnished is within the scope of practice of the therapist.

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 a RHC or FQHC, all associated costs must be carved out of the cost report.

190 - Visiting Nursing Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

190.1 - Description of Visiting Nursing Services

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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.

190.2 - Requirements for Visiting Nursing Services ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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

- The patient is considered homebound as defined in chapter 7 of this manual, <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.

190.3 - Home Health Agency Shortage Area ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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

- There is no participating HHA under Medicare, or adequate home health services are not available to RHC or FQHC patients even though a participating HHA is in the area; or
- There are patients whose homes are not within the area serviced by a participating HHA; or considering the area's climate and terrain, whose homes are not within a reasonable traveling distance to a participating HHA.

190.4 - Authorization for Visiting Nursing Services ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

RHCs or FQHCs that are located in an area that has not been determined to have a current HHA 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.

190.5 - Treatment Plans ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

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.

200 - *Telehealth Services*

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 a FQHC bills for the telehealth originating site facility fee, since this is not considered a FQHC service.

RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract. 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.

210 - *Hospice Services*

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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 **100** 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.

210.1 - *Hospice Attending Practitioner*

(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

Medicare beneficiaries who elect the Medicare hospice benefit may choose either an individual physician or NP to serve as their attending practitioner (Section 1861(dd) of the Act). RHCs and FQHCs are not authorized under the statute to be hospice attending practitioners. However, a physician or NP who works

for a 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). These services would not be considered RHC or FQHC services, since they are not being provided by a RHC or FQHC practitioner during RHC or FQHC hours.

210.2 - *Provision of Services to Hospice Patients in a RHC or FQHC* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

RHCs and FQHCs can treat hospice beneficiaries for medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from a 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 a RHC or FQHC provider, since that would result in duplicate payment for services, except under either of the following circumstances:

- The RHC or FQHC has a contract with the hospice provider to furnish core hospice services related to the patient's terminal illness and related conditions when extraordinary circumstances exist within the hospice. Extraordinary circumstances are described as "unanticipated periods of high patient loads; staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside the hospice's service area" (42CFR 418.64);
- The RHC or FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are provided by the hospice so infrequently that it would be impractical and prohibitively expensive for the hospice to employ a practitioner to provide these services. For example, a hospice may infrequently have a pediatric patient, and in those situations, contract with a RHC or FQHC that has a pediatric nurse on staff to furnish hospice services to the patient.

In these situations, all costs associated with the provision of hospice services must be carved out of the RHC or FQHC cost report, and the RHC or FQHC would be reimbursed by the hospice. (42 CFR 418.64(b)(3)).

Any service provided to a hospice beneficiary by a RHC or FQHC practitioner must comply with Medicare prohibitions on commingling. (See section *100* of this chapter).

220 - *Preventive Health Services* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met *and frequency limits have not been exceeded*. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWW, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B. HCPCS coding is required on all claims to allow for the coinsurance and deductible to be waived.

220.1 - *Preventive Health Services in RHCs* ***(Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)***

Influenza (G0008) and Pneumococcal and Vaccines (G0009)

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. No visit is billed, and these costs should not be included on the claim. The beneficiary coinsurance and deductible are waived.

Hepatitis B Vaccine (G0010)

Hepatitis B vaccine and its administration is included in the RHC visit and is 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 RHC provides. The beneficiary coinsurance and deductible applies.

Initial Preventive Physical Exam (G0402)

The IPPE is a one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, two visits may be billed. The beneficiary coinsurance and deductible are waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a personalized prevention plan for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Diabetes Counseling and Medical Nutrition Services

Diabetes counseling or medical nutrition services provided by a registered dietician or nutritional professional at a RHC may be considered incident to a visit with a RHC practitioner provided all applicable conditions are met. DSMT and MNT are not billable visits in a RHC, although the cost may be allowable on the cost report. RHCs cannot bill a visit for services furnished by registered dietitians or nutritional professionals. 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 AIR. The beneficiary coinsurance and deductible apply.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

NOTE: Hepatitis C Screening (G0472) is a technical service only and therefore it is not paid as part of the RHC visit.

220.2 - Copayment and Deductible for RHC Preventive Health Services (Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

When one or more qualified preventive service is provided as part of a 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, and Medicare would pay 80 percent of the \$100, and 100 percent of the \$50 (minus any deductible). If no other RHC service took place along with the preventive service, there would be no copayment or deductible applied, and Medicare would pay 100 percent of the payment amount.

220.3 - Preventive Health Services in FQHCs (Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

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. 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 *necessarily qualify as FQHC billable visits or for the waiver of the beneficiary coinsurance.*

Influenza and Pneumococcal Vaccines

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The cost is included in the cost report and no visit is billed. FQHCs must include these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance is waived.

Hepatitis B Vaccine (G0010)

Hepatitis B vaccine and its administration is included in the FQHC visit and is 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.

Initial Preventive Physical Exam (G0402)

The IPPE is a one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a personalized prevention plan for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Diabetes Counseling and Medical Nutrition Services

DSMT and MNT furnished by certified DSMT and MNT providers are billable visits in FQHCs when they are provided in a one-on-one, face-to-face encounter and all program requirements are met. Other diabetes

counseling or medical nutrition services provided by a registered dietician at the FQHC may be considered incident to a visit with a FQHC provider. The beneficiary coinsurance is waived for MNT services and is applicable for DSMT.

DSMT must be furnished by a certified DSMT practitioner, and MNT must be furnished by a registered dietitian or nutrition professional. 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.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

NOTE: Hepatitis C Screening (G0472) is a technical service only and therefore not paid as part of the FQHC visit.

220.4 - Copayment for FQHC Preventive Health Services (Rev. 217, Issued: 12-31-15, Effective: 02-01-16, Implementation: 02-01-16)

When one or more qualified preventive services are provided as part of a FQHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment. 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, and Medicare would pay 80 percent of the \$100, and 100 percent of the \$50. If no other FQHC service took place along with the preventive service, there would be no copayment applied, and Medicare would pay 100 percent of the payment amount.

FQHCs that are authorized to bill under the FQHC PPS would follow the same process, but would deduct the total charges for the preventive services from the lesser of the FQHC's charge or the PPS rate.