CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 201	**Date: December 12, 2014**
	Change Request 8981

SUBJECT: Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13

I. SUMMARY OF CHANGES: Chapter 13 of the Benefit Policy Manual has been updated to include new information on the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) as required by Section 10501(i)(3)(B) the Affordable Care Act., and to clarify existing information.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/Table of Contents
R	13/Index of Acronyms
R	13/10.1/RHC General Information
R	13/10.2/FQHC General Information
R	13/30.1.1/Requirements
R	13/30.2/FQHC Staffing
R	13/40/RHC and FQHC Visits
R	13/40.1/Location
R	13/40.2/Hours of Operation
R	13/40.3/Multiple Visits on Same Day and Exceptions
R	13/40.4/Global Billing
R	13/50.1/RHC Services
R	13/50.2/FQHC Services

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/60/Non RHC/FQHC Services
R	13/60.1/Description of Non RHC/FQHC Services
R	13/70/RHC and FQHC Payment Rates, Exceptions, and Adjustments
R	13/70.1/RHCs and FQHCs Billing Under the AIR
N	13/70.1.1/RHC Per-Visit Payment Limit and Exceptions
N	13/70.1.2/FQHC Per-Visit Payment Limit
R	13/70.2/ FQHCs Billing Under the PPS Payment Rate and Adjustments
N	13/70.2.1/Payment Codes for FQHCs Billing Under the PPS
R	13/70.3/Cost Reports
R	13/70.4/Productivity Standards
R	13/80/RHC and FQHC Patient Charges, Coinsurance, Deductible and Waivers
R	13/80.1/Charges and Waivers
R	13/100.3/Graduate Medical Education
R	13/100.4/Transitional Care Management (TCM) Services
R	13/110/Services and Supplies Furnished Incident to Physician’s Services
R	13/110.1/Provision of Incident to Services and Supplies
R	13/110.3/Payment for Incident to Services and Supplies
R	13/120/Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services
R	13/160/Outpatient Mental Health Treatment Limitation
R	170/Physical and Occupational Therapy
R	13/180.1/Description of Visiting Nursing Services
R	13/180.2/Requirements of Visiting Nursing Services
R	13/180.3/Home Health Agency Shortage Area
R	13/190/Telehealth Services
R	13/210/Preventive Health Services
R	13/210.1/Preventive Health Services in RHCs
D	13/210.1.1/Preventive Health Services in RHCs
D	13/210.1.2/Hepatitis Vaccines
D	13/210.1.3/Diabetes Counseling and Medical Nutrition Services
D	13/210.1.4/Copayment and Deductible for Preventive Health Services
R	13/210.2/Copayment and Deductible for RHC Preventive Health Services
D	13/210.2.2/Pneumococcal and Influenza Vaccines
D	13/210.2.3/Hepatitis Vaccines

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	13/210.2.4/Diabetes Counseling and Medical Nutrition Services
D	13/210.2.5/Copayment and Deductible for Preventive Health Services
N	13/210.3/Preventive Health Services in FQHCs
N	13/210.4/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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instruction

Attachment - Recurring Update Notification

Pub. 100-02	Transmittal: 201	Date: December 12, 2014	Change Request: 8981

SUBJECT: Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

I. GENERAL INFORMATION

A. Background: The 2015 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 of the Social Security Act. The 2015 update includes new policies for the implementation of a prospective payment system (PPS) for FQHCs as required by Section 10501(i)(3)(B) the Affordable Care Act. FQHCs will transition to the new PPS beginning on October 1, 2014, and all FQHCs are expected to complete the transition by December 31, 2015.

B. Policy: The 2015 update of the Medicare Benefit Policy Manual, Chapter 13 includes new information on the FQHC PPS payment rate, adjustments, and codes; Medicare-covered preventive services and payment in RHCs and FQHCs; RHC employment requirements and changes to contracting with non-physician practitioners; payment for procedures and multiple visits on the same day in RHCs and FQHCs, and other clarifying information.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8981.1	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			DME MAC	CEDI
		A	B	HHH		
8981.2	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" 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 one week of the availability of the provider education 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.	X				

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

Table of Contents
(Rev. 201, Issued: 12-12-14)

Index of Acronyms

AIR – all inclusive rate
AWV – annual wellness visit
CBSA – Core Based Statistical Area
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
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. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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% 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. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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* are paid an AIR for primary *health services* and *qualified* preventive health services. *Beginning on or after October 1, 2014, FQHCs will transition to the FQHC prospective payment system (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.

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% 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.

30.1.1 - Requirements

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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% 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* is counted towards the 50 percent and does not include time spent furnishing services to a patient in a 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% 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 70.4 of this chapter for information on productivity standards for RHCs.

30.2 - FQHC Staffing

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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.

See section 70.4 of this chapter for information on productivity standards for FQHCs *that are billing under the AIR system.*

40 - RHC and FQHC Visits

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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.

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 180 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 FQHCs paid under the PPS is located on the FQHC PPS web page at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.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. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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

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

40.2 - Hours of Operation

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 both of the following occur:

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

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

Services furnished at times other than the RHC or FQHC posted hours of operation to Medicare beneficiaries who are RHC or FQHC patients may not be billed to Medicare Part B if the practitioner's compensation for these services is included in the RHC/FQHC cost report. Services whose cost is not included in the RHC/FQHC cost report may be billed as Part B services if appropriate (See Section 90 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 *and Exceptions*

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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*) (2 visits *can be billed*), or

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

- *For RHCs and FQHCs that bill under AIR,* 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 visits *can be billed*).

- *For FQHCs that bill under the AIR, the patient has a DSMT/MNT visit and a separate medical and/or mental health visit on the same day (2 or 3 visits can be billed).*

40.4 - Global Billing

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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.* The Medicare global billing requirements do not apply to RHCs and FQHCs.

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. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

RHC services include:

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

RHC services also include certain preventive services when specified in statute or when established through the National Coverage Determination (NCD) process and not specifically excluded *(see section 210 – Preventive Health Services*. These services include:

- Influenza, Pneumococcal, Hepatitis B vaccinations;
- *Hepatitis C screenings*;
- 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. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 their AIR, or, for FQHCs that are authorized to bill under the PPS, based on the lesser of the FQHC's charge or the PPS rate for the specific payment code (see section 70.2.1 - Payment Codes for FQHCs Billing Under the PPS).

60 - Non RHC/FQHC Services

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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. All costs associated with *the provision of* non-RHC or FQHC services, such as space, equipment, supplies, facility overhead, and personnel, must be identified and removed from allowable costs on the Medicare RHC or FQHC cost report.

60.1 - Description of Non RHC/FQHC Services

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 the RHC or FQHC by a RHC or FQHC practitioner or furnished incident to a RHC or FQHC service*, and it is included in the per-diem payment when furnished in a FQHC that is authorized to bill under the PPS.*

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

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 190 of this chapter for additional information on telehealth services in RHCs and FQHCs.

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

70 - RHC and FQHC Payment Rate*s,* Exceptions, *and Adjustments*

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

70.1 *– RHCs and FQHCs Billing Under the AIR*

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

For RHCs and FQHCs that bill under the AIR, Medicare pays 80 percent of the RHC or FQHC's AIR, subject to a payment limit, for medically-necessary *medical, and qualified preventive*, face- to- face (one-on-one) visits with a RHC or FQHC practitioner (as defined in section 30) for RHC or FQHC services (as defined in section 50)*, unless otherwise noted*. The rate is subject to a payment limit, except for RHCs that have an exception to the payment limit (see section 70.1.*1*). An interim rate *for newly certified RHCs, and for FQHCs certified prior to October, 1, 2014,* is established based on the RHC's or FQHC's anticipated average cost for direct and supporting services. At the end of the reporting period, the *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 or FQHC 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 or FQHC services.

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

70.1.1 - RHC Per-Visit Payment Limit and Exceptions

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

The RHC payment limit was set by Congress in 1988 and is adjusted yearly based on the MEI. The payment limit is adjusted annually based on the MEI and 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 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/.*

70.1.2 - FQHC Per-Visit Payment Limit

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

There is a payment limit for rural FQHCs and a payment limit for urban FQHCs that bill under the AIR. These payment limits are adjusted annually based on the MEI and released annually via Recurring Update Notifications. There are no payment limit exceptions for FQHCs.

FQHCs that are located within a Metropolitan Statistical Area (MSA) are considered urban FQHCs. MSAs are Core-Based Statistical Areas (CBSA) that are associated with at least one urbanized area that has a population of at least 50,000 people. FQHCs that are not in an MSA are considered rural FQHCs. Rural FQHCs cannot be reclassified as an urban FQHC for purposes of the FQHC payment limit.

70.2 – *FQHCs Billing Under the PPS Payment Rate and Adjustments*

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

For FQHCs that are authorized to bill under the PPS, Medicare pays 80 percent of the lesser of the FQHC's charge or the PPS payment rate for the specific payment code, unless otherwise noted. The 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 PPS base rate will be updated annually by the MEI or by a FQHC market basket.

Geographic Adjustment: The PPS base rate will be 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 will be 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 AWV Adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary.

70.2.1 – Payment Codes for FQHCs Billing Under the PPS

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

FQHCs that are authorized to bill under the PPS 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. 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. Charges must be uniform for all patients.

The five specific payment codes to be used by FQHCs submitting claims under the PPS 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 70.2), 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 AWV: A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

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 70.2),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.

70.3 - Cost Reports

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

RHCs and FQHCs *that bill under the AIR* 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 or FQHC is in its initial 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. RHCs and FQHCs may file consolidated cost reports if approved by the *A/B* MAC.

FQHCs that are authorized to bill under the FQHC PPS are also 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 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 at on the CMS Website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html.

70.4 - Productivity Standards

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHC*s and* FQHC*s that are paid under the AIR*. 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 that are authorized to bill under the FQHC PPS are not subject to the productivity standards.

80 - RHC and FQHC Patient Charges, *Coinsurance, Deductible, and Waivers*

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 and FQHCs billing under the AIR, the coinsurance amount is 20 percent of the total charges. For FQHCs billing under the PPS, the coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate.*

80.1 - Charges and Waivers

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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))

100.3 - Graduate Medical Education

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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).

100.4 – Transitional Care Management (TCM) Services

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

"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 DME*POS* 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 and FQHC 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.

110.1 - Provision of Incident to Services and Supplies

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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.

110.3 - Payment for Incident to Services and Supplies

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 or FQHC'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.

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

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 100), 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, EKG*s* 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.

160 - Outpatient Mental Health Treatment Limitation

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

Since the inception of the Medicare Part B program, most covered services furnished by qualified practitioners for the treatment of mental, psychoneurotic, and personality disorders have been subject to an outpatient mental health treatment limitation of 62.5 percent of the Medicare approved amount for those services. This limitation *was* phased out and *mental health services are now* paid at the same level as most other Part B services The yearly percentage *during the phasing out of the mental health treatment limitation have been:*

- January 1, 2010 – December 31, 2011 - 68.75%. (Medicare pays 55% and the patient pays 45%).
- January 1, 2012 – December 31, 2012, the limitation percentage is 75%. (Medicare pays 60% and the patient pays 40%).
- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%. (Medicare pays 65% and the patient pays 35%).
- January 1, 2014 – onward, the limitation percentage is 100%. (Medicare pays 80% and the patient pays 20%).

170 - Physical and Occupational Therapy

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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.

180.1 - Description of *Visiting Nursing* Services

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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

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

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. Where the patient needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

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

180.2 – Requirements *for Visiting Nursing Services*

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf;

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

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

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

- Drugs and biological products are not provided.

180.3 - Home Health Agency Shortage Area

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 - Telehealth Services

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 - Preventive Health Services

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade or A or B. HCPCS coding is required on all claims to allow for the coinsurance and deductible to be waived.

FQHCs are also required by Section 330(b)(1)(A)(i)(III) of the PHS Act to furnish certain preventive health services including:

- *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.*

These services do not necessarily qualify as FQHC billable visits or for the waiver of the beneficiary coinsurance.

210.1 - Preventive Health Services in RHCs

(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

Influenza (G0008) and Pneumococcal and Vaccines (G0009)

*Influenza and p*neumococcal 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.*

Hepatitis C Screening (GO472)

Hepatitis C screening is included in a RHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the RHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance and deductible are waived.

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 past12 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 dieticians *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.

210.2 - *Copayment and Deductible for RHC Preventive Health Services*
(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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*.

210.3 - Preventive Health Services in FQHCs
(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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 billing under the AIR must report these services with their charges on the claim for informational and data collection purposes. FQHCs billing under the PPS 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.

Hepatitis C Screening (GO472)
Hepatitis C screening is included in a FQHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the FQHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance is waived.

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 that are paid under the AIR may bill for two visits. FQHCs that are authorized to bill under the FQHC PPS may not bill for a separate visit if the IPPE is furnished on the same day as another billable visits. 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 past12 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.

FQHCs that bill under the AIR may bill for a separate visit if DSMT is furnished on the same day as another billable visit. FQHCs that are authorized to bill under the PPS may not bill for a separate visit if DSMT is furnished on the same day as another medical visit.

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.

210.4 - Copayment for FQHC Preventive Health Services
(Rev. 201, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-05-15)

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.