

§ 405.2462

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services provided by rural health clinics and Federally qualified health centers, except that preventive primary services, as defined in §405.2448, are covered in Federally qualified health centers and not excluded by the provisions of section 1862(a) of the Act.

§ 405.2462 Payment for rural health clinic and Federally qualified health center services.

(a) *Payment to provider-based rural health clinics and Federally qualified health centers.* A rural health clinic or Federally qualified health center is paid in accordance with parts 405 and 413 of this subchapter, as applicable, if—

(1) The clinic or center is an integral and subordinate part of a hospital, skilled nursing facility or home health agency participating in Medicare (that is, a provider of services); and

(2) The clinic or center is operated with other departments of the provider under common licensure, governance and professional supervision.

(b) *Payment to independent rural health clinics and freestanding Federally qualified health centers.* (1) All other clinics and centers will be paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. This rate will be determined by the intermediary, in accordance with this subpart and general instructions issued by CMS.

(2) The amount payable by the intermediary for a visit will be determined in accordance with paragraphs (b)(3) and (4) of this section.

(3) *Federally qualified health centers.* For Federally qualified health center visits, Medicare will pay 80 percent of the all-inclusive rate since no deductible is applicable to Federally qualified health center services.

(4) *Rural health clinics.* (i) If the deductible has been fully met by the beneficiary prior to the rural health clinic visit, Medicare pays 80 percent of the all-inclusive rate.

(ii) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the clinic's reasonable customary charge for the services that is applied to the deductible is—

(A) Less than the all-inclusive rate, the amount applied to the deductible will be subtracted from the all-inclusive rate and 80 percent of the remainder, if any, will be paid to the clinic;

(B) Equal to or exceeds the all-inclusive rate, no payment will be made to the clinic.

(5) To receive payment, the clinic or center must follow the payment procedures specified in §410.165 of this chapter.

(6) Payment for treatment of mental psychoneurotic or personality disorders is subject to the limitations on payment in §410.155(c).

[71 FR 55345, Sept. 22, 2006]

§ 405.2463 What constitutes a visit.

(a) *Visit—(1) General.* (i) For rural health clinics, a visit is a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker.

(ii) For FQHCs, a visit is—

(A) A face-to-face encounter, as described in paragraph (a)(1)(i) of this section; or

(B) A face-to-face encounter between a patient and a qualified provider of medical nutrition therapy services as defined in part 410, subpart G of this chapter; or a qualified provider of outpatient diabetes self-management training services as defined in part 410, subpart H of this chapter.

(2) *Medical visit.* A medical visit is a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse midwife, or a visiting nurse; and for FQHCs only, a medical visit also includes a separately billable medical nutrition therapy visit or a diabetes outpatient self-management training visit.

(3) *Other health visit.* An other health visit is a face-to-face encounter between a clinic or center patient and a clinical psychologist, clinical social worker, or other health professional for mental health services.

(b) *Encounters.* Encounters with more than one health professional and multiple encounters with the same health professional that take place on the

same day and at a single location constitute a single visit, except when one of the following conditions exist:

(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

(2) The patient has a medical visit and other health visit(s), as defined in paragraph (a) of this section.

(c) *Payment.* Medicare pays for more than one visit per day when the conditions in paragraph (b) of this section are met or a separate visit under paragraph (a)(1)(ii)(B) of this section is made.

[71 FR 69782, Dec. 1, 2006]

§ 405.2464 All-inclusive rate.

(a) *Determination of rate.* (1) An all-inclusive rate is determined by the intermediary at the beginning of the reporting period.

(2) The rate is determined by dividing the estimated total allowable costs by estimated total visits for rural health clinic or Federally qualified health center services.

(3) The rate determination is subject to any tests of reasonableness that may be established in accordance with this subpart.

(b) *Adjustment of rate.* (1) The intermediary, during each reporting period, periodically reviews the rate to assure that payments approximate actual allowable costs and visits for rural health clinic or Federally qualified health center services and adjusts the rate if:

(i) There is a significant change in the utilization of clinic or center services;

(ii) Actual allowable costs vary materially from the clinic or center's allowable costs; or

(iii) Other circumstances arise which warrant an adjustment.

(2) The clinic or center may request the intermediary to review the rate to determine whether adjustment is required.

§ 405.2466 Annual reconciliation.

(a) *General.* Payments made to a rural health clinic or a Federally qualified health center during a reporting period are subject to reconciliation to assure that those payments do not exceed or fall short of the allowable costs

attributable to covered services furnished to Medicare beneficiaries during that period.

(b) *Calculation of reconciliation.* (1) The total reimbursement amount due the clinic or center for covered services furnished to Medicare beneficiaries is based on the report specified in § 405.2470(c)(2) and is calculated by the intermediary as follows:

(i) The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for rural health clinic or Federally qualified health center services furnished during the period. The average cost per visit is subject to tests of reasonableness which may be established in accordance with this subpart.

(ii) The total cost of rural health clinic or Federally qualified health center services furnished to Medicare beneficiaries is calculated by multiplying the average cost per visit by the number of visits for covered rural health clinic or Federally qualified health center services by beneficiaries.

(iii) For rural health clinics, the total reimbursement due the clinic is 80 percent of the amount calculated by subtracting the amount of deductible incurred by beneficiaries that is attributable to rural health clinic services from the cost of these services. The reimbursement computation for Federally qualified health centers does not include a reduction related to the deductible because Federally qualified health center services are not subject to a deductible.

(iv) For rural health clinics and FQHCs, payment for pneumococcal and influenza vaccine and their administration is 100 percent of Medicare reasonable cost.

(2) The total reimbursement amount due is compared with total payments made to the clinic or center for the reporting period, and the difference constitutes the amount of the reconciliation.

(c) *Notice of program reimbursement.* The intermediary sends written notice to the clinic or center:

(1) Setting forth its determination of the total reimbursement amount due the clinic or center for the reporting