

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

period and the amount, if any, of the reconciliation; and

(2) Informing the clinic or center of its right to have the determination reviewed at a hearing under the procedures set forth in subpart R of this part.

(d) *Payment of reconciliation amount—*

(1) *Underpayments.* If the total reimbursement due the clinic or center exceeds the payments made for the reporting period, the intermediary makes a lump-sum payment to the clinic or center to bring total payments into agreement with total reimbursement due the clinic or center.

(2) *Overpayments.* If the total payments made to a clinic or center for the reporting period exceed the total reimbursement due the clinic or center for the period, the intermediary arranges with the clinic or center for repayment through a lump-sum refund, or, if that poses a hardship for the clinic or center, through offset against subsequent payments or a combination of offset and refund. The repayment must be completed as quickly as possible, generally within 12 months from the date of the notice of program reimbursement. A longer repayment period may be agreed to by the intermediary if the intermediary is satisfied that unusual circumstances exist which warrant a longer period.

[57 FR 24976, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996]

§ 405.2468 Allowable costs.

(a) *Applicability of general Medicare principles.* In determining whether and to what extent a specific type or item of cost is allowable, such as interest, depreciation, bad debts and owner compensation, the intermediary applies the principles for reimbursement of provider costs, as set forth in part 413 of this subchapter.

(b) *Typical rural health clinic and Federally qualified health center costs.* The following types and items of cost are included in allowable costs to the extent that they are covered and reasonable:

(1) Compensation for the services of a physician, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, and clinical social worker who owns, is

employed by, or furnishes services under contract to an FQHC. (RHCs are not paid for services furnished by contracted individuals other than physicians.)

(2) Compensation for the duties that a supervising physician is required to perform under the agreement specified in § 491.8 of this chapter.

(3) Costs of services and supplies incident to the services of a physician, physician assistant, nurse practitioner, nurse-midwife, qualified clinical psychologist, or clinical social worker.

(4) Overhead costs, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

(5) Costs of services purchased by the clinic or center.

(c) *Tests of reasonableness for rural health clinic cost and utilization.* Tests of reasonableness authorized by sections 1833(a) and 1861(v)(1)(A) of the Act may be established by CMS or the carrier with respect to direct or indirect overall costs, costs of specific items and services, or costs of groups of items and services. Those tests include, but are not limited to, screening guidelines and payment limitations.

(d) *Screening guidelines.* (1) Costs in excess of amounts established by the guidelines are not included unless the clinic or center provides reasonable justification satisfactory to the intermediary.

(2) Screening guidelines are used to assess the costs of services, including the following:

(i) Compensation for the professional and supervisory services of physicians and for the services of physician assistants, nurse practitioners, and nurse-midwives.

(ii) Services of physicians, physician assistants, nurse practitioners, nurse-midwives, visiting nurses, qualified clinical psychologists, and clinical social workers.

(iii) The level of administrative and general expenses.

(iv) Staffing (for example, the ratio of other clinic or center personnel to physicians, physician assistants, and nurse practitioners).

(v) The reasonableness of payments for services purchased by the clinic or center, subject to the limitation that