

Medicare Benefit Policy Manual

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

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(Rev. 49, 03-31-06)

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10 - Rural Health Clinics (RHCs) Defined

(Rev. 1, 10-01-03)

§1861(aa)(2) of the Act

The statutory requirements that RHCs must meet to qualify for the Medicare benefit are in §1861(aa)(2) of the Social Security Act (the Act.)

Rural Health Clinics (RHCs) are clinics that are located in areas designated by the Bureau of the Census as rural and by the Secretary of Department of Health and Human Services (DHHS) or the State as medically underserved. RHCs have been eligible for participation in the Medicare program since March 1, 1978. Services rendered by approved RHCs to Medicare beneficiaries are covered under Medicare effective with the date of the clinic's approval for participation. See §30 for a description of covered services

20 - Federally Qualified Health Centers (FQHCs) Defined

(Rev. 1, 10-01-03)

§1861(aa), A3-3192.2 of the Act

A. General

Section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 amended §1861(aa) of the Act to establish federally qualified health centers (FQHCs) as entities to provide a new Medicare benefit effective October 1, 1991. The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in §1861(aa)(4) of the Act.

The FQHC services consist of services that are similar to those provided in rural health clinics (RHC). See §30.

The FQHC services also include preventive primary health services. The law defines Medicare preventive services as the preventive primary health services that an FQHC is required to provide under §330 of the Public Health Service (PHS) Act. Medicare may specifically not cover some of the preventive services that FQHCs currently provide. For example, the Medicare law contains exclusion for dental services that are, therefore, excluded from the FQHC benefit. No Part B deductible is applied to expenses for services that are payable under the FQHC benefit. The Medicare beneficiary is responsible for 20 percent of billed charges. Note that FQHCs can waive collection of all or part of the coinsurance, depending upon the beneficiary's ability to pay.

B. Special Requirements

An entity may qualify as an FQHC if it:

- Is receiving a grant under §330 of the PHS Act; or

- Is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant under §330 of the PHS Act; or
- Is determined by the Secretary to meet the requirements for receiving such a grant (look-alike) based on the recommendation of the Health Resources and Services Administration within PHS; or
- Is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act as of October 1, 1991.

Note that specific certification requirements are identified in the State Operations Manual.

An RHC cannot be concurrently approved for Medicare as both an FQHC and an RHC. An entity that qualifies as an independent or provider-based FQHC is assigned an FQHC identification number in the provider number range 1800-1989. RHCs are assigned a provider number in the following ranges: provider-based ranges: 3975-3999, 3400-3499, 8500-8899; and independent ranges: 3800-3974, 8900-8999.

30 - Rural Health Clinic and Federally Qualified Health Center Service Defined

(Rev. 49, Issued: 03-31-06; Effective: 01-01-06; Implementation: 06-29-06)

Payments for covered RHC/FQHC services furnished to Medicare beneficiaries are made on the basis of an all-inclusive rate per covered visit (except for pneumococcal and influenza vaccines and their administration, which is paid at 100 percent of reasonable cost). The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. *As a result of section 5114 of the Deficit Reduction Act of 2005 (DRA), the FQHC definition of a face-to-face encounter is expanded to include encounters with qualified practitioners of Outpatient Diabetes Self-Management Training Services (DSMT) and medical nutrition therapy (MNT) services when the FQHC meets all relevant program requirements for the provision of such services.*

Encounters with (1) more than one health professional; and (2) multiple encounters with the same health professional which take place on the same day and at a single location, constitute a single visit. An exception occurs in cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

30.1 - RHC Services

(Rev. 49, Issued: 03-31-06; Effective: 01-01-06; Implementation: 06-29-06)

RHC services are the following services furnished by an RHC:

- Physicians' services, as described in [§50](#);
- Services and supplies incident to a physician's services, as described in [§60](#);
- Services of nurse practitioners (NP), physician assistants (PA) (including certified nurse midwives (CNM)), as described in [§70](#);
- Services and supplies incident to the services of nurse practitioners and physician assistants (including services furnished by nurse midwives), as described in [§80](#);
- Visiting nurse (VN) services to the homebound, as described in [§90](#);
- Clinical psychologist (CP) and clinical social worker services (CSW), as described in [§100](#) and [§110](#);
- Services and supplies incident to the services of *CPs* and *CSWs*, as described in [§100](#) and [§110](#);
- Services of registered dietitians or nutritional professionals for diabetes training services and medical nutrition therapy; and
- Otherwise covered drugs that are furnished by, and incident to, services of physicians and non physician practitioners of the RHC/FQHC.

The Medicare program makes payment directly to the RHCs for covered services furnished to Medicare beneficiaries. RHC services are covered when furnished to a patient at the clinic or center, the patient's place of residence, or elsewhere (e.g., the scene of an accident).

30.2 - FQHC Services

(Rev. 49, Issued: 03-31-06; Effective: 01-01-06; Implementation: 06-29-06)

The FQHC services include all of the RHC services listed as included in [§30.1](#) as well as preventive primary services, as described in [§40](#). *As a result of section 5114 of the DRA of 2005, FQHC services now include DSMT and MNT services as billable FQHC visits when the FQHC meets all relevant program requirements for the provision of such services as set forth in part 410, Subpart H for DSMT and in part 410, Subpart G for MNT. Additional guidance in Medicare Manuals regarding DSMT and MNT services can be found at Pub. 100-02, Chapter 15, Section 300. The DRA amendment is effective for services furnished on or after January 1, 2006.*

The Medicare program makes payment directly to the FQHCs for covered services furnished to Medicare beneficiaries. The FQHC services are covered when furnished to a patient at the clinic or center, the patient's place of residence, or elsewhere (e.g., at the scene of an accident).

30.3 - Services Furnished by Clinics Which Are Not RHC or FQHC Services

(Rev. 1, 10-01-03)

A3-3191.2, B3-2260.2, RHC-401, RHC-402, PM A-00-30

Occasionally, a clinic which is also certified as an FQHC or RHC may furnish services beyond the scope of those services covered under the FQHC or RHC benefits. If covered under another separate Medicare benefit category, the services must be separately billed to the Medicare carrier/intermediary (as appropriate) under the appropriate Medicare benefit category by the appropriate Medicare provider/supplier furnishing the services, using the clinic's provider/supplier number. Since these services are NOT RHC or FQHC services, any related costs for space, equipment, supplies, facility overhead, and personnel associated with these services must be identified and removed from allowable costs on the clinic's Medicare RHC/FQHC cost report or the RHC/FQHC sub-schedules, as appropriate.

Payment for these non-RHC/FQHC services is made under the payment rules that apply to the service.

The following services are NOT RHC/FQHC services:

- Although RHCs must furnish certain lab services to be approved as an RHC (see the Medicare Claims Processing Manual, Chapter 9, "Rural Health Clinics/Federally Qualified Health Centers," §130), these services are not included within the scope of RHC/FQHC services;
- Durable medical equipment (whether rented or sold) including crutches, hospital beds, and wheelchairs used in the patient's place of residence;
- Ambulance services;
- Technical components of diagnostic tests such as x-rays and EKGs (the professional component is an RHC/FQHC service if performed by a RHC/FQHC physician or nonphysician practitioner);
- The technical component of the following specific preventive services (the professional component is an RHC/FQHC service if performed by a RHC/FQHC physician or nonphysician practitioner)
 - Screening pap smears and screening pelvic exams;
 - Prostate cancer screening;
 - Diabetes outpatient self-management training services;

- o Colorectal cancer screening tests;
 - o Screening mammography;
 - o Bone mass measurements; and
 - o Glaucoma screening.
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags), and supplies directly related to colostomy care, and the replacement of such devices; and
 - Leg, arm, back, and neck braces and artificial legs, arms and eyes, including replacements (if required because of a change in the patient's physical condition).

30.4 - RHC/FQHC Services for Hospital/Skilled Nursing Facility (SNF) Outpatients or Inpatients

(Rev. 40, Issued: 11-18-05; Effective: 10-01-05; Implementation: 02-16-06)

For a more complete description of SNF PPS provisions see Pub. 100-04, the Medicare Claims Processing Manual, Chapter 6, "SNF Inpatient Billing." For further information, also see the Claims Processing Manual, Chapter 3, "Inpatient Hospital Billing."

A. Hospital

The hospital bundling provisions in §1862(a)(14) of the Act provides that Medicare payment may not be made to an RHC/FQHC for services provided to hospital inpatients and outpatients.

If the RHC/FQHC practitioner should provide services to a hospital patient, these services are not covered under the RHC/FQHC benefit.

RHC/FQHC services furnished to hospital patients are subject to the Medicare hospital bundling provisions and thus may not be billed by the RHC or FQHC since they are excluded from Medicare coverage under that provision. In other words, professional services furnished to hospital patients by practitioners who are compensated for the services under agreement with the RHC/FQHC cannot be billed because these are RHC/FQHC services and such services are not covered when furnished to hospital patients. However if, under the terms of its agreement with the practitioner, the RHC/FQHC does NOT compensate the practitioner for services rendered to hospital patients, the practitioner may seek Medicare payment for those services under the appropriate Medicare coverage provision.

B. SNF

Although Congress excluded physician services and several other services listed under “Medical and Other Health Services” in §1861(s) of the Act from the payment under the SNF PPS, RHC/FQHC services were not among the services that appear on the excluded list in §1888(e)(2)(A)(ii) of the Act. Consequently, RHC/FQHC services furnished to a resident who is in a covered Part A stay as of the SNF’s PPS start date (that is, as of the facility’s first cost reporting period that begins on or after July 1, 1998) are included in the SNF PPS. This means that rather than submitting a separate bill for these services, the RHC or FQHC must look to the SNF for its payment.

Prior to January 1, 2005, services furnished by an RHC/FQHC’s physician and non-physician practitioners were generally considered a part of “RHC/FQHC” services, and were included within the SNF’s PPS per diem payment when furnished to a Part A resident. However, under limited circumstances these services were considered to be practitioner services that were excluded from SNF consolidated billing and separately billable to Part B (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, §50.4.2B). Specifically, visits to SNF residents by an RHC/FQHC’s physicians and other excluded types of medical practitioners could be separately billed to the Medicare Part B carrier in those situations where the services were furnished off the RHC’s premises and the RHC did not compensate the practitioner for them. In other words, as long as the practitioner was not under agreement with the RHC to provide services at the SNF, the practitioner could bill the Part B carrier directly for those services under his or her own Medicare provider number.

Effective with services furnished on or after January 1, 2005, section 410 of the Medicare Modernization Act (MMA) of 2003 amended the law to specify that when a SNF Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from an RHC or FQHC, those services are not subject to consolidated billing merely by virtue of being furnished under the auspices of the RHC or FQHC. Accordingly, under section 410 of the MMA of 2003, services otherwise included within the scope of RHC and FQHC services that are also described in clause (ii) of section 1888(e)(2)(A) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay.

40 - Preventive Primary Services Which Are Federally Qualified Health Center Services

(Rev. 1, 10-01-03)

RHC-404

40.1 - FQHC Primary Preventive Services Defined

(Rev. 1, 10-01-03)

RHC-404.1, A-02-44, A3-3192.1 B

Preventive primary services must be furnished by or under the direct supervision of a physician, a nurse practitioner, a physician assistant, certified nurse midwife, clinical psychologist, or a clinical social worker.

Preventive primary services must be furnished by a member of the center's health care staff who is an employee of the center or by a physician under arrangements with the center.

Preventive primary services include only drugs and biologicals that are not usually self-administered, unless §1861(s) of the Act provides for coverage of the drug irrespective of whether it is self-administered.

The following preventive primary services may be covered and billed to the intermediary when provided by FQHCs to Medicare beneficiaries:

- Medical social services;
- Nutritional assessment and referral;
- Preventive health education;
- Children's eye and ear examinations;
- Prenatal and post-partum care;
- Prenatal services;
- Well child care, including periodic screening;
- Immunizations, including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;

- Stool testing for occult blood;
- Dipstick urinalysis;
- Risk assessment and initial counseling regarding risks; and
- For women only:
 - Clinical breast exam;
 - Referral for mammography; and
 - Thyroid function test.

40.2 - Preventive Services Excluded Under FQHC Benefit
(Rev. 1, 10-01-03)
RHC-404.2, A3-3192.1.C

FQHC preventive primary services do not include:

- Group or mass information programs, health education classes, or group education activities, including media productions and publications;
- Eyeglasses, hearing aids, and preventive dental services; and
- Services described in §30.3 above

50 - Physician Services
(Rev. 1, 10-01-03)
RHC-405

50.1 - Definition of Physician Services
(Rev. 1, 10-01-03)
RHC-405.1

Physician services are the professional services performed by a physician for a patient including diagnosis, therapy, surgery, and consultation.

A service may be considered to be a physician service if the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization is possible by means of X-rays, electrocardiogram (EKG) and electroencephalogram tapes, tissue samples, etc. For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of verbal description) is a covered service.

50.2 - Telephone Services

(Rev. 1, 10-01-03)

RHC-405.2

Services by means of a telephone call between a physician and a beneficiary (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are Medicare covered services that are included in the payment made to the RHC/FQHC. However, such encounters may not be billed as visits.

50.3 - Prescription Services

(Rev. 1, 10-01-03)

RHC-405.3

Visits for the sole purpose of obtaining or renewing a prescription, the need for which was previously determined (so that no examination of the patient is performed), are not covered services.

50.4 - Physician Services That Are RHC/FQHC Services

(Rev. 1, 10-01-03)

RHC-405.6

In determining whether the professional services of a physician are RHC/FQHC services, the general rules in the following sections apply.

50.4.1 - Physician Services at the Clinic or Center

(Rev. 1, 10-01-03)

RHC-405.6.A

The services of a physician performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

50.4.2 - Physician Services Away From the Clinic or Center

(Rev. 1, 10-01-03)

RHC-405.6.B

A. Full-Time and Part-Time Physician Employees - RHC Services

Full time and part time physicians who are employees of an RHC or FQHC or who are compensated under agreement by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, e.g., in a patient's home. These services are RHC/FQHC services and are payable only to the clinic or center. A physician who is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the

carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.

Clinic/center patients include individuals who receive services at the clinic/center facility or services provided elsewhere for which the costs are included in the costs of the RHC or FQHC.

B. Full - Time and Part -Time Physician Employees - Non-RHC/FQHC Services

If the clinic/center does not compensate a physician for services furnished to clinic/center patients in a location other than at the RHC/FQHC location, the physician may bill the carrier for Medicare payment under the Part B payment system.

50.5 - Consultations

(Rev. 1, 10-01-03)

RHC-405.7

An RHC or FQHC may obtain a consultation, which is covered when it is a professional service furnished a patient by a second physician or consultant at the request of the attending physician. Such a consultation includes the history and examination of the patient as well as the written report furnished to the attending physician for inclusion in the patient's clinic or center records.

50.6 - More Than One Physician Renders Services

(Rev. 1, 10-01-03)

RHC-405.8

Concurrent care exists when more than one physician renders services during a period of time. The reasonable and necessary services of each physician rendering concurrent care are covered if each physician is required to play an active role in the patient's treatment. This occurs, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.

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

(Rev. 1, 10-01-03)

RHC-406, PM A-01-49

Services and supplies incident to a physician's professional services are covered as RHC or FQHC services as long as they are:

- Furnished as an incidental, although integral, part of a physician's professional services;
- Of a type commonly rendered either without charge or included in the RHC or FQHC's bill;

- Services provided by clinic employees other than those nonphysician practitioners listed in §30.1 (PA/NP/CNM and CP/CSW), furnished under the direct, personal supervision of a physician;
- Services provided by clinic employees other than those services listed in §20 furnished under the direct, personal supervision of a physician; and
- Furnished by a member of the clinic or center's staff who is an employee of the clinic or center.

This benefit includes drugs and services of clinic or center health care staff e.g., a nurse, therapist, technician, or other aide, and supplies such as tongue depressors, bandages.

60.1 - Incidental and Integral Part of Physician's Professional Services
(Rev. 1, 10-01-03)
RHC-406.1

Services and supplies incident to a physician's professional services are covered as RHC or FQHC services as long as they are an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. In other words, there must be a physician's personal service rendered to which the nonphysician's service (or the supply) is an incidental, although integral part. This does not mean, however, each occasion of service by a nonphysician (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. This requirement is also met for nonphysician services furnished during a course of treatment in which the physician performs an initial and subsequent service with a frequency which reflects his or her active participation in and management of the course of treatment. However, the direct personal supervision requirement explained in §60.3 must still be met with respect to every nonphysician service for it to be covered as an incident to service. Although incident to services are covered, they are covered as part of an otherwise billable encounter. If no medically necessary face-to-face encounter with a physician or midlevel practitioner, CP or CSW has also occurred during the visit with the incident to staff then no encounter can be billed.

60.2 - Commonly Furnished in Physician's Office
(Rev. 1, 10-01-03)
RHC-406.2

Commonly furnished services and supplies are those customarily incident to a physician's personal services in the office or in physician-directed clinic settings. The requirement is not met where supplies are clearly of a type a physician is not expected to have on hand in his or her office or where services are of a type not medically appropriate in the office setting. The performance of an appendectomy, for example, is not a service that is commonly furnished in a physician's office.

60.3 - Direct Personal Supervision

(Rev. 1, 10-01-03)

RHC-406.3

Coverage for services and supplies furnished incident to physician's services is limited to situations in which there is direct physician supervision of the clinic or center performing the service. Direct personal supervision does not mean that the physician must be present in the same room. However, the physician must be on the premises and immediately available to provide assistance and direction throughout the time the practitioner is performing services.

When clinic or center auxiliary personnel perform services outside the entity, e.g., in the patient's home or in an institution, these services are covered as incident to a physician's services only if there is direct personal supervision by the physician. For example, if a nurse on the staff of a clinic or center accompanies the physician on a house call and administers an injection, the nurse's services can be covered. If the same nurse makes the call alone and administers an injection, the services are not incident to services since the physician is not providing direct personal supervision. (This rule applies only to the incident to provision. It does not apply to visiting nursing services described in §90.)

60.4 - Clinic or Center Employee

(Rev. 1, 10-01-03)

RHC-406.4

To be "incident to", the services must be provided by a member of the clinic health care staff who is a clinic or center employee. Services provided by auxiliary personnel not in the employ of the clinic or center, even if provided on the physician's order or included in the clinic or center's bill (e.g., services of an independently practicing therapist who forwards his/her bill to the clinic or center for inclusion in the entity's statement of services), are not covered as incident to a physician's service. Thus, nonphysician diagnostic and therapeutic services which a clinic or center obtains, for example, from an independent laboratory or a hospital outpatient department are not covered as RHC or FQHC services and cannot be billed to Medicare by the RHC or FQHC.

60.5 - Clinic or Center Expense

(Rev. 1, 10-01-03)

RHC-406.5

As with the physician's personal professional service, the services (or supplies) must be rendered without charge or be included in the clinic or center's bill. The patient's financial liability for the incidental services (or supplies) is to the clinic or center. Therefore, the 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 drug is not covered as an RHC or FQHC service.

60.6 - Incident to Physician's Services in Physician-Directed RHC or FQHC

(Rev. 1, 10-01-03)

RHC-406.6

For purposes of the incident to provision, a physician-directed RHC or FQHC is one where:

- A physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic or center is open;
- Each patient is under the care of a clinic or center physician; and
- The nonphysician services are under medical supervision.

In highly organized entities, particularly those which are departmentalized, direct personal physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. In this situation, medical management of all services provided in the RHC or FQHC is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by therapists and other aides are covered even though they are performed in another department. Supplies provided by the clinic or center during the course of treatment are also covered. To be covered under Medicare as a service that is incident to a physician's service, the services of auxiliary personnel performed outside the clinic or center premises must be performed under the direct personal supervision of a clinic or center physician. If the clinic or center refers a patient for auxiliary services performed by personnel it does not employ, such services are not incident to a physician's service.

60.7 - Coverage of Services and Supplies

(Rev. 1, 10-01-03)

RHC-406.7, PM-A-01-49

Covered services and supplies include such items such as bandages, gauze, assistance by a nurse to a practitioner performing a covered nurse practitioner or physician's assistant's service, etc. Only drugs and biologicals that are not usually self-administered or are specifically covered by Medicare law (e.g., antigens prepared by a physician for a particular patient) are covered under this provision. If Medicare covered drugs are furnished by physicians and nonphysician practitioners of the RHC/FQHC to Medicare patients, the drugs must be covered and paid for as RHC/FQHC services. The costs of such drugs are allowable costs and are part of the clinic's all-inclusive rate calculation.

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

(Rev. 1, 10-01-03)

RHC-408

70.1 - Basic Requirements

(Rev. 1, 10-01-03)

RHC-408.1

Services performed by nonphysician practitioners listed in §30.1 are covered as RHC or FQHC services. They are covered if:

- Furnished by an employee of the RHC or FQHC or an individual who receives compensation from an RHC or FQHC;
- Furnished under the general (or direct, if required by State law) medical supervision of a physician (see §70.6);
- Furnished in accordance with clinic or center policies and any physician medical orders for the care and treatment of a patient;
- Of a type which the nurse practitioner, physician assistant, or certified nurse midwife who furnished the service is legally permitted to perform by the State in which the service is rendered; and
- Of a type which would be covered under Medicare if furnished by a physician.

70.2 - Covered Nonphysician Practitioner RHC/FQHC Services

(Rev. 1, 10-01-03)

RHC-408.2

Nonphysician practitioner (refer to list in §30.1) services are professional services performed for a patient. Services include diagnosis, treatment, therapy and consultation. The service must be rendered directly by the practitioner, i.e., the practitioner must either examine the patient in person or be able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization is possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

In general, Medicare covers services provided by nonphysician practitioners which would be considered covered physician services under Medicare (see §50), and which are permitted by State laws and clinic or center policies to be furnished by a nurse practitioner or physician assistant, or a certified nurse midwife. As with physician services under Medicare, a service will not be covered if it is not reasonable and necessary for the treatment of a patient's illness or condition or to improve the functioning of a malformed body member.

70.3 - Services by Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives as RHC/FQHC Services

(Rev. 1, 10-01-03)

RHC-408.3

In determining whether the professional services of a nurse practitioner, physician assistant or certified nurse midwife are RHC/FQHC services, the following general rules apply.

70.3.1 - Services at the Clinic or Center

(Rev. 1, 10-01-03)

RHC-408.3.A

The professional services of full time or part time nurse practitioner or physician assistant (including services furnished by certified nurse midwives) performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

70.3.2 - Services Away From the Clinic or Center

(Rev. 1, 10-01-03)

RHC-498.3.B

Full-time and part-time nurse practitioners, physician assistants (including nurse midwives) who are employees of an RHC or FQHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home. These services are RHC/FQHC services and are reimbursable only to the clinic or center.

A nurse practitioner, physician assistant (including nurse midwives) who is not compensated by the clinic/center for services in locations other than the clinic/center, may bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.

70.4 - Effect of State Law

(Rev. 1, 10-01-03)

RHC-408.4

The services of a nurse practitioner and physician assistant (including services of certified nurse midwives) are covered if the practitioner or assistant is legally permitted to furnish them in the State in which they are performed. The coverage of nurse practitioner and physician assistant services is also subject to any State restrictions as to setting and supervision. Thus, when State law requires that physician assistant, nurse practitioner, or certified nurse midwife be furnished under the direct supervision of a physician, Medicare cannot cover such services furnished without physician supervision or under only general (i.e., other than direct on the premises) physician supervision.

70.5 - Effect of Clinic or Center Policies

(Rev. 1, 10-01-03)

RHC-408.5

Nurse practitioner and physician assistant services (including services of certified nurse midwives) must be furnished in accordance with written policies governing the furnishing of services by the clinic/center to its patients. The clinic or center is required to have this as a condition for RHC or FQHC approval. These policies must specify what services nurse practitioners, physician assistants, and nurse midwives may furnish to clinic or center patients. The RHC and FQHC are expected to comply with such policies and operate within their bounds. Services that do not comply with the policies of the RHC or FQHC are not covered.

70.6 - Physician Supervision

(Rev. 1, 10-01-03)

RHC-408.6

Clinics or centers which are not physician- directed must have an arrangement with a physician which provides for the supervision and guidance of physician assistants and nurse practitioners. The arrangement must be consistent with State law and provide for at least one onsite supervisory visit by the physician every two weeks (except in extraordinary circumstances). The physician must be a doctor of medicine or osteopathy. See the State Operations Manual for examples of extraordinary circumstances.

In the case of a physician-directed clinic or center, the general supervision of physician assistants and nurse practitioners must be performed by one or more of the clinic or center's staff physicians.

80 - Services and Supplies Incident to Nurse Practitioner's, Certified Nurse Midwives's or Physician Assistant's Services

(Rev. 1, 10-01-03)

RHC-410

80.1 - Basic Requirements

(Rev. 1, 10-01-03)

RHC-410.1

To be covered as a RHC or FQHC service, the service or supply must be:

- Of a type commonly furnished in physician's offices;
- Of a type commonly rendered either without charge or included in the RHC or FQHC's bill;
- Furnished as an incidental, although integral, part of professional services furnished by a nurse practitioner, physician assistant, or certified nurse midwife;
- Furnished under the direct, personal supervision of a physician, nurse practitioner, physician assistant, or a certified nurse midwife; and

- In the case of services, furnished by a member of the clinic or center's staff who is an employee of the clinic or center.

80.2 - Scope of Coverage

(Rev. 1, 10-01-03)

RHC-410.2

Services and supplies covered under this provision are generally the same as described in §60 as incident to a physician's services and include services and supplies incident to the services of a nurse practitioner, physician assistant, or a certified nurse midwife.

80.3 - Direct, Personal Supervision

(Rev. 1, 10-01-03)

RHC-410.3

This requirement is met in the case of a nurse practitioner, physician assistant, or certified nurse midwife who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC.

90 - Conditions for Coverage of Visiting Nurse Services

(Rev. 1, 10-01-03)

RHC-412

90.1 - General Requirements

(Rev. 1, 10-01-03)

RHC-412.1

Visiting nurse services are covered as RHC or FQHC services if:

- The RHC or FQHC is located in an area in which CMS has determined that there is a shortage of home health agencies (see §90.2 below);
- The services are rendered to patients who are homebound (see §§90.3 and 90.4);
- The patient is furnished part time or intermittent nursing care by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by the RHC/FQHC (see §90.5); and
- The services are furnished under a written plan of treatment, as described in §90.6.

90.2 - Shortage of Home Health Agencies

(Rev. 1, 10-01-03)

RHC-412.2

The RHC or FQHC may be reimbursed for visiting nurse services furnished to Medicare patients if it is located in an area CMS has determined to have a shortage of home health agencies. CMS considers that a shortage of home health agencies exists if an RHC or FQHC:

- Is located in a county, parish or similar geographic area in which:
 - There is no participating home health agency under Medicare; or
 - Adequate home health services are not available to clinic or center patients even though a participating home health agency is in the area;
- Has patients whose homes are not within the area serviced by a participating home health agency; or
- Have patients, whose homes are not within a reasonable traveling distance, considering the area's climate and terrain, to a participating home health agency.

An RHC which believes that its area meets these conditions and wishes to offer visiting nurse services must make a written request to the State Agency along with written justification that the area it serves meets one of the above conditions. The State Agency decides whether the clinic qualifies to offer this benefit.

An FQHC which believes its area meets these conditions and wishes to offer visiting nurse services must make written request to its CMS RO along with written justification that the area it serves meets one of the above conditions. The CMS RO will decide whether the center qualifies to offer this benefit.

90.3 - Services Are Furnished to Homebound Patients

(Rev. 1, 10-01-03)

RHC-412.3, A-01-21 added per CMS comment

The visiting nurse benefit is restricted to patients who are homebound.

See §30 of the Medicare Benefit Policy Manual, Chapter 7, Home Health Services, for a description of "homebound."

The visiting nurse benefit is restricted to patients who are homebound.

90.4 - Patient's Place of Residence

(Rev. 1, 10-01-03)

RHC-412.4

See §30.1.2 of the Medicare Benefit Policy Manual, Chapter 7, Home Health Services, for a description of "the patients place of residence."

90.5 - Services Furnished by Licensed Nurse

(Rev. 1, 10-01-03)

RHC-412.5

The services must be furnished by a registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.).

1. A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, the reviewer considers both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice.

Some services may be classified as a skilled nursing service on the basis of complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters, and if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse.

2. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by a nonmedical person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.
3. 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.
4. The skilled nursing service 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. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. A patient's overall medical condition is a valid factor in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

90.6 - Services Furnished Under Plan of Treatment
(Rev. 1, 10-01-03)
RHC-412.6

Items and services must be furnished under a written plan established by a supervising physician, nurse practitioner, physician assistant, or a certified nurse midwife. A supervising physician of the RHC or FQHC must review it at least once every 60 days. The plan must relate the items and services to the patient's condition. Home nursing visits furnished before the plan is put into writing are covered if authorized in writing by the supervising physician.

The plan of care must contain all pertinent diagnoses, including the beneficiary's mental status, the types of services, supplies, and equipment ordered, the frequency of the visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, discharge plans, and any additional items the home health agency or physician chooses to include.

The signature of the supervising physician, nurse practitioner, physician assistant, or certified nurse midwife must be obtained on a plan prior to the submission of claims to the intermediary. The plan must be incorporated into the clinic or center's permanent record for the patient. Any charges must be made in writing and signed by the supervising physician. The physician must sign all changes in orders for dangerous drugs and narcotics.

Each review of the patient's plan must contain the initials of the physician and show the date performed. The clinic or center's records need not be forwarded to the intermediary for review but must be retained in the clinic or center's files.

If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated for the purpose of Medicare coverage unless:

- The supervising physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient, or
- It is clear from the facts in the case that nursing visits are required at intervals less frequently than once every 60 days, but the intervals are predictable, e.g., it is

predictable that a visit is required only every 90 days for the purpose of changing a silicone catheter.

100 - Clinical Psychologist Services Away and at the RHC/FQHC Clinic or Center

(Rev. 1, 10-01-03)

RHC-419.1

100.1 - Clinical Psychologist (CP) Defined

(Rev. 1, 10-01-03)

RHC-419.1.A

To qualify as a CP, a practitioner must meet the following requirements:

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

100.2 - Qualified Clinical Psychologist Services Defined

(Rev. 1, 10-01-03)

RHC-419.1.B

Effective July 1, 1990, the diagnostic and therapeutic services of CPs, and services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. However, the CP must be legally authorized to perform the services under applicable licensure laws of the State in which they are furnished.

100.3 - Types of Covered Clinical Psychologist Services

(Rev. 1, 10-01-03)

RHC-419.1.C

The CPs may provide the following services:

- Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and regulation.
- Services and supplies furnished incident to a CP's services are covered if the requirements that apply to services incident to a physician's services, as described

in §60, are met and they are furnished by an employee of the RHC or FQHC. To be covered, these services and supplies must be:

- o Mental health services that are commonly furnished in CPs' offices;
- o An integral, although incidental, part of professional services performed by the CP; and
- o Performed under the direct personal supervision of the CP, i.e., the CP must be physically present and immediately available.

Appropriate State laws and regulations governing a CP's scope of practice must be considered.

100.4 - Noncovered CP Services

(Rev. 1, 10-01-03)

RHC-419.1.D

The services of CPs are not covered if they are otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by State law to perform them. For example, §1862(a)(1)(A) of the Act excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, even though State law authorizes the services, the services of a CP that are determined to be not reasonable and necessary are not covered.

100.5 - Requirement for Consultation

(Rev. 1, 10-01-03)

RHC-419.1.E

The CP must provide written notification to the patient's designated attending or primary care physician that services are being provided to the patient, or must consult directly with the physician to consider medical conditions that may be contributing to the patient's symptoms, unless the patient specifically requests that such notification or consultation not be made.

100.6 - Outpatient Mental Health Services Limitation for CP Services

(Rev. 1, 10-01-03)

RHC-419.1.F

All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health services limitation (i.e., only 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). The limitation does not apply to diagnostic services.

100.7 - CP Services at the Clinic or Center

(Rev. 1, 10-01-03)
RHC-419.1.G

The services of a CP performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

100.8 - CP Services Away From the Clinic or Center
(Rev. 1, 10-01-03)
RHC-419.1.H

Clinical psychologists who are employees of an RHC or FQHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home. These services are RHC/FQHC services and are reimbursable only to the clinic or center.

A clinical psychologist who is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.

110 - Clinical Social Worker (CSW) Services Away and at the RHC/FQHC Clinic or Center
(Rev. 1, 10-01-03)
RHC-419.2

The RHC/FQHC services include the services provided by a clinical social worker.

110.1 - Clinical Social Worker Defined
(Rev. 1, 10-01-03)
RHC-419.2.A

A clinical social worker is an individual who:

- Possesses a master's or doctor's degree in social work;
- Has performed at least two years of supervised clinical social work; and
- Either:
 - Is licensed or certified as a clinical social worker by the State in which the services are performed; or
 - In the case of an individual in a State that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the

supervision of a master's level social worker in an appropriate setting such as a hospital, SNF, or clinic

110.2 - Clinical Social Worker Services Defined

(Rev. 1, 10-01-03)

RHC-419.2.B

Clinical social worker services for the diagnosis and treatment of mental illnesses and services and supplies furnished incident to such services are covered as long as the CSW is legally authorized to perform them under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed. The services that are covered are those that are otherwise covered if furnished by a physician or as an incident to a physician's professional service. Services furnished to an inpatient or outpatient that a hospital is required to provide as a requirement for participation are not included.

110.3 - Covered CSW Services

(Rev. 1, 10-01-03)

RHC-419.2.C

Clinical social worker services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. (See §60.) Coverage is limited to the services a CSW is legally authorized to perform in accordance with State law, including services and supplies furnished incident to such services and are those that are otherwise covered if furnished by a physician or incident to a physician's professional service. The services of a CSW may be covered in an RHC/FQHC if they are:

- The type of services that are otherwise covered if furnished by a physician, or incident to a physician's service;
- Performed by a person who meets the above definition of a CSW; and
- Not otherwise excluded from coverage.

State law or regulatory mechanism governing a CSW's scope of practice in the service area must be considered. Development of a list of services within the scope of practice is encouraged.

110.4 - Noncovered CSW Services

(Rev. 1, 10-01-03)

CSW services are not covered if they are otherwise excluded from Medicare coverage even though a CSW is authorized by State law to perform them. For example, the Medicare law excludes from coverage services that are not "reasonable and necessary for

the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

110.5 - Outpatient Mental Health Services Limitation
(Rev. 1, 10-01-03)

All covered therapeutic services furnished by qualified CSWs are subject to the outpatient psychiatric services limitation (i.e., only 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). The limitation does not apply to diagnostic services.

110.6 - Services at the Clinic or Center
(Rev. 1, 10-01-03)
RHC-419.2.F

The services of clinical social workers performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

110.7 - Services Away From the Clinic or Center
(Rev. 1, 10-01-03)
RHC-419.2.G

Clinical social workers who are employees of an RHC or FQHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home. These services are RHC/FQHC services and are reimbursable only to the clinic or center.

A clinical social worker that is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R49BP	03/31/2006	Payment of Federally Qualified Health Centers (FQHCs) for Diabetes Self-Management Training Services (DSMT) and Medical Nutrition Therapy (MNT) Services	06/29/2006	4385
R40BP	11/18/2005	Skilled Nursing Facility Prospective Payment System	02/16/2006	4079
R1BP	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A