

- (14) Visual acuity screening.
- (15) Hearing screening.
- (16) Cholesterol screening.
- (17) Stool testing for occult blood.
- (18) Dipstick urinalysis.
- (19) Risk assessment and initial counseling regarding risks.
- (20) Tuberculosis testing for high risk patients.
- (21) For women only.
  - (i) Clinical breast exam.
  - (ii) Referral for mammography; and
  - (iii) Thyroid function test.
- (c) Preventive primary services do not include group or mass information programs, health education classes, or group education activities, including media productions and publications.
- (d) Screening mammography is not considered a FQHC service, but may be provided at a FQHC if the FQHC if the center meets the requirements applicable to that service specified in § 410.34 of this subchapter. Payment is made under applicable Medicare requirements.
- (e) Preventive primary services do not include eyeglasses, hearing aids, or preventive dental services.

[57 FR 24980, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996; 79 FR 25477, May 2, 2014; 80 FR 71371, Nov. 16, 2015]

#### § 405.2449 Preventive services.

For services furnished on or after January 1, 2011, preventive services covered under the Medicare FQHC benefit are those preventive services defined in section 1861(ddd)(3) of the Act, and § 410.2 of this chapter. Specifically, these include the following:

- (a) The specific services currently listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms.
- (b) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act as added by section 611 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173) and § 410.16 of this chapter).
- (c) The Personalized Prevention Plan Services (PPPS), also known as the “Annual Wellness Visit” (as specified by section 1861(hhh) of the Act as added by section 4103 of the Affordable Care

Act (Pub. L. 111-148) and § 410.15 of this chapter).

[75 FR 73613, Nov. 29, 2010, as amended at 79 FR 25477, May 2, 2014]

#### § 405.2450 Clinical psychologist and clinical social worker services.

(a) For clinical psychologist or clinical social worker professional services to be payable under this subpart, the services must be—

- (1) Furnished by an individual who owns, is employed by, or furnishes services under contract to the FQHC;
- (2) Of a type that the clinical psychologist or clinical social worker who furnishes the services is legally permitted to perform by the State in which the service is furnished;
- (3) Performed by a clinical social worker or clinical psychologist who is legally authorized to perform such services under State law or the State regulatory mechanism provided by the law of the State in which such services are performed; and
- (4) Covered if furnished by a physician.

(b) If State law prescribes a physician supervision requirement, it is met if the conditions specified in § 491.8(b) of this chapter and any pertinent requirements of State law are satisfied.

(c) The services of clinical psychologists or clinical social workers are not covered if State law or regulations require that the services be performed under a physician's order and no such order was prepared.

[57 FR 24980, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996]

#### § 405.2452 Services and supplies incident to clinical psychologist and clinical social worker services.

(a) Services and supplies incident to a clinical psychologist's or clinical social worker's services are reimbursable under this subpart if the service or supply is—

- (1) Of a type commonly furnished in a physician's office;
- (2) Of a type commonly furnished either without charge or included in the FQHC's bill;
- (3) Furnished as an incidental, although integral part of professional services furnished by a clinical psychologist or clinical social worker;

## § 405.2460

## 42 CFR Ch. IV (10–1–23 Edition)

(4) Services and supplies must be furnished in accordance with applicable State law; and

(5) Furnished under the direct supervision of a clinical psychologist or clinical social worker.

(b) The direct supervision requirement in paragraph (a)(5) of this section is met only if the clinical psychologist or clinical social worker is permitted to supervise such services under the written policies governing the FQHC.

[43 FR 8261, Mar. 1, 1978, as amended at 78 FR 74810, Dec. 10, 2013; 79 FR 25477, May 2, 2014; 79 FR 68001, Nov. 13, 2014]

### PAYMENT FOR RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES

SOURCE: 57 FR 24976, 24977, June 12, 1992, unless otherwise noted.

#### § 405.2460 Applicability of general payment exclusions.

The payment conditions, limitations, and exclusions set out in subpart C of this part, part 410 and part 411 of this chapter are applicable to payment for services provided by RHCs and FQHCs, except that preventive primary services, as defined in § 405.2448, are statutorily authorized for FQHCs and not excluded by the provisions of section 1862(a) of the Act.

[79 FR 25477, May 2, 2014]

#### § 405.2462 Payment for RHC and FQHC services.

(a) *Payment to independent RHCs that are authorized to bill under the reasonable cost system.* (1) RHCs that are authorized to bill under the reasonable cost system are paid on the basis of an all-inclusive rate, subject to a payment limit per visit determined in paragraph (b) of this section, for each beneficiary visit for covered services. This rate is determined by the Medicare Administration Contractor (MAC), in accordance with this subpart and general instructions issued by CMS.

(2) The amount payable by the MAC for a visit is determined in accordance with paragraphs (i)(1) and (2) of this section.

(b) *RHC payment limit per visit.* (1) In establishing limits on payment for rural health clinic services provided by

rural health clinics the limit for services provided prior to April 1, 2021:

(i) In 1988, after March 31, at \$46 per visit; and

(ii) In a subsequent year (before April 1, 2021), at the limit established for the previous year increased by the percentage increase in the Medicare Economic Index (MEI) (as defined in section 1842(i)(3) of the Act) applicable to primary care services (as defined in section 1842(i)(4) of the Act) furnished as of the first day of that year.

(2) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by rural health clinics or any rural health clinic that is enrolled on or after January 1, 2021 under section 1866(j) of the Act), the limit for services provided:

(i) In 2021, after March 31, at \$100 per visit;

(ii) In 2022, at \$113 per visit;

(iii) In 2023, at \$126 per visit;

(iv) In 2024, at \$139 per visit;

(v) In 2025, at \$152 per visit;

(vi) In 2026, at \$165 per visit;

(vii) In 2027, at \$178 per visit; and

(viii) In 2028, at \$190 per visit.

(ix) In a subsequent year, at the limit established for the previous year increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such year.

(3) In establishing limits on payment for rural health services furnished on or after April 1, 2021, by provider-based rural health clinics as described in section (c)(4) of this part, the limit for services provided:

(i) In 2021, after March 31, at an amount equal to the greater of:

(A) For rural health clinics that had an all-inclusive rate established for services furnished in 2020—

(I) The all-inclusive rate applicable to the rural health clinic for services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021, or

(2) The payment limit per visit applicable in paragraph (b)(2) of this section.

(B) For rural health clinics that did not have an all-inclusive rate established for services furnished in 2020—