

(1) Geographic differences in cost based on the Geographic Practice Cost Indices (GPCIs) in accordance with section 1848(e) of the Act and 42 CFR 414.2 and 414.26 are used to adjust payment under the physician fee schedule during the same period, limited to only the work and practice expense GPCIs.

(2) Furnishing of care to a beneficiary that is a new patient with respect to the FQHC, including all sites that are part of the FQHC. A new patient is one that has not been treated by the FQHC's organization within the previous 3 years.

(3) Furnishing of care to a beneficiary receiving a comprehensive initial Medicare visit (that is an initial preventive physical examination or an initial annual wellness visit) or a subsequent annual wellness visit.

(f) *Payment to grandfathered tribal FQHCs.* (1) A “grandfathered tribal FQHC” is a FQHC that:

(i) Is operated by a tribe or tribal organization under the Indian Self-Determination Education and Assistance Act (ISDEAA);

(ii) Was billing as if it were provider-based to an IHS hospital on or before April 7, 2000; and

(iii) Is not operating as a provider-based department of an IHS hospital.

(2) A grandfathered tribal FQHC is paid at the Medicare outpatient per visit rate as set annually by the IHS.

(3) The payment rate is not adjusted:

(i) By the FQHC Geographic Adjustment Factor;

(ii) For new patients, annual wellness visits, or initial preventive physical examinations; or

(iii) Annually by the Medicare Economic Index or a FQHC PPS market basket.

(4) The payment rate is adjusted annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Pub. L. 83–568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 *et seq.*).

(g)(1) Except for preventive services for which Medicare pays 100 percent under § 410.152(l) of this chapter, Medicare pays—

(i) Eighty (80) percent of the lesser of the FQHC's actual charge or the PPS

encounter rate for FQHCs authorized to bill under the PPS; or

(ii) Eighty (80) percent of the lesser of a grandfathered tribal FQHC's actual charge, or the outpatient rate for Medicare as set annually by the IHS for grandfathered tribal FQHCs that are authorized to bill at this rate.

(2) No deductible is applicable to FQHC services.

(h) For RHCs visits, payment is made in accordance with one of the following:

(1) If the deductible has been fully met by the beneficiary prior to the RHC visit, Medicare pays 80 percent of the all-inclusive rate.

(2) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is less than the all-inclusive rate, the amount applied to the deductible is subtracted from the all-inclusive rate and 80 percent of the remainder, if any, is paid to the RHC.

(3) If the deductible has not been fully met by the beneficiary before the visit, and the amount of the RHC's reasonable customary charge for the services that is applied to the deductible is equal to or exceeds the all-inclusive rate, no payment is made to the RHC.

(i) To receive payment, the RHC or FQHC must do all of the following:

(1) Furnish services in accordance with the requirements of subpart X of part 405 of this chapter and subpart A of part 491 of this chapter.

(2) File a request for payment on the form and manner prescribed by CMS.

(3) *HCPCS coding.* FQHCs and RHCs are required to submit HCPCS and other codes as required in reporting services furnished.

[79 FR 25477, May 2, 2014, as amended at 80 FR 71371, Nov. 16, 2015; 83 FR 60073, Nov. 23, 2018; 86 FR 65660, Nov. 19, 2021]

§ 405.2463 What constitutes a visit.

(a) *Visit—General.* (1) For RHCs, a visit is either of the following:

(i) Face-to-face encounter (or, for mental health disorders only, an encounter that meets the requirements under paragraph (b)(3) of this section) between an RHC patient and one of the following:

(A) Physician.
 (B) Physician assistant.
 (C) Nurse practitioner.
 (D) Certified nurse midwife.
 (E) Visiting registered professional or licensed practical nurse.
 (G) Clinical psychologist.
 (H) Clinical social worker.
 (ii) Qualified transitional care management service.
 (2) For FQHCs, a visit is either of the following:
 (i) A visit as described in paragraph (a)(1)(i) or (ii) of this section.
 (ii) A face-to-face encounter between a patient and either of the following:
 (A) A qualified provider of medical nutrition therapy services as defined in part 410, subpart G, of this chapter.
 (B) A qualified provider of outpatient diabetes self-management training services as defined in part 410, subpart H, of this chapter.
 (b) *Visit—Medical.* (1) A medical visit is a face-to-face encounter between a RHC or FQHC patient and one of the following:
 (i) Physician.
 (ii) Physician assistant.
 (iii) Nurse practitioner.
 (iv) Certified nurse midwife.
 (v) Visiting registered professional or licensed practical nurse.
 (2) A medical visit for a FQHC patient may be either of the following:
 (i) Medical nutrition therapy visit.
 (ii) Diabetes outpatient self-management training visit.
 (3) *Visit—Mental health.* A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder, including an in-person mental health service, beginning 152 days after the end of the COVID-19 public health emergency, furnished within 6 months prior to the furnishing of the telecommunications service and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via tele-

communications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record, between an RHC or FQHC patient and one of the following:

(i) Clinical psychologist.
 (ii) Clinical social worker.
 (iii) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.

(c) *Visit—Multiple.* (1) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, 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 the patient—

(i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day;

(ii) Has a medical visit and a mental health visit on the same day; or

(iii) Has an initial preventive physical exam visit and a separate medical or mental health visit on the same day.

(2) For RHCs and FQHCs that are authorized to bill under the reasonable cost system, Medicare pays RHCs and FQHCs for more than 1 visit per day when the conditions in paragraph (c)(1) of this section are met.

(3) For FQHCs that are authorized to bill under the reasonable cost system, Medicare pays for more than 1 visit per day when a DSMT or MNT visit is furnished on the same day as a visit described in paragraph (c)(1) of this section are met.

(4) For FQHCs billing under the PPS, and grandfathered tribal FQHCs that are authorized to bill as a FQHC at the outpatient per visit rate for Medicare as set annually by the Indian Health Service—

(i) Suffers an illness or injury subsequent to the first visit that requires additional diagnosis or treatment on the same day; or

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(ii) Has a medical visit and a mental health visit on the same day.

[79 FR 68001, Nov. 13, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 86 FR 65661, Nov. 19, 2021; 87 FR 70222, Nov. 18, 2022]

§ 405.2464 Payment rate.

(a) *Payment rate for RHCs that are authorized to bill under the reasonable cost system.*

(1) Except as specified in paragraphs (d) and (e) of this section, an RHC that is authorized to bill under the reasonable cost system is paid an all-inclusive rate that is determined by the MAC at the beginning of the cost reporting period.

(2) The rate is determined by dividing the estimated total allowable costs by estimated total visits for RHC services.

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

(4) The MAC, during each reporting period, periodically reviews the rate to assure that payments approximate actual allowable costs and visits and adjusts the rate if:

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

(ii) Actual allowable costs vary materially from allowable costs; or

(iii) Other circumstances arise which warrant an adjustment.

(5) The RHC may request the MAC to review the rate to determine whether adjustment is required.

(b) *Payment rate for FQHCs that are authorized to bill under the prospective payment system.* (1) Except as specified in paragraphs (d) and (e) of this section, a per diem rate is calculated by CMS by dividing total FQHC costs by total FQHC daily encounters to establish an average per diem cost.

(2) The per diem rate is adjusted as follows:

(i) For geographic differences in the cost of inputs according to § 405.2462(c)(1).

(ii) When the FQHC furnishes services to a new patient, as defined in § 405.2462(c)(2).

(iii) When a beneficiary receives either of the following:

(A) A comprehensive initial Medicare visit (that is, an initial preventive

physical examination or an initial annual wellness visit).

(B) A subsequent annual wellness visit.

(c) *Payment for care management services.* For chronic care management services furnished between January 1, 2016 and December 31, 2017, payment to RHCs and FQHCs is at the physician fee schedule national non-facility payment rate. For care management services furnished on or after January 1, 2018, payment to RHCs and FQHCs is at the rate set for each of the RHC and FQHC payment codes for care management services.

(d) *Payment for FQHCs that are authorized to bill as grandfathered tribal FQHCs.* Grandfathered tribal FQHCs are paid at the outpatient per visit rate for Medicare as set annually by the Indian Health Service for each beneficiary visit for covered services. There are no adjustments to this rate.

(e) *Payment for communication technology-based and remote evaluation services.* For communication technology-based and remote evaluation services furnished on or after January 1, 2019, payment to RHCs and FQHCs is at the rate set for each of the RHC and FQHC payment codes for communication technology-based and remote evaluation services.

[79 FR 25478, May 2, 2014, as amended at 80 FR 71372, Nov. 16, 2015; 83 FR 60073, Nov. 23, 2018]

§ 405.2466 Annual reconciliation.

(a) *General.* Payments made to RHCs or FQHCs that are authorized to bill under the reasonable cost system during a reporting period are subject to annual 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 for RHCs or FQHCs that are authorized to bill under the reasonable cost system.* (1) The total reimbursement amount due the RHC or FQHC for covered services furnished to Medicare beneficiaries is based on the report specified in § 405.2470(c)(2) and is calculated by the MAC as follows: