PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. A-00-30 **Date January 2000**

CHANGE REQUEST 1133

SUBJECT: Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases and Policy Clarifications and Guidance for Services Furnished by RHCs and FQHCs.

Change in FQHC and RHC Payment Rates

RHCs:

For calendar year (CY) 2000, the Medicare RHC upper payment limit per visit is increased to $61.85 effective January 1, 2000 through December 31, 2000. The 2000 rate reflects a 2.4 percent increase over the 1999 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by §1833(f) of the Social Security Act (the Act).

FQHCs:

For CY 2000, the Medicare FQHC upper payment limit per visit for urban FQHCs is increased to $96.02 effective January 1, 2000 through December 31, 2000, and the maximum Medicare payment limit per visit for rural FQHCs is increased to $82.55 effective January 1, 2000 through December 31, 2000. The 2000 FQHC rates reflect a 2.4 percent increase over the 1999 rates, in accordance with the rate of increase in the MEI.

The effective date of January 1, 2000 is necessary in order to update FQHC and RHC payment rates in accordance with §1833(f) of the Act. Adjust all bills paid at previous upper payment limits to CY 2000 upper payment limits for services provided on or after January 1, 2000 through December 31, 2000.

Laboratory

In light of recent inquiries regarding laboratory services, we are clarifying whether diagnostic laboratory tests furnished in the RHC/FQHC by their personnel are covered RHC/FQHC services paid under the all-inclusive rate, or whether such services are beyond the scope of RHC/FQHC services.

While the law requires a facility seeking to be certified by Medicare as an RHC to provide routine diagnostic services, clinical diagnostic laboratory services are not within the scope of services covered and paid for under the RHC provisions. Consequently, laboratory services (**including** the six required laboratory tests for RHC certification at 42 CFR §491.9) furnished by a clinic should be paid under the laboratory fee schedules.

When clinics separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of RHC/FQHC cost report. Furthermore, freestanding clinics should bill laboratory services to the Part B carrier and provider-based clinics should bill these services to the fiscal intermediary that serves the main provider (e.g., the hospital's intermediary).

The effective date of January 1, 2001 should be applied to implement this pronouncement to avoid the administrative burden of retroactively adjusting claims and cost reports.

Preventive Services

Federal statute requires HCFA to cover and pay for specific preventive services when provided to a Medicare beneficiary. The preventive physician and nonphysician services that are covered under Medicare are pap/pelvic exams, prostate cancer screening, diabetes outpatient self-management training services, colorectal cancer screening tests, screening mammography and bone mass measurements.

Under the regular Medicare fee-for-service program, the preventive services listed above are only covered by Medicare when furnished by a physician or nonphysician practitioner. See Medicare regulations, manuals and operational guidelines for specific coverage and certification requirements for the provision of these services.

Preventive physician and nonphysician services and any services or supplies incident to such services are covered when performed in an RHC/FQHC to the same extent as other RHC/FQHC services. In other words, if the preventive service is furnished within an RHC/FQHC by a physician or nonphysician, the service must be covered and paid for as an RHC/FQHC service. Please note the RHC/FQHC must be qualified to furnish the preventive service and like other covered RHC/FQHC services, only the **professional services** performed by a physician or nonphysician practitioner are covered RHC/FQHC services.

This policy clarification supersedes the billing guidance at §3660.10 of the Medicare Intermediary Manual regarding the professional component. Please note that provider-based RHCs/FQHCs should continue to bill the intermediary for the technical component and independent RHC/ FQHCs should bill their carrier for the technical component.

The effective date of January 1, 2001 should be applied to implement this pronouncement to avoid the administrative burden of retroactively adjusting claims and cost reports.

RHC/FQHC Services Provided to Patients in Skilled Nursing Facilities (SNFs)

HCFA released Program Memorandum (PM) A-99-8 in March, 1999. This PM communicated the effect on RHCs/FQHCs of implementation of the consolidated billing provision for skilled nursing facilities (SNFs) contained in §4432 of the Balanced Budget Act of 1997 (P.L. 105-33).

Although Congress excluded physician services and several other services listed under "Medical and Other Health Services" in §1861(s) of the Act from the SNF bundle of services, RHC/FQHC services are not among the services that appear on the excluded list in §1888(e)(2)(A)(ii) of the Act. However, the PM also notes that due to systems modification delays in connection with achieving CY 2000 compliance, consolidated billing implementation is currently on hold with regard to those SNF residents who are not in a covered Part A stay that is paid by the prospective payment system (PPS). Accordingly, RHC/FQHC services are currently bundled to the SNF only when furnished to a resident who is in a covered Part A stay, and only 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).

As explained in PM A-99-8, RHC/FQHC services furnished to SNF residents are by law subject to the SNF consolidated billing provision and may not be billed by the RHC or FQHC. In other words, professional services furnished to these SNF residents by practitioners who are compensated under agreement by the RHC/FQHC cannot be billed because these are RHC/FQHC services. If the RHC/FQHC does **not** compensate the practitioner under agreement and the practitioner is excluded from the consolidated billing requirement, the practitioner may submit a bill using its own Medicare provider number and should file the claim to the appropriate Part B carrier.

Please notify your independent and provider-based RHCs/FQHCs in a newsletter of the above clarification and payment rate changes.

These instructions should be implemented within your current operating budget.

Please see above instructions regarding implementation and effective dates.

For questions pertaining to payment and coverage, please contact David Worgo, on (410) 786-5919. For questions concerning claims processing, contact Gertrude Saunders (410) 786-5888.

This PM may be discarded after May 31, 2001.