(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 between a 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 prospective payment system, Medicare pays for more than 1 visit per day when the patient—

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

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

[79 FR 25478, May 2, 2014]

§ 405.2464 Payment rate.

(a) *Determination of the payment rate for RHCs and FQHCs that are authorized to bill on the basis of reasonable cost.* (1) An all-inclusive rate 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 or FQHC 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 or FQHC may request the MAC to review the rate to determine whether adjustment is required.

(b) *Determination of the payment rate for FQHCs billing under the prospective payment system.* (1) 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.

[79 FR 25478, May 2, 2014]

§ 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:

(i) The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for RHC or FQHC 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 RHC or FQHC services furnished to Medicare beneficiaries is calculated by multiplying the average cost per visit by the number of visits for covered RHC or FQHC services by beneficiaries.

(iii) The total payment due the RHC is 80 percent of the amount calculated by subtracting the amount of deductible incurred by beneficiaries that is attributable to RHC services from the cost of these services. FQHC services are not subject to a deductible and the payment computation for FQHCs does not include a reduction related to the deductible.

(iv) For RHCs 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 RHC or FQHC for the reporting period, and the difference constitutes the amount of the reconciliation.

(c) *Notice of program reimbursement.* The MAC notifies the RHC or FQHC that is authorized to bill under the reasonable-cost system:

(1) Setting forth its determination of the total reimbursement amount due the RHC or FQHC for the reporting period and the amount, if any, of the reconciliation; and

(2) Informing the RHC or FQHC 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 RHC or FQHC that is authorized to bill under the reasonable cost system exceeds the payments made for the reporting period, the MAC makes a lump-sum payment to the RHC or FQHC to bring total payments into agreement with total reimbursement due the RHC or FQHC.

(2) *Overpayments.* If the total payments made to a RHC or FQHC for the reporting period exceed the total reimbursement due the RHC or FQHC for the period, the MAC arranges with the RHC or FQHC for repayment through a lump-sum refund, or, if that poses a hardship for the RHC or FQHC, 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 MAC if the MAC 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; 79 FR 25478, May 2, 2014]