

Medicare Rural Health Clinic and Federally Qualified Health Center Manual
Chapter I - General Information About the Program

Table of Contents

Administration of Medicare Program

- 100. INTRODUCTION
- 102. FINANCING THE PROGRAM
- 104. HOSPITAL INSURANCE (HI) -- A BRIEF DESCRIPTION
- 106. SUPPLEMENTARY MEDICAL INSURANCE (SMI) -- A BRIEF DESCRIPTION
- 108. ASSIGNMENT OF RESPONSIBILITIES
 - 108.1 Role of HCFA
 - 108.2 Role of HCFA ROs
 - 108.3 Role of the Public Health Service
 - 108.4 Role of SSA
 - 108.5 Role of Part A Intermediaries
 - 108.6 Role of Part B Carriers
 - 108.7 Role of Peer Review Organizations (PROs)
 - 108.8 Role of State Agencies
- 118. DISCRIMINATION PROHIBITED
- 120. FRAUD AND ABUSE--GENERAL
 - 120.1 Definition and Examples of Fraud
 - 120.2 Definition and Examples of Abuse
 - 120.3 Responsibility for Combating Fraud, Waste, and Abuse

Provider Participation in Medicare

- 122. DEFINITION OF PROVIDER
 - Physicians and Suppliers of Services under Medicare
- 123. DEFINITION OF PHYSICIAN
- 124. DEFINITION OF SUPPLIER OF SERVICES
- 126. PARTICIPATION OF HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Disclosure of Information

- 130. DISCLOSURE OF HEALTH INSURANCE INFORMATION--GENERAL
- 132. DISCLOSURE OF HEALTH INSURANCE INFORMATION TO A BENEFICIARY OR IN CONNECTION WITH A CLAIM
 - 132.1 Disclosure to the Beneficiary or His/Her Authorized Representative
 - 132.2 Disclosure to Contractors
 - 132.3 Disclosure to Third Parties for Proper Administration of the Health Insurance Program
 - 132.4 Disclosure to Third Parties for Other Than Program Purposes
 - 132.5 Disclosure of Claims Payment Information in Alcohol and Drug Abuse Cases

- 132.6 Disclosure of Itemized Statement to an Individual for Any Item or Service Provided
- 134. DISCLOSURE OF INFORMATION ABOUT PROVIDERS BY HCFA
 - 134.1 Medicare Reports
 - 134.2 Disclosure of Medicare Statistics
 - 134.3 Other Information That May Be Disclosed
- 136. COST TO A PROVIDER THAT REQUESTS INFORMATION AVAILABLE TO THE PUBLIC

10-92 GENERAL INFORMATION ABOUT THE PROGRAM 106

Administration of Medicare Program

100. INTRODUCTION

The Health Insurance for the Aged and Disabled Act (title XVIII of the Act), known as Medicare, has made available to nearly every American 65 years of age and older a broad health insurance program designed to assist the elderly to meet hospital, medical, and other health care costs. Health insurance coverage has been extended to persons under age 65 qualifying as disabled and to those having end stage renal disease (ESRD). The program includes two related health insurance programs -- hospital insurance (Part A) and supplementary medical insurance (Part B).

A patient is free to choose any qualified institution, agency, or person offering him/her services. The responsibility for treatment remains with the individual's physician and the hospital, other facility, or agency furnishing services. The individual may obtain or keep any other health insurance he/she desires.

The law does not permit the Federal government to exercise supervision or control over the practice of medicine, the manner in which medical services are provided, or the administration or operation of medical facilities.

102. FINANCING THE PROGRAM

Part A of the Medicare program (hospital insurance) is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the Federal Hospital Insurance Trust Fund account and are used only for hospital insurance benefits and administrative expenses. The cost of providing Part A benefits to persons who are not Social Security or Railroad Retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B of the Medicare program (supplementary medical insurance) is financed by monthly premiums paid by those who voluntarily enroll in the program and by the Federal government which makes contributions. These funds are deposited in a separate account known as the Federal Supplementary Medical Insurance Trust Fund. Money from this fund is used only to pay for Part B benefits and administrative expenses.

104. HOSPITAL INSURANCE (HI) -- A BRIEF DESCRIPTION

HI is that part of Medicare designed to help patients with expenses incurred by hospitalization and related care by paying participating providers of services for costs of furnishing covered services. In

addition to inpatient hospital services, hospital insurance covers the reasonable cost of post-hospital care furnished by participating skilled nursing facilities (SNFs) and home health agencies (HHAs).

106. SUPPLEMENTARY MEDICAL INSURANCE (SMI) -- A BRIEF DESCRIPTION

To obtain SMI, an eligible individual must enroll during an enrollment period and pay the required premiums. An individual is eligible to enroll if he/she is entitled to HI or is 65 years of age and a resident citizen, or an alien who meets certain residence requirements.

The voluntary medical insurance program is designed to supplement the basic hospital insurance coverage. It provides payment (after a yearly cash deductible has been met) for 80 percent of the reasonable charge (or of the reasonable cost if the service is furnished by a participating provider of services) or the fee schedule amount for the following specified medical and other health services:

- o Physicians' services including surgery, consultation, and home, office, and institutional calls (since January 1, 1992, paid on the basis of a fee schedule);
- o Services and supplies as follows:
 - Services and supplies (including drugs and biologicals that cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his/her office and that are commonly rendered without charge or included in his/her bill (paid on the basis of a fee schedule);
 - Hospital services (including drugs and biologicals that cannot be self-administered) incident to physicians' services rendered to outpatients;
 - Diagnostic services that are furnished on an outpatient basis by the hospital or others furnishing the services under arrangements, and ordinarily furnished by the hospital (or others under arrangements) to outpatients for diagnostic study;
- o Diagnostic X-ray, laboratory, and other diagnostic tests (paid on the basis of a fee schedule);
- o X-ray, radium, and radioactive isotope therapy including material and services of technicians (paid on the basis of a fee schedule);
- o Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- o Rental or purchase of durable medical equipment (DME) (e.g., iron lungs, oxygen tents, wheelchairs, special beds) for use in the patient's home or place considered to be his/her residence (paid on the basis of a fee schedule fee);
- o Ambulance service since the use of other transportation is not advisable because of the patient's condition;
- o Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ including replacement or repairs of such devices (paid on the basis of or fee schedule);
- o Leg, arm, back, and neck braces, trusses, and artificial legs, arms, eyes including replacements, if required, because of a change in the patient's physical condition; and
- o Outpatient physical therapy (OPT), occupational therapy (OT), or speech pathology (SP) services furnished by or under arrangements made by participating providers of services (including clinics, rehabilitation agencies, and public health agencies). Coverage also includes the services of a qualified physical therapist or occupation therapist in independent practice when furnished in his/her office or the beneficiary's home. Expenses incurred for such services in a calendar year may not exceed \$750.

108. ASSIGNMENT OF RESPONSIBILITIES

The conduct of the program has been delegated by the Secretary of the Department of Health and Human Services (DHHS) to the Administrator of the Health Care Financing Administration (HCFA). The Public Health Services (PHS) and the Social Security Administration (SSA) also delegate certain responsibilities for administration of the program. In addition, Congress has also provided substantial administrative roles to the States and voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

108.1 Role of HCFA.--HCFA is responsible for policy formulation. The central office (CO) and regional offices (ROs) are responsible for the general management and operation of the program. In brief, HCFA's responsibilities include the following:

- o Determining an individual's entitlement to benefits in consultation with SSA;
- o Determining the nature and duration of services for which benefits may be paid;
- o Establishing, maintaining, and administering agreements with State agencies, providers of services, and intermediaries;
- o Formulating major policies regarding conditions of participation for providers and suppliers in consultation with the PHS;
- o Developing and maintaining statistical research and actuarial programs;
- o Managing general finances of the program; and
- o Determining costs and amounts to be paid to providers, physicians, and suppliers.

108.2 Role of HCFA ROs.-- HCFA ROs exercise authority in implementing the Medicare program in a geographic area. ROs serve as the focal point for control and liaison between intermediary, carrier, and SSA activities. The ROs have a wide range of administrative responsibilities that include the following:

- o Emphasizing and reiterating program instructions from CO to intermediaries and carriers;
- o Appraising current specific program or operational issues that may require compiling and reporting selective data within designated time periods to HCFA;
- o Interpreting policy and referring recommendations for policy revisions to CO;
- o Communicating directly with carriers and intermediaries concerning operational activities and program effectiveness; and
- o Working with other agencies and organizations that are directly or indirectly involved in the Medicare program.

108.3 Role of the Public Health Service .--The Public Health Service (PHS) is responsible for administering the professional health aspects of the Medicare program. In brief, their responsibilities include the following:

- o Consulting and recommending to HCFA matters concerning the development of health and safety standards and other guidelines needed for determining whether providers of services meet conditions of participation under the program;
- o Consulting and advising State agencies concerning application of standards for providers;
- o Coordinating with HCFA regarding the names addresses and qualifications of entities under the PHS Act when this information is relevant to HCFA's responsibilities; and

- o Coordinating programs and activities necessary in studying the utilization of services under the program.

108.4 Role of SSA.--In brief, SSA's responsibilities include the following:

- o Determining an individual's entitlement to benefits;
- o Performing hearings and appeals resulting from entitlement determinations;
- o Maintaining eligibility and utilization records; and
- o Providing locations (district and branch offices and teleservice centers) where the public can easily acquire program information.

108.5 Role of Part A Intermediaries.--The Part A intermediary is a national, State, public or private agency or organization that has entered into an agreement with HCFA to process Medicare claims, under both Part A and Part B, for providers of services and others. These agencies or organizations perform such administrative duties as the following:

- o Determining the costs of services furnished by providers under both Part A and Part B;
- o Providing consultative services to assist providers in maintaining necessary fiscal records and participation qualifications;
- o Conducting audits of records of providers and others;
- o Helping providers with utilization review (UR) procedures;
- o Providing the Office of Inspector General (OIG) with needed information and assistance in fraud and abuse claims investigations;
- o Establishing controls, developed in conjunction with OIG, to minimize the possibility of incorrect Medicare payment;
- o Paying directly to nonprovider renal dialysis facilities under Part B;
- o Applying safeguards against unnecessary use of covered services;
- o Serving as a center to communicate with providers; and
- o Assisting in the beneficiary appeals process.

Intermediaries make payments to providers and others. The amount of payment to any provider is restricted to the lesser of and others (a) the reasonable cost of covered services and items, or (b) the customary charges with respect to such services. (See Provider Reimbursement Manual, Part I, §§2600ff.) (Most hospitals certified to participate in Medicare are paid based on a prospective payment system (PPS). Under this system, Medicare pays on a pre-determined, specific rate for each hospital discharge.)

HCFA makes payment for the intermediary's administrative costs and funds advances. The Federal Government determines what payments are necessary and proper for carrying out the functions covered by the contract.

The agreement for an entity to serve as an intermediary may be terminated by either the intermediary or HCFA under conditions specified in the Act and regulations.

108.6 Role of Part B Carriers.--The law requires the Secretary to enter into contracts with carriers to serve as intermediaries in the operation and administration of the non-provider Part B program. The carrier's responsibilities include the following:

- o Determining whether physician and supplier charges for covered Part B services constitute "reasonable charges" within the meaning of the law and determining the amount to be paid to physicians, suppliers, and others under fee schedules;

- o Making payments;
- o Maintaining benefit payment and related program records that determine the quality of carrier performance;
- o Relaying to the physician and supplier community information pertinent to the administration of the program;
- o Providing OIG with needed information and assistance in fraud and abuse claims investigations; and
- o Establishing controls, developed in conjunction with OIG, to minimize the possibility of incorrect Medicare payments.

The contract provides for payment of the carrier's administrative costs and funds advances. The Federal Government determines the necessary and proper payments for carrying out the functions covered by the contract.

Carriers are generally assigned to serve a geographical area in which medical and other health services are furnished. All providers and suppliers located within a geographic area are serviced by a particular Part B carrier.

Carrier contracts are for a term of at least one year. Contracts are automatically renewed for successive one-year periods unless one of parties gives notice, 90 days in advance, that it will not renew the contract.

HCFA can terminate a contract if the carrier has substantially failed to carry out its responsibilities. Likewise, HCFA can also terminate a contract if the carrier fails to carry out its administrative functions in a manner consistent with the efficient administration of the supplemental medical insurance program.

108.7 Role of Peer Review Organizations (PROs).--PROs promote effective, efficient, and economical delivery of health care services. A PRO assures that service payments, under the Act, are made only when they are medically necessary (as determined in the exercise of reasonable limits of professional discretion), they are of acceptable quality, and, in the case of inpatient services, when they could not be provided on an outpatient basis or more economically in a different type of health care facility. Thus, a PRO assumes review at an initial and reconsideration level for coverage determinations based on these criteria.

PROs are also used, where appropriate, by the Secretary for professional consultations in the exclusion or termination of physicians or other suppliers of health care items or services. If a PRO determines that a physician or other supplier of health care is guilty of abuse against the Medicare or Medicaid programs, the PRO must report this to OIG for the imposition of whatever sanctions are appropriate. In addition, PROs are available to advise OIG or the contractors as a peer review body with respect to potential over-utilization of services, unnecessary services, or services of generally inferior quality.

Where PROs have implemented binding review authority in a provider, the UR conditions of participation are presumed to be met.

108.8 Role of State Agencies.--The States, by agreement with the Secretary, are assigned significant administrative functions to the extent that each is willing and capable of discharging such responsibilities.

A State agency (usually a component of the State Health Department) surveys and recommends to the Secretary whether providers and suppliers are eligible to participate in the Medicare program. The State agency's principal activities in this area include the following:

- o Identifying an institution or facility that might qualify as a provider or supplier for the Medicare and Medicaid programs using guidelines provided by the Secretary;
- o Inspecting, certifying, and recommending to the Secretary whether the provider or supplier qualifies as a participating provider or supplier;
- o Consulting with providers and suppliers to help them sustain their quality standards compliance; and
- o Determining, for title XIX purposes, whether an institution can be paid for treating Medicaid beneficiaries.

A. Certification.--Facilities that want to participate in the Medicare and Medicaid programs must meet conditions of participation for certification. State agencies certify to the Secretary indicating whether providers of services, e.g., hospitals, SNFs, comprehensive outpatient rehabilitation facilities (CORFs), community mental health centers (CMHCs), home health agencies (HHAs), independent laboratories, portable X-ray facilities and providers furnishing outpatient physical therapy (OPT), occupational therapy (OT), and speech-language pathology (SLP) services, satisfy their respective conditions of participation. (Suppliers of ESRD services must meet the conditions for coverage described in regulations.)

The Secretary certifies facilities requesting participation in both the Medicare and Medicaid programs. States certify those facilities that request participation in the Medicaid program only. This State certification function is intended to be a natural adjunct to ongoing State activities (such as the licensing of health care facilities and the setting of standards).

B. Consultation.--A State consults with providers of services that need and request assistance for meeting conditions of participation or for coverage. For Medicare program participation, the Secretary must approve consultation services furnished by the State certifying agency.

C. Coordination.--A State coordinates with other State programs that involve payment for health care, quality of care, and distribution of health facilities. Coordination of these activities prevents duplication of effort and is essential in assuring effective and economical use of existing State facilities and trained personnel.

D. State Agency as a Medical Insurance Intermediary.--Where a State enters into an agreement with the Federal Government to pay medical insurance premiums on behalf of certain recipients the agreement may provide for a designated State agency to serve as an intermediary on behalf of its recipients.

118. DISCRIMINATION PROHIBITED

Participating providers of services must comply with the requirements of Federal nondiscrimination provisions such as title VI of the Civil Rights Act of 1964 and the American Disabilities Act. Under these provisions, a participating provider/supplier is prohibited from making a distinction on the grounds of race, color, national origin or disability in the treatment of patients, the use of equipment and other facilities, and the assignment of personnel to provide services.

The Office of Civil Rights in DHHS is responsible for investigating complaints of noncompliance.

120. FRAUD AND ABUSE--GENERAL

Providers and suppliers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud and abuse committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, there is also a range of administrative sanctions (such as exclusion from participation in the program) and civil monetary penalties that may be imposed when facts and circumstances warrant such action.

Following are definitions and examples of fraud and abuse. These definitions and examples give a better understanding of the types of practices that are forbidden, under law, in the Medicare program.

120.1 Definition and Examples of Fraud.--Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In order to prove that fraud has been committed against the government, it is necessary to prove that fraudulent acts were performed knowingly, willfully, and intentionally.

Examples of fraud include, but are not limited to, the following:

- o Billing for services that were not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- o Altering claims forms and/or receipts in order to receive a higher payment amount;
- o Duplicate billings including billing both the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive payment greater than allowed;
- o Offering, paying, soliciting, or receiving bribes, kickbacks, or rebates, directly or indirectly, in cash or in kind, in order to induce referrals of patients or the purchase of goods or services that may be paid for by the Medicare program;
- o Falsely representing the nature of the services furnished. This encompasses describing a noncovered service in a misleading way that makes it appear as if a covered service was actually furnished;
- o Billing a person who has Medicare coverage for services provided to another person not eligible for Medicare coverage;
- o Repeatedly violating the participation agreement, assignment agreement, and the or limitation amount;
- o A provider's completing certificates of medical necessity (CMN) for patients not personally and professionally known by the provider;
- o A suppliers completing a prohibited CMN;
- o Using another person's Medicare card to obtain medical care;
- o Giving false information about provider ownership in a clinical laboratory;
- o Conspiracy to submit or manipulate bills resulting in higher costs or charges to the program, by a provider and a beneficiary, two or more providers and suppliers, or a provider and a carrier employee;
- o Billing procedures over a period of days when all treatment occurred during one visit (e.g., split billing schemes);
- o Using the payment adjustment process to generate fraudulent payments; and
- o Billing for "gang visits," (e.g., a physician visits a nursing home, walks through the facility, and bills for 20 nursing home visits without rendering any specific service to the individual patients).

120.2 Definition and Examples of Abuse.--Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally.

Medicare services must:

- o Be medically necessary;
- o Conform to professionally recognized standards; and
- o Be provided at a fair price.

HCFA uses these three standards when judging whether abusive acts in billing were committed against the Medicare program

Examples of abuse include, but are not limited to, the following:

- o Providing medically unnecessary services or services that do not meet professionally recognized standards;
- o Billing Medicare significantly more than for non-Medicare patients;
- o Submitting bills to Medicare that are the responsibility of other insurers under the Medicare secondary payer (MSP) regulation;
- o Violating the participating physician/supplier agreement;
- o Breaches in the assignment agreement; and
- o Violating the limitation amount.

Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject knowingly and willfully committed the abusive practice.

120.3 Responsibility for Combating Fraud, Waste, and Abuse.--OIG, in DHHS, is responsible for investigating instances of fraud, waste, and abuse in the Medicare and Medicaid programs. OIG concentrates its efforts in the following areas:

- o Conducting investigations of specific providers suspected of fraud, waste, or abuse for purposes of determining whether to warrant criminal, civil, or administrative remedies;
- o Conducting audits, special analyses and reviews for purposes of discovering and documenting Medicare and Medicaid policy and procedural weaknesses contributing to fraud, waste, or abuse, and making recommendations for corrections;
- o Conducting reviews and special projects to determine the level of effort and performance in health provider fraud and abuse control;
- o Participating in a program of external communications to inform the health care community, the Congress, other interested organizations, and the public of OIG's concerns and activities related to health care financing integrity;
- o Collecting and analyzing Medicare contractor and State Medicaid agency-produced information on resources and results; and
- o Participating with other Government agencies and private health insurers in special programs to share techniques and knowledge on preventing health care provider fraud and abuse.

122. DEFINITION OF PROVIDER

A. A provider of Services (Also Called "Provider") ,--is a hospital, a rural primary care hospital, a home health agency (HHA), a comprehensive outpatient rehabilitation facility (CORF), a hospice, and for the limited purpose of furnishing outpatient physical therapy (OPT), speech language pathology therapy (SLP), occupational therapy (OT), a clinic, rehabilitation agency, or a public health agency that meets the applicable conditions of participation.

B. Participating Providers.-- To be a participating provider, a provider must be in compliance with applicable provisions of title VI of the Civil Rights Act of 1964. It must enter into an agreement under §1866 of the Social Security Act that provides inter alia that (1) it will not charge any individual or other person for items and services covered by the health insurance program other than deductibles and coinsurance amounts; and (2) it will return any money incorrectly collected from the individual or other person on his/her behalf or make such other disposition as required by statute or regulation.

Physicians and Suppliers of Services under Medicare

123. DEFINITION OF PHYSICIAN

Physicians under Medicare are doctors of medicine or osteopathy who are legally authorized to practice medicine or surgery by the State where the service is performed. Podiatrists, optometrists, dentists and chiropractors are included for certain procedures.

124. DEFINITION OF SUPPLIER OF SERVICES

The term suppliers of services includes certain entities that furnish health services. The following suppliers must meet the conditions for coverage in order to receive Medicare payment: ambulatory surgical centers, independent physical therapists, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, rural health clinics and Federally-qualified health centers.

126. PARTICIPATION OF HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Section 1876 of the Act allows a Medicare beneficiary eligible for Part A and Part B, or Part B only, to choose to have covered items and services furnished through a Medicare qualified HMO. An HMO enters into a contract with the Secretary in order to participate under Medicare.

An HMO, for Medicare purposes, is a public or private organization that provides, either directly or through arrangement with others, comprehensive health services to enrolled members. An HMO must service those who live within a specified service area. It must provide services based on a predetermined periodic rate or periodic per capita rate basis without regard to the frequency or extent of covered services it furnishes. An HMO must also meet other statutory requirements.

An HMO's service area is a geographic area in which a full range of its services are offered to its members. This geographic area differs from an HMO's enrollment area since it may include locations outside its service area where it offers less than its full range of services. For example, an HMO may cover house calls in emergencies in its service area but not for members who live outside the service area.

Disclosure of Information

130. DISCLOSURE OF HEALTH INSURANCE INFORMATION--GENERAL

Records and information, acquired in the administration of the Medicare program, may be disclosed only under prescribed rules and regulations or under the authority of the Administrator of HCFA. Information furnished specifically for purposes of a claim under the health insurance program is subject to these rules and regulations.

These regulations apply to governmental or private agencies that participate in program administration. These entities include the following:

- o Institutions;
- o Agencies;
- o Person(s) providing services; and
- o Providers of services.

The type of information includes, but is not limited to, the following:

- o The individual's health insurance claim number (HICN);
- o Facts regarding his/her entitlement to health insurance benefits; and
- o Medical and other information obtained from HCFA, an intermediary, or a carrier (contractor).

Information not subject to these rules and regulations includes the following:

- o Name;
- o Date of Birth;
- o Sex;
- o Marital status; and
- o Address.

A provider's own records are subject to requirements listed in the "Conditions of Participation".

Providers are also responsible for following conditions for coverage. A provider or supplier that receives a request for disclosure of information about a Medicare beneficiary, Medicare claim, or related information should refer the requestor to the appropriate contractor for further consideration.

132. DISCLOSURE OF HEALTH INSURANCE INFORMATION TO A BENEFICIARY OR IN CONNECTION WITH A CLAIM

132.1 Disclosure to the Beneficiary or His/Her Authorized Representative.--Information such as Medicare entitlement or eligibility data may be disclosed to a beneficiary or his/her authorized representative (this includes the beneficiary's representative payee).

132.2 Disclosure to Contractors .--Providers and suppliers may not disclose confidential, expressed, or implied medical information to contractors. Under the Privacy Act, any medical information obtained by a contractor is subject to disclosure to the individual to whom the information pertains or to the beneficiary's authorized representative.

Some providers and suppliers document findings on medical forms pre-printed "confidential" or routinely stamp all records "confidential" whether or not such records are ever intended for disclosure to

a contractor. Such records can only be transmitted to the contractor if they are accompanied by a signed statement. The statement must indicate the following:

- o That the provider or supplier understands the information is subject to disclosure to the patient under the Privacy Act, and
- o That the transmitted records are confidential and may be disregarded if the patient or his/her representative requests them from the contractor or from HCFA.

132.3 Disclosure to Third Parties for Proper Administration of the Health Insurance Program.-- Disclosure of any record, report, or other information about an individual is not authorized without the consent of the individual. This applies to any claim or other proceeding under the Social Security Act unless disclosure is necessary for proper performance of the duties for the following:

- o Any officer or employee of the Department; or
- o Any officer or employee of a State agency, intermediary, provider of services, or other agency or organization participating in the administration of the program, by contract or agreement, in carrying out such contract or agreement.

These limitations apply whether or not the individual to whom the information pertains authorizes further disclosure to third parties (e.g., to a private medical plan).

132.4 Disclosure to Third Parties for Other Than Program Purposes.--Information obtained from HCFA or its contractor is confidential and may be disclosed only under conditions prescribed in rules and regulations or on the express authorization of the Administrator of HCFA. However, certain limited information about a beneficiary's Medicare eligibility status and related claims information may be released to third party payers with the beneficiary's express authorization.

The following information may be released subject to necessary authorization:

- o Beneficiary HICN;
- o Coinsurance and deductible status;
- o Dates of entitlement to Medicare;
- o Copies of Medicare claims forms;
- o Medicare report of eligibility; and
- o Explanation of Medicare benefits (EOMB).

Refer requests for other information to your intermediary.

Adhere to the following authorization guidelines to ensure that information is not released without the required authorization. Authorization must:

- o Be in writing;
- o Be signed and dated by the individual or someone authorized to act on his/her behalf;
- o Specify the name of the provider authorized to disclose information;
- o Specify what information the individual is authorizing the provider to disclose;
- o Specify the names of the third party payers to whom the information is being released;
- o Specify the purpose for which the information is being released;
- o Specify an expiration date for the authorization that should not exceed 2 years from the date it was signed; and
- o Specify that it may be revoked at any time.

132.5 Disclosure of Claims Payment Information in Alcohol and Drug Abuse Cases.--The law requires providers to observe more stringent rules when disclosing medical information for claims processing purposes from the records of alcohol and drug abuse patients. Since the standard consent statement on the provider billing form is not sufficient authority, under the law, to permit the provider to release information from the records of alcohol or drug abuse patients, more explicit consent statements are required.

Providers that participate in Medicare and alcohol and drug abuse prevention and treatment programs must obtain written consent in each alcohol or drug abuse case from beneficiaries to release medical information. This written consent, which allows the provider to disclose the records of the patient, should include all of the following:

- o The name of the organization (e.g., hospital name) that is to make the disclosure;
 - o The name or title of the person or organization to which disclosure is to be made (e.g., HCFA, including the appropriate intermediary or carrier, specified by name);
 - o The name of the patient;
 - o The purpose or need for the information to be disclosed (e.g., for processing a claim for Medicare payment and for such evaluation of the treatment program as is legally and administratively required in the overall conduct of the Medicare program);
 - o The specific extent or nature of information to be disclosed (e.g., all medical records regarding the beneficiary's treatment, hospitalization, and/or outpatient care including treatment for drug abuse or alcoholism);
 - o A statement that the beneficiary may revoke his/her consent at any time to prohibit disclosures on or after date or revocation;
 - o A statement specifying a date (not to exceed 2 years), event, or condition upon which consent expires without revocation;
- The date on which the consent is signed; and
- The signature of the patient or the signature of his/her authorized or legal representative.

If the beneficiary wishes, the consent statement may be expanded to permit disclosure by the provider to any other person, organization, or program (e.g., PRO), as appropriate. You may also give authorization to HCFA and its contractors to re-disclose specific information to third party payers for complementary insurance purposes.

The provider keeps the consent statement with the patient's medical and other records. The duration of the consent statement is not to exceed 2 years after which it must be renewed by the beneficiary if further disclosures are necessary.

132.6 Disclosure of Itemized Statement to an Individual for Any Item or Service Provided.--

A.General.--Section 4311 of the Balanced Budget Act of 1997 requires that if a Medicare beneficiary submits a written request to a health services provider for an itemized statement for any Medicare item or service provided to that beneficiary, the provider must furnish this statement within 30 days of the request. The law also states that a health services provider not furnishing this itemized statement may be subject to a civil monetary penalty of up to \$100 for each unfulfilled request. Since most institutional health practices have established an itemized billing system for internal accounting procedures as well as for billing other payers, the furnishing of an itemized statement should not pose any significant additional burden.

B.30-Day Period to Furnish Statement.--You will furnish to the individual described above, or duly authorized representative, no later than 30 days after receipt of the request, an itemized statement describing each item or service provided to the individual requesting the itemized statement.

C.Suggested Contents of Itemized Statement.--Although §4311 of the Balanced Budget Act of 1997 does not specify the contents of an itemized statement, suggestions for the types of information that might be helpful for a beneficiary to receive on any statement include: beneficiary name, date(s) of service, description of item or service furnished, number of units furnished, provider charges, and an internal reference or tracking number. If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are: amounts paid by Medicare, beneficiary responsibility for co-insurance, and Medicare claim number. The statement should also include a name and telephone number for the beneficiary to call if there are further questions.

D.Penalty.--A knowing failure to furnish the itemized statement shall be subject to a civil monetary penalty of up to \$100 for each such failure.

134. DISCLOSURE OF INFORMATION ABOUT PROVIDERS BY HCFA

Information about participating providers may be disclosed by HCFA under the Freedom of Information Act in response to requests from the public.

134.1 Medicare Reports.--

A.Provider Survey Reports and Related Information.--Information concerning provider survey reports, as well as statements of deficiencies, based on survey reports are available at the local Social Security office or the public assistance office in the area where the facility is located.

The following survey data may be released:

- The official Medicare report of a survey;
- Statements of deficiencies that have been conveyed to the provider after a survey; and
- Plans of correction and pertinent comments submitted by the provider relating to Medicare deficiencies cited after a survey is concluded.

State agencies certify whether institutions or other entities meet Medicare conditions of participation. A State agency may disclose information it obtains relating to the qualification and certification status of providers it surveys. FQHCs are not included in such surveys.

B.Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of providers are made available to the public. After the survey reports and other formal evaluations are prepared by HCFA personnel, the provider is given an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. The provider's comments are incorporated in the report, if pertinent.

Program validation review reports are generally released from the HCFA RO serving the area in which the provider is located. Generally, informal reports and other evaluations of the performance of providers that are prepared by the contractor are available to the public.

C.Provider Cost Reports.--

1.General.--Submit to HCFA or the contractor in writing requests by the public either to inspect or to obtain a copy of a provider cost report. The request must identify the provider and specific cost report(s) in question.

Contractors are required to respond to requests in writing within 10 working days after receipt of a written request to advise the requestor of the date the reports will be made available. The date the report is to be made available is no earlier than 10 working days from the date of the contractor's response. A copy of the response to the requestor is sent simultaneously to the provider putting the provider on notice that its report has been requested by a particular person or organization. If a request for a report is submitted by a former owner of a provider, copies of the contractor's response to the requestor is sent to both the present owner and the former owner of the provider. If the request is for a report submitted by a provider no longer participating in the Medicare program, a copy of the contractor response is sent to the provider. In the case of both a former owner and a former participating provider, the copy of the response is sent to the last known address of the party.

2.Information That May Be Disclosed.--Disclosure by the contractor is limited to cost report documents that providers are required to submit by HCFA regulations and instructions, and, in case of a settled cost report, the contractor's notice of program payment. Cost reports and notices of program payment include the following information:

- Statistical page;

- Settlement pages;

- Trial balance of expenses; and

- Cost finding schedules or documents required by HCFA as part of the regular cost report process.

(Where a provider, after first obtaining program approval, has submitted equivalent documents in lieu of official program documents, these documents are subject to the same disclosure rules as official forms.)

If a request is received to inspect or to obtain a copy of a report that has not been settled, i.e., the final settlement notice of program payment has not been sent, the contractor discloses a copy of the report as submitted by the provider. If settlement has been made, the contractor discloses the settled report. If a requester specifically asks for both the settled and unsettled cost reports of a provider, the contractor complies with such a request. When a report is made available for inspection or copying, it is clearly marked with one of the following captions, as applicable:

- Cost report as submitted;

- Settlement subject to audit; or

- Audited settlement.

When a contractor discloses a settled report, schedules applicable to the settlement that have been reworked by the contractor are disclosable. The general rule is that if the contractor has reworked any of the schedules that were required to be submitted by the provider with its original submission, these schedules become an integral part of the report for disclosure purposes. However, any details containing contractor or auditor comments concerning the settlement, details of specific adjustments, or supporting schedules applicable to the settlement of the provider's operation are not disclosed by the contractor.

Information obtained in auditing provider cost reports and other financial records may be released by HCFA.

3.Information That May Not Be Disclosed.--If a provider chooses to submit with its cost report additional information not specifically required by regulations or instructions, the contractor does not disclose such information unless it is contained within an official document. For example, some providers may submit supplementary analyses of certain expenses, details of the professional component adjustment, financial statements (other than the statement of income and expenses and the balance sheet as required by cost reporting instructions), or income tax returns that are not required by the program. These items are not to be disclosed by the contractor as part of the cost report.

Except where a provider has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the contractor requires the provider to submit in support of its cost representations would also not be disclosed by the contractor as part of the cost report. In addition, the following are not disclosed by the contractor as part of a cost report:

- Audits;
- Schedules;
- Letters;
- Notes;
- General comments;
- Comments on results of desk reviews (including copies of the actual desk review documents);
- Contractor notices and comments (including transmittal letters);
- Audit adjustment summaries that are required to be prepared by contractors and auditors; and
- Information pertaining to an individual patient.

NOTE:

Any information under the Privacy Act that is not to be disclosed by the contractor may be subject to disclosure under the Freedom of Information Act upon review by HCFA CO and RO or a court in response to a request for such information.

134.2 Disclosure of Medicare Statistics.--Numerous statistics on individual providers are available to the public. They include, but are not limited to, the following:

- Waiver of liability statistics;
- Interim rate payment data;
- Amount of Medicare payment;
- Overpayment data;
- Data from the Provider Monitor Listing; and
- Information from the Directory of Medical Facilities and the Directory of Medicare Providers and Suppliers of Services.

134.3 Other Information That May Be Disclosed.--The following information may also be disclosed:

- Provider presumptive waiver of liability status; and
- Information as to whether a provider participates in the Medicare program.

136. COST TO A PROVIDER THAT REQUESTS INFORMATION AVAILABLE TO THE PUBLIC

Providers are required to pay appropriate fees for information they request pertaining to other providers, Medicare contractors, or State agencies. A provider may claim such fees as allowable costs only if it

demonstrates to the contractor the information is necessary in developing and maintaining the operations of patient care facilities and activities.

Medicare Rural Health Clinic Manual
Chapter III - Agreements and Terminations

Table of Contents

Filing and Duration of Agreement

- 310. FILING PROCEDURES
- 311. DURATION OF RHC/FQHC AGREEMENT
- 313. APPEALS BY ENTITIES WITH RESPECT TO AGREEMENTS (CERTIFICATION)

Content and Terms of Agreements

- 320. MAINTENANCE OF COMPLIANCE
- 321. CHARGES TO BENEFICIARIES
- 322. REFUNDS TO BENEFICIARIES
- 323. TREATMENT OF BENEFICIARIES

Termination of Agreements

- 330. TERMINATION BY CLINIC OR CENTER
- 331. TERMINATION BY HCFA
- 332. EFFECT OF TERMINATION
- 333. NOTICE TO THE PUBLIC
- 334. CONDITIONS FOR REINSTATEMENT OF CLINIC OR CENTER TERMINATED BY HCFA

06-94 AGREEMENTS AND TERMINATIONS 311

Filing and Duration of Agreement

310. FILING PROCEDURES

A. HCFA enters into an agreement with a rural health clinic (RHC) or federally qualified health center (FQHC) that wishes to participate in the Medicare program. (RHCs are also referred to in this manual as clinics and FQHCs as centers.)

(1) RHCs.--If a clinic is certified as an RHC, it receives a notice to that effect from HCFA and two copies of the agreement.

(2) FQHCs.--The Public Health Service (PHS) recommends to HCFA those entities that meet the requirements of §§329, 330, and 340 of the PHS Act and

wish to participate in Medicare as FQHCs. The entity must then seek approval from HCFA by signing an agreement (i.e., an attestation statement) similar to the agreement signed by RHCs. The center receives a notice regarding approval of FQHC status from HCFA and two copies of the agreement.

(3) The following instructions are applicable both to RHCs and FQHCs. The RHC/FQHC must:

- (a) Have both copies of the agreement signed by an authorized representative of the clinic or center (e.g., the director, supervising physician, or some other individual empowered to sign binding agreements on behalf of the clinic or center); and
- (b) Return (file) both copies to the responsible HCFA office or official as is specified in the instructions accompanying the agreement.

B. If HCFA accepts the agreement filed by the clinic or center, it signs both copies of the agreement on behalf of the Secretary and returns one copy to the clinic or center along with a notice of acceptance and the date on which the agreement is effective.

NOTE: FQHC regulations were published on June 12, 1992. HCFA mailed copies of the FQHC agreement (attestation statement) to entities qualified for FQHC status, including all entities approved by the PHS under §§329, 330, and 340 of the PHS Act and federally funded health centers.

OBRA 1993 has added a new program to the definition of FQHCs. 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 are considered FQHCs as of October 1, 1991.

FQHCs are required to meet all Federal requirements as of the date they select to begin furnishing services to Medicare beneficiaries.

After August 11, 1992, FQHCs, except those facilities approved under the Indian Self-Determination Act or the Indian Health Care Improvement Act, cannot submit agreements seeking to qualify to provide FQHC services for periods prior to the date of submission.

311. DURATION OF RHC/FQHC AGREEMENT

Agreements between RHCs/FQHCs and HCFA are generally for a term of one year. They may be annually renewed by mutual agreement of the RHC/FQHC and HCFA, i.e., a new agreement need not be signed each year. Special circumstances may result in a term of less than one year for an initial agreement, e.g., a clinic or center may wish the agreement year to run concurrently with the RHC/FQHC's fiscal year or have some other technical considerations. If HCFA refuses to renew an agreement, the RHC/FQHC may appeal as explained in §313.

If the RHC/FQHC wishes to terminate the agreement during the term of the agreement, see §330. If HCFA terminates the agreement during the term of the agreement, see §331.

313. APPEALS BY ENTITIES WITH RESPECT TO AGREEMENTS (CERTIFICATION)

A. Appeals Regarding Failure to Certify or HCFA Refusal to Enter Into or Renew an Agreement.--A clinic or center may appeal HCFA's decision in accordance with the provisions of 42 CFR Part 498, if HCFA makes a determination with respect to the following matters:

- o Whether a clinic or center meets the appropriate conditions for approval;
- o Whether a non-grantee center meets the requirements under the PHS law and the appropriate conditions for approval;
- o Whether a prospective RHC/FQHC qualifies as a supplier; or
- o Whether a supplier continues to meet the appropriate conditions for approval.

B. Filing Appeals.--A clinic or center dissatisfied with one of the above determinations may file a request for hearing with the Associate Regional Administrator, Health Care Financing Administration, Division of Health Standards and Quality. The RO provides a description of the procedure to be followed and the necessary forms and other requirements for filing such an appeal.

Content and Terms of Agreements

320. MAINTENANCE OF COMPLIANCE

In the agreement/attestation statement signed by an RHC or FQHC, the clinic or center agrees to maintain its compliance with all of the conditions for certification/coverage in 42 CFR 491. If a clinic/center fails to maintain compliance with one or more of the conditions, it must promptly report this (usually within 30 days of the failure) to the responsible HCFA office or official. Failure to report promptly may be a cause for termination of the clinic/center's agreement.

321. CHARGES TO BENEFICIARIES

In the agreement/attestation statement signed by the RHC or FQHC, the clinic or center agrees not to charge Medicare beneficiaries (or any other person acting on a beneficiary's behalf) for any RHC/FQHC service for which Medicare beneficiaries are entitled to have payment made on their behalf by the Medicare program. This includes items or services for which the beneficiary would have been entitled to have payment made had the RHC or FQHC filed a request for payment as described in §610. The following explanations discuss beneficiary liability for deductible or coinsurance amounts. (Also see §§ 606 and 607 which discuss deductible and coinsurance.)

A. Part B Deductible.--

- o The Part B deductible applies to services covered under the RHC benefit.
- o The Part B deductible does not apply to expenses for services provided by an FQHC under the FQHC benefit.
- o The Part B deductible applies to Medicare covered non-RHC and non-FQHC services furnished to the beneficiary by the RHC or FQHC. The clinic or center may charge the beneficiary for items and services which are not covered RHC or FQHC services.

B. Part B Coinsurance.--If the item or service is covered under the RHC or FQHC benefit, the beneficiary is responsible for coinsurance amounting to 20 percent of the customary charge.

If the service is covered under Part B but not under the RHC or FQHC benefit, the beneficiary is responsible for 20 percent of the Medicare approved charge on an assigned claim. If the claim is not assigned, payment of 80 percent of the Medicare approved charge is made to the beneficiary, and he or she is responsible for the full charge (limited to 115 percent of the Medicare approved charge for a physician or other service subject to the physician fee schedule).

The amount of Medicare payment to an FQHC is unaffected by its waiver of the Part B coinsurance for those beneficiaries with incomes up to 200 percent of the poverty level in accordance with the requirements of the PHS sliding fee scale. (See the PHS "Program Expectations for Community and Migrant Health Centers.").

C. Charges for Other Services.--The clinic or center may charge the beneficiary for items and services which are not Medicare covered services.

322. REFUNDS TO BENEFICIARIES

A. Money Incorrectly Collected.--In the agreement between HCFA and the RHC or FQHC , the clinic/center agrees to refund as promptly as possible any money incorrectly collected from Medicare beneficiaries or from someone on their behalf.

B. Definition of Money Incorrectly Collected.--Money incorrectly collected means any amount for covered services that is greater than the amount for which the beneficiary was liable because of the deductible (for non-FQHC services) and coinsurance requirements.

Amounts are considered to have been incorrectly collected because the clinic or center believed the beneficiary was not entitled to Medicare benefits but:

- o The beneficiary was later determined to have been entitled to Medicare benefits;
- o The beneficiary's entitlement period fell within the time the clinic or center's agreement with HCFA was in effect; and
- o Such amounts exceed the beneficiary's deductible (for non-FQHC services) and coinsurance liability.

323. TREATMENT OF BENEFICIARIES

In the agreement between HCFA and the RHC or FQHC, the clinic or center agrees to accept Medicare beneficiaries for care and treatment. The clinic or center cannot impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not also impose on all other persons seeking care and treatment from the RHC or FQHC. If the RHC or FQHC does not furnish treatment for certain illnesses and conditions to patients who are not Medicare beneficiaries, it need not furnish such treatment to Medicare beneficiaries in order to participate in the Medicare program. It may not, however, refuse to furnish treatment for certain illnesses or conditions to Medicare beneficiaries if it furnishes such treatment to others. Failure to abide by this rule is a cause for termination of the clinic or center's agreement to participate in the Medicare program.

Termination of Agreements

330. TERMINATION BY CLINIC OR CENTER

A. General Rule.--An RHC or FQHC that wishes to terminate its agreement to participate in the Medicare program may do so by: (1) filing with HCFA a written notice stating its intention to terminate its agreement; and (2) informing HCFA of the date upon which it wishes the termination to take effect.

B. Effective Date.--Upon receiving the clinic or center's notice of its intention to terminate the agreement, HCFA will set a date upon which the termination will take effect. This effective date may be:

- o The date proposed by the clinic or center in its notice of intention to terminate the agreement; or
- o A date set by HCFA, which can be no later than 6 months after the date the clinic or center's notice of intention to terminate was received.

The effective date of termination may be less than 6 months following HCFA's receipt of the clinic or center's notice of its intention to terminate if HCFA determines that termination on that date would not:

- o Unduly disrupt the furnishing of RHC/FQHC services to the community serviced by the clinic or center; or
- o Otherwise interfere with the effective and efficient administration of the Medicare program.

C. Voluntary Termination Without Notice of Intent.--An RHC or FQHC is considered to have voluntarily terminated its agreement if it ceases to furnish RHC or FQHC services to the community. The termination is effective after the last day of business of the clinic or center.

331. TERMINATION BY HCFA

A. General Rule.--HCFA may terminate an agreement with an RHC or FQHC if it finds that the clinic or center:

- o No longer qualifies as a supplier; or
- o Is not in substantial compliance with:
 - The provisions to the agreement;
 - The requirements of 42 CFR Part 405, Subpart X and Part 491;
 - Any other applicable Medicare regulations in 42 CFR; or
 - Any other applicable provisions of title XVIII of the Act.

B. Notice by HCFA.--HCFA will notify the RHC or FQHC in writing of its intention to terminate the agreement at least 15 days before the effective date stated in the written notice.

C. Clinic or Center Appeal.--An RHC or an FQHC may request an appeal of HCFA's decision to terminate the agreement in accordance with the provisions of 42 CFR Part 498.

D. Change of Ownership.--When an RHC or FQHC undergoes a change of ownership, the agreement with the existing clinic or center is automatically assigned to the new owner so that there is no interruption in service. However, a new agreement with updated information must subsequently be signed. Only if the clinic or center, under the change of ownership, meets the applicable requirements for approval can the agreement be executed. For FQHCs, these requirements include PHS approval.

An RHC or FQHC which plans to change ownership must give advance notice of its intention so that a new agreement can be negotiated or so that the public may be given sufficient notice in the event that the new owners do not wish to participate in the Medicare program. A clinic or center which plans to enter into a lease arrangement (in whole or in part) should also give advance notice of its intention.

A change of ownership occurs, for example, when:

- o A sole proprietor transfers title and property to another party (applicable only to RHCs);
- o In the case of a partnership, there is an addition, removal, or substitution of a partner;

- o An incorporated RHC or FQHC merges with an incorporated entity which is approved by the program and the non-approved entity is the surviving corporation. It also occurs when two or more corporate clinics or centers consolidate and the consolidation results in the creation of a new corporate entity;
- o An unincorporated RHC (a sole proprietorship or partnership) becomes incorporated; or
- o The lease of all or part of an entity constitutes a change of ownership of the leased portion.

332. EFFECT OF TERMINATION

When an RHC or FQHC agreement is terminated, whether by the entity or by HCFA, no payment is available to the RHC or FQHC for services it furnishes to Medicare beneficiaries on or after the effective date of the termination.

333. NOTICE TO THE PUBLIC

Public notice of both the effective date and the effect of termination of an RHC or FQHC agreement is made 15 days before the effective date of the termination in at least one newspaper of general circulation in the area serviced by the clinic or center. This notice must be given by:

- o The clinic or center if it has voluntarily terminated the agreement, and HCFA has approved the termination and set an effective date for the termination; and
- o HCFA when it has terminated the agreement.

334. CONDITIONS FOR REINSTATEMENT OF CLINIC OR CENTER TERMINATED BY HCFA

When an agreement with an RHC or FQHC has been terminated by HCFA, HCFA does not enter into another agreement with the clinic or center to participate in the Medicare program unless HCFA:

- o Finds that the reason for the termination no longer exists; and
- o Is assured that the reason for termination of the prior agreement will not recur.

Rural Health Clinic and Federally Qualified Health Center Manual
Chapter IV - Coverage and Exclusions

Table of Contents

Covered Services

- 400. RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES DEFINED
- 401. PAYMENT
- 402. SERVICES FURNISHED BY RHCs and FQHCs WHICH ARE NOT RHC/FQHC SERVICES
- 404. PREVENTIVE PRIMARY SERVICES WHICH ARE FEDERALLY QUALIFIED HEALTH CENTER SERVICES
 - 404.1 Primary Preventive Services Defined
 - 404.2 Preventive Services Excluded Under FQHC Benefit
- 405. PHYSICIAN SERVICES
 - 405.1 Definition
 - 405.2 Telephone Services
 - 405.3 Prescription Services
 - 405.6 Physician Services as RHC/FQHC Services
 - 405.7 Consultations
 - 405.8 Concurrent Care
- 406. SERVICES AND SUPPLIES FURNISHED INCIDENT TO PHYSICIAN'S SERVICES
 - 406.1 Incidental and Integral Part of Physician's Professional Services
 - 406.2 Commonly Furnished in Physician's Office
 - 406.3 Direct Personal Supervision
 - 406.4 Clinic or Center Employee
 - 406.5 Clinic or Center Expense
 - 406.6 Incident to Physician's Services in Physician-Directed RHC or FQHC
 - 406.7 Coverage of Services and Supplies
- 408. NURSE PRACTITIONER AND PHYSICIAN ASSISTANT SERVICES
 - 408.1 Basic Requirements
 - 408.2 Services Covered
 - 408.3 Services by Nurse Practitioners, Physician Assistants, and Nurse Midwives as RHC/FQHC Services
 - 408.4 Effect of State Law
 - 408.5 Effect of Clinic or Center Policies
 - 408.6 Physician Supervision
- 410. SERVICES AND SUPPLIES INCIDENT TO NURSE PRACTITIONER'S OR PHYSICIAN ASSISTANT'S SERVICES
 - 410.1 Basic Requirements
 - 410.2 Scope of Coverage
 - 410.3 Direct, Personal Supervision
- 412. CONDITIONS FOR COVERAGE OF VISITING NURSE SERVICES
 - 412.1 General Requirements

- 412.2 Shortage of Home Health Agencies
- 412.3 Services Are Furnished to Homebound Patients
- 412.4 Patient's Place of Residence
- 412.5 Services Furnished by Licensed Nurse
- 412.6 Services Furnished Under Plan of Treatment
- 419. CLINICAL PSYCHOLOGIST AND CLINICAL SOCIAL WORKER SERVICES
 - 419.1 Clinical Psychologists Services
 - 419.2 Clinical Social Worker (CSW) Services
- General Exclusions From Medicare Coverage
- 430. GENERAL EXCLUSIONS
- 431. SERVICES NOT REASONABLE AND NECESSARY
- 432. NO LEGAL OBLIGATION TO PAY FOR OR PROVIDE
- 433. ITEMS AND SERVICES FURNISHED OR PAID FOR BY GOVERNMENT INSTRUMENTALITIES
 - 433.1 Payment to Federal Provider of Services or Other Federal Agency
 - 433.2 Items and Services Which Provider or Supplier Is Obligated to Furnish Under Federal Government Contract or Law
 - 433.3 Items and Services Which are Paid Directly or Indirectly by Government Entity
- 434. SERVICES RECEIVED BY MEDICARE BENEFICIARIES OUTSIDE UNITED STATES
 - 434.1 Physician and Ambulance Services Furnished in Connection With Covered Foreign Inpatient Hospital Services
- 435. SERVICES RESULTING FROM WAR
- 436. PERSONAL COMFORT ITEMS
- 437. ROUTINE SERVICES AND APPLIANCES
- 438. FOOT CARE AND SUPPORTIVE DEVICES FOR THE FEET
- 439. CUSTODIAL CARE
- 440. COSMETIC SURGERY
- 442. DENTAL SERVICES EXCLUSION
- 443. ITEMS AND SERVICES UNDER WORKERS' COMPENSATION PLAN
 - 443.1 Characteristics of Workers' Compensation Programs
 - 443.2 Effect of Payments Under Workers' Compensation Plan
 - 443.3 Private Right of Action
 - 443.4 Partial Payments Under Workers' Compensation
 - 443.5 Workers' Compensation Cases Involving Liability Claims
 - 443.6. Provider Handling of Cases Involving Work Related Conditions
 - 443.7 Conditional Primary Medicare Benefits
 - 443.8 You Receive Duplicate Payments
 - 443.9 Effect of Lump Sum Compromise Settlement
 - 443.10 Apportionment of Lump Sum Compromise Settlement of Workers' Compensation Claim
 - 443.11 Lump-Sum Settlement
 - 443.12 Action by Provider When Benefits May Be Payable Under Federal Black Lung Program
 - 443.13 Special DOL Coverage Rules
 - 443.14 Medicare Payment
 - 443.15 Questionable Cases
 - 443.16 DOL Does Not Make Payment in Full
 - 443.17 Overpayment Due to Workers' Compensation (WC) Payments
- Other Limitations on Payment
- 445. SERVICES REIMBURSABLE UNDER NO FAULT INSURANCE

445.1 Definitions

445.2 Provider Actions

445.3 No Fault Insurance Does Not Pay In Full

445.4 No Fault Insurance Does Not Make Full Payments Because of Deductible or Coinsurance

Provision in Policy

445.5 State Law or Contract Provides That No Fault Insurance Is Secondary To Other Insurance

445.6 Provider And Beneficiary's Responsibility With Respect To No Fault Insurance

445.7 Private Right of Action

Liability Insurance

446. SERVICES REIMBURSABLE UNDER LIABILITY INSURANCE

446.1 General

446.2 Definitions

446.3 Provider Actions

446.4 Automobile or Liability Insurer Pays in Part for Services

447. LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS SOLELY ON BASIS OF END STAGE RENAL

DISEASE WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

447.1 General

447.2 Definitions

447.3 Retroactive Application

447.4 Determining Months During Which Medicare May Be Secondary Payer

447.5 Effect of Changed Basis for Medicare Entitlement

447.6 Subsequent Periods of ESRD Entitlement

447.7 Identification of Cases in Which Medicare May Be Secondary to Employer Group Health

Plans

447.8 Billing

447.9 Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays in Part for Items and Services

447.10 Employer Group Health Plan Pays in Full

447.11 Effect of EGHP Payments On Deductible and Coinsurance

447.12 Limitation on Right of a Rural Health Clinic or Federally Qualified Health Center to Charge

Beneficiary

447.13 EGHP Erroneously Pays Primary Benefits

447.14 Claimant's Right to Take Legal Action Against EGHP

447.15 You Receive Duplicate Payments

Limitation on Payment for Services to Employed Aged

Beneficiaries and Spouses

448. LIMITATION ON PAYMENT FOR SERVICES TO EMPLOYED AGED AND AGED SPOUSES OF EMPLOYEES COVERED BY EMPLOYER

GROUP HEALTH PLANS

448.1 General

448.2 Definitions

448.3 Individuals Subject to Limitation on Payment

448.4 Individuals Not Subject to Limitation on Payment

448.5 Identification of Individuals Subject to Limitation on Payment

448.6 Identification of Prior Claims That May Involve Employer Plan Payment

448.7 Action by RHC/FQHC Where Employer Group Health Plan Is Primary Payer

448.8 Limitation on Right of RHC/FQHC to Charge Beneficiary

- 448.9 Crediting Expenses Toward Deductible and Coinsurance Amounts
 - 448.10 Employer Plan Denies Claim for Primary Benefits
 - 448.11 Amount of Secondary Medicare Payments Where EGHP Pays in Part for Items and Services
 - 448.12 Action By Intermediary to Recover Incorrect Payments
 - 448.13 Advice to Physicians and Beneficiaries
 - 448.14 Incorrect EGHP Primary Payments
 - 448.15 Claimant's Right to Take Legal Action Against EGHP
 - 448.16 You Receive Duplicate Payments
449. MEDICARE AS SECONDARY PAYER FOR DISABLED INDIVIDUALS

10-92 COVERAGE AND EXCLUSIONS 402

Covered Services

400. RURAL HEALTH CLINIC (RHC) AND FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES DEFINED

- A. RHC services are the following services furnished by an RHC:
- o Physicians' services, as described in §405;
 - o Services and supplies incident to a physician's services, as described in §406;
 - o Services of nurse practitioners, physician assistants (including clinical nurse midwives), as described in §408;
 - o Services and supplies incident to the services of nurse practitioners and physician assistants (including services furnished by nurse midwives), as described in §410;
 - o Visiting nurse services to the homebound, as described in §412;
 - o Clinical psychologist and clinical social worker services, as described in §419; and
 - o Services and supplies incident to the services of clinical psychologists and clinical social workers, as described in §419.
- B. FQHC services include all of the RHC services listed in subsection A as well as preventive primary services, as described in §404.

401. PAYMENT

The Medicare program makes payment directly to the RHCs and FQHCs for covered RHC and FQHC services furnished to Medicare beneficiaries. RHC and FQHC services are covered when furnished to a patient at the clinic or center, a skilled nursing facility or other medical facility, the patient's place of residence, or elsewhere (e.g., at the scene of an accident). The payment methods used are described in detail in Chapter V.

Services provided to hospital patients by RHC or FQHC practitioners (including emergency room services) are not RHC/FQHC covered services. Such services are billed to the Part B Medicare carrier.

NOTE: Services provided by hospital-based FQHCs/RHCs in the hospital are covered under the RHC/FQHC benefit only if provided in the RHC/FQHC.

402. SERVICES FURNISHED BY RHCs and FQHCs WHICH ARE NOT RHC/FQHC SERVICES

There are items and services covered and payable under Part B which do not fall under the definition of RHC or FQHC services listed in §400 but which RHCs and FQHCs may furnish. The RHC or FQHC bills the carrier for these services on the Form HCFA-1500. Further information concerning coverage and payment procedures may be obtained from the Part B carrier or the HCFA RO servicing the clinic or center's area. The clinic or center may also wish to obtain a copy of the Medicare Carriers Manual (HCFA Pub. 14) via the carrier or RO.

Items or services which are covered under Part B, but which are not RHC or FQHC services as defined in §400 include:

- o Durable medical equipment (whether rented or sold) including lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's place of resident;
- o Ambulance services;
- o Diagnostic tests such as x-rays and EKGs unless an interpretation of the test is provided by the RHC/FQHC physician (see §405.1);
- o Screening mammography services;
- o 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
- o 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).

NOTE: There are several conditions, limitations and exclusions with respect to coverage and payment for RHC and FQHC services. These guidelines apply generally throughout the Medicare program, not just to RHC and FQHC services. These are described in §401 and §§430ff. The application of these general Medicare conditions, exclusions, and limitations can result in situations in which services that are RHC and FQHC services are not covered.

404. PREVENTIVE PRIMARY SERVICES WHICH ARE FEDERALLY QUALIFIED HEALTH CENTER SERVICES

404.1 Primary Preventive Services Defined.--Preventive primary services must be furnished by or under the direct supervision of a physician, a nurse practitioner, a physician assistant, 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 cannot be 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 when provided by FQHCs to Medicare beneficiaries:

- o Medical social services;
- o Nutritional assessment and referral;
- o Preventive health education;
- o Children's eye and ear examinations;
- o Prenatal and post-partum care;
- o Prenatal services;
- o Well child care, including periodic screening;
- o Immunizations, including tetanus-diphtheria booster and influenza vaccine;
- o Voluntary family planning services;
- o Taking patient history;
- o Blood pressure measurement;
- o Weight measurement;
- o Physical examination targeted to risk;
- o Visual acuity screening;
- o Hearing screening;
- o Cholesterol screening;
- o Stool testing for occult blood;
- o Dipstick urinalysis;
- o Risk assessment and initial counseling regarding risks; and
- o For women only:
 - Clinical breast exam;
 - Referral for mammography; and
 - Thyroid function test.

404.2 Preventive Services Excluded Under FQHC Benefit.--FQHC preventive primary services do not include:

- o Group or mass information programs, health education classes, or group education activities, including media productions and publications; and
- o Eyeglasses, hearing aids, and preventive dental services.

NOTE: Screening mammography (which is a service covered under Part B) can be provided at an FQHC even though it is not included under the FQHC benefit if the center meets the requirements applicable to the service. Bill the Part B carrier for covered screening mammography services.

405. PHYSICIAN SERVICES

405.1 Definition.--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.

405.2 Telephone Services.--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.

405.3 Prescription Services.--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.

405.6 Physician Services as RHC/FQHC Services.--In determining whether the professional services of a physician are RHC/FQHC services, the following general rules apply:

A. Services at the Clinic or Center.--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.

B. Services Away From the Clinic or Center.--

1. 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 an employee of an RHC or FQHC, or 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.

2. 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.

405.7 Consultations.--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.

405.8 Concurrent Care.--Concurrent care exists when services are rendered by more than one physician during a period of time. (Consultation services do not constitute concurrent care.) 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. (For an explanation of how these services are treated in the RHC/FQHC setting, see § 405.6.)

406. SERVICES AND SUPPLIES FURNISHED INCIDENT TO PHYSICIAN'S SERVICES

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

- o Furnished as an incidental, although integral, part of a physician's professional services;
- o Of a type commonly rendered either without charge or included in the RHC or FQHC's bill;
- o Of a type commonly furnished in a physician's office;
- o Services provided by clinic employees other those services listed in §400A furnished under the direct, personal supervision of a physician; and
- o Furnished by a member of the clinic or center's staff who is an employee of the clinic or center.

This benefit includes services of clinic or center health care staff e.g., a nurse, therapist, technician, or other aide, and supplies such as tongue depressors, bandages, etc. These requirements do not apply to services of nurse practitioners, physician assistants, or certified nurse midwives if their services are covered as directly furnished services in the RHC and FQHC settings. (See §410.)

406.1 Incidental and Integral Part of Physician's Professional Services.--The service or supply must be 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 reflect his or her active participation in and management of the course of treatment. However, the direct personal supervision requirement explained in § 406.3 must still be met with respect to every nonphysician service for it to be covered as an incident to service.

406.2 Commonly Furnished in Physician's Office.--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.

406.3 Direct Personal Supervision.--Coverage is limited to situations in which there is direct physician supervision of the clinic or center staff 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 §412.)

406.4 Clinic or Center Employee.--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.

406.5 Clinic or Center Expense.--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.

406.6 Incident to Physician's Services in Physician-Directed RHC or FQHC.--For purposes of the incident to provision, a physician-directed RHC or FQHC is one where:

- o 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;
- o Each patient is under the care of a clinic or center physician; and
- o 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.

406.7 Coverage of Services and Supplies.--Services and supplies covered under this provision 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 which cannot be 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.

408. NURSE PRACTITIONER AND PHYSICIAN ASSISTANT SERVICES

408.1 Basic Requirements.--Nurse practitioner or physician assistant services (including services furnished by nurse midwives) are covered as RHC or FQHC services. They are covered if:

- o Furnished by a nurse practitioner, physician assistant or certified nurse midwife who is employed by or receives compensation from an RHC or FQHC;
- o Furnished under the general (or direct, if required by State law) medical supervision of a physician (see §408.5);
- o Furnished in accordance with clinic or center policies and any physician medical orders for the care and treatment of a patient;
- o 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
- o Of a type which would be covered under Medicare if furnished by a physician.

408.2 Services Covered.--Nurse practitioner and physician assistant (including certified nurse midwife) services are professional services performed by a nurse practitioner, physician assistant, or certified nurse midwife 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 a nurse practitioner, physician assistant, and certified nurse midwife, which would be considered covered physician services under Medicare (see §405), 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.

408.3 Services by Nurse Practitioners, Physician Assistants, and Nurse Midwives as RHC/FQHC Services.--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.

A. Services at the Clinic or Center.--The services of a 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.

B. Services Away From the Clinic or Center.--

1. Full-Time and Part-Time Nurse Practitioners, Physician Assistants And Nurse Midwives-FQHC/RHC Services.--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 an employee of an RHC or FQHC, or 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.

NOTE: Services of physician assistants are covered in any setting in rural health manpower shortage areas and services of nurse practitioners are covered in any rural settings. Such services are billed to the Part B carrier, and payment may be made directly to the physician assistant and nurse practitioner.

408.4 Effect of State Law.--The services of a nurse practitioner and physician assistant (including services of 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.

408.5 Effect of Clinic or Center Policies.--Nurse practitioner and physician assistant services 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.

408.6 Physician Supervision.--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 2 weeks (except in extraordinary circumstances). The physician must be a doctor of medicine or osteopathy.

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.

410. SERVICES AND SUPPLIES INCIDENT TO NURSE PRACTITIONER'S OR PHYSICIAN ASSISTANT'S SERVICES

410.1 Basic Requirements.--To be covered as a RHC or FQHC service, the service or supply must be:

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

410.2 Scope of Coverage.--Services and supplies covered under this provision are generally the same as described in §406 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.

410.3 Direct, Personal Supervision.--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.

412. CONDITIONS FOR COVERAGE OF VISITING NURSE SERVICES

412.1 General Requirements.--Visiting nurse services are covered as RHC or FQHC services if:

- o The RHC or FQHC is located in an area in which HCFA has determined that there is a shortage of home health agencies (see §412.2 below),
- o The services are rendered to patients who are homebound (see §§ 412.2 and 412.4),
- o 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 or receives compensation for the services from the RHC/FQHC (see §412.5); and
- o The services are furnished under a written plan of treatment, as described in §412.6.

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

- o 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;
- o Has patients whose homes are not within the area serviced by a participating home health agency; or
- o Has patients whose homes are not within a reasonable traveling distance, considering the area's climate and terrain, to a participating home health agency.

NOTE: 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 Medicare RO along with written justification that the area it serves meets one of the above conditions. The HCFA RO will decide whether the center qualifies to offer this benefit.

412.3 Services Are Furnished to Homebound Patients.--The visiting nurse benefit is restricted to patients who are homebound. Homebound means a patient who is permanently or temporarily confined to his or her place of residence because of a health condition.

An individual does not have to be bedridden to be considered confined to his/her home. However, the condition of these patients must be such that there exists a normal inability to leave home and

consequently that leaving home requires a considerable and taxing effort. If the patient does leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration or are attributable to the need to receive medical treatment.

Generally speaking, a beneficiary is considered to be homebound if he/she has a condition due to an illness or injury which restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, special transportation, or the assistance of another person. An individual is also considered homebound if he/she has a condition which is such that leaving his/her home is medically contraindicated.

412.4 Patient's Place of Residence.--A patient's residence is where he/she makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution is not considered a patient's residence if it:

Page 4-14 /Rev. 1

10-92 COVERAGE AND EXCLUSIONS 412.6

- o Meets at least the basic requirement in Medicare's definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick inpatients, or providing rehabilitation services to injured, disabled, or sick persons, or

- o Meets at least the basic requirement in Medicare's definition of a skilled nursing facility, i.e., it is primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care, or providing rehabilitation services for injured, disabled, or sick persons. If a patient is transferred from a participating skilled nursing facility to a nonparticipating part of the facility which the patient considers home, the nonparticipating part is not considered the patient's residence if it meets the definition of a skilled nursing facility.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides hospital or skilled nursing services he/she is not entitled to have payment made for visiting nurse services since such an institution is not considered his/her residence.

If a clinic or center has any questions as to whether an institution meets the hospital or skilled nursing facility requirements, contact the HCFA RO.

When a patient remains in a Medicare participating skilled nursing facility following discharge from active care, the facility is not considered his/her residence for purposes of visiting nurse services.

412.5 Services Furnished by Licensed Nurse.--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.).

412.6 Services Furnished Under Plan of Treatment.--Items and services must be furnished under a written plan established by a supervising physician, nurse practitioner, physician assistant, or a certified nurse midwife. It must be reviewed at least once every 62 days by a supervising physician of the RHC or FQHC. 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. All changes in orders for dangerous drugs and narcotics must be signed by the physician.

The plan must be reviewed by the supervising physician (in consultation with clinic/center nursing personnel) at such intervals as the severity of the patient's illness requires but at least every 62 days. 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:

- o 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
- o 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.

419. CLINICAL PSYCHOLOGIST AND CLINICAL SOCIAL WORKER SERVICES

419.1 Clinical Psychologists Services.--

A. Clinical Psychologist (CP) Defined.--To qualify as a CP, a practitioner must meet the following requirements:

- o 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;
- o Meet licensing or certification standards for psychologists in independent practice in the State in which he or she practices; and
- o Possess 2 years of supervised clinical experience, at least one of which is postdegree.

B. Qualified Clinical Psychologist Services Defined.--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.

- C. Types of Covered Clinical Psychologist Services.--CPs may provide the following services:
- o Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and regulation.
 - o 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 §406, are met. To be covered, these services and supplies must be:
 - Mental health services that are commonly furnished in CPs' offices;
 - An integral, although incidental, part of professional services performed by the CP; and
 - 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.

D. Noncovered Services.--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 the services are authorized by State law, the services of a CP that are determined to be not reasonable and necessary are not covered.

E. Requirement for Consultation.--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.

F. Outpatient Mental Health Services Limitation.--All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health services limitation in §613 (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.

G. Services at the Clinic or Center.--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.

H. Services Away From the Clinic or Center.--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 an employee of an RHC or FQHC, or 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.

419.2 Clinical Social Worker (CSW) Services.--RHC/FQHC services include the services provided by a clinical social worker.

A. **Clinical Social Worker Defined.**--A clinical social worker is an individual who:

- o Possesses a master's or doctor's degree in social work;
- o Has performed at least 2 years of supervised clinical social work; and
- o 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 2 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.

B. **Clinical Social Worker Services Defined.**-- Covered services are services that the CSW is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed for the diagnosis and treatment of mental illnesses. Services furnished to an inpatient of a hospital or an inpatient of a SNF that the SNF is required to provide as a requirement for participation are not included. 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.

C. **Covered CSW Services.**--Coverage is limited to the services a CSW is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law). The services of a CSW may be covered in an RHC/FQHC if they are:

- o The type of services that are otherwise covered if furnished by a physician, or incident to a physician's service;
- o Performed by a person who meets the above definition of a CSW; and
- o 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.

D. **Noncovered Services.**--Services of a CSW are not covered when furnished to inpatients of a hospital or to inpatients of a SNF if the services furnished in the SNF are those that the SNF is required to furnish as a condition of participation in Medicare. In addition, 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."

E. **Outpatient Mental Health Services Limitation.**--All covered therapeutic services furnished by qualified CSWs are subject to the outpatient psychiatric services limitation in §613 (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.

F. **Services at the Clinic or Center.**--The services of a clinical social workers performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.

G. **Services Away From the Clinic or Center.**--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 who is an employee of an RHC or FQHC, or 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.

General Exclusions From Medicare Coverage

430. GENERAL EXCLUSIONS

No payment may be made under either the hospital insurance or supplementary medical insurance programs for items and services with the following characteristics:

- o Not reasonable and necessary (see §431),
- o No legal obligation to pay for or provide (see §432),
- o Furnished or paid for by government instrumentalities (see §433),
- o Not provided within United States (see §434),
- o Resulting from war (see §435),
- o Personal comfort (see §436),
- o Routine services and appliances (see §437),
- o Supportive devices for feet (see §438),
- o Custodial care (see §439),
- o Cosmetic surgery (see §440),
- o Charges by immediate relatives or members of household (see §441),
- o Dental services (see §442), or
- o Paid or expected to be paid under workers' compensation or other Medicare secondary payer provisions. (See §§443ff.)

431. SERVICES NOT REASONABLE AND NECESSARY

In general, RHC/FQHC covered services do not include items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Notwithstanding any other provisions of the law, FQHC preventive primary services, as defined in §404.1, are covered services.

432. NO LEGAL OBLIGATION TO PAY FOR OR PROVIDE

This exclusion applies when items and services are furnished gratuitously without regard to the individual's ability to pay and without expectation of payment from any source. Examples include free X-rays or immunizations provided by health organizations as provided for in §1862(a)(2) of the Act, except for expenses incurred for items or services furnished by an FQHC.

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. However, Medicare coverage is not

excluded where a third party, rather than the patient, is obligated to pay for or provide the items and services. Furthermore, payment is not precluded merely because a provider, physician, or supplier waives its charge in the case of a particular patient or a group or class of patients as the waiver of charges for some patients does not impair the right to charge others (including Medicare patients). The determinative factor in applying this exclusion is the reason the particular individual is not charged.

The following sections illustrate the applicability of this exclusion to various situations involving services furnished by nongovernmental providers. (For a discussion of services paid for by a government instrumentality, see §433.)

A. Indigence.--This exclusion does not apply when items and services are furnished to an indigent individual without charge because of inability to pay if the provider, physician, or supplier bills other patients to the extent that they are able to pay.

B. Provider, Physician, or Supplier Bills Only Insured Patients.--Many providers, physicians, and suppliers waive their charges for individuals of limited means, but they also expect to be paid when the patient has insurance which covers the items or services they furnish. Because, in such a situation, it is clear that a patient would be charged if insured, benefits are payable for services rendered to patients with Medicare insurance if the provider, physician, or supplier customarily bills insured patients even though non-insured patients are not charged.

Individuals with conditions which are the subject of a research project may receive treatment financed by a private research foundation. The foundation may establish its own clinic to study certain diseases or it may make grants to various other organizations. In most cases, the patient is not expected to pay for his treatment out-of-pocket, but if he/she has insurance, then the parties expect that the insured pays for the services. In this situation, a legal obligation is considered to exist in the case of a Medicare patient even though other patients may not have insurance and are not charged.

C. Ambulance Services.--There are numerous methods of financing ambulance companies. For example, some volunteer organizations do not charge the patient or any other person but ask the recipient of such services for a donation to help offset the cost of the service. Although the recipients may be under considerable moral and social pressure to donate, they are not required to do so, and there is no enforceable obligation on the part of the individual or anyone else to pay for the services. Thus, Medicare benefits are not payable. However, services of volunteer ambulance corps are not categorically excluded. Many such companies regularly charge for their services and these services are covered by Medicare.

Some ambulance companies provide services without charge to residents of specific geographical areas who do not have private insurance to cover such services. If the patient does have insurance, the ambulance company expects the insurer to pay for the services. Since the ambulance company does not provide free services for insured individuals, and all patients are charged if insured, a legal obligation to pay exists and the services are covered. If, however, the residents receive free services without exception, but the ambulance company charges non-residents to the extent they are able to pay (e.g., through private insurance) the free services provided the residents are excluded from coverage while the services furnished non-residents are covered.

433. ITEMS AND SERVICES FURNISHED OR PAID FOR BY GOVERNMENT INSTRUMENTALITIES

The Medicare law places limitations on the circumstances under which payment may be made for items and services furnished or paid for by State, local or Federal Government instrumentalities. However, §1862(a)(3) of the Act permits payment to FQHCs for services to beneficiaries that are paid for directly or indirectly by a governmental entity.

With the exception of items and services provided by FQHCs, the law contains separate limitations applicable to Federal providers of services (see §433.1), items and services which the provider or supplier is obligated under a Federal Government contract or law to furnish at public expense (see §433.2), and items and services paid for directly or indirectly by a government entity (State, Federal, or local). (See §433.3.)

The following sections discuss these limitations in greater detail and how they are to be applied under various circumstances.

433.1 Payment to Federal Provider of Services or Other Federal Agency.--Payment may not be made to a Federal provider of services or other Federal agency unless the services are (a) emergency inpatient services, or (b) items and services furnished by a Federal provider which is determined by the Secretary to be providing services to the public generally as a community institution or agency.

For the purpose of this exclusion, a provider or other facility acquired by the Department of Housing and Urban Development (DHUD) in the administration of an Federal Housing Administration mortgage insurance program is not considered to be a Federal provider or agency. Accordingly, Medicare payment may be made for services furnished by such DHUD owned facilities.

433.2 Items and Services Which Provider or Supplier Is Obligated to Furnish Under Federal Government Contract or Law.--Payment may not be made for items or services which a provider or other person is obligated by law of, or contract with, the United States to render at public expense.

433.3 Items and Services Which are Paid Directly or Indirectly by Government Entity.--

A. General.--Benefits are not payable under Medicare Part A or B for items and services paid for by an agency of a State or local government or of the Federal Government, except as specified in subsections B and C. This exclusion applies to services furnished by government operated facilities as well as services furnished by non-governmental facilities which are paid for by a governmental agency.

B. Statutory Exceptions.-- The exclusion of items and services paid for by a governmental entity does not apply in the following situations. Therefore, payment may be made under Medicare where:

- o The items or services are furnished by an RHC or an FQHC;
- o The items or services are furnished under a health benefits or insurance plan established for employees of the governmental entity;
- o The items or services are furnished under one of the titles of the Social Security Act (such as medical assistance under title XVI of XIX).

C. Exceptions Approved by the Secretary.--The Secretary of Health and Human Services is authorized by law to specify additional exceptions to this exclusion. The Secretary has approved Medicare payment for services provided or paid for by a governmental entity in the following additional situations:

- o The items or services are furnished by a participating State or local government- operated hospital, including a psychiatric or tuberculosis hospital, which serves the general community. A psychiatric hospital to which patients convicted of crimes are committed involuntarily is considered to be servicing the general community if State law provides for voluntary commitment to the institution. However, payment may not be made for services furnished in State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals; and
- o The items or services are paid for by a State or local government entity and furnished an individual as a means of controlling infectious diseases or because the individual is medically indigent. These services need not be furnished in or by a hospital.

434. SERVICES RECEIVED BY MEDICARE BENEFICIARIES OUTSIDE UNITED STATES

Items and services which are provided outside the United States are not covered except for:

- o Certain inpatient hospital services provided in Canadian and Mexican hospitals;
- o Physician services and ambulance services furnished in connection with and during a period of such covered inpatient services, and
- o Certain services rendered on board a ship.

NOTE: These exceptions do not apply to RHCs/FQHCs.

The term "United States" refers to the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. For purposes of services rendered on a ship, it includes the territorial waters adjoining the land areas of the United States.

Services rendered on board a ship in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been rendered in United States territorial waters. Services not furnished in a United States port or rendered more than 6 hours before arrival at, or after departure from, a United States port are considered to have been furnished outside United States territorial waters even if the ship is of United States registry.

A hospital that is not physically situated in one of the above named jurisdictions is considered to be outside the United States even if it is owned or operated by the United States Government.

434.1 Physician and Ambulance Services Furnished in Connection With Covered Foreign Inpatient Hospital Services.--Effective January 1, 1973, payment can be made for necessary physician and ambulance services which meet the other coverage requirements of the Act and which are furnished in connection with and during a period of covered foreign hospitalization. In general, payments may be made under Part A for inpatient hospital services in the situations described in subsections A and B.

A. Emergency Hospital Admissions.--Payment may be made for emergency inpatient hospital services furnished outside the United States by a foreign hospital which was nearer to or more accessible from the site of the emergency than the nearest U.S. hospital adequately equipped and available to treat the individual's condition provided that, at the time of the emergency, the individual was either (1) physically present in the United States, or (2) in Canada while traveling without unreasonable delay by the most direct route between Alaska and another State.

B. Nonemergency Inpatient Services Furnished in Foreign Hospitals.-- Effective with admissions on and after January 1, 1973, payment may be made for inpatient hospital services in a foreign hospital furnished to a beneficiary who is a resident of the United States, provided the foreign hospital is closer to or substantially more accessible from his/her residence than the nearest hospital within the U.S. which is adequately equipped to deal with and available for the treatment of his/her illness or injury, whether or not an emergency existed and without regard to where the illness or injury occurred. Residence means the place in the U.S. where a person has a fixed and permanent home to which he/she intends to return whenever he/she is away. At the time such services are furnished, the foreign hospital must be accredited by the JCAH or by a hospital approval program of the country in which it is located which has standards essentially equivalent to those of the JCAH.

C. Coverage of Physician and Ambulance Services Furnished Outside U.S.-When inpatient services in a foreign hospital are covered, payment may also be made for (1) physician services rendered to the beneficiary while an inpatient, (2) physicians' services rendered to the beneficiary outside the hospital on the day of his admission as an inpatient, provided the services were for the same condition for which the beneficiary was hospitalized, and (3) ambulance services, if necessary, for the trip to the hospital in conjunction with the beneficiary's admission as an inpatient. Return trips from a foreign hospital are not covered.

In cases involving foreign ambulance services, the general requirements regarding vehicle and crew requirements, medical necessity and covered destinations are also applicable subject to the following special rules. If the foreign hospitalization was determined to be covered on the basis of emergency services (see subsection A), the necessity requirement and the destination requirement are considered met.

The definition of "physician," for purposes of coverage of services furnished outside the U.S. is expanded to include a foreign practitioner, provided the practitioner is legally licensed to practice in the country in which the services were rendered.

The regular deductible and coinsurance requirements apply to physician and ambulance services rendered outside the U.S.

435. SERVICES RESULTING FROM WAR

Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

436. PERSONAL COMFORT ITEMS

Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

437. ROUTINE SERVICES AND APPLIANCES

In general, routine physician examination, eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting or changing eyeglasses; eye refractions; and hearing aids and examinations for hearing aids are not Medicare covered services. However, under the FQHC benefit, Medicare covers certain primary preventive services provided by the FQHC, such as physical

examinations targeted to risk, visual screening, hearing screening, and immunizations when they are provided by an FQHC. See §404 for a list of those preventive primary services.

NOTE: Eyeglasses, contact lenses, refractive services, hearing aids, and examinations for hearing aids are not FQHC primary preventive services and are not covered.

The routine physical checkup exclusion, which applies in the case of RHC services, applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties e.g. insurance companies, business establishments or Government agencies. Certain screening pap smears and screening mammograms, as well as chest X-rays for the detection of respiratory disease, which are performed as part of the routine admitting procedure of a hospital are exempt from this exclusion.

If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173, Black Lung Benefits, advise the claimant to contact his/her social security office regarding the filing of a claim for reimbursement under that program.

The exclusions apply to eyeglasses or contact lenses. They also apply to eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physician services (and services incident to a physicians' service) performed in conjunction with an eye disease, e.g., glaucoma or cataracts. They also do not apply to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed and to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such a prosthetic lens is a replacement for an internal body organ (the lens of the eye).

The coverage of services rendered by an ophthalmologist is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition. If a beneficiary goes to an ophthalmologist with a complaint or symptoms of an eye disease or injury, the ophthalmologist's services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, if a beneficiary goes to an ophthalmologist for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathological condition.

Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

With the exception of immunizations furnished as primary preventive services by an FQHC, vaccinations or inoculations are excluded from Medicare coverage as immunizations unless they are for the prevention of pneumococcal pneumonia, for the prevention of hepatitis B for certain persons at risk, or they are directly related to the treatment of an injury or to direct exposure such as antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera or immune globulin.

438. FOOT CARE AND SUPPORTIVE DEVICES FOR THE FEET

The scope of covered foot care services is limited by excluding the following types of services under Part A and Part B.

A. Treatment of Flat Foot.--The term "flat foot" is defined as a condition in which one or more arches in the foot have flattened out. Services directed toward the care or correction of such condition are not covered.

B. Treatment of Subluxations of the Foot.--Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles of the foot.

Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis and treatment (except by the use of orthopedic shoes or other supportive devices for the foot) of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxated foot structure that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

The exclusion does not apply to the ankle joint (talo-crural joint).

C. Routine Foot Care.--Routine foot care includes the removal of corns, or calluses, the trimming of nails (including mycotic nails), and other hygienic and preventive maintenance care in the realm of self-care, e.g., cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury, or symptoms involving the foot. Routine treatment of a mycotic nail is a noncovered service regardless of the type of treatment. Treatment of mycotic nails is only covered when all other conditions of coverage for routine foot care are met, i. e., the patient must have a systemic condition that has resulted in severe circulatory embarrassment in the legs or feet.

Certain foot care procedures that are generally considered to be routine (e.g., cutting or removal of corns, warts, calluses, or nails) may pose a hazard when performed by a nonprofessional person on patients with a systemic condition that has resulted in severe circulatory embarrassment or of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parenthesis) most commonly represent the underlying conditions contemplated:

*Diabetes mellitus

Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)

Buerger's disease (thromboangiitis obliterans)

*Chronic thrombophlebitis

Peripheral neuropathies involving the feet

*Associated with malnutrition and vitamin deficiency

malnutrition (general, pellagra)

alcoholism

malabsorption (celiac disease, tropical sprue)

pernicious anemia

*Associated with carcinoma

- *Associated with diabetes mellitus
- *Associated with drugs and toxins
 - Associated with multiple sclerosis
- *Associated with uremia (chronic renal disease)
 - Associated with traumatic injury
 - Associated with leprosy or neurosyphilis
 - Associated with hereditary disorders
 - hereditary sensory radicular neuropathy
 - angiokeratoma corporis diffusum (Fabry's)
 - amyloid neuropathy

When the patient's condition is one of those designated by an asterisk (*), routine procedures are payable only if the patient is under the active care of a physician for such a condition.

Services ordinarily considered routine are also covered if they are performed as a necessary and integral part of otherwise covered services, e.g., diagnosis and treatment of diabetic ulcers, wounds, and infections.

D. Supportive Devices for the Feet.--Orthopedic shoes and other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

439. CUSTODIAL CARE

Custodial care is excluded from coverage under Medicare. The concept of custodial care pertains only to inpatient institutional care.

440. COSMETIC SURGERY

Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns, repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

441. CHARGES IMPOSED BY IMMEDIATE RELATIVES OF PATIENT OR MEMBERS OF PATIENT'S HOUSEHOLD

A. General.--Payment may not be made under Part A or Part B for expenses which constitute charges by immediate relatives of the beneficiary or by members of his/her household. The intent of this exclusion is to bar Medicare payment for items and services which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. This exclusion applies to items and services rendered by providers to immediate relatives of the owner(s). It also applies to services rendered by physicians to their immediate relatives and items furnished by suppliers to immediate relatives of the owner(s).

B. Immediate Relative.--The following degrees of relationship are included within the definition of immediate relative.

- o Husband and wife;
- o Natural or adoptive parent, child, and sibling;
- o Stepparent, stepchild, stepbrother, and stepsister;
- o Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- o Grandparent and grandchild; and
- o Spouse of grandparent and grandchild.

A brother-in-law or sister-in-law relationship does not exist between the owner of a provider (or supplier) and the spouse of his wife's (her husband's) brother or sister.

A father-in-law or mother-in-law relationship does not exist between the owner of a provider and his/her spouse's stepfather or stepmother.

A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. Thus, for example, if a provider treats the stepfather of the owner after the death of the owner's natural mother or after the owner's stepfather and natural mother are divorced, or if the provider/supplier treats the owner's father-in-law or mother-in-law after the death of his wife, the services are considered to have been furnished to an immediate relative and are excluded from coverage.

C. Members of Patient's Household.--These are persons sharing a common abode with the patient as a part of a single family unit (including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit). A mere roomer or boarder is not included.

D. Charges for Provider Services.--Payment may not be made under Part A or Part B for items and services furnished by providers to immediate relatives of the owner(s) of the providers. This exclusion applies whether the provider is a sole proprietor who has an excluded relationship to the patient, or a partnership in which even one of the partners is related to the patient.

E. Charges for Physician and Physician-Related Services .--This exclusion applies to physician services (including services of a physician who belongs to a professional corporation) and services furnished incident to those services (e.g., by the physician's nurse or technician if the physician who furnished the services or who ordered or supervised services incident to his/her services has an excluded relationship to the beneficiary.

A professional corporation is a corporation that is completely owned by one or more physicians, or is owned by other health care professionals as authorized by State law, and is operated for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic. Any physician or group of physicians which is incorporated constitutes a professional corporation. (Generally, physicians who are incorporated identify themselves by adding letters such as P.C. or P.A. after their title.)

F. Charges for Items Furnished by Nonphysician Suppliers.--This exclusion applies to charges imposed by a nonphysician supplier that is not incorporated whether the supplier is owned by a sole

proprietor who has an excluded relationship to the patient or by a partnership in which even one of the partners is related.

The exclusion does not apply to charges imposed by a corporation (other than a professional corporation) regardless of the patient's relationship to any of the stockholders, officers or directors of the corporation or to the person who furnished the service.

442. DENTAL SERVICES EXCLUSION

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. However, payment may be made in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of the underlying medical condition and clinical status requires hospitalization in connection with the provision of such services. Structures directly supporting the teeth refers to the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process.

NOTE: RHC and FQHC benefits do not include routine dental services.

When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoloplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. However, if a procedure or service that is not covered is performed by a dentist as an integral part of a covered procedure or service performed by him or her, the total procedure or service is covered.

Coverage is available for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone including dental splints or other appliances used for this purpose. In general, the jaw or any structure contiguous of the jaw includes structures of the facial area below the eyes, e.g., mandible, gums, tongue, palate, salivary gland, sinuses.

The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a noncovered procedure or service performed by a dentist must be incident to and an integral part of a covered procedure or service performed by him/her. Ordinarily, the dentist extracts the patient's teeth but another physician, e.g., a radiologist, administers the radiation treatments.

A dental examination for patients requiring certain complex surgical procedures may be covered. To date, the only identified procedures for which dental examinations are covered are kidney transplants and heart valve replacements.

Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.

The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

443. ITEMS AND SERVICES UNDER WORKERS' COMPENSATION PLAN

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made promptly for such items or services under a workers' compensation law or plan of the United States or a State. Moreover, if it is determined that any Medicare payment has been made for items or services which can be or could have been paid for under workers' compensation, the Medicare payment may be recovered.

This limitation is applicable to the workers' compensation plans of the 50 States, the District of Columbia, Guam, Puerto Rico, the Virgin Islands and American Samoa. It also applies to the Federal Workers' compensation plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung program).

These Federal programs provide workers' compensation protection for Federal civil service employees and certain other categories of employees not covered or not adequately covered under State workers' compensation programs, e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from nonappropriated Federal funds (such as employees of post exchanges), and offshore oil field workers.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a workers' compensation law or plan for purposes of this exclusion. Similarly, some States have employer liability acts. These are not considered workers' compensation acts for purposes of this provision.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under Workers' compensation where payment under that system can reasonably be expected. If failure to take proper and timely action results in a loss of workers' compensation benefits, Medicare benefits are precluded to the extent that payment could reasonably have been expected under workers' compensation.

443.1 Characteristics of Workers' Compensation Programs.--A workers' compensation program is a government supervised and employer supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people.

Although workers' compensation programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well. The Federal Black Lung Benefit program, administered by the Department of Labor (DOL) is a form of Workers' compensation.

Claims for medical services directly related to pneumoconiosis (black lung) and other respiratory diseases filed by or on behalf of Medicare beneficiaries who have applied for black lung medical benefits are denied Medicare coverage under §1862(b) of the Act because they are payable under a workers' compensation plan. Submit claims for these services to the Department of Labor. Claims for medical services for illness or injury other than those related to treatment of black lung or other work-related illness or injury are processed as usual by the intermediary.

All workers' compensation acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services.

However, in some States, there are limits on the amount of medical and hospital care provided. For specific information regarding the workers' compensation plan of a particular State or territory, contact the intermediary in the locality.

443.2 Effect of Payments Under Workers' Compensation Plan.--In general, expenses for services which are compensable under a workers' compensation program are not reimbursable under Medicare. (However, see §443.3 for policies governing situations where the workers' compensation plan does not pay for all services.)

443.3 Private Right of Action.--Section 1862(b)(3)(A) of the Act provides that where an individual is awarded workers' compensation benefits but the workers' compensation carrier does not pay primary benefits, the Medicare beneficiary has a right to take legal action against the workers' compensation carrier and can collect double the amount that would have been payable had primary benefits been paid. If such litigation is successful, the Medicare program can recover the amount paid by Medicare. Under the law, the Medicare program can also take legal action to recover double damages.

443.4 Partial Payments Under Workers' Compensation.--

A. General.--If workers' compensation payments for medical services are based on a fee schedule, secondary Medicare benefits may not be paid to supplement the amount paid by workers' compensation. This is because workers' compensation medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patients' liability for the services.

However, if a workers' compensation plan does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work related, Medicare benefits may be paid in accordance with subsection C to supplement the amount paid by Workers' compensation. A provider is permitted under workers' compensation law to charge an individual or the individual's insurer for the services which are not work related.

You may not charge a beneficiary or any other party for Medicare covered services if you have been paid by workers' compensation an amount that equals your charges or equals or exceeds the gross amount payable by Medicare as defined in subsection C. This prohibition is based on the terms of the Medicare participation agreements under which a provider may bill a Medicare beneficiary only for deductible and coinsurance amounts and for noncovered services.

B. Possible Coverage of Work Related Services Under No Fault Insurance or an Employer Group Health Plan.--When services are covered in part by workers' compensation and there is also coverage under no fault insurance, workers' compensation pays first, the no-fault insurance pays second, and Medicare is the residual payer. (See §445ff.) If the individual is covered by an employer group health plan, and is age 65 or over, is one of certain disabled individuals who are covered by a large group health plan (see §449), or is under age 65 and entitled to Medicare solely because of end stage renal disease (ESRD), the employer plan coverage may also be primary to Medicare (generally for 18 months). (See §§447ff. and 448ff.) Accordingly, whenever workers' compensation pays in part for provider services, take steps to assure that payment is made by a no-fault insurer, an employer group health plan or a large group health plan if there is also such primary coverage.

If the services are related to an accident, ascertain whether your records show coverage under no fault insurance. When they do not show such coverage, contact the beneficiary to ascertain whether such coverage exists. If there is coverage under no fault insurance, submit the unpaid portion of the bill to the no fault insurer and follow the instruction in §635.

If there is no coverage under no fault but another insurer is shown on the bill and one of the following conditions is met, bill the other insurer for the services not paid for by workers' compensation.

- o The individual is age 65 or over;
- o The individual is under age 65 and entitled to Medicare solely on the basis of ESRD and the services were provided in a 18-month period (see §447); or
- o The individual is an active disabled individual as defined in §449.

The other insurer is billed because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is a group health plan.

If the services provided to the Medicare beneficiary are not related to an accident as described in §445, and there is no indication of primary employer group health plan coverage under §§447 or 448, bill Medicare for secondary Medicare payments determined in accordance with subsection C.

When you receive such a claim for services not paid for by workers' compensation because certain services were determined not to be for treatment of the work related condition, process the claim in accordance with §634. However, if there is an indication that the services were related to an accident, an indication that a liability claim may be filed or has been filed, or an indication of primary coverage by an employer plan, follow the applicable instructions in §443.5, §445ff., §447ff. or §448ff., as appropriate.

C. Secondary Medicare Payments.--If a no-fault insurer pays for Medicare covered services an amount which is less than your charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by workers' compensation) and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payment can be made. The Medicare secondary payment is the lower of:

- o The gross amount payable by Medicare minus the amount paid by the Workers' compensation plan for Medicare covered services;
- o The gross amount payable by Medicare minus any applicable deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges) minus the amount payable by the Workers' compensation plan; or

- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges) minus the applicable Medicare deductible and coinsurance amounts.

NOTE: The gross amount payable by Medicare is the current Medicare interim reimbursement amount (as defined in §638) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible or coinsurance or the payment by the workers' compensation plan.

See §637 for detailed reimbursement and billing instructions.

443.5 Workers' Compensation Cases Involving Liability Claims--Most State laws provide that if an employee is injured at work due to the negligent act of a third party, he or she cannot receive payments from both workers' compensation and the third party for the same injury. Generally, the workers' compensation carrier pays benefits while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, the workers' compensation carrier may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

Accordingly, if a workers' compensation carrier does not pay for services which are otherwise covered by Medicare or recovers benefits it previously paid for such services solely because a third party is determined to be liable, Medicare is not the secondary payer under this provision to the extent of the nonpayment or recovery by workers' compensation. However, the services may be excluded under the provision which prohibits Medicare payment for services that have been paid for under liability insurance. These cases are considered under the policies in §446.

443.6. Provider Handling of Cases Involving Work Related Conditions.--

A. General.--A condition is considered work related if it resulted from (1) an accident that occurred on the job, or (2) an occupational disease. Situations which indicate the possibility of a work related condition include the following:

- o The physician or the patient states that the condition is work related;
- o The condition, or serious aggravation thereof resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;
- o The diagnosis is one which is commonly associated with employment e.g., pneumoconiosis (including silicosis, asbestosis and black lung disease in the case of a coal miner, see §§443.12 - 443.16); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic or mercury poisoning;
- o The beneficiary previously received workers' compensation for the same condition;
- o There is indication that a workers' compensation claim is pending; or
- o There is other indication that the condition arose on the job.

B. Responsibility of Provider to Document Cases in Which There Is a Possibility of Workers' Compensation Coverage.--Inquire of the beneficiary or admitting physician at the time of admission whether the condition is work related. When the patient or physician indicates that the condition is work related or there is other indication that the condition is work related (see subsection A), ask the patient or physician, whenever possible, whether workers' compensation is expected to pay for the services. (Frequently, when services are covered under a workers' compensation program, the services are authorized in advance by the workers' compensation carrier or the employer).

If the patient denies that workers' compensation benefits are payable for a condition which the provider believes may be covered by Workers' compensation, provide an explanation in the "Remarks" on the Form HCFA-1450 containing information about the circumstances of the accident and the reasons it is claimed that workers' compensation benefits are not payable.

443.7 Conditional Primary Medicare Benefits --Conditional Medicare payments may be made in workers' compensation cases under the following circumstances:

- o The beneficiary has filed a claim with the workers' compensation insurer and the intermediary determines that the insurer will not pay promptly (i.e., within 120 days of receipt of the claim) for any reason except when the workers' compensation insurer claims that its benefits are secondary to Medicare; or
- o The beneficiary, because of physical or mental incapacity, failed to meet a claim filing requirement of the workers' compensation insurer.

When such conditional Medicare payments are made, they are made on condition that the beneficiary will reimburse the program to the extent that payment is subsequently made by the workers' compensation insurer. When making such payments, the beneficiary and the insurer are notified by the intermediary of the requirement for repayment. (However, failure to do so does not relieve them of the obligation to refund the payments.)

443.8 You Receive Duplicate Payments.--Refund the excess Medicare payment by submitting an adjustment bill within 60 days if you receive duplicate payments from a no-fault insurer and from Medicare, regardless of which payment you received first and even if you refund the insurance payment to the beneficiary or the insurer. If you received Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

443.9 Effect of Lump Sum Compromise Settlement.--Negotiated compromise settlements of workers' compensation claims, by their very nature, provide less than full benefits for both income replacement and medical expenses. If there was real doubt as to the compensability of a work injury and a lump-sum compromise is agreed upon and approved by the workers' compensation board or agency to effect settlement of the claim, the lump sum is deemed a Workers' compensation payment for Medicare purposes even if the settlement agreement stipulates that there is no liability under the workers' compensation law. In such cases, payment may be made for past expenses to the extent provided in §443.10. If the individual signed a final release of all rights under workers' compensation (which precludes the possibility of further workers' compensation benefits) medical expenses incurred after the date of the final release are reimbursable under Medicare insofar as such subsequent medical expenses were not contemplated by and incorporated into the settlement.

However, notwithstanding the written agreement between the parties, the Medicare program does not accept any manipulation of the State program calculated to shift liability for work-related medical expenses to the Medicare program. If it appears that a settlement represents an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement is not recognized. Workers' compensation settlements of this type may occur, for example, when the parties to a settlement attempt to maximize the amount of disability benefits paid an injured employee under workers' compensation by releasing the workers' compensation carrier from liability for a particular course of medical treatment despite the existence of facts showing a relationship between the work injury and the condition which necessitated the treatment. In such cases, it must be

determined that the services could have been paid for under workers' compensation and are therefore not covered under Medicare.

443.10 Apportionment of Lump Sum Compromise Settlement of Workers' Compensation Claim.-- If a lump-sum compromise settlement specifies the items of medical expense which it is intended to cover, Medicare payments may not be made for the expenses specified in the settlement as covered by the workers' compensation award.

If the award does not identify which items of medical expense it is intended to cover, the amount of the award allocated to medical expense incurred up to the date of the award is applied at the prevailing workers' compensation schedule in that jurisdiction first to those medical services covered by workers' compensation (but not covered by Medicare) and second to expenses covered by workers' compensation and by Part B (excluding provider services).

Any remainder of the workers' compensation settlement is treated as payment for provider services. The amount to be recovered from the beneficiary for provider services is any amount Medicare paid in excess of the amount that it should have paid as secondary payer, but in no case does Medicare recover more than the provider's charges.

If a lump sum workers' compensation settlement covers both medical care and disability benefits, but does not apportion the sum granted between medical expenses and income replacement, send all information to the intermediary. The intermediary calculates the amount of the workers' compensation award deemed to be payment of medical expenses and notifies the RHC or FQHC of this amount.

443.11 Lump-Sum Settlement -- Effect on Payment for Services Furnished After Date of Settlement.-- If the lump sum settlement does not state that it is payment for future medical expenses, medical expenses incurred after the date of the settlement are payable by Medicare. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump- sum settlement allocated to future medical expenses.

443.12 Action by Provider When Benefits May Be Payable Under Federal Black Lung Program.--

A. General.--If you are aware that a Medicare beneficiary may be entitled to have the services reimbursed by the Department of Labor (DOL) under the Federal Black Lung Program, bill DOL (see §443.16 for DOL's address). However, if the services rendered a black lung beneficiary were solely for a non black lung condition e.g., diabetes or a fracture, bill the Medicare intermediary.

It is your responsibility to identify beneficiaries who may be entitled to benefits under the Federal Black Lung Program. These are generally cases in which the beneficiary (or his/her representative) states that he/she is entitled to black lung medical benefits.

B. Situations in Which Provider Bills DOL.--If you are aware that the beneficiary may be entitled to receive medical benefits under the Federal Black Lung Program administered by DOL, bill DOL in the following situations:

- o The diagnosis is black lung related, or
- o The diagnosis is not black lung related, and:

- The bill is for an inpatient stay during which some black lung procedures and the circumstances under which they are furnished are covered by the Black Lung Program. Bill all services to DOL.
- The bill is for outpatient services which include one or more black lung related procedures.

443.13 Special DOL Coverage Rules.--In some instances, DOL covers certain items and services under limited conditions only. In such cases, a Certificate of Medical Necessity (CMN) is required. This DOL form (CM-893) is completed by the prescribing physician and must be approved by DOL before it reimburses for the services or items. Approvals may be given for a specific time only and in such case it is not necessary to submit a copy of the CMN with each bill during the approved period. For example, a CMN is required for the payment by DOL for pulmonary rehabilitation.

If the CMN is rejected by DOL, then the items or services can be billed to Medicare with a copy of the DOL denial attached. However, if the individual's condition changes and test results confirm this, submit a new CMN to DOL for review. Any items or services billed to DOL are not billed to the Medicare program unless a denial has been received from DOL.

443.14 Medicare Payment.--If the bill is for outpatient services, Medicare may pay for any service that is not related to black lung disease (e.g., treatment of diabetes or fracture). Medicare does not pay for the coverage of services or drugs needed to treat the black lung conditions.

443.15 Questionable Cases.--If there is a question regarding whether a procedure is related to black lung disease, check with DOL.

443.16 DOL Does Not Make Payment in Full.--If you bill DOL, but DOL does not pay for the services in full, bill Medicare as provided in §443.4 attaching a copy of DOL's denial notice. The denial notice must give the specific reason for nonpayment. If a claim is denied because of your failure to furnish documentation needed by DOL, payment may not be made under Medicare. The address for sending bills to DOL is:

Federal Black Lung Program
P.O. Box 740
Lanham, MD 20706

443.17 Overpayment Due to Workers' Compensation (WC) Payments.--If you learn that you will receive a WC payment after you have been reimbursed by Medicare for the same items and services, prepare a corrected bill. The noncovered charges include the charges for items and services paid for under WC. The overpayments may be repaid by direct refund or adjustment or program payments to you. The excess Medicare payment must be refunded within 60 days.

Other Limitations on Payment

445. SERVICES REIMBURSABLE UNDER NO FAULT INSURANCE

Payment is not made under Medicare for otherwise covered items or services to the extent that payment has been made or can reasonably be expected to be made promptly for the items or services under any no fault insurance (including a self insured plan). Medicare is secondary to no fault insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits

or otherwise limits its payments to Medicare beneficiaries. If Medicare payments have been made in error, or if the payments were made on a conditional basis, they are subject to recovery. If services are covered under no fault insurance, bill the no fault insurer first. If the insurer does not pay all of the charges, submit a claim for secondary Medicare benefits to supplement the amount paid by the insurer. Medicare pays for services related to an accident if benefits are not currently available under the individual's no fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on nonmedical items such as lost wages.

The question in each case involving accident related medical expenses is whether no fault benefits can be paid for these particular services. If so, the no fault insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save his/her insurance benefits to pay for future services or for noncovered medical services or nonmedical services. Since no fault insurance benefits are currently available in that situation, they are used before billing Medicare.

A. Effective Dates.--The general rule pertaining to automobile or nonautomobile no fault insurance is that these provisions are effective with respect to injuries which occurred on or after December 5, 1980.

These rules apply to services covered under no fault insurance furnished on or after June 6, 1983, and services covered under nonautomobile medical and no-fault insurance furnished on or after November 13, 1989.

B. Effect on Deductibles, Coinsurance and Utilization.--Expenses for services for which Medicare payment is not made because payment has been made or can reasonably be expected to be made promptly under any no fault insurance are counted toward Part A or Part B deductible amounts. Also, no fault payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, the no fault payments are credited to deductibles before being used to satisfy the coinsurance. Inpatient hospital and SNF care that is paid for by a third party payer is not counted against the number of days available to the beneficiary under Medicare Part A.

NOTE: For services provided prior to November 13, 1989, payments by the primary payer are not counted toward the Medicare deductible. Use the discharge date for determining when the services were furnished.

445.1 Definitions.--

A. Automobile.--This is a self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

B. No Fault Insurance.--This is insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or sustained in the use, occupancy, or operation of an automobile regardless of who may have been responsible for causing the accident. It is sometimes called medical payments coverage, personal injury protection, or medical expense coverage. Examples of no fault insurance include automobile no-fault insurance, often referred to as personal injury protection (PIP), and homeowners and commercial medical payments insurance, commonly referred to as Med-pay coverage.

C. **Liability Insurance.**--This is insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

D. **Prompt or Promptly.**--This is payment within 120 days after receipt of the claim.

E. **Proper Claim.**--This is a claim that is filed timely and meets all other claim filing requirements specified by the no fault insurer.

F. **Self-Insured Plan.**--This means a plan under which an individual or a private or governmental entity carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay for liability claims under the Federal Tort Claims Act.

G. **Underinsured Motorist Insurance.**-- This is insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

H. **Uninsured Motorist Insurance.**--This is liability insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance, carries less than the amount of insurance required by law, or is underinsured.

445.2 Provider Actions.

A. **Information Obtained from Patient or Representative At Time of Admission or Start of Care.**-- Medicare regulations require that you agree to obtain information on possible Medicare secondary payer situations. Ask Medicare patients or their representatives at admission or start of care if the services are for the treatment of an injury or illness which resulted from an accident for which no fault insurance may pay or for which he or she holds another party responsible. Obtain the name, address and policy number of any no fault or liability insurance company which may be responsible for payment of medical expenses that resulted from the accident. Retain this information in your system of records.

B. **Billing When Services Are Accident Related.**--

1. **No Fault Insurer May Pay Primary.**--If you learn from the response to the questions asked at the start of services that a no-fault insurance company may pay for otherwise covered services, bill the insurance company as primary insurer. Bill Medicare for secondary benefits per §445.3C if the insurer does not pay in full. If the insurer pays for all Medicare covered services, submit a no payment bill.

2. **No-Fault Insurer Does not Pay.**--If the services are related to an automobile accident and an automobile insurer has been billed but does not make payment because, for example, the individual's automobile coverage expired, the no-fault benefits are exhausted, or there will be substantial delay of at least 120 days in resolving the claim, bill Medicare. Unless you submit a satisfactory explanation that full or partial payment cannot be made under the no-fault insurance policy, the Medicare claim is denied

since Medicare is not the primary insurer. If you bill Medicare and later receive payment from the no-fault insurer, refund the Medicare payment by submitting an adjustment bill.

Refusal by an individual to file a claim with a no-fault insurer or to cooperate in your filing such a claim is not a basis for claiming a conditional Medicare payment.

3. **Liability Claim Also Involved.**--If the individual files a claim against a third party for injuries suffered in an automobile or other accident, bill Medicare for otherwise covered expenses to the extent that payment has not or cannot be made promptly by a no fault insurer or has not been made promptly by a liability insurer. For example, an individual incurs \$20,000 in medical expenses due to an automobile accident. The individual receives \$5,000 in no fault insurance benefits and also has a liability claim pending against the driver of the other car. Medicare does not pay benefits for the \$5,000 in expenses paid for by the no fault insurer but pays benefits based on the additional \$15,000 in expenses (provided the liability insurer has not paid promptly). Medicare recovers from the liability insurer or the beneficiary when the liability claim is settled.

4. **No Fault Payment Is Reduced Because Proper Claim Not Filed.**--When you receive a reduced no fault payment because of failure to file a proper claim (see §445.1), the Medicare secondary payment does not exceed the amount payable if the no fault insurer has paid on the basis of a proper claim.

You must inform HCFA that a reduced payment was made and the amount that would have been paid if a proper claim had been filed. Failure to notify Medicare of the latter amount constitutes the filing of a false claim against the United States and could result in prosecution.

C. **Request From Insurance Company or Attorney.**--Notify the intermediary promptly if you receive a request for a copy of a medical record or bill concerning a Medicare patient from an attorney or insurance company. Send the intermediary a copy of the request or, if it is unavailable, details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and the date(s) of services for which you have billed or will bill Medicare. Follow the usual rules on release of information in responding to such requests.

D. **You Receive Duplicate Payments.**--Refund the excess Medicare payment by submitting an adjustment bill within 60 days if you receive duplicate payments from a no fault insurer and from Medicare regardless of which payment you received first and even if you refunded the insurance payment to the beneficiary or the insurer. If you received Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

E. **You Learn You Should Have Billed No Fault Insurance Instead of Medicare.**--If, after you received a primary Medicare payment, you learn that the items or services could be paid for under no fault insurance, notify your intermediary. The intermediary seeks refund of Medicare's payment from the no fault insurer and prepares an adjustment bill, if required.

445.3 No Fault Insurance Does Not Pay In Full.--

A. **Insurance Pays Service Benefits.**--If the amount of payment for particular services under no fault insurance is less than your charges but is deemed payment in full under State law, Medicare benefits are not payable. The insurance payment constitutes a service benefit, i.e., the payment constitutes full discharge of the patient's liability to the provider.

B. Other Situations.--In other cases, no fault insurance may not pay your charges because the beneficiary's total medical expenses exceed the dollar limit of the coverage or because of some other coverage limit, deductible or coinsurance applicable to all policyholders. (See §445.4.) You are not permitted to charge a beneficiary or any other party for Medicare covered services if you have been paid by a no fault insurer an amount that equals or exceeds the gross amount payable by Medicare as defined in subsection C. This prohibition is based on the terms of your Medicare participation agreement under which you may bill a Medicare beneficiary only for deductible and coinsurance amounts and for noncovered services.

C. Secondary Medicare Payments.--If a no fault insurer pays for Medicare covered services an amount which is less than your charges and less than the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the no fault insurer) and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made.

The Medicare secondary payment is the lower of:

- o The gross amount payable by Medicare minus the amount paid by the no fault insurer for Medicare covered services;
- o The gross amount payable by Medicare minus any applicable Medicare deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full if that is less than the charges) minus the amount payable by the no fault payer; or
- o Your charges (or the amount you are obligated to accept as payment in full if that is less than the charges) minus the applicable Medicare deductible and coinsurance amounts.

NOTE: The gross amount payable by Medicare is (1) the current Medicare interim reimbursement amount (as defined in §638) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible and coinsurance or the payment by the no fault insurer.

D. Conditional Primary Medicare Benefits.--Conditional Medicare payments may be made in no fault cases under the following circumstances:

- o The beneficiary has filed a claim with the no fault insurer and the intermediary determines that the insurer will not pay promptly (i.e., within 120 days of receipt of the claim) for any reason except when the no fault insurer claims that its benefits are secondary to Medicare; or
- o The beneficiary, because of physical or mental incapacity, failed to meet a claim filing requirement of the no fault insurer.

When such conditional Medicare payments are made, they are made on condition that the beneficiary reimburses the program to the extent that payment is subsequently made by the no fault insurer. When making such payments, the beneficiary and the insurer are notified by the intermediary of the requirement for repayment. (However, failure to do so does not relieve them of the obligation to refund the payments.)

E. No Fault Insurer Denies That It Is Primary Payer.--If a no fault insurer denies the claim on the basis that Medicare is the primary payer, refer a copy of the claim, the no fault insurer's denial, and any other relevant material to your intermediary for further action.

445.4 No Fault Insurance Does Not Make Full Payments Because of Deductible or Coinsurance Provision in Policy.-- In a number of States, no fault insurers may reduce no fault insurance benefits by deductible or coinsurance amounts or may offer the option for such a reduction. If such contract provisions apply to all policyholders, Medicare pays benefits with respect to otherwise Medicare covered expenses that are not reimbursable under such a no fault contract. Therefore, if a no fault insurer has been billed and has made no payment because of a deductible or coinsurance, or has made only a partial payment (e.g., the insurance deductible has been bridged), you may bill Medicare. If no payment was made under no fault, apply the usual Medicare deductibles and coinsurance in calculating the Medicare secondary payment.

EXAMPLE: The beneficiary receives outpatient hospital services covered by no fault insurance. Total charges are \$200. The no fault insurer is billed but makes no payment because of \$1000 deductible in policy. You bill Medicare for \$200.

445.5 State Law or Contract Provides That No Fault Insurance Is Secondary To Other Insurance.-- Even though State laws or insurance contracts specify that benefits paid under their provisions are secondary to any other source of payment or limit a portion of their benefits to payments only when all other sources of health insurance are exhausted, Medicare does not make payment when benefits are otherwise available. For example, a State provides \$2,000 in no fault benefits for medical expenses and an additional \$6,000 in no fault benefits are available but only after the claimant has exhausted all other health insurance. In such cases, the Medicare law has precedence over State laws and private contracts. Medicare only makes secondary payments after the total no-fault benefits are exhausted.

445.6 Provider And Beneficiary's Responsibility With Respect To No Fault Insurance.--The provider and the beneficiary (or representative) are responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under no fault insurance. Therefore, unless conditional payments can be made under §445.3D, Medicare payments are not made until you or the beneficiary has exhausted the entire claims process under no fault insurance. Conditional benefits are not payable if payment cannot be made under no fault insurance because the provider or the beneficiary failed to file a proper claim. (See §445.1.) When failure to file a proper claim is due to mental or physical incapacity of the beneficiary and the provider could not have known that a no fault claim was involved, this rule does not apply.

445.7 Private Right of Action.--Any beneficiary has the right to take legal action against the responsible entity that fails to pay primary benefits, and can collect double damages. If such litigation is successful, the Medicare program can recover the amount paid by Medicare. Under the law, the Medicare program also has the right to take legal action and collect double damages.

Liability Insurance

446. SERVICES REIMBURSABLE UNDER LIABILITY INSURANCE

446.1 General.--Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly for the items or services under a liability insurance policy or plan (including a self insured plan). (If Medicare payments have been made but should not have been because the services are excluded under this provision or if the payments were made on a conditional basis in accordance with §446.3B, they are subject to recovery.)

If a Medicare beneficiary has filed or plans to file a liability claim against a party that allegedly caused an injury or illness, Medicare may not pay for services related to that injury or illness (if they are otherwise covered), unless payment by a liability insurer is not made promptly (i.e., within 120 days). Since liability claims are usually not settled or adjudicated until after protracted negotiations and possible litigation, payment by a liability insurer generally cannot be expected promptly merely because a beneficiary has filed a liability claim. However, Medicare payment is conditioned on recovery from the beneficiary if the beneficiary later receives a judgment on (or settlement of) the claim which results in payment by a liability insurer or by a self-insured party.

A. Effective Dates.--The general rule is that these provisions are effective for services related to injuries which occurred on or after December 5, 1980. (In the case of a liability claim based on illness rather than trauma, these provisions are effective for services furnished on or after December 5, 1980, unless the liability award or settlement specifies that the illness was caused solely by an occurrence or activity that took place before December 5, 1980.) The specific application of the general rule when a liability (including automobile liability) insurance claim is filed is as follows:

1. Liability Payment Made.--
(a) Denial of Medicare payment; or
(b) Recovery of Medicare payment for services rendered up to the date of the liability payment (but not if the beneficiary received the liability payment before June 6, 1983).

2. Liability Payment Not Made.--
(a) Conditional Medicare payment; and
(b) Recovery of Medicare payment (but not if the beneficiary receives liability payment before June 6, 1983).

B. Effect on Deductibles.--Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made promptly under liability insurance are counted toward the applicable deductible amounts.

NOTE: No deductible is applicable to expenses for FQHC services furnished by FQHCs.

446.2 Definitions.--

A. Automobile.--This is a self-propelled land vehicle of a type that must be registered and licensed in the State where it is owned.

B. Liability Insurance.--This is insurance (including a self insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, payments under the Federal Tort Claims Act, automobile liability insurance, uninsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. This exclusion does not apply when the homeowner receives payment under his or her own homeowners insurance policy since such a payment does not constitute a liability insurance payment.

C. Self-Insured Plan.--This is a plan under which an entity (or an individual) carries its own risk instead of insuring itself with a carrier.

D. Uninsured Motorist Insurance.--This is insurance under which the policy holder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law or is underinsured.

E. Accident.--This is any occurrence or activity that the individual believes resulted in injury or illness for which he or she holds another party liable.

446.3 Provider Actions.--

A. Information Obtained from Patient/Representative at Time of Start of Care, or From Hospital or SNF.--Ask the Medicare patient, or the patient's representative, at the time of start of care, if the services are for treatment of an injury or illness which resulted from an automobile or other accident or for which he or she otherwise holds another party responsible. If the services are for treatment of an automobile accident, ask the beneficiary for the name and address of any automobile medical, no fault or liability insurance company which may be responsible for payment of medical expenses which resulted from the accident. Some or all of this information may be available from the hospital or SNF when a beneficiary inpatient stay preceded RHC services.

B. Billing When Services Are Related to an Automobile Accident.--In the following circumstances, annotate the billing form in accordance with the applicable instructions in §635:

1. If you have evidence establishing that the services are not covered under the individual's automobile medical or no fault insurance, e.g., the individual's automobile insurance coverage expired, bill Medicare. The intermediary may contact the beneficiary about possible liability coverage.

2. If expenses are covered under automobile medical or no fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, bill Medicare for otherwise covered expenses not covered by the automobile medical or no fault insurance and not paid for by a liability insurer. For example, an individual incurs \$20,000 in medical expenses due to an automobile accident. The individual receives \$5,000 in reimbursement from an automobile insurer and also has a liability claim pending against the driver of the other car. Medicare does not pay benefits for the \$5,000 in expenses paid for by the automobile insurer but pays benefits based on the additional \$15,000 in expenses (provided the liability insurer has not paid promptly), subject to recovery when the liability claim is paid.

C. Billing When Services Are Related to an Accident Other Than an Automobile Accident.--If you learn that otherwise covered services are related to an accident that was not an automobile accident, bill Medicare to the extent that the services have not been paid for promptly by a liability insurer and annotate the bill in accordance with §635. The intermediary may contact the beneficiary about possible liability coverage. (If a liability insurer is willing to pay for the services, you may bill the insurer instead of Medicare.)

D. Request From Insurance Company or Attorney.--Notify the intermediary promptly if you receive (from an attorney or insurance company) a request for a copy of a medical record or bill concerning a Medicare patient. Send the intermediary a copy of the request or, if it is unavailable, full details of the

request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and the date(s) of services for which you have billed or will bill Medicare. Follow the usual rules on release of information in responding to such requests.

E. Provider Receives Duplicate Payment.--Refund the excess Medicare payment by submitting an adjustment bill within 60 days if you receive duplicate payments from a no fault insurer and from Medicare, regardless of which payment you received first and even if you refunded the insurance payment to the beneficiary or the insurer. If you received Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

If you have received payment from Medicare, and the beneficiary received an automobile or liability insurance payment through you or directly from the insurer, the beneficiary is required to refund the Medicare payment up to the amount of the insurance payment, but not if he or she received the insurance payment before June 6, 1983.

446.4 Automobile or Liability Insurer Pays in Part for Services.--If a no fault insurer pays for Medicare covered services an amount which is less than your charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the no fault insurer) and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made.

The Medicare secondary payment is the lower of:

- o The gross amount payable by Medicare minus the amount paid by the no fault insurer for Medicare covered services;
- o The gross amount payable by Medicare minus any applicable Medicare deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges) minus the amount payable by the no fault payer; or
- o Your charges (or the amount you are obligated to accept as payment in full if that is less than the charges) minus the applicable Medicare deductible and coinsurance amounts.

NOTE: The gross amount payable by Medicare is (1) the current Medicare interim payment amount (as defined in §638) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible and coinsurance or the payment by the no fault insurer.

447. LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS SOLELY ON BASIS OF END STAGE RENAL DISEASE WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

447.1 General.--Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) in the case of individuals entitled to benefits solely on the basis of end stage renal disease (ESRD) during a period of up to 18 months. (See §§447.4 and 447.5.) Medicare is secondary during this period even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare's or otherwise excludes or limits its payments to Medicare beneficiaries.

Under this provision, RHCs/FQHCs must bill the EGHP first for services rendered on or after January 21, 1988. Medicare secondary benefits are payable in accordance with §447.9 if:

- o The gross amount payable by Medicare minus the amount paid by the no fault insurer for Medicare covered services;
- o The gross amount payable by Medicare minus any applicable Medicare deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the no fault payer; or
- o Your charges (or the amount you are obligated to accept as payment in full if that is less than the charges) minus the applicable Medicare deductible and coinsurance amounts.

This provision applies to all Medicare covered items and services furnished to beneficiaries who are in an 18-month period. It includes services for non-ESRD treatment. Consider the possible application of this limitation when processing claims for items or services furnished to ESRD beneficiaries who are in their first 18 months of entitlement.

NOTE: These instructions do not apply to beneficiaries entitled to Medicare because of age 65 or disability.

447.2 Definitions.--

A. Employer.--The term "employer" means, not only individuals and organizations engaged in a trade or business, but organizations exempt from income tax, i.e., religious, charitable, and educational institutions as well as the governments of the United States, the States, Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands and the District of Columbia, as well as their agencies, instrumentalities and political subdivisions. For purposes of the ESRD secondary payer provision, the term "employer" is defined without regard to the number of employees.

B. Employer Group Health Plan or Employer Plan.--This refers to any health plan that is of, or contributed to by, an employer and that provides medical care, directly or through other methods such as insurance or reimbursement, to current employees, former employees, and/or their families. It includes the Federal Employees Health Benefits (FEHB) program but not the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Employee pay all plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the employer, also meet the definition of EGHP. Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the current or former employment of the beneficiary or of a member of the beneficiary's family meets this definition.

C. Secondary--The term "secondary," when used with respect to Medicare payment, means that Medicare is the residual payer to all employer group health plans under which the Medicare beneficiary is covered. Medicare does not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation exclusion (see §443) and no fault and liability insurance provisions (see §§445 and 446) in determining the extent of Medicare's liability as a residual payer since in some cases there may be a primary insurer in addition to the EGHP. (See §447.8C.)

D. Coordination Period.--The coordination period is a period of up to 18 months (determined in accordance with §§447.4 and 447.5) during which Medicare benefits are secondary to benefits payable under employer group health plans.

447.3 Retroactive Application.--If the intermediary notifies you, or if you learn from other sources that an employer plan may be primary payer for services for which Medicare paid primary benefits, take the following actions:

1. Ascertain whether there is EGHP coverage and, if so, obtain the name and address of the EGHP, if that information is not annotated on the claim,
2. Check your records and ascertain whether Medicare paid primary benefits for other services rendered during a coordination period for which an EGHP may be primary, and
3. Notify the intermediary of the results of your development efforts.

This information is necessary for Medicare to determine its proper payment. If the employer plan pays or has already paid you for all or part of the services, submit a corrected bill to the intermediary within 60 days along with the employer plan's explanation of benefits (EOB). The intermediary recoups from you the amount of Medicare benefits paid in excess of any amount it is obligated to pay as secondary payer.

447.4 Determining Months During Which Medicare May Be Secondary Payer.--Medicare is secondary to EGHPs for items and services furnished during a period of up to 18 consecutive months which begins with the earlier of:

- o The first month in which the individual becomes entitled to benefits under Part A due to ESRD; or
- o The first month in which the individual would have been entitled to benefits due to ESRD if the individual had filed an application for such benefits.

447.5 Effect of Changed Basis for Medicare Entitlement.--If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period terminates with the month before the month in which the change is effective.

447.6 Subsequent Periods of ESRD Entitlement.--If an individual has more than one period of entitlement based solely on ESRD, a coordination period is determined for each period of entitlement in accordance with §§447.4 and 447.5.

447.7 Identification of Cases in Which Medicare May Be Secondary to Employer Group Health Plans.--Investigate cases in which information available to you (e.g., the beneficiary's Medicare card) indicates that the beneficiary is entitled to Medicare based on ESRD for 18 months or less at the time the services were rendered to ascertain whether the services were rendered during the 18-month period described in §§447.4 and 447.5. Determine whether the services were rendered in the 18-month period by checking your own records or, if the potential Medicare payment is \$50 or more, by consulting with other providers or facilities. If necessary, contact the beneficiary's physician to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant). If the individual is in the 18-month period, ask the beneficiary if he/she is insured under any health insurance plan providing coverage through the employer or union. If the response is yes, ask for the name and address of the plan and the beneficiary's identification number.

If the information you obtain does not indicate EGHP coverage but Medicare was the secondary payer on a previous claim based on ESRD, verify the absence of EGHP coverage by inquiring of the beneficiary or the beneficiary's representative. If you verify the absence of EGHP coverage, annotate the bill to that effect (e.g., EGHP coverage lapsed, benefits exhausted). If the information you obtain indicates that EGHP coverage exists, obtain the information cited above from the beneficiary or the beneficiary's representative.

447.8 Billing.--

A. General.--If you determine, based on your development, that Medicare may be secondary to an employer plan, you must bill the EGHP for primary benefits.

B. Billing Medicare for Primary Benefits.--Bill Medicare for primary benefits only if:

- o The services were not rendered during a coordination period,
- o The EGHP denies a claim because the beneficiary is not entitled to any benefits under the plan,
- o Benefits under the plan are exhausted for the particular services, or
- o The services are not covered by the EGHP.

If you believe that an EGHP is primary payer, ascertain whether primary EGHP benefits are payable. If so, bill the EGHP for primary benefits. If an EGHP has denied your claim for primary benefits, annotate item 94 "Remarks" of the Medicare claim form with the reason for the denial of EGHP primary benefits and enter occurrence code 24 and date of denial in items 28 through 32. No attachment is needed. However, do not bill Medicare if the reason for the EGHP denial is that the EGHP offers only secondary coverage of services covered by Medicare. Medicare primary benefits may not be paid in this situation even if the EGHP has only collected premiums for secondary rather than primary coverage.

C. Billing Medicare for Secondary Benefits.--Medicare secondary payments may be made in accordance with §447.10 if an EGHP payment for Medicare covered services is:

- o An amount which is less than your charges and
- o Less than the gross amount payable by Medicare (as defined in section 447.10) in the absence of EGHP payment, and
- o You do not accept and are not obligated to accept the plan payment as payment in full.

Prepare the bill in accordance with §636.

There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual covered under an EGHP as well as a spouse's EGHP or an automobile insurance policy. In such cases, the other primary payers customarily coordinate benefits. If a portion of the Medicare gross amount payable remains unpaid after the other insurers have paid primary payments, a secondary Medicare payment may be made.

D. Intermediary Recovery of Primary Benefits.--If primary Medicare benefits are paid to a RHC/FQHC and the intermediary learns that an EGHP should have paid primary benefits for the items and services, the intermediary either recovers directly from the EGHP or from the RHC/FQHC. When recovering from a RHC/FQHC, the intermediary instructs you to file a claim with the EGHP for primary benefits, and upon receipt of the EGHP payment, refund to Medicare the amount Medicare paid less the amount received from the EGHP. After the intermediary instructs you to file a claim for primary benefits with an EGHP, the intermediary follows up with you in 45 days to ascertain whether a claim

has been filed and whether payment has been made by the EGHP. If you do not file a claim for primary benefits within 30 days after you have been instructed to do so, the intermediary recovers the Medicare primary payment from you except if you do not file a claim with the EGHP because the beneficiary declines to sign the claims form. In that case, the intermediary recovers the overpayment directly from the EGHP.

Upon receipt of the EGHP refund, submit an adjustment bill showing the revised Medicare liability. When you receive an EGHP refund, credit amounts paid by the EGHP toward the deductible and coinsurance to the beneficiary's account or return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. You may retain any excess EGHP payment over the gross amount payable by Medicare. (See §447.10)

If duplicate payment was or will be made to you, i.e., you received or expect to receive both primary EGHP payments and primary Medicare benefits, the intermediary recovers from you the Medicare overpayment (the difference between the Medicare primary payment and the amount Medicare should have paid as secondary payer). If Medicare paid you and the EGHP paid the beneficiary, the beneficiary is liable.

If the intermediary has not received an adjustment bill within 120 days of notifying you to file a claim with the EGHP, the intermediary follows up to determine the status of the claim. If the EGHP has denied the claim for a reason the intermediary would find acceptable had the intermediary requested payment from the EGHP directly, the recovery action may be cancelled. If the EGHP has denied the claim for any other reason or has not responded to your claim, the intermediary attempts to recover from the EGHP. Advise the intermediary immediately if you receive payment from the EGHP.

E. Recovery When a State Medicaid Agency Has Also Requested a Refund.--When both Medicare and Medicaid have paid you benefits and you recover an amount from an EGHP, you are obligated to refund the Medicare payment up to the full amount of the EGHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim do you have the right to reimburse Medicaid or any other entity.

447.9 Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays in Part for Items and Services.--If an EGHP pays for Medicare covered services an amount which is less than your charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the EGHP) and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made.

The Medicare secondary payment is the lower of:

- o The gross amount payable by Medicare minus the amount paid by the EGHP for Medicare covered services;
- o The gross amount payable by Medicare minus any applicable Medicare deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the EGHP; or
- o Your charges (or the amount you are obligated to accept as payment in full if that is less than the charges) minus the applicable Medicare deductible and coinsurance amounts.

NOTE: The gross amount payable by Medicare is the current Medicare interim reimbursement amount (as defined in §638) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible or coinsurance or the payment by the EGHP.

For detailed billing and reimbursement instructions, see §636.

447.10 Employer Group Health Plan Pays in Full.--If an employer plan payment for Medicare covered services equals or exceeds your charges or the gross amount payable by Medicare for the services in the absence of employer plan coverage, or if you accept or are obligated to accept the plan payment as payment in full, no Medicare payment is due. Any excess of the employer plan payment over the gross amount payable by Medicare is not be subtracted from your Medicare payment. When appropriate, submit a no payment bill in accordance with §636.

447.11 Effect of EGHP Payments On Deductible and Coinsurance.--Expenses that would be credited to a beneficiary's Part B cash or blood deductibles if Medicare were primary payer are credited to the deductibles even if the expenses are reimbursed by an EGHP. This is true even if the EGHP paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments to an RHC/FQHC are applied to a beneficiary's Part B coinsurance. However, EGHP payments are credited to the deductible before being used to satisfy the coinsurance. (See §636.) However, the deductible is not applicable to expenses incurred for items and services provided by the FQHC.

447.12 Limitation on Right of a Rural Health Clinic or Federally Qualified Health Center to Charge Beneficiary.--An RHC/FQHC that receives direct payment from the Medicare program may not charge a beneficiary or any other party (other than an insurer that is primary under §1862(b) of the Act) for Medicare covered services, if the RHC/FQHC has been or may be paid by an employer plan an amount at least equal to any applicable deductible or coinsurance amount. This limitation applies to situations where an insurer is primary under §1862(b) of the Act but offers only secondary benefits.

EXAMPLE: Outpatient services were furnished to a Medicare beneficiary for which covered charges were \$190. No part of the beneficiary's \$100 Part B deductible had been met previously. An EGHP paid \$155 for the Medicare covered services. The current Medicare interim payment amount (without regard to Medicare deductible and coinsurance amounts) for these services at 80 percent of the all-inclusive rate is \$144 ($\$60 \text{ rate} \times 3 \text{ visits} = \180 , $80\% \text{ of } \$180 = \144). Medicare makes no payment since the EGHP payment (\$155) was greater than Medicare's interim payment amount of \$144. The RHC/FQHC may not charge the beneficiary for the \$45 difference between its charges and the EGHP payment since the beneficiary's obligation (\$96 for the Medicare deductible (in the case of charges for RHC services or non-FQHC and coinsurance*) was met by the EGHP payment.

* The coinsurance is calculated as follows:

\$180 charges minus \$100 deductible = \$80.

\$80 X 20 percent = \$16 coinsurance.

The beneficiary's obligation of \$96 is met by the EGHP payment of \$155.

447.13 EGHP Erroneously Pays Primary Benefits.--If you determine that an EGHP has inappropriately paid primary benefits, bill Medicare as primary payer and refund to the EGHP the amount it paid, less an amount equivalent to Medicare the deductible and coinsurance, and charges for noncovered services.

447.14 Claimant's Right to Take Legal Action Against EGHP.--The OBRA of 1986 provides that any claimant has the right to take legal action against, and to collect double damages from, an EGHP that fails to pay primary benefits for services covered by the EGHP when required to do so under §1862(b) of the Act. Under OBRA 1989, the Medicare program also has the right to take legal action and collect double damages.

447.15 You Receive Duplicate Payments.--Refund the excess Medicare payment by submitting an adjustment bill within 60 days if you receive duplicate payments from an EGHP and from Medicare, regardless of which payment you received first and even if you refunded the insurance payment to the beneficiary or the insurer. If you receive Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

Limitation on Payment for Services to Employed Aged

Beneficiaries and Spouses

448. LIMITATION ON PAYMENT FOR SERVICES TO EMPLOYED AGED AND AGED SPOUSES OF EMPLOYEES COVERED BY EMPLOYER GROUP HEALTH PLANS

448.1 General.--Medicare benefits are secondary to benefits payable under employer group health plans (EGHPs) for employed individuals age 65 or over and the spouses age 65 or over of employed individuals of any age. Section 448.3 further defines individuals subject to this limitation on payment.

If primary Medicare benefits have been paid for services furnished on or after January 1, 1983 to an individual who meets the criteria in §448.3, recover the excess Medicare payment in accordance with §448.12. Billing instructions are in §637.

If an EGHP pays for Medicare covered services an amount which is less than your charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the EGHP) and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made.

The Medicare secondary payment is the lower of:

- o The gross amount payable by Medicare minus the amount paid by the EGHP for Medicare covered services;
- o The gross amount payable by Medicare minus any applicable Medicare deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the EGHP; or
- o Your charges (of the amount you are obligated to accept as payment in full if that is less than the charges), minus the applicable Medicare deductible and coinsurance amounts.

NOTE: The gross amount payable by Medicare is the current Medicare interim payment amount (as defined in §638) for services paid on a reasonable cost basis without considering the effect of the Medicare deductible and coinsurance or the payment by the EGHP.

Employers (as defined in §448.2A) are required to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare. From January 1, 1985 through April 30, 1986, employers were required to furnish such coverage to their age 65 - 69 employees and to the age 65 - 69 spouses of employees of any age through age 69. From January 1, 1983 through December 31, 1984, employers were required to offer primary EGHP coverage to their employees age 65 - 69 and to the spouses age 65 - 69 of such employees.

Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as the primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouses secondary coverage of items and services covered by Medicare.

When an EGHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid as prescribed in §448.11 to supplement the amount paid by the EGHP for Medicare covered services. If an EGHP denies payment for particular services because they are not covered by the plan, primary Medicare benefits may be paid for them if covered by Medicare.

An EGHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on the Medicare intermediary. Medicare continues to evaluate claims under existing guidelines derived from the law and regulations to assure that services are in fact covered by the program regardless of employer plan involvement.

448.2 Definitions.--

A. Employer.--The term "employer" (as used in these instructions) means not only individuals and organizations engaged in a trade or business, but also includes organizations exempt from income tax, e.g., religious, charitable, and educational institutions. Included are the governments of the United States, the States, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, Puerto Rico and the District of Columbia.

The 20-or-more employees requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. If such an employer does not have 20 or more employees in the preceding year, he is required to offer his employees and spouses age 65 or over primary coverage beginning with the point in time at which the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year even if the number of employees drops below 20 after the employer has met the requirement. The "20 or more employees" requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. If at that time, the employer has met the "20 or more employees" requirement in the current year or in the preceding calendar year, the employer's group health plan is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the employer plan.

Self-employed individuals who participate in the plan are not counted as employees for purposes of determining if the "20 or more employees" requirement is met. There is no requirement that an employer provide coverage to self employed individuals. However, any coverage provided to self-employed persons by an employer of 20 or more employees must be primary to Medicare. Assume for purposes of

the requirement that EGHPs are billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. An employer allegation that the 20-employee requirement is not met or a multiemployer plan's statement identifying specific members as employees of employers of fewer than 20 employees, can be accepted as a basis for making Medicare primary payer.

B. Employed Individual

1. General.--The term "employed individual" as used in these instructions refers not only to employees but to also self-employed persons e.g., directors of corporations and owners of businesses. A self employed individual is considered "employed" during a particular tax year only if, during the preceding tax year, the individual's net earnings, from work related to the employer that offers the group health coverage, are at least equal to the amount specified in §211(b)(2) of the Act, which defines "self-employment income" for social security purposes. That amount is \$400. If a self-employed individual enrolls in an EGHP which meets the definition in Subsection C, the employer plan is primary for that individual and the individual's spouse.

2. Individuals Who Receive Disability Payments.--A person receiving disability payments from an employer is considered employed if such payments are subject to taxes under the Federal Insurance Contributions Act (FICA). Employer disability payments are subject to FICA tax for the first 6 months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE: Adam Green stopped working because of disability in December 1985 at age 66. His employer began paying him disability payments as of January 1986. Since sick pay is taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 1986. Beginning with July 1986, Medicare becomes the primary payer as the sick payments are no longer be considered wages under FICA.

C. Employer Group Health Plan or Employer Plan (EGHP).--This refers to any health plan that is of, or contributed to by, an employer of 20 or more employees and which provides medical care, directly or through other methods, e.g., insurance or reimbursement, to current employees, former employees, or current or former employees and their families. This includes a multiemployer group health plan that has at least one employer with 20 or more employees. These plans may identify members who are employees of employers with fewer than 20 employees. Such members and their spouses are considered not to meet the conditions in §448.3.

The Federal Employees Health Benefits program meets this definition of an EGHP. Employee pay all plans, i.e., group health plans under the auspices of an employer which do not receive any contribution from the employer, also meet the definition of EGHP.

Assume, in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the beneficiary's or the spouse's employment meets this definition.

NOTE: Medicare is secondary to EGHP coverage only if the EGHP coverage is by reason of the employee's current employment. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. (See §448.4.)

D. Secondary.--For purposes of this instruction, the term "secondary," when used with respect to Medicare payment, means that Medicare is the residual payer to all EGHPs under which the Medicare beneficiary is covered by reason of current employment and will not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation, no fault and liability insurance secondary payment provisions (§§445 and 446) in appropriate cases in determining the extent of Medicare's liability.

Also see §448.7C regarding claims in which there is an EGHP and another primary and/or secondary payer involved, e.g., an EGHP, a no fault insurer and a retirement plan.

E. Age 65 through 69.--This is a period beginning with the first day of the month in which an individual attains age 65 and ending with:

- o For services furnished on or after July 18, 1984, the last day of the month before the month the individual attains age 70, or
- o For services furnished before July 18, 1984, the last day of the month in which the individual attains age 70.

An individual attains a particular age on the day preceding his or her birthday.

448.3 Individuals Subject to Limitation on Payment.--

A. General.--Medicare is secondary payer for Part A and Part B benefits under this provision for an individual who:

1. For services on or after May 1, 1986, is age 65 or over; for services before May 1, 1986, is age 65 through 69; and
2. Is entitled to Part A (hospital insurance) of Medicare on the basis of the individual's own social security or railroad retirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person, and
3. Is either:
 - o Employed and covered by reason of that employment by an EGHP; or
 - o The spouse of an employed person covered by an EGHP by reason of that person's employment and the employed person is:
 - For services on or after May 1, 1986, any age;
 - For services on or after January 1, 1985 through April 30, 1986, any age through 69; or
 - For services on or after January 1, 1983 through December 31, 1984, age 65 - 69.

B. Reemployed Retirees and Annuitants.--If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that he/she furnishes to other employees (i.e., non retirees). Medicare is secondary payer to the EGHP that the employer provides to the reemployed retiree even if the premiums for coverage in the plan are paid from a retirement pension or fund. Medicare is also secondary payer for consultants who are former employees if the employer provides coverage for other such consultants.

448.4 Individuals Not Subject to Limitation on Payment.--This Medicare secondary provision does not apply to:

- o Individuals entitled, or who could upon application become entitled, to Medicare under the ESRD provisions, i.e., individuals who meet the requirements for ESRD entitlement even though their current Medicare entitlement may be on the basis of age 65. (See §447 for secondary Medicare payment instructions for an ESRD beneficiary under age 65 who has employer group health plan coverage.)
 - o Individuals who are enrolled in Part B only.
 - o Individuals enrolled in Part A on the basis of a monthly premium.
 - o Anyone who is under age 65. (Effective for items and services rendered on or after January 1, 1987 through September 30, 1985, §9319 of OBRA 86 provides that Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.
 - o With respect to services rendered before May 1, 1986, anyone who is over age 69 and age 65-69 spouses of employees over age 69.
 - o Individuals covered by a health plan other than an EGHP as defined above, e.g., a plan that is purchased by the individual privately and not as a member of a group.
 - o Employees of employers of fewer than 20 employees.
 - o Members of multiemployer plans whom the plan identifies as employees of employers with fewer than 20 employees.
 - o Retired beneficiaries (other than spouses of employed individuals) who are covered by EGHPs as a result of past employment and who do not have EGHP coverage as the result of current employment.
 - o Activities of a member of a religious order whose members are required to take a vow of poverty, if those activities are considered employment only because of an election of social security coverage by the order under §3121(r) of the Internal Revenue Code (IRC). This means that Medicare is primary payer to group health coverage provided as a result of those activities, and that those activities are not considered in determining whether a member of the order meets the indicators of employee status. The effective date of this statutory change (see §6202(e) of OBRA 1989) is October 1, 1989.

The exception applies only to religious functionaries who are members of a religious order and who have taken a vow of poverty. It does not apply to Protestant and Jewish clergy who do not take vows of poverty. It does not usually apply to Catholic parish priests, most of whom do not take vows of poverty, neither does it apply to any member of a religious order who has not taken a vow of poverty. Furthermore, the exception does not apply to group health coverage based on work performed by members of religious order for employers outside their orders.

448.5 Identification of Individuals Subject to Limitation on Payment.--In order to ascertain whether to bill an employer plan as primary payer, ask each Medicare beneficiary age 65 or over if he/she is employed and covered by an EGHP. Also inquire as to whether the beneficiary's spouse is employed and age 65 or over and, if so, if the beneficiary is covered under the group health plan of the spouse's employer. If the response is yes to either question, ask the beneficiary for the name and address of the EGHP and the beneficiary's identification number.

If based on the information obtained in response to the questions above, the criteria in §448.3 appear to be met, bill the employer plan first. (See §448.7.) If Medicare is determined to be the primary payer, annotate the Medicare billing form to that effect.

448.6 Identification of Prior Claims That May Involve Employer Plan Payment.-Intermediaries may identify prior claims for services furnished on or after January 1, 1983, to individuals who meet the criteria in §448.3, for which it paid primary benefits. Where such a prior claim is identified, the intermediary instructs you to ascertain from your records whether there is indication that the individual

was employed and, if so, to bill the employer plan identified in the current claim for the prior stay (unless the information available to the intermediary on the prior claim clearly shows why the employer plan is not primary). Submit an adjustment bill per §637 when the employer plan payment is received.

448.7 Action by RHC/FQHC Where Employer Group Health Plan Is Primary Payer.-

A. General.--Seek reimbursement from the EGHP before billing Medicare when there is indication that an EGHP is primary payer, i.e., when the services were rendered to an individual who meets the criteria in §448.3 and there is no evidence that the definitions in §448.2 are not met. The EGHP is billed as primary payer even when there may be EGHP coverage for only part of the stay (e.g., split stays where the beneficiary terminates employment during the stay and EGHP coverage terminated concurrently).

B. Submittal of Bill to Medicare After Employer Plan Has Made Payment.-If an EGHP pays primary benefits to an RHC/FQHC, secondary Medicare benefits may be payable in accordance with §448.11 to supplement the amount paid by the EGHP. If the EGHP primary payment for a particular stay or particular services is less than your charges for Medicare covered services, is less than the gross amount payable by Medicare (as defined in §448.11) and you are not obligated to accept the EGHP payment as payment in full, submit a bill for secondary benefits in accordance with §637. If the EGHP payment equals or exceeds the gross amount payable by Medicare (as defined in §448.11), or equals or exceeds your charges for Medicare covered services or you are obligated to accept the EGHP payment as payment in full, submit a no payment bill in accordance with §637. Any excess of the EGHP payment over the gross amount payable by Medicare is not subtracted from your Medicare reimbursement. If the EGHP denies your claim for primary benefits, submit a claim for primary Medicare benefits or conditional primary benefits as provided for in §448.10.

C. Multiple Insurers.--There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual who meets the criteria in §448.3 is also covered under his/her own EGHP, and under the EGHP of an employed spouse who meets the criteria in §448.3, or under no fault insurance. In such cases, the other primary payers customarily coordinate benefits. If a portion of the Medicare gross amount payable remains unpaid after the other insurers have paid primary payments, a secondary Medicare payment may be made.

Coordination of benefits arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to certain employee group health plans for individuals and spouses age 65 or over. Therefore, if the individual has EGHP coverage based on current employment in addition to EGHP coverage as a retiree, Medicare is secondary to EGHP coverage based on current employment and is primary to the EGHP coverage based on retirement (regardless of the coordination of benefits arrangements between the plans).

448.8 Limitation on Right of RHC/FQHC to Charge Beneficiary.--You may not charge a beneficiary or any other party other than an insurer which is primary under §1862(b) of the Act for Medicare covered services if you have been paid or could have been paid by an EGHP an amount which equals or exceeds any applicable deductible or coinsurance amount. This applies to situations where an insurer is primary under §1862(b) of the Act but offers only secondary benefits. (See example in §637C.)

448.9 Crediting Expenses Toward Deductible and Coinsurance Amounts.--Expenses that serve to meet the beneficiary's Part A or Part B cash or blood deductibles if Medicare were primary payer are credited to those deductibles even if the expenses are reimbursed by an EGHP. This is true even if the EGHP

paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, EGHP payments are credited to deductibles before being used to satisfy the coinsurance. However, the deductible is not applicable to expenses for items and services furnished by an FQHC.

448.10 Employer Plan Denies Claim for Primary Benefits.--

A. Primary Medicare Benefits.--When an employer plan denies a claim for primary benefits for one of the following reasons, submit a claim for Medicare primary benefits unless you have reason to believe that the EGHP is primary payer.

- o The employer does not employ 20 or more employees;
- o The beneficiary is not entitled to benefits under the plan;
- o Benefits under the EGHP are exhausted for the services involved; or
- o The services are not covered by the EGHP.

For example, if the EGHP offers only secondary coverage of services covered by Medicare, and the EGHP does not allege that the employer has fewer than 20 employees, do not bill Medicare. Medicare primary benefits may not be paid in this situation even if the EGHP has only collected premiums for secondary rather than primary coverage.

B. Annotation of Claims Denied by EGHP's.--Whenever an EGHP denies a claim for primary benefits, annotate in item 94 "Remarks" of the Medicare claim form the reason for the denial of EGHP primary benefits and enter occurrence code 24 and date of denial in items 29 - 32. No attachment is needed to the Medicare claim. The annotation is needed to avoid needless recoupment efforts under §448.12.

448.11 Amount of Secondary Medicare Payments Where EGHP Pays in Part for Items and Services.--If an LGHP pays for Medicare covered services an amount which is less than your charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the LGHP and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made.

The Medicare secondary payment is the lower of:

- o The gross amount payable by Medicare minus the amount paid by the LGHP;
- o The gross amount payable by Medicare minus any applicable deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full, in that is less than the charges), minus the amount payable by the LGHP; or
- o Your charges (or the amount you are obligated to accept as payment in full if that is less than the charges), minus the applicable Medicare deductible and coinsurance.

NOTE: The gross amount payable by Medicare is the current Medicare interim payment amount (as defined in §638) for services paid on a reasonable cost basis without considering the effect of the Medicare deductible or coinsurance or the payment by the LGHP.

Detailed reimbursement and billing instructions are in §637.

448.12 Action By Intermediary to Recover Incorrect Payments.--

A. General.--If primary Medicare benefits are paid to an RHC/FQHC and the intermediary learns that an EGHP should have paid primary benefits for the items and services, the intermediary either recovers directly from the EGHP or from the RHC/FQHC. When recovering from an RHC/FQHC, the intermediary instructs you to file a claim with the EGHP for primary benefits. Upon receipt of the EGHP payment, refund to Medicare the amount Medicare paid less the amount received from the EGHP.

B. Recovery From the RHC/FQHC.--After the intermediary instructs you to file a claim for primary benefits with an EGHP, the intermediary follows up with you in 45 days to ascertain whether a claim has been filed and whether payment has been made by the EGHP. If you do not file a claim for primary benefits within 30 days after you have been instructed to do so, the intermediary recovers the Medicare primary payment from you except if you do not file a claim with the EGHP because the beneficiary declines to sign the claims form. In that case, the intermediary recovers the overpayment directly from the EGHP.

Upon receipt of the EGHP refund, submit an adjustment bill showing the revised Medicare liability and utilization. When you receive an EGHP refund, credit amounts paid by the EGHP toward the deductible and coinsurance to the beneficiary's account or return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. You may retain any excess EGHP payment over the gross amount payable by Medicare. (See §448.7B.)

If duplicate payment was or will be made to you, i.e., you received or expect to receive both primary EGHP payments and primary Medicare benefits, the intermediary recovers from you the Medicare overpayment (the difference between the Medicare primary payment and the amount Medicare should have paid as secondary payer). If Medicare paid you and the EGHP paid the beneficiary, the beneficiary is liable.

If the intermediary has not received an adjustment bill within 120 days of notifying you to file a claim with the EGHP, the intermediary follows up to determine the status of the claim. If the EGHP has denied the claim for a reason the intermediary finds acceptable if the intermediary requested payment from the EGHP directly, the recovery action may be cancelled. If the EGHP has denied the claim for any other reason or has not responded to your claim, the intermediary attempts to recover from the EGHP. Advise the intermediary immediately if you receive payment from the EGHP.

C. Recovery When State Medicaid Agency Has Also Requested Refund.--When both Medicare and Medicaid have paid you incorrect benefits and you recover an amount from an EGHP, you are obligated to refund the Medicare payment up to the full amount of the EGHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim do you have the right to reimburse Medicaid or any other entity.

448.13 Advice to Physicians and Beneficiaries.--In your professional and public relations activities, inform physicians and beneficiaries that claims are directed first to the EGHP when there is EGHP coverage for the services involved.

448.14 Incorrect EGHP Primary Payments.--Your intermediary may advise you that an EGHP has incorrectly paid you primary benefits, e.g., primary payments made by the EGHP of an employer of less than 20 employees. In such cases, bill Medicare as primary payer and refund to the EGHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for noncovered services.

448.15 Claimant's Right to Take Legal Action Against EGHP.--OBRA 1986 provides that any claimant has the right to take legal action and to collect double damages from an EGHP that fails to pay primary benefits or fails to make appropriate reimbursement to Medicare for services for which the EGHP is primary payer. Under OBRA 1989, the Medicare program also has the right to take legal action and collect double damages.

448.16 You Receive Duplicate Payments.--Refund the excess Medicare payment by submitting an adjustment bill within 60 days if you receive duplicate payments from a no fault insurer and from Medicare, regardless of which payment you received first and even if you refunded the insurance payment to the beneficiary or the insurer. If you received Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

449. MEDICARE AS SECONDARY PAYER FOR DISABLED INDIVIDUALS

A. General.--Under §1862(b)(4) of the Act, Medicare is secondary payer to large group health plans for active individuals (as defined in subsection C3) under age 65 entitled to Medicare on the basis of disability. Under the law, a large group health plan (LGHP) may not take into account that an "active individual" is eligible for or receives benefits based on disability. The individual's coverage under the LGHP must be based on the individual's employment or the employment of a family member as explained in subsection C4.

A. Apply the instructions in §§448.7 through 448.13 in processing claims where Medicare is secondary payer for disabled individuals. When those sections refer to an EGHP of 20 or more employees, substitute the term "large group health plan," (as defined in subsection C1) for the purpose of applying them to disabled individuals.

B. Effective Date.--This provision is effective for items and services furnished on or after January 1, 1987 and before October 1, 1995. The effective dates are fixed by law.

C. Definitions.--

1. Large Group Health Plan.--A large group health plan is any health plan of, or contributed to by an employer or by, an employee organization (including a self insured plan) that provides health care directly or through other methods, e.g., insurance or reimbursement, to employees or former employees, the employer, others associated, or formerly associated with the employer in a business relationship, or their families. The plan covers employees of at least one employer that normally employed at least 100 full or part time employees on a typical business day during the previous calendar year. The term "employer" for purposes of this provision has the same meaning as the term has for purpose of the working aged provision. (See §448.2A.) It includes the Federal government and other governmental entities. The tax penalty for nonconforming LGHPs does not apply to Federal and other governmental entities. (See subsection I.)

A group health plan that covers employees of at least one employer that had 100 or more employees on 50% or more of its business days during the preceding calendar year is considered to meet the above definition of LGHP. If the plan is a multiemployer plan, e.g., a union plan, which covers employees of some small employers and also employees of at least one employer that meets the 100 or more employees requirement, Medicare is secondary for all employees enrolled in the plan. This includes

those that work for small employers. This differs from the rule for multiemployer plans under the working aged provision. (See §448.4)

2. Nonconforming Large Group Health Plan.--A nonconforming large group health plan is an LGHP that, at any time during the calendar year, takes into account that an active individual is eligible for or receives benefits based on disability, e.g., an LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with subsection C3.

NOTE: Although the term "large group health plan" includes a plan for former employees or persons formerly associated with the employer in a business relationship (or their families), these individuals are not included within the definition of "active individual" in subsection 3, i.e., Medicare is not secondary for them. These individuals are included within the definition of LGHP for tax purposes. (See the tax penalty described in subsection I.)

3. Active Individuals Subject to This Limitation on Payment.--An active individual is an employee, an employer (e.g., proprietor or partner), a self employed individual (such as the employer), an individual associated with the employer in a business relationship (e.g., suppliers and contractors who do business with the employer and their employees) or a member of the family of any of these persons e.g., the spouse, parent or child of such an individual. Medicare is secondary payer under this provision for active individuals entitled to Medicare based on disability who have coverage under an LGHP.

In some cases, the disabled individual may be the employee, employer, or individual associated with the employer in a business relationship. In other cases, the disabled person may be the family member of the employee, employer, or individual associated with the employer in a business relationship. A disabled person who is not an employee as defined in subsection 4, but who is covered under an LGHP of a spouse, parent, or any other family member, is considered to be an active individual.

4. Employee.--An employee is (1) an individual who is actively working for an employer or (2) since disabled persons are not usually working, a person whose relationship to an employer is indicative of employee status. Whether or not such a person is an employee is established by the unique facts applicable to the person's relationship to the employer. The question to be decided is whether the employer treats a disabled individual who is not working as an employee in light of commonly accepted indicators of employee status rather than whether the person is categorized in any particular way by the employer. In general, an individual who is not actively working may be considered to have employee status if the relationship is such that:

- o The individual is receiving payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA) or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the Internal Revenue Code.
- o The individual is termed an employee under State or Federal law or in accordance with a court decision.
- o The employer pays the same taxes for the individual as he/she pays for actively working employees.
- o The individual continues to accrue vacation time or receives vacation pay.
- o The individual participates in an employer's benefit plan in which only employees may participate.
- o The individual has rights to return to duty if his/her condition improves.
- o The individual continues to accrue sick leave.

D. Individuals Not Subject To This Limitation on Payment.--Medicare is not secondary for:

- o Individuals entitled, or who would upon application be entitled, to Medicare under the ESRD provision, i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability. However, in accordance with §447, Medicare is secondary payer for persons under age 65 with ESRD during a period of up to 18 months regardless of the number of employees.

- o Individuals who are covered by an EGHP of employer(s) of less than 100 employees, unless the EGHP is a multiemployer plan in which there is at least one employer of 100 or more employees. (See subsection C.1.)

- o Individuals whose coverage by an LGHP is not based on either employment or a relationship to an employee, employer, or an individual associated with an employer in a business relationship. For example, Medicare is primary for a disabled individual who is covered under an LGHP as a retired former employee (and who does not meet any of the criteria in subsection C4) or as the spouse of a retired former employee.

- o Activities of a member of a religious order whose members are required to take a vow of poverty, if those activities are considered employment only because of an election of social security coverage by the order under §3121(r) of the Internal Revenue Code (IRC). This means that Medicare is primary payer to group health coverage provided as a result of those activities, and that those activities are not considered in determining whether a member of the order meets the indicators of employee status. The effective date of this statutory change (see §6202(e) of OBRA 1989) is October 1, 1989.

The exception applies only to religious functionaries who are members of a religious order and who have taken a vow of poverty. It does not apply to Protestant and Jewish clergy (who do not take vows of poverty). It does not usually apply to Catholic parish priests, most of whom do not take vows of poverty, neither does it apply to any member of a religious order who has not taken a vow of poverty. Furthermore, the exception does not apply to group health coverage based on work performed by members of religious orders for employers outside their orders. Also, the indicators of employee status remain applicable to employees of religious orders who provide services and are reimbursed by the orders but who are not themselves members of the orders. Medicare is secondary to large group health plan coverage for all such individuals who satisfy the indicators of employee status in this section.

E. Action to Identify Individuals Subject to Limitation on Payment.--Identify individuals who meet the conditions in subsection C3. by asking every Medicare beneficiary under age 65 (1) if the individual is an employee, a self-employed individual, or a member of the family of an employee or self-employed individual and (2) if so, whether the individual has group health coverage through an employer. If the individual responds affirmatively to both questions, request the name and address of the employer plan and the individual's identification number. Bill the plan for primary benefits except if you have information that clearly shows that the employer plan is not primary payer. If the individual responds that he or she does not meet either (1) or (2) above, and you have otherwise determined that the employer plan is not primary payer, bill Medicare for primary benefits and annotate item 57A on Form HCFA-1450, "Medicare."

For audit purposes and to ensure that you have developed for other primary payer coverage, retain a record of the development or other information on which you based the determination that Medicare is primary payer.

F. Medicare Secondary Payments.--If a no fault insurer pays for Medicare covered services an amount which is less than your charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the no fault insurer) and you are

not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made.

The Medicare secondary payment is the lower of:

- o The gross amount payable by Medicare minus the amount paid by the LGHP for Medicare covered services;
- o The gross amount payable by Medicare minus any applicable Medicare deductible and coinsurance amount;
- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the LGHP; or
- o Your charges (or the amount you are obligated to accept as payment in full, if that is less than the charges), minus the applicable Medicare deductible and coinsurance amounts.

NOTE: The gross amount payable by Medicare in the current Medicare interim reimbursement amount (as defined in (§638) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible and coinsurance or the payment by the LGHP.

G. Recovery of Primary Medicare Payments.--Under the law, the government may recover incorrect primary Medicare benefits from any LGHP which is primary payer. To recover Medicare payments the government:

- o May bring legal action against the LGHP and may collect double damages;
- o May take legal action to recover its benefits from any entity that has been paid by the LGHP for items and services furnished an individual who meets the conditions in subsection C3,
- o May join or intervene in any legal action against the LGHP related to the events that gave rise to the need for the items or services; and
- o Is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from an LGHP.

H. Claimants' Right to Take Legal Action Against Large Group Health Plan.--Any claimant (including an individual who received services the provider or supplier) has the right to take legal action against an LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare and to collect double damages.

I. Tax Penalty for Noncompliance.--An excise tax is imposed by §5000 of the Internal Revenue Code (IRC) on any employer or employee organization that contributes to a nonconforming LGHP (see subsection C2.) during a calendar year. The amount of tax is 25% of the total amount that the employer or employee organization contributed to LGHPs during that year. This tax penalty does not apply to Federal and other governmental entities.

J. Identification of Cases and Action When There Is Indication of LGHP Coverage In Prior Claims.--Whenever you determine that an individual's employer plan is primary payer for items or services furnished on or after January 1, 1987, search your records for any prior claims on which Medicare paid primary benefits for services rendered that individual on or after January 1, 1987 for which there has not been a valid prior LGHP denial. When you identify such claims, bill the plan for the prior stays. When the employer plan payment is received, submit an adjustment bill to the intermediary. See §448.12 for further guidance regarding recovery of incorrect Medicare benefits where an employer plan may pay primary benefits if billed.

Intermediaries also seek to identify prior claims for items and services furnished on or after January 1, 1987 to beneficiaries for whom Medicare is secondary in accordance with subsection C.3 and for which Medicare paid primary benefits. When such a prior claim is identified, the intermediary instructs you to bill the employer plan identified in the current claim for the prior stay. Submit an adjustment bill when the employer plan payment is received.

K. You Receive Duplicate Payments.--Refund the excess Medicare payment by submitting an adjustment bill within 60 days if you receive duplicate payments from a no fault insurer and from Medicare, regardless of which payment you receive first and even if you refunded the insurance payment to the beneficiary or the insurer. If you received Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

Rural Health Clinic and Federally Qualified Health Center Manual
Chapter 5 Payment

Table of Contents

500. METHOD OF MEDICARE PAYMENT FOR RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES

501. ALLOWABLE COSTS

 501.1 Costs Excluded From Allowable Costs

502. ALLOWABLE COSTS SUBJECT TO TESTS OF REASONABLENESS

503. SCREENING GUIDELINES OF CLINIC/CENTER HEALTH CARE STAFF PRODUCTIVITY

504. ALL INCLUSIVE RATE OF PAYMENT

 504.1 Determination of Rate

 504.2 Adjustment of Rate

505. MAXIMUM PAYMENT PER VISIT

 505.1 Rural Health Clinics

 505.2 Federally Qualified Health Centers

 505.3 Federally Qualified Health Center Networks

506. DETERMINATION OF TOTAL MEDICARE PAYMENT

 506.1 Payment Reconciliation

 506.2 Notice of Program Reimbursement

 506.3 Recovery of Overpayments

507. REPORTING REQUIREMENTS

508. SUBMISSION OF COST REPORTS

509. EXCEPTION OPTION FOR FEDERALLY FUNDED HEALTH CENTERS AS OF 9/30/91

510. AUDIT

02-94 PAYMENT 501

500. METHOD OF MEDICARE PAYMENT FOR RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES

A. Payment Rate.--Payment to independent rural health clinics (RHCs) and Federally qualified health centers (FQHCs) for covered RHC/FQHC services (as defined in §400) furnished to Medicare patients is made by means of an all- inclusive rate for each visit. Payment is made for covered services provided by an RHC/FQHC physician, physician assistant, nurse practitioner, clinical psychologist, clinical social worker or (if the conditions specified in §412.2 are met) visiting nurse. Payment of pneumococcal and influenza vaccine and their administration is at 100 percent of reasonable cost.

B. Calculation of Medicare Program Payment.--Your interim Medicare payments are based on the all-inclusive rate per visit established by the Medicare intermediary. The rate is paid, subject to the Medicare deductible and coinsurance requirements, for each covered visit with a Medicare beneficiary. No deductible applies to FQHC services provided at FQHCs. Only FQHC services are exempt from the deductible.

C. Determination of Payments.--The payment rate is calculated, in general, by dividing your total allowable cost by the number of total visits for RHC/FQHC services. An interim rate is determined at the beginning of the reporting period on the basis of your estimated allowable costs and estimated visits for RHC/FQHC services. Submit a report of estimated costs and utilization (see §§507-508 for reporting requirements) on the Independent Rural Health Clinic/Freestanding Federally Qualified Health Center Worksheets for Form HCFA-222-92 at the beginning of the reporting period. Also submit any other information as may be required to establish the rate. This rate may be adjusted during the reporting period as provided in §504.2.

At the end of the reporting period, submit a report to your intermediary of your actual allowable costs and actual visits for RHC/FQHC services for the reporting period. Also submit any other information as may be required. (See §§507-508.) After reviewing the report, the intermediary divides your actual allowable costs by the number of actual visits to determine a final rate for the period. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the clinic's productivity, a payment limit, and psychiatric services limit as explained in §§503, 505, and 613.

D. Annual Reconciliation.--At the end of the reporting period, the intermediary determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due to you. (See §506.) Underpayments or overpayments are treated as discussed in §§506.1 and 506.3.

501. ALLOWABLE COSTS

Allowable costs are the costs actually incurred by you which are reasonable in amount and necessary and proper to the efficient delivery of your services.

The allowability of costs is governed by the applicable Medicare principles of reimbursement for provider costs as set forth in 42 CFR 413 and the Provider Reimbursement Manual. These are the general Medicare principles that define allowable costs of hospitals and other facilities paid on a reasonable cost or cost related basis. The lesser of cost or charges principle does not apply to freestanding RHCs and FQHCs.

Typical allowable costs include, to the extent reasonable:

- o Compensation for the services of physicians, physician assistants, nurse practitioners, nurse midwives, specialized nurse practitioners, clinical psychologist, and clinical social workers you employed;
- o Compensation for the duties that a supervising physician is required to perform;
- o Costs of services and supplies incident to the services of a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, clinical psychologist, or clinical social worker;
- o Overhead costs, including RHC/FQHC administration, costs applicable to the use and maintenance of the RHC/FQHC facility, and depreciation costs;
- o The costs of physician services furnished under agreements with you; and
- o If you are located in an area with a shortage of home health agency (HHA) services, the cost of visiting nurse services and related supplies you furnished.

501.1 Costs Excluded From Allowable Costs.--As provided in §500, the all-inclusive rate of payment is used to pay you for Medicare's share of the cost of RHC/FQHC services. The cost incurred by you in furnishing other services is not allowable under Medicare. The following are examples of such other services.

- o Items and services not covered under the Medicare program, e.g., dental services, eyeglasses, and routine examinations. Preventive primary physical examinations targeted to risk are allowable at FQHCs. See chapter IV for more information on the coverage of services; and
- o Items and services which are covered under Part B of Medicare, but are not included in the definition of RHC/FQHC services, e.g., independent laboratory services, durable medical equipment, and ambulance services. Obtain Medicare fee schedule/reasonable charge payment for these covered items or services through the Medicare carrier servicing your area.

502. ALLOWABLE COSTS SUBJECT TO TESTS OF REASONABLENESS

Allowable costs are limited to amounts which are reasonable. HCFA has established screening guidelines which intermediaries use to test the reasonableness of an RHC/FQHC's productivity and a payment limit which the per visit rate may not exceed. These are explained in detail in §§503 and 505. Costs for which screening guidelines have not been established by HCFA are disallowed to the extent the intermediary determines they are unreasonable.

503. SCREENING GUIDELINES OF CLINIC/CENTER HEALTH CARE STAFF PRODUCTIVITY

Payments for your services are subject to guidelines to test the reasonableness of the productivity of your clinic/center's health care staff. These guidelines are applied to your staff for RHC/FQHC services furnished both at your clinic/center's site and in other locations. They are as follows:

- o At least 4,200 visits per year per full time equivalent physician employed by the clinic/center;
- o At least 2,100 visits per year per full time equivalent physician assistant or nurse practitioner employed by the clinic/center; or
- o If staffing levels consist of various combinations of physicians and nurse practitioners or physician assistants, a combined screening approach may be used. For example, if a clinic/center has three physicians and one nurse practitioner, calculate the screening guidelines as follows: $3 \times 4,200 = 12,600$; $1 \times 2,100 = 2,100$ ($12,600 + 2,100 = 14,700$). Another example is a clinic/center with four nonphysician practitioners ($4 \times 2,100 = 8,400$).

The number of full time equivalent employees (FTE) of each type (i.e., physician, physician assistant, or nurse practitioner) is determined by the following formula. Divide the total number of hours per year worked by all employees of that type by the greater of:

- o The number of hours per year for which one employee of that type must be compensated to meet your clinic/center's definition of an FTE. (If your clinic/center is open on a full time basis, the usual definition of an FTE is 2,080 hours per year, 40 hours per week for 52 weeks); or
- o 1,600 hours per year (40 hours per week for 40 weeks).

Intermediaries may waive the productivity guideline in cases in which a clinic/center has demonstrated reasonable justification for not meeting the standard. In these cases in which an exception is granted, the intermediary, no longer restricted by the number of actual visits, sets the number of visits that it determines is reasonable. For example, the guideline number is 4,200 visits, and the clinic/center has only furnished 1,000 visits. The intermediary does not accept the 1,000 visits as reasonable but permits 2,500 visits to be used in the calculation.

504. ALL INCLUSIVE RATE OF PAYMENT

Payments to you 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, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. (See chapter IV for definitions of these personnel.) Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

504.1 Determination of Rate.--If you are in your initial reporting period, the all-inclusive rate is determined on the basis of a budget you submit, which sets forth estimates of the allowable cost to be incurred by the RHC/FQHC during the reporting period and the number of visits for RHC/FQHC services you expect to furnish during the reporting period. Supply this information using Form HCFA-222-92. In determining the payment rate, the intermediary applies screening guidelines and the maximum payment per visit limitation as set forth in §§503, 505.1, and 505.2.

For subsequent reporting periods, your all-inclusive rate is determined, at the discretion of the intermediary, on the basis of a budget or the prior year's actual costs and visits with adjustments to reflect anticipated changes in expenses or utilization.

A. Bad Debts.--RHCs/FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.80. For FQHCs, bad debts are limited to Medicare coinsurance amounts that remain unpaid by the Medicare beneficiary since no deductible is applied to FQHC services. As with RHCs, an FQHC must establish that reasonable efforts were made to collect these coinsurance amounts in order to receive payment for bad debts. When the FQHC waives coinsurance, it may not claim bad debt amounts for which it assumed the beneficiary's liability.

B. Pneumococcal and Influenza Vaccine.--Medicare payment for pneumococcal vaccine and its administration is 100 percent of reasonable cost. For influenza vaccine and its administration provided on or after May 1, 1993, payment is also 100 percent of reasonable cost. The cost for these services is accounted for on the RHC/FQHC cost report and is not subject to the payment limits in §§505.1 and 505.2.

504.2 Adjustment of Rate.--During your reporting period, the intermediary periodically reviews the all-inclusive payment rate to determine if a change in the current rate is needed to reflect variations in costs or the volume of services you furnished from the estimates made when the rate was determined.

Although the intermediary has discretion regarding the frequency of this review, you may request the intermediary to review the rate to determine whether an adjustment is required.

You are required to furnish the intermediary with sufficient cost and utilization information to enable the intermediary to assess the adequacy of the current rate of payment to you. If an adjustment in the payment rate is required, the intermediary makes a lump sum adjustment to total payments already made or adjusts the rate to take into account any excess or deficiency in payments to date.

505. MAXIMUM PAYMENT PER VISIT

505.1 Rural Health Clinics.--Section 1833(f) of the Act establishes the payment limit for RHC services provided from April 1, 1988 through December 31, 1988 at \$46 per visit. For services furnished on or after January 1 of each subsequent year, the RHC payment limit is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physician services. The MEI is defined in §1842(b)(3) and (i)(3) of the Act and 42 CFR 405.504(a)(3). The MEI percentage increase for 1997 is 2.0 percent. The RHC payment limits and the annual adjustments are as follows:

Payment Limit	Annual Adjustment	Period
\$46.00	---	04/01/88 - 12/31/88
\$47.38	3.0%	01/01/89 - 03/31/90
\$49.37	4.2%	04/01/90 - 12/31/90
\$50.36	2.0%	01/01/91 - 12/31/91
\$51.77	2.8%	01/01/92 - 12/31/92
\$53.17	2.7%	01/01/93 - 12/31/93
\$54.39	2.3%	01/01/94 - 12/31/94
\$55.53	2.1%	01/01/95 - 12/31/95
\$56.64	2.0%	01/01/96 - 12/31/96
\$57.77	2.0%	01/01/97 - 12/31/97

Since §1833(f) of the Act provides that each payment limit applies to services provided during a calendar year, it is possible for different payment limits to apply during one reporting period. Medicare visits to which different payment limits apply and the resulting Medicare costs must be separately identified on Form HCFA-222-92.

505.2 Federally Qualified Health Centers.--The FQHC payment methodology includes one urban and one rural payment limit. The payment limit for an FQHC is \$72.39 (urban) and \$62.25 (rural) for covered services provided October 1, 1991 through December 31, 1991.

For services furnished on or after January 1 of each subsequent year, the FQHC payment limit is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physicians services. Additionally, the 1992 through 1996 payment limits include adjustments reflecting the general increase in family practice physician payments resulting from the transition to the physician fee schedule. For services furnished on or after January 1, 1997, the FQHC payment limits have been adjusted to reflect the 1997 increase in the MEI of 2.0 percent.

An FQHC is designated as an urban or rural entity based on the urban and rural definitions in §1886(d)(2)(D) of the Act. If your FQHC is located within a Metropolitan Statistical Area (MSA) or New England County Metropolitan area (NECMA) and can be classified as a large or other urban area as determined by the Bureau of Census, then the urban limit applies. If your FQHC is not in an MSA or NECMA and cannot be classified as a large or other urban area, the rural limit applies. Rural FQHCs cannot be reclassified into an urban area (as determined by the Bureau of Census) for FQHC payment limit purposes.

The 1997 FQHC payment limits reflect 2.0 percent increase over the 1996 FQHC payment limits resulting from application of the 1997 MEI increase of 2.0 percent. The FQHC payment limits and annual adjustments are listed below.

Payment Limit		Annual	Period
Rural	Urban	Adjustment	
\$62.25	\$72.39	---	10/01/91 - 12/31/91
\$63.99	\$74.42	2.8%	01/01/92 - 12/31/92
\$65.72	\$76.43	2.7%	01/01/93 - 12/31/93
\$69.65	\$81.00	5.98%	01/01/94 - 12/31/94
\$72.63	\$84.47	4.28%	01/01/95 - 12/31/95
\$75.60	\$87.93	4.09%	01/01/96 - 12/31/96
\$77.11	\$89.69	2.00%	01/01/97 - 12/31/97

Section 1833(f) of the Act provides that each RHC payment limit applies to services provided during a calendar year. Since the FQHC payment limit application is consistent with §1833(f) of the Act, it is possible for different payment limits to apply during one reporting period. Medicare visits to which different payments limits apply and the resulting Medicare costs must be separately identified on Form HCFA-222-92.

505.3 Federally Qualified Health Center Networks.--An FQHC network consists of a group of two or more FQHCs which are owned, leased, or through any other device, controlled by one organization. FQHCs that are part of networks have the option to file either a single consolidated cost report for the entire network or separate cost reports for each site within the network. See §508.D for a discussion of the consolidated worksheet option.

A. Separate Payment Limits.--If your FQHC network chooses to file individual cost reports for each site, you are paid the lower of your specific all-inclusive rate or your appropriate payment limit. The appropriate payment limit depends on your geographic designation (either urban or rural). The home office must allocate costs that are applicable to individual sites appropriately to each site within the network. These allocations are subject to intermediary review.

B. Consolidated Payment Limit For Networks Having Mixture of Urban and Rural Sites.--If your network includes both urban and rural sites, you are paid the lower of the network all-inclusive rate or a single weighted payment limit calculated for your entire network. The payment limit is weighted by the percentage of urban and rural visits as a percentage of total visits for the entire FQHC network. The urban payment limit is weighted by the percentage of visits attributed to urban sites and the rural payment limit is weighted by the percentage of visits attributed to rural sites.

A weighted calculation based on the 1991 urban limit of \$72.39 and rural limit of \$62.25 is illustrated below. This FQHC network illustration contains 3 urban sites and 2 rural sites.

FQHC Site Limit Adjusted By Percent Of Total Visits

Urban Site #1 25% of total network visits

Urban Site #2 22% of total network visits

Urban Site #3 18% of total network visits

Total Urban
Limit Component $65\% \times \$72.39 = \47.05

Rural Site #1 20% of total network visits

Rural Site #2 15% of total network visits

Total Rural
Limit Component $35\% \times \$62.25 = \21.79

Weighted Network Limit $\$47.05 \text{ (Urban Weight)} + \$21.79 \text{ (Rural Weight)} = \68.84

The 1991 weighted FQHC payment limit for this example is \$68.84. The entire network is paid the lower of the urban/rural network weighted payment limit or the network all-inclusive rate (total costs divided by visits) for each covered visit.

The annual adjustment (as discussed in §505.2) is applied to the urban and rural payment limits prior to the network single weighted payment limit calculation.

C. Consolidated Payment Limit For Networks With All Urban Or All Rural Sites.--If your network includes all urban or all rural sites, you are paid the lower of the network all inclusive rate or the applicable network urban/rural payment limit. The consolidated weighted payment limit calculation is only applicable to networks with a mixture of both urban and rural sites.

506. DETERMINATION OF TOTAL MEDICARE PAYMENT

Within 90 days after the end of your reporting period, you are required to submit to your intermediary a cost report showing the actual costs incurred during the period and the total number of visits for RHC/FQHC services you furnished. You will also show the total cost incurred for pneumococcal vaccine and its administration. Using this information, the intermediary determines the total payment amount due for covered services furnished to Medicare beneficiaries.

506.1 Payment Reconciliation.--The intermediary compares the total payment due you with the total payments made for services furnished during the reporting period. If the total payment due you exceeds the total payments made, you have been underpaid. The underpayment is made up by a lump sum payment.

If the total payment due is less than the total payments made, you have been overpaid for services furnished to Medicare patients. Methods for recovery of overpayment are discussed in §506.3

506.2 Notice of Program Reimbursement.--When the intermediary determines the total reimbursement due and the amount of any overpayment or underpayment, it furnishes you with a written notice of program reimbursement (NPR). The NPR sets out the intermediary's determination of the total payment due you and the amount of any overpayment or underpayment. The notice also advises you of your appeal rights if you disagree with the determination.

506.3 Recovery of Overpayments.--Once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government.

When you receive the NPR stating the amount of the overpayment, immediately make a lump sum refund to the intermediary. If you are unable to make a lump sum refund, work out arrangements with the intermediary for recovery through an extended repayment schedule. Generally, the period of recovery is not to exceed 12 months from the date of the NPR. If, however, you demonstrate that repayment within the 12 month period creates a financial hardship, the period for recoupment may be extended.

507. REPORTING REQUIREMENTS

A. Requirement.--In order to receive payment, maintain and provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. Maintain the cost data on the accrual basis of accounting. However, if you are a government institution which operates on a cash basis of accounting, cost data on this basis is acceptable subject to appropriate treatment of capital expenditures.

If you maintain your records on a cash basis, you need only adjust a relatively few items from the cash basis to an accrual basis at the end of your reporting period to meet the accrual requirement. These adjustments need not be recorded in your formal accounting records. It is acceptable for these adjustments to be made in supplementary records. These adjustments are necessary, for example, if you prepay expenses applicable to future periods, incur expenses in one reporting period which are not paid until the next period, purchase supplies to be used in subsequent periods, or record expenses for capital asset expenditures rather than the allowable depreciation on such assets.

Develop cost information that is current, accurate and in sufficient detail to support payments made for services rendered to Medicare beneficiaries. This includes all ledgers, records and original evidences of cost (e.g., purchase requisitions, purchase orders, vouchers, payroll vouchers) which pertain to the determination of reasonable cost. Maintain financial and statistical records in a consistent manner from one period to another.

B. Definitions.--

1. Accrual Basis of Accounting.--Revenue and expense are identified with specific periods of time (such as a month or year) to which they apply regardless of when revenue is received or disbursement made for expenses.

2. Cash Basis of Accounting.--Revenue and expense are recorded on the books of account when they are received and paid, respectively, without regard to the period to which they apply.

3. Government Institution.--This is an RHC/FQHC owned and operated by a Federal, State or local government agency.

508. SUBMISSION OF COST REPORTS

A. Requirement.--For payment purposes, submit an annual report covering a 12 month period of operations based upon your reporting period. (The first and last reporting periods may be less than 12 months.) Select any annual period for Medicare reporting purposes, but this reporting period is subject to approval by the intermediary. Once you have selected your reporting period and have obtained the approval of the intermediary, adhere to the period initially selected unless a change has been authorized in writing by the intermediary. Such a change is made only after the intermediary has established that the reason for such a change is valid.

B. Exception.--If you do not furnish any covered services to Medicare beneficiaries during the entire cost reporting period, you are not required to file the Medicare cost report. You are required, however, to submit to your intermediary a statement which identifies your reporting period, states that no covered services were rendered during the reporting period to Medicare beneficiaries, and states that no claims for Medicare payment will be filed for this reporting period. The statement is signed by an authorized official of your RHC/FQHC.

C. Filing of Cost Report.--

1. Due Dates.--Cost Reports are required to be filed following the close of your reporting period. The due dates for the cost reports to be filed with the respective servicing intermediary are given below.

o If you continue to participate in the Medicare program, cost reports are due 90 days after the closing date of your selected reporting period unless extension of the due date for filing the cost report is granted by the intermediary. Such an exception does not normally exceed 30 days. Prior to the cost report due date, submit a written request for an extension and the justification for such a request to your servicing intermediary. Your servicing intermediary provides you with a written response to your request for extension.

o If you terminate (voluntarily or involuntarily) participation in the Medicare program, including any changes of ownership, cost reports are due 45 days after the effective date of termination or change of ownership. An extension of the due date is not granted when you terminate or experience a change of ownership.

2. Failure to File Cost Reports Timely.--Failure to submit cost reports within the time frames specified previously may result in a reduction or suspension of payments to you by your intermediary.

3. Failure to File Cost Reports.--Failure to submit cost reports may result in the treatment of all previous payments made during the current reporting period as overpayments.

D. Consolidated Cost Reports.--If you are part of the same organization with one or more RHCs/FQHCs, you may elect to file consolidated worksheets. Under this type of reporting, each RHC/FQHC in the organization need not file individual cost reports. Rather, the group of RHCs/FQHCs may file a single report which accumulates the costs and visits for all RHCs/FQHCs in the organization.

In order to qualify for consolidation reporting, all RHCs/FQHCs in the group must be owned, leased, or through any other device, controlled by one organization.

Make the election to file consolidated worksheets in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, do not revert to individual reporting without the prior approval of the intermediary.

509. EXCEPTION OPTION FOR FEDERALLY FUNDED HEALTH CENTERS AS OF 9/30/91

If you were a Federally funded health center (FFHC) paid on a charge-related-to-cost basis before 9/30/91, you may file a request for an exception to the FQHC payment limits.

A payment adjustment can be made only to the extent the costs are reasonable under Medicare principles of payment, attributed to the circumstances specified below and verified by the intermediary.

A. Basis for Exceptions.--You can file for an exception on one basis only. You must document a disadvantage due to a decrease in revenues as a result of the application of the FQHC payment limit. HCFA's determination on an exception request is based on the center's filing of an FFHC cost report (Form HCFA 242) consistent with the current FFHC payment methodology. The FFHC cost report must be submitted to the FQHC fiscal intermediary within 180 days after the date of the intermediary's initial notice of program reimbursement (NPR).

B. Adjustment Amount.--The amount of the adjustment is calculated based on payments that would have been made using the FFHC methodology and cost report. This amount is based on the lower of your FFHC all-inclusive rate or the applicable FFHC payment limit multiplied by the number of physician encounters consistent with current FFHC payment procedures. FQHCs filing an FFHC cost report must calculate their all-inclusive-rate using Medicare covered FQHC services only. Costs of Medicare part B services not covered under the FQHC benefit are not allowable for all-inclusive- rate determination.

The intermediary adjusts the FFHC payment limits to reflect the FQHC scope of services, i.e., the FFHC payment limit exception will exclude services not covered under the FQHC benefit and include preventive services. The addition of the preventive services and exclusion of non FQHC covered services yields an overall net 2.1 percent increase to the otherwise applicable FFHC payment limit.

C. Time Frame of the Exceptions Option.--This exception option is limited to three cost reporting years ending August 31, 1995. You may include 3 full year cost reports or a combination of 1 partial and 2 full years. A separate exception request must be filed each year. The 8/31/95 fiscal year end date is the last ending date that an FFHC could complete 3 full fiscal years from the start of the benefit.

510. AUDIT

The intermediary is responsible for determining if an audit of your cost report is necessary. The intermediary audits cost reports and records as necessary to assure proper payment.

Rural Health Clinic and Federally Qualified Health Center Manual
Chapter 6 Billing Procedures

Table of Contents

Identifying Medicare Beneficiaries

- 600. HEALTH INSURANCE CARD AND OTHER EVIDENCE OF MEDICARE ENTITLEMENT
- 604. IDENTIFYING HEALTH INSURANCE (HI) CLAIM NUMBERS
 - 604.1 HICNs Assigned by the RRB
 - 604.2 All-Inclusive List of Potentially Valid RRB HICNs
 - 604.3 Change in HICNs
- 605. REDUCTION IN PAYMENT DUE to P.L. 99-177
- 606. PART B DEDUCTIBLE
- 607. PART B COINSURANCE
- 608. DETERMINING HOW MUCH TO CHARGE PATIENT BEFORE BILLING IS SUBMITTED FOR PART B PAYMENT
- 609. CLAIMS PROCESSING JURISDICTION FOR RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS
- 610. FILING A REQUEST FOR PAYMENT
 - 610.1 Billing Forms as Request for Payment
 - 610.2 Time Limitation for Filing Claims

Beneficiary Request for Payment

- 611. EXECUTION OF THE REQUEST FOR PAYMENT
 - 611.1 Request for Payment
 - 611.2. FREQUENCY OF BILLING
- 612. MENTAL HEALTH SERVICES LIMITATION-EXPENSES INCURRED FOR PHYSICIANS', CLINICAL PSYCHOLOGISTS' AND CLINICAL SOCIAL WORKERS' SERVICES RENDERED IN A RURAL HEALTH CLINIC OR FEDERALLY QUALIFIED HEALTH CENTER
- 613. PSYCHIATRIC SERVICES LIMITATION COMPUTATION FOR INDEPENDENT RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS
- 614. BILLING OF PNEUMOCOCCAL PNEUMONIA, INFLUENZA VIRUS AND HEPATITIS B VACCINES BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS
- 620. COMPLETION OF FORM HCFA-1450 BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS
- 621. SPECIAL BILLING INSTRUCTIONS FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)
- 623. BILLING FOR MAMMOGRAPHY SCREENING BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Refunds

- 624. REFUND OF MONEYS INCORRECTLY COLLECTED

- 624.1 Return or Other Disposition of Moneys Incorrectly Collected
- 624.2 Appropriate Time Limits Within Which Clinic/Center Must Dispose of Sums Incorrectly Collected
- 625. CREDIT BALANCE REPORTING REQUIREMENTS -- GENERAL
 - 625.1 Submitting the HCFA-838
 - 625.2 Completing the HCFA-838
 - 625.3 Payment of Amounts Owed Medicare
 - 625.4 Records Supporting HCFA-838
 - 625.5 Provider-Based Home Health Agencies (HHAs)
 - 625.6 Exception for Low Utilization Providers
 - 625.7 Compliance with MSP Regulations
- Protests and Appeals
- 626. CLINIC/CENTER PROTESTS OF PAYMENT DETERMINATION
- 628. BENEFICIARY APPEALS
- 630. REOPENING AND REVISION OF MEDICARE CLAIMS DECISIONS
- Retention of Records
- 632. RETENTION OF HEALTH INSURANCE RECORDS
 - 632.1 Destruction of Health Insurance Records
- Billing Where Medicare Is Secondary Payer
- 634. BILL PREPARATION WHERE SERVICES ARE PAYABLE UNDER WORKERS' COMPENSATION
- 635. BILL PREPARATION WHERE SERVICES ARE PAYABLE UNDER NO-FAULT INSURANCE OR ANY LIABILITY INSURANCE
- 636. BILL PREPARATION WHERE MEDICARE BENEFITS ARE SECONDARY TO EMPLOYER GROUP HEALTH PLANS WHEN INDIVIDUALS ARE ENTITLED TO BENEFITS SOLELY ON THE BASIS OF ESRD
- 637. BILL PREPARATION WHERE MEDICARE BENEFITS ARE SECONDARY TO EMPLOYER GROUP HEALTH PLANS FOR EMPLOYED BENEFICIARIES/SPOUSES AND THE DISABLED
- 638. HOW TO DETERMINE CURRENT MEDICARE INTERIM PAYMENT AMOUNT
- Claims Processing Timeliness Requirements
- 639. CLAIMS PROCESSING TIMELINESS
- 640. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)
- 641. MAMMOGRAPHY QUALITY STANDARDS ACT (MQSA)

11-92 BILLING PROCEDURES 600

Identifying Medicare Beneficiaries

600. HEALTH INSURANCE CARD AND OTHER EVIDENCE OF MEDICARE ENTITLEMENT

You must verify a patient's eligibility in order to process the bill. Obtain this eligibility information directly from the patient or through your intermediary's on-line limited Medicare eligibility data. Contact your intermediary to obtain technical instructions regarding how access may be implemented along with hardware/software compatibility details.

Disclosure of HCFA eligibility data is restricted under the provisions of the Privacy Act of 1974. This information is confidential, and it may be used only for verifying a patient's eligibility to benefits under

the Medicare program. Penalties for misuse include being found guilty of a misdemeanor and paying a fine of not more than \$5,000.

This information does not represent definitive eligibility status. If the individual is not on file, use the usual billing procedure in effect independent of this data access.

The Social Security Administration maintains the records of all persons entitled to health insurance (HI). After entitlement is established, each beneficiary is issued a health insurance card (see §699, Exhibit 1) by the central office of the Social Security Administration (or in some cases, by the Railroad Retirement Board). Use the card in preparing claims for hospital and medical insurance. A health insurance card is acceptable without a signature. However, ask the patient to sign the card if he/she has not already done so. If the patient cannot furnish his/her health insurance card, contact the SSO. If a patient or prospective patient is within 3 months of age 65, or is disabled and has not applied for HI entitlement, advise him/her to contact the SSO, or have someone do so on his/her behalf. Make arrangements with the SSO to routinely bring such cases to its attention.

Several other notices are acceptable in lieu of the HI card. Where the patient has not been issued a HI card and is in need of services, the following notices may be used as evidence of Medicare entitlement.

- o Temporary Notice of Medicare Eligibility.--The SSO may issue a temporary health insurance eligibility notice, pending the issuance of a HI card, when the beneficiary is in need of medical services. Enter the patient's name and claim number from the temporary eligibility notice on the bill; or

- o Certificate of Social Insurance Award.--Health insurance beneficiaries receive a Certificate of Social Insurance Award, showing the HI claim number, dates of entitlement to Part A and/or Part B benefits, and the following statement:

"This notice may be used if Medicare services are needed before you receive your health insurance card."

The HI claim number on these notices or the card is essential in locating the patient's record when a claim for benefit payment is made. Do not forward a billing form without the correct claim number. The claim cannot be processed if the number is missing or incorrect.

If the patient cannot furnish his/her health insurance card, or other notice, as described above, he/she may have a utilization notice or explanation of benefits which shows his/her claim number. Such notices are sent to the beneficiary by HCFA, the intermediary, or the carrier after payments are made under Part A or Part B. These notices, if current, may also indicate to the clinic the patient's deductible status under Part B.

Ask each patient for his/her HI card (or other notice) to determine health insurance entitlement status and to obtain the correct HI claim number. If a patient who appears to be eligible for Medicare (See 100 Chapter) has not yet applied for health insurance entitlement, advise him/her or someone acting on his/her behalf, to contact the nearest social security office (SSO). The SSO can also help a beneficiary replace a lost health insurance card.

604. IDENTIFYING HEALTH INSURANCE (HI) CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter, or letter and numeral suffix, e.g., 000-00-0000A. They may also be 6 or 9 digit numbers with lettered prefixes, e.g., A-000-00-0000 or WD-000000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

The potentially valid health insurance claim number assigned by SSA is a 9-digit number followed by one of the following suffixes:

A, B, B1, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ C1, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, etc.
D, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA, DD, DG, DH, DJ, DK, DL, DN, DP, DQ, DR, DT, DV, DW, DY E, E1, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM F1, F2, F3, F4, F5, F6, F7, F8 HB, HB1, HB2, HB3, HB4, HB5, HB6, HB9 HCl, HC2, HC3, HC4, HC5, HC6, HC7, HC8, HC9 J1, J2, J3, J4, (See Note 1) K1, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM (See Note 1) W, W1, W2, W3, W4, W5, W6, W7, W8, W9, WB, WC, WF, WG, WJ M, M1, and T (See Note 2)

NOTE No. 1: Supplementary medical insurance entitlement may exist for all J and K suffixes. However, for subscripts J3, J4, K3, K4, K7, K8, KB, KC, KF, KG, KL, and KM, entitlement to hospital insurance benefits is possible only when the beneficiary is a qualified uninsured individual who secures coverage on a voluntary basis under the 1972 amendments.

NOTE No. 2: Suffix T indicates the individual is entitled to hospital or hospital and medical insurance and is not entitled to monthly social security benefits.

Suffix M indicates that the individual is entitled to supplementary medical insurance benefits. The individual may also be entitled to hospital insurance benefits but only as an uninsured individual who has voluntarily secured coverage under the 1972 amendments.

Suffix M1 indicates the individual is entitled to supplementary medical insurance benefits and has refused hospital insurance benefits.

604.1 HICNs Assigned by the RRB.--The RRB began using the SSN in its numbering system during 1964. The numbers assigned prior to that time are 6-digit numbers; these were assigned in numerical sequence and have no special characteristics. However, both those 6-digit numbers and the 9-digit SSN, when used as claim numbers by the RRB, always have letter prefixes. (In rare cases, where a qualified railroad retirement beneficiary may have a claim number with less than 6-digits, add sufficient zeros between the prefix and other digits to make a 6-digit number, e.g., WD-001234.)

604.2 All-Inclusive List of Potentially Valid RRB HICNs.--*

A-000000 or	PA-000000,or
A-000-00-0000	PA-000-00-0000
MA-000000,or	PD-000000, or
MA-000-00-0000	PD-000-00-0000
WA-000000,or	H-000000
WA-000-00-0000	MH-000000
WD-000000, or WD-000-00-0000	
	WH-000000

CA-000000, or
CA-000-00-0000
WCA-000000, or WCA-000-00-0000
WCD-000000, or WCD-000-00-0000

WCH-000000
PH-000000
JA-000000

*Zeros show the number of digits

604.3 Change in HICNs.--Changes in an individual's entitlement to social security or railroad retirement benefits may result in assignment of a different suffix or of a completely different HICN; e.g., an individual not entitled to monthly benefits (000-00-0000T) marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B).

605. REDUCTION IN PAYMENT DUE to P.L. 99-177

A. General.--Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings), provides for an automatic deficit reduction procedure to be established for Federal FYs 1986 through 1991.

Each payment amount is reduced by a specified percentage which cannot exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration takes place. The reduction percentages are proportionately decreased in any year in which the excess deficit is small enough to permit a smaller reduction.

The intermediary reduces all Medicare program payments after applying deductible, coinsurance, and any applicable MSP adjustments. It reduces each claim or interim payment (including PIP).

B. Definitions.--

Date of Service: The intermediary applies the reduction for all RHC services based upon the through date on the bill. You may bill earlier services separately to avoid the reduction.

Reduction Amount: The applicable reduction percentages by FY are:

- o Federal FY 1986 - 1 percent for all services (Part A and Part B) for the period March 1, 1986 through September 30, 1986.
- o Federal FY 1987 - There is no sequestration order for this period.
- o Federal FY 1988 - 2.324 percent as follows:
 - November 21, 1987 through March 31, 1988, for all Part A inpatient hospital services and all items and services (other than physicians' services) under Part B.
 - November 21, 1987 through December 31, 1987, all other Part A services.
- o Federal FY 1989 - There is no sequestration order for this period.
- o Federal FY 1990 -
 - 2.092 percent from October 17, 1989 through December 31, 1989, for items and services under Part A.
 - 2.092 percent from October 17, 1989 through March 31, 1990, for items and services under Part B.
 - 1.4 percent from April 1, 1990 through September 30, 1990, for items and services under Part B.
- o Federal FY 1991 -

- There is no sequestration for Part A.
- 2.00 percent from November 1, 1990 through December 31, 1990, for items and services under Part B.

The amount of reduction is determined by October 15 of each year. Your intermediary will inform you of the specific percentage by which bills are reduced after the final determination of the amount is made.

C. Changes Required in Bill Payment Procedures.--You may bill separately for all services prior to the effective date in order to avoid the reduction of the entire bill.

The intermediary reduces all bills with dates of service or through dates on or after the effective date. It will not develop bills which may contain earlier services and will not accept adjustment bills to correct earlier bills spanning the effective date.

You can expect reduction on final payments and interim payments (cost based interim payments).

The intermediary adjusts payment amounts. It applies the reduction to the amount that would have been paid before P.L. 99-177, i.e., after reduction for deductible (for RHCs only), coinsurance, and MSP. This provides a slightly higher payment to you than applying the percentage reduction before deductible, coinsurance, and MSP.

You may not collect the reduction amount from beneficiaries.

606. PART B DEDUCTIBLE

In each calendar year a cash deductible must be satisfied before payment can be made under supplementary medical insurance (SMI). Currently, the cash deductible is \$100; this amount is subject to change.

Bills count toward the deductible on the basis of incurred, rather than paid, expenses and are based on the reasonable charge and/or the Medicare fee schedule amount. Noncovered expenses do not count toward the deductible. Even though an individual is not eligible for the entire calendar year, i.e., his/her insurance coverage begins after the first month of the year or he/she dies before the last month of the year, he/she is still subject to the full Part B cash deductible. Medical expenses incurred in any portion of the year preceding entitlement to SMI are not credited toward the Part B deductible.

The Part B deductible does not apply to FQHC services. It does apply to non-FQHC services billed to the carrier and to RHC services. (See §420 for a list of non-FQHC's services.)

607. PART B COINSURANCE

After the deductible has been satisfied, RHCs will be paid 80 percent of the all-inclusive interim payment rate. The patient is responsible for a coinsurance amount equal to 20 percent of the customary charges.

FQHCs will be paid 80 percent of the all-inclusive interim rate. The patient is responsible for a coinsurance amount equal to 20 percent of the customary charges.

608. DETERMINING HOW MUCH TO CHARGE PATIENT BEFORE BILLING IS SUBMITTED FOR PART B PAYMENT

For RHC's, ask the patient if he/she has any evidence that he/she has met the deductible, such as an Explanation of Medicare Benefits form. You may take into account any other available information of the patient's deductible status.

Where the deductible is met for RHCs collect no more than 20 percent of the charges. For RHC services where the deductible is known to be met in part, collect no more than the unmet deductible and 20 percent of the remaining charge. When the deductible is not met or its status is unknown, collect no more than the cash deductible and 20 percent of the balance. Once you have billed the intermediary for services, do not collect or accept any additional money from the patient for such services until the intermediary notifies you how much of the deductible has been met.

For FQHC services, the Part B deductible does not apply. Collect no more than 20 percent of the charges.

609. CLAIMS PROCESSING JURISDICTION FOR RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Claims processing jurisdiction for independent RHCs (i.e., those that are not part of a hospital, SNF, or HHA) is allocated within regions as follows:

Region I – Boston, Connecticut, Massachusetts, Rhode Island -- Blue Cross of Western Pennsylvania
Maine -- Associated Hospital Services of Maine
New Hampshire and Vermont -- New Hampshire-Vermont Health Service

Region II - New York, New Jersey, New York, Puerto Rico and Virgin Islands -- Blue Cross of Western Pennsylvania

Region III – Philadelphia, Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia -- Blue Cross of Western Pennsylvania

Region IV – Atlanta, Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi and Tennessee -- Blue Cross and Blue Shield of Tennessee

Region V – Chicago, Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin -- Aetna Life and Casualty

Region VI – Dallas, Arkansas, Louisiana, New Mexico, Oklahoma and Texas -- Blue Cross and Blue Shield of New Mexico

Region VII - Kansas City, Iowa, Kansas, Missouri and Nebraska -- Aetna Life and Casualty

Region VIII – Denver, Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming -- Blue Cross and Blue Shield of New Mexico

Region IX - San Francisco, American Samoa, Arizona, California, Guam, Hawaii and Nevada -- Aetna Life and Casualty

Region X – Seattle - Alaska, Idaho, Oregon and Washington -- Aetna Life and Casualty

For provider-based RHCs, the intermediary who services the provider in which the RHC is based maintains jurisdiction.

Claims processing jurisdiction for independent FQHCs is maintained nationally by Aetna Life Insurance Company, Peoria, Illinois. For provider-based FQHCs, the intermediary who services the provider in which the FQHC is based maintains jurisdiction.

610. FILING A REQUEST FOR PAYMENT

Medicare payment may not be made unless the beneficiary or his/her representative files a timely written request for payment and you file a claim. To ensure that payment is neither curtailed nor denied, it is important that the beneficiary be made aware of the following circumstances:

- o All claims must be filed timely. (See §610.2 for a definition of timely);
- o Payment may not be made unless the services are "reasonable and medically necessary." (See §§400ff.); and
- o Incomplete or incorrect identifying information can delay the processing of a claim. Claims may be delayed because they have to be returned by the intermediary for redevelopment.

610.1 Billing Forms as Request for Payment.--Submit "bills" for each Medicare beneficiary to whom you furnish services. Bill services using form HCFA-1450. (See §622 for special instructions on how to complete the HCFA-1450.)

610.2 Time Limitation for Filing Claims.-- The beneficiary's request and the clinic's/center's claim form must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year, i.e., the time limit is 2 years after the year in which such services were furnished. For example, a claim for services furnished September 30, 1991, must be filed by December 31, 1992. A claim for services furnished October 1, 1991, must be filed by December 31, 1993. No payment can be made for claims filed after the time limitation except under the following conditions:

611 BILLING PROCEDURES 10-92

- o Where failure to file a timely claim was due to SSA, HCFA, carrier or intermediary error, the time will be extended through the last day of the sixth calendar month after the month in which the error is rectified; or
- o The time limit is extended to the next workday if it falls on a day which is not a Federal workday (e.g., Saturday, Sunday, legal holiday).

When bills are not timely filed they will be denied. However, submit all bills even though they are not filed timely.

If error of SSA, HCFA, or their agents, or the patient caused the bill to be filed late, attach a statement outlining the facts to the bill.

Beneficiary Request for Payment

611. EXECUTION OF THE REQUEST FOR PAYMENT

If at all practicable, have the patient sign the request for payment at the time services begin.

In certain circumstances, this is impracticable. For example, when the individual is incompetent or otherwise is in such a condition that he/she can not transact any business, his/her representative payee (i.e., a person designated by SSA to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (including the clinic/center) usually responsible for his/her care, or a representative of a governmental entity providing welfare assistance should, if present at time of start of services, be asked and permitted to sign on his/her behalf.

611.1 Request for Payment.--In place of signatures on the HCFA-1450, use a procedure under which the signature of the patient (or his/her representative) on its records will serve as the request for payment for services.

To implement the procedure, incorporate the following language in your records:

Statement to Permit Payment of Medicare Benefits

NAME OF BENEFICIARY

HICN

I request payment of authorized Medicare benefits on my behalf for any services furnished me by (name of clinic/center). I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

This request is effective until revoked.

In using this procedure, you must:

- o Complete and promptly submit the HCFA-1450 whenever you furnish services to a Medicare beneficiary; and
- o Incorporate on any bills you send to Medicare patients, by stamp or otherwise, information to the effect that: "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf." This requirement is necessary to prevent patients from submitting duplicate claims.

Make the patient signature files available for intermediary inspection on request. Your intermediary must be able to make periodic audits of signature files selected on a random basis.

611.2. FREQUENCY OF BILLING

Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Outpatient Billing

Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Services are:

Service Revenue Code

- DME Rental 290-299
- Therapeutic Radiology 330-339
- Therapeutic Nuclear Medicine 342
- Respiratory Therapy 410-419
- Physical Therapy 420-429
- Occupational Therapy 430-439
- Speech Pathology 440-449
- Home Health Visits 550-599
- Hospice Services 650-659
- Kidney Dialysis Treatments 820-859
- Cardiac Rehabilitation Services 482, 943
- Psychological Services (910-919 in a psychiatric facility)

Where there is an inpatient stay, or outpatient surgery, during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay. This permits you to submit a single bill for the month, and simplifies the review of these bills. One outpatient bill is required for services prior to admission or outpatient surgery and another for those following discharge. This is in addition to the bill for the inpatient stay or outpatient surgery.

Other one time Part B services must be billed upon completion of the service.

Bills for outpatient surgery must contain on a single bill, all services provided on the day of surgery except kidney dialysis services, which are billed on a 72X bill type. These services normally include:

- o Nursing services, services of technical personnel, and other related services;
- o The patient's use of the hospital's facilities;
- o Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- o Diagnostic or therapeutic items and services (except lab services);
- o Blood, blood plasma, platelets, etc.; and
- o Materials for anesthesia.

See Addendum C for list of applicable revenue codes.

612. MENTAL HEALTH SERVICES LIMITATION-EXPENSES INCURRED FOR PHYSICIANS', CLINICAL PSYCHOLOGISTS' AND CLINICAL SOCIAL WORKERS' SERVICES RENDERED IN A RURAL HEALTH CLINIC OR FEDERALLY QUALIFIED HEALTH CENTER

Regardless of the actual expenses for physicians', clinical psychologists' and/or clinical social workers', services incurred in connection with the treatment of mental, psychoneurotic or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that may be counted in a calendar year is the lesser of 62.5 percent of expenses or the amount shown in the following table:

Year	Recognized Limit	Payment Limit
Through 12/31/87	\$ 312.50	\$ 250.00
1/1/88 - 12/31/88	\$ 562.50	\$ 450.00
1/1/89 - 12/31/89	\$ 1,375.00	\$ 1,100.00
12/31/89 and later	No Limit	No Limit

These limits apply to revenue code 910.

After 1989, there is no dollar limit.

Mental, psychoneurotic, and personality disorders are defined as the specific psychiatric conditions described in the American Psychiatric Association's Diagnostic and Statistical Manual-Mental Disorders. The limitation applies to expenses incurred in connection with one of these psychiatric conditions. It is applicable to physicians' services or items and supplies furnished by physicians. No distinction is made when applying the limitation between the services of psychiatrists and nonpsychiatric physicians. Therapeutic services furnished by other health practitioners are subject to the mental health treatment limitation when rendered in connection with a condition included in the definition of "mental, psychoneurotic, and personality disorders".

Charges for initial diagnostic services (i.e., psychiatric testing and evaluation used to diagnose the patient's illness) are not subject to this limitation. The limitation is applied only to therapeutic services. Apply the outpatient mental health limitation to the physician's or other mental health professional's therapeutic services, but not to his/her diagnostic services (except those administered to follow the progress of a course of psychiatric treatment for a diagnosed condition). Bill therapeutic services under revenue code 910.

An initial psychiatric visit to a physician for his personal professional services often combines diagnostic evaluation and the start of therapy; such a visit is neither solely diagnostic nor solely therapeutic. Therefore, the reasonable course is to deem the initial visit to be diagnostic so that the limitation does not apply. Separating diagnostic and therapeutic components of a visit is not administratively feasible, and determining the entire visit to be therapeutic is not justifiable since some diagnostic work must be done before even a tentative diagnosis can be made, and certainly before therapy can be instituted. Moreover, the patient must not be disadvantaged because therapeutic as well as diagnostic services were provided in the initial visit. Similarly, in the cases where a physician's diagnostic psychiatric services take more than one visit, the limitation is not applied to the additional visits. However, it is expected such cases are few. Therefore, when you bill for more than one visit for diagnostic services, document the case to show the reason for more than one diagnostic visit.

Thus, the following types of diagnostic services would be exempt from the limitation:

- o Psychiatric testing - this refers to use of actual testing instruments such as intelligence tests;
- o Psychiatric consultations - evaluation made by a physician or non-physician for purposes of preparing a report for the attending physician; or

- o Initial psychiatric visits - evaluation made by a physician who will test the patient.

613. PSYCHIATRIC SERVICES LIMITATION COMPUTATION FOR INDEPENDENT RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

The beneficiary is responsible for at least 37.5 percent of the all-inclusive rate for psychiatric therapy services. Additionally, the beneficiary is responsible for the coinsurance and any unmet deductible (for RHCs only) which is based on the remaining 62.5 percent of the reasonable charges. Therefore, the patient's liability is a two-part calculation as follows:

Part 1 -- 62.5 percent limitation:

1. Multiply the charges for revenue code 910 by 37.5 percent.

Part 2 -- Deductible and coinsurance calculation:

1. Multiply charges for revenue code 910 by 62.5 percent to calculate recognized charges.
2. For RHCs, apply any portion of recognized charges necessary toward the deductible, if it is applicable and has not yet been fully satisfied. For FQHCs, there is no deductible obligation, therefore, this step is not applicable.
3. Multiply remaining recognized charges by 20 percent to calculate coinsurance.

Total beneficiary liability for RHCs is 37.5 percent of revenue code 910 charges plus 20 percent of recognized charges (coinsurance) plus any unmet deductible (as calculated from recognized charges.)

Total beneficiary liability for FQHCs is 37.5 percent of revenue code 910 charges plus 20 percent of recognized charges (coinsurance.)

Use the following computation to determine Medicare payment for FQHCs and for RHCs when the deductible has already been completely satisfied or will be completely satisfied by the current claim. The computation for Medicare payment is as follows:

1. Subtract the 37.5 psychiatric liability (plus for RHCs any amount applied toward the deductible) from the clinic's/center's all-inclusive payment rate.
2. Multiply the remainder by 80 percent.

The following examples illustrate how payment is made to a clinic and how beneficiary liability is computed for the outpatient psychiatric limitation for RHC services.

Assume the deductible is \$100 for the following examples:

EXAMPLE A: Total outpatient mental health limit amount for therapy is \$60.00. Your all-inclusive rate is \$48.00. No part of the deductible has been met. In this instance, your total charges are applied to the beneficiary deductible. The beneficiary's liability is the full \$60 and \$37.50 is applied toward the deductible (62.5% of \$60). No payment is made to you by Medicare.

EXAMPLE B: Total outpatient mental health limit amount for therapy is \$64. Your all-inclusive rate is \$48. Thirty-seven dollars and fifty cents is applied toward the deductible from Example A. The computation for patient liability is as follows:

$$\text{Part 1: } \$64 \times 37.5\% = \$24.$$

$$\text{Part 2: } \$64 \times 62.5\% = \$40, \text{ which is applied to the deductible.}$$

No Medicare payment can be made since only \$77.50 of the deductible has been met. The beneficiary is liable for the full \$64 charges.

EXAMPLE C: Total outpatient mental health limit amount for therapy is \$48. Your all-inclusive rate is \$48. The beneficiary deductible is credited with \$77.50. The computation for patient liability is as follows:

$$\text{Part 1: } \$48 \times 37.5\% = \$18.$$

$$\text{Part 2: } \$48 \times 62.5\% = \$30. \$22.50 \text{ is applied to the deductible. } \$7.50 \times 20\% = \$1.50 \text{ coinsurance. Total beneficiary liability} = \$18 \text{ (Part 1) plus } \$22.50 \text{ (deductible) plus } \$1.50 \text{ (coinsurance) } = \$42.00.$$

The computation for Medicare payment is as follows:

The all-inclusive rate minus the beneficiary liability of \$43.00 leaves \$5.00 to be paid to the clinic.

EXAMPLE D: Total outpatient mental health limit amount for therapy is \$40. Ninety dollars of nonpsychiatric expenses had previously been incurred and applied to the deductible. Your all-inclusive rate is \$48. The computation for patient liability is as follows:

$$\text{Part 1: } \$40 \times 37.5\% = \$15.00$$

$$\text{Part 2: } \$40 \times 62.5\% = \$25.00. \$10 \text{ of deductible remains to be met. } \$25.00 - \$10.00 \times 20\% = \$3.00 \text{ coinsurance. Total beneficiary liability} = \$15.00 + \$10 + \$3.00 = \$28.00.$$

The computation for Medicare payment is as follows:

The all-inclusive rate of \$48.00 minus the beneficiary liability of \$28.00 leaves \$20.00 Medicare payment to the clinic.

614. BILLING OF PNEUMOCOCCAL PNEUMONIA, INFLUENZA VIRUS AND HEPATITIS B VACCINES BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Part B of Medicare pays 100 percent for physician professional services under the Part B payment methodology. It also pays 100 percent of the reasonable cost for provider services for pneumococcal pneumonia vaccines (PPV), influenza virus vaccines, and its administration to a patient if it is ordered by a physician who is a doctor of medicine or osteopathy. Neither deductible nor coinsurance applies.

Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply for RHCs. For FQHCs, the deductible does not apply and coinsurance may be waived.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

In order to provide for minimum disruption to the billing system, follow the procedures below:

- o Do not include any charges for PPV or influenza virus vaccine administration on Form HCFA-1450;
- o Count visits as under current procedures, except do not count or bill for visits when the only service involved is the administration of PPV and influenza virus; and
- o Payment for PPV and influenza virus vaccine and their administration is made at the time of cost settlement, and intermediaries may adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.

RHCs and FQHCs bill for the hepatitis B vaccine just as any other RHC/FQHC service, using revenue code 52X (freestanding clinic). Payment for the vaccine is included in the all inclusive rate.

620. COMPLETION OF FORM HCFA-1450 BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Bill Medicare for RHC or FQHC services you provide using form HCFA-1450 or approved electronic media. Data elements required are described below. A number of elements not required by Medicare, but are required by other third party payers, are included on the HCFA-1450 and in the HCFA standard electronic bill specifications (EMC). Items shown as "not required" in the following description need not be completed for Medicare bills.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number The minimum entry is your name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used with the Medicare provider number (FL 51) to verify provider identity. Phone and/or FAX numbers are desirable.

FL 2. Untitled

Not required. This is one of four fields reserved for use within a State by a State Uniform Billing Committee (SUBC). Once such assignment is made within a State, that item may be used only for the designated purpose.

FL 3. Patient Control Number

Not required. Enter the patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill

Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is a "frequency" code.

Code Structure (Only codes used to bill Medicare are shown.)

1st Digit-Type of Facility

- 7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
- 9 - Reserved for National Assignment

2nd Digit-Bill Classification (Clinics Only)

- 1- Rural Health Clinic (RHC)
- 3- Free-Standing Provider-Based Federally Qualified Health Centers (FQHC)
- 7-8 Reserved for National Assignment

3rd Digit-Frequency

Definition

- | | |
|-----|---|
| 1 - | Admit Through Discharge Claim |
| | Use this code for bill encompassing an entire inpatient confinement or course of outpatient treatment for which you expect payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP. |
| 5 - | Late Charges Only |
| | Use for outpatient claims only. Late charges are not accepted for Medicare inpatient or ASC claims. |
| 7- | Replacement of Prior Claim |
| | Use to correct a previously submitted bill. Apply this code to the corrected or "new" bill. |
| 8- | Void/Cancel of a Prior Claim |
| | Use this code to indicate that this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information |

FL 5. Federal Tax Number

Not required.

FL 6. Statement Covers Period (From-Through)

Required. Enter the beginning and ending dates of the period covered by this bill as (MM-DD-YY). Enter the date of discharge or death in the space provided under "Through". Bills may not span two accounting years. Do not show days before the patient's entitlement.

FL 7. Covered Days

Not required.

FL 8. Noncovered Days
Not required.

FL 9. Coinsurance Days
Not required.

FL 10. Lifetime Reserve Days
Not required.

FL 11. (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC, and is uniform within a State.

FL 12. Patient's Name
Required. Enter the patient's last name, first name, and middle initial, if any.

FL 13. Patient's Address
Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and ZIP code.

FL 14. Patient's Birthdate
Required. The month, day, and year of birth (MM-DD-YYYY) of patient. If the full correct date is not known, use zeros to complete the field.

FL 15. Patient's Sex
Required. Enter "M" for male or "F" for female; one must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Patient's Marital Status
Not required.

FL 17. Admission Date
Not required.

FL 18. Admission Hour
Not required.

FL 19. Type of Admission
Not required.

FL 20. Source of Admission
Not required.

FL 21. Discharge Hour
Not required.

FL 22. Patient Status
Not required.

FL 23. Medical Record Number

Required. This is the number assigned to the patient's medical/health record by the provider. If the provider enters a number, you must carry the number through your system and return it to the provider.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes

Required. Enter the corresponding code to describe any of the following conditions that apply to this billing period.

Code	Title	Definition
02	Condition is Employment Related	Enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from his employment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Enter this code if the beneficiary would not provide you with information concerning other insurance coverage.
09	Neither Patient Nor Spouse is Employed	Enter this code to indicate that in response to development questions, the patient and spouse have denied any employment.
10	Patient and/or Spouse is Employed but No EGHP Coverage Exists	Enter this code to indicate that in response to development questions, the patient and/or spouse indicated that one or both are employed but have no group insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary, But No LGHP Coverage	Enter this code to indicate that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance that covers the patient.
77	Provider Accepts or is Obligated/Required Due to Contractual Arrangement or Law to Accept Payment by A Primary Payer as Payment in Full	Enter this code to indicate you have accepted or are obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by HMO	

Enter this code for a Medicare newly covered service for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.)

Special Program Indicator Codes Required The only special program indicators that apply to Medicare are:

Code	Title	Definition
A3	Special Federal Funding	This code has been designed for uniform use by State uniform billing committees
A5	Disability	This code has been designed for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumonia/Influenza 100% Payment	This code identifies that pneumococcal/influenza vaccine (PPV) services given are to be paid under special Medicare program provisions.
A7	Induced Abortion-Danger to Life	Abortion was performed to avoid danger to woman's life.
A8	Induced Abortion-Victim Rape/Incest	Self-explanatory
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.

M0-M9 Payer Only Codes

M0	All-Inclusive Rate for Outpatient	Used by a Rural Primary Care Hospital electing to be paid an all-inclusive rate for outpatient services.
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)	Enter this code to indicate the influenza virus vaccine or (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when the payment to an HHA is significantly in excess of covered billed charges.

Claim Change Reasons

D0	Changes to Service Dates	Self-explanatory.
D1	Changes to Charges	Self-explanatory
D2	Changes to Revenue Codes/HCPCS	Self-explanatory
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Change is GROUPER Input	Self-explanatory
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation or an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory
D8	Change to Make Medicare the Primary Payer	Self-explanatory
D9	Any Other Change	Self-explanatory
E0	Change in Patient Status	Self-explanatory

Not Required. This is one of four fields which is not assigned. Use of the field, if any, is assigned by the NUBC.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates

Required. Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two alphanumeric digits, and dates are six numeric digits (MM-DD-YY). When you enter occurrence codes 01-04 and 24, be sure the entry includes the appropriate value code in Fls 39- 41.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When Fls 36 A and B are fully used with occurrence span codes, Fls 34 A and B and 35 A and B may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" dates is in the occurrence span "Through" date is in the date field.

Code	Title	Definition
01	Auto Accident	Enter the date of an auto accident. Use this code to report an auto accident that involves liability insurance. (See sec. 428.)
02	No-Fault Insurance Involved- Including Auto Accident/Other	Enter the date of an accident including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt). Use this code to report a non-automobile accident. Auto accidents are covered by codes 01 and 02 above.
03	Accident/Tort Liability	Enter the date of an accident (excluding automobile) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment from the third party, other than no-fault liability. Use this code to report a non-automobile accident. Auto accidents are covered by codes 01 and 02 above.
04	Accident/Employment Related	Enter the date of an accident which relates to the patient's employment. (See §434.)
05	Other Accident	Enter the date of an accident that is not described by any preceding occurrence codes. Use this code to report that you have developed for other casualty related payers and have determined that there are none.
18	Date of Retirement - Patient/Beneficiary	Enter the date of retirement for the patient/beneficiary
19	Date of Retirement - Spouse	Enter the date of retirement for the patient's spouse.
24	Date Insurance Denied	Enter the date of receipt of a denial of coverage by a higher priority payer.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries	Covered by EGHP. Enter the first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. (This is required only for ESRD beneficiaries.)

FL 36. Occurrence Span Code and Dates
Not required.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. Enter the control number assigned to the original bill here. Utilized by all provider types on adjustment requests (Bill Type, FL 4 = XX7). All providers requesting an adjustment to a previously processed claim insert the ICN/DCN of the claim to be adjusted. Payer As ICN/DCN must be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

6-24/Rev. 31

11-98 BILLING PROCEDURES 620

FL 38. Responsible Party Name and Address
Not required.

FLs 39, 40, and 41. Value Codes and Amounts
Required. Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "A" through line "D".

Use FLs 39A through 41A before 39A through 41B (i.e., use the first line before the second).

Code	Title	Definition
------	-------	------------

06	Medicare Blood Deductible	Enter this code to indicate the amount shown is the product of the number of unreplaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each unreplaced pint furnished. If all deductible pints have been replaced, this code is not to be used. When you give a discount for unreplaced deductible blood, show charges after the discount is applied.
----	---------------------------	--

12	Working Aged Beneficiary/Spouse With an EGHP	Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the EGHP has denied coverage. When you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim
----	--	--

13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
----	---	--

14 No-Fault, Including Auto/Other Insurance . Enter this code to indicate the amount shown is that portion of a higher priority no-fault insurance payment including auto/other insurance, payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced no-fault payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim

15 Workers' Compensation (WC) Enter this code to indicate the amount shown is that portion of a higher priority WC insurance payment, made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.

16 PHS, Other Federal Agency Enter this code to indicate the amount shown is that portion of a higher priority PHS or other Federal agency's payment made, on behalf of a Medicare beneficiary, that you are applying to Medicare charges. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment.

37 Pints of Blood Furnished Enter the total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.

38 Blood Deductible Pints Enter the number of unreplaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.

39 Pints of Blood Replaced Enter the total number of pints of blood which were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for unreplaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39X revenue code series (blood administration) or under the 30X revenue code series (laboratory).

41 Black Lung (BL) Enter this code to indicate the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there are been a substantial delay in its payment. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.

42 VA Enter this code to indicate the amount shown is that portion of a higher priority VA payment made on behalf of a Medicare beneficiary that you are applying to Medicare charges on this bill.

43 Disabled Beneficiary Under Age 65 With EGHP Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of a disabled beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field, if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim. 73-79 Payer Codes (For use by third party payers only.)

A1 Deductible Payer A Enter the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer

B1 Deductible Payer B Enter the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer

- C1 Deductible Payer C Enter the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer
- A2 Coinsurance Payer A Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
- B2 Coinsurance Payer B Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
- C2 Coinsurance Payer C Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
- A3 Estimated Responsibility Payer A Enter the amount estimated to be paid by the indicated payer
- B3 Estimated Responsibility Payer B Enter the amount estimated to be paid by the indicated payer
- C3 Estimated Responsibility Payer C Enter the amount estimated to be paid by the indicated payer
- D3 Estimated Responsibility Patient Enter the amount estimated to be paid by the indicated patient
- A4 A4 Covered Self-Administrable Drugs - Emergency The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self- administered drug are for insulin administered to a patient in a diabetic coma.)

Rev. 31/6-27

620 (Cont.) BILLING PROCEDURES 11-98

FL 42. Revenue Code

Required. Enter the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. Enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. This data takes the place of fixed line item descriptions on the billing form.

Additionally, there is no fixed "Total" line in the charge area. Enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges in FL 48, if any, are summed. Right justify all 3 digit revenue codes to prevent confusion.

To assist in bill review, list revenue codes in ascending numeric sequence and do not repeat on the same bill to the extent possible. To limit the number of line items on each bill, sum revenue codes at the "zero" level to the extent possible.

Providers have been instructed to provide detailed level coding for the following revenue code series:

- 290s - rental/purchase of DME
- 304 - rental and dialysis/laboratory
- 330s - radiology therapeutic
- 367 - kidney transplant
- 420s - therapies
- 520s - type of clinic visit (RHC or other)
- 550s - home health services
- 590s - home health services

624 - Investigational blood clotting factors
636 - hemophilia blood clotting factors
800s - 850s ESRD services
9000 - 9044 Medicare SNF demonstration project

Zero level billing is encouraged for all other services. However, based upon your knowledge of a particular provider's facilities or billing practices, you may require detailed break-outs of other revenue code series. This is acceptable to the extent that it is used for bill review purposes. See Medicare Intermediary Manual, Part 3, §3626.4 concerning the level of coding for outpatient surgical procedures.

NOTE: In general, independent RHCs and FQHCs use revenue codes 52X and 91X with appropriate subcategories to complete the HCFA-1450. The other codes provided are not generally used by RHCs and FQHCs and are provided for informational purposes.

25X Pharmacy

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual providers may wish to identify because of internal or third party payer requirements. Subcode 4 is for providers that do not bill drugs used for other diagnostic services as part of the charge for the diagnostic service. Subcode 5 is for providers that do not bill for drugs used for radiology under radiology revenue codes as part of the radiology procedures charge.

Subcategory Standard Abbreviation

0 - General Classification PHARMACY

1 - Generic Drugs DRUGS/GENERIC

2 - Non-generic drugs DRUGS/NONGENERIC

3 - Take Home Drugs DRUGS/TAKE HOME

4 - Drugs Incident to Other Diagnostic Services DRUGS/INCIDENT ODX

5 - Drugs Incident to Radiology DRUGS INCIDENT RAD

6 - Experimental Drugs DRUGS/EXPERIMT

7 - Non-prescription Drugs DRUGS/NONSCRIPT

8 - IV Solutions IV SOLUTIONS

9 - Other Pharmacy DRGS/OTHER

26X IV Therapy

Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, providers must identify the actual cost for each type of pump for updating the per diem rate.

Subcategory Standard Abbreviation

- 0 - General Classification IV THERAPY
- 1 - Infusion Pump IV THER/INFSN PUMP
- 2 - IV Therapy/Pharmacy Services IV THER/INFSN/SVC
- 3 - IV Therapy/Drug/Supply/Delivery IV THER/DRUG/SUPPLY DELV
- 4 - IV Therapy/Supplies IV THER/SUPPLIES
- 9 - Other IV Therapy IV THERAPY/OTHER
- 27X Medical/Surgical Supplies and Devices

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that RHCs/FQHCs may wish to identify because of internal or third party payer requirements.

Subcategory Standard Abbreviation

- 0 - General Classification MED-SUR SUPPLIES
- 1 - Nonsterile Supply NONSTER SUPPLY
- 2 - Sterile Supply STERILE SUPPLY
- 3 - Take Home Supplies TAKEHOME SUPPLY
- 4 - Prosthetic/Orthotic Devices PROSTH/ORTH DEV
- 5 - Pace maker PACE MAKER
- 6 - Intraocular Lens INTR OC LENS
- 7 - Oxygen-Take Home O2/TAKEHOME
- 8 - Other Implants SUPPLY/IMPLANTS
- 9 - Other Supplies/Devices SUPPLY/OTHER

28X Oncology

Charges for the treatment of tumors and related diseases.

Subcategory Standard Abbreviation

- 0 - General Classification ONCOLOGY
- 9 - Other Oncology ONCOLOGY/OTHER

29X Durable Medical Equipment (DME) (Other Than Renal)

Charges for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory Standard Abbreviation

- 0 - General Classification MED EQUIP/DURAB
- 1 - Rental MED EQUIP/RENT
- 2 - Purchase of new DME MED EQUIP/NEW
- 3 - Purchase of used DME MED EQUIP/USED

- 4 - Supplies/Drugs for DME Effectiveness (HHAs Only)
- 9 - Other Equipment MED EQUIP/OTHER

30X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet provider needs or third party billing requirements.

Subcategory

Standard Abbreviation

0 - General Classification

LABORATORY or (LAB)

1 - Chemistry

LAB/CHEMISTRY

2 - Immunology

LAB/IMMUNOLOGY

3 - Renal Patient (Home)

LAB/RENAL HOME

4 - Nonroutine Dialysis

LAB/NR DIALYSIS

5 - Hematology

LAB/HEMATOLOGY

6 - Bacteriology & Microbiology

LAB/BACT-MICRO

7 - Urology

LAB/UROLOGY

9 - Other Laboratory

LAB/OTHER

31X Laboratory Pathology

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas providers may wish to identify is provided.

Subcategory

Standard Abbreviation

0 - General Classification

PATHOLOGY LAB or
(PATH LAB)

1 - Cytology

PATHOL/CYTOLOGY

2 - Histology

PATHOL/HYSTOL

4 - Biopsy

PATHOL/BIOPSY
9 - Other
PATHOL/OTHER

6-30/Rev. 31

11-98 BILLING PROCEDURES 620 (cont.)

32X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining, and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures providers or third party payers may wish to identify.

Subcategory
Standard Abbreviation
0 - General Classification
DX X-RAY
1 - Angiocardiology
DX X-RAY/ANGIO
2 - Arthrography
DX X-RAY/ARTH
3 - Arteriography
DX X-RAY/ARTER
4 - Chest X-Ray
DX X-RAY/CHEST
9 - Other
DX X-RAY/OTHER
33X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. This includes therapy by injection or ingestion of radioactive substances.

Rationale: A breakdown is provided of the major areas providers or third parties may wish to identify.

Subcategory
Standard Abbreviation
0 - General Classification
RX X-RAY
1 - Chemotherapy Injected
CHEMOTHER/INJ
2 - Chemotherapy Oral
CHEMOTHER/ORAL
3 - Radiation Therapy

RADIATION RX
5 - Chemotherapy IV
CHEMOTHERP-IV
9 - Other
RX X-RAY/OTHER
38X Blood

Rationale: Separately identify charges for blood for private payer purposes.

Subcategory
Standard Abbreviation
0 - General Classification
BLOOD
1 - Packed Red Cells
BLOOD/PKD RED
2 - Whole Blood
BLOOD/WHOLE
3 - Plasma
BLOOD/PLASMA
4 - Platelets
BLOOD/PLATELETS
5 - Leucocytes
BLOOD/LEUCOCYTES
6 - Other components
BLOOD COMPONENTS
7 - Other derivatives
BLOOD/DERIVATIVES
8 - (Cryoprecipitates)

9 - Other Blood
BLOOD/OTHER
39X Blood Storage and Processing
Charges for the storage and processing of whole blood.

Rev. 31/6-31

620 (Cont.) BILLING PROCEDURES 11-98

11-98
Subcategory
Standard Abbreviation
0 -General Classification
BLOOD/STOR-PROC
1 - Blood Administration
BLOOD/ADMIN.
9 - Other Blood Storage &
Processing
BLOOD/OTHER STOR

40X Other Imaging Services

Subcategory

Standard Abbreviation

0 - General Classification

IMAGE SERVICE

1 - Diagnostic Mammography

MAMMOGRAPHY

2 - Ultrasound

ULTRASOUND

3 - Screening Mammography

SCR MAMMOGRAPHY/GEN MAMMO

4 - Positron Emission Tomography

PET SCAN

9 - Other Imaging Services

OTHER IMAG SVS

41X Respiratory Services

Charges for the administration of oxygen and certain potent drugs through inhalation or positive pressure, other forms of rehabilitative therapy through measurement of inhaled and exhaled gases, analysis of blood, and the evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory

Standard Abbreviation

0 - General Classification

RESPIRATORY SVC

2 - Inhalation Services

INHALATION SVC

3 - Hyperbaric Oxygen Therapy

HYPERBARIC 02

9 - Other Respiratory Services

OTHER RESPIR SVS

42X Physical Therapy

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

Subcategory

Standard Abbreviation

0 - General Classification

PHYSICAL THERP

1 - Visit Charge

PHYS THERP/VISIT

2 - Hourly Charge
PHYS THERP/HOUR
3 - Group Rate
PHYS THERP/GROUP
4 - Evaluation or Re-evaluation
PHYS THERP/EVAL
9 - Other Physical Therapy
OTHER PHYS THERP

43X Occupational Therapy
Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity of the patient.

6-32/Rev. 31

11-98 BILLING PROCEDURES 620 (cont.)

Subcategory
Standard Abbreviation
0 - General Classification
OCCUPATION THER
1 - Visit Charge
OCCUP THERP/VISIT
2 - Hourly Charge
OCCUP THERP/HOUR
3 - Group Rate
OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation
OCCUP THERP/EVAL
9 - Other Occupational Therapy
OTHER OCCUP THERP

(may include restorative therapy)

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory
Standard Abbreviation
0 - General Classification
SPEECH PATHOL
1 - Visit Charge
SPEECH PATH/VISIT
2 - Hourly Charge
SPEECH PATH/HOUR
3 - Group Rate
SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation

SPEECH PATH/EVAL
9 - Other Speech Language
OTHER SPEECH PAT
Pathology

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory
Standard Abbreviation
0 - General Classification
AUDIOLOGY
1 - Diagnostic
AUDIOLOGY/DX
2 - Treatment
AUDIOLOGY/RX
9 - Other Audiology
OTHER AUDIOL
52X Free-Standing Clinic/Center

Rationale: Provides a breakdown of some clinics that providers or third party payers may require.

Subcategory
Standard Abbreviation
0 - General Classification
FREESTAND CLINIC
1 - Rural Health-Clinic
RURAL/CLINIC
2 - Rural Health-Home
RURAL/HOME
3 - Family Practice
FR/STD FAMILY CLINIC
6 - Urgent Care Clinic
FR/STD URGENT CLINIC
9 - Other Freestanding Clinic
OTHER FR/STD CLINIC

55X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient, and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Rev. 31/6-33

620 (Cont.) BILLING PROCEDURES 11-98

Subcategory

Standard Abbreviation

0 - General Classification

SKILLED NURSING

1 - Visit Charge

SKILLED NURS/VISIT

2 - Hourly Charge

SKILLED NURS/HOUR

9 - Other Skilled Nursing

SKILLED NURS/OTHER

56X Medical Social Services

Charges for services such as counseling patients, interviewing patients and interpreting problems of social situation provided to them on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by RHC.

Subcategory

Standard Abbreviation

0 - General Classification

MED SOCIAL SVS

1 - Visit Charge

MED SOC SERVS/VISIT

2 - Hourly Charge

MED SOC SERV/HOUR

9 - Other Med. Social Services

MED SOC SERV/OTHER

57X Home Health Aide (Home Health)

Charges made by a HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory

Standard Abbreviation

0 - General Classification

AIDE/HOME HEALTH

1 - Visit Charge

AIDE/HOME HLTH/VISIT

2 - Hourly Charge

AIDE/HOME HLTH/HOUR

9 - Other Home Health Aide
AIDE/HOME HLTH/OTHER

58X Other Visits (Home Health)

Charges by a HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory

Standard Abbreviation

0 - General Classification

VISIT/HOME HEALTH

1 - Visit Charge

VISIT/HOME HLTH/VISIT

2 - Hourly Charge

VISIT/HOME HLTH/HOUR

9 - Other Home Health Aide

VISIT/HOME HLTH/OTHER

59X Units of Service (Home Health)

Revenue code used by a HHA that bills on the basis of units of service.

Rationale: Necessary for Medicare home health billing requirements.

6-34/Rev. 31

11-98 BILLING PROCEDURES 620 (cont.)

Subcategory

Standard Abbreviation

0 - General Classification

UNIT/HOME HEALTH

9 - Home Health Other Units

UNIT/HOME HEALTH/OTHER

61X Magnetic Resonance Imaging (MRI)

Code indicates charges for MRI of the brain and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory

Standard Abbreviation

0 - General Classification

MRI

1 - Brain (including Brainstem)

MRI - BRAIN

2 - Spinal Cord (including Spine)
MRI - SPINE
9 - Other
MRI MRI - OTHER

62X Medical/Surgical Supplies - Extension of 27X

Code indicates charges for supply items required for patient care. This category is an extension of 27X for reporting additional breakdown where needed.

Subcode 1 is for providers that do not bill supplies used for radiology revenue codes as part of the radiology procedure charges. Subcode 2 for radiology is for providers that do not bill supplies used for other diagnostic services as part of the charge for services in the diagnostic service.

Subcategory

Standard Abbreviation

1 - Supplies Incident to Radiology

MED-SUR SUPP/INCIDNT RAD

2 - Supplies Incident to Other Diagnostic Services

MED-SUR SUPP/INCIDNT ODX

3 - Surgical Dressings

SURG DRESSING

4 - Investigational Device Exemption

IDE

64X Home IV Therapy Services

Codes indicate the charges for intravenous drug therapy services which are performed in the patient's residence. For Home IV providers, the HCPCS code must be entered for all equipment and all types of covered therapy.

Subcategory

Standard Abbreviation

0 - General Classification

IV THERAPY SVC

1 - Nonroutine Nursing

NON RT NURSING/CENTRAL

2 - IV Site Care, Central Line

IV SITE CARE/CENTRAL

3 - IV Start/Change Peripheral Line

IV STRT/CHNG/PERIPHRL

4 - Nonroutine Nursing, Peripheral Line

NONRT NURSING/PERIPHRL

5 - Training Patient/Caregiver, Central Line

TRNG/PT/CARGVR/CENTRAL

6 - Training, Disabled Patient, Central Line

TRNG DSBLPT/CENTRAL

7 - Training Patient/Caregiver, Peripheral Line

TRNG/PT/CARGVR/PERIPHRL

8 - Training, Disabled Patient, Peripheral Line
TRNG/DSBLPT/PERIPHRL
9 - Other IV Therapy Services
OTHER IV THERAPY SVC

NOTE: Units need to be reported in 1 hour increments. Revenue code 642 relates to the HCPCS code.

Rev. 31/6-35

620 (Cont.) BILLING PROCEDURES 11-98

65X Hospice Services

Code indicates the charges for hospice care services for a terminally ill patient if he/she elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory

Standard Abbreviation

0 - General Classification

HOSPICE

1 - Routine Home Care

HOSPICE/RTN HOME

2 - Continuous Home Care - 1/2

HOSPICE/CTNS HOME

3 - RESERVED

4 - RESERVED

5 - Inpatient Care

HOSPICE/IP RESPITE

6 - General Inpatient Care(nonrespite)

HOSPICE/IP NON RESPITE

7 - Physician Services

HOSPICE/PHYSICIAN

9 - Other Hospice

HOSPICE/OTHER

66X Respite Care (HHA only)

Charges for hours of care under the respite care benefit for service of a homemaker or home health aide, personal care services, and nursing care provided by a license professional nurse.

Subcategory

Standard Abbreviation

0 - General Classification

RESPITE CARE

1 - Hourly Charge/Skilled Nursing

RESPITE/SKILLED NURSE

2 - Hourly Charge/Home Health Aide/Homemaker

RESPITE/HMEAID/HMEMKE

67X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

Subcategory

Standard Abbreviation

0 - General Classification

OP SPEC RES

1 - Hospital Based

OP SPEC RES/HOSP BASED

2 - Contracted

OP SPEC RES/CONTRACTED

9 - Other Special Residence Charges

OP SPEC RES/OTHER

68X Not Assigned

69X Not Assigned

6-36 Rev. 31

11-98 BILLING PROCEDURES 629 (cont.)

73X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle or an electrocardiograph for diagnosis of heart ailments.

Subcategory

Standard Abbreviation

0 - General Classification

EKG/ECG

1 - Holter Monitor

HOLTER MONT

3 - Telemetry

TELEMETRY

9 - Other

EKG/EGG OTHER EKG/ECG

74X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory
Standard Abbreviation
0 - General Classification
EEG
9 - Home Health Other Units
OTHER EEG

75X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in the operating room.

Subcategory
Standard Abbreviation
0 - General Classification
GASTR-INST SVS
9 - Other Gastro-Intestinal
OTHER GASTRO-INTS

77X Preventive Care Services

Charges for the administration of vaccines.

Subcategory
Standard Abbreviation
0 - General Classification
PREVENT CARE SVS
1 - Vaccine Administration
VACCINE ADMIN
9 - Other
OTHER PREVENT

78X Telemedicine

Future use to be announced - Medicare Demonstration Project.

Subcategory
Standard Abbreviation
0 - General Classification
TELEMEDICINE
9 - Other Telemedicine
TELEMEDICINE/OTHER

91X Psychiatric/Psychological Services

Charges for providing nursing care, and professional services for emotionally disturbed patients for diagnosis and treatment.

Rationale: Provides additional identification of services as necessary.

Rev. 31 /6-37

620 (Cont.) BILLING PROCEDURES 11-98

Subcategory

Standard Abbreviation

0 - General Classification

PSYCH/SERVICES

1 - Rehabilitation

PSYCH/REHABTD

2 - Partial Hospitalization* - Less Intensive

PSYCH/PARTIAL HOSP

3 - Partial Hospitalization - Intensive

PSYCH/PARTIAL INTENSIVE

4 - Individual Therapy

PSYCH/INDIV RX

5 - Group Therapy

PSYCH/GROUP RX

6 - Family Therapy

PSYCH/FAMILY RX

7 - Bio Feedback

PSYCH/BIOFEED

8 - Testing

PSYCH/TESTING

9 - Other

PSYCH/OTHER

* Medicare does not recognize codes 912 and 913 services under its partial hospitalization program.

92X Other Diagnostic Services

Charges for other diagnostic services not otherwise categorized.

Subcategory

Standard Abbreviation

0 - General Classification

OTHER DX SVS

1 - Peripheral Vascular Lab

PERI VASCUL LAB

2 - Electromyelgram

EMG

3 - Pap Smear

PAP SMEAR

4 - Allergy Test
ALLERGY TEST
5 - Pregnancy Test
PREG TEST
9 - Other Diagnostic Service
ADDITIONAL DX SVS

93X Not Assigned

94X Other Therapeutic Services

Charges for other therapeutic services not otherwise categorized.

Subcategory

Standard Abbreviation

0 - General Classification

OTHER RX SVS

1 - Recreational Therapy

RECREATION RX

2 - Educational/Training (includes diabetes related dietary therapy)

EDUC/TRAINING

3 - Cardiac Rehabilitation

CARDIAC REHAB

4 - Drug Rehabilitation

DRUG REHAB

5 - Alcohol Rehabilitation

ALCOHOL REHAB

6 - Complex Medical Equipment Routine

RTN COMPLX MED EQUIP

7 - Complex Medical Equipment,

Equipment Ancillary

COMPLX MED EQUIP

9 - Other Therapeutic Services

ADDITIONAL RX SVS

95X Not Assigned

6-38/Rev. 31

11-98 BILLING PROCEDURES 620 (cont.)

FL 43. Revenue Description

Not Required. Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories description are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also, see FL 84, Remarks.)

FL 44. HCPCS/Rates
Not Required.

FL 45. Service Date
Not Required. For outpatient claims providers report a separate date for each day of service.

FL 46. Units of Service
Required. Enter the number of digits or units of service, i.e., visits as defined below, on the line adjacent to revenue code and description where appropriate. Enter up to three numeric digits.

A "visit" is defined as a face-to-face encounter between a clinic/center patient, and one of the certified RHC or FQHC health professionals. Encounters with more than one health professional, and encounters with the same health professional which take place on the same day and at a single location constitute a single "visit", except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

EXAMPLE 1: A known diabetic visits you on the morning on May 1 and sees the physician assistant. The physician assistant believes an adjustment in current medication is required, but wishes to have the clinic's physician, who will be present in the afternoon, check the determination. The patient returns in the afternoon and sees the physician, who revises his prescribed medication. The physician recommends that the patient return the following week, on May 8, for a fasting blood sugar analysis to check the response to the change in medication. In this situation, bill the Medicare program for one visit. Also, include a line item charge for laboratory services for May 1.

EXAMPLE 2: A patient visits you on July 1 complaining of a sore throat, and sees the physician assistant. The physician assistant examines the patient, takes a throat culture and requests that the patient return on July 8 for a follow-up visit to the physician assistant. In this situation, bill the Medicare program for two visits. Also, include an entry for laboratory.

FL 47. Total Charges
Required. Sum the total charges for the billing period by revenue code (FL 42) or in the case of diagnostic laboratory tests for outpatients or nonpatients by HCPCS procedure code and enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 "0001" which represents the grand total of all charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

HCFA policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement reports (PS&R) that you derive from the bill.

For outpatient Part B billing, only charges believed to be covered are submitted in FL 47. Non-covered charges are omitted from the bill.

FL 48. Non-Covered Charges

Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49. (Untitled)

Not Required. This is one of the four fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLs 50A, B, and C. Payer Identification

Required. If Medicare is the primary payer, enter "Medicare" on Line A. When Medicare is entered on line 50A, this indicates that you have developed for other insurance coverage, and have determined that Medicare is the primary payer. All additional entries across Line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, identify the primary payer on Line A, and enter Medicare information on Line B or C, as appropriate.

FLs 51A, B, and C. Provider Number

Required. This is the six-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 52A, B, and C. Release of Information Certification Indicator

Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations to adjudicate a claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

NOTE: The back of Form HCFA-1450 contains a certification that all necessary release statements are on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator

Not Required.

FLs 54A, B, and C. Prior Payments

Not Required.

FLs 55A, B, and C. Estimate Amount Due From Patient

Not Required.
(Unnumbered Line below 57-64C.)

FL 56 (Untitled)

Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 57. (Untitled)

Not Required. This is one of the seven fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

6-40/Rev. 31

11-98 BILLING PROCEDURES 620(cont.)

FLs 58A, B, and C. Insured's Name

Required. On the same lettered Line (A, B or C) corresponding to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's name as shown on the HI card or other Medicare notice. All additional entries across Line A (FLs 59-66) pertain to the person named in FL 58. The instructions which follow explain when to complete these items.

Enter the name of the individual in whose name the insurance is carried if there are payer(s) of higher priority than Medicare, and you are requesting payment because:

- o Another payer paid some of the charges, and Medicare is secondarily liable for the remainder;
- o Another payer denied the claim; or
- o You are requesting conditional payment as described in §§634D, 635E, 636E, or 637E.

If that person is the patient, enter "Patient." Payers of higher priority than Medicare include:

- o EGHPs for employed beneficiaries and spouses age 65 or over;
- o EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a Medicare Coordination Period;
- o LGHPs for disabled beneficiaries;
- o Auto-medical, no-fault, or liability insurer; or
- o WC including BL.

FLs 59A, B, and C. Patient's Relationship to Insured

Required. If you are claiming a payment under any of the circumstances described under FLs 58A, B or C, you may enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Code	Title Definition
01	Patient is Insured Self-explanatory
02	Spouse Self-xplanatory
03	Natural Child/Insured Financial Responsibility Self-explanatory
04	Natural Child/Insured Does Not Have Financial Responsibility Self-explanatory
05	Step Child Self-explanatory
06	Foster Child Self-explanatory
08	Employee Patient is employed by the insured.
09	Unknown Patient's relationship to the insured is unknown.
15	Injured Plaintiff Patient is claiming insurance as a result of injury covered by insured.

Rev. 31 /6-41

620 (Cont.) BILLING PROCEDURES 11-98

FLs 60A, B, and C. Certificate/Social Security Number/Health Insurance Claim/Identification Number Required. On the same lettered Line (A, B, or C) corresponding to the line on which Medicare payer information is shown in FLs 50-54, enter the patient's Medicare HICN, i.e., if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's Health Insurance Card,

Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the SSO.

FLs 61A, B, and C. Group Name

Required. Where you are claiming a conditional payment because a higher priority employer group health plan has denied a working aged beneficiary, enter the name of the group or plan through which that insurance is provided.

FLs 62A, B, and C. Insurance Group Number

Required. Where you are claiming a conditional payment under the circumstances described under FLs 61A, B or C above, enter the identification number, control number or code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

FL 63. Treatment Authorization Code

Not Required.

GUIDELINES FOR EMPLOYMENT INFORMATION

The following items are grouped together for ease in transmitting instructions upon their completion: 64, 65, 66. Space is reserved for reporting the necessary employment data for up to two individuals. Use the following sequence of decision-making in completing these fields.

INDIVIDUALS CLAIMING INSURANCE

1. If any of the insureds named under A, B, or C in the insurance section of the form (FL 58) has group insurance provided by an organization other than the employer, enter the insured's employment information. (For example, FL 61 records Group Name as Washington Area Ford Dealers, Inc., but the insured employer is Capital Ford, Inc. Because the insurance is held with a company other than the employer, the employer information is required for the insured.)

2. If any of the individual's recorded under A, B, or C in this insurance section of the form (FL 58) has group insurance coverage provided by an employer who operates from multiple locations, enter employment information (and location).

FL 64. Employment Status Code

Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified, if the information is readily available.

Code Title Definition

- 1 Employed Full-Time Individual stated that he or she is employed full-time.
- 2 Employed Part-Time Individual stated that he or she is employed part-time.
- 3 Not Employed Individual stated that he or she is not employed full-time or part-time.
- 4 Self-employed Self-explanatory
- 5 Retired Self-explanatory
- 6 On Active Military Duty Self-explanatory
- 7-8 Reserved for National Assignment
- 9 Unknown Individual's Employment Status is unknown

FL 65. Employer Name

Required. Where you are claiming a payment under the circumstances described under FL 58A, B, or C, and there is involvement of WC or an EGHP, enter the name of the employer providing health care coverage for the individual.

FL 66. Employer Location

Required. Where you are claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual. A specific location is the city, plant, etc. in which the employer is located.

FL 67. Principal Diagnosis Code

Required for bill types 11x, 12x, and 13x.

Inpatient-Required. Enter the ICD-9-CM code for the principal diagnosis. The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, do not fill with zeros.

The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, enter the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a DRG and cause you to be incorrectly paid under PPS.

Outpatient-Required. Report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. Report the diagnosis to your highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported (786.2). If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), report the definitive diagnosis (466.0).

When a patient arrives for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70- V82).

Examples include:

- o Routine general medical examination (V70.0);
- o General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); and
- o Examination of ears and hearing (V72.1).

NOTE: Diagnosis codes are not required on nonpatient claims for laboratory services where you function as an independent laboratory.

FLs 68-75. Other Diagnoses Codes

Inpatient--Required. Enter the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently and have an effect upon the treatment or the length of stay.

Do not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

Outpatient--Required. Enter the full ICD-9-CM codes in FLs 68-75 for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

FL 76. Admitting Diagnosis

Required. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. (See MIM §3770.1.) Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL 77. E-Code

Not Required.

FL 78. (Untitled)

Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 79. Procedure Coding Method Used

Not required.

FL 80. Principal Procedure Code and Date

Not required.

FL 81. Other Procedure Codes and Dates
Not required.

FL 82. Attending/Requesting Physician I.D.

Required. Enter on inpatient bills the UPIN and name of the attending physician or the physician that requested outpatient services. This requirement applies to inpatient bills (hospitals and SNF Part A) with a "Through" date of January 1, 1992, or later, and to outpatient and other Part B bills with a "From" date of January 1, 1992, or later.

Inpatient Part A.--Enter the UPIN and name of the attending physician. For hospital services the Uniform Hospital Discharge Data Set definition for attending physician is used. This is the clinician services, i.e., swing bed. The attending physician is the practitioner who certifies the SNF plan of care. Enter the UPIN in the first six positions, followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

Outpatient and Other Part B.--Enter the UPIN and name of the physician that requested the surgery, therapy, diagnostic tests, or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

If the patient is self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a name.

6-44/Rev. 31

11-98 BILLING PROCEDURES 620 (cont.)

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, the Department of Veterans Affairs, or the Indian Health Service. Use the following UPINs to report these physicians:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Service physicians, including Indian Health Service;
- VAD000 for Department of Veterans Affairs physicians;
- RET000 for retired physicians;
- SLF000 for providers to report the patient is self-referred; and
- OTH000 for all other unspecified entities not included above.

SLF will be accepted, except where the revenue code or HCPCS code indicates that the service can be provided only as a result of physician referral. The SLF000 and OTH000 ID may be audited.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

If more than one referring physician is indicated, enter the UPIN of the physician requesting the service with the highest charge.

FL 83. Other Physician I.D.
Not Required.

FL 84. Remarks.
Required. Enter any remarks needed to provide information not shown elsewhere on the bill, but which are necessary for proper payment.

FL 85. Provider Representative Signature
Required An RHC or FQHC representative signs to certify that required physician's certifications and recertifications are in its records. A stamped signature is acceptable.

FL 86. Date.
Not Required. Enter date of provider representatives signature.

621. SPECIAL BILLING INSTRUCTIONS FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

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 which FQHCs must meet to qualify for the Medicare benefit are in §1861(aa)(4) of the Act.

FQHC services consist of services similar to those provided in RHCs. These include services furnished by physicians, physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and under certain circumstances (as defined in §412.2), visiting nurses. It also includes services and supplies incident to these practitioners' services.

FQHC services also include preventive primary health services, a new benefit under Medicare and available only as FQHC services. The law defines Medicare preventive services as preventive primary health services a FQHC is required to provide under §§329, 330 and 340 of the Public Health Service (PHS) Act. These services are described in more detail in §404. No Part B deductible is applied to expenses for services which are payable under the FQHC benefit. The Medicare beneficiary is responsible for 20 percent of billed charges. (See §§504 and 505ff for Medicare payment procedures.)

B. Special Requirements.--You are eligible to qualify as an FQHC if you:

- o Are receiving a grant under §§329, 330, or 340 of the PHS Act, or are receiving funding from such a grant under a contract with the PHS recipient of such a grant, and meet the requirements to receive a grant under §§329, 330, or 340 of the PHS Act;
- o Based on the recommendation of the Health Resources and Service Administration within the Public Health Service, are determined by the Secretary to meet the requirements for receiving such a grant (look-alikes);
- o Were treated by the Secretary, for purposes of Part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990; or

o Are 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.

An RHC cannot be concurrently approved for Medicare as both an FQHC and an RHC. If you qualify as an FQHC, you will be assigned an FQHC identification number in the provider number range 1800-1989. If you are an FFHC converting to an FQHC, a new number will not be assigned to you. Converting FFHCs will retain the number assigned to them as FFHCs.

If you decide to become a physician directed clinic instead of an FQHC, you will be paid under physician payment rules including billing to your carrier on Form HCFA-1500.

C. Billing Requirements.--Bill Aetna Life Insurance Company for FQHC services on Form HCFA-1450 using bill type 73X.

If you continue an election to be paid under the Part B payment methodology, continue to use Form HCFA-1500, and bill your carrier as long as that option is in effect. You are not entitled to be paid for the additional benefits provided under the FQHC benefit package.

Bill revenue code 910 for services subject to the psychiatric limit. Bundle all other services under revenue code 520, or use other revenue codes depending upon your preference and your intermediary needs for cost settlement. Report units under revenue codes 910 and 520, as applicable. HCPCS coding is not required. Follow bill completion instructions in §620 with the exceptions in §621.C.

623. BILLING FOR MAMMOGRAPHY SCREENING BY RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 (OBRA) added §1834(c) of the Act to provide for coverage of mammography screening for certain women entitled to Medicare effective for screenings performed on or after January 1, 1991. The term "screening mammography" means a radiologic provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. Payment may be made for a screening mammography furnished to a woman at her direct request.

Prior to October 1, 1994, if you perform screening mammographies, you must request and be recommended for certification by the State certification agency and approved by HCFA before payment is made. Effective October 1, 1994, if you perform mammography services (diagnostic or screening), you must be issued a certificate from the Food and Drug Administration (FDA) before payment can be made. (See §641 for more detailed instructions.) Your carrier will deny claims when it determines you are not certified.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over 39 and waives the Part B deductible. Coverage applies as follows:

No payment may be made for a screening mammography performed on a woman under 35 years of age;

You will be paid for only one screening mammography performed on a woman between her 35th and 40th birthdays (ages 35 thru 39); and

For a woman over 39, pay for a screening mammography performed after 11 full months have passed following the month in which the last screening mammography was performed.

A.Determining the 11 and 23 Month Periods.--To determine the 11 and 23 month periods, your carrier starts its count beginning with the month after the month in which a previous screening mammography was performed.

EXAMPLE:

The beneficiary received a screening mammography in January 1991. Carriers start their count beginning with February 1991. The beneficiary will be eligible to receive another screening mammography in January 1992, the month after 11 full months have elapsed, or in January 1993, the month after 23 full months have elapsed as appropriate.

If a beneficiary eligible for a yearly screening mammography has a birthday which puts her into an age in which the 23 month rule applies, she must wait for the full 23 month period to pass.

EXAMPLE:

The beneficiary received a screening mammography in January 1991. Start your count beginning with February 1991. The beneficiary is eligible to receive another screening mammography in January 1992 (the month after 11 full months have elapsed).

B.Payment Limitations.--There is no Part B deductible. However, coinsurance is applicable. Following are three categories of billing for mammography services:

Professional component of mammography services (that is, for the physician's interpretation of the results of the examination),

Technical component (all other services), and

Both professional and technical components (global).

There are payment limits for each. The professional component is 32 percent of the total limit for the complete service. The technical component is 68 percent.

Contact your carrier regarding how the payment amount is calculated for both the professional and technical components or for both (global).

The payment equals 80 percent of the least of:

The actual charge for the service;

The amount determined under the radiology fee schedule in 1991 or for services furnished on or after 1992 under the Medicare physicians' fee schedule; or

The screening mammography limit of \$59.63 in calendar year 1994 by 63 percent, \$60.88 in calendar year 1995, \$62.10 in calendar year 1996,

\$63.34 in calendar year 1997 by 68 percent, and \$64.73 in calendar year 1998, \$66.22 in calendar year 1999, and \$67.81 in calendar year 2000.

On January 1 of each subsequent year, the overall limit will be updated by the percentage increase in the Medicare Economic Index.

C. Billing Requirements.--Bill for the screening mammography to your carrier on Form HCFA-1500. Enter your 10-digit HCFA assigned certification number in Field 32 and HCPCS code 76092 in Field 24D. HCPCS code 76092 differentiates screening mammography claims from diagnostic mammography claims. It is defined as follows:

76092 Screening mammography, bilateral (two view film study of each breast).

Since this benefit is not considered an RHC service, do not bill your intermediary.

On every screening claim with dates of service October 1, 1997 through December 31, 1997, where the patient is not a high risk individual, enter in Field 21 on Form HCFA-1500 the following code:

V76.12 "Other screening mammography."

If the screening is for a high risk individual, enter in Field 21 on Form HCFA-1500 the following code:

V76.11 "Screening mammogram for high risk patient."

In addition, for high risk individuals, report one of the following applicable codes in Field 21:

High Risk Category	Appropriate Diagnosis Code
A personal history of breast cancer	V10.3 (Personal history-malignant neoplasm female breast)
A mother, sister, or daughter who has breast cancer	V16.3 (Family history-malignant neoplasm breast)
Not given birth prior to age 30	V15.89 (Other specific personal history representing hazards to health)
A personal history of biopsy-proven benign breast disease	V15.89 (Other specific personal history representing hazards to health)

On every screening claim with dates of service on or after January 1, 1998, providers enter in Field 21 on Form HCFA-1500 the following code:

- o V76.12 "Other screening mammography."

D. Actions Required.--Your carrier will consider the following when determining whether payment may be made:

- o Presence of HCPCS code 76092;
- o Presence of high risk diagnosis code indicator;
- o Date of last screening mammography;
- o Age of beneficiary; and
- o Presence of your HCFA-assigned 10-digit certification number.

NOTE: Code ICD-9 diagnosis codes for mammography to the appropriate fourth or fifth digit. Omit decimal points for data entry purposes. In addition, due to the BBA of 1997, there is no need for you to continue to report the high risk diagnosis codes effective January 1, 1998.

E. Special Billing Instructions When a Radiologist Interpretation Results in Additional Films.-- Radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while the beneficiary is still at your facility for the screening exam. Where a radiologist interpretation results in the need for additional films the mammography is no longer considered a screening exam for payment purposes. When this occurs, your carrier will pay the claim as a diagnostic mammography instead of a screening mammography. However, since the original intent for the exam was for a screening, age and frequency standards will apply and for statistical purposes, the claim would be considered a screening.

Contact your carrier to determine how to bill in this situation.