



Medicare Rural Health Clinic Version

KEY CONCEPTS OUTLINE

Module 1: Designation as a Rural Health Clinic, including Required Practitioners and Services

I. Rural Health Clinic (RHC) Defined

- A. RHCs were established by the Rural Health Care Services Act of 1977 to assist rural communities to meet the healthcare needs of its Medicare beneficiaries where inadequate supplies of physicians existed. <Public Law 95-210; 43 Fed. Reg. 136>
 - 1. The Act also provided a way to utilize non-physician practitioners (i.e., physician assistant or nurse practitioner) to provide care in an alternative setting under limited physician supervision. <See Medicare Benefit Policy Manual, Chapter 13 § 10.1>
 - 2. Although the benefits are similar, an RHC cannot be simultaneously approved as a Federally Qualified Health Center (FQHC). <See Medicare State Operations Manual, Appendix G Rural Health Clinics>
 - a. An RHC must provide primary medical services typically provided in an outpatient clinic and can choose whether to provide certain preventive services that are covered under its Medicare certification. <See Medicare Benefit Policy Manual, Chapter 13 § 10.1>
 - b. An FQHC must provide certain preventive services under its enrollment agreement with Medicare, as well as meet other criteria for payment. <Medicare Benefit Policy Manual, Chapter 13 § 10.2>

CMS publishes a helpful fact sheet that provides an overview of the RHC benefit. A copy of the most recent version is included in Module 6 – Appendices of Source Authority.

Link: MLN Publications – MLN Catalog under Medicare Related Sites – General

B. CMS Certification Requirement

1. An RHC can be certified by CMS only if the state does not explicitly prohibit the delivery of primary healthcare by a physician assistant (PA), nurse practitioner (NP), or certified nurse-midwife (CNM). <See *Medicare State Operations Manual*, Appendix G § 491.4 B>
 - a. A surveyor may consider this condition met if the state law is silent or does not specifically prohibit a PA, NP, or CNM from providing services under limited physician supervision, as required by the RHC regulations.

II. Location Requirements

- A. To be certified by CMS as an RHC, the clinic must meet two location requirements. <See 42 *C.F.R.* 491.5; see *Medicare Benefit Policy Manual*, Chapter 13, §§ 20, 20.1, 20.2>

1. Non-urbanized area

- a. The clinic must be located in a non-urbanized area as determined by the U.S. Census Bureau.

Information on whether an area is in an urbanized area can be obtained from the appropriate CMS Regional Office or at: <http://factfinder.census.gov>.

2. Shortage area

- a. The clinic must be located in a federally designated area where a shortage of personal health services exists and the designation occurred within the previous four years.
- b. Determination that a shortage of personal health services exists is based on many factors; however, only the following shortage area designations are considered by CMS for RHC certification.
 - (i) Primary Care Health Professional Shortage Area (HPSA), either geographic or population-group

- (a) The ratio of primary care physicians practicing in the area to the population and the ratio indicates the physicians are over-utilized, excessively distant, or inaccessible to the population in the area.

(ii) Medically-Underserved Area (MUA)

- (a) The ratio of primary care physicians practicing in the area to the resident population which has been determined to be an MUA.

(iii) Governor-Designated and Secretary-Certified Shortage Area

- (a) This classification does not include a Governor's Medically Underserved Population designation.

3. A clinic applying to become a Medicare-certified RHC must initially meet both the rural and underserved location requirements. <See *Medicare Benefit Policy Manual*, Chapter 13, § 20>
 - a. Once certified, an existing RHC whose location no longer meets the rural, non-urbanized location requirement is not automatically decertified and may continue to operate as an RHC.
 - b. However, if an existing RHC wants to relocate, the new location must meet both the rural location and the shortage area or underserved designation requirements.

Caution: An RHC that plans to relocate or expand should contact their CMS Regional Office to determine if the location requirements will continue to be met.

- B. When the location requirements are met, an RHC may be physically located in a permanent structure or in a mobile unit. <See 42 C.F.R. 491.5; see *Medicare Benefit Policy Manual*, Chapter 13 § 20>

1. If an RHC is located in several permanent locations, each location is independently certified by CMS.
2. If an RHC is located in a mobile unit, it must have a fixed schedule that specifies the date(s) and applicable location(s) for providing services.

C. Exception during the COVID-19 Public Health Emergency (PHE)

1. CMS is temporarily waiving the requirement that more than one permanent location must be independently considered for Medicare approval. This allows flexibility for existing RHCs to expand service locations to meet the needs of Medicare beneficiaries which may be outside of the usual location

requirements. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 08/20/20>

III. Staffing Requirements and Related Services

A. Physician Staffing

1. An RHC must be under the medical direction of at least one physician (i.e., MD or DO) who oversees the operations of the clinic and provides medical supervision of the healthcare staff. <See 42 C.F.R. 491.8>

The physician may own the clinic, be employed by the clinic, or provide services "under arrangement" to the clinic.

- a. CMS has determined that many of the physician's required oversight functions may be performed remotely via electronic means. Where state law allows, the RHC physician is no longer required to provide a supervisory visit for non-physician practitioners at least once every two weeks. <79 Fed. Reg. 27107>
- b. The physician, in collaboration with at least one NP and/or PA:
 - (i) Develops and biennially reviews the clinic's policies and procedures to determine if they are appropriate and being followed; and,
 - (ii) Conducts reviews of the patients' records, including review of the types and volume of services provided based on its patient population. <See 42 C.F.R. 491.8; see 42 C.F.R. 491.11>
2. If the loss of a physician reduces the RHC's staff below the required minimum, the clinic will be given a reasonable time to comply with the staffing requirement. The RHC must be able to demonstrate a good faith effort was made to obtain the services of a physician on a permanent basis. <See *Medicare State Operations Manual*, Appendix G § 491.8(a)>
 - a. The clinic must make arrangements for a temporary physician(s) to perform the required physician responsibilities.

Caution: *The clinic should inform the state of all actions being taken to recruit a replacement to prevent loss of RHC certification.*

3. Exception during the COVID-19 PHE

- a. The physician, either in person or through telehealth or other remote communications, remains responsible for providing medical direction,

consultation, and supervision for the RHC's health care staff. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 08/20/20>

- b. This allows RHCs to use NPs to the fullest extent possible and allows physicians to direct their time to more critical tasks during the PHE. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 08/20/20>

B. Physician Services

1. The term "physician" includes a doctor of medicine (MD), doctor of osteopathy (DO), dental surgery/medicine, podiatry, optometry, or chiropractic that are licensed and practicing within their scope. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 110, 110.1>
 - a. An RHC is required to mainly provide primary health care. Since dentists, podiatrists, optometrists, and chiropractors are not considered primary care physicians, they do not meet the requirements to be either:
 - (i) A physician medical director; or
 - (ii) The physician or non-physician practitioner (NP, PA, or CNM) that must be available at all times during the clinic's posted hours.
 - (iii) A qualifying visit by a dentist, podiatrist, optometrist, or chiropractor can be performed only when a physician (MD or DO) or other qualified RHC non-physician practitioner (NP, PA, or CNM) is also available in the clinic, when the service is provided.
 - (a) HCPCS codes must be reported to reflect the actual service(s) that were furnished by non-RHC physicians.
2. Services furnished by a physician include those that would normally be provided in a physician's office, such as the examination and diagnosis of the patient, preventive services, therapy services, consultations, and minor surgical procedures. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 10.1, 110>

Prior to January 1, 2017, CMS provided a Qualifying Visit List that included frequently reported HCPCS codes that met the requirements for a face-to-face visit between the patient and an RHC practitioner. The list was last updated on August 1, 2016, and was not intended to be an all-inclusive list of stand-alone billable visits.

C. Non-Physician Practitioner Staffing

1. The RHC must employ at least one NP or PA on a part-time or full-time basis. <79 Fed. Reg. 25480; see *Medicare Benefit Policy Manual*, Chapter 13 § 30.1>

Caution: An NP or PA that is providing services similar to a locum tenens or fee-for-time physician does not meet the statutory requirement that one of these professionals must be employed by the clinic. In addition, an Advance Practice Registered Nurse (APRN) who is not a licensed NP or PA does not meet the statutory staffing requirement.

- a. The clinic may enter into staffing contracts with other NPs, PAs, CNMs, CPs or CSWs, if there is always at least one NP or PA employed by the RHC. <See 42 C.F.R. 491.8; see *Medicare Benefit Policy Manual*, Chapter 13 § 30.1>

A clinic located on an island (i.e., surrounded by water, regardless of size and accessibility to the mainland) is not required to employ an NP or PA. However, under this exception, an NP or PA must continue to meet the regulatory requirement to provide services in the RHC during its posted hours.

2. An NP, PA, or CNM must be available to provide patient care in the RHC at least 50% of the time that the clinic is open, according to its posted schedule. This requirement may be fulfilled through any combination of NPs, PAs, or CNMs, if the total time equals 50%. <See *Medicare Benefit Policy Manual*, Chapter 13 § 30.1>

- a. Time spent furnishing patient care in the RHC or the time spent directly furnishing patient care in another location (e.g., home, SNF, etc.) as an RHC practitioner is counted towards the 50% requirement.
 - (i) Travel time to another location or any time spent not furnishing patient care in non-RHC locations will not count towards the 50% requirement.

- b. Exception during the COVID-19 PHE

- (i) CMS is waiving the requirement that an NP, PA, or CNM be available to furnish patient care services at least 50% of the time the RHC operates. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 08/20/20>

- (ii) CMS is not waiving the requirement that a physician, NP, PA, CNM, clinical social worker, or clinical psychologist be available to furnish patient care services at all times the RHC operates according to its posted hours. <COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated 08/20/20>

c. Temporary staffing waiver

- (i) If an existing RHC loses its non-physician practitioner(s) and is unable to meet the requirement for the minimum 50% availability during the RHC's operating hours, it may request a temporary staffing waiver. <See *Medicare Benefit Policy Manual*, Chapter 13 § 30.2>
 - (a) The RHC must demonstrate in the 90-day period prior to the request that it made a good faith effort to recruit and retain the required NP or PA.
 - (b) A waiver cannot be extended beyond one year and another waiver cannot be granted until a minimum of six months have passed since the prior waiver has expired.

Caution: The RHC should inform the state of any changes in staffing which would affect its certification status and it should continue to recruit the required provider(s) to avoid termination of its certification.

- 3. In addition to providing patient care, an NP or PA must also review patients' records and assist the RHC physician in the development and biennial review of its policies. <See 42 C.F.R. 491.8; see 42 C.F.R. 491.11>

D. Non-Physician Practitioner (NP, PA, or CNM) Services

- 1. Services furnished by an NP, PA, or CNM are those that would also be considered covered physician services under the Medicare benefit, such as the examination and diagnosis of the patient, preventive services, therapy services, consultations, and minor surgical procedures. <See *Medicare Benefit Policy Manual*, Chapter 13 § 130>
 - a. Services provided by an NP, PA, or CNM must meet additional requirements, including:
 - (i) Must be provided under the general supervision of a physician (or direct supervision, if required by state law);

- (ii) Must be furnished according to the RHC's internal policies that specify what services non-physician practitioners may order and furnish to its patients; and,
 - (iii) Must be within the practitioner's scope of practice and permitted under state law. <See *Medicare Benefit Policy Manual*, Chapter 13 § 130.1>
- b. An RHC that is not physician-directed must have an arrangement with a physician that provides supervision for the NP, PA, and CNM in accordance with state law. <See *Medicare Benefit Policy Manual*, Chapter 13 § 130.2>

IV. Services Provided by Other Healthcare Professionals

A. Clinical Psychologist (CP)

1. A CP must hold a doctoral degree in psychology and be licensed or certified to practice independently in the state in which he or she practices. <See *Medicare Benefit Policy Manual*, Chapter 13 § 150>

B. Clinical Social Worker (CSW)

1. A CSW must hold a master's or doctor's degree in social work, have performed two years of supervised clinical social work, and be licensed or certified as a CSW by the state in which he or she practices. <See *Medicare Benefit Policy Manual*, Chapter 13 § 150>
 - a. Where a state does not provide licensure, a CSW must have completed at least two years or 3,000 hours of post master's degree clinical social work practice and was supervised by a master's level social worker in an appropriate setting, such as a hospital, SNF, or clinic. <42 C.F.R. 410.73(a)(3)>
2. Services furnished by a CP or CSW are those that would also be covered physician services under the Medicare benefit, including the examination and diagnosis of patients and providing consultations. <See *Medicare Benefit Policy Manual*, Chapter 13 § 150>
3. Services furnished by a CP or CSW must also meet the following requirements:
 - a. Must be performed under the general supervision of a physician (or direct supervision, if required by state law);
 - b. Must be furnished according to the RHC's policies that specify what services a CP or CSW may order and furnish to patients; and,

- c. Must be within the practitioner's scope of practice and permitted under state law.

Caution: A CSW is only authorized to furnish services for the diagnosis and treatment of mental illnesses.

V. Hours of Operation

- A. A physician, NP, PA, CNM, CP, or CSW must be available to furnish patient care services within their scope of practice when the RHC is open to provide patient care. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 30.1, 40.2>
 - 1. The days of the week and the hours of operation must be posted at or near the clinic's entrance.
 - 2. The notice must be easily readable and accessible for all patients (e.g., patients with vision problems or patients in wheelchairs).
 - 3. A clinic that is open solely to address administrative matters or to provide shelter from inclement weather is not considered to be in operation during that time and is not subject to the staffing requirements.
- B. Services that are provided after the posted hours of operation can be billed by the clinic only when provided by a practitioner that is compensated by the RHC and only when those services are reported on the cost report. <See *Medicare Benefit Policy Manual*, Chapter 13 § 40.2>
 - 1. If the services are provided after the posted hours of operation in accordance with the RHC's policies, procedures and employment contracts, and are ***not*** reported on the cost report, the practitioner may separately bill those services to Medicare Part B.
 - a. The appropriate Medicare coverage policies and payment methodology will apply.
 - b. All costs associated with non-RHC services billed separately to Part B must be removed from the cost report, including costs associated with space, equipment, supplies, facility overhead, and personnel. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60>

VI. RHC Services Defined

- A. RHC services are those services generally provided in a physician's office and ***must*** include at a minimum: <42 C.F.R. 405.2400 – 405.2417; see *Medicare Benefit Policy Manual*, Chapter 13 § 50.1>

1. Physician services and supplies incident to a physician's service; and
 2. NP and/or PA services and supplies incident to their services.
- B. An RHC is also required to be able to furnish certain laboratory services onsite for the immediate diagnosis and treatment of its patients, which include:
1. Chemical examination of urine;
 2. Hemoglobin or hematocrit;
 3. Blood glucose;
 4. Occult blood stool examination;
 5. Pregnancy testing; and
 6. Primary culturing for transmittal to a certified laboratory. <See 42 C.F.R. § 491.9>
 - a. Although an RHC is required to be able to furnish certain laboratory services onsite, these services are not within the scope of the RHC benefit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60.1>

Caution: *Excluding venipunctures performed by an RHC practitioner or qualified staff member, laboratory services are non-RHC services. Laboratory services must be billed separately on the appropriate claim form (i.e., 1500 or UB-04). All costs associated with the laboratory services must be excluded from the RHC's cost report.*

- i. Billing for laboratory services will be discussed in detail in a later module.

Case Study 1

Facts: A patient presents to the RHC complaining of dizziness and weakness. The patient sees their usual physician who orders a hemoglobin and hematocrit. The nurse draws the blood and the laboratory tests are performed in the RHC. The physician documents and charges for a Level III office visit (99213).

- Can the charges for the laboratory services performed in the RHC be included in the qualifying visit charge?

C. In general, an RHC may provide certain additional services under its certification, including but not limited to: <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 10.1, 50.1>

1. Services of a clinical nurse midwife (CNM) or clinical psychologist (CP) and services incident to a qualifying visit;
2. Services of a clinical social worker (CSW);
3. Visiting nurse services for patients confined to home, in certain circumstances;
4. Services of registered dietitians or nutrition professionals for diabetes self-management training services and medical nutrition therapy, when incident to a qualifying visit with an RHC practitioner;
5. Covered drugs, biologicals, and other services when provided incident to a qualifying visit with an RHC practitioner;
6. Routine diagnostic services;

Caution: When performed by an RHC practitioner or furnished incident to a qualifying visit, only the professional component of a diagnostic service is within the scope of the RHC benefit. The technical component cannot be billed on the RHC claim. Billing for diagnostic services will be discussed in detail in a later module.

7. Certain care management and virtual communication services;
8. Certain preventive services when specified by statute or National Coverage Determination (NCD) policy, which may include:
 - a. Influenza, pneumonia, and Hepatitis B vaccines;
 - b. Initial Preventive Physical Examination (IPPE);
 - c. Annual Wellness Visit (AWV); and,
 - d. Other covered preventive services as recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B.
 - i. An RHC practitioner may refer patients to other facilities for preventive services which are not usually provided in a physician's office.

D. Non-RHC Services

1. An RHC may provide other services beyond the scope of its certification and the RHC benefit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60>
 - a. If the service is covered under another Medicare benefit category, the service must be billed separately (not by the RHC) under the payment rules that apply to that service (i.e., Medicare Physician Fee Schedule (MPFS) or Clinical Laboratory Fee Schedule (CLFS)).

Caution: All costs associated with non-RHC services (e.g., overhead, staff, supplies, etc.) are not considered to be allowable costs and may not be reported on the RHC's cost report. Billing for certain non-RHC services will be discussed in detail in a later module.

2. Non-RHC services include, but are not limited to:
 - a. Services excluded from coverage under the Medicare program (e.g., routine physical exams, hearing tests, eye exams, and self-administered drugs (SADs));
 - b. The technical component of a diagnostic service performed in an RHC (e.g., x-ray or EKG);
 - c. Laboratory services;
 - d. Durable medical equipment, prosthetic devices, body braces;
 - e. Medically necessary ambulance transport services to the nearest appropriate facility;
 - f. Practitioner services furnished to inpatients or outpatients in a hospital or CAH, ambulatory surgery center, or comprehensive outpatient rehabilitation facility;
 - g. Telehealth distant-site services;
 - h. Hospice services; and,
 - i. Group services including education activities or classes. <See *Medicare Benefit Policy Manual*, Chapter 13 § 60.1>

VII. Services and Supplies Provided "Incident to" an RHC Practitioner's Services

A. Definition of "Incident to"

1. In general, “incident to” refers to those covered services and supplies that are integral, though incidental, to an RHC practitioner’s service and are:
 - a. Usually provided in an outpatient clinic setting;
 - b. Usually included in the RHC all-inclusive rate (AIR) payment;
 - c. Performed by a staff member of the RHC in a medically appropriate timeframe; and,
 - d. Generally, furnished under the appropriate RHC practitioner’s direct supervision. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120, 140, 160>

B. Exceptions to “Incident to”

1. Transitional Care Management (TCM) and General Care Management may be furnished under general supervision rather than direct supervision (discussed in detail in a later module). <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120, 140, 160>

Caution: *The Part B benefit does not authorize a CSW to have services furnished incident to their professional services and must personally perform their own services.*

C. Services Provided by RHC Staff “Incident to” a Qualifying Visit

1. Services provided by auxiliary staff, either employed by or under an employment contract with the RHC, are covered as incident to when provided as a result of a qualifying visit and performed under the RHC practitioner’s direct supervision, excluding care management services. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120.1, 140, 160>
 - a. Services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the RHC for inclusion on the claim, services provided by an independent laboratory or a hospital outpatient department, services furnished by a nurse, medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the RHC, including services provided by a third party under contract. <See *Medicare Benefit Policy Manual* Transmittal 263>
 - b. Direct supervision does not require that the practitioner be present in the same room; however, the supervising practitioner must be in the RHC and immediately available to provide assistance and direction during the time when the services are being provided. <See *Medicare Benefit Policy Manual*, Chapter 13 § 120.1>

- c. Direct supervision is met for an NP, PA, CNM, or CP who supervises the performance of services by RHC staff only if the non-physician practitioner can provide supervision under the RHC's written policies, their scope of practice, and as allowed under state law. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 140, 160>
- d. Services furnished by an RHC employee incident to a physician's visit in a patient's home or location other than in the RHC must be provided under the direct supervision of a physician. <See *Medicare Benefit Policy Manual*, Chapter 13 § 120.2>
 - (i) The availability of the physician by telephone or in a different location in the same building does not meet the definition of direct supervision.

Note: The direct supervision requirement does not apply to visiting nurse services appropriately provided in the home or to certain care management services provided by RHC staff (discussed in detail in a later module).

- 2. Incident to services or supplies are either provided without charge (e.g., routine supplies) or are included in the RHC's total charge for the qualifying visit (e.g., venipuncture performed by a nurse or medical assistant). <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 120, 140, 160>
 - a. More than one incident to service can be provided during a qualifying visit with an RHC practitioner.
 - b. Supplies that must be billed to the DME MAC or to Part D are not included as part of the qualifying visit.
- 3. Most drugs and biologicals are covered when they are provided as part of a qualifying visit and **are not** "usually self-administered". Payment for Medicare-covered Part B drugs is included in the AIR. <See *Medicare Benefit Policy Manual*, Chapter 13 § 120.3>
 - a. Drugs that **are** usually self-administered (e.g., oral pain medication or oral antibiotic) are not included in the RHC's total charge for the qualifying visit. <See *Medicare Benefit Policy Manual*, Chapter 13 § 120>

Coverage and billing for drugs and self-administered drugs will be discussed in detail in a later module.

- b. Certain drugs that are specifically covered by a Medicare statute (i.e., influenza or pneumococcal vaccine) are not paid as part of the qualifying visit and are not reported on the RHC claim. <See *Medicare Benefit Policy Manual*, Chapter 13 § 220.1>

Reporting vaccines and their administration will be discussed in detail in a later module.

VIII. Other RHC Requirements

A. Emergency Care

1. Generally, an RHC must provide limited emergency care as a first response to common life-threatening injuries and acute illnesses. The RHC must maintain a supply of commonly used drugs and biologicals adequate to handle the volume and type of medical emergencies it typically encounters. <See 42 C.F.R. § 491.9; see *Medicare Benefit Policy Manual*, Chapter 13 §§ 10.1, 50.3; see *Medicare State Operations Manual* Transmittal 194>
 - a. An RHC, either independent or provider-based, is not subject to the Emergency Medical Treatment and Active Labor Act (EMTALA).
 - b. When a physician, NP, PA, CNM, CP, or CSW is not present, any care provided in an emergency must be within the staff's ability, training, and scope of practice, and in accordance with state laws.
2. The final rule for *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* went into effect on November 16, 2016. All healthcare providers and suppliers were required to comply and implement all applicable regulations by November 16, 2017. <81 Fed. Reg. 63860-64044>
 - a. In general, an RHC must comply with all federal, state, and local emergency preparedness requirements, including but not limited to the following elements:
 - (i) Emergency plan;
 - (ii) Policies and procedures;
 - (iii) Communication plan;
 - (iv) Training and testing; and,

(v) Integration with the healthcare system, where applicable. <See 42 C.F.R. 491.12; *Medicare State Operations Manual*, Appendix Z>

B. Arrangements with Other Providers

1. An RHC must have an agreement or arrangement with other providers participating under Medicare and/or Medicaid to furnish additional services to its patients, including:
 - a. Inpatient hospital care;
 - b. Physicians' services; and
 - c. Specialized diagnostic and laboratory services not available at the clinic. <See 42 C.F.R. § 491.9>
 - (i) If the agreement is not in writing, there must be evidence that patients being referred by the RHC practitioner are being accepted and treated by other providers (i.e., consultation reports, procedure reports, etc.).

C. Commingling in an RHC

1. Definition of commingling
 - a. Commingling refers to when an RHC shares space, employed or contracted staff, supplies, equipment, and/or other resources with another onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC practitioner. <See *Medicare Benefit Policy Manual*, Chapter 13 § 100>
2. Prohibition on commingling
 - a. During the RHC's posted hours of operation, the clinic practitioner may not provide services as an independent Part B provider in the RHC or in an area outside of the designated RHC space (i.e., adjacent treatment room). <See *Medicare Benefit Policy Manual*, Chapter 13 § 100>
 - (i) Covered services provided by a clinic practitioner during the RHC's hours of operation cannot be carved out of the cost report and billed separately to Part B.

- (ii) This prohibition is intended to prevent duplicate payments to the RHC and the practitioner and to prevent selectively choosing a higher or lower reimbursement rate for the same service.

Case Study 2

Facts: An RHC is staffed by one physician Monday-Friday, 8:00 a.m. to 4:00 p.m. During the clinic's posted hours of operation, the physician goes across the hall into a separate procedure room (not part of the RHC) to perform a simple biopsy on a non-RHC patient.

- Can the physician bill for the services on a separate Part B claim (1500 claim form)?

D. Sharing RHC Practitioners with a Hospital Emergency Department

1. If the conditions of coverage are met during the time when an RHC practitioner is away from the clinic (e.g., at least one physician, NP, PA, or CNM is present in the RHC during its posted hours), the commingling policy does not prohibit a provider-based RHC from:
 - a. Sharing its practitioners with the hospital emergency department in an emergency; or,
 - b. Providing on-call services to the emergency department. <See *Medicare Benefit Policy Manual*, Chapter 13 § 100>

Caution: CMS expects that the sharing of the RHC practitioner with the hospital emergency department would not be a common practice.

2. The clinic must appropriately allocate the practitioner's salary on the cost report to differentiate between RHC time and emergency department time.

E. Further Defining Shared Space

1. When an RHC is in the same building with another entity (e.g., an unaffiliated medical practice, x-ray facility, or emergency room), the RHC's space must be clearly defined to prevent duplicate reimbursement. <See *Medicare Benefit Policy Manual*, Chapter 13 § 100>
 - a. An RHC that shares resources (e.g., a waiting room, receptionist, or telephones) with another entity must appropriately allocate shared staff, space, and resources on the cost report.

- b. An RHC that leases space to another entity must appropriately report the leased space on the cost report.

XI. Classification of an RHC for Payment Purposes

A. Independent RHC

1. An independent RHC is a freestanding or stand-alone clinic that is not an integral and subordinate part of another healthcare entity. <See *Medicare Benefit Policy Manual*, Chapter 13 § 10.1>
 - a. An RHC can be owned by a practitioner, hospital, CAH, SNF, or home health agency and operated as an independent RHC.
 - b. An independent RHC is assigned a provider number (CMS Certification Number or CCN) in the range of 3800-3974 or 8900-8999.

Note: The national upper payment limit will apply to an independent RHC (discussed in detail in a later module).

B. Provider-based RHC

1. A provider-based RHC is owned, operated, and otherwise controlled by a hospital or other healthcare entity. <See 42 C.F.R. 413.65>
2. A provider-based RHC is an integral and subordinate part of a hospital, CAH, SNF, or home health agency. <See *Medicare Benefit Policy Manual*, Chapter 13 § 10.1>
 - a. A provider-based RHC is assigned a provider number (CCN) in the range 3400-3499, 3975-3999 or 8500-8899.
 - (i) However, a provider-based provider number is not an indication that the RHC has a provider-based determination for the purposes of an exception to the national upper payment limit.
3. In general, a provider-based RHC must meet all Medicare requirements which require that the clinic is integrated into the operations of the hospital or other healthcare entity. <See 42 C.F.R. 413.65>

- a. Although a provider-based RHC must be fully integrated with its parent provider, an RHC is not considered to be a department of the provider for the purposes of application of the entire regulation. <See 42 C.F.R. 413.65(a)(2)>

Note: The national upper payment limit will apply to a provider-based RHC unless it qualifies as a “grandfathered provider-based RHC” (discussed in detail in a later module).

Version 03/15/2023
Check for Updates

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A patient presents to the RHC complaining of dizziness and weakness. The patient sees their usual physician who orders a hemoglobin and hematocrit. The nurse draws the blood and the laboratory tests are performed in the RHC. The physician documents and charges for a Level III office visit (99213).

- Can the charges for the laboratory services performed in the RHC be included in the qualifying visit charge?

Analysis: No. Although an RHC must be able to provide certain lab services onsite according to its CMS certification, laboratory is a non-RHC service. Excluding the venipuncture, laboratory services must be billed separately from the clinic visit on the appropriate claim for either an independent RHC (1500 claim form) or a provider-based RHC (UB04 claim form by the parent provider). A Medicare patient is not responsible for coinsurance or deductible for lab services. In this case, the charge for the venipuncture will be included in the total visit charge and reimbursed under the all-inclusive rate (AIR).

Case Study 2

Facts: An RHC is staffed by one physician Monday-Friday, 8:00 a.m. to 4:00 p.m. During the clinic's posted hours of operation, the physician goes across the hall into a separate procedure room (not part of the RHC) to perform a simple biopsy on a non-RHC patient.

- Can the physician bill for the services on a separate Part B claim (1500 claim form)?

Analysis: No – covered services that are provided during the RHC's posted hours of operation by an RHC practitioner cannot be carved out of the cost report and billed separately to Part B. The practice that CMS refers to as "commingling" is prohibited to prevent duplicate payments to the RHC. It also prevents selectively choosing a higher or lower reimbursement for the same service that may be billed on different claim types/forms. In this case, the staffing requirements would not be met during the RHC's posted hours (i.e., at least one physician, NP, PA, or CNM must be in the clinic to provide services).

Version 03/15/2023
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