

Chapter 29

Rural Health Clinic (RHC)

This chapter refers to services provided by a Rural Health Clinic and applies to only those programs outlined in your organization's participation agreement with South Country Health Alliance – for detailed information providers are encouraged to use the Noridian web site:

https://www.noridianmedicare.com/p-meda/train/manuals/rhc_manual.pdf

Certification Criteria

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are clinics that are located in areas that are designated both by the Bureau of the Census as rural and by the Secretary of DHHS as medically underserved and Section 1861 (aa)(4) of the Social Security Act. Services rendered by approved RHCs and FQHCs to Medicare beneficiaries are covered under Medicare effective with the date of the clinic's approval for participation. A RHC cannot be concurrently approved for Medicare as both an FQHC and an RHC. Covered services are described in the Medicare Benefit Policy Manual.

- CMS will enter into an agreement with the RHC or FQHC that participates in the Medicare program. These are usually renewed on an annual basis. The agreement doesn't need to be resigned each year. If there is a change in ownership (CHOW) the agreement with the existing clinic or center is automatically assigned to the new owner so there is no interruption in service. A new agreement with the updated information must be signed if the clinic meets all applicable requirements.
- A RHC must have a physician on staff that provides medical supervision for the clinic's staff. The physician must be present at the clinic at least every two weeks for medical direction, consultation and supervision and be available by telecommunication at all times for assistance with medical emergencies and patient referrals.
- The clinic must employ at least one nurse practitioner, physician assistant or certified nurse midwife who is on duty at least 50 percent of the time the clinic is open and who is under the general direction of the physician. One of these professionals must be present to provide service whenever the clinic is open.

Claims processing Jurisdiction for RHCs and FQHCs

MMSI/SCHA processes all claims for provider based RHCs.

RHC/FQHC Covered Services

Payments for covered RHC/FQHC services furnished to South Country Health Alliance members are made on the basis of an all-inclusive rate per covered visit. The term "visit" is defined as a face-to-face encounter between the patient and a physician,

physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. Encounters with (1) more than one health professional; and (2) multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. An exception occurs in cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment. With the Deficit Reduction Act of 2005 FQHC definition of a face-to-face encounter is expanded to include encounters with qualified practitioners of Outpatient Diabetes Self-Management Training Services and medical nutrition therapy services for services provided 6-29-06 and after.

RHC/FQHC services are the following, and additional information may be found in the Internet Only Manual (IOM) at <http://www.cms.hhs.gov/manuals> Chapter 13 Subsection 50-110 of the Medicare Benefit Policy Manual, Medicare Claims Processing Manual Chapter 9 Subsection 413 and Provider Reimbursement Manual (PRM) section 15-I. The PRM Part 2, Chapter 36, section 3662-3666 completion of the M services worksheets on form 2552.

- Compensation for the services of physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers compensated by the RHC/FQHC
- Compensation for the duties that a supervising physician is required to perform
- Costs of services and supplies incident to the services of a physician, physician assistant (PA), nurse practitioner (NP), nurse midwife (NM), clinical psychologist (CP), or clinical social worker (CSW)
- Services of registered dietitians or nutritional professionals for diabetes training services and medical nutrition therapy. Otherwise covered drugs that are furnished by, and incident to, services of physicians and non physician practitioners of the RHC/FQHC.
- Overhead costs, including RHC administration, costs applicable to the use and maintenance of the RHC facility and depreciation costs
- The costs of physician services furnished under agreements with the RHC
- If the RHC is located in an area with a shortage of home health agency (HHA) services, the costs of visiting nurse services and related supplies furnished.

South Country Health Alliance makes payment directly to the RHCs for covered services furnished to South Country Health Alliance member. RHC services are covered when furnished to a patient at the clinic or center, the patient's place of residence, or elsewhere (e.g., the scene of an accident).

Services and Supplies "Incident To" the Services

Services and supplies which are "incident to" the services of the physician, nurse practitioner, physician assistant, clinical psychologist or clinical social worker are also

covered in the RHC/FQHC. This would include services of other clinic employees including registered nurses, licensed vocational nurses, technicians, or aides. This also includes supplies such as casts, bandages, splints, etc., used for these services. Only drugs and biologicals, which cannot be self-administered, are covered in the RHC/FQHC. Clinical laboratory test, furnished in the RHC/FQHC laboratory, are also covered as RHC/FQHC services.

RHC/FQHC Services Not Covered

Services that are provided outside of the scope of a RHC/FQHC are non-covered as a RHC/FQHC benefit. If these services are covered under another Medicare benefit category they may be separately billable to the Medicare carrier/intermediary as appropriate.

The following services are NOT RHC/FQHC services

- Durable Medical Equipment (DME) (whether rented or sold) including crutches, hospital beds and wheelchairs used in the patient's place of residence
- Ambulance services
- Technical component of diagnostic tests such as x-rays and EKGs (the professional component is a RHC service if performed by a RHC/FQHC physician or non-physician practitioner)
- The technical component of the following specific preventive services (the professional component is a RHC/FQHC service if performed by a RHC/FQHC physician or non-physician practitioner)
 - Screening pap smears and screening pelvic exams
 - Prostate cancer screening
 - Diabetes outpatient self-management training services
 - Colorectal cancer screening tests
 - Screening mammography
 - Bone mass measurements and
 - Glaucoma screening
- 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
- 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)

RHC/FQHC Services for Hospital Inpatient and Outpatients

Payment may not be made to practitioners for services provided to hospital inpatients and outpatients for practitioners who are compensated under the RHC/FQHC agreement. If the practitioner isn't compensated under the RHC/FQHC agreement they may seek payment for those services from South Country Health Alliance.

Skilled Nursing Facility Services

Payment may be made to the practitioner for services provided to a SCHA member in a Part A stay in a Medicare certified Skilled Nursing Facility (SNF).

Preventive Primary Services Which Are FQHC Services

Preventive primary services must be furnished by or under the direct supervision of a physician, a NP, PA, CNMW, CP, CSW who is an employee of the clinic or a physician under arrangements with the clinic.

Preventive primary services include only drugs and biologicals that are not usually self-administered.

The following preventive primary services may be covered and billed to MMSI/SCHA when provided by FQHCs when provided to South Country Health Alliance member.

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

Preventive Services Excluded Under FQHC Benefit

FQHC preventive primary services do not include:

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

General Exclusions from Medicare Coverage

No payment can be made under Medicare Part A or Part B for items and services with the following characteristics:

- Not reasonable and necessary
- No legal obligation to pay for or provide
- Furnished or paid for by other government entities
- Not provided within the United States
- Personal comfort
- Routine services and appliances
- Supportive devices for feet
- Custodial care
- Cosmetic surgery
- Charges by immediate relatives or members of household.
- Dental services
- Paid or expected to be paid under a Medicare Secondary Payer (MSP) provision
- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital

Health Care Professionals

Physician services are the professional services performed by a physician for a patient including diagnosis, therapy, surgery and consultation.

Physician

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 EKG or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of verbal description) is a covered service.

Professional Services

In determining what constitutes the professional services of a physician in a RHC/FQHC the following general rules apply:

- The services of a physician performed at the clinic are RHC/FQHC services and are payable only to the clinic.
- 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, these are not considered encounters so are not separately billable.
- Visits for the sole purpose of obtaining or renewing a prescription, the need for which was previously determined without an exam are not covered services
- Time used in completion of claim forms.

Full-time and part-time physicians who are employees of an RHC/FQHC or who are compensated under agreement by the clinic for providing services furnished to clinic patients in a location other than at the clinic, may furnish services to clinic's patients at the clinic or in other locations (e.g., in a patient's home). These services are RHC/FQHC services and are payable only to the clinic. Clinic patients include individuals who receive services at the clinic facility or services provided elsewhere for which the costs are included in the costs of the RHC/FQHC.

A physician who is an employee of an RHC/FQHC or who is compensated by the clinic for services in locations other than the clinic, may not bill the Medicare Part B program through the carrier for services furnished to SCHA members at locations away from the clinic.

If the clinic does not compensate a physician for services furnished to clinic patients in a location other than at the RHC/FQHC location, the physician may bill for payment under Part B for a location away from the clinic.

A RHC/FQHC may obtain a consultation, which is covered when it is a professional service furnished to a patient by a second physician or consultant at the request of the attending physician. Such a consultation includes the H&P of the patient as well as the written report furnished to the attending physician for inclusion in the patient's clinic or center records.

Concurrent care exists when more than one physician renders services during a period of time. 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.

Services and Supplies

Services and Supplies Incident to Physician's Services

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

- Furnished as an incidental, although integral, part of a physician's professional services
- A type commonly rendered either without charge or included in the RHC/FQHC bill.
- Services provided by clinic employees other than those non-physician practitioners, furnished under the direct, personal supervision of a physician
- Furnished by a member of the clinic or staff who is an employee of the clinic.
- This benefit includes drugs and services of clinic staff e.g., a nurse, therapist, technician, or other aide, and supplies such as tongue depressors, bandages.

Incidental and Integral Part of Physician's Professional Services

Services and supplies must be an integral, although incidental, part of the RHC/FQHC practitioner's personal professional services in the course of diagnosis or treatment of an injury or illness. There must be a practitioner's personal service furnished in which the clinical staff member's service (or the supply) is an incidental, although integral part. However, this does not mean that each occasion of service by a clinical staff member (or the furnishing of a supply) need to also always be the occasion of the actual furnishing of a personal professional service by the RHC/FQHC practitioner. This requirement is also met for non-physician services furnished during a course of treatment in which the physician performs an initial and subsequent service with a frequency that reflects his active participation in and management of the course of treatment. However, the direct and personal supervision requirement must still be met with respect to every clinical staff member's service for it to be covered as an incident to service.

Although incident to services are covered, they are covered as part of an otherwise billable encounter. If no medically necessary face-to-face encounter with a physician or midlevel practitioner, CP or CSW has occurred during the visit with the incident to staff then no encounter can be billed.

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 when supplies are clearly types of materials that a physician is not expected to have on hand in his office or where services are a type that are not medically appropriate in the office setting.

Direct Personal Supervision and Incident to

Coverage is limited to situations where there is direct supervision of the clinic staff performing the service. Direct and personal supervision does not mean that the RHC/FQHC practitioner must be present in the same room. However, the practitioner must be on the premises and immediately available to provide assistance and direction throughout the time the practitioner is performing services.

When clinic auxiliary staff performs services outside the entity, in the patient's home or in the institution, these services are covered as incident to a physician's services only if there is direct personal supervision by the physician. If the physician makes a house call and his nurse administers an injection that would meet the direct supervision requirements.

As with the physician's personal professional service, the services (or supplies) must be supplied without charge or be included in the clinic bill. The patient's financial liability for the incidental services (or supplies) is to the clinic. Therefore, the incidental services (or supplies) must represent an expense incurred by the RHC/FQHC.

Example: If a patient purchases a drug and the physician administers it, the drug is not covered as an RHC/FQHC service.

Services and supplies covered under this provision include such items 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 that 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.

Nurse Practitioner, Physician Assistant, and Nurse Midwife Basic Requirements

Services performed by non-physician practitioners are covered as RHC services if:

- Furnished by an employee of the RHC/FQHC or an individual who receives compensation from the RHC/FQHC, nurse practitioner, physician assistant, or certified-nurse midwife (Mid-levels cannot be contracted workers, they can only be an employee of the clinic or clinic owner).
- Furnished under the general or direct medical supervision of a physician as required by state laws.
- Furnished in accordance with clinic policies and any physician's medical orders for the care and treatment of a patient.
- A service 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 furnished.
- A type which would be covered under Medicare if furnished by a physician.

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. These 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, EKG and electroencephalogram tapes, tissue samples, etc.

Medicare covers services provided by a nurse practitioner, physician assistant, and certified nurse midwife, which would be considered covered physician services under Medicare, and are permitted by state laws and clinic. 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.

Basic Requirements for RHC/FQHC Services

To determine whether the professional services of a nurse practitioner, physician assistant, or certified-nurse midwife are RHC/FQHC services, the following rules apply:

- The services of a full or part time nurse practitioner or physician assistant (including services furnished by certified-nurse midwives) performed at the clinic are RHC/FQHC services and are payable only to the clinic.
- 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 not separately billable since no face to face encounter occurred but can be included as part of a previous billable visit by the RHC/FQHC practitioner (e.g., revenue code 52x).
- 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.
- Time used in completion of claim forms.
- Care-plan oversight is not allowed for Part A RHC/FQHC providers.

Full and part-time nurse practitioners, physician assistants (including nurse midwives) who are employees of an RHC/FQHC or who are compensated by the clinic for providing services furnished to the clinic's patients in locations other than at the clinic, may furnish services to clinic patients at the clinic or in other locations, such as the patient's home. These services are RHC/FQHC services and are reimbursable only to the clinic.

Nurse practitioner and physician assistant services (including services of certified nurse midwives) must be furnished in accordance with written policies governing the furnishing of services by the clinic to its patients. As part of the RHC/FQHC provider agreement the clinic must have specific policies in place and comply with these policies. Services that don't comply with the policies are not covered RHC/FQHC services.

Visiting Nurse Services

Visiting nurse services are covered as RHC/FQHC services if:

- The RHC/FQHC has received special certification from CMS to provide visiting nurse services because the RHC/FQHC is located in an area in which CMS has determined there is a shortage of home health agencies (contact your state Department of Health).
- The services are rendered to patients who are homebound and meet the coverage criteria as specified for a Home Health Agency.
- The patient is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse (under the supervision of the registered nurse) that is employed by or receives compensation for the services from the RHC/FQHC.
- The services require the skills of a nurse based on their complexity and the condition of the patient under acceptable standards of medical and nursing practices.
- The services are furnished under a written plan of treatment that is recertified every 60 days.

Clinical Psychologist Services

To qualify as a clinical psychologist a practitioner must meet the following requirements:

- 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.
- Meet licensing or certification standards for psychologists in independent practice in the state in which he practices.
- Have two years of supervised clinical experience, at least one of which is post-degree.

Services provided at the RHC/FQHC or outside the clinic e.g. patients home by a clinical psychologist who is an employee of the clinic or compensated by the clinic are only reimbursable to the clinic.

Psychiatric Limitations

All covered therapeutic services furnished by qualified clinical psychologists in a RHC/FQHC are subject to the outpatient mental health services limitation (i.e., 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). This limitation does not apply to diagnostic services.

Clinical Social Worker Services

RHC/FQHC services include the services provided by a clinical social worker. A clinical social worker is an individual who:

- Possesses a master or doctor's degree in social work.
- Has performed at least two years of supervised clinical social work; and 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 two 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, Skilled Nursing Facility (SNF) or clinic.

Clinical Social Worker Covered Services

Coverage is limited to the services a clinical social worker is legally authorized to perform in accordance with state law (or state regulatory mechanism established by state law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses and services and supplies furnished incident to such services.

The services of a clinical social worker may be covered in an RHC if they are:

- The type of services that are otherwise covered if furnished by a physician, or incident to a physician's service.
- Performed by a person who meets the above definition of clinical social worker.
- Not otherwise excluded from coverage.

Note: Services of a clinical social worker 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 to Medicare. Services at the RHC/FQHC or away from the RHC/FQHC are covered. See the previous information in the "Physician" section.

Note: Only the direct "hands on" services of a clinical social worker are covered. No coverage is available for services and supplies furnished incident to the professional services of a clinical social worker.

Psychiatric Limitations

All covered therapeutic services furnished by qualified clinical social workers in an RHC/FQHC are subject to the outpatient mental health services limitation (i.e., 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). This limitation does not apply to diagnostic services.

General Billing Requirements

Effective December 1, 2009 Rural Health Clinics are required to bill Medicaid Services (PMAP, MNCare and GAMC) to SCHA using the 837P (CMS 1500) format. DHS had implemented this change effective July 15, 2009. If claims have been submitted to SCHA/MMSI on the CMS 1500 prior to December 1, 2009 claims will be process.

Providers are required to continue to bill services using the 837I (UB04) format for services provided to SCHA member/patients on any of the Medicare programs (AbilityCare - SNBC or SeniorCare Complete - MSHO).

Type of Bill

All charges submitted by an RHC will appear under Type of Bill (TOB) 71X. All charges submitted by an FQHC will appear under Type of Bill (TOB) 73X. The third digit of the TOB provides additional information regarding the individual claim.

The third digit descriptions are listed below:

- 710 or 730-Non-payment
- 711 or 731-Admit through discharge (original claim)
- 717 or 737-Replacement of prior claim (adjustment)
- 718 or 738-Void/cancel prior claim (cancellation)

RHC/FQHC claims cannot overlap calendar years so the statement from and through dates would need to be separated e.g. claims for 2008 and 2009 charges would need to be submitted on two separate claims, one for 2008 and one for 2009.

To comply with HIPAA guidelines RHC/FQHC claims are defined as outpatient institutional claims and should follow those guidelines to be HIPAA compliant.

Revenue Codes

Provider-based and Independent clinics that submit HCPC codes on their claims are only allowed to submit HCPC codes that are allowable under the specified revenue codes for RHC e.g. 52X, 900, 780, or 0519 (only for FQHCs). All charges associated with the patient's visit should be combined into a single dollar amount that is reflected under the appropriate encounter code. The maximum number of units associated with the encounter code is one per visit.

If you submit multiple dates of service on one claim, line item dates of services are required on the claim.

Applicable Revenue Codes

- 0519 - FQHC claims when providing a covered FQHC service provided on DOS for supplemental payment under contract with Medicare Advantage Plans
- 0521 - Clinic visit by member to RHC/FQHC
- 0522 - Home visit by RHC/FQHC practitioner
- 0524 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
- 0525 - Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
- 0527 - RHC/FQHC Visiting Nurse service(s) to a member's home when in a home health shortage area
- 0528 - Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident)
- 0780 - with HCPC Q3014 for originating site facility fees for Telemedicine
- 0900 - Psychiatric/Psychological Services (Oct.16, 2003, and after)*
- 0001 - Total Charges

Charges for the RHC/FQHC services, furnished during an encounter, are reported under 52X revenue code. It is not appropriate for RHC/FQHCs to fragment the visit/encounter into unique components, e.g., separate charges for pharmacy, supplies, surgeries, etc. For RHC/FQHCs all these services should be combined into one encounter (revenue code 52X or 900). Charges for the interpretation of diagnostic tests performed by RHC/FQHC staff (physician or midlevel) are included with the charges for the encounter under revenue code 52X.

Technical Component (TC)

Additional Reimbursement for the Technical Component (TC)

The Technical Component (TC) of a diagnostic procedure is reimbursed outside of the encounter rate. For a provider-based RHC, this reimbursement is made to the base provider.

This billing occurs under the base provider's type of bill and provider number such as inpatient hospital billing on a 13x, 85x or 14x TOB.

Preventive Services

The professional component of the preventive services is within the scope of a RHC and part of the overall encounter for provider based and independent RHC/FQHCs. Preventive service HCPCs are not required on the 71x or 73x TOB.

The RHC/FQHC does not receive reimbursement on the 71x or 73x TOB for the technical component. The technical component of the preventive service would be billed through the base provider where tracking will be done through the common working file (CWF) for the Medicare frequency and medical necessity criteria on a 13x or 85x TOB.

Diagnostic Laboratory

Additional Reimbursement For Diagnostic Laboratory Services

All diagnostic laboratories, including the six waived tests are reimbursed outside of the encounter rate. For a provider-based RHC/FQHC, this reimbursement is made to the base provider. The RHCs base provider for provider based RHC/FQHC and Carrier for Independent RHC/FQHCs will complete billing for diagnostic laboratory services. These services will be billed on the 14x TOB to the fiscal intermediary under the base provider's provider number for (**provider based RHC/FQHCs**). These services will receive fee schedule reimbursement. For Independent RHC/FQHCs, these services are billed on the CMS 1500 claim form. These services will receive fee schedule reimbursement.

Six basic lab tests

- Primary culturing for transmittal to a certified lab
- Chemical examinations of urine by stick or tablet method or both
- Hemoglobin or hematocrit
- Blood sugar
- Examination of stool specimens for occult blood
- Pregnancy tests

Skilled Nursing Facility (SNF)

Additional Reimbursement for Skilled Nursing Facility (SNF) Services

Physician services provided to a SNF resident in a Part A stay are separately billable by the RHC/FQHC. Services that would not be on the exclusion listing would need to be bundled back to the SNF e.g. lab, x-ray.