mln BOOKLET
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# Information for Rural Health Clinics



**What's Changed?**

- We extended some telehealth flexibilities through September 30, 2025, for:
  - Originating site requirements and using audio-only for non-behavioral and non-mental telehealth services (page 12)
  - Rural health clinics as distant site providers for non-behavioral and non-mental telehealth services (page 13)
  - In-person visit requirements for behavioral and mental health services (page 14)
- We added coding information for mental telehealth visits (page 14)

Substantive content changes are in dark red.



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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A rural health clinic (RHC) is a clinic located in a rural, underserved area with a shortage of primary care providers, personal health services, or both. Currently, about 5,200 RHCs nationwide provide primary care and preventive health services in underserved rural areas.

## Practitioners

RHCs and their staff must comply with all licensure and certification laws and regulations. Medicare pays RHCs for qualified primary and preventive health services provided by RHC practitioners, including:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs)

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View Infectious diseases for a list of waivers and flexibilities that were in place during the PHE.

## RHC Patient Services

RHCs provide:

- Physician services.
- Primary care and preventive services.
- Services and supplies incident to RHC practitioner services, like taking blood pressure or administering shots.
- Services and supplies incident to NP, PA, CNM, CSW, MFT, and MHC services.
- Medicare patient homebound visiting nurse services when a registered nurse (RN) or licensed practical nurse (LPN) provides them in an area we certify as having a shortage of home health agencies. Check eligibility before providing visiting nurse services to make sure the patient isn't already under a home health plan of care.
- Certain care coordination services, including transitional care management (TCM), chronic care management (CCM), general behavioral health integration (BHI), principal care management (PCM), advanced primary care management (APCM), psychiatric collaborative care model (CoCM), chronic pain management services (CPM), remote physiological monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI), principal illness navigation (PIN), and PIN-peer support (PIN-PS).
- Virtual communication services, like communications-based technology and remote evaluation services.
- Mental health services using telehealth. You may provide mental health visits using interactive, real-time telecommunications technology.
- Hospice attending physician services from an RHC physician, an NP, or a PA employed or working under contract for an RHC, instead of employed by a hospice program. During a hospice election, attending physician services can take place at the patient's home, a Medicare-certified hospice freestanding facility, a skilled nursing facility (SNF), or a hospital.
- Intensive outpatient program (IOP) services, which provide treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a partial hospitalization program. See CR 13496 for details.
- For CY 2025, we're implementing a payment rate for when you provide 4 or more IOP services per day in an RHC. The IOP payment rate is:
  - $269.19 for 3 services per day
  - $408.55 for 4 or more services per day
- Dental services that are inextricably linked to other covered medical services, including when RHCs provide these services during separate visits on the same day.

# Certification

For us to certify a clinic as an RHC, it must meet all state and federal requirements, including location, staffing, and health care services requirements. RHCs must also have a quality assessment and quality improvement program.

## Location Requirements

An RHC must:

- Be in an area defined by the U.S. Census Bureau as non-urbanized
- Be in an area currently designated by the Health Resources & Services Administration within the last 4 years as 1 of these:
  - Primary Care Geographic Health Professional Shortage Area (HPSA)
  - Primary Care Population-Group HPSA
  - Medically Underserved Area
  - Governor-Designated and Secretary-Certified Shortage Area
- Post operation days and hours

## Staffing Requirements

An RHC must:

- Employ an NP or a PA, and RHCs may contract with NPs, PAs, CNMs, CPs, CSWs, MFT, or MHCs when the RHC employs at least 1 NP or PA
- Have an NP, a PA, or a CNM working at least 50% of the time during operational hours

## Health Care Services Requirements

An RHC must:

- Provide outpatient health services
- Provide primary care services
- Directly provide routine diagnostic and lab services
- Have arrangements with 1 or more hospitals to provide medically necessary services the RHC doesn't provide
- Have drugs and biologicals available to treat emergencies
- Provide these lab tests on site:
  - Stick or tablet chemical urine exam or both
  - Hemoglobin or hematocrit
  - Blood sugar
  - Pregnancy tests
  - Collection of patient specimens to send to a certified lab for culturing
- Not be primarily a mental disease treatment facility or a rehabilitation agency
- Not be a Federally Qualified Health Center (FQHC)

# Visits

RHC visits **must** be:

- Medically necessary
- Medical or mental health visits, qualified preventive health visits, or face-to-face visits between the patient and an RHC practitioner
- A qualified RHC service needing an RHC practitioner
- To provide primary care services rather than being "primarily engaged" in rendering these services

RHC visits **can** take place at:

- An RHC
- A patient's home, including an assisted living facility
- A Medicare-covered Part A SNF
- The scene of an accident
- The location of a hospice patient, including their home or a hospice facility

RHC visits **can't** take place at:

- An inpatient or outpatient hospital department, including a critical access hospital
- A facility with specific requirements excluding RHC visits

## Multiple Visits on the Same Day

Visits with more than 1 RHC practitioner on the same day, or multiple visits with the same RHC practitioner on the same day, count as a single visit, **except** when a patient:

- Returns to the RHC to diagnose or treat an injury or illness that happened after the initial visit (for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the RHC)
- Has a qualified medical and mental health visit on the same day
- Has an initial preventive physical exam and a separate medical or mental health visit on the same day, or both
- Has IOP services on the same day with a medical visit
- Has a dental visit on the same day with a medical visit

# Payments

We pay RHCs a bundled payment, or all-inclusive rate (AIR) per visit, for qualified primary care and preventive health services an RHC practitioner provides. We subject the AIR to a payment limit per visit, meaning an RHC won't get any payment beyond the specified limit amount per visit.

The per visit payment limit is:

- $152 for CY 2025
- $165 for CY 2026

The payment limit is based on the national statutory limit for:

- Independent RHCs
- Provider-based RHCs in a hospital with 50 or more beds
- RHCs enrolled in Medicare on or after January 1, 2021

## RHC Payment Limit Clarification

Medicare Administrative Contractors (MACs) will use a cost report that reports costs for 12 consecutive months to establish the payment limit for specified provider-based RHCs. If the RHC doesn't have a 12-consecutive month cost report, MACs will use the next most-recent final settled cost report that reports costs for 12 consecutive months. MACs shouldn't combine cost report data to equal a 12-consecutive month cost report.

For CY 2025, we established the payment limit for specified provider-based RHCs that meet the qualifications in section 1833(f)(3)(B) of the Social Security Act, which is the larger of:

- The payment limit per visit starting January 1, 2024, increased by the Medicare Economic Index for primary care services in 2025, which is 3.5%
- The RHC national statutory payment limit per visit for CY 2025, which is $152 per visit

## Cost Reports

RHCs must file an annual cost report, including graduate medical education adjustments, bad debt, flu, pneumococcal and COVID-19 shots, and your administration payments.

- Independent RHCs must complete Form CMS-222-17, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center (HCLINIC) Cost Report
- Provider-based RHCs located in a hospital must complete the entire M series of worksheets of Hospital Form (CMS-2552-10), Hospital and Hospital Health Care Complex Cost Report
- Freestanding or independent RHCs that aren't affiliated with a hospital must complete the RHC cost report Form CMS-222-17

We won't use costs for providing certain telehealth services to decide the RHC AIR, but you must report these costs on the proper cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services."

The Provider Reimbursement Manual – Part 2 has more information on cost reports and forms.

## Annual Reconciliation

At the end of the annual cost reporting period, RHCs submit a report to their MACs, which includes total allowable costs, total RHC service visits, and other required reporting period information. After reviewing the report, MACs decide a final period rate by dividing allowable costs by the number of actual visits.

MACs decide the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. They review interim and final payment rates for productivity, reasonableness, and payment limitations.

For more information, find your MAC's website.

## Care Coordination Services

- We pay for these general care coordination services either alone or with other payable services. General care coordination services include the following:
  - CCM
  - General BHI
  - PCM
  - APCM
  - CPM
  - RPM/RTM
  - CHI
  - PIN
- You can bill TCM services with CCM, RPM, and RTM care coordination services.
- The coinsurance is 20% of the total charges, G0511's, or the individual HCPCS code's payment rate for care coordination services.
- You can report care coordination costs in the cost report's non-reimbursable section, and we don't consider these costs under the RHC AIR. Don't include administrative activities like transcription or translation services.
- Auxiliary personnel may provide care coordination services under general supervision.
- RHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below if they've met all requirements and there isn't double counting. For example, RHCs can bill HCPCS code G0511 twice for 20 minutes of qualifying CCM services and 30 minutes of qualifying PCM services if the clinical staff minutes don't overlap.
- We don't require face-to-face services for RHC care coordination services. Auxiliary personnel may provide them under general supervision.
- RHCs can't bill care coordination services if another practitioner or facility bills them during the same period.

Starting in CY 2025:

- RHCs will report individual HCPCS codes describing care coordination services instead of HCPCS code G0511.
- You have a 6-month transition period (to at least July 1, 2025) to update billing systems. For those that are ready, you may bill the individual HCPCS codes starting January 1, 2025. RHCs should do one or the other on a facility basis.
- We'll pay for these services and their associated add-on codes at the national, non-facility PFS payment rate.

**Table 1. Care Coordination Service Codes**

| Care Coordination Services | HCPCS/CPT Codes | Add-on codes |
|---|---|---|
| CCM | 99487, 99490, 99491 | 99437, 99439, 99489 |
| PCM | 99424, 99426 | 99425, 99427 |
| APCM | G0556, G0557, G0558 | N/A |
| CPM | G3002 | G3003 |
| General BHI | 99484, G0323 | N/A |
| RPM | 99453, 99454, 99457, 99474, 99091 | 99458 |
| RTM | 98975, 98976, 98977, 98980 | 98981 |
| CHI | G0019 | G0022 |
| PIN | G0023 | G0024 |
| PIN-PS | G0140 | G0146 |

**Note:** The table includes add-on codes that describe additional minutes when RHCs perform them in conjunction with the primary service.

See FAQs About Practitioner Billing for Chronic Care Management Services and the Medicare Benefit Policy Manual, Chapter 13, section 230 for more information on care coordination services.

## Psychiatric CoCM Services (G0512)

- We pay at the national non-facility Physician Fee Schedule (PFS) payment rate for CPT code 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when HCPCS code G0512 is on an RHC claim either alone or with other payable services
- You must provide at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services to bill for this service
- The coinsurance is 20% of the total charges or G0512's payment rate for general care management services
- You can bill G0512 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services and your services meet all other requirements
  - You can count only RHC practitioner or auxiliary personnel services within the scope of service elements toward the 60-minute psychiatric CoCM billing minimum
  - **Don't** include administrative activities like transcription or translation services
- See the Medicare Benefit Policy Manual, Chapter 13, section 230.3 for more information on psychiatric CoCM services

## Medicare Part B Vaccines & Administration

We pay for flu, pneumococcal, hepatitis B, and COVID-19 shots and their administration at 100% of reasonable cost. Influenza virus, hepatitis B, pneumococcal, and COVID-19 vaccines don't count as RHC visits. RHCs report these services on a separate cost report worksheet.

Starting July 1, 2025, RHCs can bill and we'll pay for these part B vaccines and their administration at the time of service.

- We'll pay for these preventive vaccine products at 95% of the average wholesale price and their administration at the non-facility PFS payment rate
- You'll reconcile these rates annually with your facility's actual vaccine cost on your cost report

RHCs should report the vaccine and the administration code on the claim using the type of bill 71X if there was another reason for the visit, for information and data collection purposes only.

## COVID-19 Monoclonal Antibody Therapies

For **Original Medicare patients**, we pay for administering COVID-19 monoclonal antibody products and the service for their administration at 100% of reasonable cost through the cost report.

For COVID-19 monoclonal antibodies used for post-exposure prophylaxis or treatment of COVID-19, we'll continue to pay at 100% of reasonable cost through the cost report through the end of the CY in which the Emergency Use Authorization (EUA) declaration for COVID-19 drugs and biologicals ends. The EUA declaration is distinct from, and isn't dependent on, the COVID-19 PHE.

Starting January 1 of the year after the EUA declaration ends:

- We'll pay you for monoclonal antibody products used for **post-exposure prophylaxis or treating** COVID-19 in the same way we pay for other Part B drugs and biological products through the RHC AIR
- We'll continue to pay for covered monoclonal antibody products and their administration when used as **pre-exposure prophylaxis for preventing** COVID-19 at 100% of reasonable cost through the cost report

For Medicare Advantage (MA) patients, submit claims for administering COVID-19 vaccines and COVID-19 monoclonal antibody products to the MA Plan. Original Medicare won't pay these claims.

## Drugs Covered as Additional Preventive Services: Pre-exposure Prophylaxis for HIV Drugs

Effective September 30, 2024, Medicare Part B covers pre-exposure prophylaxis (PrEP) for HIV drugs and other services to decrease an individual's risk of acquiring HIV without cost-sharing. RHCs bill for these services separately from the AIR. PrEP for HIV has more information.

# Telehealth

Telehealth substitutes for an in-person visit and generally involves 2-way, interactive technology that permits communication between the practitioner and patient. For some services, RHCs can provide telehealth to extend care when a patient is in a different place.

During the COVID-19 PHE, we used emergency waivers and other regulatory authorities so you could provide more services to your patients via telehealth. Learn more about Medicare telehealth services, including technology and other requirements.

Through September 30, 2025:

- Medicare patients can get non-behavioral and non-mental telehealth services in their home
- You can deliver non-behavioral and non-mental telehealth services using audio-only communication platforms.

You may continue to bill for telehealth services using HCPCS code G2025. We'll base the payment amount using the national average payment rates for comparable services under the PFS through December 31, 2025.

You may use 2-way, interactive, audio-only technology for telehealth visits if the distant site provider is technically capable of using an audio-video telehealth system, but the patient isn't capable of, or doesn't consent to, using video technology. You don't need any additional documentation except to append the FQ modifier on the claim.

**Note:** Section 2207 of the Full-Year Continuing Appropriations and Extensions Act, 2025 extends certain telehealth policies until September 30, 2025.

## Originating Site

An originating site is the location where a patient gets physician or practitioner medical services through telehealth. Before the COVID-19 PHE, patients needed to get telehealth at an originating site located in a certain geographic location.

For behavioral and mental telehealth services, patients can get telehealth wherever they're located. They don't need to be at an originating site, and there aren't any geographic restrictions. For non-behavioral and non-mental health services, patients can get telehealth wherever they're located through September 30, 2025.

RHCs can be originating sites for telehealth if they're in a qualifying area. RHCs serving as telehealth originating sites get an originating site facility fee. You may include the originating site facility fee charges on the claim.

## Distant Site

A distant site is the location where a physician or practitioner provides telehealth. Before the COVID-19 PHE, only certain types of distant site providers could provide and get paid for telehealth.

For behavioral and mental telehealth services, RHCs can serve as a distant site provider. For non-behavioral and non-mental health services, RHCs can serve as a distant site provider through September 30, 2025.

Practitioners can provide telehealth from any distant site location, including their home, during the time they're working for the RHC, and they can provide any distant site-approved telehealth under the PFS. You can't bill the visit's cost or include it in the cost report.

# Virtual Communication Services

You can also provide virtual communication services. RHCs bill virtual communication services differently than telehealth.

Virtual communication services are services where a practitioner meets with a patient for at least 5 minutes to decide if the patient needs a visit. There are 2 ways to provide virtual communication services:

1. Through communication-based technology
2. With remote evaluation services

We pay for virtual communication services when an RHC practitioner meets certain requirements, including:

- The practitioner provides at least 5 minutes of billable RHC virtual communications, either through communication-based technology or remote evaluation services
- The patient had at least 1 face-to-face billable visit within the previous year
- The virtual visit isn't related to service provided within the last 7 days
- The virtual visit doesn't lead to an in-person RHC service within the next 24 hours or at the next appointment

When an RHC practitioner provides a patient with virtual communication services, they don't need to meet face-to-face, and we apply the Part B coinsurance and deductible.

See Virtual Communication Services FAQs for more information.

## Consent for Chronic Care Management & Virtual Communication Services

We require patient consent for all services, including non-face-to-face services. This means that someone working under your general supervision can get patient consent. We don't require direct supervision to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services.

## Mental Health Visits

We'll pay for mental health visits using telehealth in the same way as face-to-face services. You may also use audio-only telehealth in cases where patients can't, or don't consent to, using audio-video telehealth. You can report and get paid in the same way as in-person visits.

**Table 2. RHC Claims for Mental Telehealth Visits**

| Revenue Code | HCPCS Code | Modifiers |
|---|---|---|
| 0900 | Qualifying mental health visit code | 95 (audio-video) or FQ or 93 (audio-only)<br>CG (required) |

You can provide a mental health visit and an IOP service on the same day; however, we'll only pay the IOP rate, and we'll consider the mental health service as packaged.

42 CFR 405.2463(b)(3) states you must provide an in-person mental health service to the patient 6 months before providing telehealth, and you must provide an in-person, non-telehealth visit at least every 12 months for these services. However, we may make exceptions to the in-person visit requirement based on patient circumstances (with the reason documented in the patient's medical record), allowing more frequent visits as driven by clinical needs on a case-by-case basis.

**Note:** Section 2207 of the Full-Year Continuing Appropriations and Extensions Act, 2025 continues to delay the in-person visit requirements for mental health visits until September 30, 2025.

## Productivity Standards

We no longer apply productivity standards for cost reporting periods ending after December 31, 2024.

## Resources

- Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule fact sheet
- Medicare Benefit Policy Manual, Chapter 13
- Medicare Claims Processing Manual, Chapter 9
- Rural Health Clinics Center
- Rural Health Reports and Publications

### Regional Office Rural Health Coordinators

Get contact information for CMS Regional Office Rural Health Coordinators who offer technical, policy, and operational help on rural health issues.