



RURAL HEALTH CLINIC

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Background

The Rural Health Clinic Service Act of 1977 addressed an inadequate supply of physicians serving Medicare beneficiaries in rural areas and increased the use of nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs) in these areas. Medicare pays RHCs an all-inclusive rate (AIR) for medically necessary, face-to-face primary health services and qualified preventive health services furnished by an RHC practitioner. RHC practitioners are physicians, NPs, PAs, CNMs, clinical psychologists (CPs), and clinical social workers (CSWs).

Currently there are about 4,500 RHCs nationwide providing primary care and preventive health services in underserved rural areas. For a list of RHCs by region, see [Survey and Certification's Quality, Certification and Oversight Reports \(QCOR\)](#).

RHC Services

RHCs provide:

- Physician services
- Services and supplies furnished "incident to" physician services
- NP, PA, CNM, CP and CSW services
- Services and supplies furnished "incident to" NP, PA, CNM, CP or CSW services
- Medicare-covered Part B-covered drugs furnished "incident to" RHC practitioner services

- Visiting nurse services to the homebound where the Centers for Medicare & Medicaid Services (CMS) certified there is a shortage of home health agencies and certain criteria are met
- Certain care management services
- Certain virtual communication services

Medicare RHC Certification

To qualify as an RHC, a clinic must be in:

- A U.S. Census Bureau-defined non-urbanized area
- An area currently designated or certified by the Health Resources and Services Administration within the previous 4 years as **one** of these types of areas:
 - Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act
 - Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act
 - Medically Underserved Area under Section 330(b)(3) of the PHS Act
 - Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1989

RHCs must:

- Employ an NP or PA (RHCs may contract with NPs, PAs, CNMs, CPs, and CSWs when the RHC employs at least one NP or PA)
- During operational hours, have an NP, PA, or CNM working at least 50 percent of the time
- Directly provide routine diagnostic and laboratory services
- Have arrangements with one or more hospitals to provide medically necessary services unavailable at the RHC
- Have drugs and biologicals available to treat emergencies
- Provide all these laboratory tests on site:
 - Stick or tablet chemical urine examination or both
 - Hemoglobin or hematocrit
 - Blood sugar
 - Occult blood stool specimens examination
 - Pregnancy tests
 - Primary culturing to send to a certified laboratory
- Have a quality assessment and performance improvement program
- Post operation days and hours
- Not be primarily a mental disease treatment facility or a rehabilitation agency
- Not be a Federally Qualified Health Center (FQHC)
- Meet all other state and Federal requirements

RHC Visits

RHC visits must be:

- Medically necessary
- Face-to-face medical or mental health visits or qualified preventive visits between the beneficiary and an RHC practitioner (physician, NP, PA, CNM, CP, or CSW)
- A qualified RHC service that requires the skill level of the RHC practitioner

RHC visits **may** take place:

- In the RHC
- At the beneficiary's home (including an assisted living facility)
- In a Medicare-covered Part A Skilled Nursing Facility (SNF)
- At the scene of an accident

RHC visits **cannot** take place at:

- An inpatient or outpatient hospital (including a Critical Access Hospital)
- A facility with specific requirements that exclude RHC visits

More than one visit with an RHC practitioner on the same day, or multiple visits with the same RHC practitioner on the same day, counts as a single visit, except for the following:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC)
- A qualified medical visit and a qualified mental health visit on the same day
- An Initial Preventive Physical Examination (IPPE) and a separate medical and/or mental health visit on the same day

RHC Payments

Except for certain provider-based RHCs, RHCs are subject to a maximum payment rate per visit, which was established by Congress and is annually updated based on the Medicare Economic Index percentage. Medicare pays for laboratory tests (excluding venipuncture) and the technical components of RHC services separately. The Medicare beneficiary's coinsurance is 20 percent of total charges, except for certain preventive services.

Part B coinsurance and deductible are waived for the U.S. Preventive Services Task Force-recommended grade A or B preventive services, such as the IPPE, and Annual Wellness Visit. See the [RHC Preventive Services Chart](#) for more information about preventive services, including coinsurance and deductible requirements.

Medicare applies the Part B deductible to RHC services based on total charges. Non-covered expenses do not count toward the deductible. When the deductible is met, Medicare pays RHCs 80 percent of the AIR for each RHC visit, except preventive services. Medicare pays preventive services at 100 percent.

Care Management Services

RHCs may provide general care management services (which includes chronic care management (CCM) and general behavioral health integration (BHI)) and psychiatric collaborative care model (CoCM) services. Medicare waives the RHC face-to-face services requirement for care management services, and auxiliary personnel may furnish these services under general supervision.

Medicare pays RHCs for care management services using HCPCS code G0511 and G0512. RHCs cannot bill for care management services if another practitioner or facility already billed them during the same time period. Find more information about billing care management services by reviewing the [Care Management Services in RHCs and FQHCs Frequently Asked Questions](#).

Go to the Medicare Learning Network® (MLN) Article, [Medicare Benefit Policy Manual, Chapter 13 – RHC and FQHC Services](#) to get information on RHC payment policy requirements.

Flu and Pneumonia Vaccine Administration Payment

Medicare pays the costs of the influenza and pneumococcal vaccines and their administration at annual cost settlement. RHCs report the vaccines and their administration costs on a separate cost report worksheet. RHCs should not report these costs on their billing claims when billing RHC services. The beneficiary pays no Part B deductible or coinsurance for these services.

An RHC cannot bill a visit when the practitioner only sees the beneficiary to administer a vaccine(s). Instead, the RHC includes vaccines and their administration on the annual cost report and Medicare reimburses them at cost settlement.

Hepatitis B Vaccine (HBV) Administration and Payment

The RHCs AIR covers the cost of the HBV and its administration. If a beneficiary gets other qualifying RHC services on the same day they get the HBV, the RHC bills the vaccine and its administration separately. This ensures the beneficiary pays no deductible or coinsurance.

When an RHC practitioner sees a beneficiary to administer the HBV, the RHC cannot bill a visit. The RHC includes the vaccine and its administration costs on the annual cost report. However, the RHC can include the HBV on a claim for the beneficiary's next visit.

Payment for Telehealth Services

RHCs can serve as a telehealth services originating site if the RHC is in a qualifying area. An originating site is where an eligible Medicare beneficiary is located during the telehealth service. RHCs that serve as an originating site for telehealth services are paid an originating site facility fee. Charges for the originating site facility fee may be included on a claim.

RHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is where the practitioner is located during the time of the telehealth service.

Virtual Communication Services

Starting January 1, 2019, Medicare pays RHCs for Virtual Communication Services when an RHC practitioner provides a beneficiary at least 5 minutes of a billable RHC communication technology-based or remote evaluation service. The beneficiary must have had a billable visit within the previous year, and the services must meet **both** the following requirements:

- The beneficiary did not get any RHC related services within the previous 7 days of the virtual medical discussion or remote evaluation
- The beneficiary needs no RHC service within the next 24 hours or at the soonest available appointment

Medicare requires RHCs to submit Virtual Communication Services claims with HCPCS code G0071 alone or with other payable services to get payment.

When an RHC practitioner provides a beneficiary Virtual Communication Services, Medicare waives the RHC face-to-face requirements and applies the coinsurance and deductible. Go to the [Virtual Communication Services Frequently Asked Questions](#) for more information.

Cost Reports

RHCs must file an annual cost report to determine their payment rate and reconcile interim payments, including payment for graduate medical education adjustments, bad debt, and influenza and pneumonia vaccines and their administration. Independent RHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report.

Hospital-based RHCs must complete Worksheet M of Form CMS-2552-10, Hospital and Hospital Health Care Complex Cost Report. Other provider-based RHCs must complete the appropriate set of RHC worksheets the parent provider files.

To find more cost reports and forms, go to the [Provider Reimbursement Manual – Part 2](#).

Annual Reconciliation

At the end of the annual cost reporting period, the RHC submits a report to their Medicare Administrative Contractor (MAC) that includes total allowable costs, total visits for RHC services, and any other required reporting period information. After reviewing the report, the MAC divides allowable costs by the number of actual visits to determine a final period rate.

The MAC determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. The MAC reviews interim and final payment rates for productivity, reasonableness, and payment limitations.

If you have questions, contact your MAC(s) for more information. Find MAC websites at <http://go.cms.gov/MAC-website-list>.

Table 1. Resources

For More Information About...	Resource
RHCs	CMS.gov/center/provider-type/rural-health-clinics-center.html CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c08.pdf

Table 2. Hyperlink Table

Embedded Hyperlink	Complete URL
Care Management Services in RHCs and FQHCs Frequently Asked Questions	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
Medicare Benefit Policy Manual, Chapter 13 – RHC and FQHC Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11019.pdf
Provider Reimbursement Manual – Part 2	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html
RHC Preventive Services Chart	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf
Survey and Certification's Quality, Certification and Oversight Reports (QCOR)	https://qcor.cms.gov/main.jsp
Virtual Communication Services Frequently Asked Questions	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

Helpful Websites

American Hospital Association Small or Rural Hospitals

<https://www.aha.org/advocacy/small-or-rural>

Critical Access Hospitals Center

<https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html>

Disproportionate Share Hospitals

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>

Federally Qualified Health Centers Center

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

Health Resources and Services Administration

<https://www.hrsa.gov>

Hospital Center

<https://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

Medicare Learning Network®

<http://go.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

Regional Office Rural Health Coordinators

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to [CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf).

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National Association of Rural Health Clinics

<https://narhc.org>

National Rural Health Association

<https://www.ruralhealthweb.org>

Rural Health Clinics Center

<https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Rural Health Information Hub

<https://www.ruralhealthinfo.org>

Swing Bed Providers

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSS/SwingBed.html>

Telehealth

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

Telehealth Resource Centers

<https://www.telehealthresourcecenter.org>

U.S. Census Bureau

<https://www.census.gov>