Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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(Rev. 13600; Issued: 02-20-26)

Transmittals for Chapter 13

Index of Acronyms

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

ACP – advance care planning

AIR – all inclusive rate

AWV – annual wellness visit

BHI – behavioral health integration

CCM – chronic care management

CCN – CMS certification number

CHI – community health integration

CNM – certified nurse midwife

CoCM – collaborative care model

CP – clinical psychologist

CPM – chronic pain management

CSW – clinical social worker

DSMT – diabetes self-management training

EKG – electrocardiogram

E/M – evaluation and management

FQHC – federally qualified health center

FTE – full time equivalent

GAF – geographic adjustment factor

GME – graduate medical education

HCPCS – Healthcare Common Procedure Coding System

HHA – home health agency

HHS – Health and Human Services

HPSA – health professional shortage area

HRSA – Health Resources and Services Administration

IPPE – initial preventive physical exam

IOP – intensive outpatient program

LDTC – low dose computed tomography

LPN – licensed practical nurse

MAC – Medicare Administrative Contractor

MHC – mental health counselor

MEI – Medicare Economic Index
MFT – marriage and family therapist
MNT – medical nutrition therapy
MSA – metropolitan statistical area
MUA – medically-underserved area
MUP – medically-underserved population
NCD – national coverage determination
NECMA – New England County Metropolitan Area
NP – nurse practitioner
OBRA - Omnibus Budget Reconciliation Act
PA – physician assistant
PCE - primary care exception
PCM – principal care management
PFS – physician fee schedule
PIN - principal illness navigation
PIN-PS – principal illness navigation – peer support
PPS – prospective payment system
PHS – public health service
RHC – rural health clinic
RN – registered nurse
RO – regional office
RPM – remote patient monitoring
RTM – remote therapeutic monitoring
RUCA – rural urban commuting area
SDOH – Social Determinants of Health
SLP – speech language therapy
SNF – skilled nursing facility
TCM – transitional care management
UA – urbanized area
USPSTF – U.S. Preventive Services Task Force

10 - RHC and FQHC General Information

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

10.1 - RHC General Information

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Rural Health Clinics (RHCs) were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas. RHCs have been eligible to participate in the Medicare program since March 1, 1978, and are paid an all-inclusive rate (AIR) for medically-necessary primary health services, and qualified preventive health services, furnished by an RHC practitioner.

RHCs are defined in section 1861(aa)(2) of the Social Security Act (the Act) as facilities that are engaged primarily in providing services that are typically furnished in an outpatient clinic. RHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW), marriage and family therapist (MFT), and mental health counselor (MHC) services; and
- Services and supplies furnished incident to an NP, PA, CNM, CP, MFT or MHC services.

RHC services may also include nursing visits to patients confined to the home that are furnished by a registered professional nurse (RN) or a licensed professional nurse (LPN) when certain conditions are met. (See section 190 of this manual)

To be eligible for certification as an RHC, a clinic must be located in a non-urbanized area, as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary, Health and Human Services (HHS), in any one of the four types of shortage area designations that are accepted for RHC certification. (See section 20 of this manual)

In addition to the location requirements, an RHC must:

- Employ an NP or PA;
- Have an NP, PA, or CNM working at the clinic at least 50 percent of the time the clinic is operating as an RHC;
- Directly furnish routine diagnostic and laboratory services;

- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC;
- Have available drugs and biologicals necessary for the treatment of emergencies;
- Meet all health and safety requirements;
- Not be a rehabilitation agency or a facility that is primarily for mental health treatment;
- Furnish onsite all of the following six laboratory tests:
    - Chemical examination of urine by stick or tablet method or both;
    - Hemoglobin or hematocrit;
    - Blood sugar;
    - Examination of stool specimens for occult blood;
    - Pregnancy tests; and
    - Primary culturing for transmittal to a certified laboratory.
- Not be concurrently approved as an FQHC, and
- Meet other applicable State and Federal requirements.

RHCs can be either independent or provider-based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (A/B MAC). They are assigned a CMS Certification Number (CCN) in the range 3800-3974 or 8900-8999. Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH). They are assigned a CCN in the range 3400-3499, 3975-3999, or 8500-8899. (**NOTE:** A provider-based CCN is not an indication that the RHC has met the qualifications for the special payment rules applicable to payment limits discussed in section 70.2 of this chapter.)

The statutory requirements for RHCs are found in section 1861(aa) of the Act. The regulations pertaining to RHCs can be found at 42 CFR 405.2400 Subpart X and 42 CFR 491 Subpart A.

For information on claims processing, see Pub. 100-04, Medicare Claims Processing Manual, chapter 9, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

For information on certification requirements, see Pub. 100-07, State Operations Manual, Chapter 2, and Appendix G, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf

10.2 - FQHC General Information

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Federally Qualified Health Centers (FQHCs) were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and were effective beginning on October 1, 1991. As with RHCs, they are also facilities that are primarily engaged in providing services that are typically furnished in an outpatient clinic. FQHCs were paid an AIR for primary health services and qualified preventive health services until October 1, 2014, when they began to transition to the FQHC prospective payment system (PPS). Beginning on January 1, 2016, all FQHCs are paid under the provisions of the FQHC PPS, as required by Section 10501(i)(3)(B) of the Affordable Care Act.

FQHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW), marriage and family therapist (MFT), and mental health counselor (MHC) services;
- Services and supplies furnished incident to an NP, PA, CNM, CP, MFT or MHC services; and
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for beneficiaries with diabetes or renal disease.

The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in section 1861(aa)(4) of the Act. No Part B deductible is applied to expenses for services that are payable under the FQHC benefit. An entity that qualifies as an FQHC is assigned a CCN in the range 1800-1989 and 1000-1199.

FQHC services also include certain preventive primary health services. The law defines Medicare-covered preventive services provided by an FQHC as the preventive primary health services that an FQHC is required to provide under section 330 of the Public Health Service (PHS) Act. Medicare may not cover some of the preventive services that FQHCs provide, such as dental services, which are specifically excluded under Medicare law.

There are 3 types of organizations that are eligible to enroll in Medicare as FQHCs:

- Health Center Program Grantees: Organizations receiving grants under section 330 of the PHS Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers;
- Health Center Program Look-Alikes: Organizations that have been identified by HRSA as meeting the definition of "Health Center" under section 330 of the PHS Act, but not receiving grant funding under section 330; and
- Outpatient health programs/facilities operated by a tribe or tribal organization (under the Indian Self-Determination Act) or by an urban Indian organization (under Title V of the Indian Health Care Improvement Act).

NOTE: Information in this chapter applies to FQHCs that are Health Center Program Grantees and Health Center Program Look-Alikes. It does not necessarily apply to tribal or urban Indian FQHCs or grandfathered tribal FQHCs.
An FQHC must:

- Provide comprehensive services and have an ongoing quality assurance program;
- Meet other health and safety requirements;
- Not be concurrently approved as an RHC; and
- Meet all requirements contained in section 330 of the Public Health Service Act, including:
    - Serve a designated Medically-Underserved Area (MUA) or Medically-Underserved Population (MUP);
    - Offer a sliding fee scale to persons with incomes below 200 percent of the federal poverty level; and
    - Be governed by a board of directors, of whom a majority of the members receive their care at the FQHC.

Additional information on these and other section 330 requirements can be found at http://bphc.hrsa.gov/.
Per 42 CFR 413.65(n), only FQHCs that were operating as provider-based clinics prior to 1995 and either a) received funds under section 330 of the PHS Act or b) were determined by CMS to meet the criteria to be a look-alike clinic, are eligible to be certified as provider-based FQHCs. Clinics that do not already have provider-based status as an FQHC are no longer permitted to receive the designation.
For information on claims processing, see to Pub. 100-04, Medicare Claims Processing Manual, chapter 9, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf, and Pub. 100-07, State Operations Manual chapter 2, sections 2825 and 2826, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf.

20 - RHC and FQHC Location Requirements

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

To be eligible for certification as an RHC, a clinic must be located in 1) a non-urbanized area, as determined by the U.S. Census Bureau, and 2) an area designated or certified within the previous 4 years by the Secretary, HHS, in any one of the four types of shortage area designations that are accepted for RHC certification as listed in section 20.2.

A clinic applying to become a Medicare-certified RHC must meet both the rural and underserved location requirements. Mobile clinics must have a fixed schedule that

specifies the date and location for services, and each location must meet the location requirements.

Existing RHCs are not currently required to continue to meet the location requirements. RHCs that plan to relocate or expand should contact their Regional Office (RO) to determine their location requirements.

FQHCs may be located in rural or urban areas. FQHCs that are Health Center Program Grantees or Look-Alikes must be located in or serve people from a HRSA-designated MUA or MUP.

20.1 - Non-Urbanized Area Requirement for RHCs
(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

The U.S. Census Bureau determines if an area is an urbanized area (UA). Any area that is not in a UA is considered a non-urbanized area. A clinic located in an area that is not a UA would meet the RHC requirement for being in a non-urbanized area. Information on whether an area is in an urbanized area can be found at http://factfinder.census.gov; or http://www.raconline.org; or by contacting the appropriate CMS RO at http://www.cms.gov/RegionalOffices/.

20.2 - Designated Shortage Area Requirement for RHCs
(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

The HRSA designates areas as MUAs/MUPs and/or Health Professional Shortage Areas (HPSAs). To be eligible for RHC certification, a clinic must be located in an area that has one of the following types of shortage area designations:

- Geographic Primary Care HPSA;
- Population-group Primary Care HPSA;
- MUA (this does not include the population group MUP designation); or
- Governor-Designated and Secretary-Certified Shortage Area (this does not include a Governor's Medically Underserved Population designation).

No other type of shortage area designation is accepted for purposes of RHC certification. The designation cannot be more than 4 years old in order to meet the requirement of being in a currently designated area. For RHC purposes, the age of the designation is calculated as the last day of the year 4 years from the date of the original designation, or the date the area was last designated. For example, a clinic that is located in an area that was most recently designated or updated on June 1, 2010, would be considered as meeting this location requirement through December 31, 2014.

Areas that are listed as "proposed for withdrawal" are considered designated. The designation date is the date that the area was last updated, not when the area was proposed for withdrawal. To determine the designation date of an area that is listed as "proposed for withdrawal", contact HRSA's Shortage Designation Branch at sdb@hrsa.gov or call 1-888-275-4772.

30 - RHC and FQHC Staffing Requirements

(Rev. 166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

30.1 - RHC Staffing Requirements

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

In addition to the location requirements, an RHC must:

- Employ an NP or PA; and

- Have an NP, PA, or CNM working at the clinic at least 50 percent of the time the clinic is operating as an RHC.

The employment may be full or part time, and is evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100 percent ownership of the RHC, the W-2 form can be from that entity as long as all the non-physician practitioners employed in the RHC receive their W-2 from this owner.

The following are examples of situations that would NOT satisfy the employment requirement:

- An NP or PA who is employed by a hospital that has an ownership interest in the RHC but is not physically present and working in the RHC;

- A CNM who is employed by the RHC;

- An Advanced Practice Registered Nurse who is not an NP or PA; or

- An NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician.

An RHC practitioner is a physician, NP, PA, CNM, CP, CSW, MFT or MHC. At least one of these practitioners must be present in the RHC and available to furnish patient care at all times the RHC is in operation. 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 this period and is not subject to the staffing requirements.

An NP, PA, or CNM must be available to furnish patient care at least 50 percent of the time that the RHC is open to provide patient care. This requirement can be fulfilled through any combination of NPs, PAs, or CNMs as long as the total is at least 50 percent

of the time the RHC is open to provide patient care. Only the time that an NP, PA, or CNM spends in the RHC, or the time spent directly furnishing patient care in another location as an RHC practitioner, is counted towards the 50 percent time. It does not include travel time to another location, or time spent not furnishing patient care when in another location outside the RHC (e.g. home, SNF, etc.).

A clinic located on an island that otherwise meets the requirements for RHC certification is not required to employ an NP or PA, although it is still required to have an NP or PA at least 50 percent of the time that the RHC is in operation (OBRA '89, Sec 4024). An island is a body of land completely surrounded by water, regardless of size and accessibility (e.g., bridges).
As of July 1, 2014, RHCs may contract with non-physician practitioners (PAs, NPs, CNM, CPs or CSWs and MFTs and MHCs effective January 1, 2024) if at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at section 1861(aa)(7) of the Act).

It is the responsibility of the RHC to assure that all staffing requirements are met and that RHC practitioners provide services in accordance with state and federal laws and regulations.
See section 80.4 of this chapter for information on productivity standards for RHCs.

30.2 - RHC Temporary Staffing Waivers

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

An existing RHC may request a temporary staffing waiver if the RHC met the staffing requirements before seeking the waiver, and either or both of the following occur:

- An NP or PA is not currently employed by the RHC.

- An NP, PA, or CNM is not furnishing patient care at least 50 percent of the time the RHC operates.

To receive a temporary staffing waiver, an RHC must demonstrate that it has made a good faith effort to recruit and retain the required practitioner(s) in the 90 day period prior to the waiver request. Recruitment activities should begin as soon as the RHC becomes aware that they will no longer be in compliance with this requirement. Good faith efforts can include activities such as advertising in an appropriate newspaper or professional journal, conducting outreach to an NP, PA, or CNM school, or other activities.

Staffing waivers are for a period not to exceed 1 year. The waiver cannot be extended beyond 1 year, and another waiver cannot be granted until a minimum of 6 months have elapsed since the prior waiver expired. RHCs should continue their recruitment activities during the waiver period to avoid termination when the waiver period ends.

An RHC will be terminated if any of the following occur:

- The RHC does not meet the staffing requirements and does not request a temporary staffing waiver;

- The RHC requests a temporary staffing waiver and the request is denied due to a lack of good faith effort to meet the requirements;

- The RHC does not meet the staffing requirements and is not eligible for a temporary staffing waiver because less than 6 months have passed since the expiration of the previous waiver;

- The RHC reaches the expiration date of the temporary staffing waiver and has not come into compliance; or

- Other non-compliance issue.

30.3 - FQHC Staffing Requirements

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHCs must have a core staff of appropriately trained primary care practitioners and meet other clinical requirements. It is the responsibility of the FQHC to assure that all staffing requirements are met and that FQHC practitioners provide services in accordance with State and Federal laws and regulations. Additional information on FQHC staffing requirements can be found at: http://bphc.hrsa.gov/about/requirements/index.html.

40 - RHC and FQHC Visits

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, CSW, MFT or MHC during which time one or more RHC or FQHC services are rendered. Effective January 1, 2022, a mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder.

A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC

or FQHC visits.

An RHC or FQHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions. See section 190 of this chapter for information on visiting nursing services to home-bound patients.

Under certain conditions, an FQHC visit also may be provided by qualified practitioners of outpatient DSMT and MNT when the FQHC meets the relevant program requirements for provision of these services.

RHC and FQHC visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. A list of qualifying visits for FQHCs is located on the FQHC web page at https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html.

40.1 – Location

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

RHC or FQHC visits may take place in:

- the RHC or FQHC,
- the patient's residence (including an assisted living facility),
- a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims ProcessingManual, chapter 6, section 20.1.1),
- the scene of an accident, or
- the location of the patient during a Hospice election, including a patient's residence or a Medicare certified facility

RHC and FQHC visits may not take place in:

- an inpatient or outpatient department of a hospital, including a CAH, or
- a facility which has specific requirements that preclude RHC or FQHC visits(e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility (except when the RHC/FQHC is furnishing hospice attending physician services during a hospice election), etc.).

Qualified services provided to a RHC or FQHC patient are considered RHC or FQHC services if:

- the practitioner is compensated by the RHC or FQHC for the services provided;
- the cost of the service is included in the RHC or FQHC cost report; and;
- other requirements for furnishing services are met.

This applies to full and part time practitioners, and it applies regardless of whether the practitioner is an employee of the RHC or FQHC, working under contract to the RHC orFQHC, or is compensated by the RHC or FQHC under another type of

arrangement.

RHCs and FQHCs should have clear policies regarding the provision of services in other locations and include this in a practitioner's employment agreement or contract. RHCs and FQHCs providing RHC or FQHC services in locations other than the RHC or FQHCfacility must continue to meet all certification and cost reporting requirements. Services in other locations may be subject to review by the A/B MAC. RHC or FQHC services furnished by an RHC or FQHC practitioner may not be billed separately by the RHC or FQHC practitioner, or by another practitioner or an entity other than the RHC or FQHC, even if the service is not a stand-alone billable visit. Services furnished to patients in any type of hospital setting (inpatient, outpatient, or emergency department) are statutorilyexcluded from the RHC/FQHC benefit and may not be billed by the RHC or FQHC.

40.2 - Hours of Operation

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs are required to post their hours of operations at or near the entrance in a manner that clearly states the days of the week and the hours that RHC or FQHC services are furnished, and days of the week and the hours that the building is open solely for administrative or other purposes, if applicable. This information should be easily readable, including by people with vision problems and people who are in wheel chairs. Qualified services provided to an RHC or FQHC patient other than during the posted hours of operation are considered RHC or FQHC services when the practitioner is compensated by the RHC or FQHC for the services provided, and when the cost of the service is included in the RHC's cost report.

Services furnished at times other than the RHC or FQHC posted hours of operation to Medicare beneficiaries who are RHC or FQHC patients may not be billed to Medicare Part B if the practitioner's compensation for these services is included in the RHC/FQHC cost report. (See Section 100 on Commingling).

This applies to full and part time practitioners, practitioners who are employees, practitioners working under contract to the RHC or FQHC, and practitioners who are compensated by the RHC or FQHC under another type of arrangement. RHCs and FQHCs should have clear policies regarding the provision of services at other times, and include this in a practitioner's employment agreement or contract.

40.3 - Multiple Visits on Same Day

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled

appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where an RHC or FQHC patient has a medically-necessary face-to-face visit with an RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

Exceptions are for the following circumstances only:

- 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 afall and returns to the RHC or FQHC). In this situation only, the FQHC would use modifier 59 on the claim and the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits;

- The patient has a medical visit and a mental health visit on the same day (2 billable visits);

- For RHCs only, the patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits); or

- An IOP service and medical visit on the same day.

Note: A mental health visit and IOP service may occur on the same day; however, if a mental health visit is furnished on the same day as IOP services, payment will only be made at the IOP rate, and the mental health visit will be considered packaged.

NOTE: These exceptions do not apply to grandfathered tribal FQHCs.

40.4 - Global Billing

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, the charges for the procedure go on the claim with the visit. Payment is included in the AIR when the procedure is furnished in an RHC, and payment is included in the PPS methodology when furnished in an FQHC. The Medicare global billing requirements do not apply to RHCs and FQHCs, and global billing codes are not accepted for RHC or FQHC billing or payment.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If an RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.

Services not included in the global surgical package are listed in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 40.1.B, and include, but are not limited to: initial consultation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed (unless the visit occurs due to complications of the surgery); treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery; etc.

For additional information on global billing, see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

40.5 - 3-Day Payment Window

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare's 3-day payment window applies to outpatient services furnished by a hospital (or an entity that is wholly owned or wholly operated by the hospital). The statute requires that hospitals' bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with section 1886 of the Act.

RHCs and FQHC services are not subject to the Medicare 3- day payment window requirements.

For additional information on the 3 day payment window, see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7502.pdf

50 - RHC and FQHC Services

(Rev. 166, Issued: 01-31-13, Effective: 03-01-13, Implementation: 03-01-13)

50.1 - RHC Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

RHC services include:

- Physicians' services, as described in section 110;
- Services and supplies incident to a physician's services, as described in

section120;

- Services of NPs, PAs, and CNMs, as described in section 130;
- Services and supplies incident to the services of NPs, PAs, and CNMs, asdescribed in section 140;
- CP and CSW services, as described in section 150;
- MFT and MHC services, as described in section 150;
- Services and supplies incident to the services of CPs and CSWs, as described in section 160;
- Services and supplies incident to the services of MFTs and MHCs, as described in section 160;
- Visiting nurse services to patients confined to the home, as described in section 190;
- Certain care *coordination* services, as described in section 230;
- Certain virtual communication services, as described in section 240*; and*
- *Intensive Outpatient Program (IOP) Services, as described in section 250.*

RHC services also include certain preventive services when specified in statute or when established through the National Coverage Determination (NCD) process and not specifically excluded (see section 220 – Preventive Health Services). These services include:

- Influenza, Pneumococcal, Hepatitis B, COVID-19 vaccinations, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19;
- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.
- Drugs Covered as Additional Preventive Services (DCAPS) and related supply and administration fees.

The professional component of the IPPE, AWV, and other qualified preventive services is paid based on the AIR.

50.2 - FQHC Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

FQHC services include all of the RHC services listed in section 50.1 of this chapter. While the following services may also be furnished in an RHC, the statute specificallylists certain services as FQHC services, including but not limited to:

- Screening mammography;
- Screening pap smear and screening pelvic exam;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- DSMT services;
- Diabetes screening tests;
- MNT services;
- Bone mass measurement;
- Screening for glaucoma;
- Cardiovascular screening blood tests; and
- Ultrasound screening for abdominal aortic aneurysm.

50.3 - Emergency Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

RHCs provide outpatient services that are typically furnished in a physician's office or outpatient clinic and generally provide only limited emergency care. Neither independent nor hospital-based RHCs are subject to Emergency Medical Treatment and Active Labor Act regulations. However, RHC practitioners are required to provide medical emergency procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. The definition of a "first response" is a service that is commonly provided in a physician's office.

If a patient presents at the RHC with an emergency when the RHC is not open for patient care because a physician, NP, PA, CNM, CP, CSW, MFT or MHC is not present, other staff may attend to the patient until care of the individual can be transferred. Any care provided in this situation must be within the individual's ability, training, and scope of practice, and in accordance with state laws, and would not be considered an RHC service. During their regular hours of operations, FQHC practitioners are required to provide medical procedures as a first response to common life threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. After their operating hours, FQHCs must provide telephone access to an individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open.

Additional information on emergency preparedness requirements for RHCs and FQHCs can be found 42 CFR 491.12.

60 - Non RHC/FQHC Services

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit, such as laboratory services or the technical component of an RHC or FQHC service. If these services are authorized to be furnished by the RHC or FQHC and are covered under a separate Medicare benefit category, the services must be billed separately (not by the RHC or FQHC) to the appropriate A/B MAC under the payment rules that apply to the service. RHCs and FQHCs must identify and remove from allowable costs on the Medicare cost report all costs associated with the provision of non-RHC/FQHC services such as space, equipment, supplies, facility overhead, and personnel.

60.1 - Description of Non RHC/FQHC Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Certain services are not considered RHC or FQHC services either because they 1) are notincluded in the RHC or FQHC benefit, or 2) are not a Medicare benefit. Non-RHC/FQHC services include, but are not limited to:

Medicare excluded services - Includes routine physical checkups, dental care (that are not inextricably linked to other covered medical services), hearing tests, routine eye exams, etc. For additional information, see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf

Technical component of an RHC or FQHC service - Includes diagnostic tests such as x-rays, electrocardiograms (EKGs), and other tests authorized by Medicare statute or the NCD process. These services may be billed separately to the A/B MAC by the facility).(The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner or furnished incident to an RHC or FQHC visit).

Laboratory services - Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see section 1861(aa)(2)(G) of the Act, and for FQHCs seesection 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the AIR when furnished in an RHC by an RHC practitioner or furnished incident to an RHC service, and it is included in the per-diem payment when furnished in an FQHC by an FQHC practitioner or furnished incident to an FQHC service.

Durable medical equipment - Includes crutches, hospital beds, and wheelchairs used inthe patient's place of residence, whether rented or purchased.

Ambulance services - The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest

appropriate facility that can treat the patient's condition, and any other methods of transportation arecontraindicated. See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf for additional information on covered ambulance services.

Prosthetic devices - Prosthetic devices are included in the definition of "medical and other health services" in section 1861(s)(8) of the Act and are defined as devices (other than dental) which replace all or part of an internal body organ (including colostomy bagsand supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. Other examples of prosthetic devices include cardiac pacemakers, cochlear implants, electrical continence aids, electrical nerve stimulators, and tracheostomy speaking valves.

Body Braces – Includes leg, arm, back, and neck braces and their replacements.

Practitioner services at certain other Medicare facility – Includes services furnished to inpatients or outpatients in a hospital (including CAHs), ambulatory surgical center, Medicare Comprehensive Outpatient Rehabilitation Facility, etc., or other facility whoserequirements preclude RHC or FQHC services. (**NOTE:** Covered services provided to aMedicare beneficiary by an RHC or FQHC practitioner in a SNF may be an RHC or FQHC service.)

Telehealth distant-site services - See section 200 of this chapter for additionalinformation on telehealth services in RHCs and FQHCs.

Hospice Services (with the exception of hospice attending physician services) – See section 210 of this chapter for additional information on hospice services in RHCs and FQHCs.

Group Services – Includes group or mass information programs, health education classes,group therapy, or group education activities, including media productions and publications (except for certain IOP services, see section 250 of this chapter).

For additional information on these services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 on Covered Medical and Other Health Service at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

70 - RHC and FQHC Payment

(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHCs and FQHCs must submit claims for RHC or FQHC services under the RHC or FQHC payment methodologies and are not authorized to submit claims under the Physician Fee Schedule (PFS) for RHC or FQHC services. Newly certified RHCs or

FQHCs should work with their A/B MAC to ensure that all claims filed for RHC or FQHC services are paid as RHC or FQHC claims as of the date of their certification.

70.1 - RHC Payment

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare pays 80 percent of the RHC AIR, subject to a payment limit, for medically-necessary medical, and qualified preventive, face- to- face (one-on-one) visits with an RHC practitioner (as defined in section 30) for RHC services (as defined in section 50.1), unless otherwise noted. The rate is subject to a payment limit, except for RHCs that have an exception to the payment limit (see section 70.2). An interim rate for newly certified RHCs is established based on the RHC's anticipated average cost for direct and supporting services. At the end of the reporting period, the A/B MAC determines the total payment due and reconciles payments made during the period with the total payments due.

In general, the AIR for an RHC is calculated by the A/B MAC by dividing total allowable costs by the total number of visits for all patients. Productivity, payment limits, and other factors are also considered in the calculation. Allowable costs must be reasonable and necessary and include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services.

Services furnished incident to an RHC professional service are included in the AIR and are not billed as a separate visit. The professional component of a procedure is usually a covered service, but is not a stand-alone billable visit. The costs of covered services provided incident to a billable visit may be included on the RHC cost report. To receive payment for qualified services, HCPCS coding is required on all claims.

70.2 - RHC Payment Limit

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Prior to April 1, 2021, the RHC payment limit was set by Congress in 1988 and was adjusted annually based on the Medicare Economic Index (MEI). The payment limit was released annually via Recurring Update Notifications.

Prior to April 1, 2021, a provider-based RHC that is an integral and subordinate part of a hospital (including a CAH), as described in regulations at 42 CFR 413.65, could receive an exception to the per-visit payment limit if:

- the hospital had fewer than 50 beds as determined at 42 CFR 412.105(b); or
- the hospital's average daily patient census count of those beds described in 42 CFR 412.105(b) did not exceed 40 and the hospital meets both of the following conditions:
    - it was a sole community hospital as determined in accordance with 42 CFR

412.92 or an essential access community hospital as determined in accordance with 42 CFR 412.109(a), and

- it was located in a level 9 or level 10 Rural-Urban Commuting Area (RUCA). (For additional information on RUCAs, see http://depts.washington.edu/uwruca/.

The exception to the payment limit applied only during the time that the RHC met the requirements for the exception.

70.2.1 – Payment Limits Applicable to Independent RHCs, Provider-Based RHCs in a Hospital with 50 or More Beds, and New RHCs

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, independent RHCs, provider-based RHCs in a hospital with 50 or more beds, and RHCs enrolled under Medicare on or after January 1, 2021 will receive a prescribed national statutory payment limit per visit increase over an 8-year period for each year from 2021 through 2028.

The national statutory payment limit for RHCs over the 8-year period is as follows:

- In 2021, after March 31, at $100 per visit;
- In 2022, at $113 per visit;
- In 2023, at $126 per visit;
- In 2024, at $139 per visit;
- In 2025, at $152 per visit;
- In 2026, at $165 per visit;
- In 2027, at $178 per visit; and
- In 2028, at $190 per visit.

Beginning in 2029 and each year thereafter the limit established for the previous year is increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such year.

We note that new RHCs are those that have submitted an application and are enrolled under Medicare on or after January 1, 2021.

70.2.2 – Payment Limits Applicable to Provider-Based RHCs in a Hospital with Less than 50 Beds

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, provider-based RHCs that meet a specified criteria are entitled to special payment rules that establish a payment limit based on the provider-based RHC's per visit payment amount (or AIR) instead of the national statutory payment limit. For purposes of this section of the manual, we use the term "specified" interchangeably with the term "grandfathered" since those RHCs that meet the specified criteria are considered to be "grandfathered" into the establishment of their payment limit per visit.

The specified criteria that an RHC must meet in order to be eligible for the special payment rules are as follows:

- As of December 31, 2020, was in a hospital with less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the Public Health Emergency (PHE) for COVID-19); and one of the following circumstances:
  - As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the PHE for COVID-19); or
  - Submitted an application for enrollment in Medicare (or a request for temporary enrollment during the PHE for COVID-19) that was received not later than December 31, 2020.

Medicare Administrative Contractors (MACs) will calculate the payment limit per visit for specified provider-based RHCs (that is, grandfathered RHCs) as discussed in sections 70.2.2.1 and 70.2.2.2 below.

A grandfathered provider-based RHC will lose this designation if the hospital does not continue to have less than 50 beds. If this occurs, the provider-based RHC will be subject to the statutory payment limit per visit applicable for such year for RHCs discussed in section 70.2.1 of this manual.

70.2.2.1 – Determining Payment Limits for Specified Provider-Based RHCs with an AIR Established for RHC Services Furnished in 2020

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, specified provider-based RHCs that had a per visit payment

amount (that is, AIR) established for services furnished in 2020, the payment limit per visit shall be set at an amount equal to the greater of:

1. the per visit payment amount applicable to such RHC for services furnished in 2020, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of 2021; or
2. the national statutory payment limit for RHCs per visit (see section 70.2.1 of this chapter).

For subsequent years, the specified provider-based RHC's payment limit per visit shall be set at an amount equal to the greater of:

1. the payment limit per visit established for the previous year, increased by the percentage increase in the MEI applicable to primary care services furnished as of the first day of such subsequent year; or
2. the national statutory payment limit for RHCs (see section 70.2.1 of this chapter).

Note: For purposes of establishing the payment limit effective April 1, 2021 for specified provider-based RHCs defined in section 1833(f)(3)(A)(i)(I) of the Act, that is, had an AIR established for services furnished in 2020, MACs shall use the cost report ending in 2020 that reports costs for 12-consecutive months. If the RHC does not have a 12-consecutive month cost report ending in 2020, the MACs shall use the next available 12-consecutive month cost report that reports costs for RHC services furnished in 2020. MACs should not combine cost report data to equal a 12-consecutive month cost report.

70.2.2.2 – Determining Payment Limits for Specified Provider-Based RHCs that did not have an AIR Established for RHC Services Furnished in 2020

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Beginning April 1, 2021, specified provider-based RHCs that did not have a per visit payment amount (that is, AIR) established for services furnished in 2020, the payment limit per visit shall be at an amount equal to the greater of:

1. the per visit payment amount applicable to the provider-based RHC for services furnished in 2021; or
2. the national statutory payment limit for RHCs (see section 70.2.1 of this chapter).

For subsequent years, the provider-based RHCs payment limit per visit shall be set at an amount equal to the greater of:

1. the payment limit per visit established for the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of such subsequent year; or

2. the national statutory payment limit for RHCs (see section 70.2.1 of this chapter).

   Note: For purposes of establishing the payment limit effective April 1, 2021 for specified provider-based RHCs defined in section 1833(f)(3)(A)(i)(II) of the Act (that is, those that did not have an AIR established for services furnished in 2020), the MACs shall use the cost report ending in 2021 that reports costs for 12 consecutive months. If the RHC does not have a 12-consecutive month cost report ending in 2021, the MACs shall use the next most-recent final settled cost report that reports cost for 12- consecutive months. MACs should not combine cost report data to equal a 12-consecutive month cost report.

70.3 - FQHC PPS Payment Rate and Adjustments

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Medicare pays 80 percent of the lesser of the FQHC's charge or the FQHC PPS payment rate for the specific payment code, unless otherwise noted. Except for grandfathered tribal FQHCs, the FQHC PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment based on the location where services are furnished, and other applicable adjustments as described below. The 2015 and 2016 FQHC PPS base rates were updated by the MEI. Beginning in 2017, the FQHC PPS rate is updated annually by the FQHC market basket. To receive payment for qualified services, HCPCS coding is required on all claims.

Geographic Adjustment: The PPS base rate is adjusted for each FQHC based on its location by the FQHC Geographic Adjustment Factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished. Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs are updated periodically and can be found at: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html.

New Patient Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

IPPE and AWV Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes an IPPE or an AWV to a Medicare beneficiary.

NOTE: These adjustments do not apply to grandfathered tribal FQHCs.

70.4 - FQHC Payment Codes

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G code based on a typical

bundle of services that they would furnish per diem to a Medicare beneficiary. The FQHC should maintain records of the services included in each FQHC G code and the charges associated with the service at the time the service was furnished. Each FQHC decides what documentation is appropriate to record the services included in each G-code pursuant to its own determination. Charges must be reasonable and uniform for all patients, regardless of insurance status. G code services and charges can be changed by the FQHC, but must be the same for all patients and cannot be changed retrospectively.

FQHCs must include one or more of the FQHC payment codes listed below on claims to receive payment for services furnished:

1. G0466 – FQHC visit, new patient: A medically-necessary medical, or a qualified preventive health, face-to-face encounter (one-on-one) between a new patient (as defined in section 70.3), and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an FQHC visit.

2. G0467 – FQHC visit, established patient: A medically-necessary medical, or a qualifying preventive health, face-to-face encounter (one-on-one) between an established patient and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an FQHC visit.

3. G0468 – FQHC visit, IPPE or AWV: An FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

4. G0469– FQHC visit, mental health, new patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient (as defined in section 70.3), and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

5. G0470 – FQHC visit, mental health, established patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and an FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

80 - RHC and FQHC Cost Reports

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

80.1 - RHC and FQHC Cost Report Requirements

(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

RHCs are required to file a cost report annually in order to determine their payment rate and reconcile interim payments, including adjustments for GME payments, bad debt,

influenza, pneumococcal, hepatitis B and COVID-19 vaccines, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration. If in its initial reporting period, the RHC submits a budget that estimates the allowable costs and number of visits expected during the reporting period. The A/B MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

FQHCs are required to file a cost report annually and are paid for the costs of GME, bad debt, influenza, pneumococcal, hepatitis B and COVID-19 vaccines, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration through the cost report. All FQHCs, including an FQHC that does not have GME costs, bad debt, or costs associated with influenza, pneumococcal, hepatitis B and COVID-19 vaccines, or covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration, must file a cost report.

The RHC and FQHC cost reports were updated to reflect costs related to COVID-19 shots and COVID-19 monoclonal antibody products and their administration, and to include hepatitis B vaccines with the other Part B vaccines (influenza, pneumococcal and COVID-19).

Effective for dates of service on or after July 1, 2025, RHCs and FQHCs, shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, hepatitis B and COVID-19 -- on the claim at the time of service. Although paid at the time of service, payments for these services must be annually reconciled with the RHC or FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report. This includes any in-home additional costs, if applicable. See section 220.1 and 220.3 of this Chapter for more information.

Note: Until the end of the calendar year in which the Emergency Use Authorization (EUA) declaration for drugs and biological products with respect to COVID-19 ends, CMS covers and pays for these infusions or injections the same way it covers and pays for COVID-19 vaccines when furnished consistent with the EUA. That is, for RHCs and FQHCs COVID-19 monoclonal antibody products (when purchased from the manufacturer) and their administration are paid at 100 percent of reasonable cost through the cost report. Effective January 1 of the year following the year in which the EUA declaration ends, CMS will cover and pay for monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 in the same way we pay for other Part B drugs and biological products. For RHCs, payment is through the All-Inclusive Rate and for FQHCs payment is through the FQHC Prospective Payment System.

RHCs and FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors.

RHCs and FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.89. RHCs may claim unpaid coinsurance and deductible, and FQHCs may claim unpaid coinsurance. RHCs and FQHCs that claim bad debt must establish that reasonable efforts were made to collect these amounts Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed.

80.2 - RHC and FQHC Consolidated Cost Reports
(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

RHCs and FQHCs with more than one site may file consolidated cost reports, as described below, if approved by the A/B MAC in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC or FQHC may not revert to individual reporting without the prior approval of the A/B MAC.
New RHCs (enrolled under section 1866(j) of the Act on or after January 1, 2021) are permitted to file consolidated cost reports with:

- New RHCs that are provider-based,
- New RHCs that are independent,
- Existing independent RHCs, and/or
- Existing provider-based RHCs that are in a hospital that has more than 50 beds.

In addition, specified provider-based RHCs are not permitted to file a consolidated cost report with a new RHC.

NOTE: Once a specified provider-based RHC's individual payment-limit is established, the payment-limit remains with the RHC. Therefore, once the payment-limit has been calculated for an individual RHC, they do not have the option to consolidate. In addition, if a consolidated group has a RHC that is terminated, the surviving consolidated group would still be held to the consolidated payment-limit, that is, MACs would not recalculate the payment-limit.

80.3 – RHC and FQHC Cost Report Forms
(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

RHCs and FQHCs use one of the following cost report

forms:<u>RHCs:</u>

RHCs: Form CMS-222-17, Independent Rural Health Clinic Cost Report.

Hospital-based RHCs: Worksheet M of Form CMS-2552-10, Hospital and Hospital CareComplex Cost Report.

FQHCs:

FQHCs: Form CMS-224-14, Federally Qualified Health Center Cost Report.

Information on these cost report forms is found in Chapters 44, 46, and 40, of the "Provider Reimbursement Manual - Part 2" (Publication 15-2), whichcan be located on the CMS Website at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html.

80.4 – RHC Productivity Standards

(Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. The current productivity standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent non-physician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined. The FTE on the cost report for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time.

The A/B MAC has the discretion to make an exception to the productivity standards based on individual circumstances. All visits (Medicare, Medicaid, Managed Care, etc.) are included in determining the productivity standards for the cost report.

At the end of the cost reporting year, the A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator). In this example, this would have the effect of lowering the AIR.

Physician services that are provided on a short term or irregular basis under agreements are not subject to the productivity standards. Instead of the productivity limitation, purchased physician services are subject to a limitation on what Medicare would otherwise pay for the services under the Physician Fee Schedule (PFS), in accordance with 42 CFR 405.2468(d)(2)(v). Practitioners working on a regular, ongoing basis are subject to the productivity standards, regardless of whether they are paid as an employee or independent contractor.

FQHCs are not subject to the productivity standards.

90 - RHC and FQHC Charges, Coinsurance, Deductible, and Waivers

(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

Except for certain preventive services for which the coinsurance is statutorily waived, the beneficiary in an RHC must pay the deductible and coinsurance amount, and the beneficiary in an FQHC must pay the coinsurance amount (there is no Part B deductible in FQHCs for FQHC-covered services). For RHCs, the coinsurance is 20 percent of the total charges. For FQHCs, the coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate. For claims with a mix of waived and non-waived services, applicable coinsurance and deductibles are assessed only on the non-waived services. For both RHCs and FQHCs, coinsurance for care management and virtual communication services is 20 percent of the lesser of submitted charges or the payment rate.

90.1 - Charges and Waivers

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

Charges for services furnished to Medicare beneficiaries must be the same as the charges for non-Medicare beneficiaries. FQHCs may waive collection of all or part of the copayment, depending on the beneficiary's ability to pay. RHCs may waive the copayment and deductible after a good faith determination has been made that the patient is in financial need, provided the waivers are not routine and not advertised. (See 42 U.S.C. 1320a-7a(6)(A))

90.2 - Sliding Fee Scale

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs may establish a sliding fee scale if it is uniformly applied to all patients. An RHC that chooses to offer a sliding fee scale must post the policy so that all patients are aware of the policy. If the payment policy is based on an individual's income, the RHC must document that income information from the patient was obtained in order to determine that the patient qualified. Copies of their wage statement or income tax return are not required, and self-attestations are acceptable.

FQHCs that are approved by HRSA are required to establish a sliding fee scale in accordance with statutory and HRSA requirements.

100 – Commingling

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Commingling refers to the sharing of RHC or FQHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an onsite Medicare Part B or Medicaid fee-for-service practice operated by the same RHC or FQHC physician(s) and/or non-physician(s) practitioners. Commingling is prohibited in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC or FQHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or

- Selectively choosing a higher or lower reimbursement rate for the services.

RHC and FQHC practitioners may not furnish or separately bill for RHC or FQHC-covered professional services as a Part B provider in the RHC or FQHC, or in an area outside of the certified RHC or FQHC space such as a treatment room adjacent to the RHC or FQHC, during RHC or FQHC hours of operation.

If an RHC or FQHC practitioner furnishes an RHC or FQHC service at the RHC or FQHC during RHC or FQHC hours, the service must be billed as an RHC or FQHC service. The service cannot be carved out of the cost report and billed to Part B.

If an RHC or FQHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC or FQHC space must be clearly defined. If the RHC or FQHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.

RHCs and FQHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to assure that all costs claimed for Medicare reimbursement are only for the RHC or FQHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC or FQHC and non-RHC or non-FQHC usage to avoid duplicate reimbursement.

This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency, or prohibit an RHC practitioner from providing on-call services for an emergency room, as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the practitioner with the hospital emergency department would not be a common occurrence.

The A/B MAC has the authority to determine acceptable accounting methods for allocation of costs between the RHC or FQHC and another entity. In some situations, the practitioner’s employment agreement will provide a useful tool to help determine appropriate accounting.

110 - Physician Services

(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

The term "physician" includes a doctor of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractic who is licensed and practicing within the licensee's scope of practice, and meets other requirements as specified.

Physician services are professional services furnished by a physician to an RHC or FQHC patient and include diagnosis, therapy, surgery, and consultation. The physician must either examine the patient in person or be able to visualize directly some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization includes review of the patient's X-rays, EKGs, tissue samples, etc.

Except for services that meet the criteria for authorized care management or virtual communications services, telephone or electronic communication between a physician and a patient, or between a physician and someone on behalf of a patient, are considered physicians' services and are included in an otherwise billable visit. They do not constitute a separately billable visit.

Qualified services furnished at an RHC or FQHC or other authorized site by an RHC or FQHC physician are payable only to the RHC or FQHC. RHC and FQHC physicians are paid according to their employment agreement or contract (where applicable).

110.1 - Dental, Podiatry, Optometry, and Chiropractic Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare statute, and qualified services furnished by physicians are billable visits in an RHC or FQHC. These practitioners can provide RHC or FQHC services that are within their scope of practice and not excluded from coverage (e.g., Medicare coverage of chiropractic services is limited to manual manipulation of the spine for a demonstrated subluxation).

An RHC or FQHC can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is a qualifying visit for RHCs or FQHCs and all other requirements are met. All services furnished must be within the state scope of practice for the practitioner, and all HCPCS codes must reflect the actual services that were furnished.

RHCs and FQHCs are required to primarily 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 the clinic is open. Therefore, a dentist, podiatrist, optometrist, or chiropractor can provide a medically necessary, face-to-face visit with an RHC or FQHC patient only when the statutory and regulatory staffing requirements are otherwise met.

For additional information on these services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 on Covered Medical and Other Health Service at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

110.2 - Treatment Plans or Home Care Plans

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Except for comprehensive care plans that are a component of authorized care management services (see section 230), treatment plans and home care oversight provided by RHC or FQHC physicians to RHC or FQHC patients are considered part of the RHC or FQHC visit and are not a separately billable service.

110.3 - Graduate Medical Education

(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)

Freestanding RHCs and FQHCs may receive direct graduate medical education (GME) payment for residents if the RHC or FQHC incurs the salaries and fringe benefits (including travel and lodging expenses where applicable) of residents training at the RHC or FQHC. Allowable costs incurred by the RHC or FQHC for GME are paid on a reasonable cost basis and are not subject to the payment limit. RHCs and FQHCs may claim allowable costs only while residents are on their RHC or FQHC rotation.

RHCs and FQHCs that are receiving GME payment may not separately bill for an RHC or FQHC visit provided by a resident, as the cost of these practitioners is included in the GME payment. A medically-necessary medical, or a qualifying preventive health, face-to-face encounter with a teaching physician who is an RHC or FQHC practitioner may be a billable visit if applicable teaching physician supervision and documentation requirements are met.

Under Pub. 100-04, Chapter 12, section 100.1.1.C., the Primary Care Exception (PCE) only applies in an outpatient department or an ambulatory setting where a hospital is claiming on the cost report the residents for indirect medical education and direct GME purposes. Therefore, in the instance where the RHC or FQHC is incurring the cost of the resident(s), the PCE would not apply.

For additional information see 42 CFR 405.2468 (f) and 42 CFR 413.75(b).

120 - Services and Supplies Furnished "Incident to" Physician's Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

"Incident to" refers to services and supplies that are an integral, though incidental, part of the physician's professional service and are:

- Commonly rendered without charge and included in the RHC or FQHC payment;

- Commonly furnished in an outpatient clinic setting;

- Furnished under the physician's direct supervision; except for authorized care management services which may be furnished under general supervision; and

- Furnished by RHC or FQHC auxiliary personnel.

Incident to services and supplies include:

- Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal);

- Venipuncture;

- Bandages, gauze, oxygen, and other supplies; or

- Services furnished by auxiliary personnel such as a nurse, medical assistant, or other clinical personnel acting under the supervision of the physician.

Supplies and drugs that must be billed to the DME MAC or to Part D are not included.

NOTE: Payment for Medicare-covered Part B drugs that are not usually self-administered and are furnished by an RHC or FQHC practitioner to a Medicare patient are included in the RHC AIR or the FQHC's PPS per diem payment. However, Section 1861(s)(2)(G) of the Act provides an exception for RHCs when a physician prepares a specific formulation of an antigen for a patient if the antigen is "forwarded to another qualified person (including a rural health clinic) for administration to such patient…, by or under the supervision of another such physician." An RHC practitioner (physician, NP, PA, or CNM) acting within their scope of practice may administer the drug and the cost of the administration may be included on the RHC's cost report as an allowable expense. The cost of the antigen prepared by a physician outside of the RHC is not included in the RHC AIR. Physicians who prepare an antigen that is forwarded to an RHC should submit a claim for the antigen in accordance with instructions from the contractor that processes their Part B claims and applicable CMS requirements.

120.1 - Provision of Incident to Services and Supplies

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physician's visit must result from the patient's encounter with the physician and be furnished in a medically appropriate timeframe. More than one incident to service or supply can be provided as a result of a single physician visit.
Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC or FQHC to provide services. Services or supplies provided by individuals who are not employed by or under direct contract with the RHC or FQHC, even if provided on the physician's order or included in the RHC or FQHC's bill, are not covered as incident to a physician's service. Services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the RHC or FQHC for inclusion in the entity's statement of services, 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 or FQHC, including services provided by a third party under contract, etc.

Services and supplies furnished incident to physician's services are limited to situations in which there is direct physician supervision of the person performing the service, except for authorized care *coordination* services (as described in section 230) which may be furnished under general supervision. Direct supervision does not require the physician to be present in the same room. However, the physician must be in the RHC or FQHC and immediately available to provide assistance and direction throughout the time the incident to service or supply is being furnished.

Effective January 1, 2024, behavioral health services can be furnished under general supervision of the physician (or other practitioner) when these services are provided by auxiliary personnel incident to the services of a physician (or another practitioner).
When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or FQHCs

For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.

120.2 - Incident to Services and Supplies Furnished in the Patient's Home or Location Other than the RHC or FQHC

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Except for authorized care *coordination* services, services furnished incident to a physician's visit by RHC or FQHC auxiliary personnel in the patient's home or location other than the RHC or FQHC must have direct supervision by the physician. For

example, if an RHC or FQHC nurse accompanies the physician to a patient's home and administers an injection, the nurse's services would be considered incident to the physician's visit. If the same nurse makes the call alone and administers an injection, the services are not incident to services since the physician is not providing direct supervision. The availability of the physician by telephone and the presence of the physician somewhere in the building does not constitute direct supervision. (This rule applies only to the incident to provision. It does not apply to visiting nursing services described in section 190.)

For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.

For information on supervision requirements for Part B services incident to physician services see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 60.1.

120.3 - Payment for Incident to Services and Supplies

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with an RHC or FQHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services. The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit. Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.

Incidental services or supplies must represent an expense incurred by the RHC or FQHC. For example, if a patient purchases a drug and the physician administers it, the cost of the drug is not covered and cannot be included on the cost report.

If a Medicare-covered Part B drug is furnished by an RHC or FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the RHC's AIR or the FQHC's PPS payment. RHCs and FQHCs cannot bill separately for Part B drugs or other incident to services or supplies.

130 - Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

Professional services furnished by an NP, PA, or CNM to an RHC or FQHC patient are services that would be considered covered physician services under Medicare (see section 110), and which are permitted by state laws and RHC or FQHC policies. Services may include diagnosis, treatment, and consultation. The NP, PA, or CNM must directly

examine the patient, or directly review the patient's medical information such as X-rays, EKGs and electroencephalograms, tissue samples, etc. Except for services that meet the criteria for authorized care management or virtual communication services, telephone or electronic communication between an NP, PA, or CNM and a patient, or between such practitioner and someone on behalf of a patient, are considered NP, PA, or CNM services, and are included in an otherwise billable visit. They do not constitute a separately billable visit.

130.1 - NP, PA, and CNM Requirements

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

Services performed by NPs, PAs, and CNMs must be:

- Furnished under the general (or direct, if required by state law) medical supervision of a physician;
- Furnished in accordance with RHC or FQHC policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the NP, PA, or CNM who furnished the service is legally permitted to furnish by the state in which the service is rendered;
- Furnished in accordance with state restrictions as to setting and supervision;
- Furnished in accordance with written RHC or FQHC policies that specify what services these practitioners may furnish to patients; and
- A type of service which would be covered under Medicare if furnished by a physician.

130.2 - Physician Supervision

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

RHCs and FQHCs which are not physician-directed must have an arrangement with a physician that provides for the supervision and guidance of NPs, PAs, and CNMs. The arrangement must be consistent with state law.

130.3 - Payment to Physician Assistants

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Section 1842(b)(6)(C) of the Act prohibits PAs from enrolling in and being paid directly for Part B services. The only exception to this is found in Section 4205(d)(3)(B) of the Balanced Budget Act (BBA), which amended Section 1842(b)(6)(C) of the Act to allow Medicare to directly pay a PA when the PA was the owner of an RHC for a continuous

period beginning before the date of the enactment of the BBA, and ending on the date the Secretary determines the RHC no longer meets the requirements of Section 1861(aa)(2) of the Act.

140 - Services and Supplies Furnished Incident to NP, PA, and CNM Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Services and supplies that are integral, though incident to an NP, PA, or CNM service are:

- Commonly rendered without charge or included in the RHC or FQHC payment
- Commonly furnished in an outpatient clinic setting;
- Furnished under the direct supervision of an NP, PA, or CNM, except for authorized care management services which may be furnished under general supervision; and
- Furnished by a member of the RHC or FQHC staff.

NOTE: The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC.

Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of an NP, PA, or CNM.

For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.

150 - Clinical Psychologist (CP), Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), and Mental Health Counselor (MHC) Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

A CP is an individual who:

- Holds a doctoral degree in psychology, and

- Is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

For additional information on CP's, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 160.

A CSW is an individual who:

- Possesses a master's or doctor's degree in social work;
- After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
- 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, meets the requirements listed in 410.73(a)(3)(i) and (ii).

For additional information on CSW's, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 170.

A MFT is an individual who:

- Possesses a master's or doctor's degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law of the State in which such individual furnishes the services defined as marriage and family therapist services;
- After obtaining such degree, has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in marriage and family therapy in an appropriate setting such as a hospital, SNF, private practice, or clinic; and
- Is licensed or certified as a marriage and family therapist by the State in which the services are performed.

A MHC is an individual who:

- Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, professional counselor under the State law of the State in which such individual furnishes the services defined as mental health counselor services;
- After obtaining such a degree, has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice, or clinic; and

- Is licensed or certified as a mental health counselor, clinical professional counselor, professional counselor by the State in which the services are performed.

For additional information on MFTs and MHCs, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, sections 330 and 340, respectively.

Services may include diagnosis, treatment, and consultation. The CP, CSW, MFT or MHC must directly examine the patient, or directly review the patient's medical information. Except for services that meet the criteria for authorized care management or virtual communication services, telephone or electronic communication between a CP, CSW, MFT or MHC and a patient, or between such practitioner and someone on behalf of a patient, are considered CP, CSW, MFT or MHC services and are included in an otherwise billable visit. They do not constitute a separately billable visit. CSWs are statutorily authorized (1861(hh)(2) of the Act) to furnish services for the diagnosis and treatment of mental illnesses only. MFTs and MHCs are statutorily authorized (section 1861(lll)(1) and 1861(lll)(3) of the Act, respectively) to furnish services for the diagnosis and treatment of mental illnesses only.

Services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service. Services that a hospital or SNF is required to provide to an inpatient or outpatient as a requirement for participation are not included.

Services performed by CPs, CSWs, MFTs and MHCs must be:

- Furnished in accordance with RHC or FQHC policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the CP, CSW, MFT or MHC who furnished the service is legally permitted to furnish by the state in which the service is rendered; and
- Furnished in accordance with state restrictions as to setting and supervision, including any physician supervision requirements.

160 - Services and Supplies Incident to CP, CSW, MFT and MHC Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Services and supplies that are integral, though incident to a CP, CSW, MFT or MHC service are:

- Commonly rendered without charge or included in the RHC or FQHC payment;
- Commonly furnished in an outpatient clinic setting;

- Furnished under the direct supervision of the CP, CSW, MFT and MHC except for authorized care management services which may be furnished under general supervision; and
- Furnished by a member of the RHC or FQHC staff.

NOTE: The direct supervision requirement is met in the case of a CP, CSW, MFT or MHC who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC. Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of a CP, CSW, MFT or MHC.

For services provided under direct supervision, the requirement that the supervising physician or practitioner must be immediately available to provide assistance and direction throughout the procedure may be satisfied through virtual presence using real-time, interactive audio and video telecommunications.

170 - Mental Health Visits

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

A mental health visit is a medically-necessary face-to-face encounter between an RHC or FQHC patient and an RHC or FQHC practitioner during which time one or more RHC or FQHC mental health services are rendered. Effective January 1, 2022, a mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder.

The requirement that there must be an in-person mental health service furnished within 6 months prior to the furnishing of the mental health service furnished via telecommunications and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record *will not apply to services furnished before January 31, 2026.*

RHCs and FQHCs are instructed to append modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) in instances where the mental health visit was furnished using audio-video communication technology and to append modifier 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only

Telecommunications System) in cases where the service was furnished using audio only communication.

Mental health services that qualify as stand-alone billable visits in an FQHC are listed on the FQHC center website, http://www.cms.gov/Center/Provider-Type/FederallyQualified-Health-Centers-FQHC- Center.html. Services furnished must be within the practitioner's state scope of practice.

Medicare-covered mental health services furnished incident to an RHC or FQHC visit are included in the payment for a medically necessary mental health visit when an RHC or

FQHC practitioner furnishes a mental health visit. Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in an FQHC or RHC.

Note: Beginning January 1, 2024, group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law may be covered and paid under the IOP benefit (see section 250 of this chapter).

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and for FQHCs, an appropriate FQHC mental health payment code. For detailed information on reporting mental health services and claims processing, see Pub. 100-04, Medicare Claims Processing Manual, chapter 9, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

Medication management, or a psychotherapy "add on" service, is not a separately billable service in an RHC or FQHC and is included in the payment of an RHC or FQHC medical visit. For example, when a medically-necessary medical visit with an RHC or FQHC practitioner is furnished, and on the same day medication management or a psychotherapy add on service is also furnished by the same or a different RHC or FQHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code. For FQHCs, an FQHC mental health payment code is not required for reporting medication management or a psychotherapy add on service furnished on the same day as a medical service.

180 - Physical Therapy, Occupational Therapy, and Speech Language Pathology Services

(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)

Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) services may be provided in the RHC or FQHC directly by a physician, NP, or PA, if included in the practitioner's scope of practice. A physician, NP, or PA may also supervise the provision of PT, OT, and SLP services provided incident to their professional services in the RHC or FQHC by a PT, OT, or SLP therapist. PT, OT, and SLP therapists who provide services incident to a physician, NP, or PA visit may be an

employee of the RHC or FQHC or contracted to the RHC or FQHC. PT, OT, and SLP services furnished by an RHC or FQHC practitioner or furnished incident to a visit with an RHC or FQHC practitioner are not billable visits.
If the services are furnished on a day when no otherwise billable visit has occurred, the PT, OT, or SLP service provided incident to the visit would become part of the cost of operating the RHC or FQHC. The cost would be included in the costs claimed on the cost report and there would be no billable visit.

190 - Visiting Nursing Services
(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

190.1 - Description of Visiting Nursing Services
(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

A visiting nurse provides skilled nursing services. The determination of whether a service requires the skills of a nurse is based on the complexity of the service (e.g., intravenous and intramuscular injections or insertion of catheters), the condition of the patient (e.g., a non-skilled service that, because of the patient's condition, can only be safely and effectively provided by a nurse), and accepted standards of medical and nursing practice. All services must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition.

A service that can be safely and effectively self-administered or performed by a nonmedical person without the direct supervision of a nurse, is not considered a skilled nursing service, even if provided by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. If a patient needs skilled nursing care and there is no one trained or able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

The determination of whether visiting nurse services are reasonable and necessary is made by the physician based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

190.2 - Requirements for Furnishing Visiting Nursing Service
(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHCs and FQHCs are paid for visiting nursing services when G0490 is on an RHC or FQHC claim and all of the following requirements are met:

- The patient is considered confined to the home as defined in section 1835(a) of the Act and the Medicare Benefit Policy Manual, Chapter 7 (see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf;
- The RHC or FQHC is located in an area that has a shortage of home health agencies;
- The services and supplies are provided under a written plan of treatment;
- Nursing services are furnished on a part-time or intermittent basis only; and
- Drugs and biological products are not provided.

190.3 - Home Health Agency Shortage Area

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

A shortage of HHAs exists if an RHC or FQHC is currently located in a county, parish or similar geographic area in which the Secretary has determined that:

- There is no participating HHA under Medicare, or adequate home health services are not available to RHC or FQHC patients even though a participating HHA is in the area; or

- There are patients whose homes are not within the area serviced by a participating HHA; or considering the area's climate and terrain, whose homes are not within a reasonable traveling distance to a participating HHA.

190.4 - Authorization for Visiting Nursing Services

(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

RHCs or FQHCs that are located in an area that has not been determined to have a current HHA shortage and are seeking to provide visiting nurse services must make a written request to the CMS RO along with written justification that the area it serves meets the required conditions.

190.5 - Treatment Plans for Visiting Nursing Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

For services and supplies that require a treatment plan, the treatment plan must be written and reviewed by a supervising physician, NP, PA, CNM, CP, CSW, MFT, or MHC as appropriate, at least once every 60 days; and meet other documentation requirements. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated for the purpose of Medicare coverage unless:

- The supervising physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient, or
- Nursing visits are required at intervals less frequently than once every 60 days, but the intervals are predictable (e.g., it is predictable that a visit is required only every 90 days for the purpose of changing a silicone catheter, etc.).

Home nursing visits furnished before the plan is put into writing are covered if authorized in writing by the supervising physician.

200 - Telehealth Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 3704 of the CARES Act authorized RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Section 4113 of the Consolidated Appropriations Act, 2023, extended this authority through December 31, 2024 *and section 2207(c) of the Full-Year Continuing Appropriations and Extensions Act, 2025 amended section 1834(m)(8) of the Act to continue payment for RHC and FQHC services as Medicare telehealth services through September 30, 2025. Most recently, section 6208 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 extended these services through January 30, 2026.*

However, through regulation, CMS provides payment to RHCs and FQHCs *when they furnish non-behavioral health visits via telecommunication technology, through December 31, 2026. That is,* on a temporary basis, *RHCs and FQHCs are paid* under the methodology that has been in place for these services during and after the COVID-19 PHE through December 31, *2026*. Specifically, RHCs and FQHCs can bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, *2026*. *P*ayment for *HCPCS code G2025* is based on the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. *RHC and FQHC p*ractitioners can provide distant site telehealth services – approved by Medicare as a distant site telehealth service under the physician fee schedule (PFS) – from any location in the United States (see 42 CFR 411.9(a)(1)), including their home, during the time that they're employed by or under contract with the RHC or FQHC.

210 - Hospice Services

(Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)

210.1 - Hospice Attending Physician Services Payment

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Medicare beneficiaries who elect the Medicare hospice benefit may choose either an individual physician, NP or PA to serve as their designated attending practitioner (Section 1861(dd) of the Act). Beginning January 1, 2022, under section 132 of the CAA 2021, RHCs and FQHCs are authorized to serve in this role. A physician, NP, or PA who works for an RHC or FQHC may provide hospice attending physician services during a time when he/she is working for the RHC or FQHC (unless prohibited by their RHC or FQHC contract or employment agreement). The RHC or FQHC would bill for these services as they would for any other qualified service to be paid the RHC AIR or the FQHC PPS rate, respectively.

A physician, NP, or PA who works for an RHC or FQHC may provide hospice attending services during a time when he/she is not working for the RHC or FQHC (unless prohibited by their RHC or FQHC contract or employment agreement). These services would not be considered RHC or FQHC services and the physician or NP would bill for these services under regular Part B rules using his/her own provider number. Any service provided to a hospice beneficiary by an RHC or FQHC practitioner must comply with Medicare prohibitions on commingling. (See section 100 of this chapter).

210.2 - Provision of Services to Hospice Patients in an RHC or FQHC

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

For hospice services that are not described above in section 210.1, RHCs and FQHCs can treat hospice beneficiaries for medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from an RHC or FQHC related to his/her terminal illness, the RHCor FQHC cannot be reimbursed for the visit, even if it is a medically necessary, face-to-face visit with an RHC or FQHC practitioner, since that would result in duplicate payment for services, except under either of the following circumstances:

- The RHC or FQHC has a contract with the hospice provider to furnish core hospice services related to the patient's terminal illness and related conditionswhen extraordinary circumstances exist within the hospice. Extraordinary circumstances are described as "unanticipated periods of high patient loads; staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside the hospice's service area" (42CFR 418.64);

- The RHC or FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are provided by the hospice so infrequently thatit would be impractical and prohibitively expensive for the hospice to employ a practitioner to provide these services. For example, a hospice may infrequently have a pediatric patient, and in those situations, contract with an RHC or FQHC that has a pediatric nurse on staff to furnish hospice services to the patient.

In these situations, all costs associated with the provision of hospice services must be

carved out of the RHC or FQHC cost report, and the RHC or FQHC would be reimbursedby the hospice. (42 CFR 418.64(b)(3)).

Any service provided to a hospice beneficiary by an RHC or FQHC practitioner must comply with Medicare prohibitions on commingling. (See section 100 of this chapter).

220 - Preventive Health Services

(Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)

RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits (where applicable) have not been exceeded. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade or A or B.

220.1 - Preventive Health Services in RHCs

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Influenza (G0008), Pneumococcal (G0009), and COVID-19 (90480) Vaccines, and Certain COVID-19 Monoclonal Antibody Products

Prior to July 1, 2025, influenza, pneumococcal, COVID-19 vaccines, and their administration were not paid at the time of service and were paid at 100 percent of reasonable cost through the cost report.

Effective for dates of service on or after July 1, 2025, RHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, and COVID-19 on the claim at the time of service. A visit/encounter is not required for these services; however, if reported on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance and deductible do not apply to these vaccines or their administration.

Although paid at the time of service, payments for these services must be annually reconciled with the RHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing to reflect the seasonal influenza virus vaccines and their applicable payment allowances that are effective August 1 through July 31 of the following year. RHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season.

Note: An additional payment for influenza, pneumococcal, COVID-19 vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for RHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E.

Covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

Hepatitis B Vaccine (G0010)

Prior to January 1, 2025, hepatitis B vaccine and its administration was included in the RHC visit and was not separately billable. The cost of the vaccine and its administration could be included in the line item for the otherwise qualifying visit. A visit could not be billed if vaccine administration was the only service the RHC provides. The beneficiary coinsurance and deductible were waived.

Effective January 1, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the RHC AIR.

Effective for dates of service on or after July 1, 2025, RHCs shall report all Part B preventive vaccines and their administration – including hepatitis B on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance and deductible do not apply to these vaccines or their administration.

Note: An additional payment for hepatitis B vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for RHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E for more information.

Although paid at the time of service, payments for these services must be annually reconciled with the RHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, two visits may be billed. The beneficiary coinsurance and deductible are waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a face-to-face personalized prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. Advance Care Planning (ACP) *and administration of a standardized, evidence-based assessment of physical activity and nutrition* can be furnished as a part of the AWV. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

More information regarding *ACP and an evidence-based assessment of physical activity and nutrition as an optional AWV element* is available on the CMS website: *https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits/annual-wellness-visit*

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)

Diabetes self-management training or medical nutrition therapy provided by a registered dietician or nutritional professional at an RHC may be considered incident to a visit with an RHC practitioner provided all applicable conditions are met. DSMT and MNT are not billable visits in an RHC, although the cost may be allowable on the cost report. RHCs cannot bill a visit for services furnished by registered dieticians or nutritional professionals. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their AIR. The beneficiary coinsurance and deductible apply.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day

as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Prostate Cancer Screening (G0102)
Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Drugs Covered as Additional Preventive Services (DCAPS) DCAPS drugs, and any supply and administration fee, are paid at 100 percent of the Medicare payment amount. The Medicare payment amount for DCAPS drugs, and any supply and administration fee, is described in the Medicare Claims Processing Manual (100-04), Chapter 18, Section 250. The beneficiary coinsurance and deductible are waived.

These services are separately billable and are paid on a claim-by-claim basis. Therefore, they do not affect any other claims billed on the same day.

Coding for DCAPS drugs and related supply and administration fees is listed on the CMS webpage:

• The coding and other guidance for Part B coverage and payment of PrEP for HIV is located at https://www.cms.gov/medicare/coverage/prep. The HCPCS code for the injection of PrEP for HIV is G0012.

NOTE: Hepatitis C Screening (G0472) is a technical service only and therefore it is not paid as part of the RHC visit.

220.2 - Copayment and Deductible for RHC Preventive Health Services
(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

When one or more qualified preventive service is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of

calculating beneficiary copayment and deductible. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment and deductible is based on $100 of the total charge, and Medicare would pay 80 percent of the $100, and 100 percent of the $50 (minus any deductible). If no other RHC service took place along with the preventive service, there would be no copayment or deductible applied, and Medicare would pay 100 percent of the payment amount.

220.3 - Preventive Health Services in FQHCs

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

FQHCs must provide preventive health services on site or by arrangement with another provider. These services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, CSW, MFT or MHC. Section 330(b)(1)(A)(i)(III) of the Public Health Service (PHS) Act required preventive health services can be found at http://bphc.hrsa.gov/policies regulations/legislation/index.html, and include:

- prenatal and perinatal services;
- appropriate cancer screening;
- well-child services;
- immunizations against vaccine-preventable diseases;
- screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; • voluntary family planning services; and
- preventive dental services.

NOTE: The cost of providing these services may be included in the FQHC cost report but they do not necessarily qualify as FQHC billable visits or for the waiver of the beneficiary coinsurance.

Influenza (G0008), Pneumococcal (G0009), and COVID-19 (90480) Vaccines and Certain COVID-19 Monoclonal Antibody Products

Prior to July 1, 2025, influenza, pneumococcal, and COVID-19 vaccines and their administration were not paid at the time of service and were paid at 100 percent of reasonable cost through the cost report. The cost was included in the cost report and no visit was billed. FQHCs must have included these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance was waived.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, and COVID-19 -- on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance does not apply to these vaccines or their administration.

Although paid at the time of service, payments for these services must be annually reconciled with the FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing to reflect the seasonal influenza virus vaccines and their applicable payment allowances that are effective August 1 through July 31 of the following year. FQHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season.

Note: An additional payment for influenza, pneumococcal, COVID-19 vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for FQHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E.

Covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

Hepatitis B Vaccine (G0010)

Prior to January 1, 2025, hepatitis B vaccine and its administration was included in the FQHC visit and was not separately billable. The cost of the vaccine and its administration could be included in the line item for the otherwise qualifying visit. A visit could not be billed if vaccine administration was the only service the FQHC provides. The beneficiary coinsurance was waived.

Effective January 1, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the FQHC PPS rate.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – including hepatitis B, on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance does not apply to these vaccines.

Although paid at the time of service, payments for these services must be annually reconciled with the FQHC's actual vaccine and vaccine administration costs, to ensure

these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Note: An additional payment for hepatitis B vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for FQHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E for more information.

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a personalized face-to-face prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. Advance Care Planning (ACP) *and administration of a standardized, evidence-based assessment of physical activity and nutrition* can be furnished as a part of the AWV. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

More information regarding ACP and an evidence-based assessment of physical activity and nutrition as an optional AWV element is available on the CMS website: https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits/annual-wellness-visit

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)

DSMT and MNT furnished by certified DSMT and MNT providers are billable visits in FQHCs when they are provided in a one-on-one, face-to-face encounter and all program requirements are met. Other diabetes counseling or medical nutrition services provided by a registered dietician at the FQHC may be considered incident to a visit with an FQHC provider. The beneficiary coinsurance is waived for MNT services and is applicable for DSMT.

DSMT must be furnished by a certified DSMT practitioner, and MNT must be furnished by a registered dietitian or nutrition professional. Program requirements for DSMT services are set forth in 42 CFR 410 Subpart H for DSMT and in Part 410, Subpart G for MNT services, and additional guidance can be found at Pub. 100-02, chapter 15, section 300.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Drugs Covered as Additional Preventive Services (DCAPS)

DCAPS drugs, and any supply and administration fee, are paid at 100 percent of the Medicare payment amount. The Medicare payment amount for DCAPS drugs, and any supply and administration fee, is described in the Medicare Claims Processing Manual

(100-04), Chapter 18, Section 250. The beneficiary coinsurance and deductible are waived.

These services are separately billable and are paid on a claim-by-claim basis. Therefore, they do not affect any other claims billed on the same day.

Coding for DCAPS drugs and related supply and administration fees is listed on the CMS webpage:

- The coding and other guidance for Part B coverage and payment of PrEP for HIV is located at https://www.cms.gov/medicare/coverage/prep. The HCPCS code for the injection of PrEP for HIV is G0012.

NOTE: Hepatitis C Screening (G0472) is a technical service only and therefore not paid as part of the FQHC visit.

220.4 - Copayment for FQHC Preventive Health Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

Under the FQHC PPS, coinsurance will generally be 20 percent of the lesser of the FQHC's charge or the PPS rate. When one or more qualified preventive services are provided as part of an FQHC visit, the A/B MAC will use the lesser of the FQHC's charge for the specific FQHC payment code or the PPS rate to determine the total payment amount. To determine the amount of Medicare payment and the amount of coinsurance that should be waived, the A/B MAC will use the FQHC's reported line-item charges and subtract the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount.

For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, Medicare pays 100 percent of the lesser of the FQHC's charge or the FQHC PPS rate, and no beneficiary coinsurance is assessed.

230 – Care Management Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Care coordination services are RHC and FQHC services and include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), chronic pain management (CPM), general behavioral health integration (BHI), Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Community

Health Integration (CHI), Principal Illness Navigation (PIN), Principal Illness Navigation Peer Support (PIN-PS), Advanced Primary Care Management (APCM) and psychiatric collaborative care model (CoCM) services.

The RHC and FQHC face-to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.) Except for TCM services, care management services are paid separately from the RHC AIR or FQHC PPS.

Prior to January 1, 2022, RHCs and FQHCs *could* not bill for care management services for a beneficiary if another practitioner or facility *had* already billed for care management services for the same beneficiary during the same time period. *E*ffective January 1, 2022, RHCs and FQHCs may bill for care management and TCM services and other care management services (outside of the RHC AIR or FQHC PPS), for the same beneficiary during the same time period. Coinsurance and deductibles are applied as applicable to RHC claims, and coinsurance is applied as applicable to FQHC claims.

Effective January 1, 2025, RHCs and FQHCs are required to bill the individual codes that make up the general care management HCPCS code, G0511. RHCs and FQHCs *must* report the individual CPT/HCPCS base codes and add-on codes (as necessary) for each of the care coordination services which replace*d the reporting of* HCPCS code G0511.

Note: Effective January 1, 2026, RHCs and FQHCs can bill care coordination services established under the Physician Fee Schedule (PFS) as designated care management services. The care coordination codes can be found in the table entitled Designated Care Management Services, which is published annually with the PFS Final Rule Addenda on the CMS website. Care coordination services are paid separately and should meet all of the billing requirements. Except for TCM services, which can be an RHC or FQHC visit (see section 230.1 of this Chapter).

230.1 - Transitional Care Management Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Effective January 1, 2013, RHCs and FQHCs are paid for TCM services furnished by an RHC or FQHC practitioner when all TCM requirements are met. TCM services must befurnished within 30 days of the date of the patient's discharge from a hospital (including

outpatient observation or partial hospitalization), SNF, or community mental healthcenter.

Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT code 99495),or within 7 days of discharge for high complexity decision making (CPT code 99496).
The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-dischargeperiod.

TCM services are billed by adding CPT code 99495 or CPT code 99496 to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical serviceprovided on that day with an RHC or FQHC practitioner it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit is paid.

230.2 – General Care Management Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

General Care Management Services include: Chronic Care Management (CCM), Principal Care Management (PCM), Chronic Pain Management (CPM), General Behavioral Health Integration (BHI) services, Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Community Health Integration (CHI), Principal Illness Navigation (PIN) and PIN Peer-Support (PIN-PS).

Beneficiary consent remains in effect unless the beneficiary opts out of receiving care management services. If the beneficiary chooses to resume care management services after opting out, beneficiary consent is required before care management services can resume. If the beneficiary has not opted out of care management services but there has been a period where no care management services were furnished, a new beneficiary consent is not required.

230.2.1– Chronic Care Management (CCM) Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before care management services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services. Care management services do not need to have been discussed during the initiating visit. Beneficiary consent to receive care management services can be obtained by auxiliary staff under general supervision of the RHC or FQHC primary care practitioner as well as by the billing practitioner, may be written or verbal and must be documented in the patient’s medical record before CCM

services are furnished. The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:

- There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
- Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
- They can stop care management services at any time, effective at the end of the calendar month.

230.2.2– Principal Care Management (PCM) Services

(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Effective January 1, 2021, RHCs and FQHCs are paid for PCM services when a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month. PCM services may be furnished to patients with a single high-risk or complexcondition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death.

PCM service requirements include:

- A single complex chronic condition lasting at least 3 months, which is the focus ofthe care plan;
- The condition is of sufficient severity to place patient at risk of hospitalization orhave been the cause of a recent hospitalization;
- The condition requires development or revision of disease-specific care plan;
- The condition requires frequent adjustments in the medication regiment; and
- The condition is unusually complex due to comorbidities.

230.2.3– Chronic Pain Management (CPM) Services
(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Effective January 1, 2023, RHCs and FQHCs are paid for CPM services when a minimum of 30 minutes of qualifying non-face-to-face CPM services are furnished during a calendar month. CPM services may be furnished to patients with multiple chronic conditions that involve chronic pain, and may include a person-centered plan of care, care coordination, medication management, and other aspects of pain care.

230.2.4– General Behavioral Health Integration (BHI) Services
(Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

BHI is a team-based, collaborative approach to care that focuses on integrative treatmentof patients with primary care and mental or behavioral health conditions. Effective January 1, 2018, RHCs and FQHCs are paid for general BHI services when a minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished topatients with one or more new or pre-existing behavioral health or psychiatric conditionsbeing treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services. General BHI service requirements include:

- An initial assessment and ongoing monitoring using validated clinical ratingscales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose statuschanges;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy,counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

230.2.5 – Remote Patient Monitoring (RPM) Services
(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for RPM services when a minimum of 20 minutes of qualifying non-face-to-face RPM services are furnished during a calendar month. RPM services include the collection, analysis, and interpretation of digitally collected physiologic data, followed by the development of a treatment plan, and the managing of a patient under the treatment plan. RHCs and FQHCs are also paid for the initial set-up and patient education on use of the equipment that stores the physiologic data for RPM services.

230.2.6 – Remote Therapeutic Monitoring (RTM) Services
(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for RTM services when a minimum of 20 minutes of qualifying non-face-to-face RTM services are furnished during a calendar month. RTM services include remote monitoring of respiratory system status, musculoskeletal status, therapy adherence, or therapy response. RHCs and FQHCs are also paid for the initial set-up and patient education on use of the equipment that stores the physiologic data for RTM services.

230.2.7 – Community Health Integration (CHI) Services
(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for CHI services when a minimum of 60 minutes of qualifying non-face-to-face CHI services are furnished during a calendar month. CHI services include coordination of care, facilitation of access to services, and communication between settings to address the SDOH need(s) that may interfere with, or present a barrier to, the diagnosis or treatment of a patient.

230.2.8 - Principal Illness Navigation (PIN) Services
(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for PIN services when a minimum of 60 minutes of qualifying non-face-to-face PIN services are furnished during a calendar month. PIN services include health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.

230.2.9 PIN-Peer Support (PIN-PS) Services
(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for PIN-PS services when a minimum of 60 minutes of qualifying PIN-PS services are furnished during a calendar month. PIN-PS services include the treatment of high-risk behavioral health conditions.

230.2.10– Payment for General Care Management Services
(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Advanced Primary Care Management services combine elements of several existing care management and communication technology-based services that include essential elements such as Chronic Care Management (CCM), Transitional Care Management (TCM), and Principal Care Management (PCM). *Effective January 1, 2025,* RHCs and FQHCs can bill for APCM services once per patient per calendar month using an APCM HCPCS code when the billing requirements are met. APCM services aren't time based.

Effective January 1, 2026, RHCs and FQHCs can bill optional add-on codes for APCM services that would facilitate providing complementary BHI or CoCM services.

Detailed information regarding APCM can be found on the CMS Website: https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services

230.3 – Psychiatric Collaborative Care Model (CoCM) Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

CCM services furnished between January 1, 2016, and December 31, 2017, are paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim.

CCM or general BHI services furnished between January 1, 2018, and December 31, 2018, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490 (30 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM or general BHI services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491(30 minutes or more of CCM furnished by a physician or other qualified health care professional), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM, PCM or general BHI services furnished on or after January 1, 2021 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, and 99491, and CPT codes 99424 (30 minutes or more of PCM services furnished by physicians or non-physician practitioners (NPPs)) and 99426 (30 minutes or more of PCM services furnished by clinical staff under the direct supervision of a physician or NPP), when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

CCM, PCM, CPM or general BHI services furnished on or after January 1, 2023 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, 99491, 99424, 99426, and G3002 (30 minutes or more of CPM services) when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

CCM, PCM, CPM, general BHI, RPM, RTM, CHI or PIN services furnished on or after January 1, 2024, are paid at the weighted average of the national non-facility PFS payment rate by taking the utilization of the base code for the service furnished and any applicable add-on codes used in the same month, as well as any base code reported alone in a month, when general care management HCPCS code G0511 is on an RHC or FQHC claim, either alone or with other payable services. The actual utilization of the services that comprise G0511 will be obtained by using the most recently available data for the services paid under the PFS. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

RHCs and FQHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below as long as all requirements are met and there is not double counting. For example, RHCs and FQHCs can bill HCPCS code G0511 twice for 20 minutes of qualifying CCM services and 30 minutes of qualifying PCM services, as long as, the clinical staff minutes do not overlap.

Effective January 1, 2025, RHCs and FQHCs *are required to bill* the individual CPT/HCPCS base codes and add-on codes for each of the care coordination services *to receive payment separate from the RHC AIR or FQHC PPS. Billing the individual codes* replace*d the reporting of* HCPCS code G0511. Care coordination services are paid at the national non-facility PFS payment rates.

Note: CMS permitted billing of HCPCS code G0511 to continue through September 30, 2025.

Advanced Primary Care Management Services (APCM) *furnished on or after January 1, 2025, are paid at the national non-facility PFS payment rates.*

A list of all care coordination services for RHCs and FQHCs are available on the RHC and FQHC websites at https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center and https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center, respectively.

Coinsurance

For FQHCs, coinsurance for care *coordination* services is 20 percent of *the* lesser of submitted charges or the *national non-facility PFS* payment rate for each individual HCPCS code.

For RHCs, coinsurance *for care coordination services* is 20 percent of the *lesser of the submitted charges* or the *national non-facility PFS* payment rate for each individual HCPCS code.

Care *coordination* costs are reported in the non- reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

230.4 – Psychiatric Collaborative Care Model (CoCM) Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment. It includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving. The primary care team regularly reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care, as needed. Patients with mental health, behavioral health, or psychiatric conditions, including substance use disorders, who are being treated by an RHC or FQHC practitioner may be eligible for psychiatric CoCM services, as determined by the RHC or FQHC primary care practitioner. A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before psychiatric CoCM services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services.

Psychiatric CoCM services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for psychiatric CoCM as for CCM and BHI services, as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of psychiatric CoCM services. Beneficiary consent to receive care management services must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, may be written or verbal and must be documented in the patient's medical record before psychiatric CoCM services are furnished. The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:

- There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
- Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
- They can stop care management services at any time, effective at the end of the calendar month.

Beneficiary consent remains in effect unless the beneficiary opts out of receiving care management services. If the beneficiary chooses to resume care management services

after opting out, beneficiary consent is required before care management services can resume. If the beneficiary has not opted out of care management services but there has been a period where no care management services were furnished, a new beneficiary consent is not required.

Behavioral Health Care Manager Requirements

The behavioral health care manager is a designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs. The behavioral health care manager furnishes both face-to-face and nonface-to-face services under the general supervision of the RHC or FQHC practitioner and may be employed by or working under contract to the RHC or FQHC. The behavioral health care manager:

- Provides assessment and care management services, including the administration of validated rating scales;
- Provides behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Provides brief psychosocial interventions;
- Maintains ongoing collaboration with the RHC or FQHC practitioner;
- Maintains a registry that tracks patient follow-up and progress;
- Acts in consultation with the psychiatric consultant;
- Is available to provide services face-to-face with the beneficiary; and
- Has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.

Psychiatric Consultant Requirements

The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant is not required to be on site or to have direct contact with the patient and does not prescribe medications or furnish treatment to the beneficiary directly. The psychiatric consultant:

- Participates in regular reviews of the clinical status of patients receiving psychiatric CoCM services;
- Advises the RHC or FQHC practitioner regarding diagnosis and options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments; and
- Facilitates referral for direct provision of psychiatric care when clinically indicated.

Payment for Psychiatric CoCM

Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when psychiatric CoCM HCPCS code, G0512, is on an RHC or FQHC claim, either alone or with other payable services. This rate is updated annually based on the PFS amounts for these codes. At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service.

Coinsurance for psychiatric CoCM services is 20 percent of the lesser of submitted charges or the payment rate for G0512. Psychiatric CoCM costs are reported in the nonreimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate. G0512 can be billed once per month per beneficiary when all requirements have been met.

Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes that is required to bill for psychiatric CoCM services and does not include administrative activities such as transcription or translation services.

Effective January 1, 2026, RHCs and FQHCs must report the individual CPT/HCPCS base codes and add-on codes for each of the psychiatric CoCM services. Billing of the individual codes replaced the reporting of HCPCS code G0512. Psychiatric CoCM services are paid separately at the national non-facility PFS payment rates. A claim should not contain both G0512 and the corresponding CPT/HCPCS codes. Only the individual CPT/HCPCS codes will be paid.

240 – Virtual Communication Services

(Rev. 13600; Issued: 02-20-26; Effective: 01-01-26; Implementation:03-23-26)

Virtual communication services are RHC and FQHC services and include communications-based technology and remote evaluation services. The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient.

Effective January 1, 2019, RHCs and FQHCs receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR or the FQHC PPS payment when the requirements for these services are met. Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

Requirements

The following requirements must be met for RHCs and FQHCs to bill for virtual communication services:

- At least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient that has had a billable visit in the RHC or FQHC within the previous year; and
- The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC or FQHC service within the next 24 hours or at the soonest available appointment.

If the discussion between the patient and the RHC or FQHC practitioner is related to a billable visit furnished by the RHC or FQHC within the previous 7 days or within the next 24 hours or at the soonest available appointment, the cost of the RHC or FQHC practitioner's time would be included in the RHC AIR or the FQHC PPS payment and is not separately billable.

Beneficiary consent to receive virtual communication services may be obtained under general supervision by auxiliary staff.

Payment for Virtual Communication Services

Virtual communication services furnished by RHCs and FQHCs on or after January 1, 2019 *through December 31, 2025*, are paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services), when the virtual communication HCPCS code, G0071, is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0071 is updated annually based on the PFS amounts for these codes.

Effective January 1, 2026, RHCs and FQHCs must report the individual CPT/HCPCS base codes and add-on codes for each of the virtual communication services. Billing of the individual codes replaced the reporting of HCPCS code G0071. Virtual communication services will be paid separately at the national non-facility PFS payment rates. A claim should not contain both G0071 and the corresponding CPT/HCPCS codes. Only the individual CPT/HCPCS codes will be paid.

Note: Due to the similarities between CPT code 98016 and HCPCS code G2012, HCPCS code G2012 was replaced with CPT 98016. That is, HCPCS code G2012 was terminated effective December 31, 2024.

250 – Intensive Outpatient Program (IOP) Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, section 4124 of the Consolidated Appropriations Act of 2023 (CAA, 2023) establishes Medicare coverage and payment for Intensive Outpatient Program (IOP) services for individuals with mental health needs when furnished by hospital outpatient departments, Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). An IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to conditions such as depression, schizophrenia, and substance use disorders.
For information regarding IOP services scope of benefits and services, certification and plan of care requirements, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 70.4.

250.1 Payment for IOP Services

(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

The CAA, 2023 requires payment for IOP services furnished by RHCs and FQHCs to be made at the same payment rate as if it were furnished by a hospital. Section 4124(c) of the CAA, 2023 also requires that costs associated with IOP services furnished by RHCs and FQHCs to not be used to determine payment amounts under the RHC all-inclusive rate (AIR) methodology or FQHC prospective payment system (PPS). FQHCs that contract with MA organizations must be paid at least the same amount they would have received for the same service under the FQHC PPS. This provision ensures FQHCs are paid at least the Medicare amount for FQHC services. Therefore, if the MA organization contract rate is lower than the amount Medicare would otherwise pay for FQHC services, FQHCs that contract with MA organizations would receive a wrap-around payment from Medicare to cover the difference. IOP services are included as part of the wrap-around payment policy.

Effective January 1, 2024, payment for IOP Services furnished by RHCs will be the rate determined for (Intensive Outpatient (3 services per day) for hospital-based IOPs) and not the RHC AIR.

Payment for IOP services furnished in FQHCs will be the lesser of a FQHC's actual charges or the rate determined for hospital-based IOPs and not the FQHC PPS. Additionally, grandfathered tribal FQHCs will have their payment based on the IHS Medicare outpatient per visit rate when furnishing IOP services. That is, payment is

based on the lesser of a grandfathered tribal FQHC's actual charges or the IHS Medicare outpatient per visit rate.

Multiple Visits

When IOP services are furnished on the same day as a mental health visit or on the same day as a medical visit, all services are covered under Medicare Part B. However, in the event IOP services are furnished on the same day as a mental health visit, CMS will make one payment at the IOP rate. That is, payment for the mental health visit will be included under the IOP rate. In the event IOP services are furnished on the same day as a medical visit, CMS will make one payment for the medical visit under the FQHC PPS or under the RHC AIR methodology and one payment for IOP services at the IOP rate.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R13600BP	02/20/2026	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update for Calendar Year (CY) 2026	03/23/2026	14363
R13547BP	12/18/2025	Revisions to Publication 100-04, Medicare Claims Processing Manual, Chapters 9, 18, and Publication 100-02, Medicare Benefit Policy Manual, Chapter 13 To Include Updated Information	01/20/2026	14254
R12832BP	09/12/2024	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	10/14/2024	13493
R11803BP	01/26/2023	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	02/27/2023	13063
R10729BP	04/26/2021	Updates to Medicare Benefit Policy Manual for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (Manual Updates Only)	05/26/2021	12252
	12/20/2019	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	01/23/2020	11575
R252BP	12/07/2018	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	01/02/2019	11019
R239BP	01/09/2018	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	01/22/2018	10350
R238BP	11/17/2017	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update	02/15/2018	10350

R230BP	12/09/2016	Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Updates	03/09/2016	9864
R220BP	01/15/2016	Rural Health Clinic and Federally Qualified Health Center - Medicare Benefit Policy Manual Update	02/01/2016	9442
R217BP	12/31/2015	Rural Health Clinic and Federally Qualified Health Center - Medicare Benefit Policy Manual Update – Rescinded and replaced by Transmittal 220	02/01/2016	9442
R201BP	12/12/2014	Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13	01/05/2015	8981
R173BP	11/22/2013	Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13	01/06/2014	8504
R166BP	01/31/2013	Reorganization of Chapter 13	03/01/2013	7824
R114BP	10/30/2009	Outpatient Mental Health Treatment Limitation	01/04/2010	6686
R49BP	03/31/2006	Payment of Federally Qualified Health Centers (FQHCs) for Diabetes Self-Management Training Services (DSMT) and Medical Nutrition Therapy (MNT) Services	06/29/2006	4385
R40BP	11/18/2005	Skilled Nursing Facility Prospective Payment System	02/16/2006	4079
R1BP	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

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