mln BOOKLET
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Information for Rural Health Clinics

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

- We permanently adopted the definition of direct supervision to include supervision through audio-visual telecommunications technology (page 5)
- We updated the CY 2026:
  - Intensive outpatient program rates (page 5)
  - Rural health clinic (RHC) all-inclusive rate payment limits (pages 8 and 9)
  - Telehealth originating site fee (page 13)
- We added 3 new optional add-on HCPCS codes for behavioral health integration and psychiatric collaborative care model (CoCM) when you provide advanced primary care management services (page 10)
- We discontinued the use of:
  - HCPCS code G0512 for psychiatric CoCM services (page 11)
  - HCPCS code G0071 for virtual communication services (page 14)
- We added a new resource link to the latest telehealth information (pages 13 and 15)
- RHCs may continue to bill medical telehealth services using HCPCS code G2025 and serve as a distant site telehealth provider through December 31, 2026 (pages 13 and 14)

Substantive content changes are in dark red.

Table of Contents

A rural health clinic (RHC) is a clinic located in a rural, underserved area with a shortage of primary care providers, personal health services, or both. Section 1861(aa) of the Social Security Act defines RHC's services and facilities.

Practitioners

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

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

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

RHC Patient Services

RHCs provide:

- Physician services.
- Primary care and preventive services.
- Services and supplies incident to RHC practitioner services, like taking blood pressure or administering shots.
- Services and supplies incident to NP, PA, CNM, CP, CSW, MFT, and MHC services.

We permanently adopted the definition of direct supervision that allows the supervising practitioner to provide supervision through a virtual presence using real-time, audio-visual communications technology, excluding audio-only.

- Visiting nurse services for homebound patients when a registered nurse (RN) or licensed practical nurse (LPN) provides them in an area we certify as having a shortage of home health agencies. Check eligibility before providing visiting nurse services to make sure the patient isn't already under a home health plan of care.
- Certain care coordination services.
- Virtual communication services, like communication-based technology and remote evaluation services.
- Mental health services using telehealth. You may provide mental health visits using interactive, real-time telecommunications technology.
- Hospice attending physician services from an RHC physician, an NP, or a PA employed or working under contract for an RHC instead of employed by a hospice program. During a hospice election, attending physician services can take place at the patient's home, a Medicare-certified hospice freestanding facility, a skilled nursing facility (SNF), or a hospital.
- Intensive outpatient program (IOP) services, which provide treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation but less intense than a partial hospitalization program. See the Medicare Benefit Policy Manual, Chapter 6, section 70.4. We base the IOP payment rates on the amount of IOP services you provide per day. For CY 2026, the IOP payment rates are:
  - $319.38 for 3 or fewer services per day
  - $418.45 for 4 or more services per day
- Dental services that are inextricably linked to other covered medical services, including when RHCs provide these services during separate visits on the same day.

Certification

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

Location Requirements

An RHC must:

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

Staffing Requirements

An RHC must:

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

Health Care Services Requirements

An RHC must:

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

Effective January 1, 2025, you're no longer required to directly provide hemoglobin or hematocrit lab tests and examination of stool specimens for occult blood.

Visits

RHC visits **must** be:

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

RHC visits **can** take place at:

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

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

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

Multiple Visits on the Same Day

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

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

Payments

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

The per-visit payment limit is:

- $165 for CY 2026
- $178 for CY 2027

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

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

RHC Payment Limit Clarification

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

The payment limit for specified provider-based RHCs that meet the qualifications in section 1833(f)(3)(B) of the Social Security Act is the larger of:

- The payment limit per visit starting January 1, 2025, increased by the Medicare Economic Index for primary care services in 2026, which is 2.7%
- The RHC national statutory payment limit per visit for CY 2026, which is $165 per visit

Cost Reports

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

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

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

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

Annual Reconciliation

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

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

For more information, find your MAC's website.

Care Coordination Services

Care coordination services include:

- Transitional care management (TCM)
- Chronic care management (CCM)
- Behavioral health integration (BHI)
  - General BHI
  - Psychiatric collaborative care model (CoCM)
- Principal care management (PCM)
- Advanced primary care management (APCM)
- Chronic pain management (CPM)
- Remote monitoring
  - Remote physiological monitoring
  - Remote therapeutic monitoring (RTM)
- Community health integration (CHI)
- Principal illness navigation (PIN)
- PIN-peer support (PIN-PS)

Care Coordination Requirements

- We pay for care coordination services either alone or with other payable services.
- You can bill TCM services with CCM, remote physiological monitoring, and RTM care coordination services.
- We apply the deductible and a 20% coinsurance based on the lesser of the submitted charges or the individual HCPCS code's national non-facility rate for care coordination services.
- You can report care coordination costs in the cost report's non-reimbursable section, and we don't consider these costs under the RHC AIR. Don't include administrative activities, like transcription or translation services.
- We don't require face-to-face services for RHC care coordination services. Auxiliary personnel may provide them under general supervision.
- RHCs can't bill care coordination services if another practitioner or facility bills them during the same period.
- Starting January 1, 2026, we added 3 new optional, add-on HCPCS codes when you provide general BHI and psychiatric CoCM services in the same month as APCM services.
  - You must report an APCM base code (G0556, G0557, or G0558) in the same month as the optional add-on codes
  - HCPCS add-on codes G0568 and G0569 are for psychiatric CoCM services you deliver to patients also receiving APCM services
  - HCPCS add-on code G0570 is for general BHI services you deliver to patients also receiving APCM services
- We pay for care coordination services and their associated add-on codes at the national, non-facility Physician Fee Schedule (PFS) payment rate.

Table 1. Care Coordination Service Codes

Care Coordination Services	HCPCS or CPT Codes	Add-On Codes
CCM	99487, 99490, 99491	99437, 99439, 99489
TCM	99495, 99496	N/A
PCM	99424, 99426	99425, 99427
APCM	G0556, G0557, G0558	G0568, G0569, G0570
CPM	G3002	G3003
General BHI	99484, G0323	N/A
Psychiatric CoCM	99492, 99493, G2214	99494
Remote Physiological Monitoring	99091, 99453, 99454, 99457, 99470, 99474	99458
RTM	98975, 98976, 98977, 98980	98981
CHI	G0019	G0022
PIN	G0023	G0024
PIN-PS	G0140	G0146

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

See the Medicare Benefit Policy Manual, Chapter 13, section 230 for more information on care coordination services.

Psychiatric CoCM Services

- Starting January 1, 2026, RHCs will report individual CPT and HCPCS codes (99492, 99493, 99494, and G2214) describing psychiatric CoCM services instead of HCPCS code G0512.
- We pay for psychiatric CoCM service codes and the add-on code at the national, non-facility PFS payment rate.
- You must provide at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services to bill for this service.
- The 20% coinsurance is based on the lesser of the submitted charges or the national non-facility rate for psychiatric CoCM services.
- You can bill 99493 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services and your services meet all other requirements.
- You can count only RHC practitioner or auxiliary personnel services within the scope of service elements toward the 60-minute psychiatric CoCM billing minimum. Don't include administrative activities, like transcription or translation services.

Medicare Part B Vaccines & Administration

We pay for COVID-19, flu, hepatitis B, and pneumococcal shots and their administration at 100% of reasonable cost. See Vaccine Pricing for more information. Effective July 1, 2025, RHCs must bill and we pay for these part B vaccines and their administration at the time of service.

- We pay for these preventive vaccine products at 95% of the average wholesale price and their administration based on the National Vaccine Administration Fee Schedule
- You'll reconcile these rates annually with your facility's actual vaccine cost on your cost report
- Coinsurance and deductible don't apply to these vaccine products or their administration

RHCs must report the vaccine and the administration code on the claim using the type of bill 71X. You don't need to bill a qualifying visit code to bill for these services. See MLN Matters® article MM13923 for more information.

COVID-19 Monoclonal Antibody Therapies

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

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

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

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

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

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

Part B covers pre-exposure prophylaxis (PrEP) for HIV drugs and other services to decrease an individual's risk of acquiring HIV without cost-sharing. Starting January 1, 2025, RHCs bill for these services separately from the AIR. PrEP for HIV has more information.

Telehealth

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

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

Visit the CMS Telehealth webpage for the latest information. It's intended to help physicians, practices, and health systems navigate changes to Medicare telehealth policy.

You may continue to bill for non-behavioral and non-mental telehealth services using HCPCS code G2025. We'll base the payment amount using the national average payment rates for comparable services under the PFS through December 31, 2026.

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

Originating Site

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

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

RHCs can be originating sites for telehealth if they're in a qualifying area. RHCs serving as telehealth originating sites get an originating site facility fee. You may include the originating site facility fee charges on the claim. For CY 2026, the originating site fee is $31.85.

Distant Site

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

For behavioral and mental telehealth services, RHCs can serve as a distant site provider. For non-behavioral and non-mental health services, RHCs can serve as a distant site provider through December 31, 2026.

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

Virtual Communication Services

You can also provide virtual communication services, which RHCs bill differently than telehealth. Virtual communication services are services where a practitioner meets with a patient for at least 5 minutes to decide if the patient needs a visit. There are 2 ways to provide virtual communication services:

1. Through communication-based technology (CPT code 98016)
2. With remote evaluation services (HCPCS codes G2010 and G2250)

Starting January 1, 2026, RHCs will report individual CPT and HCPCS codes (98016, G2010, and G2250) describing virtual communication services instead of HCPCS code G0071.

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

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

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

See Virtual Communication Services FAQs for more information.

Consent for Care Coordination & Virtual Communication Services

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

Mental Health Visits

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

Table 2. RHC Claims for Mental Telehealth Visits

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

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

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

Visit the CMS Telehealth webpage for the latest information. It's intended to help physicians, practices, and health systems navigate changes to Medicare telehealth policy.

Productivity Standards

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

Resources

- Rural Health Clinics Center
- CY 2025 Medicare PFS Final Rule fact sheet
- CY 2026 Medicare PFS Final Rule fact sheet
- Medicare Benefit Policy Manual, Chapter 13
- Medicare Claims Processing Manual, Chapter 9

Regional Office Rural Health Coordinators

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