

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11803	Date: January 26, 2023
	Change Request 13063

SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 13 to reflect payment policies finalized for 2022 and 2023.

EFFECTIVE DATE: January 1, 2023

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: February 27, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/10.1/RHC General Information
R	13/40/RHC and FQHC Visits
R	13/40.1/Location
R	13/40.3/Multiple Visits on Same Day
R	13/50.1/RHC Services
R	13/50.2/FQHC Services
R	13/60.1/Description of Non-RHC/FQHC Services
R	13/70.2/RHC Payment Limit
N	13/70.2.1/Payment Limits Applicable to Independent RHCs, Provider-Based RHCs in a Hospital with 50 or More Beds, and New RHCs
N	13/70.2.2/Payment Limits Applicable to Provider-Based RHCs in a Hospital with Less Than 50 Beds
N	13/70.2.2.1/Determining Payment Limits for Specified Provider-Based RHCs with an AIR Established for RHC Services Furnished in 2020
N	13/70.2.2.2/Determining Payment Limits for Specified Provider-Based RHCs that did not have an AIR Established for RHC Services Furnished in 2020
R	13/80.1/RHC and FQHC Cost Report Requirements
R	13/80.2/RHC and FQHC Consolidated Cost Reports
R	13/80.3/RHC and FQHC Cost Report Forms
R	13/170/Mental Health Visits
R	13/210.1/Hospice Attending Physician Services Payment
R	13/220.1/Preventive Health Service in RHCs
R	13/220.3/Preventive Health Services in FQHCs
R	13/230/Care Management Services
R	13/230.2/General Care Management Services
N	13/230.2.1/Chronic Care Management (CCM) Services
N	13/230.2.2/Principal Care Management (PCM) Services
N	13/230.2.3/Chronic Pain Management (CPM) Services
N	13/230.2.4/General Behavioral Health Integration (BHI) Services
N	13/230.2.5/Payment for General Care Management Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 11803	Date: January 26, 2023	Change Request: 13063
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SUBJECT: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

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I. GENERAL INFORMATION

A. Background: The 2022 and 2023 update of the Medicare Benefit Policy Manual, Chapter 13 - RHC and FQHC Services provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act.

B. Policy: Chapter 13 of the Medicare Benefit Policy Manual has been revised to include payment policy for RHCs and FQHCs as finalized in the CY 2022 and CY 2023 Physician Fee Schedule Final Rules. All other revisions serve to clarify existing policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
13063.1	Contractors shall be aware of the updates to the Medicare Benefit Policy Manual - Chapter 13.	X									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			D M E M A C	C E D I	
		A	B	H H H			
13063.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may	X					

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C M E D I
		A	B	H H H		
	supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Michele Franklin, 410-786-9226 or Michele.Franklin@cms.hhs.gov , Lisa Parker, 410-786-4949 or Lisa.Parker1@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Benefit Policy Manual

Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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(Rev.11803)

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10.1 - RHC General Information

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

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), and clinical social worker (CSW) services; and
- Services and supplies furnished incident to an NP, PA, CNM, or CP 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)), skilled nursing facility (SNF), or a home health agency (HHA). 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. Many of the regulations pertaining to RHCs can be found at [42 CFR 405.2400 Subpart X](#) and following, and [42 CFR 491 Subpart A](#) and following.

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>

40 - RHC and FQHC Visits

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

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, or a CSW during which time one or more RHC or FQHC services are rendered. *However, 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 Processing

- Manual, 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 or FQHC, 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 FQHC facility 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 statutorily excluded from the RHC/FQHC benefit and may not be billed by the RHC or FQHC.

40.3- Multiple Visits on Same Day

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

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 a fall 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); or
- 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).

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

50.1 - RHC Services

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

RHC services include:

- Physicians' services, as described in section 110;
- Services and supplies incident to a physician's services, as described in section 120;
- Services of NPs, PAs, and CNMs, as described in section 130;
- Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 140;
- CP and CSW services, as described in section 150;
- Services and supplies incident to the services of CPs, as described in section 160; and
- Visiting nurse services to patients confined to the home, as described in section 190.
- Certain care management services, as described in section 230.
- Certain virtual communication services, as described in section 240.

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.

Influenza, pneumococcal *and COVID-19* vaccines, *and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* and their administration are paid through the cost report, and payment for the hepatitis B vaccine and its administration is included in an otherwise billable visit. The professional component of the IPPE, AWV, and other qualified preventive services is paid based on the AIR.

Note: 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.

50.2 - FQHC Services

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

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 specifically lists 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.

Influenza, pneumococcal *and COVID-19* vaccines, *and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19* their administration are paid through the cost report, and payment for the hepatitis B vaccine and its administration is included in an otherwise billable visit. The professional component of the IPPE, AWW, and other qualified preventive services is paid based on the lesser of the FQHC's charge or the PPS rate for the specific payment code, with an adjustment for IPPE and AWW (see section 70.4 – FQHC Payment Codes).

Note: 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.

60.1 - Description of Non RHC/FQHC Services

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

Certain services are not considered RHC or FQHC services either because they 1) are not included 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, 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 see section 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 in the 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 are contraindicated. 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 bags and 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 whose requirements preclude RHC or FQHC services. (**NOTE:** Covered services provided to a Medicare 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 additional information 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.

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.

80.1 - RHC and FQHC Cost Report Requirements

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

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, and influenza, pneumococcal *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, and influenza, pneumococcal *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 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.

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

RHCs and FQHCs with more than one site may file consolidated cost reports 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 allowed to file a consolidated cost report with a new RHC.

80.3 – RHC and FQHC Cost Report Forms

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

RHCs and FQHCs use one of the following cost report forms:

Independent RHCs and Freestanding FQHCs:

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

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

Provider-based RHCs and FQHCs:

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

Hospital-based FQHCs: Worksheet N of Form CMS-2552-10, Hospital and Hospital Care Complex Cost Report.

Skilled Nursing Facility based: Worksheet I series of form CMS-2540-10, “Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report”.

Information on these cost report forms is found in Chapters 44 *and 46; and* 40 and 41, respectively, of the “Provider Reimbursement Manual - Part 2” (Publication 15-2), which can be located on the CMS Website at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>.

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).

170 - Mental Health Visits

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

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 CAA, 2023 extends the telehealth policies of the CAA, 2022 through December 31, 2024 if the PHE ends prior to that date. The in-person visit requirements for mental health telehealth services and mental health visits furnished by RHCs and FQHCs begin on January 1, 2025 if the PHE ends prior to that date. 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.

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/Federally-Qualified-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.

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.

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 RHC or 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 conditions when 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 that it 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 reimbursed by 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).

220.1 - Preventive Health Services in RHCs

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

Influenza (G0008), Pneumococcal (G0009) and COVID-19 vaccines, and certain COVID-19 monoclonal antibody products

Influenza, pneumococcal *and COVID-19 vaccines and 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. No visit is billed, and these costs should not be included on the claim. The beneficiary coinsurance and deductible are waived.

Hepatitis B Vaccine (G0010)

Hepatitis B vaccine and its administration is included in the RHC visit and is not separately billable. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the RHC provides. The beneficiary coinsurance and deductible are waived.

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 AWW 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 AWW within the past 12 months. The AWW 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 AWW is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

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 dietitians 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 (O0091)

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.

NOTE: Hepatitis C Screening (GO472) is a technical service only and therefore it is not paid as part of the RHC visit.

220.3- Preventive Health Services in FQHCs

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

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, or CSW. 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 vaccines and certain COVID-19 monoclonal antibody products

Influenza, pneumococcal *and COVID-19* vaccines *and 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. The cost is included in the cost report and no visit is billed. FQHCs must include these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance is waived.

Hepatitis B Vaccine (G0010)

Hepatitis B vaccine and its administration is included in the FQHC visit and is not separately billable. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the FQHC provides. The beneficiary coinsurance is waived.

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 AWW 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 AWW within the past 12 months. The AWW 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 AWW 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.

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 (O0091)

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.

NOTE: Hepatitis C Screening (GO472) is a technical service only and therefore not paid as part of the FQHC visit.

230 – Care Management Services

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

Care management 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),

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 payment methodology. RHCs and FQHCs may not bill for care management services for a beneficiary if another practitioner or facility has already billed for care management services for the same beneficiary during the same time period. *However effective 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 payment), 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.

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 be furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or community mental health center.

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-discharge period.

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 service provided 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. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

General Care Management Services include: *Chronic Care Management (CCM)*, *Principal Care Management (PCM)*, *Chronic Pain Management (CPM)* and *general Behavioral Health Integration (BHI)* services. 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, and the same initiating visit can be used for CCM, *PCM*, *CPM* and *general* BHI services as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of care management 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 CCM, *PCM*, *CPM* or *general* BHI 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.

230.2.1– Chronic Care Management (CCM) Services (Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

Effective January 1, 2016, RHCs and FQHCs are paid for CCM services when a minimum of 20 minutes of qualifying CCM services during a calendar month is furnished. CCM services may be furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CCM service requirements include:

- Structured recording of patient health information using Certified EHR Technology including demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care;
- 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication

- reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications;
- Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
 - Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver;
 - Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
 - Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record; and

- Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non- face-to-face consultation methods.

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 complex condition 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 of the care plan;
- The condition is of sufficient severity to place patient at risk of hospitalization or have 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 regimen; 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 treatment of 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 to patients with one or more new or pre-existing behavioral health or psychiatric conditions being 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 status changes;
- 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– Payment for General Care Management Services (Rev. 11803; Issued: 01-26-23; Effective: 01-01-23; Implementation: 02-27-23)

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 and 99426 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.

Coinsurance for care management services is 20 percent of lesser of submitted charges or the payment rate for G0511. Care management 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. G0511 can be billed once per month per beneficiary when at least 20 minutes of CCM services, at least 30 minutes of PCM services, or at least 20 minutes of general BHI services have been furnished and all other 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 20 minutes that is required to bill for CCM and general BHI services and the minimum 30 minutes that is required to bill for PCM services, and does not include administrative activities such as transcription or translation services.