



RURAL HEALTH CLINIC

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This publication provides the following information about Rural Health Clinics (RHCs):

- ❖ Background;
- ❖ RHC services;
- ❖ Medicare certification as a RHC;
- ❖ RHC visits;
- ❖ RHC payments;
- ❖ Cost reports;
- ❖ Annual reconciliation;
- ❖ Resources; and
- ❖ Lists of helpful websites and Regional Office Rural Health Coordinators.

Background

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners (NPs) and physician assistants (PAs) in rural areas. Currently, about 4,000 RHCs nationwide furnish primary care and preventive health services in rural and underserved areas. For a list of Medicare certified RHCs, refer to the document “Medicare Certified Rural Health Clinics” under “Contacts” at <https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html> on the Centers for Medicare & Medicaid Services (CMS) website.

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RHC Services

RHCs furnish:

- ❖ Physician services;
- ❖ Services and supplies incident to the services of a physician;
- ❖ NP, PA, certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- ❖ Services and supplies incident to the services of a NP, PA, CNM, CP, and CSW;
- ❖ Medicare Part B-covered drugs furnished by and incident to services of a RHC practitioner; and
- ❖ Visiting nurse services to the homebound in an area where CMS has certified that there is a shortage of Home Health Agencies.

Medicare Certification as a RHC

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

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

RHCs must:

- ❖ Employ a NP or PA (RHCs may contract with NPs, PAs, CNMs, CPs, and CSWs when at least one NP or PA is employed by the RHC);
- ❖ Have a NP, PA, or CNM working at the clinic at least 50 percent of the time the RHC operates;
- ❖ 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;
- ❖ Furnish all of the following laboratory tests on site:
 - 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;
- ❖ Have an annual program evaluation;
- ❖ Post their days and hours of operation;
- ❖ Not be a rehabilitation agency or a facility that is primarily for the treatment of mental disease;
- ❖ Not be a Federally Qualified Health Center; and
- ❖ Meet other applicable State and Federal requirements.

RHC Visits

RHC visits are medically necessary face-to-face medical or mental health visits or qualified preventive visits between the patient and a physician, NP, PA, CNM, CP, or CSW during which a qualified RHC service is furnished. A Transitional Care Management (TCM) service can also be a RHC visit. In certain limited situations, RHC visits may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient.

RHC visits may take place:

- ❖ In the RHC;
- ❖ At the patient's residence (including an assisted living facility);
- ❖ In a Medicare-covered Part A Skilled Nursing Facility; or
- ❖ At the scene of an accident.

RHC visits may not take place at:

- ❖ An inpatient or outpatient hospital (including a Critical Access Hospital); or
- ❖ A facility which has specific requirements that preclude RHC visits.

Encounters with more than one RHC practitioner on the same day, regardless of the length or complexity of the visit or multiple encounters with the same RHC practitioner on the same day, constitute a single visit, except when the patient:

- ❖ Suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter (for example, he or she sees the practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC); or
- ❖ Has a qualified medical visit and a qualified mental health visit on the same day; or
- ❖ Has an Initial Preventive Physical Examination (IPPE) and a separate medical and/or mental health visit on the same day.

RHC Payments

RHCs are paid an all-inclusive rate (AIR), subject to a maximum payment per visit that is established by Congress and updated annually based on the percentage change in the Medicare Economic Index and subject to annual reconciliation. The per-visit limit does not apply to RHCs determined to be an integral and subordinate part of a hospital with fewer than 50 beds. Laboratory tests (excluding venipuncture) and technical components of RHC services are paid separately.

The coinsurance for Medicare patients is 20 percent of the reasonable and customary charges, except for certain preventive services. Patient cost-sharing requirements for most Medicare-covered preventive services are waived, and Medicare pays 100 percent of the costs for these services. No coinsurance or deductible is required for the IPPE, Annual Wellness Visit, and any covered preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force. For more information about preventive services, including coinsurance and deductible requirements, visit <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html> on the CMS website.

The Part B deductible applies to RHC services and is based on the reasonable and customary billed charges. Non-covered expenses do not count toward the deductible. After the deductible has been satisfied, RHCs are paid 80 percent of the AIR for each RHC visit, with the exception of any preventive services reimbursed by Medicare at 100 percent of cost.

Effective January 1, 2016:

- ❖ RHCs can bill for Chronic Care Management (CCM) services when all CCM requirements are met; and
- ❖ Advanced Care Planning (Current Procedural Terminology [CPT] code 99497) is a stand-alone billable visit in a RHC.

Influenza and Pneumococcal Vaccine Administration and Payment

The cost of the influenza and pneumococcal vaccines and their administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the cost report to report the cost of these vaccines and their administration. These costs should not be reported on a RHC claim when billing for RHC services. The patient pays no Part B deductible or coinsurance for these services. When a RHC practitioner sees a patient for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the costs of the vaccines and their administration are included on the annual cost report and reimbursed at cost settlement.

Hepatitis B Vaccine (HBV) Administration and Payment

The cost of the HBV and its administration is covered under the RHC's AIR. If other services that constitute a qualifying RHC visit are furnished on the same day as the HBV, the charges for the vaccine and its administration should be reported on a separate line item to ensure that the deductible and coinsurance are not applied. When a RHC practitioner sees a patient for the sole purpose of administering this vaccination, the RHC may not bill for a visit; however, the costs of the vaccine and its administration are included on the annual cost report. In this instance, the charges for the HBV may be included on a claim for the patient's subsequent RHC visit.

Payment for Telehealth Services

RHCs are authorized to serve as an originating site for telehealth services if the RHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. RHCs that serve as an originating site for telehealth services are paid an originating site facility fee. Charges for the originating site facility fee may be included on a claim, but the originating site facility fee may not be included on the cost report.

RHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished.

Cost Reports

Independent RHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, to identify all incurred costs applicable to furnishing covered RHC services. Please refer to Chapter 29 of the ["Provider Reimbursement Manual – Part 2"](#) (Publication 15-2) on the CMS website to find Form CMS-222-92.

Hospital-based RHCs must complete Worksheet M of Form CMS-2552-96, Hospital and Hospital Health Care Complex Cost Report, to identify all incurred costs applicable to furnishing covered RHC services. Other provider-based RHCs must complete the appropriate set of RHC worksheets on the cost report filed by the parent provider. A RHC based in a hospital with less than 50 beds is not subject to the per-visit payment limit and its AIR is based on full reasonable cost. The AIR for a RHC in its initial reporting period is determined on the basis of the RHC's submitted budget. The budget estimates the allowable cost and the number of visits the RHC expects to incur during the reporting period. Please refer to Chapter 36 of the ["Provider Reimbursement Manual – Part 2"](#) (Publication 15-2) on the CMS website to find Form CMS-2552-96.

Annual Reconciliation

At the end of the annual cost reporting period, the RHC submits a report to the Medicare Administrative Contractor (MAC) that includes actual allowable costs and actual visits for RHC services for the reporting period and any other information that may be required. After reviewing the report, the MAC divides allowable costs by the number of actual visits to determine a final rate for the period. The MAC determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. Both the interim and final payment rate are reviewed for productivity, reasonableness, and payment limitations.

Resources

The chart below provides RHC resource information.

RHC Resources

For More Information About...	Resource
RHCs	Chapter 13 of the " Medicare Benefit Policy Manual " (Publication 100-02) on the CMS website Chapter 9 of the " Medicare Claims Processing Manual " (Publication 100-04) on the CMS website
CCM Services	" Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) " on the CMS website
TCM Services	" Transitional Care Management Services " on the CMS website
Telehealth Services	https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth on the CMS website Chapter 15 of the " Medicare Benefit Policy Manual " (Publication 100-02) on the CMS website Chapter 12 of the " Medicare Claims Processing Manual " (Publication 100-04) on the CMS website " Telehealth Services " on the CMS website
All Available Medicare Learning Network® Products	" MLN Catalog " on the CMS website

RHC Resources (cont.)

For More Information About...	Resource
Provider-Specific Medicare Information	“MLN Guided Pathways: Provider Specific Medicare Resources” on the CMS website
Medicare Information for Patients	https://www.medicare.gov on the CMS website

Helpful Websites**American Hospital Association Rural Health Care**

<http://www.aha.org/advocacy-issues/rural>

Critical Access Hospitals Center

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

Disproportionate Share Hospitals

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

Federally Qualified Health Centers Center

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

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

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

Medicare Learning Network®

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

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://narhc.org>

National Rural Health Association

<http://www.ruralhealthweb.org>

Rural Health Clinics Center

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

Rural Health Information Hub

<https://www.ruralhealthinfo.org>

Swing Bed Providers

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

Telehealth

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

U.S. Census Bureau

<http://www.census.gov>

Regional Office Rural Health Coordinators

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

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