CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13133	**Date: March 20, 2025**
	Change Request 13946

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 2025.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 21, 2025

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	9/20/20.1/Timing and Content of Certification
R	13/Table of Contents
R	13/Index of Acronyms
R	13/10/10.1/RHC General Information
R	13/10/10.2/FQHC General Information
R	13/40/40.3/Multiple Visits on Same Day
R	13/50/50.1/RHC Services
R	13/60/60.1/Description of Non RHC/FQHC Services
R	13/70/70.1 RHCs Billing Under the AIR
R	13/70/70.3/FQHC PPS Payment Rate and Adjustments
R	13/80/80.1/RHC and FQHC Cost Report Requirements
R	13/80/80.2/RHC and FQHC Consolidated Cost Reports
R	13/80/80.3/RHC and FQHC Cost Report Forms
R	13/80/80.4/RHC Productivity Standards
R	13/110/110.1/Dental, Podiatry, Optometry, and Chiropractic Services
R	13/170/Mental Health Visits
R	13/200/Telehealth
R	13/220/220.1/Preventive Health Services in RHCs
R	13/220/220.3/Preventive Health Services in FQHCs
R	13/230/Care Management Services
R	13/230/230.2/Care Management Services - Chronic Care Management, Principal Care Management, and General Behavioral Health Integration Services
N	13/230/230.2.10/Advanced Primary Care Management Services
R	13/230/230.3/Payment for Care Coordination Services
N	13/230/230.4/Psychiatric Collaborative Care Model Services
R	13/250/250.1/Payment of IOP 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: 13133	Date: March 20, 2025	Change Request: 13946

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

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 21, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 13 to reflect payment policies finalized for 2025.

II. GENERAL INFORMATION

A. Background: The 2025 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 Calendar Year (CY) 2025 Physician Fee Schedule. All other revisions serve to clarify existing policy.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13946.1	Contractors shall be aware of the updates to the Medicare Benefit Policy Manual - Chapter 13.	X								

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. 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

VI. CONTACTS

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

VII. 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 9 - Coverage of Hospice Services Under Hospital Insurance

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(Rev.13133; Issued: 03-20-25)

[Transmittals for Chapter 9](#)

20.1 - Timing and Content of Certification

20.1 - Timing and Content of Certification

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

For the first 90-day period of hospice coverage, the hospice must obtain, no later than 2 calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice IDG, and the individual's attending physician if the individual has an attending physician.

No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.

The attending physician is a doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by the state in which he or she performs that function, a nurse practitioner, or physician assistant, and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. A nurse practitioner is defined as a registered nurse who performs such services as legally authorized to perform (in the state in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets training, education, and experience requirements described in 42 CFR 410.75. A PA is defined as a professional who has graduated from an accredited physician assistant educational program who performs such services as he or she is legally authorized to perform (in the State in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets the training, education, and experience requirements as the Secretary may prescribe. The PA qualifications for eligibility for furnishing services under the Medicare program can be found in the regulations at 42 CFR 410.74 (c).

Note that a rural health clinic *(RHC)* or federally qualified *health center* (FQHC) physician can be the patient's attending physician*. Refer to Chapter 13, section 210 for more information.*

Initial certifications may be completed up to 15 days before hospice care is elected. Payment normally begins with the effective date of election, which is the same as the admission date. If the physician forgets to date the certification, a notarized statement or some other acceptable documentation can be obtained to verify when the certification was obtained.

For the subsequent periods, recertifications may be completed up to 15 days before the next benefit period begins. For subsequent periods, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's IDG. If the hospice cannot obtain written certification within 2 calendar days, it must obtain oral certification within 2 calendar days. When making an oral certification, the certifying physician(s) should state that the patient is terminally ill, with a prognosis of 6 months or less. Because oral certifications are an interim step sometimes needed while all the necessary documentation for the written certification is gathered, it is not necessary for the physician to sign the oral certification. Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.

The hospice must obtain written certification of terminal illness for each benefit period, even if a single election continues in effect.
A written certification must be on file in the hospice patient's record prior to submission of a claim to the Medicare contractor. Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially,

the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.

A complete written certification must include:

1. the statement that the individual's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course;

2. specific clinical findings and other documentation supporting a life expectancy of 6 months or less;

3. the signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers (for more on signature requirements, see Pub. 100-08, Medicare Program Integrity Manual, chapter 3, section 3.3.2.4).

4. as of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms;

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature.

- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.

- The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.

- For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

5. face-to-face encounter. For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements specified in this section results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

The face to face encounter requirement is satisfied when the following criteria are met:

a. Timeframe of the encounter: The encounter must occur prior to the recertification for the third benefit period and each subsequent benefit period. The encounter must occur no more than 30 calendar days before the third benefit period recertification and each subsequent recertification. A face-to-face encounter may occur on the first day of the benefit period and still be considered timely. (Refer to section 20.1.5.d below for an exception to this timeframe).

b. Attestation requirements: A hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a nurse practitioner or non-certifying hospice physician performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.

c. Practitioners who can perform the encounter: A hospice physician or a hospice nurse practitioner can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A hospice nurse practitioner must be employed by the hospice. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice. If the hospice is a subdivision of an agency or organization, an employee of that agency or organization assigned to the hospice is also considered a hospice employee. Physician Assistants (PAs), clinical nurse specialists, and outside attending physicians are not authorized by section 1814(a)(7)(D)(i) of the Act to perform the face-to-face encounter for recertification.

d. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period: In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face to face encounter which occurs within 2 days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within 2 days of admission without a face to face encounter, a face to face encounter can be deemed as complete.

Recertifications that require a face-to-face encounter but which are missing the encounter are not complete. The statute requires a complete certification or recertification in order for Medicare to cover and pay for hospice services. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations.

The hospice must file written certification statements and retain them in the medical record. Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.

These requirements also apply to individuals who had been previously discharged during a benefit period and are being recertified for hospice care.

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

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Index of Acronyms

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

ACP – advance care planning
AIR – all inclusive rate
APCM – advanced primary care management
AWV – annual wellness visit
BHI – behavioral health integration
CCM – chronic care management
CCN – CMS certification number
CHI – community health integration
CNM – certified nurse midwife
CoCM – collaborative care model
CP – clinical psychologist
CPM – chronic pain management
CSW – clinical social worker
DSMT – diabetes self-management training
EKG – electrocardiogram
E/M – evaluation and management
FQHC – federally qualified health center
FTE – full time equivalent
GAF – geographic adjustment factor
GME – graduate medical education
HCPCS – Healthcare Common Procedure Coding System
HHA – home health agency
HHS – Health and Human Services
HPSA – health professional shortage area
HRSA – Health Resources and Services Administration
IPPE – initial preventive physical exam
IOP – intensive outpatient program
LDTC – low dose computed tomography
LPN – licensed practical nurse
MAC – Medicare Administrative Contractor
MHC – mental health counselor
MEI – Medicare Economic Index
MFT – marriage and family therapist
MNT – medical nutrition therapy
MSA – metropolitan statistical area
MUA – medically-underserved area
MUP – medically-underserved population
NCD – national coverage determination
NECMA – New England County Metropolitan Area
NP – nurse practitioner
OBRA - Omnibus Budget Reconciliation Act
PA – physician assistant
PCE - primary care exception

PCM – principal care management
PFS – physician fee schedule
PIN - principal illness navigation
PIN-PS – principal illness navigation – peer support
PPS – prospective payment system
PHS – public health service
RHC – rural health clinic
RN – registered nurse
RO – regional office
RPM – remote patient monitoring
RTM – remote therapeutic monitoring
RUCA – rural urban commuting area
SDOH – Social Determinants of Health
SLP – speech language therapy
SNF – skilled nursing facility
TCM – transitional care management
UA – urbanized area
USPSTF – U.S. Preventive Services Task Force

10.1 - RHC General Information

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

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

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

To be eligible for certification as an RHC, a clinic must be located in a non-urbanized area, as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary, Health and Human Services (HHS), in anyone 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;
- *Provide outpatient health services*
- *Provide primary care services*
- 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 laboratory tests:
    - *Stick or tablet urine examine or both*;
    - Blood sugar;
    - Pregnancy tests; and

- *Collection of patient specimens to send to a certified lab for culturing*.

- Not be concurrently approved as an FQHC, and
- Meet other applicable State and Federal requirements.

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

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

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

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

10.2 - FQHC General Information

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

FQHC services are defined as:

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

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

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

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

- Health Center Program Grantees: Organizations receiving grants under section 330 of the PHS Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers;

- Health Center Program Look-Alikes: Organizations that have been identified by HRSA as meeting the definition of "Health Center" under section 330 of the PHS Act, but not receiving grant funding under section 330; and

- Outpatient health programs/facilities operated by a tribe or tribal organization (under the Indian Self-Determination Act) or by an urban Indian organization (under Title V of the Indian Health Care Improvement Act).

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

- Provide comprehensive services and have an ongoing quality assurance program;

- Meet other health and safety requirements;

- Not be concurrently approved as an RHC; and

- Meet all requirements contained in section 330 of the Public Health Service Act, including:

    - Serve a designated Medically-Underserved Area (MUA) or Medically-Underserved Population (MUP);

    - Offer a sliding fee scale to persons with incomes below 200 percent of the federal poverty level; and

    - Be governed by a board of directors, of whom a majority of the members receive their care at the FQHC.

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

40.3 - Multiple Visits on Same Day

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where an RHC or FQHC patient has a medically-necessary face-to-face visit with an RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC

practitioner, including a specialist, for evaluation of a different condition on the same day.

Exceptions are for the following circumstances only:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has afall and returns to the RHC or FQHC). In this situation only, the FQHC would use modifier 59 on the claim and the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits;

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

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

- *A dental visit and a medical visit on the same day;*

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

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

NOTE: These exceptions do not apply to *historically excepted* tribal FQHCs.

50.1 - RHC Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

RHC services include:

- Physicians' services, as described in section 110;
- Services and supplies incident to a physician's services, as described in section120;
- Services of NPs, PAs, and CNMs, as described in section 130;
- Services and supplies incident to the services of NPs, PAs, and CNMs, asdescribed in section 140;
- CP and CSW services, as described in section 150;
- MFT and MHC services, as described in section 150;
- Services and supplies incident to the services of CPs and CSWs, as described in section 160;
- Services and supplies incident to the services of MFTs and MHCs, as described in section 160;
- Visiting nurse services to patients confined to the home, as described in section190;
- Certain care management services, as described in section 230; and
- Certain virtual communication services, as described in section 240.

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

- Influenza, Pneumococcal, Hepatitis B, COVID-19 vaccinations, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19;

- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.
- *Drugs Covered as Additional Preventive Services (DCAPS) and related supply and administration fees*

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. *Effective January 1, 2025, hepatitis B vaccines are included in that list. Prior to January 1, 2025,* payment for the hepatitis B vaccine and its administration *was* 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.

50.3 - Emergency Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

If a patient presents at the RHC with an emergency when the RHC is not open for patient care because a physician, NP, PA, CNM, CP, CSW, MFT or MHC is not present, other staff may attend to the patient until care of the individual can be transferred. Any care provided in this situation must be within the individual's ability, training, and scope of practice, and in accordance with state laws, and would not be considered an RHC service.

During their regular hours of operations, FQHC practitioners are required to provide medical procedures as a first response to common life-threatening injuries and acute illnesses and to have available the drugs and biologicals commonly used in life-saving procedures. After their operating hours, FQHCs must provide telephone access to an individual who has the qualifications and training to exercise professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer the patient to an appropriate provider or facility that is open.

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

60.1 - Description of Non RHC/FQHC Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

Technical component of an RHC or FQHC service - Includes diagnostic tests such as x-rays,

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

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

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

Ambulance services - The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat the patient's condition, and any other methods of transportation arecontraindicated. See https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/downloads/bp102c10.pdf for additional information on covered ambulance services.

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

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

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

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

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

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

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

70.1 - RHC Payment

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

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

70.3 - FQHC PPS Payment Rate and Adjustments

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

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

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

NOTE: These adjustments do not apply to *historically excepted* tribal FQHCs.

80.1 - RHC and FQHC Cost Report Requirements

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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, *hepatitis B* and COVID-19 vaccines, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration. If in its initial reporting period, the RHC submits a budget that estimates the allowable costs and number of visitsexpected 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*, hepatitis B* and COVID-19 vaccines, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration through the cost report. All FQHCs, including an FQHC that does not have GME costs, bad debt, or costs associated with influenza, pneumococcal*, hepatitis B* and COVID-19 vaccines, or covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration, must file a cost report.

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

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 andstatistical 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 effortswere 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.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

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

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

80.3 – RHC and FQHC Cost Report Forms

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

RHCs: Form CMS-222-17, *Freestanding or* Independent Rural Health Clinic *that aren't affiliated with a hospital* Cost Report.

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

FQHCs:

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

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

80.4 – RHC Productivity Standards

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

Productivity standards *were* used to help determine the average cost per patient for Medicare reimbursement in RHCs. The productivity standards require*d* 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent non-physician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may *have* be*en* combined. The FTE on the cost report for providers *was* the time spent seeing patients or scheduled to see patients and does not include administrative time *The A/B MAC had the discretion to make an exception to the productivity standards based on individual circumstances. All visits (Medicare, Medicaid, Managed Care, etc.) were included in determining the productivity standards for the cost report. Productivity standards are no longer required effective with cost reporting periods ending after December 31, 2024.*
FQHCs *were* not subject to the productivity standards.

110.1 - Dental, Podiatry, Optometry, and Chiropractic Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

Dentists, podiatrists, optometrists, and chiropractors are defined as physicians in Medicare statute, and qualified services furnished by physicians are billable visits in an RHC or FQHC. These practitioners can provide RHC or FQHC services that are within their scope of practice and not excluded from coverage (e.g., Medicare coverage of chiropractic services is limited to manual manipulation of the spine for a demonstrated subluxation).
RHCs and FQHCs can furnish dental services that are inextricably linked to specific medical services and align with the policies and operational requirements in the physician office setting. These dental services would be considered a qualifying visit and be paid at the RHC AIR or FQHC PPS payment rate. A KX modifier would be reported on an RHC or FQHC Medicare claim to indicate that the service is medically necessary, and that the provider has included appropriate documentation in the patient's medical record to justify the medical necessity of the service. RHCs and FQHCs may also report the GY modifier on an RHC or FQHC Medicare claim to indicate that a service is not covered because it is outside of the scope of

Medicare coverage authorized by the statue. Denial modifiers, such as the GY modifier, should be used when an RHC or FQHC practitioner wants to indicate that the service is statutorily not covered.
An RHC or FQHC can bill for a face-to-face, medically necessary visit furnished by a dentist, podiatrist, optometrist, or chiropractor if the service furnished is a qualifying visit for RHCs or FQHCs and all other requirements are met. All services furnished must be within the state scope of practice for the practitioner, and all HCPCS codes must reflect the actual services that were furnished.
RHCs and FQHCs are required to primarily provide primary health care. Since dentists, podiatrists, optometrists, and chiropractors are not considered primary care physicians, they do not meet the requirements to be either i) a physician medical director or ii) the physician or non-physician practitioner (NP, PA, or CNM) that must be available at all times the clinic is open. Therefore, a dentist, podiatrist, optometrist, or chiropractor can provide a medically necessary, face-to-face visit with an RHC or FQHC patient only when the statutory and regulatory staffing requirements are otherwise met.
For additional information on these services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 on Covered Medical and Other Health Service at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

120.1 - Provision of Incident to Services and Supplies

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

Incident to services and supplies can be furnished by auxiliary personnel. All services and supplies provided incident to a physician's visit must result from the patient's encounter with the physician and be furnished in a medically appropriate timeframe. More than one incident to service or supply can be provided as a result of a single physician visit.

Incident to services and supplies must be provided by someone who has an employment agreement or a direct contract with the RHC or FQHC to provide services. Services or supplies provided by individuals who are not employed by or under direct contract with the RHC or FQHC, even if provided on the physician's order or included in the RHC or FQHC's bill, are not covered as incident to a physician's service. Services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the RHC or FQHC for inclusion in the entity's statement of services, services provided by an independent laboratory or a hospital outpatient department, services furnished by a nurse, medical assistant, or other auxiliary personnel who is not an employee of or working under contract to the RHC or FQHC, including services provided by a third party under contract, etc.

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

Effective January 1, 2024, behavioral health services can be furnished under general supervision of the physician (or other practitioner) when these services are provided by auxiliary personnel incident to the services of a physician (or another practitioner).

When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or FQHCs.

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

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

A CP is an individual who:

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

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

A CSW is an individual who:

- Possesses a master's or doctor's degree in social work;
- After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the state in which the services are performed; or, in the case of an individual in a state that does not provide for licensure or certification, meets the requirements listed in 410.73(a)(3)(i) and (ii).

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

A MFT is an individual who:

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

A MHC is an individual who:

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

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

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

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

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

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

170 - Mental Health Visits

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

A mental health visit is a medically-necessary face-to-face encounter between an RHC orFQHC patient and an RHC or FQHC practitioner during which time one or more RHC orFQHC 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.

Beginning January 1, 2026, 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 areincluded 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 notmeet the criteria for a one-one-one, face-to-face encounter in an FQHC or RHC.

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

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and for FQHCs, an appropriate FQHC mentalhealth payment code. For detailed information on reporting mental health services andclaims 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 billableservice in an RHC or FQHC and is included in the payment of an RHC or FQHC medicalvisit. 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.

200 - Telehealth Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

RHCs and FQHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. RHCs and FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.
Although FQHC services are not subject to the Medicare deductible, the deductible must be applied when an FQHC bills for the telehealth originating site facility fee, since this is not considered an FQHC service.

Prior to March 27, 2020, RHCs and FQHCs were not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and they could not bill or include the cost of a visit on the cost report. This included telehealth services that are furnished by an RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract. For more information on Medicare telehealth services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, and Pub. 100-04, Medicare Claims Processing Manual, chapter 12.

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Section 3704 of the CARES Act authorized RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE. Section 4113 of the Consolidated Appropriations Act, 2023, extended this authority through December 31, 2024. *RHCs and FQHCs can continue to provide on a temporary basis, for non-behavioral health visits furnished via telecommunication technology under the methodology that has been in place for these services during and after the COVID-19 PHE through December 31, 2024. Specifically, RHCs and FQHCs can continue to bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, 2025. For payment for non-behavioral health visits furnished via telecommunication technology in CY 2025, the payment amount is based on the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.* Any health care practitioner working within their scope of practice can provide distant site telehealth services. Practitioners can provide distant site telehealth services – approved by Medicare as a distant site telehealth service under the physician fee

schedule (PFS) – from any location in the United States (see 42 CFR 411.9(a)(1)), including their home, during the time that they're employed by or under contract with the RHC or FQHC.

220 - Preventive Health Services

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

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

220.1 - Preventive Health Services in RHCs

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

Influenza (G0008), Pneumococcal (G0009), *Hepatitis B (G0010)* and COVID-19 (90480) Vaccines, and Certain COVID-19 Monoclonal Antibody Products

Influenza, pneumococcal*, hepatitis B* and COVID-19 vaccines and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration 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)

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

Annual Wellness Visit (G0438 and G0439)

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

More information regarding the SDoH risk assessment is available on the CMS website: https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

More information regarding ACP is available on the CMS website: https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802and 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 notbillable visits in an RHC, although the cost may be allowable on the cost report. RHCs cannot bill a visit for services furnished by registered dieticians or nutritional professionals. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their AIR. The beneficiary coinsurance and deductible apply.

Screening Pelvic and Clinical Breast Examination (G0101)

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

Drugs Covered as Additional Preventive Services (DCAPS)*DCAPS drugs, and any supply and administration fee, are paid at 100 percent of the Medicare payment amount. The Medicare payment amount for DCAPS drugs, and any supply and administration fee, is described in the Medicare Claims*

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

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

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

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

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

220.3 - Preventive Health Services in FQHCs

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

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

Influenza (G0008), Pneumococcal (G0009), *Hepatitis B (G0010)* and COVID-19 (90480) Vaccines and Certain COVID-19 Monoclonal Antibody Products

Influenza, pneumococcal*, hepatitis B,* and COVID-19 vaccines and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration 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)

*Prior to January 1, 2025, h*epatitis B vaccine and its administration *wa*s included in the FQHC visit and *wa*s not separately billable. The cost of the vaccine and its administration c*ould* be included in the line item for the otherwise qualifying visit. A visit *could not* be billed if vaccine administration *wa*s the only service the FQHC provides. The beneficiary coinsurance *wa*s 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 AWV is a personalized face-to-face prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past12 months. Social Determinants of Health (SDOH) assessments and Advance Care Planning (ACP) can be furnished as a part of the AWV. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

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

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

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

Screening Pelvic and Clinical Breast Examination (G0101)

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

Screening Papanicolaou Smear (Q0091)

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

Prostate Cancer Screening (G0102)

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

Glaucoma Screening (G0117 and G0118)

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

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

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

Drugs Covered as Additional Preventive Services (DCAPS)

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

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

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

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

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

230 – Care *Coordination* Services *(formerly Care Management Services)*

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

Care *coordination* services are RHC and FQHC service*s* and include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), chronic pain management (CPM), general behavioral health integration (BHI), Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Community Health Integration (CHI), Principal Illness Navigation (PIN)*, Principal Illness Navigation Peer Support (PIN-PS), Advanced Primary Care Management (APCM)* and psychiatric collaborative care model (CoCM) services. The RHC and FQHC face-to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.) Except for TCM services, care management services are paid separately from the RHC AIR or FQHC PPS 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.

Effective for dates of services on or after January 1, 2025, RHCs and FQHCs are required to bill the individual codes that make up the general care management HCPCS code, G0511. RHCs and FQHCs will report the individual CPT/HCPCS base codes and add-on codes (as necessary) for each of the care coordination services which will replace HCPCS code G0511. For a current list of the base codes and add-on codes that make up G0511, please view the RHC and FQHC webpages at https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center and

https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center, respectively.

**Note: For those RHCs and FQHCs that need additional time to update their billing systems, they may continue to bill G0511 until July 1, 2025. For those RHCs and FQHCs that are ready, bill the individual HCPCS codes. RHCs and FQHCs should continue to bill G0511 or the individual HCPCS codes on a facility basis, and not on a patient-by-patient or claims-by-claims basis. A claim should not contain G0511 and the corresponding HCPCS codes.*

230.2 –Care *Coordination* Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

Beneficiary consent remains in effect unless the beneficiary opts out of receiving caremanagement services. If the beneficiary chooses to resume care management servicesafter 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 hasbeen a period where no care management services were furnished, a new beneficiary consent is not required.

230.2.4– General Behavioral Health Integration (BHI) Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

230.2.10 Advanced Primary Care Management Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

230..*3*– Payment for Care *Coordination* Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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 isbilled 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 codes99490 (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 G0511is 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 minutesor 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 RHCor FQHC claim, either alone or with other payable services.

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

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

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

Care Coordination Services	*HCPCS Codes*
CCM	*99437, 99439,* 99487, 99490, 99491
PCM	99424, *99425*, 99426, *99427*

CPM	G3002, *G3003*
General BHI	99484, *G0323*
RPM	99453, 99454, 99457, *99458, 99474,* 99091
RTM	98975, 98976, 98977, 98980, *98981*
CHI	G0019, *G0022*
PIN	G0023, *G0024*
PIN-Peer Support	G0140, *G0146*
Advanced Primary Care Management (APCM)	*G0556, G0557, G0558*

Note: APCM codes are not included in G0511.
Starting January 1, 2025, care coordination services (previously care management services) provided in RHCs/FQHCs will include Advanced Primary Care Management Services (APCM) in the suites of care coordination services including Transitional care management (TCM), Chronic care management (CCM), Principal care management (PCM), Chronic pain management (CPM), General behavioral health integration (BHI), Remote physiologic monitoring (RPM), Remote therapeutic monitoring (RTM), Community Health Integration (CHI), Principal Illness Navigation (PIN) and Principal Illness Navigation Peer-Support (PIN-PS).
RHCs and FQHCs will report the individual CPT/HCPCS base codes and add-on codes for each of the care coordination services, which will replace HCPCS code G0511. Care coordination services are paid at the national non-facility PFS payment rates.
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For FQHCs, coinsurance for care management services is 20 percent of lesser of submitted charges or the payment rate for *each individual HCPCS code*. For RHCs, coinsurance is 20 percent of the total charges or the payment rate for *each individual HCPCS code*. 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.

230.*4* – Psychiatric Collaborative Care Model (CoCM) Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

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

services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:

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

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

RHC or FQHC Practitioner Requirements

The RHC or FQHC practitioner is a primary care physician, NP, PA, or CNM who:

- Directs the behavioral health care manager and any other clinical staff;
- Oversees the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and
- Remains involved through ongoing oversight, management, collaboration and reassessment.

Behavioral Health Care Manager Requirements

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

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

Psychiatric Consultant Requirements

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

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

Payment for Psychiatric CoCM

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

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

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

250.1 Payment for IOP Services

(Rev.13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

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

Effective January 1, 2024, payment for IOP Services furnished by RHCs will be the rate determined for (Intensive Outpatient (*up to* 3 services per day) for hospital-based IOPs) and not the RHC AIR. *Effective January 1, 2025, a 4 or more IOP Services is also available based on the outpatient hospital rate.*

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

Multiple Visits

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