



Information for Rural Health Clinics



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What's Changed?

Added:

- Marriage and family therapists and mental health counselors as practitioners (page 4)
- Remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI) and principal illness navigation (PIN) (page 5)
- Intensive outpatient program services (pages 5 and 7)
- All-Inclusive Rate (AIR) per visit for CY 2024 (page 7)
- Social determinants of health (page 8)
- Table of general care management services HCPCS/CPT codes (pages 9-10)
- Rural health reports and publications as a resource (page 14)

Substantive content changes are in dark red.

A rural health clinic (RHC) is a clinic located in a rural, underserved area with a shortage of primary care providers, personal health services, or both. Currently, about 5,200 RHCs nationwide provide primary care and preventive health services in underserved rural areas.



Together we can advance health equity and help eliminate health disparities in rural communities, territories, Tribal nations, and geographically isolated communities. Find these resources and more from the [CMS Office of Minority Health](#):

- [Rural Health](#)
- [CMS Framework for Rural, Tribal, and Geographically Isolated Areas](#)
- [Data Stratified by Geography \(Rural/Urban\)](#)
- [Health Equity Technical Assistance Program](#)

Practitioners

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

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

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

RHC Patient Services

RHCs provide:

- Physician services.
- Primary care and [preventive services](#).
- Services and supplies provided incident to RHC practitioner services, like taking blood pressure or administering injections.
- Services and supplies incident to NP, PA, CNM, CSW, MFT, and MHC services.

- Medicare patient homebound visiting nurse services provided by a registered nurse (RN) or licensed practical nurse (LPN) in CMS-certified home health agency shortage areas. You should [check eligibility](#) before providing visiting nurse services to make sure the patient isn't already under a home health plan of care.
- Certain care management services, including [transitional care management](#) (TCM), [chronic care management](#) (CCM), general [behavioral health integration](#) (BHI), principal care management (PCM), psychiatric collaborative care model (CoCM), and chronic pain management services (CPM).
- Effective January 1, 2024, remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI), principal illness navigation (PIN), and PIN-peer support (PIN-PS) are payable by billing the general care management code, G0511.
- [Virtual communication services](#), like communications-based technology and remote evaluation services.
- Mental health services using [telehealth](#) starting January 1, 2022. You may provide mental health visits using interactive, real-time telecommunications technology. Section 4113 of the [Consolidated Appropriations Act \(CAA\), 2023](#), delayed the in-person visit requirements under Medicare for mental health visits that RHCs provide via telecommunications technology. We won't require in-person visits until January 1, 2025.
- Hospice attending physician services from an RHC physician, an NP, or a PA employed or working under contract for an RHC, instead of employed by a hospice program starting January 1, 2022. These services:
 - Are subject to Medicare [Part B coinsurance and deductible](#)
 - Can take place during a hospice election at the patient's home, a Medicare-certified hospice freestanding facility, a skilled nursing facility (SNF), or a hospital
- Intensive outpatient program (IOP) services provide treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a partial hospitalization program. See [CR 13496](#) for details.

Certification

To be certified as an RHC, a clinic must meet all state and federal requirements, including location, staffing, and health care services requirements. RHCs must also have a quality assessment and quality improvement program.

Location Requirements

An RHC must:

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

Staffing Requirements

An RHC must:

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

Health Care Services Requirements

An RHC must:

- Directly provide routine diagnostic and lab services
- Have arrangements with 1 or more hospitals to provide medically necessary services the RHC doesn't provide
- Have drugs and biologicals available to treat emergencies
- Provide these lab tests on site:
 - Stick or tablet chemical urine exam or both
 - Hemoglobin or hematocrit
 - Blood sugar
 - Occult blood stool specimens exam
 - Pregnancy tests
 - Primary culturing to send to a certified lab
- Not be primarily a mental disease treatment facility or a rehabilitation agency
- Not be a [Federally Qualified Health Center](#) (FQHC)



Visits

RHC visits **must** be:

- Medically necessary
- Medical or mental health visits, qualified preventive health visits, or face-to-face visits between the patient and an RHC practitioner
- A qualified RHC service needing an RHC practitioner

Note: Mental health visits can take place using telehealth.

RHC visits **can** take place at:

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

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

- An inpatient or outpatient hospital department, including a [critical access hospital](#) (CAH)
- A facility with specific requirements excluding RHC

Multiple Visits on the Same Day

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

- Returns to the RHC to diagnose or treat an injury or illness that happened after the initial visit (for example, a patient sees their practitioner in the morning because they have flu symptoms, then later in the day they cut their finger and return to the RHC)
- Has a qualified medical and mental health visit on the same day
- Has an [Initial Preventive Physical Exam](#) (IPPE) and a separate medical or mental health visit on the same day, or both
- **Has IOP services on the same day with a medical visit**

Payments

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

Section 132 of the [CAA, 2021](#) restructures the payment limits for all independent and provider-based RHCs starting April 1, 2021. See [CR 12185](#) and [CR 12489](#) for more information on establishing certain provider-based RHC payment limits.

Per visit payment limits are:

- **\$139 for CY 2024**

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

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

For specified provider-based RHCs in a hospital with less than 50 beds, Medicare Administrative Contractors (MACs) calculate the payment limit per visit for provider-based RHCs that meet certain criteria.

For certain preventive services like the [Annual Wellness Visit](#) (AWV) and the IPPE, we pay the full AIR and patients don't pay anything. For most other services, Part B deductible and coinsurance rates apply, which means once patients meet their Part B deductible, we pay 80% of the AIR and the patient pays 20% of the total charges.

Effective January 1, 2024, payment for social determinants of health (SDOH) risk assessments (G0136), which you must provide in conjunction with a qualifying visit, including an evaluation and management (E/M) visit or the AWV and is included in the payment for the visit. When you provide SDOH services with the AWV, there's no patient cost sharing. When provided with other visits, cost sharing does apply.

RHC Payment Limit Clarification

For purposes of establishing the payment limit, effective April 1, 2021, for specified provider-based RHCs, MACs will use a cost report that reports costs for 12 consecutive months. If the RHC doesn't have a 12-consecutive month cost report, MACs will use the next most-recent final settled cost report that reports costs for 12 consecutive months. MACs shouldn't combine cost report data to equal a 12-consecutive month cost report.

Cost Reports

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

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

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

The [Provider Reimbursement Manual – Part 2](#) has more cost reports and forms.

Annual Reconciliation

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

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

For more information, find your [MAC's website](#).

Care Management Services

- Effective January 1, 2024, PIN.
- You can bill TCM services with other care management services, starting January 1, 2022.
- The coinsurance is 20% of the total charges or G0511's payment rate for general care management services.
- You can report care management costs in the cost report's non-reimbursable section and these costs aren't taken into account under the RHC AIR.
- General Care Management (G0511).
 - CCM services
 - General BHI
 - PCM services
 - CPM services
 - RPM/RTM
 - CHI
 - PIN
- RHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below as long as they've met all requirements and there isn't double counting. For example, RHCs 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 don't overlap.



General Care Management Services	HCPCS/CPT Codes
CCM	99487, 99490, 99491
PCM	99424, 99426
CPM	G3002
General BHI	99484

General Care Management Services	HCPSC/CPT Codes
RPM	99453, 99454, 99457, 99091
RTM	98975, 98976, 98977, 98980
CHI	G0019
PIN	G0023
PIN-PS	G0140

Note: The table doesn't include add-on code pairs or codes that describe additional minutes. These codes were only used to calculate the weighted average payment rate for HCPCS code G0511.

Psychiatric CoCM services (G0512)

- We pay at the national non-facility physician fee schedule (PFS) payment rate for CPT code 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when HCPCS code G0512 is on an RHC claim either alone or with other payable services
- You must provide at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services to bill for this service
- The coinsurance is 20% of the total charges or G0512's payment rate for general care management services
- You can bill G0512 once per month per patient when you deliver at least 60 minutes of psychiatric CoCM services, and your services meet all other requirements
 - You can count only RHC practitioner or auxiliary personnel services within the scope of service elements toward the 60-minute psychiatric CoCM billing minimum
 - **Don't** include administrative activities like transcription or translation services

We don't require face-to-face services for RHC care management services. Auxiliary personnel may provide them under general supervision.

RHCs can't bill care management services if another practitioner or facility billed them during the same time period.

See [FAQs About Practitioner Billing for Chronic Care Management Services](#) for more information.

See Section 230 of [Medicare Benefit Policy Manual, Chapter 13](#) for more information on care management services.

See Section 230.3 of [Medicare Benefit Policy Manual, Chapter 13](#) for more information on psychiatric CoCM services.

Flu, Pneumococcal, & COVID-19 Shots

We pay for flu, pneumococcal, and COVID-19 shots and their administration at 100% of reasonable cost. RHCs report these services on a separate cost report worksheet. RHCs shouldn't report these services on their RHC billing claims.

COVID-19 Monoclonal Antibody Therapies & Vaccines

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

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

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

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

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

An RHC can't bill a visit when the practitioner only sees a patient to administer a vaccine. Instead, the RHC includes vaccines and their administration on the annual cost report, and we reimburse them at cost settlement. Patients pay no Part B deductibles and coinsurance for these services.

Hepatitis B Shot Administration & Payment

The bundled payment, or AIR, for an RHC visit includes the hepatitis B shot and its administration costs. This means you can't bill the shot or its administration separately from the visit, and you can't bill for a visit if shot administration is the only service you provided. However, you can include it on a separate line item when you submit the visit's bill, which ensures the patient pays no Part B deductible and coinsurance. If the shot was the only service you provided, you can add it on a separate line item for the next visit.

Telehealth

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

During the COVID-19 PHE, we used emergency waiver and other regulatory authorities so you could provide more services to your patients via telehealth. Section 4113 of the [Consolidated Appropriations Act \(CAA\), 2023](#) extended many of these flexibilities through December 31, 2024, and made some of them permanent. Learn more about Medicare [telehealth services](#), including technology and other requirements.

Originating Sites

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

Through December 31, 2024, all patients can get telehealth wherever they're located. They don't need to be at an originating site, and there aren't any geographic restrictions.

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

Distant Sites

A distant site is the location where a physician or practitioner provides telehealth. Before the COVID-19 PHE, only certain types of distant site providers could provide and get paid for telehealth. Through December 31, 2024, all providers who are eligible to bill Medicare for professional services, including RHCs, can provide distant site telehealth.

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

Note: Section 4113 of the [CAA, 2023](#) extends the telehealth policies enacted in the [CAA, 2022](#) through December 31, 2024.

Virtual Communication Services

You can also provide virtual communication services. RHCs bill virtual communication services differently than telehealth.

Virtual communication services are services where a practitioner meets with a patient for at least 5 minutes to decide if the patient needs a visit. There are 2 ways to provide virtual communication services:

1. Through communication-based technology
2. With remote evaluation services

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

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

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

See [Virtual Communication Services FAQs](#) for more information.

Consent for Chronic Care Management & Virtual Communication Services

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

Mental Health Visits

In 2022, we revised current regulatory language to allow RHC mental health visits using telehealth. We're allowing these mental health visits to be paid in the same way as face-to-face services. The changes also allow you to use audio-only telehealth in cases where patients can't, or don't consent to, using audio-video telehealth. [MLN Matters® Article SE22001](#) has more information.

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



Note: Section 4113(d) of the CAA, 2023 continues to delay the in-person visit requirements for mental health visits to start on January 1, 2025.

Resources

- [Calendar Year \(CY\) 2024 Medicare Physician Fee Schedule Final Rule Fact Sheet](#)
- [Medicare Benefit Policy Manual, Chapter 13](#)
- [Medicare Claims Processing Manual, Chapter 9](#)
- [Rural Health Clinics Center](#)
- [Rural Health Reports and Publications](#)

Regional Office Rural Health Coordinators

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

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