CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12832	**Date: September 12, 2024**
	Change Request 13493

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 2024.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 14, 2024

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/Table of Contents
R	13/Index of Acronyms
R	13/10.1/RHC General Information
R	13/10.2/ FQHC General Information
R	13/30.1 /RHC Staffing Requirements
R	13/40 /RHC and FQHC Visits
R	13/40.3/Multiple Visits on Same Day
R	13/50.1/ RHC Services
R	13/50.2/ FQHC Services
R	13/50.3/ Emergency Services
R	13/60.1/ Description of Non RHC/FQHC Services
R	13/80.2/RHC and FQHC Consolidated Cost Reports
R	13/80.3/RHC and FQHC Cost Report Forms
R	13/120.1/Provision of Incident to Services and Supplies
R	13/150/Clinical Psychologist, Clinical Social Worker Services, Marriage and Family Therapist, and Mental Health Counselors
R	13/160/Services and Supplies Incident to CP, CSW, MFT, and MHC Services
R	13/170/Mental Health Visits
R	13/190.5/Treatment Plans for Visiting Nursing Services
R	13/200/Telehealth Services
R	13/220.1/Preventive Health Services in RHCs
R	13/220.3/Preventive Health Services in FQHCs
R	13/230/Care Management Services
R	13/230.2/General Care Management Services/ Chronic Care Management, Principal Care Management, and General Behavioral Health Integration Service
D	13/230.2.1/Chronic Care Management (CCM) Services
R	13/230.2.5 /Remote Patient Monitoring (RPM) Services
N	13/230.2.6/Remote Therapeutic Monitoring (RTM) Services
N	13/230.2.7/Community Health Integration (CHI) Services
N	13/230.2.8/Principal Illness Navigation (PIN) Services
N	13/230.2.9/PIN-Peer Support (PIN-PS) Services
N	13/230.2.10/ Payment for General Care Management Services

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/240/ Virtual Communication Services
N	13/250/Intensive Outpatient Program (IOP) Services
N	13/250.1/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:12832	Date: September 12, 2024	Change Request: 13493

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

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 14, 2024

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 13 to reflect payment policies finalized for 2024.

II. GENERAL INFORMATION

A. Background: The 2024 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) 2024 Physician Fee Schedule and CY 2024 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rules. 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	
13493.1	Contractors shall be aware of the updates to the Medicare Benefit Policy Manual - Chapter 13.	X								

IV. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13493.2	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.	X				

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

Table of Contents
(Rev. 12832; Issued: 09-12-24)

Index of Acronyms

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

ACP – advance care planning
AIR – all inclusive rate
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 – *f*ederally 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 – *h*ealth *p*rofessional *s*hortage *a*rea
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 – *m*edically-*u*nderserved *a*rea
MUP – *m*edically-*u*nderserved *p*opulation
NCD – national coverage determination
NECMA – New England County Metropolitan Area
NP – nurse practitioner
OBRA - Omnibus Budget Reconciliation Act
PA – physician assistant
PCE - *p*rimary *c*are exception

PCM – *p*rincipal *c*are *m*anagement
PFS – physician fee schedule
PIN - principal illness navigation
PIN-PS – principal illness navigation – peer support
PPS – prospective payment system
PHS – *p*ublic *h*ealth *s*ervice
RHC – rural health clinic
RN – registered nurse
RO – regional office
RPM – remote patient monitoring
RTM – remote therapeutic monitoring
RUCA – *r*ural *u*rban *c*ommuting *a*rea
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.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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;
- Directly furnish routine diagnostic and laboratory services;
- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC;
- Have available drugs and biologicals necessary for the treatment of emergencies;
- Meet all health and safety requirements;
- Not be a rehabilitation agency or a facility that is primarily for mental health treatment;
- Furnish onsite all of the following six laboratory tests:
    - Chemical examination of urine by stick or tablet method or both;
    - Hemoglobin or hematocrit;
    - Blood sugar;
    - Examination of stool specimens for occult blood;
    - Pregnancy tests; and

- Primary culturing for transmittal to a certified laboratory.

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

RHCs can be either independent or provider-based. Independent RHCs are stand-alone or freestanding clinics and submit claims to a Medicare Administrative Contractor (A/B MAC). They are assigned a CMS Certification Number (CCN) in the range 3800-3974 or 8900-8999. Provider-based RHCs are an integral and subordinate part of a hospital (including a critical access hospital (CAH). 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.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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 grandfathered 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.

30.1 - RHC Staffing Requirements

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

In addition to the location requirements, an RHC must:

- Employ an NP or PA; and

- Have an NP, PA, or CNM working at the clinic at least 50 percent of the time the clinic is operating as an RHC.

The employment may be full or part time, and is evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100 percent ownership of the RHC, the W-2 form can be from that entity as long as all the non-physician practitioners employed in the RHC receive their W-2 from this owner.
The following are examples of situations that would NOT satisfy the employment requirement:

- An NP or PA who is employed by a hospital that has an ownership interest in the RHC but is not physically present and working in the RHC;

- A CNM who is employed by the RHC;

- An Advanced Practice Registered Nurse who is not an NP or PA; or

- An NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician.

An RHC practitioner is a physician, NP, PA, CNM, CP, CSW*, MFT or MHC*. At least one of these practitioners must be present in the RHC and available to furnish patient care at all times the RHC is in operation. A clinic that is open solely to address administrative matters or to provide shelter from inclement weather is not considered to be in operation during this period and is not subject to the staffing requirements. An NP, PA, or CNM must be available to furnish patient care at least 50 percent of the time that the RHC is open to provide patient care. This requirement can be fulfilled through any combination of NPs, PAs, or CNMs as long as the total is at least 50 percent of the time the RHC is open to provide patient care. Only the time that an NP, PA, or CNM spends in the RHC, or the time spent directly furnishing patient care in another location as an RHC practitioner, is counted towards the 50 percent time. It does not include travel time to another location, or time spent not furnishing patient care when in another location outside the RHC (e.g. home, SNF, etc.).

A clinic located on an island that otherwise meets the requirements for RHC certification is not required to employ an NP or PA, although it is still required to have an NP or PA at least 50 percent of the time that the RHC is in operation (OBRA '89, Sec 4024). An island is a body of land completely surrounded by water, regardless of size and accessibility (e.g., bridges).

As of July 1, 2014, RHCs may contract with non-physician practitioners (PAs, NPs, CNM, CPs or CSWs *and MFTs and MHCs effective January 1, 2024)* if at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at section 1861(aa)(7) of the Act).

It is the responsibility of the RHC to assure that all staffing requirements are met and that RHC practitioners provide services in accordance with state and federal laws and regulations.

See section 80.4 of this chapter for information on productivity standards for RHCs.

40 - RHC and FQHC Visits

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, CSW*, MFT or MHC* during which time one or more RHC or FQHC services are rendered. *E*ffective January 1, 2022, a mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder.

A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits.

An RHC or FQHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions. See section 190 of this chapter for information on visiting nursing services to home-bound patients.

Under certain conditions, an FQHC visit also may be provided by qualified practitioners of outpatient DSMT and MNT when the FQHC meets the relevant program requirements for provision of these services.

RHC and FQHC visits are typically evaluation and management (E/M) type of services or screenings for certain preventive services. A list of qualifying visits for FQHCs is located on the FQHC web page at https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html.

40.3 - Multiple Visits on Same Day

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)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);

- 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*

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

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 grandfathered tribal FQHCs.

50.1 - RHC Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)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.

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

Note: Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

50.2 - FQHC Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)FQHC services include all of the RHC services listed in section 50.1 of this chapter. While the following services may also be furnished in an RHC, the statute specificallylists certain services as FQHC services, including but not limited to:

- Screening mammography;
- Screening pap smear and screening pelvic exam;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- DSMT services;
- Diabetes screening tests;
- MNT services;
- Bone mass measurement;
- Screening for glaucoma;
- Cardiovascular screening blood tests; and
- Ultrasound screening for abdominal aortic aneurysm.

50.3 - Emergency Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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 per-diem payment when furnished in an FQHC by an FQHC practitioner or furnished incident to an FQHC service.

Durable medical equipment - Includes crutches, hospital beds, and wheelchairs used 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.

80.2 - RHC and FQHC Consolidated Cost Reports

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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

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

120.1 - Provision of Incident to Services and Supplies

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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.

160 - Services and Supplies Incident to CP, CSW, *MFT and MHC* Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Services and supplies that are integral, though incident to a CP, CSW, *MFT or MHC* service are:

- Commonly rendered without charge or included in the RHC or FQHC payment;
- Commonly furnished in an outpatient clinic setting;
- Furnished under the direct supervision of the CP, CSW, *MFT and MHC* except for authorized care management services which may be furnished under general supervision; and
- Furnished by a member of the RHC or FQHC staff.

NOTE: The direct supervision requirement is met in the case of a CP, CSW, *MFT or MHC* who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC or FQHC. Services and supplies covered under this provision are generally the same as described in section 120 as incident to a physician's services and include services and supplies incident to the services of a CP, CSW, *MFT or MHC*.

170 - Mental Health Visits

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)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, 2025, 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.

190.5 - Treatment Plans for Visiting Nursing Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

For services and supplies that require a treatment plan, the treatment plan must be written and reviewed by a supervising physician, NP, PA, CNM, CP, *CSW, MFT, or MHC* as appropriate, at least once every 60 days; and meet other documentation requirements. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated for the purpose of Medicare coverage unless:

- The supervising physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient, or
- Nursing visits are required at intervals less frequently than once every 60 days, but the intervals are predictable (e.g., it is predictable that a visit is required only every 90 days for the purpose of changing a silicone catheter, etc.).

Home nursing visits furnished before the plan is put into writing are covered if authorized in writing by the supervising physician.

200 - Telehealth Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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 include*d* 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. 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.

220.1 - Preventive Health Serv(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)ices in RHCs

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Influenza (G0008), Pneumococcal (G0009) and COVID-19 *(90480) V*accines, and *C*ertain COVID-19 *M*onoclonal *A*ntibody *P*roducts

Influenza, pneumococcal and COVID-19 vaccines and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. No visit is billed, and these costs should not be included on the claim. The beneficiary coinsurance and deductible are waived.

Hepatitis B Vaccine (G0010)

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

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If an IPPE
visit is furnished on the same day as another billable visit, two visits may be billed. 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 (Q0091)

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.

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.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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) and COVID-19 *(90480) V*accines and *C*ertain COVID-19 *M*onoclonal *A*ntibody *P*roducts

Influenza, pneumococcal *and COVID-19* vaccines and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. The cost is included in the cost report and no visit is billed. FQHCs must include these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance is waived.

Hepatitis B Vaccine (G0010)

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

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Annual Wellness Visit (G0438 and G0439)

The 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.

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

230 – Care Management Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Care management 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)* and psychiatric collaborative care model (CoCM) services. The RHC and FQHC face-to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.) Except for TCM services, care management services are paid separately from the RHC AIR or FQHC PPS payment methodology. RHCs and FQHCs may not bill for care management services for a beneficiary if another practitioner or facility has already billed for care management services for the same beneficiary during the same time period. However effective January 1, 2022, RHCs and FQHCs may bill for care management and TCM services and other care management services (outside of the RHC AIR or

FQHC PPS payment), for the same beneficiary during the same time period. Coinsurance and deductibles are applied as applicable to RHC claims, and coinsurance is applied as applicable to FQHC claims.

230.2 – General Care Management Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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) and PIN Peer-Support (PIN-PS).*

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.

230.2.1– Chronic Care Management (CCM) Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before care management services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services. Care management services do not need to have been discussed during the initiating visit. Beneficiary consent to receive care management services can be obtained by auxiliary staff under general supervision of the RHC or FQHC primary care practitioner as well as by the billing practitioner, may be written or verbal and must be documented in the patient's medical record before CCM 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 acalendar month; and*
- *They can stop care management services at any time, effective at the end of the calendar month.*

230.2.5 – Remote Patient Monitoring (RPM) Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for RPM services when a minimum of 20 minutes of qualifying non-face-to-face RPM services are furnished during a calendar month. RPM services include the collection, analysis, and interpretation of digitally collected physiologic data, followed by the development of a treatment plan, and the managing of a patient under the treatment plan. RHCs and FQHCs are also paid for the initial set-up and patient education on use of the equipment that stores the physiologic data for RPM services.

230.2.6 – Remote Therapeutic Monitoring (RTM) Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for RTM services when a minimum of 20 minutes of qualifying non-face-to-face RTM services are furnished during a calendar month. RTM services include remote monitoring of respiratory system status, musculoskeletal status, therapy adherence, or therapy

response. RHCs and FQHCs are also paid for the initial set-up and patient education on use of the equipment that stores the physiologic data for RTM services.

230.2.7 – Community Health Integration (CHI) Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)*Effective January 1, 2024, RHCs and FQHCs are paid for CHI services when a minimum of 60 minutes of qualifying non-face-to-face CHI services are furnished during a calendar month. CHI services include coordination of care, facilitation of access to services, and communication between settings to address the SDOH need(s) that may interfere with, or present a barrier to, the diagnosis or treatment of a patient.*

230.2.8 - Principal Illness Navigation (PIN) Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)*Effective January 1, 2024, RHCs and FQHCs are paid for PIN services when a minimum of 60 minutes of qualifying non-face-to-face PIN services are furnished during a calendar month. PIN services include health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.*

230.2.9 PIN-Peer Support (PIN-PS) Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, RHCs and FQHCs are paid for PIN-PS services when a minimum of 60 minutes of qualifying PIN-PS services are furnished during a calendar month. PIN-PS services include the treatment of high-risk behavioral health conditions.

230.2.*10*– Payment for General Care Management Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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.

General Care Management Services	*HCPCS/CPT Codes*
CCM	*99487, 99490, 99491*
PCM	*99424, 99426*
CPM	*G3002*
General BHI	*99484*
RPM	*99453, 99454, 99457, 99091*
RTM	*98975, 98976, 98977, 98980*
CHI	*G0019*
PIN	*G0023*
PIN-Peer Support	*G0140*

Note: The table does not 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.

*For FQHCs, c*oinsurance for care management services is 20 percent of lesser of submitted charges or the payment rate for G0511. *For RHCs, coinsurance is 20 percent of the total charges or the payment rate for G0511.* Care management costs are reported in the non- reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

240 – Virtual Communication Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Virtual communication services are RHC and FQHC services and include communications-based technology and remote evaluation services. The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient.

Effective January 1, 2019, RHCs and FQHCs receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR or the FQHC PPS payment when the requirements for these services are met. Coinsurance and deductibles apply to RHC claims, and coinsurance applies to FQHC claims for these services.

Requirements

The following requirements must be met for RHCs and FQHCs to bill for virtual communication services:

- At least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient that has had a billable visit in the RHC or FQHC within the previous year; and
- The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC or FQHC service within the next 24 hours or at the soonest available appointment.

If the discussion between the patient and the RHC or FQHC practitioner is related to a billable visit furnished by the RHC or FQHC within the previous 7 days or within the next 24 hours or at the soonest available appointment, the cost of the RHC or FQHC practitioner's time would be included in the RHC AIR or the FQHC PPS payment and is not separately billable.

Beneficiary consent to receive virtual communication services may be obtained under general supervision by auxiliary staff.

Payment for Virtual Communication Services

Virtual communication services furnished by RHCs and FQHCs on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services), when the virtual communication HCPCS code, G0071, is on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0071 is updated annually based on the PFS amounts for these codes.

250 – Intensive Outpatient Program (IOP) Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

Effective January 1, 2024, section 4124 of the Consolidated Appropriations Act of 2023 (CAA, 2023) establishes Medicare coverage and payment for Intensive Outpatient Program (IOP) services for individuals with mental health needs when furnished by hospital outpatient departments, Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). An IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to conditions such as depression, schizophrenia, and substance use disorders.

For information regarding IOP services scope of benefits and services, certification and plan of care requirements, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 70.4.

250.1 Payment for IOP Services

(Rev.12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)

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 (3 services per day) for hospital-based IOPs) and not the RHC AIR.

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, grandfathered 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 grandfathered 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.