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Cracking the Code on Advanced RHC Coding and Billing

Charles James, MBA, President and CEO
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MAXIMIZING RHC REVENUE
JULY 15, 2025

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ADVANCED RHC BILLING V.2025: PRESENTATION OBJECTIVES

- ✓Advanced Claim Bundling
- ✓Minor Surgical Procedures
- ✓Allergy Injections
- ✓Specialists, Global Billing, Multiple Encounters
- ✓Preventive Services

BILLING EXAMPLE: INCIDENT-TO SERVICES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 4	99214 CG	3/8/2025	1	$ 310.00
0636	Injection Admin	96372	3/8/2025	1	$ 30.00
0636	Toradol	J1885	3/8/2025	1	$ 50.00
0001	Total Charge				$ 390.00

- ✓ A 99214 ($230) qualifying visit with RevCd 0521 is reported with an injection and medication 96372 ($30.00)/J1885 ($50.00).
- ✓ The CG modifier is used with the face-to-face, med-nec encounter.
- ✓ All services are bundled with CG line for a total charge of $310.00.
- ✓ The total charge line (0001) is inflated due to duplicating the injection/admin charges from the detail lines.

“ALTERNATE METHOD” FOR REPORTING SERVICE DETAIL

Service detail lines can be reported as $.01 or greater. The additional services lines CAN be reported as $.01. This eliminates artificial inflation of revenue, adjustments, and AR.

The CG Modifier-QVL line is used to calculate total charges for co-insurance/deductible calculations.

"ALTERNATE METHOD" SERVICE DETAIL REPORTING

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 4	99214 CG	3/8/2025	1	$ 310.02
0636	Injection Admin	96372	3/8/2025	1	$ 0.01
0636	Toradol	J1885	3/8/2025	1	$ 0.01
0001	Total Charge				$ 310.04

- ✓ The Injection and Medication Charges ($30.00/$50.00) are added to the 99214 qualifying visit line.
- ✓ The CG modifier is attached to the 0521 face-to-face, med-nec encounter.
- ✓ The detail lines are reported as $.01. The total charges are no longer inflated.

BUNDLED SERVICES – DIFFERENT DATES

"…services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe." (MBPM 13; Section 120.3)

Do NOT span dates on the "Admit From" and "Admit Through" dates. This will cause other claims submitted within those dates to reject.

BILLING EXAMPLE: BUNDLED INJECTION/DIFFERENT DATES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 5	99214 CG	03/08/2025	1	$ 310.04
0636	Allergy Injection	95115	03/08/2025	4	$ 0.04
0001	Total Charge				$ 310.08

Four weekly allergy injections @ $20.00 each were provided. An Office Visit occurred on 3.8.2025.

- ✓ Four allergy injections ($80.00) are bundled with the 99214 qualifying visit line ($230).
- ✓ CG Modifier is attached to the face-to-face, med-nec visit.
- ✓ Medicare will use the line with the qualifying visit code (99214) to determine the total charge and calculate co-insurance.

BILLING EXAMPLE: OFFICE VISIT PLUS VENIPUNCTURE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 4	99214 CG	03/08/2025	1	$ 255.00
0521	Venipuncture	36415	03/08/2025	1	$ 25.00
0001	Total Charge				$ 280.00

- ✓ An office visit and a venipuncture are performed.
- ✓ The venipuncture ($25.00) is bundled with the office visit charge ($230.00).
- ✓ Venipuncture must be bundled and submitted with a valid RHC encounter.
- ✓ If a medically-necessary encounter is not performed, a stand-alone venipuncture cannot be billed.
- ✓ It is recommended that these are ***posted, zero-charged, and NOT submitted on a claim.***

MINOR SURGICAL PROCEDURES

Minor surgical procedures performed in the RHC, during RHC hours, must be billed as encounters.

- ✓ Follow-up visits for dressing changes, or suture removal can only be billed as encounters if there is a medically-necessary, documented reason and it is performed by an RHC provider.
- ✓ If an office visit is performed during the same visit as a minor surgical procedure, the clinic will only have one encounter to bill.
- ✓ These should be bundled and submitted as one line item.

VISITING SPECIALISTS IN AN RHC

- ✓ Any qualified provider (MD, DO, NP, PA) can see patients in an RHC.
- ✓ RHC must provide primary care services fifty-one percent of ***total provider hours***. (FP, IM, Peds, OB)
- ✓ Specialists can be integrated into the RHC.
- ✓ Commercial and Medicaid enrollment should be assessed.
- ✓ All services rendered within the four walls of the

BILLING EXAMPLE: PROCEDURES ONLY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Procedure	11100 CG	03/02/2025	1	$ 250.00
0001	Total Charge				$ 250.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Procedure	99214CG	03/02/2025	1	$ 650.00
0521	Wound Rpr < 2.5 cm	12031	03/02/2025	1	$ 420.00
0001	Total Charge				$ 1,070.00

BILLING EXAMPLE: OFFICE VISIT PLUS PROCEDURE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est Level 4	99214 CG	03/08/2025	1	$ 530.00
0521	Joint Injection	20610	03/08/2025		$ 300.00
0001	Total Charge				$ 830.00

- ✓ An office visit is performed in addition to a joint-injection at the same visit.
- ✓ The joint injection ($300.00) is bundled with the ($230.00) office visit charge.
- ✓ Co-Insurance and Deductible are applied to the 99214CG modifier line.
- ✓ The joint injection is on the QVL; if performed independently it is paid at the AIR.

GLOBAL BILLING

Surgical procedures furnished in an RHC or FQHC by an RHC or FQHC practitioner are considered RHC or FQHC services.

The RHC is paid based on its all-inclusive rate and is not subject to the Medicare global billing requirements.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements.

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

MULTIPLE ENCOUNTERS ARE ALLOWED WHEN:

- ✓ The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (2 visits), or
- ✓ The patient has a medical visit and a Behavioral health visit on the same day (2 visits), or
- ✓ The patient has his/her IPPE and a separate medical and/or Behavioral health visit on the same day (2 or 3 visits).

(Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

RHC USE OF MODIFIERS -59 AND -25

Modifier-59 indicates that separate conditions on the same treated are unrelated. This is used only a subsequent illness or injury on the same day as another visit. Modifier-25 in an RHC in interchangeable with -59!

Modifier-59 and -25 indicate two encounters. -25 is different in an RHC. Modifier 25 or 59 is only on the SECOND line item UB-04 on a claim form.

RHC Pro Tip: Modifier-25 is NOT used to distinguish an Evaluation and Management Service from a procedure.

CG MODIFIER FAQ: SUBSEQUENT ILLNESS OR INJURY

Is modifier CG reported on a ***subsequent*** visit which occurs on the same day as an earlier visit?

A13. No.

Q14. Should modifier CG and modifier 25 or modifier 59 be reported on the same service line together to indicate a ***subsequent*** medically necessary visit?

A14. No.

From A15: *Modifier 25 or 59 is reported only on the line that represents the primary reason for the subsequent visit.*

MODIFIER-59 EXAMPLE: SUBSEQUENT INJURY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 4	99214 CG	04/02/2025	1	$ 230.00
0521	Laceration Repair	12002 59	04/02/2025	1	$ 300.00
0001	Total Charge				$ 530.00

Modifier CG and modifiers 25/59 are NOT reported on the same service line together to indicate a subsequent medically necessary visit.

CLAIM EXAMPLE: SICK VISIT AND BEHAVIORAL HEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est 4	99214CG	03/08/2025	1	$ 220.00
0900	Rx Management	90832CG	03/08/2025	1	$ 120.00
0001	Total Charge				$ 340.00

Modifier CG should be reported once per day for a qualified medical visit (revenue code 052x) and/or once per day for a qualified Behavioral health visit (revenue code 0900).

NOTE: Limited number of scenarios that require TWO CG Modifiers!

BEHAVIORAL HEALTH => TELEHEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min TH	90832 CG 95	03/08/2025	1	$ 180.00
0001	Total Charge				$ 180.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Audio-Only Pt 30 Min	90832 CG FQ	03/08/2025	1	$ 120.00
0001	Total Charge				$ 120.00

RHC TELEHEALTH CLINICAL SERVICE:

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025FQ	03/08/2025	1	$ 96.87
0001	Total Charge				$ 96.87

Beginning July 1, 2020, RHCs should no longer put the CG modifier on claims with HCPCS code G2025. The 2025 Payment for G2025 is **$96.87.**

MEDICARE *TELEPHONE ONLY VISITS*

RHCs and FQHCs ***can*** furnish and bill for these services using HCPCS code G2025. To bill for these services:

- ✓ at least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
- ✓ These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

TELEHEALTH COST REPORTING

Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rates but must be reported on the appropriate 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.”

PREVENTIVE SERVICES

PREVENTIVE RHC SERVICES

RHC services also include certain preventive services. These include:

- ✓ Welcome To Medicare Visit (G0402)
- ✓ Annual Wellness Visit/Subsequent Annual Wellness (G0438/G0439)
- ✓ Medicare-covered Preventive Services (DMST is NOT eligible as an RHC Visit!)
- ✓ Influenza, Pneumococcal (Medicare Cost Report – Medicare Flu/Pneumo Only)
- ✓ Chronic Care Management (G0511/G0512)
- ✓ Virtual Communication Services (G0071)

(Medicare Benefit Policy Manual Chapter 13)

PREVENTIVE SERVICES AND SAME DAY BILLING

"RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the [Certain Preventive Services] when they are performed on the same day."

MLN SE1039

The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.

INITIAL PREVENTIVE PHYSICAL EXAM (G0402)

The IPPE is a one-time exam that must occur within the first 12 months following the beneficiary's enrollment.

- ✓ If an IPPE visit is furnished on the same day as another billable visit, two visits are payable.
- ✓ No other Medicare Preventive Screenings are eligible as "same day."
- ✓ The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.
- ✓ The beneficiary coinsurance and deductible are waived.
- ✓ The CG Modifier is Optional.

BILLING EXAMPLE: IPPE ONLY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	03/08/2025	1	$ 250.00
0001	Total Charge				$ 200.00

"Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service." RHC Reporting FAQ

BILLING EXAMPLE: IPPE PLUS OFFICE VISIT => 2 AIR PAYMENTS!

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	03/08/2025	1	$ 230.00
0521	IPPE	G0402	03/08/2025	1	$ 250.00
0001	Total Charge				$ 480.00

"When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service."

RHC Reporting FAQ

STAND ALONE ENCOUNTERS

"Stand Alone" encounter is the only service rendered on a particular date of service, then it will be paid at the AIR.

Stand-Alone Encounters on the same RHC claim as another is not separately reimbursed.

IT SHOULD/MUST BE REPORTED on the RHC claim!!

STAND ALONE ENCOUNTERS

Preventive Screening	HCPCS Code	Description
Alcohol Screening and Behavioral Counseling	G0442, G0443	Annual alcohol misuse screening, 15 minute
Screening for Depression	G0444	Annual depression screening, 15 minutes
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling	G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face to-face, individual
Intensive Behavioral Therapy for Cardiovascular Disease	G0446	Annual, face-to face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

STAND ALONE ENCOUNTERS

MPS	Code	Description
Intensive Behavioral Therapy for Obesity	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
Smoking and Tobacco Cessation Counseling	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
Smoking and Tobacco Cessation Counseling	G0437	greater than 10 minutes

STAND ALONE ENCOUNTERS
PREVENTIVE SERVICE CODES

Code	Description
G0101	CA Screen/Pelvic
G0102*	Prostate screening
G0117*	Glaucoma Screen
G0118*	Glaucoma Screen - Supervised
G0296	Visit to determine LDCT Eligibility (Lung Cancer)
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel

* Co-Insurance and Deductible apply

COPAYMENT AND DEDUCTIBLE FOR PREVENTIVE SERVICES

When one or more qualified preventive service is provided as part of a RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment and deductible.

ANNUAL WELLNESS VISIT (G0438 AND G0439)

The AWV is a personalized prevention plan 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.

- ✓ The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner.
- ✓ If the AWV is furnished on the same day as another medical visit, it is not a separately payable as an encounter.
- ✓ The beneficiary coinsurance and deductible are always waived.

BILLING EXAMPLE: ANNUAL WELLNESS VISIT

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Annual Wellness Visit	G0438CG	03/08/2025	1	$ 280.00
0001	Total Charge				$ 280.00

"If only preventive services for which the coinsurance and/or deductible are waived are furnished during the visit, the RHC should report modifier CG with the preventive HCPCS code that represents the primary reason for the visit."

RHC Reporting FAQ

OFFICE VISIT AND ANNUAL WELLNESS VISIT/ACP

An established patient is seen and a qualifying visit of 99214 for $230 is generated. An Annual Wellness Visit was also performed for $280.00. Advanced Care Planning was also performed for $100.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 4	99214 CG	3/8/2025	1	$ 230.00
0521	Annual Wellness Visit	G0438	3/8/2025	1	$ 280.00
0521	Advanced Care Planning	99496	3/8/2025	1	$ 100.00
0001	Total Charge				$ 610.00

- ✓ The charge for the AWV and ACP are NOT be bundled in the 99214 line.
- ✓ The AWV and ACP do not result in direct reimbursement.
- ✓ If properly reported, this visit represents 6.02 wRVUs!!

ANNUAL WELLNESS VISIT/ACP – REVERSED

The AWV can also be the primary reason for the visit. Ou established patient presented for the AWV, and we chose to submit that as the RHC Encounter. There ill be no co-insurance on this claim. An Annual Wellness Visit was also performed for $280.00. Advanced Care Planning was also performed for $100.

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Annual Wellness Visit	G0438 CG	3/8/2025	1	$ 280.00
0521	OV Est 4	99214	3/8/2025	1	$ 230.00
0521	Advanced Care Planning	99496	3/8/2025	1	$ 100.00
0001	Total Charge				$ 610.00

- ✓ The charge for the AWV and ACP are **NEVER to** be bundled in the 99214 line.
- ✓ The AWV and ACP do not result in direct reimbursement.
- ✓ If properly reported, this visit represents 6.02 wRVUs!!

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 a 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.

BILLING EXAMPLE: WELL-WOMAN EXAM

Medicare does not pay a well-woman exams (99381-99387). An annual or subsequent wellness visit (G0438/G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091).

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Subsq AWV	G0439 CG	03/08/2025	1	$ 200.00
0521	Breast/Pelvic	G0101	03/08/2025	1	$ 100.00
0521	Pap Smear	Q0091	03/08/2025	1	$ 80.00
0001	Total Charge				$ 380.00

All Preventive Services are listed to capture quality measure and to report utilization to Medicare for COB. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

DIABETES COUNSELING AND MEDICAL NUTRITION SERVICES

Diabetes counseling or medical nutrition services provided by a registered dietician or nutritional professional at a RHC may be considered incident to a visit with a RHC practitioner provided all applicable conditions are met.

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.

BILLING EXAMPLE: OFFICE VISIT WITH DIABETIC COUNSELING*

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	03/08/2025	1	$ 390.00
0521	DSMT	G0108	03/08/2025	1	$ 80.00
0521	Medical Nutrition Therapy	97803	03/08/2025	1	$ 80.00
0001	Total Charge				$ 550.00

The MD/DO/NP/PA has seen the patient and a Diabetic Nurse Educator comes in to provide additional counseling and nutrition training.

*Coinsurance will be applied to this encounter!

ADVANCED CARE PLANNING AND AWV: 99497 AND 99498

No copayment, coinsurance, or deductible for Advance Care Planning when provided as optional AWV element

- Bill using modifier –33 (Preventive Service) on same AWV claim
- Must deliver on same day by same AWV provider

ADVANCED CARE PLANNING: 99497 AND 99498

Patient Pays

G0438 and G0439:

- No copayment, coinsurance, or deductible

G0468:

- You must provide AWV or IPPE with a standard bundle of services available to all patients; get more information at section 60.2 of Medicare Claims Processing Manual, Chapter 9
- No copayment, coinsurance, or deductible

99497 and 99498:

- No copayment, coinsurance, or deductible for Advance Care Planning when provided as optional AWV element
  - Bill using modifier –33 (Preventive Service) on same AWV claim
  - Must deliver on same day by same AWV provider

Other Notes

- Advance Care Planning is an optional preventive service when provided with an AWV.
  - You may deliver Advance Care Planning (ACP) outside the AWV multiple times in a year. You must document a patient's health change for each additional ACP service in a year.
  - Deductible and coinsurance apply when delivering ACP outside an AWV.
- Medicare Wellness Visits educational tool has more information.

BILLING EXAMPLE: TOBACCO CESSATION!!!

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Tobacco Cessation > 3 Min	99406	03/08/2025	1	$ 30.00
0001	Total Charge				$ 30.00

ANY of the Stand-Alone Medicare Preventive Screenings are paid as RHC Encounters when no other services are rendered.
Co-Insurance is not applied.

BILLING EXAMPLE: IBT OBESITY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	IBT Obesity	G0447	03/08/2025	1	$ 100.00
0001	Total Charge				$ 100.00

Frequency:

We pay up to 22 visits billed with codes G0447 and G0473, combined, in a 12-month period:

- First month: 1 face-to-face visit every week.
- Months 2–6: 1 face-to-face visit every other week.
- Months 7–12: 1 face-to-face visit every month if patient meets certain requirements.

BILLING EXAMPLE: OFFICE VISIT WITH PREVENTIVE SERVICES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214 CG	04/02/2022	1	$ 230.00
0521	Advanced Care Planning	99497	04/02/2022	1	$ 75.00
0521	Alcohol Screening	G0422	04/02/2022	1	$ 50.00
0521	IBT for Obesity	G0447	04/02/2022	1	$ 50.00
0001	Total Charge				$ 405.00

Modifier CG identifies the line service for which co-insurance and deductible should be applied. The additional preventive services are for information only.

Payment for Preventive Vaccine Costs in RHCs and FQHCs

Pneumococcal, Influenza and COVID-19, and HepB Vaccines

Flu, Pneumococcal, COVID and Hepatitis B Vaccine Reimbursement

- MLN Matters Number: MM13923 – Defines RHC/FQHC Billing For Vaccines
- Previously Hepatitis B Vaccines were reimbursed as part of the RHC All-Inclusive Rate.
- Hepatitis B vaccines are paid like other Part B preventive vaccines starting January 1, 2025.

Claims Processing Manual Chapter 18 Section 10.2.2

Effective for dates of service on or after July 1, 2025, RHCs and FQHCs may submit institutional claims for pneumococcal, influenza, hepatitis B and COVID-19 vaccinations, with or without a visit/encounter or qualifying visit on the same day.
(Section CPM Chapter 18 §10.2.2.2 for special instructions for independent RHCs and freestanding FQHCs.)

Flu/Pneumo/Hep/Covid Immunizations on claims

According to a CMS email inquiry: CMS says RHCs are REQUIRED to bill immunizations on claims.

CMS Email Correspondence 8.26.2025

Claims Processing Manual Chapter 18 Section 10.2.3

Institutional providers should bill for the vaccines and their administration on the same bill. Separate bills for vaccines and their administration are not required. These can be billed with a visit, or by themselves. The immunizations would NOT get bundled into the CG modifier line.
(See CPM Chapter 18 §10.2.3 of this chapter).

Claims Processing Manual Chapter 18 Section 10.2.3

Vaccine Payment		
Facility	Type of Bill	Payment
RHC	71x	95% of the AWP (effective for dates of service on or after July 1, 2025)
Report Condition Code A6: 100% Payment Flu/Pneumo		

Claims Processing Manual Chapter 18 Section 10.2.3

Vaccine Administration Payment		
Facility	Type of Bill	Payment
RHC	71x	95% of the AWP (effective for dates of service on or after July 1, 2025)
Report Condition Code A6: 100% Payment Flu/Pneumo		

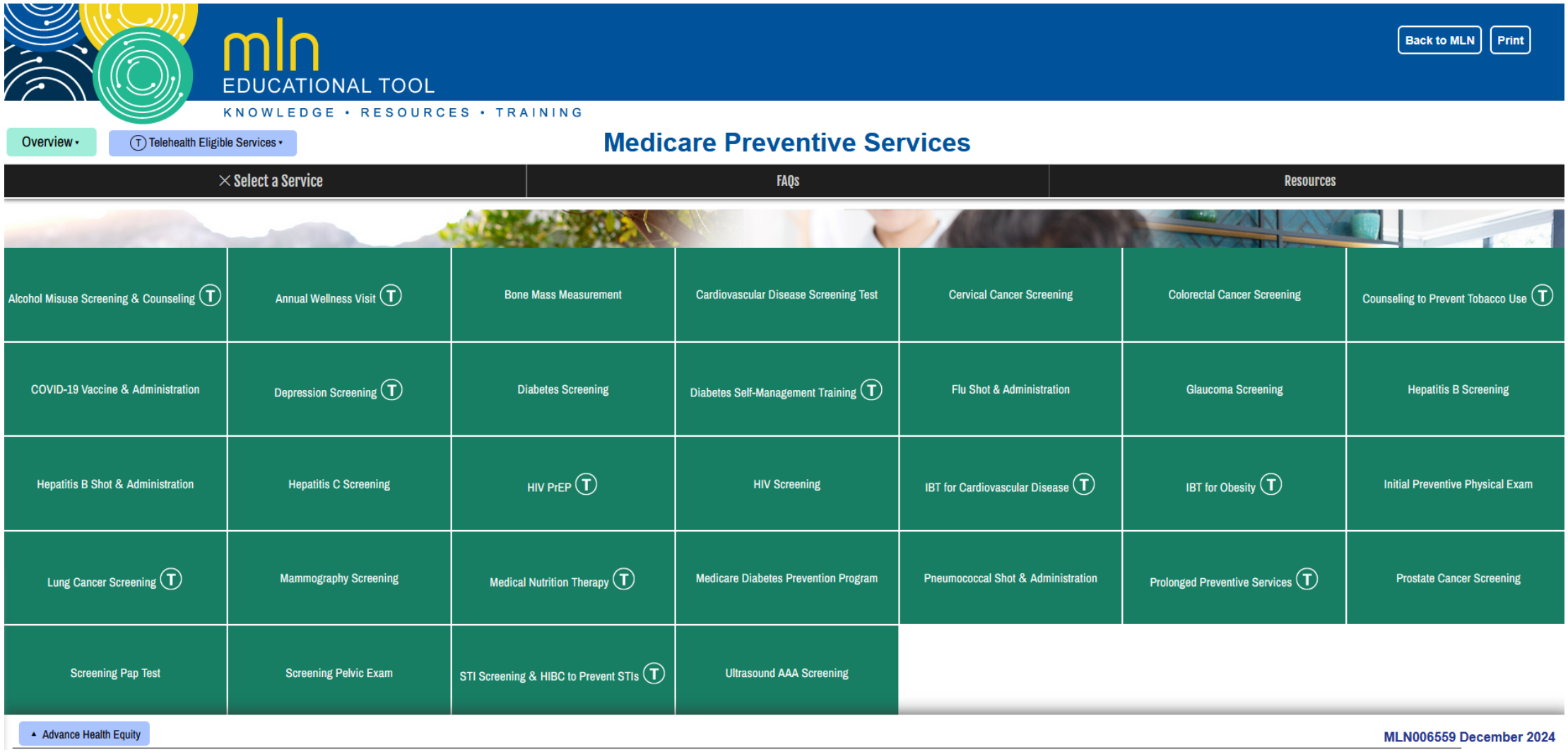
Claims Processing Manual Chapter 18 Section 10.2.3

Vaccine Claim Detail	
Revenue Code	Description
636	Pharmacy, Drugs requiring detailed coding (a)
771	Preventive Care Services, Vaccine Administration
Type of Bill: 0711 Rural Health Clinic	
ICD: Z23 Encounter for Vaccine Administration	
Condition Code A6: 100% Payment Flu/Pneumo Vaccines	

Vaccination Pricing Resources 2025

CMS Pricing Tables	Website
Pricing Tables	https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing#

MEDICARE PREVENTIVE SERVICES CHART



RHC - CMS RESOURCES

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Benefit Policy Manual- Chapter 15 Other Services

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

PROVIDER BASED CMS RESOURCES

"Guidance for Hospital Co-location with Other Hospitals or Healthcare Facilities (Revised)." CMS QSO-19-13-Hospital. May 3, 2019. Revised 11/12/21.

"Provider-based Status On or After October 1, 2002". Centers for Medicare & Medicaid Services (CMS). Transmittal A-03-030. APRIL 18, 2003.

"Requirements for a determination that a facility or an organization has provider-based status". Code of Federal Regulations. 42 CFR 413.65. Aug. 14, 2017.

RHC - CMS RESOURCES

Virtual Communication FAQ

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

Provider-Based Rules (42 CFR 413.65)

https://www.law.cornell.edu/cfr/text/42/413.65

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