2026 RHC Coding and Billing Update: Navigating Critical Changes

Oregon Office of Rural Health

December 2, 2025

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- Where are we with telehealth?
- 2026 Final MPFS Rule
- Medicare RHC Vaccine Billing
- Advanced Primary Care Management
- Other Final Rule Mentions

FINAL RULES AND PHE FLEXIBILITIES

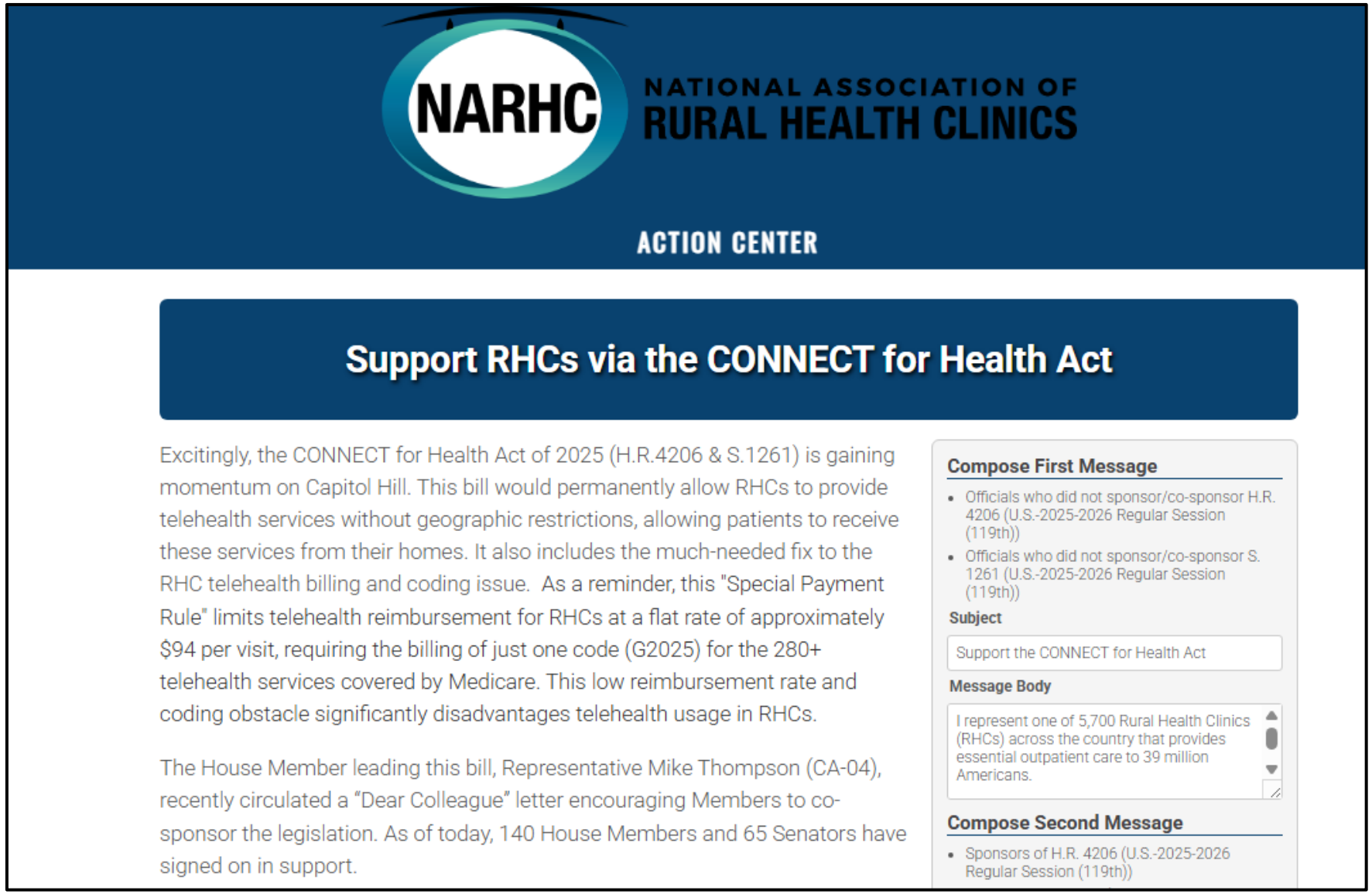
TIMELINE: TWO THINGS IN PLAY

- Proposed Rule Published: July 14, 2025
- Comment Period Ended: September 12, 2025
- Covid PHE Telehealth flexibilities set to end: September 30, 2025
- Government Shutdown Began: October 1, 2025
- New Fiscal Year Begins: October 1, 2025
- Final Rule expected by: November 1, 2025
- Final Rule Published: November 5, 2025
- Government Shutdown Ended: November 11, 2025
- Distant site medical telehealth (patient at home) ends: January 30, 2025
- Permanent Telehealth Fix still need.

No Congressional action froze distant site RHC medical telehealth

PHE Flexibilities extended until January 30, 2026

https://www.votervoice.net/NARHC/Campaigns/130749/Respond



Medical Telehealth (Distant Site)

Telehealth Definitions

Distant Site versus Originating Site

Audio/Video/Two-Way Synchronous

Provider is at the distant site away from the patient usually their normal practice location

Patient is in a qualified originating site

Distant site is defined by CMS as the telehealth site ***where the provider or specialist is "seeing" the patient at a distance.***

The provider is usually at their practice location or another appropriate location.

Patient is at a qualified originating site. When a hospital or clinic hosts a patient for a telehealth service with a distant site provider, **the hosting facility is the originating site**.

Originating site is defined by CMS as where the patient is located during the telehealth encounter or consult.

PATIENT CAN BE AT HOME FOR DISTANT SITE TELEHEALTH UNTIL JANUARY 30, 2026

HCPCS Code Q3014 describes the Medicare telehealth originating site facility fee. The Medicare originating site facility fee amount for CY 2025 is $31.01.

An originating site facility fee is billed when the patient is in a healthcare facility receiving telehealth. Medicare makes payment to the distant site practitioner for the professional services.

Note: If the patient is within a hospital and receives a hospital outpatient clinic visit (including a mental or behavioral health visit) from a practitioner located in the same physical location, the hospital would bill for the clinic visit (HCPCS code G0463).

Billing and payment methodology for originating site:

Originating site	Payment methodology	Bill type	Revenue code
Outpatient hospital - includes rural emergency hospitals (REHs)	Outside of outpatient prospective payment system (OPPS)	13X	078X
Inpatient hospital	Outside diagnostic related group codes (DRGs)	12X	078X
Critical access hospital (CAH)	Separate from cost based (80% or the originating site facility fee)	12X or 85X	078X
Federally qualified health center (FQHC) or rural health center (RHC)	Separate from prospective payment system (PPS) or all-inclusive rate (AIR)	77X or 71X	078X
Hospital-based or CAH-based renal dialysis center	In addition to ESRD PPS or monthly capitation payment	72X	078X
Skilled nursing facility (SNF)	Outside of the SNF PPS (not subject to consolidated billing)	22X or 23X	78X
Community mental health center (CHMC)	Not a partial hospitalization service (or used to determine payment for partial hospitalization). Not bundled in per diem	76X	078X

Other Originating Sites:

Outpatient Hospital

Inpatient Hospital

CAH

FQHC

RHC

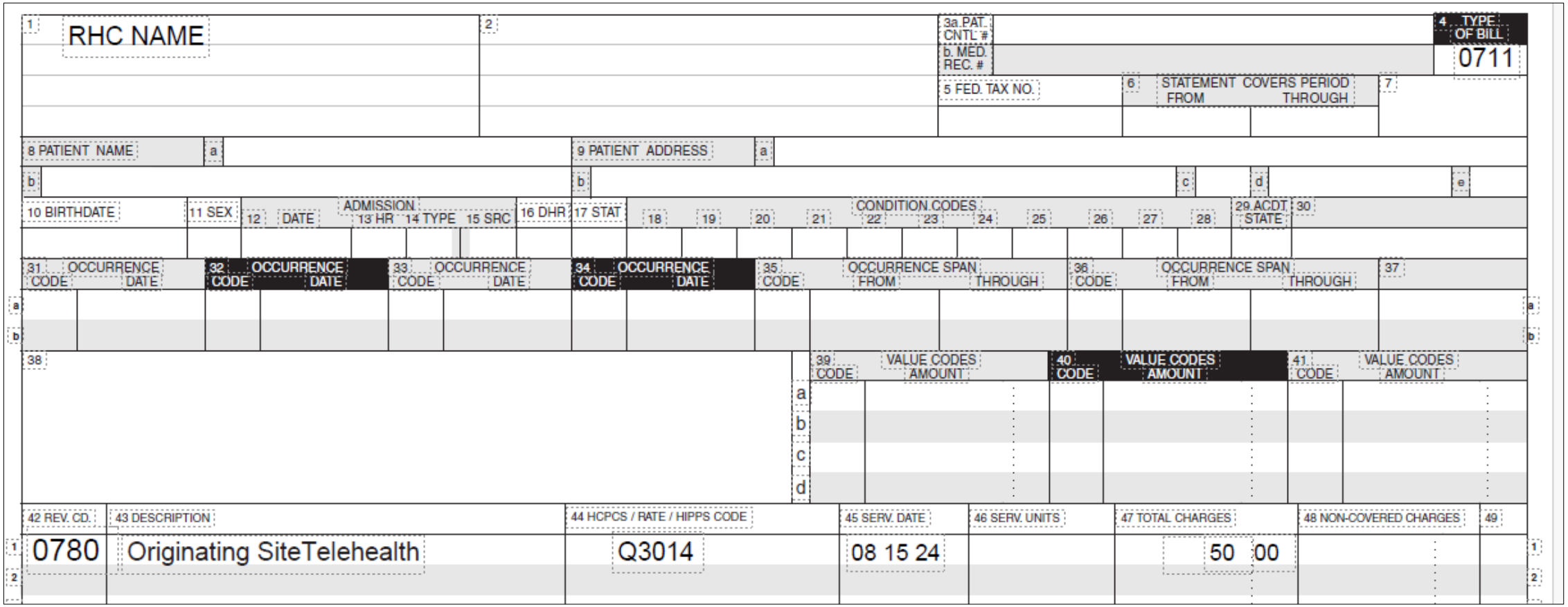
Hospital based renal dialysis center

Skilled Nursing (Swingbed)

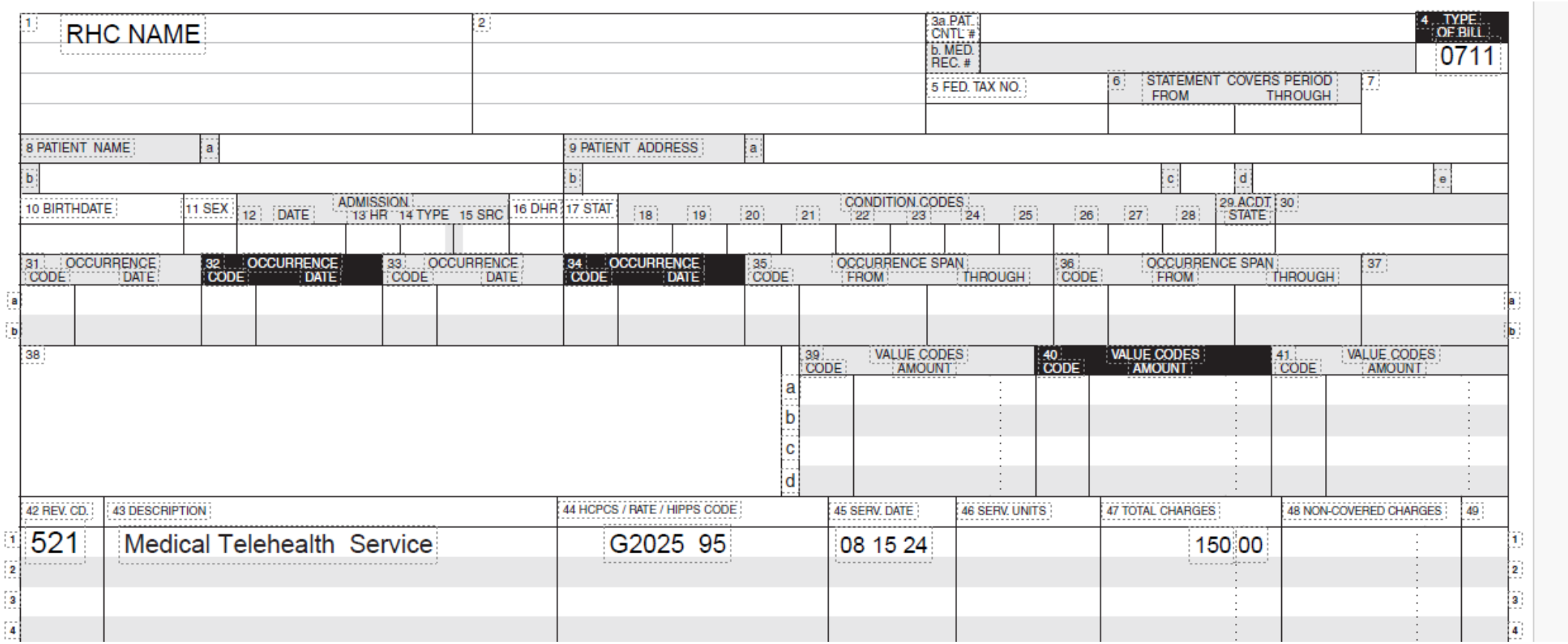
Community Mental Health Center

Claims Scenarios for Medical Telehealth

Example 1: The patient is located inside the RHC where they are being hosted for a distant site telehealth service with an outside provider who does not practice in our RHC. The revenue code is the RHC. Q3014 is reported. The RHC will be reimbursed the current fee schedule amount for Q3014. The RHC does not report an encounter for the remote provider. The revenue code is 0780 for telehealth. Payment is $31.01



<u>Example 2</u>: An RHC provider either located in the clinic or at their residence performs a **medical audio-visual telehealth service** to a patient who is located in a qualified originating site. The RHC bill type is 711. The use of modifier 95 is optional. G2025 is reported instead of the 99214. The RHC is reimbursed the current fee schedule amount for G2025. No -CG modifier is used since the AIR is not paid. **Example: the patient is in a SNF bed or another RHC/FQHC; our RHC provider is the distant site provider.**



Medicare Mental Health Telehealth

Not Changed

Audio Only Mental Health Telehealth

FQ	The service was furnished using audio-only communication technology. • Use when the patient is unable to use audio and video communications. • **Note: This modifier should only be used by RHCs and FQHCs. Report modifier for mental health visits using audio-only technology**

2022 Mental Health Telehealth Example

These visits are different from telehealth services provided during the Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See MLN Matters Article SE20016 for information on billing G2025 for professional telehealth distant site services other than mental health visits during the PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 Revised on 05/05/2022 : -CG now required
- Is an encounter; pays at the AIR.

RHC Mental Health Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Telehealth	90791 CG and either FQ or 95	05/05/2022	1	100.00
0001	Total Charge				100.00

Mental Health Services	
HCPCS Code	**Short Descriptor**
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

- Mental Health Codes on the RHC QVL
- Do NOT use –CG on medical telehealth visits-Only on mental health
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 MLN
- Reimburse at the AIR; permanent status with CMS.

NEW in 2025

Vaccine Billing

Traditional Medicare Flu, Pneumococcal and COVID

Traditional Medicare Immunizations

- Influenza, Pneumococcal, and COVID **through 6/30/2025** continue to receive reimbursement through the Cost Report and DO NOT report on claim. Maintain logs and invoices.

- Influenza, Pneumococcal, COVID and **Hep B as of 7/1/2025** are reported on the UB-04 claim for traditional/RW&B for Medicare (Still awaiting full guidance from CMS, below is based on current information provided by CMS and MACs)

  - Above vaccines can be reported with or without a billable face-to-face service
  - Report vaccine product CPT with Revenue Code of 636 along with the customary fee. Do not report at .01
  - Report administration CPT with Revenue Code of 771 along with the customary fee. Do not report at .01
  - DO NOT roll the fees for vaccine or administration into the CG line
  - Add condition code of A6 to claim
  - **There are known claims issues pertaining to vaccine/vaccine admin reporting.**

- As if 7/1/2025, Influenza, Pneumococcal, COVID, and Hep B immunizations will be reimbursed at 95% of the Fair Market Value for vaccines and at the Medicare FFS rate for the administration. Coinsurance and deductible are waived
- RHCs will reconcile to 100% of total costs for the administration of these immunizations for Medicare beneficiaries through the annual cost report
    - Continue to maintain logs for vaccines administered to Medicare beneficiaries
    - Continue to maintain invoices for vaccines
    - Awaiting further guidance from CMS on the reconciliation process through the cost report
    - Work with your cost report preparers for additional guidance
- Do NOT report Medicare Advantage immunizations on the cost report.

Influenza/Flu

Revenue codes:

- 0771 Preventive Care Services, Vaccine Administration
- 0636 Pharmacy, Drugs requiring detailed coding

Healthcare Common Procedure Coding System (HCPCS) codes:

- G0008 Administration influenza virus vaccine
- Valid code for the vaccine - refer to the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM), referenced below

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636		XXXXX	mm/dd/yy	1	XXXX		
0771		G0008	mm/dd/yy	1	XXXX		

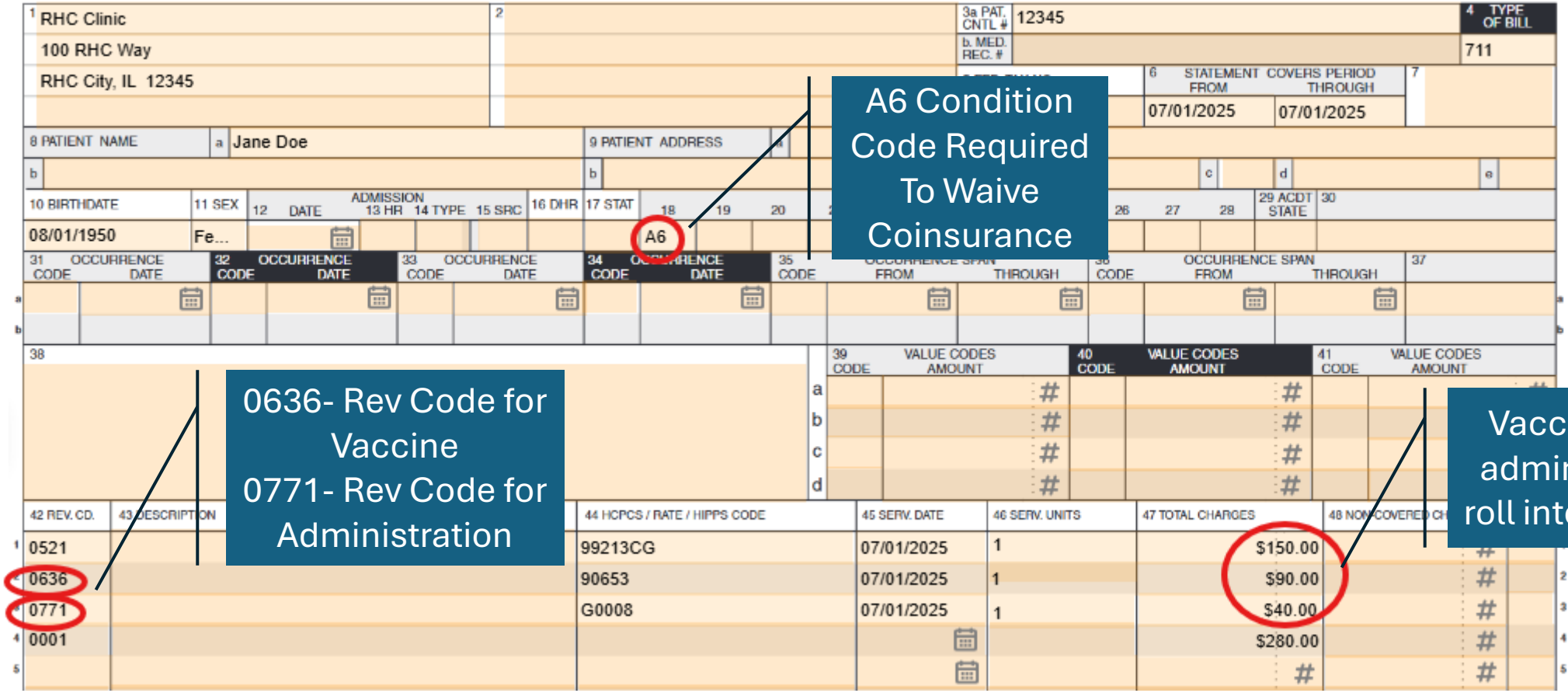
Condition Code: A6

CONDITION CODES										
18	19	20	21	22	23	24	25	26	27	28
A6										

Diagnosis code: Z23

66 DX 9									
Z23	A	B	C	D	E	F	G	H
I	J	K	L	M	N	O	P	Q

Claim Example- Qualifying Visit with Vaccine Charge



A6 Condition Code Required To Waive Coinsurance

0636- Rev Code for Vaccine
0771- Rev Code for Administration

Vaccine and admin do **not** roll into CG line

How will this be paid?

- Medicare will pay 80% of the All-Inclusive rate, with 20% coinsurance &/or deductible applied to the CG line
- Medicare will pay the 95% of the current Average Wholesale Price for the vaccine and Geographic Fee-For-Service rate for the administration

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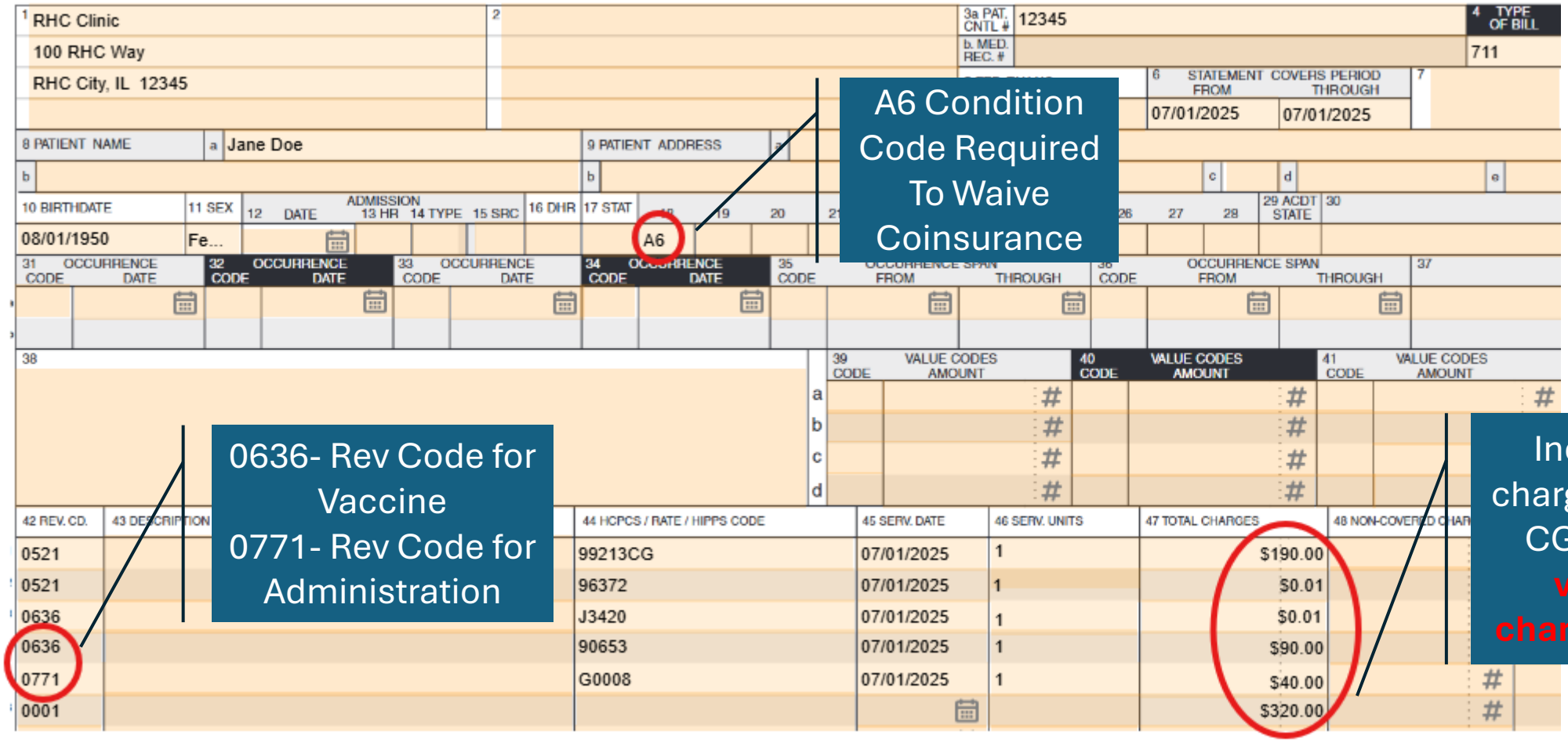
Claim Example- Qualifying Visit with Incident To Charges and Vaccine Charges



A6 Condition Code Required To Waive Coinsurance

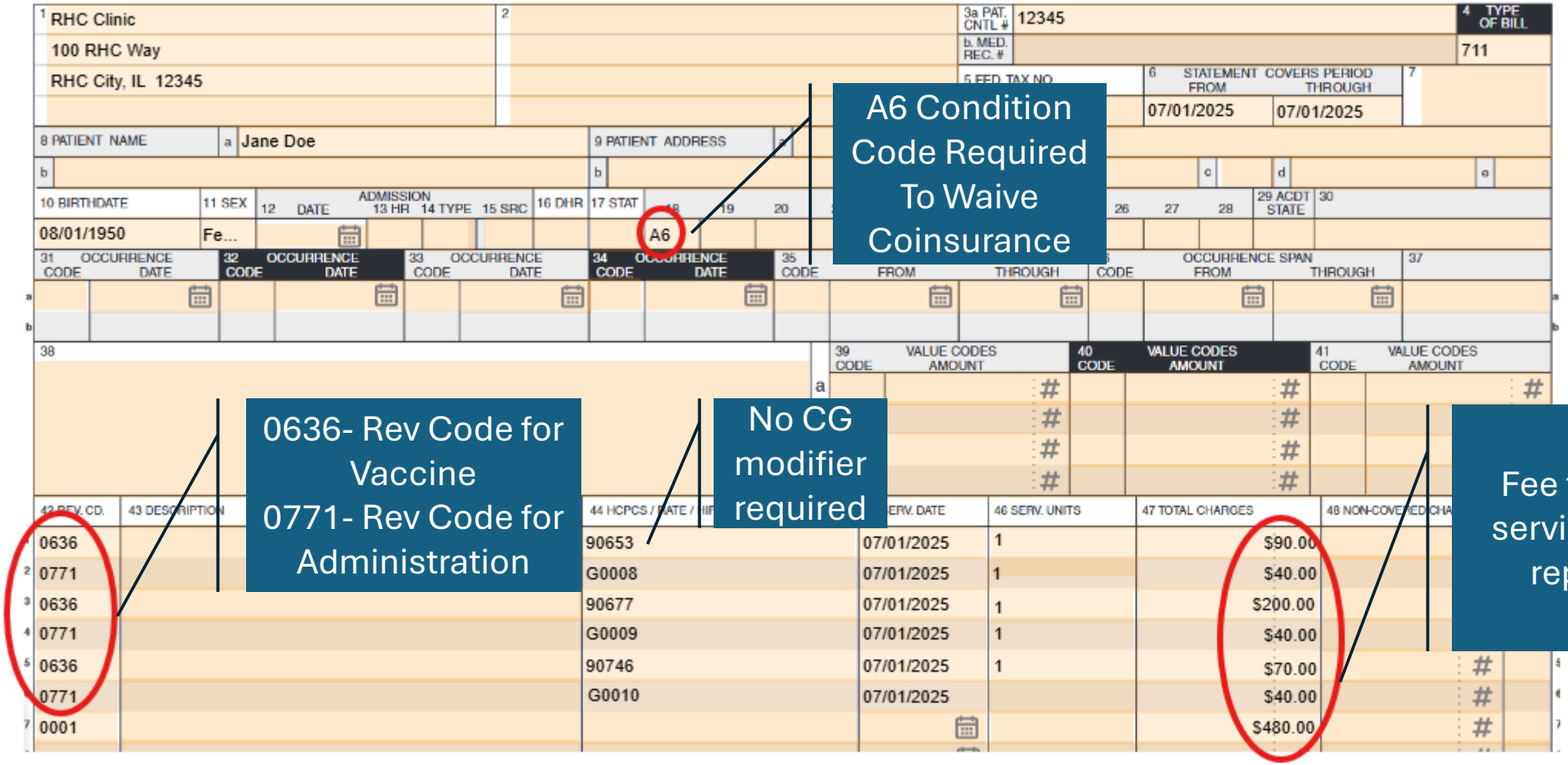
0636- Rev Code for Vaccine
0771- Rev Code for Administration

Incident to charges roll into CG line, but **vaccine charges do not**

How will this be paid?

- Medicare will pay 80% of the All-Inclusive rate, with 20% coinsurance &/or deductible applied to the CG line
- Medicare will pay the 95% of the current Average Wholesale Price for the vaccine and Geographic Fee-For-Service rate for the administration

Claim Example- No Qualifying Visit Line- Vaccine Charges Only



How will this be paid?

- Medicare will pay the 95% of the current Average Wholesale Price for each vaccine and Geographic Fee-For-Service rate for each administration

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Flu Vaccine Administration Codes

G0008	ADMIN OF FLU VACCINE	N/A	Administration of influenza virus vaccine	Please see below for **Locality-Adjusted Payment Rates**
M0201	FLU VACCINE HOME ADMIN	N/A	Administration of influenza vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home	Please see below for **Locality-Adjusted Payment Rates**

https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing

Refer to these resources for 2025-2026 COVID products and codes.

https://www.cms.gov/medicare/payment/covid-19/coding-covid-19-vaccine-shots

https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing

COVID IMMUNIZATION CODING CHART

CPT Code or HCPCS Code	CPT or HCPCS Short Descriptor	Labeler Name	Vaccine/Procedure Name	National Payment Allowance Effective for Claims with DOS on or after 03/15/2021	Effective Dates for Medicare Payment
90480	ADMN SARSCOV2 VACC 1 DOSE	N/A	N/A	$44.95[2]	09/11/2023 - TBD
M0201	Covid-19 vaccine home admin	Home vaccine admin	Covid-19 vaccine administration inside a patient's home; reported only once per individual home per date of service when only covid-19 vaccine administration is performed at the patient's home	$39.90[2]	06/08/2021 - TBD

2025 GEOGRAPHICALLY-ADJUSTED PAYMENT AMOUNTS FOR ADMINISTRATION OF INFLUENZA, PNUEMONIA, HEPATITIS B VACCINES & IN-HOME ADDITIONAL PAYMENT

Effective for Claims with Dates of Service 1/1/2025-9/30/2025

Medicare Administrative Contractor (MAC)	State	Locality Number	Locality Name	2025 GAF (with 1.0 Work Floor)	G0008	G0009	G0010	M0201
02302	OR	99	REST OF OREGON	0.979	$ 33.00	$ 33.00	$ 33.00	$ 39.06

*

Vaccine Admin Code	Description	Part B Reimbursement*
G0008	Flu Immunization Admin	$33.00
G0009	Pneumococcal Admin	$33.00
G0010	Hep B Admin	$33.00
M0201	Home Admin of Flu Vaccine	$39.06

https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing

CARE MANAGEMENT SERVICES AND CODING

CARE MANAGEMENT SERVICES

- Major Changes in how Care Management Services will be coded.
- New Codes will be reported by RHCs. **No G0511 umbrella code.**
- Addition of Advanced Primary Care Management Codes for FFS and RHCs. These codes will identify the acuity and intensity of care management services. The new codes will be stratified into three levels based.
- **Coding changes will not take effect until July 1, 2025 (was extended to September 30, 2025)** to give CMS, MACs and RHCs to configure systems and implement payment rules.
- Add-on codes will be allowed for RHC billing of care management services.
- RHCs not required to report MIPS will not be required to report the performance measures mandated for primary care management.

No G0511 for dates of service after September 30, 2025

- RHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below as long as they've met all requirements and there isn't double counting. For example, RHCs can bill HCPCS code G0511 twice for 20 minutes of qualifying CCM services and 30 minutes of qualifying PCM services, as long as the clinical staff minutes don't overlap.

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

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

~~G0511**~~
~~$54.67*~~

**Using G0511 is allowed until 7/1/2025, then the codes for the specific service will be required.

*Subject to sequestration reduction.

2025 National Fee for Service Reimbursement

98975	Rem ther mntr 1st setup&edu	$	19.73
98976	Rem ther mntr dev sply resp	$	43.02
98977	Rem ther mntr dv sply mscskl	$	43.02
98980	Rem ther mntr 1st 20 min	$	50.14
98981	Rem ther mntr ea addl 20 min	$	39.14
99091	Collj & interpj data ea 30 d	$	51.75
99424	Prin care mgmt phys 1st 30	$	80.87
99425	Prin care mgmt phys ea addl 30	$	58.87
99426	Prin care mgmt staff 1st 30	$	61.78
99427	Prin care mgmt staff ea addl 30	$	50.46
99437	Chrnc care mgmt phys ea addl 30	$	57.58
99439	Chrnc care mgmt staf ea addl 20	$	45.93
99453	Rem mntr physiol param setup	$	19.73
99454	Rem mntr physiol param dev	$	43.02
99457	Rem physiol mntr 1st 20 min	$	47.87
99458	Rem physiol mntr ea addl 20	$	38.49

2025 National Fee for Service Reimbursement

99474	Self-meas bp 2 readg bid 30d	$ 16.50
99484	Care mgmt svc bhvl hlth cond	$ 53.05
99487	Cplx chrnc care 1st 60 min	$ 131.65
99489	Cplx chrnc care ea addl 30	$ 70.52
99490	Chrnc care mgmt staff 1st 20	$ 60.49
99491	Chrnc care mgmt phys 1st 30	$ 82.16
G0019	Comm hlth intg svs sdoh 60 mn	$ 77.96
G0022	Comm hlth intg svs addl 30 m	$ 48.52
G0023	Pin srv 60 min pr m	$ 77.96
G0024	Pin srv addl 30 min pr m	$ 48.52
G0071	Comm svcs by rhc/fqhc 5 min	$ 13.91
G0140	Nav srv peer sup 60 min pr m	$ 77.96
G0146	Nav srv peer sup addl 30 pr m	$ 48.52
G0323	Care manage beh svs 20mins	$ 53.70
G0511	RHC/FQHC 20min mo	$ 54.67
G0512	RHC/FQHC 60min mo	$ 139.41

2025 National Fee for Service Reimbursement

NEW	G0556	Adv prim care mgmt lvl 1	$ 15.20
	G0557	Adv prim care mgmt lvl 2	$ 48.84
	G0558	Adv prim care mgmt lvl 3	$ 107.07
	G2025	Dis site tele svcs rhc/fqhc	$ 94.45
	G3002	Chronic pain mgmt 30 mins	$ 80.22
	G3003	Chronic pain mgmt addl 15m	$ 29.44

- Know the full CPT code descriptions
- It's easy to select the wrong code based only on the short description
- Know who can report the service
  - Provider
  - Clinical Staff
  - Auxiliary Staff

- Documentation is very important especially as we more away from some of the time-based codes.
- Remember that the vendor works for you.

ADVANCED PRIMARY CARE MANAGEMENT

ADVANCED PRIMARY CARE MANAGEMENT SERVICES (APCM)

- Principal Care Management, Transitional Care Management, and Chronic Care Management are combined.

- Unlike existing care management codes, there are no time-based thresholds included in the service elements.

- New APCM codes are stratified into three levels based on an individual's number of chronic conditions and status as a Qualified Medicare Beneficiary, reflecting the patient's medical and social complexity.

    - Level 1 (G0556) is for persons with one chronic condition; ($15.20 for 2025)
    - Level 2 (G0557) is for persons with two or more chronic conditions; ($48.84 for 2025)
    - Level 3 (G0558) is for persons with two or more chronic conditions and status as a Qualified Medicare Beneficiary. ($107.07 for 2025)

LEVEL 1:

LEVEL 2:

LEVEL 3:

Use 1 of these 3 codes:

	Code Requirements
G0556	• Clinical staff provide the APCM services • A physician or other qualified health care professional who's responsible for all primary care directs the clinical staff and serves as the continuing focal point for all needed health care services • The services include all of the elements, as appropriate, listed below under "What Are the APCM Billing Requirements?"

G0557	• The patient has 2 or more chronic conditions. These conditions must:
	  ◦ Be expected to last at least 12 months or until the death of the patient
	  ◦ Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
	• The services include all of the requirements for code G0556

G0558	• The patient is a Qualified Medicare Beneficiary with 2 or more chronic conditions. These conditions must:
	  ◦ Be expected to last at least 12 months or until the death of the patient
	  ◦ Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
	• The services include all of the requirements for code G0556

2026 APCM ADD-ON CODES FOR BHI

GPCM1 will mirror CPT 99492
GPCM2 will mirror CPT 99493
GPCM3 will mirror CPT 99484

G0511 and G0512 will NOT be used.

Discontinued Codes and Add-On Codes for APCM

In section III.B.2. of this final rule, we finalized changes to the furnishing of Advance Primary Care Management (APCM) services in RHCs and FQHCs. We finalized to adopt add-on codes for APCM that will facilitate billing for Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services when RHCs and FQHCs are providing advanced primary care.

We also finalized to require RHCs and FQHCs to report the individual codes that make up the CoCM HCPCS code, **G0512**.

We also finalized to require RHCs and FQHCs to report the individual codes that make up the ***communications technology-based services (CTBS)***, HCPCS code **G0071** as well.

In addition, we finalized to revise § 405.2464(c) and (e) to reflect our proposal on payment of CoCM and CTBS services for RHCs and FQHCs. We also finalized to adopt services that are established and paid under the PFS and designated as care management services as care coordination services for purposes of separate payment for RHCs and FQHCs.

Source: Page 1719, 2026 Final MPFS Rule

Discontinued Codes and Add-On Codes for APCM

In section III.B.2. of this final rule, we finalized changes to the furnishing of Advance Primary Care Management (APCM) services in RHCs and FQHCs. We finalized to adopt add-on codes for APCM that will facilitate billing for Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services when RHCs and FQHCs are providing advanced primary care.

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In addition, we finalized to revise § 405.2464(c) and (e) to reflect our proposal on payment of CoCM and CTBS services for RHCs and FQHCs. We also finalized to adopt services that are established and paid under the PFS and designated as care management services as care coordination services for purposes of separate payment for RHCs and FQHCs.

Source: Page 1719, 2026 Final MPFS Rule

For CY 2026, we are finalizing the creation of optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM) services.

We are finalizing the establishment of three new G-codes to be billed as add-on services when the APCM base code is reported by the same practitioner in the same month. The services of the finalized add-on codes are meant to be directly comparable to existing CoCM and BHI codes. Source:

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f

Other notable mentions in the final rule

2026 Medicare Deductibles

2026 MEDICARE DEDUCTIBLES & COINSURANCE

Medicare Part B Deductible (Applies to RHC services)

2026: $283

2025: $257

Increase: $26

Medicare Part A Deductible (Applies to Inpatient Services)

2026: $1,736

2025: $1,676

Increase: $60

RHC Deductibles and Coinsurance

- Part B Deductible amounts apply to RHCs.
- **The deductible is applied to the total encounter charges and not the AIR.**
- RHCs are expected to collect the deductible against total charges.
- RHCs can only “keep” their AIR.
- If the deductible amount is greater than the AIR, Medicare takes that difference creating a negative remittance amount or a takeback.

G0136: SODH Screening

- Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes
- Assessment to identify social determinants of health (SDOH) that limit the ability to diagnose or treat problems. SDOH may include income, education, language, access to health care, and other factors.
- Optional element of AWV
- Not separately payable to RHC when done with an AWV or with another qualified encounter.
- Was proposed for deletion, but the final rule did not delete G0136

SODH Screening from Final Rule

- For Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) the payment policy for HCPCS code G0136 remains as stated in the CY 2024 PFS final rule.
- When the assessment, as described by HCPCS code G0136, is furnished as an optional element of the AWV, only one visit is paid, that is, it will be paid under the AIR or the lesser of charges or the PPS rate with the AWV adjustment.
- Beneficiary cost sharing is not applicable when this assessment is furnished as an optional element of the AWV. Does not apply to coinsurance.
- Consequently, when this assessment is furnished with a billable visit (other than an AWV) on the same day in an RHC, only the visit will be paid under the AIR and coinsurance and deductible will be applied. Increases coinsurance.

Source: Page 465 of 2026 MPFS Final Rule

QUESTIONS OR COMMENTS?

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