Advanced Billing: Starting off 2026 Right

Oregon State Office of Rural Health

January 6, 2026

inQuiseek Consulting

Session Talking Points:

Start the new year with us as we dive into the details of RHC advanced billing.

We will discuss those pesky negative remittance advice and tips for 2026.

This webinar will also offer more detailed guidance on the 2026 MPFS final rule and other advanced billing topics.

2026 Medicare Deductibles

Everyone Needs to Understand this part even if it not your direct job!

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.

Why do a I get a negative remit?

§ 405.2410 Application of Part B deductible and coinsurance.

(a) *Application of deductible.*

(1) Medicare payment for RHC services begins only after the beneficiary has incurred the deductible.

(2) Medicare payment for services covered under the FQHC benefit is not subject to the usual Part B deductible.

(b) *Application of coinsurance.* Except for preventive services for which Medicare pays 100 percent under § 410.152(l) of this chapter, a beneficiary's responsibility is either of the following:

(1) For RHCs that are authorized to bill on the basis of the reasonable cost system—

(i) A coinsurance amount that does not exceed 20 percent of the RHC's reasonable customary charge for the covered service; and

(ii)

(A) The beneficiary's deductible and coinsurance amount for any one item or service furnished by the RHC may not exceed a reasonable amount customarily charged by the RHC for that particular item or service; or

(B) For any one item or service furnished by a FQHC, a coinsurance amount that does not exceed 20 percent of a reasonable customary charge by the FQHC for that particular item or service.

(2) For FQHCs authorized to bill under the PPS, a coinsurance amount which is 20 percent of the lesser of—

(i) The FQHC's actual charge; or

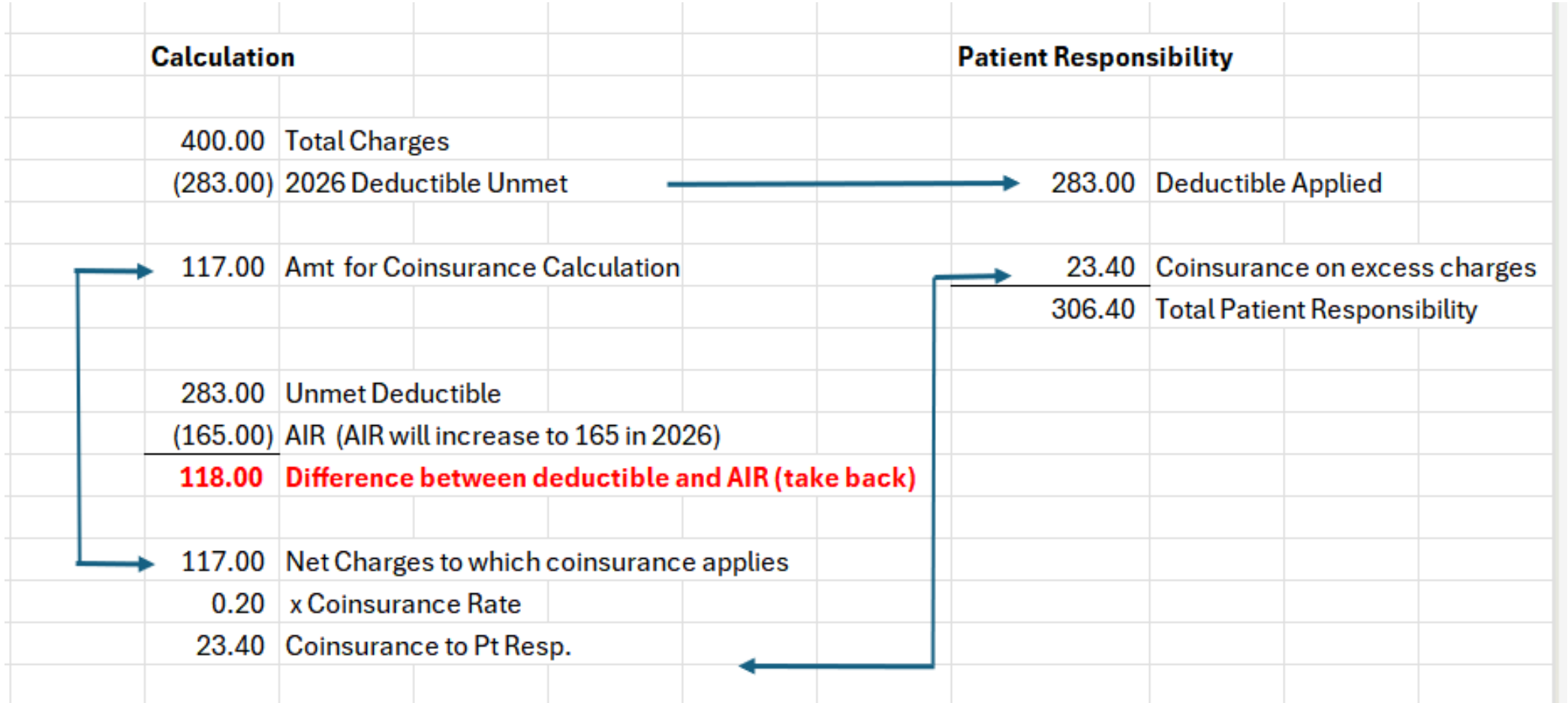
(ii) The FQHC PPS rate for the covered service.

Applying the Deductible

- Medicare will not begin paying for an RHC encounter UNTIL after the deductible has been met.
- The full Part B deductible applies to RHC services.
- The deductible is collected based on the total charge amount of all services.
- The deductible is not applied just to the RHC AIR.
- The amount of charges which are applied to the deductible are patient responsibility unless the patient has a Medi-gap plan or is dually eligible.

Calculating Coinsurance

- Coinsurance is not calculated until after the deductible has been met.
- Coinsurance for traditional Medicare is 20% of the total charges rolled up to the CG line for a qualifying encounter.
- Coinsurance is also due on any non-encounter services which is reported on the UB-04 claim or the Part B claim for independents. Examples: medical telehealth, care management.
- There is no coinsurance on Medicare labs.
- There is no coinsurance on Medicare vaccines. (A6 Condition Code)


Calculation
Patient Responsibility
400.00 Total Charges
(283.00) 2026 Deductible Unmet
283.00 Deductible Applied
117.00 Amt for Coinsurance Calculation
23.40 Coinsurance on excess charges
306.40 Total Patient Responsibility
283.00 Unmet Deductible
(165.00) AIR (AIR will increase to 165 in 2026)
118.00 Difference between deductible and AIR (take back)
117.00 Net Charges to which coinsurance applies
0.20 x Coinsurance Rate
23.40 Coinsurance to Pt Resp.

Posting Negative Remits

- Can be challenging
- Will be different for independent and provider-based RHCs.
- Will be different depending on whether the remit has to balance to cash when you post it or not.
- May require a new adjustment category.
- May require a dummy clearing account.
- Make sure that you leave all of the patient responsibility on the patient’s account.
- Don’t assume that your billing company or RCM partner understands this.

2026 Care Management Coding Changes for RHCs

Deleted Codes for 2026

Deletion of RHC CPT/HCPCS® Codes

- These codes have been deleted and cannot be reported by RHCs.

- Inactivate them from your fee schedule or chargemaster.

- If you have outstanding claims with these codes or need to track utilization for current or prior periods, **do not delete these codes**. Inactivate them instead. When you run reports, include all codes with activity whether they are active or inactive. This should be a report setting.

Deleted Code:G0511

This was the RHC-specific code for chronic care management and BHI that was created in 2015. G0511 later became the “umbrella code” used for care management, remote patient monitoring and remote therapeutic monitoring services. The code reimbursed a consolidated fee schedule amount (average) based on the current year’s MPFS.

Code Description: Rural Health Clinic or Federally Qualified Health Center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month.

Use of the G0511: Optional use through September 2025. CMS instructed RHC to stop using this code as of 10/01/25. Most MACs had problems processing the “regular” codes. This was a nationwide problem that should be resolved. G0511 is now deleted from the code set for dates of service beginning 01/01/2026. See list of qualified codes for RHCs.

Deleted Code: G0512

This was the RHC-specific code for that was created in 2015 for the Psychiatric Collaborative Care model. This CoCM model had specific requirements for both time and care team composition.

Code Description: Rural Health Clinic or Federally Qualified Health Center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

Use of the G0512: This code is now deleted from the code set and cannot be used as of 01/01/26. RHCs are now instructed to report the appropriate CPT® based on the service performed. Codes may include 99492, 99493, and 99494.

Deleted Code: G0071

This was the RHC-specific code for that was created in 2018 for use in calendar years 2019-2025. Virtual communication services were widely misunderstood and misapplied. G0071 was also manipulated during the Covid-19 PHE for use during the pandemic.

Code Description: Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

Use of the G0071: This code is now deleted from the code set and cannot be used as of 01/01/26.

RHC Care Management Codes for 2026

Link to list is found here:
https://www.narhc.org/News/31788/Summary-of-CY26-CMS-Final-Rules-for-RHCs

HCPCS	Short Descriptor	NonFac Payment CY 2026
98016	Brief communication tech-bsd	17.37
98975	Rem ther mntr 1st setup&edu	21.71
98976	Rem ther mntr dev sply resp	47.43
98977	Rem ther mntr dv sply mscskl	40.08
98980	Rem ther mntr 1st 20 min	54.11
98981	Rem ther mntr ea addl 20 min	41.42
99091	Collj & interpj data ea 30 d	55.45
99424	Prin care mgmt phys 1st 30	87.51
99425	Prin care mgmt phys ea addl 30	61.46
99426	Prin care mgmt staff 1st 30	67.80
99427	Prin care mgmt staff ea addl 30	54.11
99437	Chrnc care mgmt phys ea addl 30	63.13
99439	Chrnc care mgmt staf ea addl 20	50.44
99453	Rem mntr physiol param setup	21.71
99454	Rem mntr physiol param dev	47.43
99457	Rem physiol mntr 1st 20 min	51.77
99458	Rem physiol mntr ea addl 20	41.42
99470	Rem physiol mntr 1st 10 min	26.05
99474	Self-meas bp 2 readg bid 30d	18.37
99484	Care mgmt svc bhvl hlth cond	57.45

99487	Cplx chrnc care 1st 60 min	144.29
99489	Cplx chrnc care ea addl 30	78.16
99490	Chrnc care mgmt staff 1st 20	66.13
99491	Chrnc care mgmt phys 1st 30	89.18
99492	1st psych collab care mgmt; CocM first Month, 70 min pr m	160.32
99493	Sbsq psych collab care mgmt; CoCM sbsq month, 60 min pr m	144.96
99494	1st/sbsq psyc collab care, add-on CoCM, add'l 30 min pr m	61.46
G0019	Comm hlth intg svs sdoh 60 mn	86.51
G0022	Comm hlth intg svs addl 30 m	54.11
G0023	Pin srv 60 min pr m	87.18
G0024	Pin srv addl 30 min pr m	54.44
G0140	Nav srv peer sup 60 min pr m	89.18
G0146	Nav srv peer sup addl 30 pr m	53.44
G0323	Care manage beh svs 20mins	57.78
G0556	Adv prim care mgmt lvl 1	16.37
G0557	Adv prim care mgmt lvl 2	53.78
G0558	Adv prim care mgmt lvl 3	117.24
G0568	Int psych care mng, 1 cal mo	161.66
G0569	Subs psych care mng, subs mo	145.96
G0570	Care manage serv, pr cal mo	57.78
G2010	Remote image submit by patient	13.03
G2025	Dis site tele svcs rhc/fqhc	97.53
G2214	Init/sub psych care m 1st 30; Initial or sbsq psych collab care m, 30 min pr m	60.79
G2250	Remote image submit by patient, non-E/M	13.03
G3002	Chronic pain mgmt 30 mins	86.17
G3003	Chronic pain mgmt addl 15m	31.73

Steps to Correctly Using Care Management Codes

- Correctly identify the services that you will be performing. Terms can be tricky.
- Know the code descriptions and understand what must be done and how it should be done for each service. Educate coders and billers.
- Add these codes to your fee schedule or chargemaster. Make other changes to your bill configuration, if needed.
- Don’t rely totally on your vendors.
- Educate providers and the care management team on each service, what the reportable unit is and the documentation requirements.
- Periodically audit care management documentation and billing.

Advanced Primary Care Management in RHCs

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; ($16.37 for 2026)
    - Level 2 (G0557) is for persons with two or more chronic conditions; ($53.78 for 2026)
    - Level 3 (G0558) is for persons with two or more chronic conditions and status as a Qualified Medicare Beneficiary. ($117.24 for 2026)

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 BEHAVIORAL HEALTH INTEGRATION

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

Traditional Medicare Flu, Pneumococcal and COVID

Vaccine Billing

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. Extended to September 2025.

  - 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		

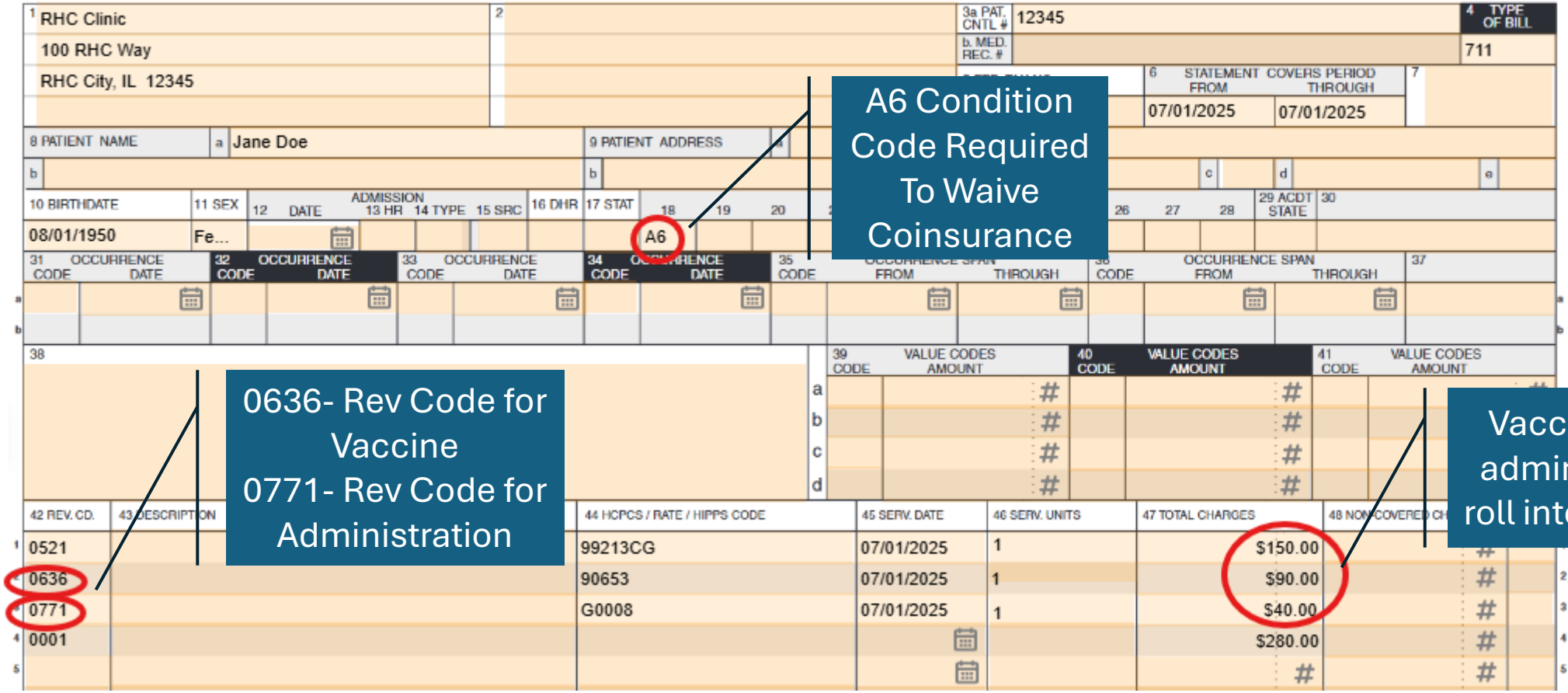
Condition Code: A6

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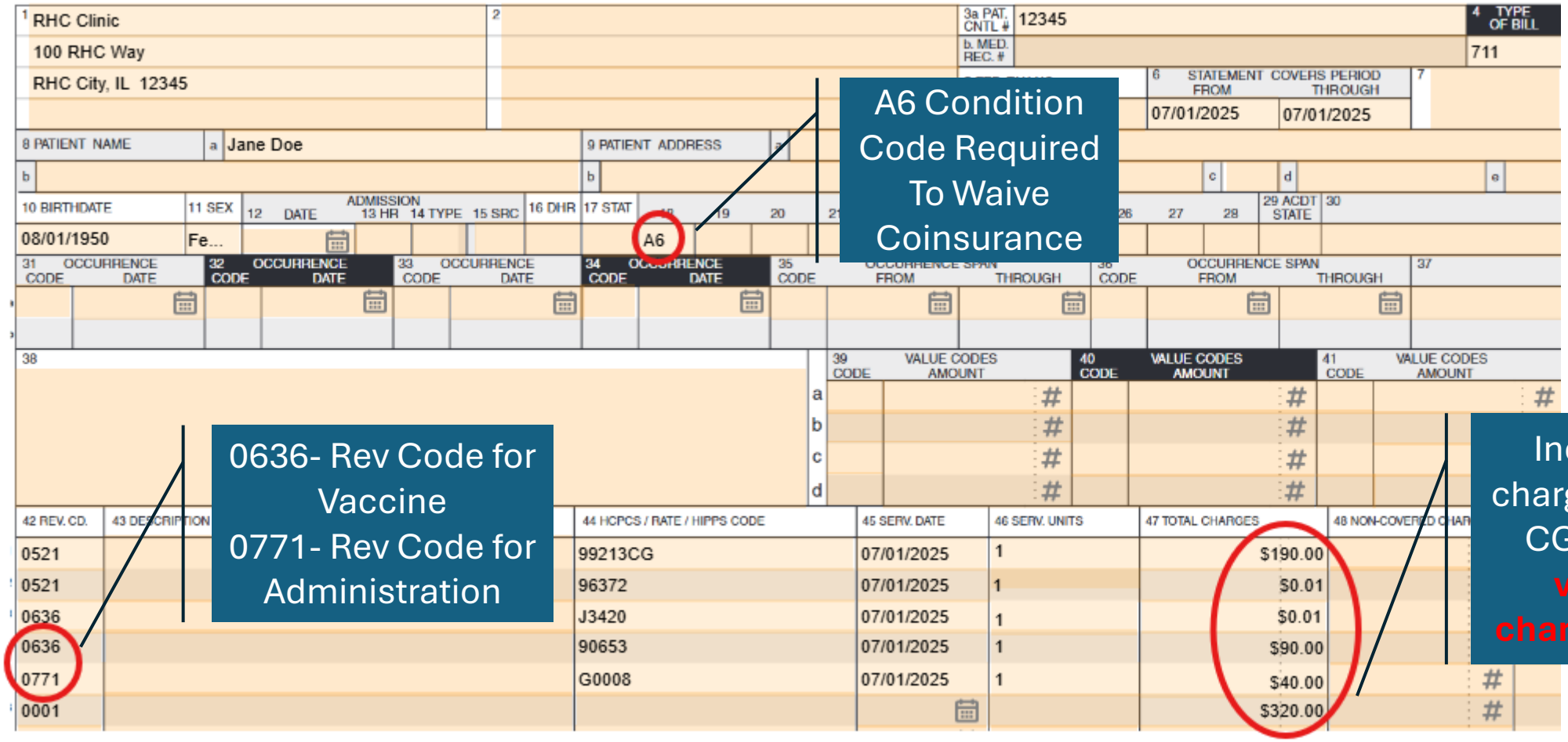
Claim Example- Qualifying Visit with Incident To Charges and Vaccine Charges



A6 Condition Code Required To Waive Coinsurance

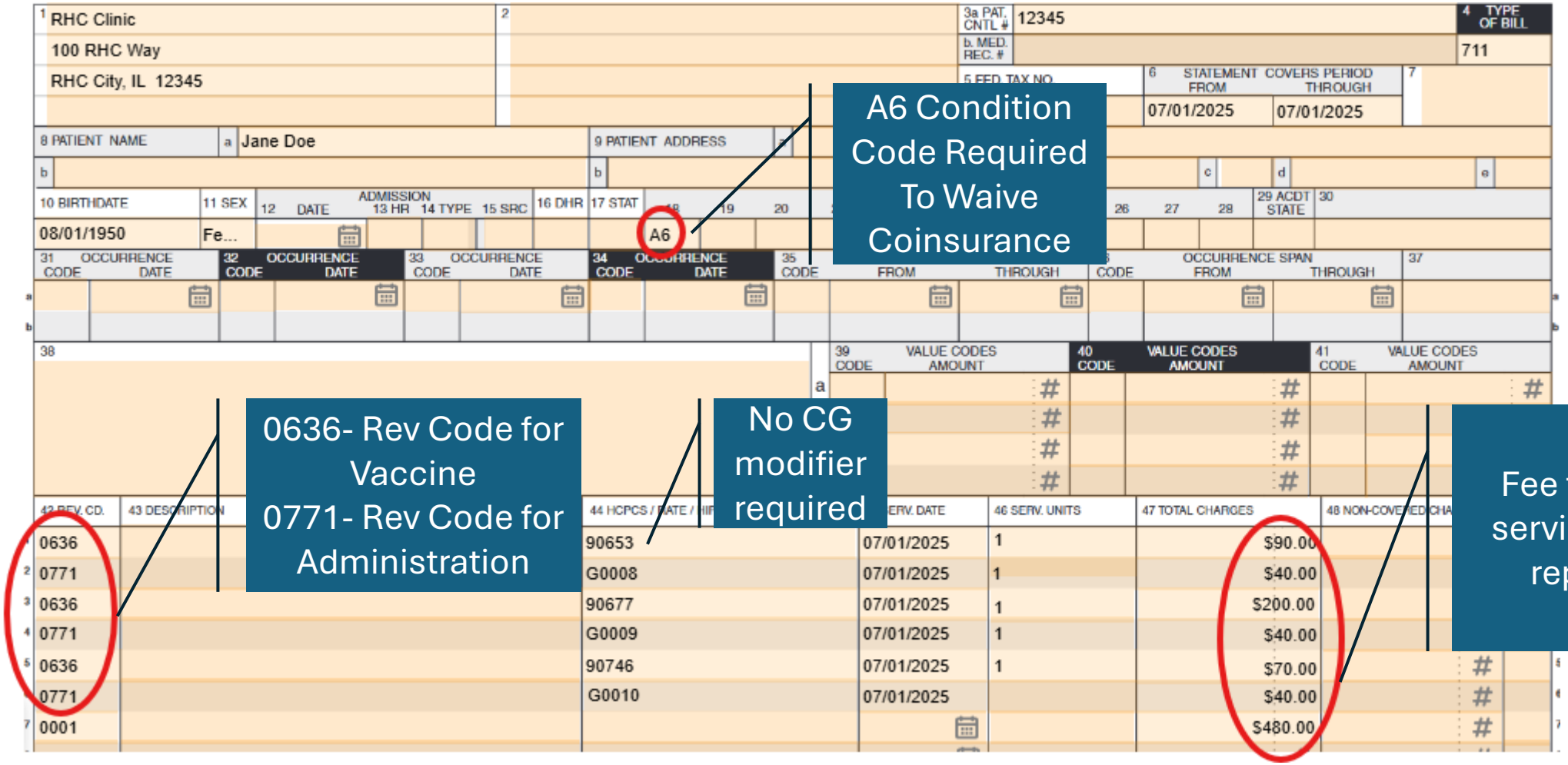
0636- Rev Code for Vaccine
0771- Rev Code for Administration

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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What if you use a 3rd party vaccine company for vaccine management and billing?

- You will want to bill traditional Medicare vaccines (flu, COVID, pneumococcal, and Hep B) DIRECTLY on your UB-04 claim.
- You will want to report the administration charge and the vaccine product on your claim.
- If you don't bill both, your cost report settlement on vaccines may be challenging.
- You can usually "buy" the vaccine product from your 3rd party by having an offset to your account. The amount of the offset will be the cost of your vaccines for the cost report along with any other private vaccine stock you purchased.
- Loop your cost report preparer in on this as soon as possible.

SDOH Screenings

Final Rule Clarification

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

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

Distant Site versus Originating Site

Where we are right now!

Medical Telehealth

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

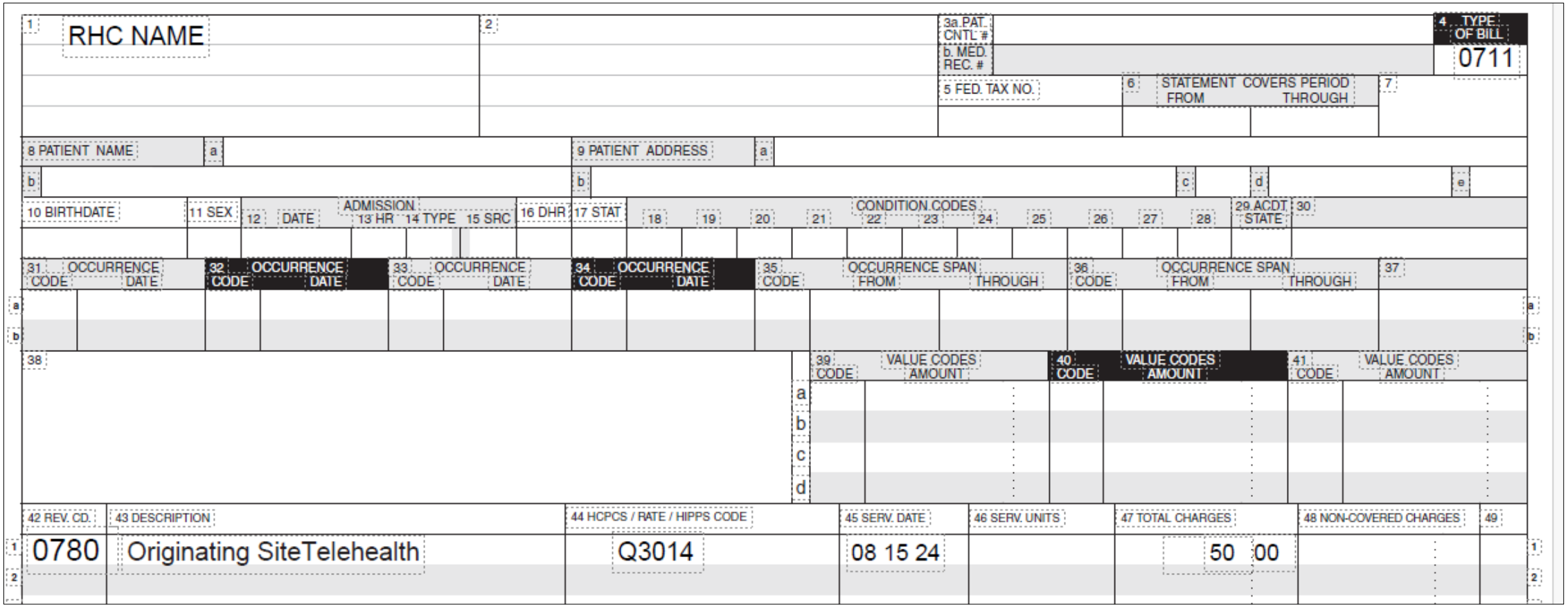
Hospital based renal dialysis center

Skilled Nursing (Swing bed)

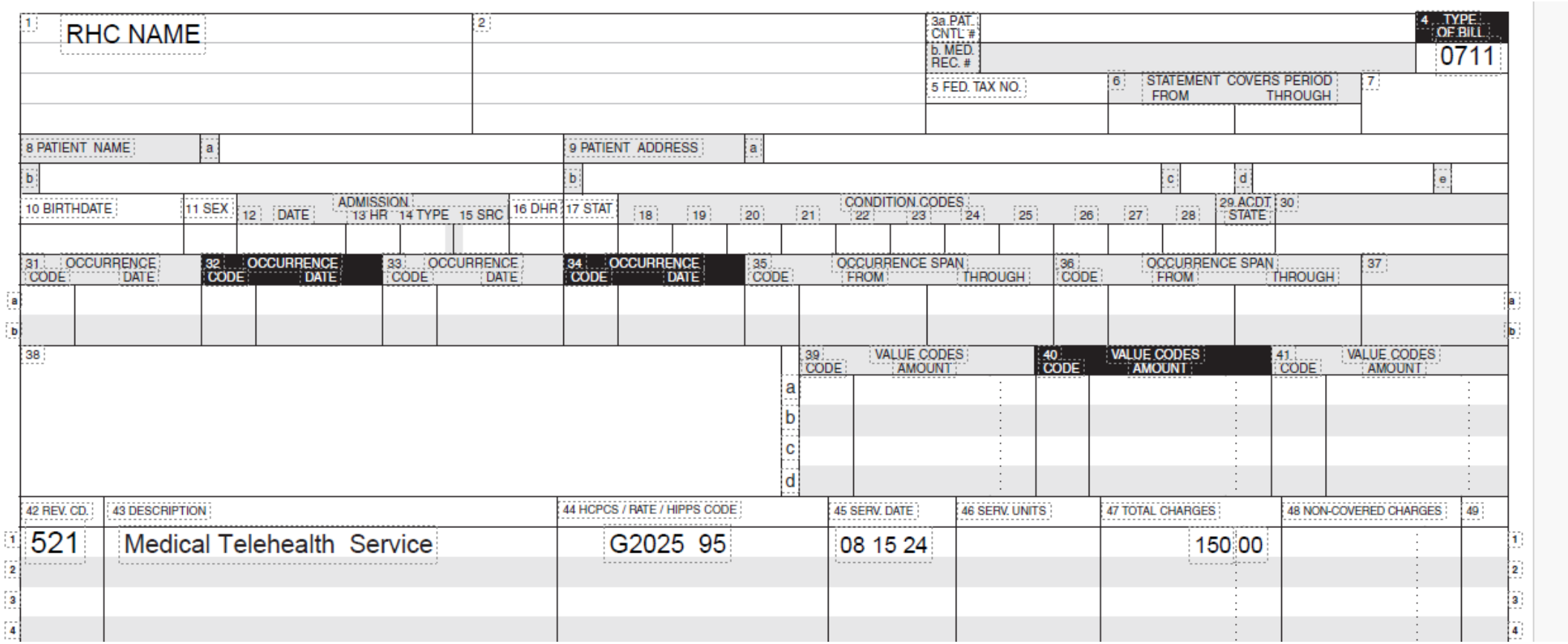
Community Mental Health Center

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



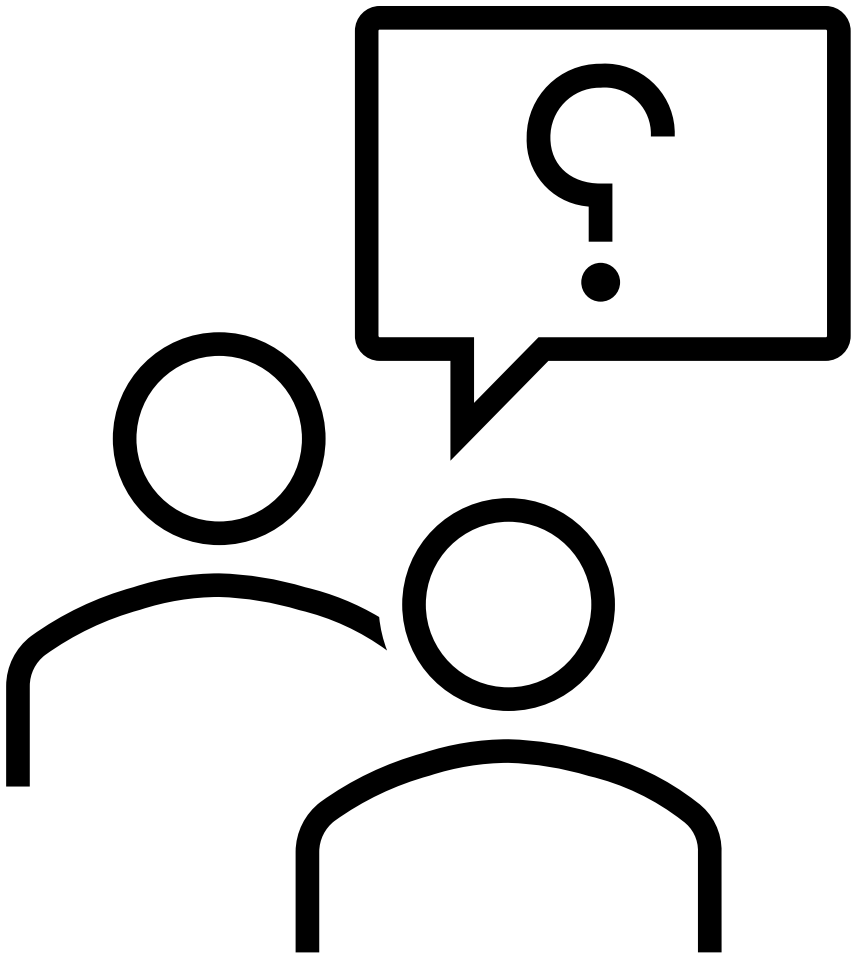
<u>Example 2</u>: An RHC provider either located in the clinic or at their residence performs a **medical audio-visual telehealth service** to a patient who is located in a qualified originating site. The RHC bill type is 711. The use of modifier 95 is optional. G2025 is reported instead of the 99214. 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.**



All of this is still subject to change when further guidance comes out.

What else?

Comments?



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