Advanced Medicare Billing
May 8, 2025

inQuiseek Consulting

Preventive Services in the RHC

CMS Policy Benefit Manual, Chapter 13

220 - Preventive Health Services
(Rev. 230, Issued: 12-09-16, Effective: 03-09-17, Implementation: 03-09-17)

RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits (where applicable) have not been exceeded. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade or A or B.

Rural Health Clinic (RHC) Preventive Services Chart

(Rev. 08-10-16)

RHCs are paid an all-inclusive rate (AIR) for qualified primary and preventive health services. Except for the initial preventive physical examination (IPPE), all preventive services furnished on the same day as another medical visit constitute a single billable visit. If an IPPE visit occurs on the same day as another billable visit, two visits may be billed. All of the preventive services listed below may be billed as a stand-alone visit if no other service is furnished on the same day. The beneficiary copayment and deductible is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force with a grade or A or B.

Additional information on RHC policy for preventive services is available in the Medicare Benefit Policy Manual, Chapter 13 (http://go.cms.gov/14BSdPN). Additional information on payment and claims processing for RHC preventive services is available in the Medicare Claims Processing Manual, Chapter 9 (http://go.cms.gov/1DFvBcO), and Chapter 18 (http://go.cms.gov/1w5l6cX). The table below lists preventive services with their associated HCPCS (Healthcare Common Procedure Coding System) code and descriptor, whether they are eligible to be paid based on the RHC's AIR when billed without another covered visit, which preventive services can be billed separately when another visit is billed on the same day, and which preventive services have the co-insurance and deductible waived.

Table 1: RHC Preventive Services

Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
IPPE	G0402	Initial preventive exam	Yes	Yes	Waived	Ch. 9 §150 Ch. 18 §80

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

Table 1: RHC Preventive Services

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IPPE	G0402	Initial preventive exam	Yes	Yes	Waived	Ch. 9 §150 Ch. 18 §80
AWV	G0438	Ppps, initial visit	Yes	No	Waived	Ch. 18 §140
	G0439	Ppps, subseq visit	Yes	No	Waived	
Screening Pelvic Exam	G0101	Ca screen; pelvic/breast exam	Yes	No	Waived	Ch. 18 §40

Only the IPPE is separately payable with a medical visit on the same day.

The AWV when performed with a sick visit is reported but is not separately payable in the RHC.

mln EDUCATIONAL TOOL

KNOWLEDGE • RESOURCES • TRAINING

November 2023 Updates

Medicare Wellness Visits

Quick Start | IPPE | AWV | Know the Differences

Early detection saves lives. Encourage patients to get their other preventive services.

Initial Preventive Physical Exam

The initial preventive physical exam (IPPE), also known as the "Welcome to Medicare" preventive visit, promotes good health through disease prevention and detection. We pay for 1 IPPE per lifetime if it's provided within the first 12 months after the patient's Part B coverage starts.

IPPE Components

IPPE Coding, Diagnosis, & Billing

IPPE Resources

- 42 CFR 410.16
- Section 30.6.1.1 of the Medicare Claims Processing Manual, Chapter 12
- Section 80 of the Medicare Claims Processing Manual, Chapter 18
- U.S. Preventive Services Task Force Recommendations

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html#IPPE

IPPE: Welcome to Medicare Exam

IPPE: Welcome to Medicare Exam

IPPE FAQs

Is the IPPE the same as a patient's yearly physical?

Are clinical lab tests part of the IPPE or AWV?

No. The IPPE and AWV don't include clinical lab tests, but you may make appropriate referrals for these tests as part of the IPPE or AWV.

Does the deductible, coinsurance, or copayment apply for the IPPE?

No. We waive the coinsurance, copayment, and Part B deductible for the IPPE (HCPCS code G0402). Neither is waived for the screening electrocardiogram (ECG) (HCPCS codes G0403, G0404, or G0405).

If a patient enrolls in Medicare in 2023, can they get the IPPE in 2024 if it wasn't performed in 2023?

A patient who hasn't had an IPPE and whose Part B enrollment began in 2023 can get an IPPE in 2024 if it's within 12 months of the patient's Part B enrollment effective date.

We suggest providers check with their MAC for available options to verify patient eligibility. If you have questions, find your MAC's website.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN

Initial Preventive Physical Exam

The initial preventive physical exam (IPPE), also known as the "Welcome to Medicare" preventive visit, promotes good health through disease prevention and detection. We pay for 1 IPPE per lifetime if it's provided within the first 12 months after the patient's Part B coverage starts.

IPPE Components

1. Review the patient's medical and social history

At a minimum, collect this information:

- Past medical and surgical history (illnesses, hospital stays, operations, allergies, injuries, and treatments)
- Current medications, supplements, and other substances the person may be using
- Family history (review the patient's family and medical events, including hereditary conditions that place them at increased risk)
- Diet
- Physical activities
- Social activities and engagement
- Alcohol, tobacco, and illegal drug use history

Learn information about Medicare's substance use disorder (SUD) services coverage.

2. Review the patient's potential depression risk factors

Depression risk factors include:

- Current or past experiences with depression
- Other mood disorders

Select from various standardized screening tools designed

Select from various standardized screening tools designed for this purpose and recognized by national professional medical organizations. APA's Depression Assessment Instruments has more information.

3. Review the patient's functional ability and safety level

Use direct patient observation, appropriate screening questions, or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the patient's:

- Ability to perform activities of daily living (ADLs)
- Fall risk
- Hearing impairment
- Home and community safety, including driving when appropriate

Medicare offers cognitive assessment and care plan services for patients who show signs of impairment.

4. Exam

Measure:

- Height, weight, body mass index (BMI) (or waist circumference, if appropriate), blood pressure, balance, and gait
- Visual acuity screen
- Other factors deemed appropriate based on medical and social history and current clinical standards

5. End-of-life planning, upon patient agreement

End-of-life planning is verbal or written information you (their physician or practitioner) can offer the patient about:

- Their ability to prepare an advance directive in case an injury or illness prevents them from making their own health care decisions
- If you agree to follow their advance directive
- This includes psychiatric advance directives

6. Review current opioid prescriptions

For a patient with a current opioid prescription:

- Review any potential opioid use disorder (OUD) risk factors
- Evaluate their pain severity and current treatment plan
- Provide information about non-opiod treatment options
- Refer to a specialist, as appropriate

The HHS Pain Management Best Practices Inter-Agency Task Force Report has more information. Medicare now covers monthly chronic pain management and treatment services.

7. Screen for potential SUDs

Review the patient's potential SUD risk factors, and as appropriate, refer them to treatment. You can use a screening tool, but it's not required. The National Institute on Drug Abuse has screening and assessment tools. Implementing Drug and Alcohol Screening in Primary Care is a helpful resource.

8. Educate, counsel, and refer based on previous components	Based on the results of the review and evaluation services from the previous components, provide the patient with appropriate education, counseling, and referrals.
9. Educate, counsel, and refer for other preventive services	Include a brief written plan, like a checklist, for the patient to get: • A once-in-a-lifetime screening electrocardiogram (ECG), as appropriate • Appropriate screenings and other covered preventive services

Diagnosis

Report a diagnosis code when submitting IPPE claims. We don't require you to use a specific IPPE diagnosis code, so you may choose any diagnosis code consistent with the patient's exam.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html#IPP

RHC Encounter: IPPE Only

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2024	1	200.00
0001	Total Charge				200.00

The physician performed IPPE (Welcome to Medicare) service on this date of service. No –CG modifier is required. The patient has no cost share for this visit because the deductible and co-insurance is waived.

Is the IPPE the same as a beneficiary's yearly physical?
No. The IPPE is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

RHC Encounter: IPPE and Sick Visit on same date of service

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est III	99213 CG	11/01/2024	1	150.00
0521	IPPE	G0402	11/01/2024	1	200.00
0001	Total Charge				350.00

The physician performed IPPE ($200) and an E & M ($150) for a problem visit on the same date of service. **The office visit for the problem visit is listed first with the -CG modifier**. The patient has no cost share for the IPPE service because the deductible and co-insurance is waived. The co-insurance amount due for the sick visit is $30.00. **No roll-up. The RHC will receive two AIR payments for this visit.**

You should track all preventive services for cost-reporting purposes.

RHC Encounter: IPPE with EKG Interpretation/Report as Part of IPPE

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	IPPE	G0402	11/01/2024	1	200.00
0521	EKG IPPE Interpret/Report	G0405	11/01/2024	1	100.00
0001	Total Charge				300.00

The RHC physician performed IPPE ($200) and also interpreted the EKG ($100) performed as part of the IPPE. Only the HCPCS codes for the two services are reported on each respective line. The clinic will receive one AIR rate but the coinsurance and deductible will be waived per HCPCS code. The EKG is optional to the IPPE but is payable. Coinsurance is due on the EKG.

You should track all preventive services for cost-reporting purposes.

Initial Annual Wellness Visit

Annual Wellness Visit Health Risk Assessment

The annual wellness visit (AWV) includes a health risk assessment (HRA). View the HRA minimum elements summary below. A Framework for Patient-Centered Health Risk Assessments has more information, including a sample HRA.

First Annual Wellness Visit Components

Perform an HRA

- Get patient self-reported information
  - You or the patient can update the HRA before or during the AWV
- Consider the best way to communicate with underserved populations, people who speak different languages, people with varying health literacy, and people with disabilities
- At a minimum, collect this information:
  - Demographic data
  - Health status self-assessment
  - Psychosocial risks, including, but not limited to, depression, life satisfaction, stress, anger, loneliness or social isolation, pain, suicidality, and fatigue
  - Behavioral risks, including, but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (for example, seat belt use), and home safety
  - Activities of daily living (ADLs), including dressing, feeding, toileting, and grooming; physical ambulation, including balance or fall risks and bathing; and instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, transportation, shopping, managing medications, and handling finances

1. Establish the patient's medical and family history

At a minimum, document:

- Medical events of the patient's parents, siblings, and children, including hereditary conditions that place them at increased risk
- Past medical and surgical history (illnesses, hospital stays, operations, allergies, injuries, and treatments)
- Use of, or exposure to, medications, supplements, and other substances the person may be using

2. Establish a current providers and suppliers list

Include current patient providers and suppliers that regularly provide medical care, including behavioral health care.

3. Measure

Measure:

- Height, weight, body mass index (BMI) (or waist circumference, if appropriate), and blood pressure
- Other routine measurements deemed appropriate based on medical and family history

4. Detect any cognitive impairments the patient may have

Check for cognitive impairment as part of the first AWV.

Assess cognitive function by direct observation or reported observations from the patient, family, friends, caregivers, and others. Consider using brief cognitive tests, health disparities, chronic conditions, and other factors that contribute to increased cognitive impairment risk. Alzheimer's and Related Dementia Resources for Professionals has more information.

Direct Interview or use of standardized assessment tools when applicable.

5. Review the patient's potential depression risk factors

Depression risk factors include:

- Current or past experiences with depression
- Other mood disorders

Select from various standardized screening tools designed for this purpose and recognized by national professional medical organizations. APA's Depression Assessment Instruments has more information.

Use of an approved depression screening tool.

6. Review the patient's functional ability and level of safety

Use direct patient observation, appropriate screening questions, or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the patient's:

- Ability to perform ADLs
- Fall risk
- Hearing impairment
- Home and community safety, including driving when appropriate

Medicare offers cognitive assessment and care plan services for patients who show signs of impairment.

Direct interview, observation or use of a screening tool.

7. Establish an appropriate patient written screening schedule

Base the written screening schedule on the:

- Checklist for the next 5–10 years
- United States Preventive Services Task Force and Advisory Committee on Immunization Practices (ACIP) recommendations
- Patient's HRA, health status and screening history, and age-appropriate preventive services we cover

8. Establish the patient's list of risk factors and conditions

Include:

- A recommendation for primary, secondary, or tertiary interventions or report whether they're underway
- Mental health conditions, including depression, substance use disorders, suicidality, and cognitive impairments
- IPPE risk factors or identified conditions
- Treatment options and associated risks and benefits

9. Provide personalized patient health advice and appropriate referrals to health education or preventive counseling services or programs

Include referrals to educational and counseling services or programs aimed at:

- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including:
  - Fall prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Social engagement
  - Weight loss
  - Cognition

10. Provide advance care planning (ACP) services at the patient's discretion

Optional

ACP is a discussion between you and the patient about:

- Preparing an advance directive in case an injury or illness prevents them from making their own health care decisions
- Future care decisions they might need or want to make
- How they can let others know about their care preferences
- Caregiver identification
- Advance directive elements, which may involve completing standard forms

Advance directive is a general term that refers to various documents, like a living will, instruction directive, health care proxy, psychiatric advance directive, or health care power of attorney. It's a document that appoints an agent or records a person's wishes about their medical treatment at a future time when the individual can't communicate for themselves. The Advance Care Planning fact sheet has more information.

We don't limit how many times the patient can revisit the ACP during the year, but cost sharing applies outside the AWV.

11. Review current opioid prescriptions

For a patient with a current opioid prescription:

- Review any potential OUD risk factors
- Evaluate their pain severity and current treatment plan
- Provide information about non-opioid treatment options
- Refer to a specialist, as appropriate

The HHS Pain Management Best Practices Inter-Agency Task Force Report has more information. Medicare now covers monthly chronic pain management and treatment services.

12. Screen for potential SUDs

Review the patient's potential SUD risk factors, and as appropriate, refer them for treatment. You can use a screening tool, but it's not required. The National Institute on Drug Abuse has screening and assessment tools. Implementing Drug and Alcohol Screening in Primary Care is a helpful resource.

13. Social Determinants of Health (SDOH) Risk Assessment

Starting in 2024, Medicare includes an optional SDOH Risk Assessment as part of the AWV. This assessment must follow standardized, evidence-based practices and ensure communication aligns with the patient's educational, developmental, and health literacy level, as well as being culturally and linguistically appropriate.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html#AWV

Medicare Annual Wellness Visit

- ❑ Is NOT a routine physical exam. Does not include a physical exam.
- ❑ Must include specific components
- ❑ Is payable as a stand-alone RHC visit when it is the only service performed
- ❑ Must include a provider face-to-face in the RHC.
- ❑ Is not payable as a separate service when performed on the same day of service as other medical or screening services.

Is the AWV the same as a beneficiary's yearly physical?
No. The AWV is not a routine physical checkup that some seniors may get periodically from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Consider Cluster Scheduling

Wellness Workflow

- Focus on Team-based Care
- Use everyone at the top of their skill level & the top of their licensure
- Think: Assembly Line—everyone adds a part to the process
- Think: Teeing the patient for the next staff engagement
- Don’t do more than is needed unless medically necessary
- Know what the required wellness components are
- Use templates and forms which minimize redundancy and complement workflow
- Create value for the patient by engaging them and showing genuine interest.

RHC SCHEDULE
Tuesday, May 6, 2025

CLUSTER SCHEDULING

	Provider A: Primary Care		Provider B: Women's Health	
9:00	WELLNESS #1	WELLNESS #2	PROCEDURE	PROCEDURE
10:00	WELLNESS #3	WELLNESS #4	PRENATAL #1	PRENATAL #2
11:00	WELLNESS #5	WELLNESS #6	PRENATAL #3	PRENATAL #4

Pre-Appt

- Review record
- Use pre-registration tools
- Use self-assessments as part of screenings

Nursing or Auxiliary Staff

- Engage/Interview Patient
- SDOH
- Conduct additional screening or use other tools, if applicable
- Summarize any findings or scoring

Provider

- Consult with Staff Prior to Entering Room
- Engage with Patient about any needed preventive services or concerns
- Convey value to patient
- Document RHC encounter

Referrals/CHW

- Hand-off to referral staff, CHW, or Population Health
- Schedule diagnostics
- Assist with appointments and referrals
- Document referrals and care management

Sick Visit with AWV

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Sick Visit	99213 CG	11/01/2023	1	100.00
0521	**AWV-Subsequent**	G0439	11/01/2023	1	150.00
0001	Total Charge				250.00

- ***-CG goes on the E & M for the follow-up of chronic conditions***
- ***AWV is reported on a separate line and NOT rolled up because there is no coinsurance and deductible on the preventive service.***
- ***The AIR is paid. Only one AIR is paid.***
- ***The patient coinsurance is $50 for the 99213.***

Reasons to perform wellness visits with a medical visit

- To keep the patient on schedule for all preventive services.
- To perform the AWV within the 12-month window.
- To retain attribution for the patient/service.
- To identify and close care gaps.
- To accommodate the patient who may have limited access to transportation or other barriers which limit access to care.
- To optimize incentives for closing care gaps.

Advanced Care Planning

- As a standalone service, the AIR is paid.
- When provided on same date of service as AWV, the service is included in the one AIR payment.
- No limit on how often the service can be performed

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	**Advance Care Planning**	99497 CG	11/01/2023	1	150.00
0001	Total Charge				150.00

Telehealth in the RHC

Telehealth Definitions

Distant Site versus Originating Site

Audio/Video/Two-Way Synchronous

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

Patient is usually at home or another appropriate location. 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.

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

Patient is at home or another facility

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

Originating Site Requirements

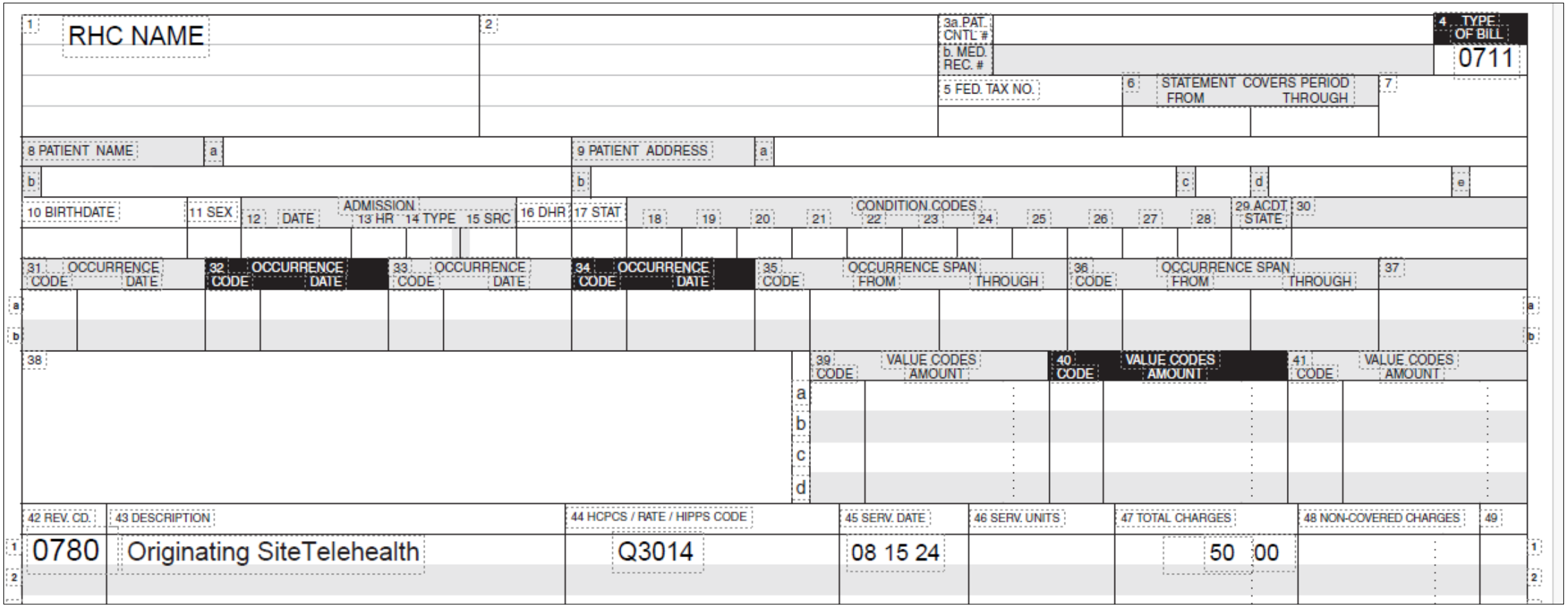
CAHs and RHCs

Social Security Act, Section 1834, Payment for Telehealth

C) Originating site.—
(i)[173] In general.—Except as provided in paragraph (5), (6), and (7), the term "originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—
(I) in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));
(II) in a county that is not included in a Metropolitan Statistical Area; or
(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.
(ii) Sites described.—The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.
(II) A critical access hospital (as defined in section 1861(mm)(1)).
(III) A rural health clinic (as defined in section 1861(aa)(2)).
(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).
(V) A hospital (as defined in section 1861(e)).
(VI) A hospital-based or critical access hospital- based renal dialysis center (including satellites).
(VII) A skilled nursing facility (as defined in section 1819(a)).
(VIII) A community mental health center (as defined in section 1861(ff)(3)(B))
(IX)[174] A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).
(X)[175] The home of an individual, but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).

Example: 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 the RHC. The revenue code is the RHC. Q3014 is reported. The RHC will be reimbursed $ 31.01 in 2025. The RHC does not report an encounter for the remote provider. The revenue code is 0780 for telehealth



Distant Site Requirements

Patient is **at home** or another originating site

Provider is in **their practice location** or their home (12/31/2024)

Extension of PHE Flexibilities in 2025

- CAHs and RHCs are statutorily excluded from being distance site providers though the Social Security Act.

- During the PHE, temporary emergency orders allowed these provider types to perform telehealth/telemedicine services.

- These flexibilities and waivers have been extended to RHCs through 09/01/2025.

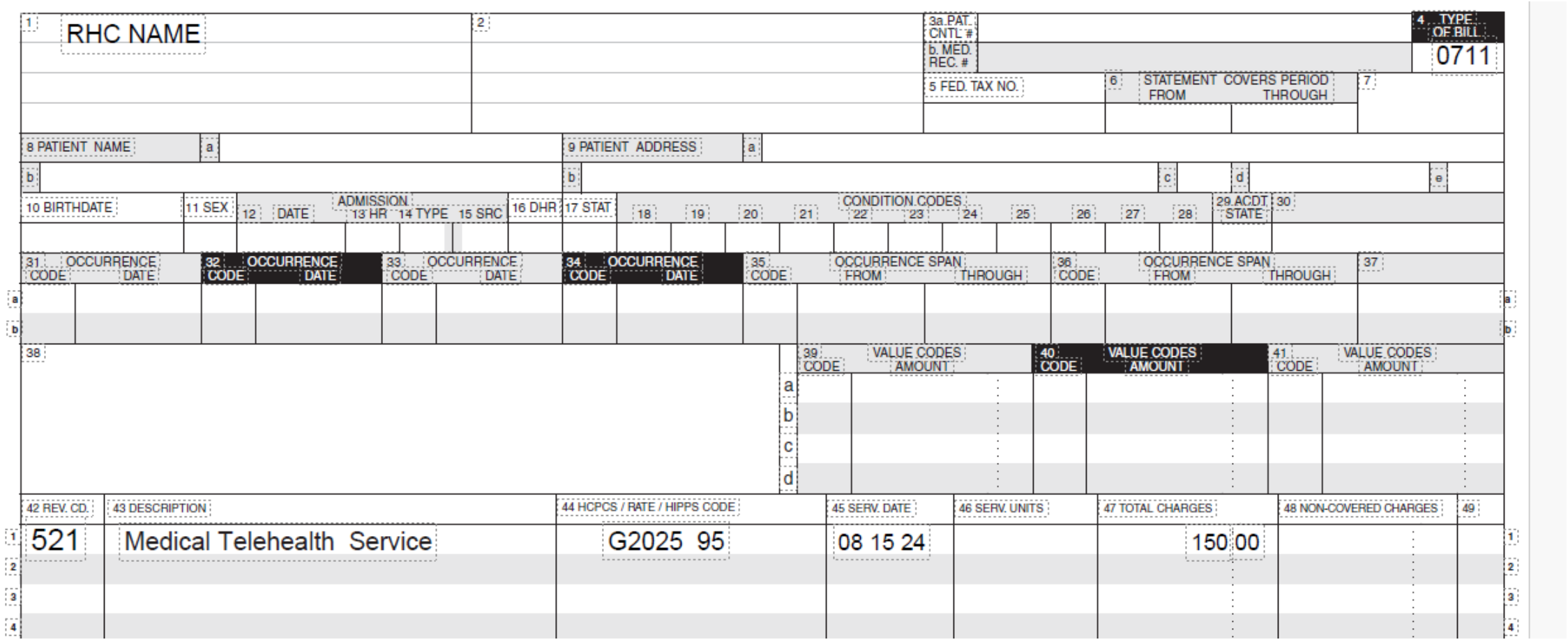
Audio-Visual Telehealth

Two-Way Synchronization/Definition

When is Audio-Only Allowed?

Medical Telehealth in the RHC

<u>Example</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 at home. The RHC bill type is 711. The use of modifier 95 is optional. G2025 is reported instead of the 99214. The RHC is reimbursed $95.27 for G2025. No -CG modifier is used since the AIR is not paid.



Audio-Only Modifiers

- Audio-Only services are only appropriate when the provider has capabilities for two-way synchronous telecommunications BUT the patient does not.
- The reason for the patient not being able to participate in audio-visual communications should be documented in the visit note.
- These modifier as used to indicate audio-only.

Type of Claim	Modifier
Fee for Service	93
Rural Health Clinic/FQHC	FQ

- Claim Examples are included in additional slides.

§ 410.78Telehealth services

FINAL
2025 MPFS ~~Proposed~~ Rule

a) * * *

- (3) Interactive telecommunications system means, except as otherwise provided in this paragraph (a)(3), multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Interactive telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology. The following modifiers must be appended to a claim for telehealth services furnished using two-way, real-time audio-only communication technology to verify that the conditions set forth in the prior sentence have been met:
  - Current Procedural Terminology (CPT) modifier “93”; and
  - (ii) For rural health clinics (RHCs) and federally qualified health centers (FQHCs), Medicare modifier “FQ”.

https://www.federalregister.gov/d/2024-14828/p-5298

RHCs: Distant Site Reimbursement

- RHCs are reimbursed by reporting G2025 on the UB-04/837I claim for the rural health clinic.
- The amount is a consolidated fee schedule amount that is determined by averaging all the applicable codes on the CMS Telehealth List.
- G2025 is approved for use through 09/01/2025.
- The current reimbursement for G2025 is $94.45 for claims submitted between January 1, 2025 – August 30, 2025.
- Since G2025 does not pay the AIR, visits and costs for G2025 are excluded from allowable costs on the RHC cost report.

2024 Reimbursement Comparison

Type of Claim	Originating Fee*	Distant Site Pro Fee	Modifiers
Rural Health Clinic	Q3014/ $29.96	G2025 for approved services $95.27 (2024)	FQ for Audio Only on approved services; No CG modifier on G2025.

- For traditional Medicare, RHCs should not report both the originating service and the distant site service for the same encounter. Some other payers will reimburse both under some situations.

Mental Health Telehealth in the RHC

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	05/05/2024	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.

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
- 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.

Questions or Comments?

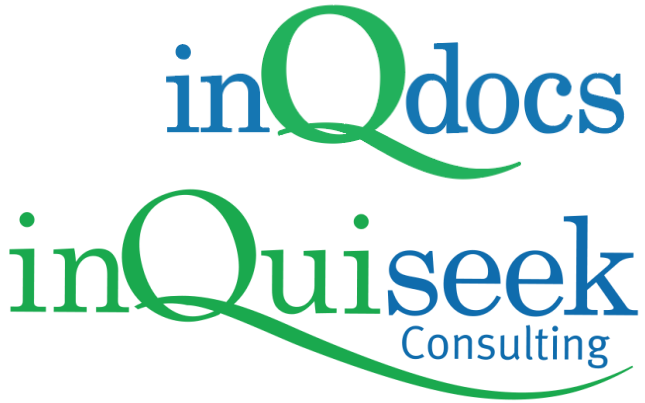
Session Presenter

Patty Harper, RHIA, CHC®

InQuiseek Consulting

pharper@inquiseek.com

318-243-2687



Patty Harper, RHIA, CHTS-PW, CHTS-IM, CHC®
InQuiseek Consulting
Pharper@inquiseek.com
318-243-2687

Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 28 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. Patty proudly served on the NARHC Board for six years.

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