

PAYMENT



Reimbursement Tips:

FQHC Requirements for Medicare Telehealth Services during the COVID-19 Public Health Emergency (PHE).

Telehealth refers to delivery of evaluation and management visits (common office visits), mental health counseling, and preventive health screenings via interactive audio and video telecommunication services to patients in remote sites, including their homes.

Program Requirements

Under the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and Section 1135 waiver authority, the Centers for Medicare and Medicaid Services (CMS) broadened access to Medicare telehealth services and added provisions specific to health centers. Information provided in this document refers to program guidance under these temporary legislative enactments and waivers.

For the duration of the COVID-19 crisis, health centers are authorized for Medicare reimbursement as distant sites in visits provided via telehealth. This means qualified FQHC providers can be paid for telehealth services provided to patients in their home and in other locations. Health centers can use telehealth in lieu of face-to-face visits to conduct eligible patient care.

Patient Eligibility & Consent

There are no separate or specific requirements for informed consent for the delivery of telehealth services. However, health centers are encouraged to document patient agreement to the use of technology services at initiation of virtual visits.

Normally, coinsurance applies to Medicare telehealth services; however, Families First Coronavirus Response Act, as amended by CARES, requires coverage of COVID-19 testing-related services without the application of cost-sharing. [CMS guidance](#) states: "Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test." FQHCs must waive the co-insurance for these COVID-19 test-related services using the "CS" modifier. When the MACs begin to reprocess these claims on July 1, 2020, they will make payment at

100% of the Medicare allowed amount. Further, CMS has [encouraged all "private" payers](#) to mitigate cost-sharing requirements and afforded "mid-year" flexibility without penalty to encourage such behavior.



Timeframe & Services

CMS/Medicare covers visits delivered via telehealth in accordance with the time requirements associated with the visit type. A Medicare telehealth visit typically requires use of interactive audio and video telecommunications system that permit real-time communication between the provider and patient; however, this definition has been expanded under the COVID PHE to allow for some "audio only" visits. See current list of permitted [telehealth codes](#) under the COVID PHE, including those permitted to be rendered as "audio only."

For telehealth services, two terms are commonly used to describe how the services are being provided.

Originating site: the **location of the patient** at the time the service is being provided.

Distant site: the **location of the provider** delivering telehealth services.

Generally, the originating site must be a health care facility located in a geographically remote area. Waivers and changes in the law relating to the COVID-19 period allowed CMS to temporarily recognize other originating site locations, including patients' homes and facilities in urban locations. This means providers can be located in the health center or even in their home (working on behalf of the health center) and deliver telehealth to patients in their homes. For FQHC distant site telehealth services furnished during the COVID emergency, the list of covered services is not limited to FQHC services.

Under the waiver, CMS has temporarily lifted rules that otherwise restrict Medicare from paying for services rendered by clinicians practicing in a state other than where they are licensed. However, state law, licensure, and scope of practice definitions must be considered.

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New vs Established Patients

New as well as established patients may be seen via telehealth. There are no frequency limitations on Medicare telehealth.

Authorized Provider/Staff

For the duration of the COVID-19 PHE, distant site telehealth services can be furnished by any health care practitioner working for the FQHC within their scope of practice (see table below).

| TREATING (BILLING) PROVIDER | | | | | Certified Registered Nurse Anesthetists | Registered Dietitians or Nutrition Professionals | Clinical Psychologists, Clinical Social Workers* | Any FQHC practitioner working within scope of practice |
|-----------------------------|-----------------------------|----|----|-----|---|--|--|--|
| Physicians (MD or DO) | Non-Physician Practitioners | | | | | | | |
| | | NP | PA | CNM | CNS | | | |
| X | X | X | X | X | X | X | X | X |

Medical Doctor (MD) or Doctor Osteopathy (DO)

Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CN), and Clinical Nurse Specialist (CNS).

*Clinical psychologists (CPs) and clinical social workers (CSWs) cannot bill for psychiatric diagnostic interview exams at the same as medical services or medical evaluation and management services.

+Any health care practitioner working for the FQHC within their scope of practice. This could, for example, include an RN, MA, CHW or other staff working within their scope of practice and whom the billing practitioner authorizes and deems qualified to perform a service under his/her direct supervision, including virtual supervision.

Documentation

Documentation of telehealth visits follows the same documentation practices in place for in-person visits. Visits should be documented in a certified electronic medical record. If emergency procedures are such that documentation is occurring via written charting, documentation should follow the SOAP (Subjective, Objective, Assessment, and Plan) note documentation procedures.

On an interim basis via [CMS-1744-IFC](#) (page 136), CMS is revising its policy “to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on [medical decision making] MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record.” This policy is similar to the policy that will apply to all E/MS beginning in January 2021, replacing the 1995 and 1997 E&M Documentation Guidelines. The statement “all of the time associated” on the day of the encounter expands the CPT

definition of time which for outpatient E&M is “face to face” time. Stated otherwise, time should include not just the visit time but all time spent managing and/or documenting the E&M service rendered via telehealth. There is no change to the current definition of MDM (i.e., use the three existing tables in the 1995 and 1997 E&M Guidelines).

In this COVID-19 emergency period, “the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communication technologies such as FaceTime or Skype.” [CMS Medicare Telemedicine Fact Sheet](#). Providers should document the modality of communication (e.g., Skype, Zoom, FaceTime, Updox, Doxy.me, etc.) in the patient record.

Coding & Billing

FQHC distant site telehealth billing can apply to services rendered on / after January 27, 2020, up to the end of the emergency period as defined in the law. FQHCs must use HCPCS code G2025, a new G code for FQHC distant site telehealth services. According to MLN Matters SE20016, Medicare will pay \$92.03 for services that qualify for reimbursement under HCPCS Code G2025. CMS has outlined a very specific claim format based on the date of service (DOS). G2025 is being used similar to HCPCS codes G4066-G4070 with health centers needing to have a “qualifying visit” that triggers or allows reimbursement under G2025.

As of this writing, CPT® code 99211 is eligible for reimbursement as a covered telehealth service under G2025. CPT® code 99211 is an “office or other outpatient visit for the evaluation and management of an established patient that may not require a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.” These are often considered ‘nurse visits’ and while they must be rendered under the “direct supervision” of the billing provider, CMS afforded virtual “direct supervision” via Interim Final Rule II. Provisions of the Interim Final Rule in Section E entitled “[Direct Supervision by Interactive Telecommunications Technology](#).”

Review the current list of permitted [telehealth codes](#), including those expanded under the COVID PHE and those permitted to be rendered as “audio only” vs. telehealth’s typically requisite audio and video service mode.

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| WHAT PROVIDER CODES | Services | What FQHC bills to CMS | CMS/Medicare 2020 Fees |
|--|--|---|---|
| Any CMS permitted telehealth code | The provider codes and services covered are the same as below. However, because CMS will need to retroactively adjust payment for the Jan-June period, it is recommended that health centers hold claims and submit using G2025 after July 1, 2020 | From Jan 27 to Jun 30 2020: Three codes: (1) PPS G codes; (2) HCPCS/CPT code with with -95 modifier G2025 with -95 modifier | Initially health center's PPS amount with post Jul-1 adjustment/recovery so payment will not exceed \$92.03 |
| Any CMS permitted telehealth code | Any from covered CMS Telehealth covered services | On and after Jul 1 2020 till the end of COVID PHE G2025* | \$92.03 |

CMS strongly urges all health centers to check with their local MAC(s) to mutually understand expectations regarding claim format, use of modifiers, and other nuances related to reimbursement.

References

- American Medical Association, CPT® 2020 Professional Edition.
- [CMS FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 \(COVID-19\).](#)
- [CMS List of Telehealth Codes.](#)
- [CMS Medicare and Medicaid Programs: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency.](#)
- [CMS Medicare Learning Network Connects: 2020-04-07-MLNC-SE.](#)
- [CMS Medicare Telemedicine Health Care Provider Fact Sheet.](#)
- [CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19.](#)
- [CMS Telehealth Services.](#)
- [Federal Register. Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency.](#)

