

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 began reprocessing

these claims on July 1, 2020, they made payments at 100% of the Medicare allowed amount. Further, CMS encouraged all "private" payers to mitigate cost-sharing requirements and many carried through those changes into 2021.



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 telecommunication systems that permit real-time communication between the provider and patient; however, this definition has been expanded under the COVID-19 PHE to allow for some "audio only" visits. See the current list of permitted [telehealth codes](#) under the COVID-19 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 patient's 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 (CNM), 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 has revised 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 new CMS policy (section 84550 of [CMS-1734-F](#)), effective January 1, 2021, that applies to E/M outpatient office visits in the code range of 99202-99215 replacing the 1995 and 1997 E&M Documentation Guidelines for

that code range. The changes in the coding guidelines for these visit levels should be reviewed to assure a comprehensive understanding of how the new time and Medical Decision Making (MDM) elements are defined and how documentation guidelines should be applied to services rendered via telehealth. Of note: If using the Time methodology to document the visit, physicians and qualified healthcare providers would include all the time associated with the patient visit limited to time spent on the date of the encounter. That encounter can be face-to-face or non-face-to-face time.

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 may be applied to services rendered on/after January 20, 2020, up until the end of the emergency period as defined in the law. FQHCs must use HCPCS code G2025, a new code created for FQHC distant site telehealth services. The 95 Modifier is optional. In 2021, Medicare will pay \$99.45 for services that qualify for reimbursement under HCPCS code G2025. CMS initially outlined a very specific claims format based upon the date of service. The submission requirements were staged to allow MACs time to update their systems to support the use of the new codes, but after July 1, 2020 the guidelines entered the final stage where G2025 became the only code to submit for telehealth services. G2025 is used by health centers for any CMS approved telehealth service, including PPS FQHC qualifying visits that are part of the traditional FQHC PPS reimbursement, as well as for non-PPS visits.

CMS added approval for health centers to provide audio-only telehealth service codes in the MLN Matters [SE20016](#). Those audio-only services include CPT codes 99441, 99442, and 99443 billable with G2025. In order to bill for an audio-only code, the physician or Qualified Health Professional (QHP) must provide

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at least 5 minutes of telephone E/M services to an established patient, parent, or guardian. They cannot bill if the services stem from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the subsequent 24 hours or soonest available appointment. It is important to review the CMS approved list of [telehealth codes](#) to see which services are telehealth permissible and which must be audio/visual versus audio-only. Note: CMS declined to continue payments for audio-only visits beyond the PHE.

In MLN Matters article [SE20011](#), CMS also explains that under the Families First Coronavirus Response Act, cost-sharing under Medicare Part B is waived for Medicare patients who receive COVID-19 testing and testing related services, including those services provided to determine the need for a test. As testing related services may be offered via telehealth, the CS modifier would be appended to the G2025 code. In addition, CMS identified preventive services for which cost-share is waived. These codes, listed in the previously mentioned CMS approved telehealth codes list, would also require the CS modifier.

For services included in the CMS approved telehealth list where cost-share is waived, Medicare will adjust the coinsurance and payment calculation to reflect the Physician Fee Schedule (PFS) methodology. This means that the coinsurance is 20% of the lesser of the allowed amount (\$99.45) or actual charges, and the payment itself is 80% of the lesser of the allowed amount (\$99.45) or actual charges. CMS notes that before the adjustment, distant site coinsurance was 20% of the actual charges and the payment was the allowed amount (\$99.45) minus the coinsurance. CMS announced in November 2020 that it would reprocess all claims with the G2025 code for services provided with a DOS of January 27 through November 16, 2020 using this “lesser of” methodology.

The addition of CPT code 99211 to the CMS list of approved telehealth service codes caused confusion in the health center setting. Generally referred to as a “nurse visit,” this code would be used by staff to address minimal problems that typically require 5 minutes or less evaluation and management time with the patient. They must be provided under the supervision of a billing provider, although CMS is allowing virtual “direct supervision” during the PHE. Because CPT code 99211 is on the CMS list of approved telehealth services list, it would be billed using G2025.

There is tremendous variation of telehealth coding, billing, payment and cost share waivers by various payers. It is important that FQHCs check with each payer for the coding and billing requirements. In addition, CMS continues to urge FQHCs to check with local MAC(s) to mutually understand expectations regarding claim format, use of modifiers, and other nuances related to reimbursement.

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	CMS/Medicare 2021 Fees
Any CMS permitted telehealth code	Any CMS Telehealth covered services	G2025* *On and after Jul 1 2020 till the end of COVID PHE	\$99.45

References

- American Medical Association, CPT® 2021 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 Telehealth Services.](#)
- [Federal Register. Medicare and Medicaid Programs: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency.](#)