

PAYMENT



Reimbursement Tips:

Mental Health Telecommunication Services

The CMS definition of a mental health visit for federally qualified health centers (FQHCs) has changed to allow for the encounter to occur through a telecommunication modality.

Program Requirements

Effective January 1, 2022, FQHCs are now permitted to furnish mental health visits to Medicare beneficiaries using interactive, real-time telecommunications technology. Audio and video telecommunications technology may be used but only when these visits are for the purpose of diagnosing, treating, or evaluating a mental health disorder. In certain situations, audio-technology may be used. These interactive, real-time telecommunication visits will be considered the same as face-to-face visits allowing FQHCs to report and receive payment at the same level as an in-person mental health visit. CMS also clarified that mental health services can include treatment for substance use disorders.

Medicare policy for telehealth services is imbedded in Federal Statute 42 US § 1395m(m). CMS cannot change that statute, but did, in the CY2022 Medicare Physician Fee Schedule Final Rule, redefine "interactive telecommunications technology", which is not otherwise defined in the federal statute, to include audio-only technology. CMS further redefined the definition of a mental health visit for FQHCs to allow them to not only be furnished face-to-face but furnished via telecommunications technology.

Patient Eligibility & Consent

For FQHCs, a mental health visit is a medically-necessary mental health encounter between patient and a qualified practitioner. As of January 1, 2022, an FQHC mental health visit is defined as a face-to-face encounter or an encounter furnished using interactive, real-time audio and video telecommunications technology or, in certain cases, audio-only technology. Medicare beneficiary consent must be written or, if furnished via telecommunications technology, verbal. Consent must be documented in the patient's medical record.

An audio-only telecommunications mental health visit is limited by CMS to being furnished by FQHC practitioners who have the capability of providing real time, two-way, audio-visual communications but the beneficiary is not capable of, cannot access, or does not consent to, the use of audio-video technology. In other words, the FQHC practitioner must have audio-visual capability while the patient may be using audio-only technology.

The decision to use telecommunication technology as a means of furnishing services should be based upon the practitioner's clinical judgement and takes into consideration the patient's needs and desires. The use of telecommunications technology must not be forced or imposed upon the patient by the practitioner. Patients must always have the choice of receiving services in-person. Patients may also opt for a hybrid delivery of services (e.g., receiving services in-person some of the time and via telecommunications technology at other times).

For mental health services furnished via telecommunications technology, two telehealth-related 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.

Historically, the definition of the telehealth originating site was a health care facility (e.g., health center) located in a geographically remote area and the patient at the health center receives services furnished via telehealth by a provider at a (different) distant site location. FQHCs had been permitted to provide certain originating site services via telehealth prior to the COVID-19 Public Health Emergency (PHE). Waivers and changes in the law relating to the PHE allowed CMS to temporarily recognize other originating site locations, including patient's homes and facilities in urban locations. Section 123 of the Consolidated Appropriations Act (CAA) of 2021 removed the originating site restrictions and permanently added the patient's home as an allowed originating site for mental health diagnosis, evaluation, or treatment via telehealth services.

In the Medicare Final Rule (CY 2022), CMS expanded the definition of a patient's home to include temporary housing such as hotels, homeless shelters, or places a patient may need to go for privacy that are a short distance from the actual home. A home does not include a hospital or other facility where the patient may be receiving care.

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During the PHE, as authorized under Section 3704 of the CARES Act, the telehealth distant site definition was temporarily modified to include FQHCs as a furnishing location allowing FQHC practitioners to be located in the health center or even in their home (working on behalf of the health center) when furnishing CMS-approved telehealth services. Prior to the PHE, FQHCs could not service as distant site providers. The distant site provider status flexibility for mental health services is permanent, meaning that it will remain in effect following the end of the PHE.

Patients with mental health or substance abuse disorders may be eligible for behavioral health integration (BHI) or psychiatric collaborative care model (CoCM) care management services. The FQHC practitioner would make this determination. A mental health visit is not an E/M visit and does not qualify as an Initiating Visit for BHI or Psych CoCM.

Timeframe & Services

In-person visit before start of service. An in-person mental health visit must be furnished within 6 months prior to the start of mental health services using telecommunications technology.

In-person requirement every 12 months. An in-person mental health visit will need to occur every 12 months while the patient is receiving services furnished via telecommunication technology for the diagnosis, evaluation, and/or treatment of mental health disorders. This in-person visit requirement means that a patient receiving mental health services via telecommunications technology will always be an established patient in the FQHC setting.

In-person requirement delay during the PHE. H.R. 2617, better known as the Consolidation Appropriations Act of 2023 ([CAA 2023](#)), extends the 2022 issued delays to the in-person mental health visit requirements until January 1, 2025. Both the requirement to have an in-person visit 6 months prior to the start of services and every 12 months after the start of services will be effective through December 31, 2024. The PHE will be allowed to expire on May 11, 2023, and the January 1, 2025 effective date for the in-person visit requirements gives FQHCs and their patients time to transition into the post-PHE era.

Exceptions to in-person requirements outside of the PHE. CMS is allowing permanent exceptions to be made to this in-person requirement at the 12-month interval based upon beneficiary circumstances. The exceptions include a situation when the patient and provider believe the risks and burdens of an in-person service outweigh the benefits. Exceptions to the 12 month,

in-person mental health visit must be documented in the patient's medical record (see 'Documentation' section for more details on documentation requirements).

Authorized Provider/Staff

An FQHC mental health visit is an encounter between the patient and an FQHC practitioner who provides the services within scope of practice and at the appropriate skill level for that practitioner.

CAA 2023 also allows for, effective January 1, 2024, the expansion of mental health services by marriage and family therapists or mental health counselors (i.e. LPCs) in FQHCs with payment under PPS. This change expands access to mental health services and better aligns Medicare with the many Medicaid programs and commercial plans that currently allow these providers to furnish mental health services to their beneficiaries.

TREATING (BILLING) PROVIDER					
Physicians (MD or DO)	Non-Physician Practitioners				
	NP	PA	CNM	CP	CSW
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 Psychologists (CPs) and Clinical Social Workers (CSWs).

Documentation

Documentation of a mental health telecommunications visit follows the same documentation practices in place for in-person visits. Visits should be documented in a certified electronic medical record. Documentation should include the telecommunications technology used, provider and patient locations, clinical participants, and patient consent.

The reason for any exceptions to two-way, audio/visual communications visits (i.e., furnished audio-only) and/or to in-person visits must be documented in the medical record:

- The limited exceptions to an in-person visit every 12 months, for a patient receiving mental health services via telecommunications technology, include when:
 - The clinician determines that an in-person visit for a clinically stable patient runs the risk of worsening the patient's condition which may create "undue hardship" on the patient or family.
 - There is a risk of the patient withdrawing from care that has been effective in managing the illness or condition via telecommunications technology.

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- The in-person visit may cause the patient's condition to worsen or would be likely to cause service delivery disruption.
- The patient is in partial or full remission and requires care to maintain status.

Providers must also document that in-person access to care is available, as is any necessary testing and vital sign monitoring. The provider and patient determine, based upon clinical need, whether the frequency of in-person visits should occur more than once in a 12-month period.

Providers should document the modality of HIPAA compliant communication (e.g., Skype for Business, Zoom for Healthcare, Updox, Doxy.me, etc.) in the patient record.

In June 2022, the Department of Health and Human Services issued [new guidance](#) on the use of audio-only communication services. The guidance will come into effect May 11, 2023 at the end of the PHE.

During the PHE, the Office of Civil Rights (OCR) issued the [Telehealth Notification](#) and will not impose penalties for noncompliance with the requirements of HIPAA Rules; and, providers can use any non-public facing remote communication. Public facing video communication applications (e.g., Facebook Live, TikTok, and Twitch, etc...) are not allowed to be used.

Coding & Billing

Mental health visits using telecommunications technology are different from the temporary distant site telehealth services allowed to be furnished by FQHCs during the PHE. The services on the [CMS-approved telehealth service](#) list may be furnished and billed for by FQHCs during the PHE using G2025, the PHE telehealth service code. Health centers must not bill G2025 for a mental health visit provided via telecommunications.

Established patients

FQHC mental health visits are billed using HCPCS G0470 for established patients. As mentioned earlier, the requirement to have an in-person mental health visit 6 months prior to the start of a mental health telecommunications visit means that the mental health telecommunications visits will always be coded for an established patient: G0470. To qualify as an FQHC mental health visit, the encounter must include a qualified mental health service (i.e., psychotherapy, or a psychiatric diagnostic evaluation). Group mental health services do not meet the criteria for an FQHC encounter.

The qualifying visit AMA CPT® codes that correspond to the G0470 payment code are:

- 90791 - Psychiatric diagnostic evaluation
- 90792 - Psychiatric diagnostic evaluation with medical services
- 90832 - Psychotherapy, 30 minutes with patient
- 90834 - Psychotherapy, 45 minutes with patient
- 90837 - Psychotherapy, 60 minutes with patient
- 90839 - Psychotherapy for crisis, first 60 minutes
- 90845 - Other psychotherapy: Psychoanalysis

New patients

The delay in the in-person visit requirements until January 1, 2025 means that FQHCs can furnish new patient mental health services via telecommunications technology. A new patient is someone who, within three years prior to the date of service, has not received any medical or mental health services from an FQHC practitioner within the FQHC organization or from any sites within the FQHC organization. FQHCs bill for a mental health, new patient visit using G0469. The qualifying CPT® visit codes for G0469 and G0470 are the same.

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	CMS/Medicare 2023 Fee
Qualifying CPT® mental health visit code	Established patient: Mental health diagnosis, evaluation, and treatment services.	G0470, FQHC Mental Health Visit, established patient	\$187.19
Qualifying CPT® mental health visit code	New patient: Mental health diagnosis, evaluation, and treatment services.	G0469, FQHC Mental Health Visit, new patient	\$251.13

Rates here are based on the 2023 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

FQHCs are reimbursed at 80 percent of the lesser of the FQHC's charge or local FQHC Prospective Payment System (PPS) payment rate. Coinsurance is 20% of the lesser of the FQHC's charge or PPS payment rate. A qualified mental health visit billed on the same day as a qualified medical visit receives an additional payment.

There is tremendous variation of 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

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FQHCs to check with their local Medicare Administrative Contractor (MAC) to mutually understand expectations regarding claim format, use of modifiers, and other nuances related to reimbursement.

Modifiers

Medicare requires that codes for mental health services furnished via telecommunications technology be appended with an appropriate modifier.

- **Modifier 95** a CPT® code modifier used by FQHCs to identify mental health services furnished using real-time, two-way, audio and video telecommunications technology.
- **Modifier 93** (new 2023 requirement) is required by Medicare to be appended to qualified mental health services furnished using audio-only technology.
- **Modifier FQ**, required by Medicare in 2022, is to be used to identify mental health services furnished using audio-only technology. Although CMS directs FQHCs to use modifier 93 for audio-only mental health visits, some MACs and other payers may still require modifier FQ and/or 93.

Note: FQHC institutional claims do not require a POS code when billing to Medicare. It's always important to first check with your payer before making changes to your coding and billing systems.

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