

Billing Coding Telehealth



Charles James Jr

President and CEO
North American HMS

Julie Quinn, CPA

VP Compliance and Cost
Reporting
Health Services Associates



Shannon Chambers

CPC, CRCA, Director of Provider Solutions
S. Carolina Office of Rural Health



Session Objectives

- Understanding the current Telehealth Billing requirements
- Learn about potential changes once the Public Health Emergency Ends
- Understanding your cost report implications

HHS Public Health Emergency: January 27, 2020



The screenshot shows the HHS Public Health Emergency website. The header features the HHS logo and the text "Public Health Emergency" and "Public Health and Medical Emergency Support for a Nation Prepared". Below the header is a breadcrumb trail: "PHE Home > Emergency > News & Multimedia > Public Health Actions > PHE > Determination that a Public Health Emergency Exists". The main heading is "Determination that a Public Health Emergency Exists". The text below states: "As a result of confirmed cases of 2019 Novel Coronavirus (2019-nCoV), on this date and after consultation with public health officials as necessary, I, Alex M. Azar II, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby determine that a public health emergency exists and has existed since January 27, 2020, nationwide." The date "01/31/2020" is circled in red. The signature line shows "Alex M. Azar II". A sidebar on the right contains "More Emergency and Response Information" with links to "Declarations of a Public Health Emergency", "Public Health Emergency Determinations to Support an Emergency Use Authorization", "Section 1135 Waivers", and "Emergency Use Authorizations". The footer includes links for Home, Contact Us, Accessibility, Privacy Policies, Disclaimer, HHS Viewers & Players, HHS Plain Language, Assistant Secretary for Preparedness and Response (ASPR), 200 Independence Ave., SW, Washington, DC 20201, U.S. Department of Health and Human Services, USA.gov, GobiernoUSA.gov, HealthCare.gov in Other Languages, and the HHS logo.

- ✓ The Public Health Emergency was declared as effective on January 27, 2020.
- ✓ Many of the Telehealth provisions currently exist ***ONLY AS LONG AS THE PUBLIC HEALTH EMERGENCY.***

Current PHE Expires 01.23.2021

Public Health Emergency
Public Health and Medical Emergency Support for a Nation Prepared

PHE Home > Emergency > News & Multimedia > Public Health Actions > PHE > Determination that a Public Health Emergency Exists

Determination that a Public Health Emergency Exists

As a result of confirmed cases of 2019 Novel Coronavirus (2019-nCoV), on this date and after consultation with public health officials as necessary, I, Alex M. Azar II, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby determine that a public health emergency exists and has existed since January 27, 2020, nationwide.

01/31/2020 /s/ Alex M. Azar II

Date

This page last reviewed: January 31, 2020

[Home](#) | [Contact Us](#) | [Accessibility](#) | [Privacy Policies](#) | [Disclaimer](#) | [HHS Viewers & Players](#) | [HHS Plain Language](#)

Assistant Secretary for Preparedness and Response (ASPR), 200 Independence Ave., SW, Washington, DC 20201

[U.S. Department of Health and Human Services](#) | [USA.gov](#) | [GobiernoUSA.gov](#) | [HealthCare.gov in Other Languages](#)

- ✓ The PHE was last updated 10.2.2020.
- ✓ All Telehealth provisions will expire on that date without a federal AND state legislative solutions.

OCR and HIPAA during COVID

- “Under this Notice, however, OCR will not impose penalties against covered health care providers for the lack of a BAA with video communication vendors or any other noncompliance with the HIPAA Rules that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency.”
- <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

Medicare Telehealth Visits via FaceTime/Skype

The following are approved platforms.

- ✓ Skype for Business / Microsoft Teams
- ✓ Updox
- ✓ VSee
- ✓ Zoom for Healthcare
- ✓ Doxy.me
- ✓ Google G Suite Hangouts Meet
- ✓ Cisco WebEx Meetings / WebEx Teams
- ✓ Amazon Chime
- ✓ GoToMeeting

The following are NOT approved:

- Facebook Live – Streams to the public!
- TikTok – If you don't know what it is your kids or grandkids do!

RHC as Distant Site: FINALLY Effective March 27, 2020

- On March 27, 2020, the (CARES Act) was signed into law. Section 3704 authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE.
- ✓ Medicare telehealth services require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient.
- ✓ *RHCs and FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.*

Distant Site Providers during PHE

- Distant site telehealth services can be furnished by *any health care practitioner* working for the RHC within their scope of practice. (This includes 99201 and 99211.)
- Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS)!!
- <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

RHC Distant Site Provider Payment

- Payment to RHCs and FQHCs for distant site telehealth services is set at **\$92.03**, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.
- Because these changes in policy were made on an emergency basis, CMS needs to implement changes to claims processing systems in several stages.

Medicare Patient Consent

- **Patient Consent:** Beneficiary consent is required for all services, including non-face-to-face services.
- For RHCs and FQHCs, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the FQHC or FQHC practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the FQHC or FQHC practitioner.
- <https://www.cms.gov/files/document/covid-final-ifc.pdf>

G2025 Only

- RHCs and FQHCs must use HCPCS code G2025, the new RHC/FQHC specific G code for distant site telehealth services, to identify services that were furnished via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective.
- <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>
- Changes in *eligible originating site locations*, including the patient's home during the COVID-19 PHE *are effective beginning March 6, 2020*.

Medicare Telephone Only Visits = G2025

- During the COVID-19 PHE, RHCs and FQHCs can furnish any telehealth service that is approved as a Medicare Telehealth Service under the PFS. (See [Medicare Approved Telehealth Services](#))
- Effective March 1, 2020, these services include CPT codes **99441, 99442, and 99443**, which are audio-only telephone evaluation and management (E/M) services. RHCs and FQHCs can furnish and bill for these services using HCPCS code G2025.
- *Prior guidance CMS had indicated that telephone only visits could only be billed as G0071 – Virtual Check-In. The **CURRENT guidance**: We can adjust telephone only claims that were billed G0071 to G2025 to be paid the higher rate – back to March 1, 2020.*
- *See MLN SE20016. Revised July 6, 2020
<https://www.cms.gov/files/document/se20016.pdf>*

Medicare *Telephone Only Visits must include:*

- ✓ at least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
- ✓ These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Annual Wellness Visits and Telehealth

- “Currently, Medicare policy allows for the billing of the AWW (G0438-G0439) when delivered via telehealth provided that all elements of the AWW are provided (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWW_Chart_ICN905706.pdf).
- For the duration of the public health emergency, the AWW may be administered using audio-only technology, if a video connection with the patient is not possible. If the patient can self-report elements of the AWW (i.e., height, weight, blood pressure, other measurements deemed appropriate based on medical and family history), those measurements may be included and recorded in the medical record as reported by the patient. Guidance for when the patient cannot self-report is currently under review, and CMS plans to issue guidance soon.”

COVID-19 Help Desk Team

Telehealth Co-Insurance and Deductible

Medicare Telehealth

Medicare WILL apply cost-sharing (co-insurance and deductible) to Telehealth services unless they are COVID-related. Read on.

CS Modifier for COVID-Related Services: Co-Insurance MUST be Waived

- ✓ For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries.
- ✓ For COVID-related services in which the coinsurance is waived, RHCs and FQHCs must report the “CS” modifier on the service line.
- ✓ The CS-modifier NOW also applies to preventive services rendered via telehealth, where patient cost sharing should not apply.

SE20016 Revised: CS – Modifier

- **CS - Cost-sharing waived:**
 - ✓ **for specified COVID-19** testing-related services that result in and order for or administration of a COVID-19 test, **and/or**
 - ✓ **for cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics** and Federally Qualified Health Centers during the COVID-19 public health emergency.

Preventive Visits + CS Modifier

- Per SE20016 revised: “There are several CPT and HCPCS codes included in the list of telehealth codes at the link above that describe preventive services that have waived cost-sharing.
- As stated earlier in this article, telehealth services on this list are billed using HCPCS code G2025. *In order to distinguish those telehealth services that do not have cost sharing waived from those that do, such as certain preventive services, RHCs and FQHCs must also report modifier CS.*

Major Cost Sharing Distinction

- ✓ Waiving cost sharing for COVID-related testing is required.
- ✓ Providers MAY waive cost sharing for ALL telehealth services if so desired, during the PHE.

Providers MAY waive Co-Insurance at their discretion

- In response to the unique circumstances resulting from the outbreak of 2019 novel coronavirus (COVID-19), the HHS Office of Inspector General (OIG) provided flexibility for healthcare providers to reduce or waive beneficiary cost-sharing for telehealth visits paid for by Federal health care programs through a policy statement issued on March 17, 2020.
- Ordinarily, if physicians or practitioners routinely reduce or waive costs owed by Federal health care program beneficiaries, including cost-sharing amounts such as coinsurance and deductibles, they would potentially implicate the Federal anti-kickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries.
- The policy statement notifies providers that OIG will not enforce these statutes if providers choose to reduce or waive cost-sharing for telehealth visits during the COVID-19 public health emergency, which the HHS Secretary determined exists and has existed since January 27, 2020.
- [HHS Office of Inspector General Fact Sheet – March 2020](#)

CS Modifier – Claims with Co-Insurance Applied

- COVID RHC and FQHC claims with the “CS” modifier were initially paid with the coinsurance applied.
- ✓ *Medicare Administrative Contractors (MAC) should have automatically begun reprocessing these claims beginning on July 1.*
- ✓ Coinsurance should not be collected for COVID-related services.

RHC Telehealth Distant Site Services: furnished between January 27, 2020, and June 30, 2020

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025CG95	01/27/2020	1	\$ 94.00
0001	Total Charge				\$ 94.00

- ✓ RHCs must report HCPCS code G2025 on their claims with the CG modifier.
- ✓ Modifier “95” (Real-Time Interactive Audio and Video) may also be appended but is not required.
- ✓ **These claims will be paid at the RHC’s all-inclusive rate (AIR), and automatically reprocessed beginning on July 1, 2020, at the \$92.03 rate.** RHCs do not need to resubmit these claims for the payment adjustment.

RHC Telehealth Distant Site Services: Beginning July 1, 2020

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025	08/21/2020	1	\$ 94.00
0001	Total Charge				\$ 94.00

Beginning July 1, 2020, RHCs should no longer put the CG modifier on claims with HCPCS code G2025.

These claims will be paid at the \$92.03.

G2025 Problems

1. No service detail for the ***Medicare Coordination of Benefits*** system to capture. Medicare will not “know” if an Annual Wellness or an E/M visit was performed.
2. How will Medicare know that this service was preventive and should not have co-insurance or deductible amounts applied.
3. How will our ACOs or other entities know that the FQHC is meeting quality measures?
4. If provider compensation is based on RVUs (Relative Value Units). How would these services be captured on our cost report? How will that work?

Posting AND SUPPRESSING Service Detail

- The example below is a ***suggestion!*** (G0439 or other CPT detail should NOT go out on the claim). This method is only a suggested

FL42	FL43	FL44	FL45	FL46	FL47
Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025CG95	4/1/2020	1	\$ 94.00
0521	Subsequent AWW	G043995			(Suppressed)
0001	Total Charge				\$ 94.00

*These services MUST be removed from Cost Report calculations!
This will inflate the patient count!

Posting AND SUPPRESSING Service Detail

- The example below is a ***suggestion!*** (G0439 or other CPT detail should NOT go out on the claim). This method is only a suggested

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	RHC Distant Site	G2025CG95	4/1/2020	1	\$ 94.00
0521	Subsequent AWV	G043995			(Suppressed)
0001	Total Charge				\$ 94.00

*These services MUST be removed from Cost Report calculations!
This will inflate the patient count!

Medicare Advantage Wrap Around

- Since telehealth distant site services are not paid under the RHC AIR or the FQHC PPS, the Medicare Advantage wrap-around payment does not apply to these services. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.

Virtual Communication Services

- RHCs can receive payment for Virtual Communication Services when *at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner* to a patient who has had an RHC billable visit within the previous year.
- ✓ The medical discussion or remote evaluation is for a condition *not related to an RHC service* provided within the previous 7 days, and -
- ✓ The medical discussion or remote evaluation ***does not lead to an RHC visit*** within the next 24 hours or at the soonest available appointment.

Virtual Communication – NOT an Encounter!

- RHCs can receive payment for Virtual Communication Services when *at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner* to a patient who has had an RHC billable visit within the previous year.
- ✓ The medical discussion or remote evaluation is for a condition *not related to an RHC service* provided within the previous 7 days, and -
- ✓ The medical discussion or remote evaluation ***does not lead to an RHC visit*** within the next 24 hours or at the soonest available appointment.

Virtual Communication Services – Billing

G0071 (Virtual Communication Services) is billed either alone or with other payable services.

Payment for G0071 is temporarily set at the PFS national average of the non-facility average for G2010, G2012, 99421, 99422, and 99423.

For 2020, the payment amount for code G0071 will be **\$24.75**.

G0071 FAQ: Types of Communication

- Virtual communication services would be initiated by the patient contacting the RHC or FQHC by:
 - *a telephone call;*
 - integrated audio/video system;
 - a store-and-forward method such as sending a picture or video to the RHC or FQHC practitioner for evaluation and follow up within 24 hours.
- The RHC or FQHC practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

G0071: Virtual Check-In

- Virtual Check-In (Brief Communication Technology-based Service):
 - MUST be initiated by the patient. The provider cannot call the patient.
 - Performed by a physician or other qualified health care professional;
 - provided to an established patient (Waived for COVID-19)
 - COVID-19: Available to ALL patients, including new effective 3.17.2020.
 - not originating from a related E/M service provided within the previous 7 days;
 - nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment;
 - 5-10 minutes of medical discussion.

G0071 FAQ: Virtual Communication Services

- ✓ Coinsurance and deductibles apply to RHC claims for G0071 and coinsurance applies to FQHC claims for G0071.
- ✓ Coinsurance is 20 percent of the lesser of the charged amount or the payment amount for code G0071.
- ✓ Beneficiary consent should be obtained before virtual communication services are furnished in order to bill for the service.

Virtual Check-In RHC Claim Example

FL42	FL43	FL44	FL45	FL46	FL47
Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	Virtual Check-In	G0071	4/2/2020	1	\$ 25.00
0001	Total Charge				\$ 25.00

- ✓ G0071 is for RHCs only.
- ✓ We do not bill G2010 OR G2012.
- ✓ Virtual Check-In G0071 encompasses Remote Check-In AND Remote Evaluation.
- ✓ It does NOT include remote monitoring.

eVisits: Medicare Telehealth via Patient Portal

These Services are now BUNDLED as a composite with G0071.

Medicare Telehealth/Patient Portal Codes: (99421 – 99423)

Description: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during 7 days.

99421 5-10 minutes

99422 11—20 minutes

99423 21 or more minutes

eVisits – 99421, 99422, 99423

- **E-Visits**, the patient must generate the initial inquiry and communications can occur over a 7-day period.
- The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.
- ✓ Patient Consent can be obtained by the staff, verbally.
- ✓ Providers can waive cost-sharing for all telehealth services and visits.

Commercial Insurance

- ✓ Commercial Insurance payers all have their own payment provisions for Telehealth services and reimbursement.
- ✓ Many follow Medicare Fee-For-Service billing guidelines.
- ✓ Please confirm reimbursement and billing policies.

Documentation for Telehealth Visits*

RECORD CONTENT

Telemedicine records should be kept in the same manner as other health records.

The specific documentation needs vary depending upon the level of telemedicine interaction. The organization using telemedicine information to make a decision on the patient's treatment must comply with all standards, including the need for assessment, informed consent, documentation of event (regardless of the media), and authentication of record entries.

<https://healthsectorcouncil.org/wp-content/uploads/2018/08/AHIMA-Telemedicine-Toolkit.pdf>

* From Patty Harper/Inquiseek RHC Telehealth

Telephone Note Example*

Patient Demographics

TELEMEDICINE/TELEPHONIC NOTE

☐ Claim Date _____
☐ Scanned to EHR by _____

Date: _____ Provider Name: _____ Provider Credential: _____

Pt Name: _____ DOB/Age _____ Start Time: _____ Stop Time: _____
☐ Minor: Parent/Guardian is present.

Account/Med Record # _____ ☐ New Pt ☐ Established Pt
☐ HIPAA Acknowledged ☐ Verbal Consent Obtained By _____

Type of Service: ☐ Audio/Visual Live ☐ Audio/Visual Stored ☐ Audio Only ☐ Phone Call
☐ Virtual Communication Service ☐ No Pt Device/Computer App Used: _____

=====

PURPOSE OF TELEMEDICINE/TELEHEALTH SERVICE:

☐ Possible Exposure to COVID-19 ☐ Symptoms of COVID-19 ☐ Other Respiratory S/S
☐ Other Acute Condition _____ ☐ Other Chronic Condition _____
☐ Other: _____ ☐ Care Management

Location of Patient: _____ Location of Provider: _____

=====

* From Patty Harper/Inquiseek RHC Telehealth slides.

HPI: Telephone Note Example*

Status of Chronic Conditions as HPI

HISTORY OF PRESENT ILLNESS or Reason for Telemedicine/Telehealth Visit

Signs and Symptoms: ☐ Cough ☐ Fever _____ ☐ Body Aches ☐ Sinus Congestion
☐ Chest Congestion ☐ Fatigue/Malaise ☐ Nausea ☐ Diarrhea ☐ Headache ☐ SOB
☐ Other Acute Signs/Symptoms: _____ ☐ **COVID Exposure**

ONSET/ Exposure Date: _____ Family/Friends/Coworkers Sick: ☐ Yes ☐ No

Travel History Self/Family/Others: _____

Status of Chronic Conditions: 1. _____ ☐ Stable ☐ Worse ☐ Better
2. _____ ☐ Stable ☐ Worse ☐ Better 3. _____ ☐ Stable ☐ Worse ☐ Better

=====

☐ Problem List Reviewed ☐ Medications Reviewed ☐ Allergies _____

Review of Systems: Experiencing Any Other Complaints Unrelated to HPI? ☐ Yes ☐ No

If yes, which body system and complaint: _____

=====

Vitals per Pt/Historian: ☐ Temp _____ ☐ Weight _____ ☐ Height _____ ☐ BP _____

Observation/Visualization:

* From Patty Harper/Inquiseek RHC Telehealth slides.

Assessment and Plan: Telephone Note Example*

Assessment and Plan

=====	
Assessment:	Plan:
1. _____	
2. _____	
3. _____	
<input type="checkbox"/> Lab Ordered: _____	<input type="checkbox"/> Send to Hospital: _____
<input type="checkbox"/> Self-Quarantine	<input type="checkbox"/> See in clinic _____
	<input type="checkbox"/> Refer to: _____
<input type="checkbox"/> Rx Ordered/Refill: _____	<input type="checkbox"/> Record Sent
Pharmacy Name/Phone _____	<input type="checkbox"/> Electronically
	<input type="checkbox"/> Called In
<input type="checkbox"/> Patient Education Given _____	<input type="checkbox"/> Follow-up _____
Signature: _____	Date/Time: _____

* From Patty Harper/Inquiseek RHC Telehealth slides.

If the PHE ended today, what happens to Telehealth?

Federal – Medicare/CMS

There has been NO legislation or policy change to make ANYTHING at the federal level permanent.

ALL RHC and FQHC Telehealth provisions would revert to Pre-COVID distant site restrictions.

RHC Modernization Act

- **Sec. 8 Raising the Cap on Rural Health Clinic Payments.**
- Increase the upper limit (or cap) on RHC reimbursement incrementally to \$105, \$110, and \$115 over 3 years with an adjustment for MEI thereafter.
- PLEASE, PLEASE, PLEASE call your Congressperson! US Representative and Senator!
- RHC Modernization Act
- <https://www.web.narhc.org/News/27847/RHC-Modernization-Act-Introduced-by-Senator-Barrasso-and-Senator-Smith>

Provider, Lab, and Medication Flexibility

- **Sec. 2 Modernizing Physician, Physician Assistant, and Nurse Practitioner Utilization Requirements.**

Modernizes physician supervision requirements in RHCs by aligning scope of practice laws with state law. Allows PAs and NPs to practice up to the top of their license without unnecessary federal supervision requirements that apply only because the PA or NP is practicing in a RHC.

- **Sec. 3 Removing Outdated Laboratory Requirements.**

Removes a requirement that RHCs maintain certain lab equipment on-site and allows RHCs to satisfy this certification requirement if they have *prompt access* to lab services.

- **Sec. 4 Allowing Rural Health Clinics to Determine the Drugs and Biologicals Necessary for Emergency Cases.**

Allows the professional personnel responsible for the RHCs policies and procedures, instead of the Secretary of Health and Human Services, to determine the drugs and biologicals necessary for emergency cases in each specific RHC.

Remove Employment Requirement Telehealth, and State HPSAs Designations.

- **Sec. 5 Allowing Rural Health Clinics the Flexibility to Contract with Physician Assistants and Nurse Practitioners.**

Removes a redundant requirement that RHCs employ a PA or NP (as evidenced by a W2) and allows RHCs to satisfy the PA, NP, or CNM utilization requirements through a contractual agreement if they choose to do so.

- **Sec. 6 Allowing Rural Health Clinics to be the Distant Site for a Telehealth Visit.**

Allows RHCs to offer telehealth services as the distant site (where the provider is located) and bill for such telehealth services as RHC visits.

- **Sec. 7 Creating a State Option for Rural Designation**

Gives new authority to States to define areas as rural for the purposes of establishing a RHC.

Telehealth Changes: SB3998

116TH CONGRESS
2D SESSION

S. _____

To amend title XVIII of the Social Security Act to simplify payments for telehealth services furnished by Federally qualified health centers or rural health clinics under the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mrs. HYDE-SMITH (for herself and Mr. KING) introduced the following bill;
which was read twice and referred to the Committee on

A BILL

To amend title XVIII of the Social Security Act to simplify payments for telehealth services furnished by Federally qualified health centers or rural health clinics under the Medicare program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Improving Telehealth
5 for Underserved Communities Act of 2020”.

“Improving Telehealth for Underserved Communities Act of 2020”

SB3998 seeks protection from the “claw back” of the AIR paid for Telehealth services to \$92.03.

H.R. 6792: AIR for Telehealth Services

“The Secretary shall pay to a FQHC or RHC serving as a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal:

- to the amount that such Federally qualified health center or rural health clinic would have been paid... had such service been furnished without the use of a telecommunications system.”

116TH CONGRESS
2^D SESSION

H. R. 6792

To amend title XVIII of the Social Security Act to simplify payments for telehealth services furnished by Federally qualified health centers or rural health clinics under the Medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 8, 2020

Mr. **SMITH** of Nebraska (for himself and Mr. O'HALLERAN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to simplify payments for telehealth services furnished by Federally qualified health centers or rural health clinics under the Medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Improving Telehealth for Underserved Communities Act of 2020”.

SEC. 2. SIMPLIFYING PAYMENTS FOR TELEHEALTH SERVICES FURNISHED BY FEDERALLY QUALIFIED HEALTH CENTERS OR RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1834(m)(8)(B) of the Social Security Act ([42 U.S.C. 1395m\(m\)\(8\)\(B\)](#)) is amended to read as follows:

“(B) PAYMENT.—The Secretary shall pay to a Federally qualified health center or rural health clinic serving as a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such Federally qualified health center or rural health clinic would have been paid under the payment methodology described in section 1834(o) or section 1833(a)(3), respectively, had such service been furnished without the use of a telecommunications system. Costs associated with the delivery of such services by a Federally qualified health center or rural health clinic serving as a distant site pursuant to this paragraph shall be considered allowable costs for purposes of the payment methodologies described in the previous sentence.”.

Section 304 CARES Act (Phase 4)



Section 304 – Extending Medicare telehealth flexibilities for Federally qualified health centers and rural health clinics This section specifies that the expansion of telehealth in Medicare for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) provided in the Coronavirus Aid, Relief, and Economic Security (CARES) Act **continues for five years beyond the end of the public health emergency.**

It enables beneficiaries to receive telehealth from FQHC and RHCs serving as a distant site regardless of where they are located, including in the safety of their own home. This section ensures a sustained period of telehealth access for the many in rural and underserved areas that rely on FQHCs and RHCs for care.

Telehealth Resources

For patients

For providers

Getting started

Planning your telehealth workflow

Preparing patients for telehealth

Policy changes during the COVID-19 Public Health Emergency

Billing and reimbursement during the COVID-19 Public Health Emergency

Legal considerations

Resources by topic

Policy changes during the COVID-19 Public Health Emergency

The federal government has taken concrete steps to make telehealth services easier to implement and access during this national emergency. These changes are temporary measures during the COVID-19 Public Health Emergency and are subject to revision. Here are some of the highlights.

[Open all sections](#)

Incorporating newly allowed technology due to HIPAA flexibility

+

Providing telehealth services for Medicare patients

+

Providing telehealth services at Federally Qualified Health Centers and Rural Health Clinics

Prescribing controlled substances

Reducing or waiving cost-sharing obligations

Last updated: July 7, 2020



mln
BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

[PRINT-FRIENDLY VERSION](#)

TELEHEALTH SERVICES





mln
MEDICARE LEARNING NETWORK

Medicare Learning Network

MEDICARE COVERAGE AND PAYMENT OF VIRTUAL SERVICES

Medicare Coverage and Payment of Virtual Services

40,000 views • May 8, 2020

117

6

SHARE

SAVE

...

CMS

CMSHHISgov

90.7K subscribers

SUBSCRIBE

RHC - CMS Resources

Medicare Claims Processing Manual – Chapter 9 RHC/FQHC Coverage Issues

www.cms.gov/manuals/downloads/clm104c09.pdf

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

[www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf](http://www.cms.gov/Regulations-and%20Guidance/Guidance/Manuals/Downloads/bp102c13.pdf)

Medicare Claims Processing Manual UB04 Completion

www.cms.gov/manuals/downloads/clm104c25.pdf

- Medicare Benefit Policy Manual- Chapter 15 Other Services

- [www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c15.pdf](http://www.cms.gov/Regulations-and%20Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)

RHC - CMS Resources

Virtual Communication FAQ

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>

State Operations Manual Appendix G (Updated 1.2.18)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf

Provider-Based Rules (42 CFR 413.65)

<https://www.law.cornell.edu/cfr/text/42/413.65>

Reference

- Centers for Medicare and Medicaid Services. [MLN 20016 Revised](#). “New and Expanded Flexibilities for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)”. April 30, 2020.
- Health and Human Services. “[HHS OIG Policy Statement on Practitioners That Reduce, Waive Amounts Owed by Beneficiaries for Telehealth Services During the COVID-19 Outbreak](#).” <https://oig.hhs.gov>. March 2020.

CMS Resources

Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) FAQ

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>

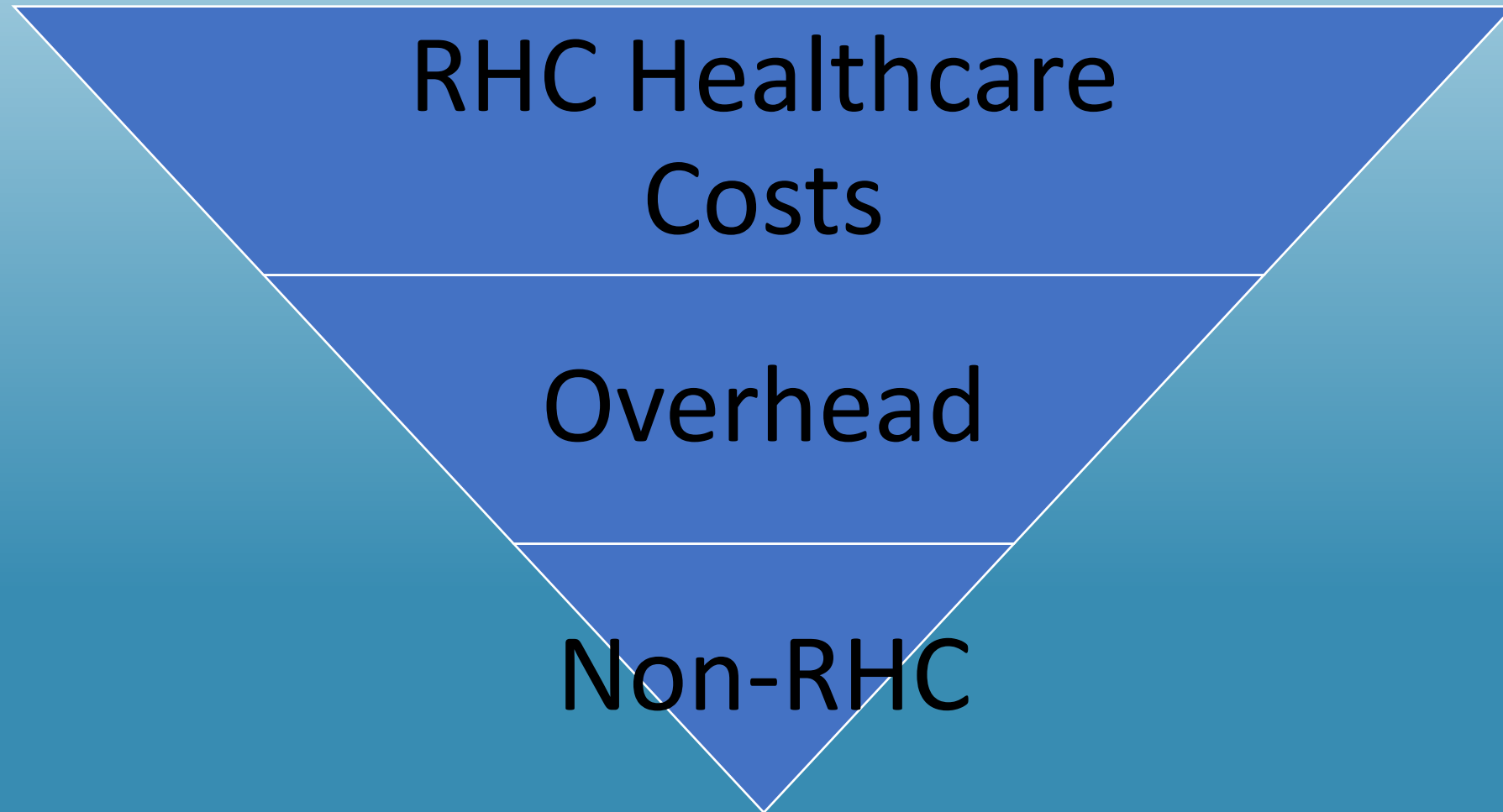
Virtual Communication FAQ

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>

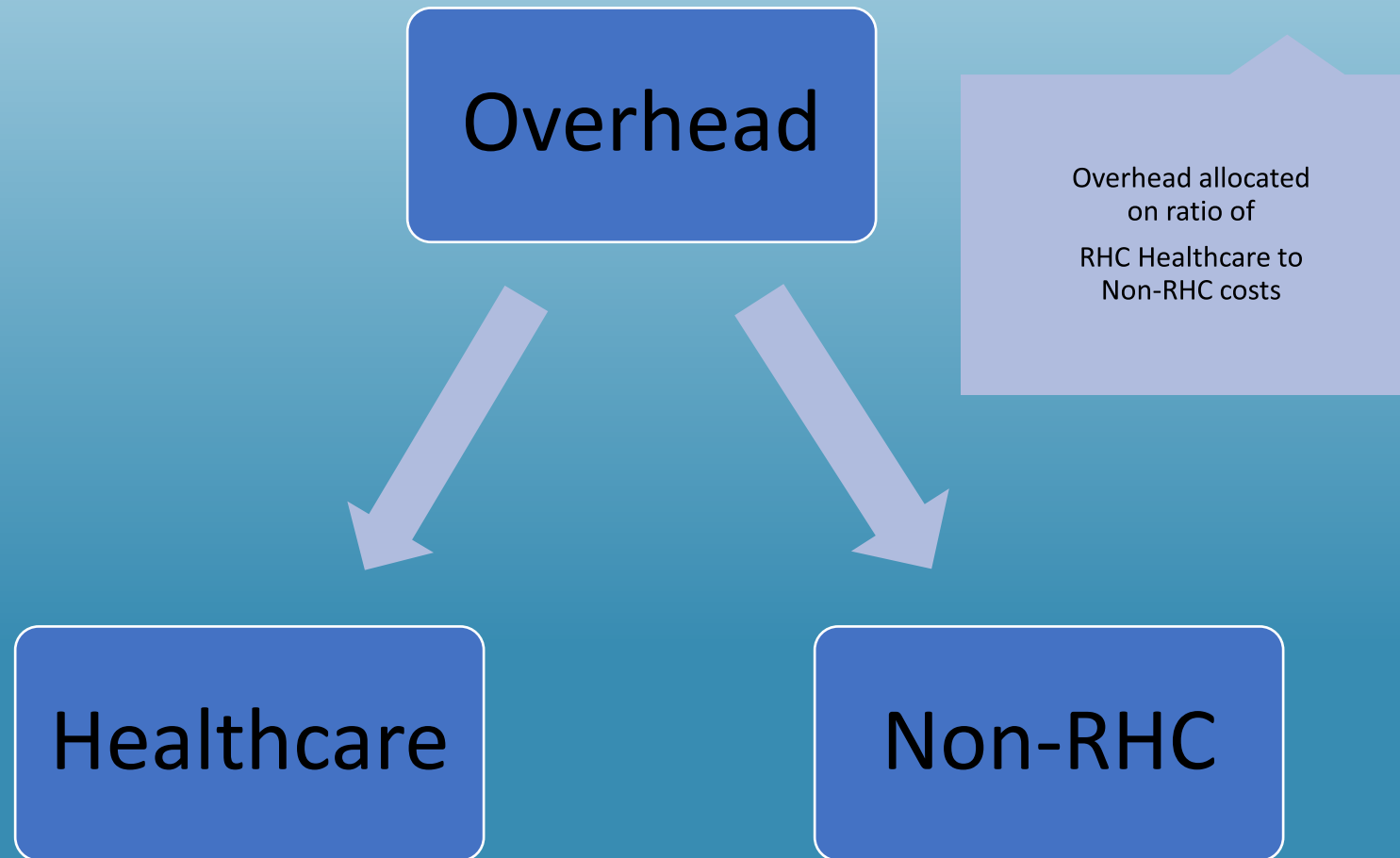
First the basics...How is the RHC rate calculated?

$$\text{RHC COSTS} / \text{RHC VISTS} = \text{RHC RATE}$$

COSTS – WORKSHEET A/M-1



Overhead allocations



Where do we put Telehealth?

Cost of providing telehealth services must be classified in the Non-RHC section on Line 79 for Independent, Line 25.01 Provider Based

Exclude or Reclassify?

- Does it use overhead at the clinic? (space, staff, etc.)
 - RECLASSIFY!
- If it is a non-allowable expense that does not use overhead:
 - EXCLUDE!

Exclude or Reclassify?

- For telehealth – if using the clinic's EMR, billers, front desk, referral coordinators, etc., you may need to reclassify direct cost.
- If telehealth visits are performed by the provider from their home, an exclusion with limited overhead components may be appropriate.
- Discuss with your RHC cost report expert

Telehealth costs are Non-RHC

For reclassifications:

- Only allocate DIRECT costs
 - Practitioner wages
- Overhead will allocate through the cost report

Telehealth – Direct Expense Calculations

- Method A – Actual time spent
 - Practitioners performing telehealth visits keep time studies of actual time spent
 - Allocate % of time for telehealth carve out for practitioners performing telehealth visits
 - Time studies of practitioners to support the allocated carve out

Telemedicine Tracking Log

Legend:

Type of Service Categories

[illegible]

V	Virtual check in
---	------------------



Telehealth – Direct Expense Calculations

- Method B – Use average time based on partial time studies or EMR records – if available
 - Multiply by number of codes performed
 - Multiply by average hourly wage
- Reclassify resulting non-RHC wages into non-reimbursable cost center

VISITS – WORKSHEET B/M-2

- Definition: Face-to-face encounter with qualified provider during which RHC services are performed.
- Telehealth visits are paid outside of the RHC rate.
- **Telehealth visits are NOT reported as an RHC visit on worksheet B**

FTE – RHC Clinical Hours only...

- FTE is based upon how many hours the practitioner is available to provide RHC patient care
- Telehealth is paid outside of the RHC rate; thus, time spent performing telehealth visits **does not count toward available time for FTE calculations.**
- Exclude telehealth time from RHC FTE calculations

FTE – RHC Clinical Hours only...

- If after carving out telehealth hours you still have COVID related FTE productivity standard issues, please contact your MAC.
- Each MAC has indicated their intent to waive the productivity standard for 2020, when requested
- Reminder - Exclude telehealth time from RHC FTE calculations, THEN, if still needed request an exception

Questions?