

Summary of CMS Regulations Issued on March 30, 2020 with New Information in Red for RHCs

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Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

1. Expansion of Virtual Communication Services Furnished by RHCs and FQHCs

a. Background

RHC and FQHC visits are face-to-face (in-person) encounters between a patient and an RHC or FQHC practitioner during which time one or more RHC or FQHC qualifying services are furnished. RHC and FQHC practitioners are physicians, NPs, PAs, certified nurse midwives, clinical psychologists, and clinical social workers, and under certain conditions, a registered nurse (RN) or licensed practical nurse furnishing care to a homebound RHC or FQHC patient. A Transitional Care Management service can also be an RHC or FQHC visit. A Diabetes Self-Management Training (DSMT) service or a Medical Nutrition Therapy (MNT) service furnished by a certified DSMT or MNT provider may also be an FQHC visit.

RHCs are paid an all-inclusive rate (AIR) for medically-necessary, face-to-face visits with an RHC practitioner. The rate is subject to a payment limit, except for those RHCs that have an exception to the payment limit for being “provider-based” (see § 413.65). FQHCs are paid the lesser of their actual charges or the FQHC PPS rate for medically-necessary, face-to-face visits with an FQHC practitioner. Only medically-necessary medical, mental health, or qualified preventive health services that require the skill level of an RHC or FQHC practitioner can be RHC or FQHC billable visits.

The RHC and FQHC payment rates reflect the cost of all services and supplies that an RHC or FQHC furnishes to a patient in a single day, and are not adjusted for the complexity of the patient health care needs, the length of the visit, or the number or type of practitioners involved in the patient’s care. Services furnished by auxiliary personnel (such as nurses, medical assistants, or other clinical personnel acting under the supervision of the RHC or FQHC practitioner) are considered to be incident to the visit and are included in the per-visit payment. This may include services furnished prior to or after the billable visit that occur within a medically appropriate time period, which is usually 30 days or less.

RHCs and FQHCs are also paid for care management services, including chronic care management services, general behavioral health integration services, and psychiatric Collaborative Care Model services. These are typically non-face-to-face services that do not require the skill level of an RHC or FQHC practitioner and are not included in the RHC or FQHC payment methodologies.

In the CY 2019 PFS proposed rule (83 FR 35863), we proposed separate payments to RHCs and FQHCs for certain CTBS referred to as “Brief Communication Technology-Based Services” for a “virtual check-in” and separate payment for remote evaluation of recorded video and/or images. “Virtual check-ins” are brief (5 to 10 minutes), non-face-to-face check ins with a patient via communication technology to assess whether the patient’s condition necessitates an office visit. This service could be billed only in situations where the medical discussion was for a condition not related to an RHC or FQHC visit furnished within the previous 7 days, and does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment. We also proposed payment for remote evaluation of patient-transmitted information conducted via pre-recorded “store and forward” video or image technology, including interpretation with

verbal follow-up with the patient within 24 business hours. We had proposed that payment would be made if the remote evaluation did not originate from a related RHC or FQHC visit furnished within the previous 7 days, or lead to an RHC or FQHC visit within the next 24 hours or soonest available appointment.

In the CY 2019 PFS final rule (83 FR 59683), we finalized requirements and payment for RHCs and FQHCs furnishing Virtual Communication Services. Effective January 1, 2019, RHCs and FQHCs are paid for Virtual Communication Services HCPCS code G0071 *Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an RHC or FQHC practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only*). HCPCS code G0071 is on an RHC or FQHC claim, either alone or with other payable services, and at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year, and the medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment. We added a new paragraph (e) to 42 CFR 405.2464 to reflect this payment.

HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services) and is updated annually based on the PFS national non-facility payment rate for these codes. RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient. Coinsurance and deductibles apply to RHC claims for HCPCS code G0071 and coinsurance applies to FQHC claims for HCPCS code G0071.

b. Improving Access to Care Management and Virtual Communication Services Furnished by

RHCs and FQHCs

RHCs and FQHCs furnish services in rural and urban areas that have been determined to be medically underserved areas or health professional shortage areas. They are an integral component of the Nation's health care safety net, and we want to ensure that Medicare patients who are served by RHCs and FQHCs are able to communicate with their RHC or FQHC practitioner in a manner that enhances access to care, consistent with evolving medical care.

Particularly in rural areas where transportation is limited and distances may be far, we believe the use of CTBS may help some patients to determine if they need to schedule a visit at the RHC or FQHC. If it is determined that a visit is not necessary, the RHC or FQHC practitioner would be available for other patients who need their care.

In the CY 2019 PFS final rule (83 FR 59452), we finalized payment for new online digital assessment services, also referred to as "E-Visits," for practitioners billing under the PFS. These are non-face-to face, patient-initiated communications using online patient portals. An online patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an Internet connection by using a secure username and password. These digital assessment services are for established patients who require a clinical decision that otherwise typically would have been provided in the office. To minimize risks associated with exposure to COVID-19, and to provide the best care possible during the PHE for the COVID-19 pandemic, we believe that RHCs and FQHC practitioners, like many other health care providers, should explore the use of interactive communications technology in the place of services that would have otherwise been furnished in person and reported and paid under the established methodologies.

To facilitate the ability of RHCs and FQHCs to take such measures when appropriate, on an interim basis, we are expanding the services that can be included in the payment for HCPCS code G0071, and update the payment rate to reflect the addition of these services. Specifically, we are adding the following three CPT codes:

- 99421 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*)
- 99422 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes*)
- 99423 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes*)

We are revising the payment rate for HCPCS code G0071 to include the national non- facility payment rates for these three new codes. Effective for services furnished on or after March 1, 2020 and throughout the PHE for the COVID pandemic, the payment rate for HCPCS code G0071 will be the average of the PFS national non-facility payment rate for HCPCS code G2012 (communication technology-based services), HCPCS code G2010 (remote evaluation services), CPT code 99421, CPT code 99422, and CPT code 99423. The RHC and FQHC face- to-face requirements are be waived for these services. Section 405.2464 (e) establishes payment for communication technology-based and remote evaluation services, and no regulatory changes are required.

The services that are payable using HCPCS code G0071 require that the beneficiary has been seen by an RHC or FQHC practitioner during the previous 12 months. Under the current PHE for the COVID-19 pandemic, we believe that it is necessary to make these services available to beneficiaries who would otherwise not have access to clinically appropriate in- person treatment. Therefore, during the PHE for the COVID-19 pandemic, we are finalizing that all virtual communication services that are billable using HCPCS code G0071 will also be available to new patients that have not been seen in the RHC or FQHC within the previous 12 months. Also, in situations where obtaining prior beneficiary consent would interfere with the timely provision of these services, or the timely provision of the monthly care management services, during the PHE for the COVID-19 pandemic consent can obtained when the services are furnished instead of prior to the service being furnished, but must be obtained before the services are billed. We will also allow patient consent to be acquired by staff under the general supervision of the RHC or FQHC practitioner for the virtual communication and monthly care management codes during the PHE for the COVID-19 pandemic. These changes are consistent with the flexibilities were are establishing for similar services paid under the PFS as described in section II.D. of this IFC.

2. Revision of Home Health Agency Shortage Area Requirements for Furnishing Visiting

Nursing Services a. Background

Sections 1861(aa)(1)(A) and (B) of the Act describes RHC and FQHC services as services and supplies furnished by a physician, PA, NP, clinical psychologist clinical social worker; and items and services furnished incident to these services, and specifies requirements for these practitioners and services.

In the case of an RHC or FQHC that is located in an area in which there exists a shortage of HHAs, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) are authorized under section 1861(aa)(1)(C) of the Act. These services can be furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment that is established

and periodically reviewed by an RHC or FQHC physician, or established by a NP or PA and periodically reviewed and approved by the RHC or FQHC physician.

In § 405.2416, we specify that visiting nurse services are covered if all of the following are met:

- The RHC or FQHC is located in an area in which the Secretary has determined that there is a shortage of HHAs;
- The services are rendered to a homebound individual;
- **The services are furnished by a registered professional nurse or licensed practical nurse that is employed by, or receives compensation for the services from the RHC or FQHC;**
- The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the RHC or FQHC; or established by an NP, PA or certified nurse midwife (CNM); and reviewed at least every 60 days by a supervising physician. The written plan of treatment must be signed by the supervising physician, NP, PA or CNM of the RHC or FQHC.

Nursing care that is covered by this section includes services that must be performed by a registered professional nurse or licensed practical nurse if the safety of the patient is to be assured and the medically desired results achieved; and personal care services, to the extent covered under Medicare as home health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to take medications. Household and housekeeping services or other services that would constitute custodial care are not covered.

Section 405.2416 also defines “homebound” as an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition, or if the individual leaves the place of residence infrequently. **It does not include a hospital or long term care facility.**

In Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13, section 190, we further describe RHC and FQHC visiting nursing services as skilled nursing services that require the skills of a nurse based on the complexity of the service (for example, intravenous and intramuscular injections or insertion of catheters), the condition of the patient (for example, a non-skilled service that, because of the patient’s condition, can only be safely and effectively provided by a nurse), and accepted standards of medical and nursing practice. All services must be reasonable and necessary to the diagnosis and treatment of the patient’s illness or injury within the context of the patient’s unique medical condition, and a service that can be safely and effectively self-administered or performed by a nonmedical person without the direct supervision of a nurse, is not considered a skilled nursing service, even if provided by a nurse. A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient’s family, or other caregivers.

If a patient needs skilled nursing care and there is no one trained or able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury. We also specify that the determination of whether visiting nurse services are reasonable and necessary is made by the physician based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

The requirements for furnishing visiting nursing services include that the patient is considered to be “confined to the home” as defined in section 1835(a) of the Act and that the RHC or FQHC is located in an area that has a shortage of HHAs. The services and supplies must be provided under a written plan of treatment; are furnished on a part-time or intermittent basis only; and drugs and biological products are not provided.

Chapter 13 of the Medicare Benefit Policy Manual, section 190, specifies the requirements for HHA shortage areas for purposes of visiting nursing services furnished by RHCs and FQHCs. The RHC or FQHC must be currently located in a county, parish or similar geographic area in which the Secretary has determined that there is no participating HHA under Medicare; or adequate home health services are not available to RHC or FQHC patients even though a participating HHA is in the area; or, there are patients whose homes are not within the area serviced by a participating HHA; or considering the area's climate and terrain, whose homes are not within a reasonable traveling distance to a participating HHA. RHCs and FQHCs that are located in an area that has not been determined to have a current HHA shortage and are seeking to provide visiting nurse services must make a written request to the appropriate CMS Regional Office along with written justification that the area it serves meets the required conditions.

b. Revision of Home Health Agency Shortage Area Requirements for Furnishing Visiting Nursing Services

To address the PHE for the COVID-19 pandemic and its impact on underserved rural and urban communities, we are implementing, on an interim basis, changes to the requirements for visiting nursing services furnished in the home by RHCs and FQHCs.

Section 405.2416(a)(1) states that visiting nurse services are covered if the RHC or FQHC is located in an area in which the Secretary has determined that there is a shortage of HHAs, and § 405.2417 provides additional requirements for an area to be determined to have a shortage of HHAs. During the PHE for the COVID-19 pandemic, we believe the need for visiting nursing services furnished by RHCs or FQHCs may increase. **Therefore, for the duration of the PHE for the COVID-19 pandemic, we are determining that any area typically served by the RHC, and any area that is included in the FQHCs service area plan, is determined to have a shortage of HHAs, and no request for this determination is required.**

We believe this flexibility is important for patient access to nursing services in the home and the potential for HHAs to be overwhelmed during PHE for the COVID-19 pandemic. However, RHCs and FQHCs should check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care. **If a patient is under a home health plan of care, the HHA must provide optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs (§ 484.105). Therefore, RHC/FQHC visiting nurse services would not be covered by Medicare if such services are found to overlap with a 30- day period of home health care. We note that an RHC/FQHC visiting nurse service solely to obtain a nasal or throat culture would not be considered a nursing service because it would not require the skills of a nurse to obtain the culture as the specimen could be obtained by an appropriately-trained medical assistant or laboratory technician. However, during an otherwise covered RHC/FQHC visiting nurse service, the nurse could obtain the nasal or throat culture to send to the laboratory for testing.**

Section 405.2416(a)(2) states that visiting nursing services are rendered to a homebound individual, and § 405.2416(d) states that homebound means an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition, and that the individual may be considered homebound if he or she leaves the place of residence infrequently. **We refer the reader to**

the definition of “homebound” as it pertains the PHE for the COVID-19 pandemic in section II.F. of this IFC, Clarification of Homebound Status under the Medicare Home Health Benefit.

c. Regulatory Changes

To make available additional visiting nursing services during the PHE for the COVID-19 pandemic in areas served by RHCs and FQHCs, we are revising, on an interim basis, § 405.2416 to add paragraph (a)(5), to state that during the PHE for the COVID-19 pandemic, an area typically served by the RHC, and an area that is included in the FQHC’s service area plan, is determined to have a shortage of HHAs, and no request for this determination is required.

Thank you for reading this document. We will add to it as we find out more. If you have corrections, additional questions, or want to elaborate on any of the information, please let us know by emailing Mark Lynn at marklynnrhc@gmail.com. To keep up with the latest information, join our Facebook Group at <https://www.facebook.com/groups/1503414633296362/> and we will post daily updates on our website at <http://www.ruralhealthclinic.com/covid19>. Best wishes and stay safe.